EC No. 982

ESTIMATES COMMITTEE

(1981-82)

TWENTY-SECOND REPORT

(SEVENTH LOK SABHA)

MINISTRY OF HEALTH AND FAMILY WELFARE
CENTRAL GOVERNMENT HEALTH SCHEME

Presented to Lok Sabha on.....

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INTRODUCTION

I, the Chairman of Estimates Committee having been authorised by the Committee to submit the Report on their behalf, present this Twenty-Second Report on the Ministry of Health and Family Welfare—Central Government Health Scheme.

2. The Committee took evidence of the representatives of the Ministry of Health and Family Welfare on 10, 11, 16 and 18 December, 1981. The Committee wish to express their thanks to the Officers of the Ministry for placing before them the material and information which they desired in connection with the examination of the subject and giving evidence before the Committee.

3. The Committee also wish to express their thanks to the representatives of the following Organisations/Associations and individuals for giving evidence and making valuable suggestions to the Committee :—

(i) Bharat Pensioners Samaj, New Delhi;
(ii) Common Cause (An Organisation for ventilating common problems of the people), New Delhi;
(iii) Confederation of Central Secretariat Service Associations, New Delhi;
(iv) Central Secretariat Section Officers Association, New Delhi;
(v) Central Government Officers' Association; Hyderabad Estate Residents, Bombay;
(vi) Central Government Class IV Employees Association, New Delhi;
(vii) All India Para-Medical Staff Association, New Delhi;
(viii) Dr. V. Ramalingaswamy, Director General, Indian Council of Medical Research, New Delhi;
(ix) All India CGHS Medical Officers Association, New Delhi.
(x) Shri Indradeep Sinha, M.P.;
(xi) Shri Jyotirmoy Bosu, M.P.

4. The Committee also wish to express their thanks to all other institutions, associations, bodies and individuals, who furnished memoranda on the subject to the Committee.

5. The report was considered and adopted by the Committee on 17 March, 1982.

6. For facility of reference the recommendations/observations of the Committee have been printed in thick type in the body of the Report. A summary of the recommendations/observations is appended to the Report (Appendix II).

S. B. P. PATTABHI RAMA RAO,
Chairman,
Estimates Committee

NEW DELHI
March 22, 1982
Chaitra 1, 1904 (*Saka*)

CHAPTER I

INTRODUCTORY

1.1 The Central Government Health Scheme (CGHS), formerly known as Contributory Health Scheme was introduced in Delhi on the 1st July, 1954. Prior to the introduction of the C.G.H.S., the Central Govt. servants and Members of their families were entitled to free Medical aid under the Civil Services (Medical Attendance) Rules. Under these rules, the Govt. Servants had first to incur the expenditure and then claim reimbursement. This system of reimbursement was a great hardship especially to the low-paid Government Servants as it involved procedural delays in the settlement of the claim. The CS(MA) Rules had also many limitations for the low-paid Central Govt. Servants in regard to entitlement to domiciliary visits, specialists consultation etc. The CGHS was introduced to remove the defects mentioned above and to provide more efficient and comprehensive medical care. Partly to meet the higher cost of the extended Scheme and partly to inculcate the idea of partnership in the social security measure, Govt. Servants are required to make a monthly contribution on a graded scale. The lowest paid Government servants are entitled to enjoy the same medical benefits as those at the highest levels.

1.2 C.G.H.S. which was initially meant for the Central Govt. Employees was later extended to various other categories of people, such as members of Parliament, ex-members of Parliament, Central Government pensioners and their families.

Objectives

1.3 The main objective of the CGHS is to provide comprehensive facilities for medical care, treatment under different system of medicine and family planning services through dispensaries, hospitals and domestic visits as deemed necessary for the health care of the beneficiaries. It also aims at doing away with the cumbersome and expensive system of medical reimbursement.

1.4 In a written reply the Ministry stated that "The objectives of the Scheme have been achieved to a large extent." During the 25 years since its inception it has expanded horizontally as well as vertically. On the one hand its coverage has been extended to 15 cities benefiting over 5½ lakhs families. A wide range of facilities and services are provided under the Scheme.

1.5 The Ministry has also stated that arrangements have been made at selected functioning dispensaries in all cities to provide round-the-clock services and medical aid in emergency. In this way the beneficiaries get comprehensive medical care and treatment facilities. The beneficiaries can also avail of facilities under Allopathy, Homoeopathy and the Indian Systems of Medicine.

1.6 In a number of memoranda submitted to the Committee, it has been stated that the working of CGHS dispensaries is very unsatisfactory. In a memorandum it is alleged that "CGHS is a monument of gross inefficiency,

corruption, mismanagement, negligence, and it has failed to fulfil its objectives."

1.7 In their memorandum to the Committee Members of Parliament have also made critical references to the various aspects of the working of CGHS dispensaries.

1.8 Asked to comment upon the CGHS beneficiaries impressions about the working of the Scheme, the Ministry stated that "it is not correct to say that CGHS is a monument of gross inefficiency, corruption, mismanagement, negligence and it has failed to fulfil its objectives." It is a fact that CGHS has provided comprehensive facilities for medical care and treatment under allopathic, Ayurvedic, Unani and homoeopathic and Siddha systems of medicine. The range of facilities provided by it has widened and also it is now operating in 15 cities benefiting about 5½ lakh families." The Ministry has further stated that "Efforts are always made to improve its functioning. With the rising population of CGHS beneficiaries and inadequate outlay of funds, the objective may not have been achieved to the desired extent. It may also be mentioned that there is a general wish that more and more CGHS dispensaries should be opened and that the CGHS should be extended to areas where it is not in operation at present."

1.9 Secretary (Health) stated in evidence that besides providing comprehensive facilities for medical care, treatment under different systems of medicine, and family planning services, the CGHS has done away with the cumbersome and expensive system of medical reimbursement. Under the old System (Civil Services Medical Attendance Rules) Government servants had to incur expenditure and seek reimbursement. This was a real hardship for low-paid employees. Also, under the old system there was no arrangement for domiciliary visits for low-paid employees. Health Secretary stated that "we feel that by and large the objectives enunciated have to a large extent been fulfilled. It is a continuous process of improvement and we intend to improve wherever there are shortcomings."

1.10. Dealing with the criticism that the scheme has been very unsatisfactory, the witness further stated in evidence :

> "We feel that it is not an unsatisfactory system. This is proved by the fact that there are more and more demands for extending the system. There is a demand that Delhi State Government employees, Delhi University employees, CSIR employees, Defence Industry employees etc. should also be covered by CGHS.....We have also received requests that the scheme should be extended to a number of other cities also. If the scheme had been functioning very unsatisfactorily, these demands would not be there."

1.11 The Committee enquired whether the Ministry had made any assessment of the Scheme on the basis of which it could be said that the objectives of the Scheme had been fulfilled. The Committee also enquired whether there was any feedback system introduced by the Department or whether any survey had been made of the beneficiaries' experiences through some independent organisation, Health Secretary stated :

> "As regards evaluation or studies, I am given to understand that one study was made in 1975 by the National Institute of

Health and Family Welfare, which was earlier called the National Institute of Health Administration, and Education. A second enquiry was made in 1977 by the Department of Personnel. One can only say there are possibly no clear indicators by which one could base any clear-cut claim."

1.12 The Committee find that the aforesaid studies in 1975 and 1977 were made not to evaluate or assess the achievements of the CGHS with reference to its objectives but only with a view to streamlining the procedures and suggesting measures to minimise waiting time and remove other irritants.

1.13 On the Committee's taking note of the fact that there was no system of monitoring or feedback under the Scheme apart from complaints lodged by the beneficiaries, the witness stated that they had a system of inspections and the working was reviewed in the Consultative Committees.

1.14 During their on-the-spot visits to the Dispensaries, the Committee had observed that in certain dispensaries, there were no Complaint books; where complaint books were there, the complaints recorded therein had not been investigated properly and prompt action was not taken on all the complaints. Referring to their observation during on-the-spot visit, when the Committee observed that the complacency shown by the representatives of the Health Ministry gave the Committee an impression that they did not appear to appreciate the problems facing the beneficiaries, Health Secretary replied that there was no intention to be complacent. He added :

"It is not that we are very happy; I may clarify that. We are always in the process of improving. We want to have all possible suggestions."

1.15 In contrast to the statement made in evidence that by and large objectives have been fulfilled to a large extent, the Ministry had earlier in a written reply stated that "with the rising population of CGHS beneficiaries and inadequate outlay of funds, the objectives may not have been achieved to the desired extent."

1.16 Clarifying the position, Health Secretary stated in evidence :

"We do not mean to say that the objectives have been achieved to a large extent. We do not mean to say that we are happy with the functioning. In fact, a lot of improvements are needed. In terms of medicines we require much more funds for supply. We would like that the patients are not to go away and all the medicines are available in the dispensary and the medicines are of the right standard also and the procedures which are there are cut to the minimum, that the patient is received in a proper atmosphere and the doctors and para-medical staff are polite.....I did not mean to protect and say that we are happy with everything."

1.17 Asked to state whether the Ministry could deny that lack of efficient management and effective control had also contributed to the objectives not being achieved to the desired extent; the witness stated "I think there is considerable scope for improvement."

1·18 Central Government Health Scheme (CGHS) was started in 1954. Prior to the introduction of CGHS, the Central Government servants and their families were entitled to free medical aid under the Central Services (Medical Attendance) Rules. Under those rules they had first to incur expenditure and then claim reimbursement. The old system caused hardship, especially to low-paid Government Servants. The main objective of CGHS is to provide comprehensive facilities for medical care, treatment under different systems of medicine and family planning services and domestic visits as deemed necessary for the health care of the beneficiaries. It has also done away with the cumbersome system of medical reimbursement.

1·19 From a large number of memoranda received by the Committee it appears that the beneficiaries of CGHS are not satisfied with the working of the scheme. A general impression seems to prevail that there is inefficiency, corruption, mismanagement and negligence in the working of the Scheme and that the scheme has failed to fulfil its objectives.

1·20 On the question of fulfilment of the objectives of the Scheme, the mind of the Ministry of Health also does not appear to be quite clear. It has made conflicting statements at various places. At one place the Ministry has stated that it is not correct to say that the Scheme has failed to fulfil its objectives. In the same context the Ministry has made another statement that "with the rising population of the CGHS beneficiaries and inadequate outlay of funds, the objective may not have been achieved to the desired extent." Similar ambivalence is evident in the statements of the Health Secretary made before the Committee in evidence. Defending the working of the Scheme, Health Secretary first stated that "we feel that by and large the objectives enunciated have to a large extent been fulfilled." Subsequently when the shortcomings of the Scheme were highlighted by the Committee, Health Secretary admitted the shortcomings and stated "we do not mean to say that the objectives have been achieved to a large extent." When asked whether the Ministry could deny that lack of efficient management and effective control had also contributed to the objectives not being achieved to the desired extent, the Health Secretary stated that "I think there is considerable scope for improvement."

1·21 The Committee find that the Ministry has made no assessment or evaluation of the Scheme with reference to its objectives. There is no independent feedback system through which it can know the experiences of the beneficiaries. In this context Health Secretary admitted that "there are possibly no clear indicators by which one could base any clear-cut claim" (that the objectives of the Scheme had been fulfilled by and large).

1·22 After an in-depth study of the working of the CGHS in the light of the memoranda received from CGHS beneficiaries and the material placed before them by the Ministry and also after paying on-the-spot study visits to various CGHS dispensaries in and outside Delhi, the Committee have come to the conclusion that the working of CGHS leaves much to be desired; it has failed to provide facilities for medical care and treatment to the satisfaction of the beneficiaries and so has not by and large achieved its objectives. (S. No.1)

1·23 The pleas advanced by the Ministry in support of the Scheme's popularity like the demands for extending it to non-Government employees and to a number of other cities where it is not in force at present, are too specious to carry conviction. The Ministry of Health would do well to shed the com-

placence under which it appears to be labouring at present about the working of the Scheme, and accept the bitter fact that CGHS has not come upto the expectations of its beneficiaries. Unless the Ministry sees the Scheme through the eyes of its beneficiaries, it will not be able to get the true picture and will lose one more opportunity to set things right. (S. No. 2)

1·24 The Committee also recommend that working of the Scheme as a whole should be evaluated at periodical intervals through an independent institution in the context of the objectives of the Scheme. Unless the Ministry organises such an evaluation, it cannot know the shortcomings of the scheme and will not be able to take corrective action in time. (S. No. 3)

1·25 There is a great lacuna in the Scheme. The Ministry has not instituted any feedback system through which it can contemporaneously know the failures and weaknesses of the Scheme and the beneficiaries' impressions on the working of the Scheme. Complaint registers do not serve this purpose. The Committee would like the Ministry to evolve a proper feedback system to invite reactions of a cross-section of beneficiaries from time to time and take serious note of their views and problem. (S. No. 4)

CHAPTER II

CGHS DISPENSARIES—GENERAL

A. C.G.H.S. Dispensaries

2.1 C.G.H.S. Dispensaries provide medical attendance at dispensaries as well as at the residence of patients. Of necessity, dispensaries have been so located that patients do not find it a great distance to travel to and fro the dispensaries. On an average a dispensary, has to cover an area of about three kilometres radius. The Scheme covers the following cities at present :

1. Delhi (inclusive of areas in Ghaziabad, Faridabad and Gurgaon).
2. Bombay
3. Allahabad
4. Meerut
5. Kanpur
6. Calcutta
7. Nagpur
8. Madras
9. Hyderabad
10. Bangalore
11. Patna
12. Pune
13. Jaipur
14. Lucknow
15. Ahmedabad.

2.2 The various categories of dispensaries functioning under C.G.H.S. are :

(a) Allopathic dispensaries which function during the normal working hours only.

(b) Allopathic "functioning" dispensaries which provide 24 hour services.

(c) Homoeopathic & *ISM Units, which are normally attached to the allopathic dispensaries for administrative purposes.

(d) A few independent homoeopathic & ISM dispensaries are also in existence in Delhi & some of the cities.

2.3 Details of CGHS facilities available in the metropolitan cities of Delhi, Bombay, Calcutta and Madras are as follows :—

	Delhi	Bombay	Caluctta	Madras
1	2	3	4	5	6
1.	No. of Allopathic Disp . .	75	22	12	1 6
2.	„ Ayurvedic Disp. .	5	—	1	—
3.	„ Ayurvedic Units . .	3	3	—	1
4.	„ Homeo. Disp . .	3	—	1	—
5.	„ Homeo. Units . .	6	3	—	1

*Indian systems of Medicines.

1	2	3	4	5	6
6.	„ Unani Disp . .	1	—	—	—
7.	„ Unani Units . .	1	—	—	—
8.	„ Sidha Units . .	—	—	—	1
9.	„ Poly Clinics . .	2	1	1	—
10.	„ CGHS laboratories .	23	15	3	2
11.	„ CGHS Hospitals .	4*	—	—	—
12.	Hospitalisation at other Govt. Hospitals	2	5 Hospitals	(Nil treated like other citizens)	15
13.	Hospitalization at Private Hospitals	5	8 Hospitals	—	3

*Four CGHS Hospitals include 2 Police Hospitals, 1 Ayurvedic Hospital & 1 Maternity Hospital.

(i) *Criteria for Setting up dispensaries*

2.4 As per existing criteria a dispensary can be opened for a minimum of 2000 beneficiary families residing within a distance of about 3 kms. from the proposed dispensary premises. For starting a Scheme in cities where CGHS is not in operation, a minimum of three dispensaries are necessary to make it economically viable.

(ii) *Workload Per Dispensary*

2.5 It is seen from the material furnished by the Ministry that a workload of 2000—2500 families per dispensary is the desired scale prescribed for the dispensaries. Where the workload exceeds 2500, opening of new dispensary is considered.

2.6 The number of families (i.e. No. of Card Holders) registered with the dispensaries in each of the 15 Cities during the year 1980-81, are given in Appendix I.

2.7 The position of card holders attached to these dispensaries has been analysed as follows :

Name of the City	No. of Dispensaries	No. of dispensaries having upto 2500 beneficiary families	No. of dispensaries having 2500 to 4000 beneficiary families	No. of dispensaries having more than 4000 beneficiary families
1 2	3	4	5	6
1. Ahmedabad	3	3	—	—
2. Bangalore	7	—	5	2
3. Lucknow	3	1	2	—
4. Meerut	5	4	1	—
5. Madras	10	4	4	2
6. Bombay	22	11	6	5
7. Pune	5	3	2	—
8. Jaipur	4	3	1	—
9. Nagpur . . .	9	6	3	—
	68	35	24	9

1	2	3	4	5
	68	35	24	9
10. Hyderabad	10	5	2	3
11. Allahabad	5	1	2	2
12. Calcutta	12	2	5	5
13. Patna	5	2	3	—
14. Kanpur	8	3	5	—
15. Delhi	72	16	28	28
Total	180	64	69	47

2.8 It is seen from the table above that out of 72 dispensaries in Delhi, the workload in 56 dispensaries was more than the prescribed scale of 2500 families in 1980-81: In 11 dispensaries it was more than twice the prescribed workload, the maximum number was 13391 in Kingsway Camp dispensary (Delhi). The position was no different in many of the dispensaries in Bangalore, Madras, Bombay, Hyderabad, Allahabad and Calcutta. At the same time there were a number of dispensaries which had much less workload than the prescribed scale.

2.9 As many as 28 out of 72 dispensaries in Delhi and 19 dispensaries outside Delhi had more than 4000 card-holders in 1980-81. Some of these dispensaries in Delhi were Kingsway Camp Dispensary with a maximum number of 13391 card-holders, G.K.G. (7847), Sadiq Nagar (7497), Srinivaspuri (7045), Shahdara (6683), Kalkaji (6375), Devnagar (6097), Netajinagar (5816), Kidwai Nagar (5667), Rajouri Garden (5659), Nangal Raya (5219) and Janakpuri (5071) card-holders. Similarly, in Bombay, dispensaries having more than 4000 card-holders include two dispensaries of Santacruz (7430 card-holders) and Chembur (5566 card-holders).

2.10 It has been represented to the Committee that certain dispensaries are catering to a very vast area resulting in inconvenience to patients in travelling a long distance and are overcrowded.

2.11 The Ministry has stated that the following factors are responsible for overcrowding in the dispensaries :

(i) the dispensaries work for 3½ hours in the morning and 2½ hours in the evening. The office goers and the non-office-goers compete for these times with the result that there is overcrowding.

(ii) Shortage of Medical Officers.

(iii) In some dispensaries, the number of beneficiaries is more than 30,000 the maximum envisaged by Staff Inspection Unit of Ministry of Finance.

2.12 It has been stated by the Ministry that the following steps are being taken :

1. Recruitment of Medical Officers is made on "monthly wage basis" outside Delhi.

2. Opening of new dispensaries where the number of beneficiaries are double or more than the usual prescribed scale of 2500 families per dispensary.

2.13 Asked to state whether the Ministry had any plan to bring down the workload per dispensary to the prescribed level or to bring about equalisation of the workload, wherever it was possible, the Ministry stated that in the Sixth Five Year Plan an amount of Rs. 1200 lakhs, has been

provided for opening of more dispensaries and augumentation of existing staff in various city units. These measures are aimed at bringing down coverage to additional beneficiaries as far as possible.

2.14 On the question of bringing down the workload per dispensary to the prescribed level the representative of the Ministry of Health explained during evidence :

> "There is a scale of strength sanctioned. But we must go by other considerations *viz.* no beneficiary should have to go more than 3 Kms. Within that 3 Kms. if the number of beneficiaries goes up, to that extent, we have to open more dispensaries. But then there is the problem of space."

2.15 Health Secretary added that "It cannot be on mathematical basis. It depends upon the density of the population."

2.16 The Committee pointed out that in certain dispensaries there was much over-crowding which resulted in inefficiency and wastage of time of beneficiaries. The Committee asked whether it would not be desirable to relieve congestion by opening more dispensaries particularly in localities where lower-paid staff lived, Health Secretary stated in evidence :

> "The observation made is very well taken. We cannot merely go by the distance formula of 3 Km, where the density of low-paid employees is high. We cannot merely add doctors and think that the problem will be solved. We should always try to split up and have more dispensaries. An effort is being made in this direction, but we need to make a more positive and imaginative approach to it and take care of such needs."

(iii) *Allocation of Doctor along Dispensaries*

2.17 From the information furnished by the Ministry for the year 1980-81, it is seen that average number of patients per doctor per day ranges as follows :

Doctor-patient ratio

	Range of patients* per doctor
Ahmedabad	12—25
Bangalore	36—53
Lucknow	21—36
Meerut	37—100
Madras	41—80
Bombay	33—85
Pune	12—65
Jaipur	92—107
Nagpur	48—159
Hyderabad	37—99
Allahabad	5—23
Calcutta	13—81
Patna	44—58
Kanpur	5—59
Delhi	39—146

*At the time of factual verification (March, 1982) the Ministry has corrected the figures as follows :—

Lucknow (17-37), Meerut (44-83), Madras (36-97), Bombay (33-104), Jaipur (57-107), Nagpur (71-149), Allahabad (53-79), Calcutta (11-78), Patna (40-59), Kanpur (21-52) and Delhi (20-157).

2.18 This table shows that there is no uniformity in the scale of doctors sanctioned for the various dispensaries. Doctors-patient ratio in almost all the cities varies sharply from dispensary to dispensary. It fluctuates from 1 : 12 to 1 : 25 in Ahmedabad, 1 : 48 to 1 : 59 in Nagpur, 1 : 12 to 1 : 65 in Pune, 1 : 33 to 1 : 85 in Bombay and 1 : 39 to 1 : 146 in Delhi. In certain dispensaries of Allahabad, Kanpur, Lucknow, Ahmedabad, Pune, Calcutta, average number of patients per doctor comes to less than 21, the least being 5 patients per day per doctor in Allahabad and Kanpur.

2.19 The Ministry informed the Committee that no norm in regard to doctor-patient ratio had been laid down for general guidance. The Staff Inspection unit (SIU) of the Ministry of Finance had suggested in its 1977 report that a doctor should on an average give a time of four minutes per patient in the CGHS dispensaries. Based on the assumption, the norm for the strength of doctors was linked to the number of beneficaries attached to the dispensaries. Thus number of doctors required for a dispensary are sanctioned according to the SIU norms. Sometime Staff have to be diverted at short notice from one dispensary to another in public interest like sudden absence, heavy rush etc. for a short duration. Besides recruitment of Medical Officers' and opening of dispensaries, a proposal to introduce the 12 hour continuous working of CGHS Dispensaries is under consideration.

2.20 As regards the ideal size of a dispensary, the Ministry added that "There cannot be any ideal size of a dispensary which can be prescribed. The number of cards attached to a dispensary varies according to the density of population of beneficiaries, the morbidity rate in different socio-economic groups affective daily average attendance. However, a dispensary normally caters for 2000—2500 card holders."

2.21 The following suggestions have been made to the Committee that for proper doctor-patient relationship on family doctor lines,

(1) not more than 1500 families should be attached to each dispensary, and

(2) There should be not more than 75 patients per doctor per working session.

2.22 As regards the second suggestion, the representative of the Health Ministry informed the Committee in evidence that, excluding leave reserves, the average medical attendance in Delhi came to 68—78 per medical officer. He added that the norm in Delhi was, therefore, already the same as suggested above.

2.23 In a written reply sent before the evidence, the Ministry of Health had informed the Committee that in terms of the norm of 4 minutes per patient as recommended by Staff Inspection Unit, a medical officer can see 90 patients per day. However 20% of the time has to be given for work not connected with the examination of the patient. "As such 75 patients per day per doctor seems to be ideal. It would, however, be difficult to implement this recommendation due to financial and other constraints."

2.24 As regards doctor-patient ratio in Ahmedabad and other cities, Health Secretary stated in evidence that :

> "Enough number of patients in Ahmedabad are not available since P&T which was to participate has not participated and on that basis the dispensaries have been set up.....So, the doctor-patient ratio varied there, compared to other cities. There are many reasons for variations in the ratio in other cities.
>
> The dispensaries are opened on the basis of norms suggested by the Staff Inspection Unit, which carries out a study of the work-load and sets the norms. Doctors are sanctioned on the basis of these norms."

2.25 The witness added :—

> "The number of dispensaries where the ratio is over 1:100 are few; and efforts are constantly afoot to bifurcate such dispensaries. It is a continuous process. In some dispensaries, the ratio is very low, because the morbidity pattern in high-income groups is comparatively low. This is so, e.g. in the Telegraph Lane dispensary in Delhi."

2.26 Asked whether the Ministry had arrived at any optimum ratios in respect of (i) Doctor-card holder ratio (ii) Doctor-beneficiaries ratio. the Secretary, Ministry of Health, stated that—

> "The Ministry has not laid down any norms with regard to the doctor-patient ratio. Such norms are laid down with regard to doctor-beneficiary ratio, because we cannot anticipate how many patients will come to the dispensary. But it is according to the card-holders.
>
> Again, the Ministry is also sanctioning new dispensaries and strengthening the existing dispensaries on the basis of norms. Similarly, there are some cases of under-utilisation. There are many factors relevant to it.
>
> Again, the dispensary at Kasturba Nagar (New Delhi) with a doctor-patient ratio of 1:123 has since been bifurcated."

2.27 The witness clarified that norms were there but these were not linked to the number of patients, but to that of beneficiaries.

2.28 The Committee pointed out that seeing the uneven doctor patient ratios in dispensaries, it appeared that the norms of doctor-beneficiaries ratios had not worked well.

2.29 Tracing the evolution of norms, the representative of the Health Ministry stated that the first study of CGHS was done by SIU in 1971. On that basis norms were issued in 1972. They were related to the strength of patients attending the dispensary. This question was discussed in the Joint Consultative Machinery meeting. After that the SIU carried out another study in 1977. They went into this issue at some length whether they should relate it to patients or whether they should relate it to the beneficiaries.

2.30 The representative told the Committee in evidence that on the question whether the norms should be related to the number of benefi-

dispensaries, the SIU said "it has been suggested that the staffing norms may be linked to the average daily attendance during peak hours. It was further considered that the pressure would be reduced with the liberalisation of the existing norms." Thus, the 1971 norms were liberalised in 1977."

2.31 The witness added :

"These are the norms that we adopted, which other similar organisations also adopt, for sanction of staff for new dispensaries or for extension of dispensary.....But this is one thing on the basis of which the staff is sanctioned and the sanctioned strength is duly available to the Director CGHS and the Chief Medical Officer and they have to allot a certain number of people with a leave reserve quota among the dispensaries. These are the norms within the framework of which the Director and CMOs have operational flexibility. But at any point of time, if the total number of beneficiaries at a particular time increases beyond a point, we examine the position again.

If the SIU goes into the norm again and it finds that the norms have to be changed, it is welcome to do so. But in operational terms these are non-plan items. Government functioning is not in water-tight compartments. This will result in a substantial increase of non-plan expenditure, and there is a ban on increase of non-plan posts."

2.32 Agreeing with the Committee on the need to review the norms, the Secretary, Ministry of Health stated that "the norms were last reviewed in 1977. It is time, I think, that they are reviewed again."

2·33 The workload of 2000-2500 families is the desired scale prescribed by the Ministry for a dispensary. But in a large number of dispensaries the workload is much in excess of the prescribed scale. 56 out of 72 dispensaries in Delhi and 60 out of the 108 dispensaries elsewhere had more than the prescribed workload in 1980-81. In 46 dispensaries in Delhi, Bangalore, Madras, Bombay, Hyderabad, Allahabad and Calcutta workload was more than 4000 families per dispensary, the maximum number being 13391 families in Kingsway Camp dispensary (Delhi). while the workload is so high in many dispensaries there are a number of dispensaries where it is much less than the prescribed scale.

2·34 The Committee also find that there is no uniformity in the scale of doctors sanctioned for the various dispensaries. The doctor-patient ratio in almost all the cities varies sharply from dispensary to dispensary. While in certain dispensaries a doctor examines only 5* patients a day, in a number of other dispensaries he has to attend to 100-159 patients a day. The maximum number that a doctor can examine is 90 according to SIU norms and the ideal according to the Ministry as well as others is 75 per day per doctor.

2·35 The Ministry has stated that in the Sixth Five Year Plan an amount of Rs. 1200 lakhs has been provided for opening of more dispensaries and augmentation of existing staff with a view to bringing down workload in dispensaries and extending its coverage to additional beneficiaries as far as possible.

2·36 With such a widespread overcrowding in dispensaries and overloading of doctors, the reasons for the CGHS beneficiaries' dissatisfaction with

*At the time of factual verification, the Ministry has corrected the figure '5' to '11'.

the working of the scheme are not far to seek. What is regrettable is that while the quality of service could be improved to a considerable extent within existing resources by a more imaginative and rational distribution of workload and deployment of doctors, little is known to have been done by the Ministry to rectify the situation.

2·37 The Committee would like the Ministry to review the workload region-wise in each city (not merely dispensary-wise) and see if the workload can be re-distributed among neighbouring dispensaries evenly without causing inconvenience to card holders. The outcome of the review may be communicated to the Committee. (Sl. No. 5)

2·38 In view of resource constraint it may not be possible to bring down the workload norm per dispensary from 2000-2500 families as at present, to 1500 as suggested by a non-offcial organisation. But there is no reason why the norm determined by the Ministry in its own wisdom should not be observed in actual practice. If service of reasonably satisfactory quality has to be provided, it is necessary that the workload in the dispensaries should not be allowed to go too much beyond the prescribed norm. This is more so in the case of dispensaries in areas where there is concentration of lower paid staff because of higher morbidity rate among them. The Committee recommend that, in the first phase, the workload in dispensaries with more than 4000 families should be brought down to the desirable level by opening more dispensaries and re-adjusting the workload. The Committee would like the Ministry to draw up a concrete programme, city-wise, to achieve this end and inform the committee. (S. No. 6)

2·39 The Committee are told that in determining the strength of doctors for dispensaries has been following a norm of doctor-beneficiary ratio and not doctor-patient ratio in pursuance of the recommendations of Staff Inspection Unit of the Ministry of Finance. The Committee do not consider this to be a scientific method of fixing staff norm. The present norm has created an absurd situation in which doctors in some dispensaries with doctor-patient ratio of 1:5 sit almost idle throughout the day, while in other dispensaries with doctor-patient ratio of 1:100-159, they have too much work to be able to see patients carefully. This norm militates particularly against the lower-paid employees among whom the morbidity rate is higher and in whose localities dispensary doctors are fewer. Strength of doctors in each dispensary should be related to the average number of patients visiting the dispensary and it should be reviewed periodically in the light of variation in attendance over a period. (S. No. 7)

2·40 The Committee find that in Delhi, the present strength of doctors is adequate to provide one doctor for 75 patients a day which, according to the Ministry, is an ideal workload for a doctor to be able to provide reasonably good service. But in actual practice the work-load per doctor goes upto 100-146 patients per day in many dispensaries. This is utterly irrational. The Committee would urge the Ministry to rationalise the workload of doctors in dispensaries not only in Delhi but also elsewhere keeping in view the average attendance in each dispensary so as to ensure that, as far as possible, no doctor remains under-utilised or over-burdened. The Committee would expect this rationalisation to be done without delay. (S. No. 8)

2·41 Even if the Ministry of Health is not in a position immediately to formally revise the norms as suggested above without prior consultation with SIU, it should in the Committee's opinion, not at all be difficult for the Ministry to rationalise the posting of doctors in the dispensaries within the overall

strength of doctors in a city. The rationalisation within the overall strength should not be postponed on the plea of prior consultation with SIU which may be necessary to revise norms but not for postings dispensary-wise. The operational flexibility within overall framework is already there with CGHS management as admitted by Health Secretary. Under-utilisation of professionally qualified manpower of such a high order as 5 patients per doctor per day or even a few more at certain places in CGHS which is already short of staff of this category is a culpable waste of medical personnel and funds. It should stop. (S. No. 9)

2·41A Fifteen cities are at present covered under the Central Government Health Scheme. The Ministry, it appears, has no proposal to extend Central Government Health Scheme to more cities during the Sixth Five Year Plan. Its aim is stated to be to consolidate the existing service before extending it further. Taking note of the Ministry's approach in this regard, the Committee would like to point out that Port Blair stands on a special footing for the reason that it being a Union Territory, there is a large concentration of Central Government employees there with the medical facilities not quite adequate to cope with the demand. They feel that the case of Port Blair deserves to be considered sympathetically and Central Government Health Scheme extended there at the earliest. (S. No 9-A)

B. CGHS Dispensary in Ghaziabad/Gurgaon

2.42 CGHS beneficiaries attached to Ghaziabad dispensary have brought to the notice of the Committee the following difficulty :—

> "The dispensary is situated in Kamla Nehru Nagar which is at a distance of more than 4 kms from Raj Nagar, Nehru Nagar and Lohia Nagar, Patients have to spend Rs. 10/- to Rs. 12/- to and fro for going to the dispensary especially from Raj Nagar and Lohia Nagar. In the event of emergency, patients have to be taken to the authorised hospital which is nearly 10 kms away. Hence it would be in public interest if the present dispensary is bifurcated into two. A branch dispensary may be opened in Sector 1 or 2 of Raj Nagar which would cater to the needs of not only Raj Nagar but also of Lohia Nagar, Nehru Nagar and some areas of Kavi Nagar. The staff of the present dispensary can be halved and its half staff can be posted in the new dispensary."

2.43 In this regard, Health Secretary stated in his evidence :

> ".....This dispensary in Ghaziabad was opened in September, 1979. It was opened at a point where there was the largest concentration of Govt. employees. But Government employees are also spread over a large area there.
>
> So it is a fact that some of the areas where Government employees are living in Ghaziabad cannot be covered. So, our norm of Government servants within three kilometers is not fulfilled.
>
> There is a proposal before us that another dispensary should be set up though I would like to mention before this Committee that even in the existing dispensary the doctor-patient ratio is very limited, i.e. 1:20.

On the whole our present dispensary is catering to all the 1,259 card-holders only, but still there is a practical difficulty. The colonies are spread over and some people have to travel over a long distance. So, we are already examining the proposal."

CGHS Dispensary at Gurgaon

2.44 The beneficiaries of CGHS at Gurgaon have brought to the notice of the Committee the following difficulties :—

(i) ***Working Hours & Emergency Provision***

The dispensary functions from	7·30 a.m. to 1·30 p.m. or from 1·30 p.m. to 7·30 pm. on the following days:
Monday, Wenesday & Friday	1·30 p.m. to 7·30 p.m.
Tuesday, Thursday & Saturday	7·30 a.m. to 1·30 p.m

Outside the dispensary hours, there is no emergency provision. Even doctors are not local residents; they come from Delhi. After dispensary timings, emergency cases are at the mercy of private doctors.

(ii) *Location of Dispensary*

The location of the dispensary at Sector IV Pase II, Urban Estate is not at a convenient place.... Majority of the employees i.e. about 92% are living in city areas which are away from the Urban Estate at a distance of 3-4 Kms. It costs Rs. 5-6 from city to other sectors to and fro the dispensary to get medicines. This is the main reason that in spite of a huge strength of eligible Government employees living in Gurgaon, only about 1425 employees have chosen to avail of this facility, and of them more than 50% do not go to the dispensary at all due to distance.

(iii) *Amenities in the Dispensary*

There is no provision for cold drinking water during summer and no easily approachable bathroom, no fan in the verandah where the patients wait. The small verandah is insufficient, and does not provide any safety from sun and rain.

(iv) *Telephone facility in the Dispensary*

There is no telephone facility to call the doctor for domiciliary visits. The doctor has to be personally approached.

(v) *Gynaecological treatment*

There is no special arrangement for Gynaecological treatment in the dispensary. There is one lady doctor from whom the patient can get routine advice but for delivery purposes they have either to go to the local civil hospital or to other hospitals in Delhi which is very inconvenient.

Further if the patients have gone to any of the Government hospitals for Gynaecological or other ailments, the prescriptions are seldom honoured.

2.45 Giving their reactions to the above difficulties, the Ministry stated :

Working norms and Emergency provisions

(i) "The number of card-holders registered at present at the CGHS Dispensary, Gurgaon, as on 28th December, 1981 is 1670. The arrangements for functioning of dispensary in the morning shift and in the evening shift only on alternate days were made in pursuance of the specific request of the beneficiaries. Adequate number of doctors and other staff to run this dispensary on functioning basis, round the clock, has already been sanctioned for CGHS, Gurgaon. It has, however, not been possible to fill up all the posts of medical officers, as generally not many doctors are prepared to go out of Delhi and work at Gurgaon. As soon as more doctors join their duty at Gurgaon, the dispensary will start functioning round the clock.

Location of Dispensaries

(ii) It is not correct to say that more than 50% of the card-holders do not avail of the services of the CGHS dispensary, Gurgaon, due to the distance barrier. Although the number of card-holders is only 1670, yet the daily attendance at the dispensary is sufficiently high and compares favourably with the attendance pattern of CGHS dispensaries in Delhi, as is evident from the figures of attendance of six days of December, 1981 below :

14-12-1981	211
15-12-1981	135
16-12-1981	179
17-12-1981	148
18-12-1981	184
19-12-1981	134

With the introduction of CGHS at Gurgaon most of the areas within the territorial limits of the city have been covered under CGHS. Efforts were made to locate accommodation in the area which has the largest concentration of the Central Government employees. The accommodation could be made available only in Urban Estate, Sector IV of Gurgaon, and as such, the dispensary was opened there. All the Heads of the Departments were then asked to register the names of their employees living in the area covered by CGHS, Gurgaon, with the dispensary and prepare their identity cards. CGHS authorities do not have any census of the total number of Central Government employees living in Gurgaon.

Efforts are, however, being made to find out some alternative accommodation so that the dispensary could be located at a place which would be more convenient to a larger number of Central Government Employees.

Amentities in CGHS Dispensary at Gurgaon

(iii) Arrangements for cold drinking water and fan are already existing. It will, however, be ensured that there is no inconvenience to the beneficiaries during the coming summer season. The bath room is already provided, according to the

lay out plan of the building. Most of the problem and inconvenience may be due to smaller space. Efforts are, however, being made to find out alternative accommodation where it would be possible to provide better facilities.

Telephone Facility in the Dispensary

(iv) Telephone was sanctioned and advance money was deposited with P & T Departments in the first week of May, 1981. It has not yet so far been installed and the matter is being actively processed with that Department to get the telephone line on priority basis.

Gynaecological Treatment

(v) The facilities for delivery cases are not provided in any of the CGHS dispensaries of Delhi and elsewhere. Such cases are to be handled in a hospital or Maternity Centre only. The matter was taken up with the Government of Haryana to allow recognition of the Government Hospital, Gurgaon, for providing services to the CGHS beneficiaries. But, in spite of repeated requests, the response from that Government has not been encouraging. The matter is further being pursued with the State Government.

It may, however, be added that the lady doctor posted at the CGHS dispensary at Gurgaon is a qualified Gynaecologist with a Postgraduate degree of M.D. in Gynaecology. She provides consultation and treatment in the case of gynaecological diseases. But, it is not permissible under CGHS rules to issue medicines on the basis of perscriptions given by other hospitals which have not been recognised under CGHS. Innoculation/immunisations and family welfare services form part of a separate component of the dispensary coming under the Department of Family Welfare. These services will be introduced after the posts of Lady Health Visitor, etc. are created for this dispensary.

2·46 The Ministry has admitted that dispensaries in Ghaziabad and Gurgaon are not located at central places with the result that CGHS beneficiaries have to travel long distances to reach there. The Committee take note that the Ministry is already considering a proposal to set up another dispensary in Ghaziabad to cater for the CGHS beneficiaries who are living far away from the present dispensary there. As regards the dispensary in Gurgaon, the Ministry is already making search for alternative accommodation in the area where there is large concentration of Central Government employees. The Committee hope that the Ministry's efforts in both these cities will bear fruit soon. (S. No. 10.)

2·47 It has been brought to the Committee's notice that though a large number of Central Government employees are living in Gurgaon, only a small part of them have chosen to avail of the CGHS services there because of the location of dispensary at an inconvenient place. CGHS authorities do not have any census of the total strength of Central Government employees living in Gurgaon and have, therefore, not offered any comments on the aforesaid statement. It will be worthwhile to take a census of Central Government

employees living in Gurgaon and other peripheral cities around the capital to find out the real position. The census will enable the Ministry to take stock of CGHS facilities in these cities. (S. No. 11)

2.48 The Committee note that the Ministry has already decided to run the Gurgaon dispensary on functioning basis as soon as adequate doctors become available, the dispensary will start functioning round the clock. With this, the Committee hope, the present difficulties of CGHS beneficiaries in Gurgaon in getting medical aid outside the dispensary hours will be solved to their satisfaction. (S. No. 12)

2.49 The CGHS beneficiaries in Gurgaon have complained of lack of ordinary amenities like drinking water, fans, shelter, etc. in the Gurgaon dispensary. But, according to the Ministry, all these amenities have already been provided there. May be, these amenities are not in proper working order. The Committee would like the Ministry to look into the matter and do the needful. (S. No. 13)

2.50 The Committee also hope that a telephone would soon be installed in the Gurgaon dispensary for the benefit of CGHS beneficiaries. (S. No. 14)

2.51 The arrangements for dealing with gynaecological problems of CGHS beneficiaries at Gurgaon are reported to be inadequate. The attempts made by CGHS authorities to persuade Government of Haryana to allow recognition of Government Hospital, Gurgaon, for providing services to CGHS beneficiaries have not so far borne fruit. The Committee suggests that the Ministry should take up the question with the Government of Haryana at higher level so as to provide all kinds of medical facilities for CGHS beneficiaries in Gurgaon city itself. (S. No. 15)

2.52 In this context the Committee would like to impress upon the Ministry that unless proper medical facilities are made available to the Central Government employees living in peripheral cities of Delhi, the employees would have no other alternative but to go to the already congested hospitals in the capital. This course would not only be inconvenient and expensive to the employees but also cast additional burden on the already over-burdened hospitals of the capital. This would also run counter to the Government's own policy not to encourage movement of people from suburban and paripheral areas to cities. from this angle also, provision of adequate medical facilities in Gurgaon, Ghaziabad and other peripheral towns is absolutely essential (S. No. 16)

C. System of Inspection of CGHS/Dispensaries

2.53 The following is the procedure laid down by the Ministry for carrying out inspections of dispensaries by CGHS Officers.

2.54 Delhi has been divided into three zones for administrative convenience. Each zone is headed by an Assistant Director General supported by Deputy Asstt. Director. These officers perform surprise inspections of each dispensary according to a roster so that each zone makes inspection on two days a week, subject to availability of transport. It is also proposed that these officers shall carry out detailed scheduled inspection of every dispensary at least twice a year. In other cities, the Deputy Director (in the case of Bombay) and Chief Medical Officers (in the case of other

cities) make surprise inspections as frequently as possible. Apart from this, Director (CGHS) who is the head of the Department, and sometimes even the Director General of Health Services makes surprise inspections of Dispensaries in Delhi as well as in other cities, when they happen to visit those cities.

2.55 From the information furnished by the Ministry it is seen that during 1980-81, Director, CGHS, did not visit any dispensary in 9 out of 15 cities where CGHS is in operation.

2.56 In Delhi, senior officers of CGHS Directorate (other than Director) paid 239 surprise inspections in 1980-81. But, according to the Ministry, the system of detailed scheduled inspection of every dispensary at least twice a year "has not yet been put to practice due to non-availability of transport." The Committee find that a formal order to carry out scheduled inspections in each dispensary at least twice a year was issued by the Director, CGHS, to all the officers concerned of the Directorate in March, 1981.

2.57 The Ministry also informed that copies of reports of surprise and Scheduled Inspections are always submitted to the next higher officers, though there are no specific instructions in this regard.

Inspections of Dispensaries

2.58 During evidence the Committee enquired whether the Ministry is satisfied that during 1980-81 each zone in Delhi did make surprise inspection on two days a week, as required under the procedure and whether it did make a detailed inspection of every dispensary twice a year and the reasons therefor.

Secretary, Ministry of Health, stated that—

> "As regards inspections there are instructions. I noticed that as early as on 26th March, 1981, I mean much earlier than this Committee took up this work, there were instructions. All these instructions specifically provide that at least twice a year each dispensary should be inspected by the Assistant Director-General or the Deputy Director General. In addition, I am also told that it was settled that twice a week there should be surprise inspections also. During 1980-81 there were as many as 239 inspections for the whole year for Delhi alone. There are 73 dispensaries in Delhi. Basically, they are less than the norms. I would admit it straightaway. These 239 inspections in Delhi alone were carried out by Zonal Officers and 25 inspections were carried out by Director, CGHS, in Delhi. The inspection reports have also been coming. I would say that we in the Ministry are not satisfied that sufficient inspections were made."

2.59 The Committee pointed out that during their on the spot visits to some of the dispensaries in Delhi and in other cities they had not come across any inspection notes left by the inspecting officers nor any record of follow-up action taken with reference to the inspections.

2.60 In reply to questions regarding inspections made by him, the Director General, Health Services, under whose supervision and control the CGHS Directorate works, informed the Committee that "the Director General visits the dispensaries as and when there is a complaint. Normally, the Director, CGHS, visits". He added that he visited dispensaries off and on—once a month or once in two months. Asked whether he kept any

record of his visits, Director General stated that, ".....I do not keep any record when I visited."

2.61 In a post evidence reply the Ministry stated :

"....Director General is not supposed to carry out the inspection of all the CGHS dispensaries as a normal function of his duties. Besides, this, it is not at all possible for him to visit all the CGHS organisations and likewise other 70 subordinate offices functioning under him in various parts of the country. His visits to an organisation or dispensary would thus be occasional or particularly whenever there is any complaint about the functioning of such organisation and require looking into at the highest level. He did not, therefore, maintain any record of inspection of CGHS dispensaries, nor was it necessary. As regards the follow up action taken on the observations which he might have made at the time of inspection, it may be stated that it is not possible to give any information in this regard as no inspection reports were maintained by Director General."

2.62 In a note submitted after the evidence (January 1982) the Ministry admitted that as stated in the official evidence "the number of inspections of CGHS dispensaries by various officers have not been commensurate with the requirements."

2.63 The number of the surprise inspections carried out during the last three years in Delhi is as under :

1. 1978-79	249
2. 1979-80	220
3. 1980-81	239

2.64 The Ministry added that "the prescribed schedule of inspections could not be followed due to inadequate number of vehicles. Efforts are being made to remove this bottleneck.

2.65 It has been stated by the Ministry that a complaint book is kept in each dispensary. The patients can record their complaints/difficulties, if any, experienced by them and give concrete suggestions for the improvement in working of the dispensaries. Complaints are attended to by the Medical Officer Incharge who refers to the higher authorities those complaints which he cannot resolve at his level.

2.66 Complaints are also received directly by the Zonal Offices in Delhi/Headquarters Office in Delhi/Office of the Deputy Director, CGHS in Bombay/offices of the Chief Medical Officers in various cities and are attended to by them. The Ministry of Health and Family Welfare and Dte. General of Health Services (CGHS Wing) also receive complaints directly. All Complaints are examined thoroughly and investigated and necessary action taken. Action taken is also intimated to the complainant(s).

2.67 The Study Group of the Committee had, however, found during their local visits that either the Complaint Register was kept locked in almirah and was not easily available to the beneficiaries; or there were no complaints recorded in the Registers during the last two-three years. At certain Dispensaries complaint Registers were not even available. Where the Complaints were recorded, the complaints had not been investigated fully nor necessary action was taken in all cases.

2.68 It has been brought to the notice of the Committee that the immediate reaction to complaints is not healthy and constructive and the staff tend to be aggressively defensive. Follow-up is lacking and complainants are not usually informed of action taken. The Committee enquired whether the Ministry could say after proper verification that Complaints Book is kept at open accessible place in each Dispensary with suitable notice to invite patients attention and that all complaints are examined thoroughly at appropriate level and necessary action taken is communicated to the complainants ?

2.69 From the material furnished to the Committee it was seen that information regarding complaints is either not kept or has not been received by the Ministry from certain cities viz. Meerut and Hyderabad. In regard to Bangalore out of 15 complaints received, only 4 were investigated in 1978-79; in Patna of 68 complaints received, only 23 were investigated in 1978-79; in 1979-80 none of the 27 complaints received in Patna was investigated. Same was the case in Allahabad where 20 complaints were received in 1979-80 and none was investigated. In Bangalore out of 20 complaints received in 1979-80, only 4 were investigated. The Committee found that the picture in 1980-81 was no different. In view of these statistics furnished by the Ministry themselves, the Committee enquired as to what was the basis on which the Ministry had stated that all complaints were examined thoroughly and necessary action taken.

2.70 In reply the Ministry stated that "the Director, CGHS has even recently reiterated instructions to all the Medical Officers incharge that complaint Books should be retained in each dispensary and a notice to the effect that such a book is available with the Medical Officer should be displayed prominently. The system of investigation of complaints and their remedy is being tightened up."

2.71 The committee enquired as to why the Supervisory officers of CGHS had not ensured during their inspection visits that Complaint Registers were kept at prominent place in dispensary with suitable notice board and why action taken on Complaints was not communicated to the complainants.

2.72 Health Secretary stated :—

"It is conceded straightaway that the complaint registers have not been maintained by some of the Medical Officers in charge of the CGHS dispensaries. The Director (CGHS) has now issued detailed instructions broadly cover five items.

First is that complaint book should be available with the Medical Officer (in charge) and notice to this effect should be prominently displayed at a suitable place.

At the dispensary there should be boards, clearly showing the place where services are provided—dressing room, injection room, medicine counter etc.

The Director CGHS has also directed the Inspecting Officers to watch the compliance of these directions.

The supervisory officers of the zones have also been asked to watch for any non-compliance during their inspections.

Action taken on the complaint will be recorded in the Complaint Register itself so that it can be persued by the complainant if

he so likes to know that what action has been taken on his complaint."

D. Area welfare officers, their functions and responsibilities.

2.73 The functions and responsibilities of Area Welfare Officers with reference to CGHS are as under :—

(i) To function as coordinating officer between the CGHS Dispensary and its beneficiaries regarding complaints from either side.

(ii) To attend to all emergency hospital work like help in expeditious hospitalisation of serious cases, attending to complaints regarding hospital care etc.

(iii) To serve on the CGHS Area Advisory Committee for considering suggestions for improvement of service and facilities.

2.74 The Committee have been informed by some CGHS beneficiaries that they are not aware of the existence of such an institution in their areas. It has been brought to the Committee's notice that the approaches made by Area Welfare Officers to secure admission of serious cases in recognised hospitals or in similar other matters are not heeded by hospital authorities. Even the medical Officers-in-charge of certain CGHS dispensaries have not shown any consideration to the suggestions made by the Area Welfare Officers.

2.75 The Ministry stated that name, designation, residential address, and telephone numbers of Area Welfare Officers are displayed at every dispensary. Instructions to display the name and address of the Area Welfare Officer have also been reiterated recently. Area Welfare Officers are appointed by the Ministry of Home Affairs. It is the responsibility of Chief Welfare Officer of the Department of Personnel and Administrative Reforms also to circulate the functions and responsibilities of Area Welfare Officers to every department/office.

2.76 It is seen from the material furnished by the Ministry that the Medical Officers Incharge hold meetings with Area Welfare Officers and the representatives of the Central Government Residents' Associations in order to have a closer liaison between the doctors and the patients but no minutes are recorded at these meetings and no official record is maintained by the Medical Officers Incharge. The Ministry has added that instructions have recently been issued to all the Medical Officer Incharge to ensure that minutes of such meetings are kept and followed up appropriately.

2.77 Clarifying the position the Secretary, Ministry of Health stated during evidence :

"The name, designation and residence address and telephone number of the Area Welfare Officer were displayed. But we admit that wherever these boards got obliterated, nobody tried to write them clearly and display them prominently. It is because of this that this question has arisen.

We issued detailed instructions on 28th November 1981 saying that the names and addresses of the Area Welfare Officers

should be very prominently displayed in each dispensary in the front portion thereof. Medical Officers-in-charge have also been asked to extend full co-operation to them.

In the case of any meeting held in the dispensary, the minutes of the meeting must be kept as a record. The action on the decisions taken may be followed up and reviewed in the next meeting.

We advise the Medical Superintendents of Dr. R.M.L. Hospital and Safdarjung Hospital about the names and addresses of Area Welfare Officers and tell them that in case they receive any advice about the admission of any patient, they should give due and full consideration to it".

2.78 It has been further stated in the memorandum that these meetings do create an awareness for improvement but nothing very tangible is achieved. CGHS authorities try to take shelter under Government orders, Government procedures, lack of resources, overall policy and so on.

2.79 Asked to furnish comments the Ministry in this regard they have stated that such meetings are being attended by the Medical officers in-charge. All problems which can be solved, are acted upon. But, if some request is not possible to be acceded to, the Medical Officers Incharge has little choice. The Medical Officers have recently been instructed to co-operate with the area welfare officer.

2.80 Delhi has been divided into three zones for administrative convenience. Each zone, which is headed by Assistant Director General supported by Deputy Assistant Director, is required to make inspection on two days a week. Similar procedure has been laid down for other cities also. Director CGHS and sometimes also the Director General of Health Services, make surprise inspections of dispensaries in Delhi as well as in other cities when they happen to visit those cities.

2.81 The Committee find that in 1980-81 Director, CGHS did not visit any dispensary in 9 out of 15 cities where CGHS is in operation. The Committee were informed in evidence that the Director General, Health Services visited dispensaries off-and-on, once a month or twice in two months, but he did not keep any record of his visits as he was not required to keep any such record. The Committee appreciate that surprise visits are paid to dispensaries by Director General, Health Services and Director, CGHS at their convenience. Such visits can prove more productive if the officers concerned record their observations in the inspection books of the dispensaries or in their own records to enable the CGHS directorate to watch the follow-up action on their observations.

2.82 In Delhi senior officers of CGHS Directorate (other than the Director) paid 239 surprise inspections in 1980-81. Health Secretary was frank enough in evidence to admit that the number of surprise inspections paid by officers in Delhi was less than the norm and that the Ministry was not satisfied that sufficient number of inspections had been made. The Committee expect that the Ministry would tighten their control to ensure that each zonal officer in Delhi as well as outside Delhi pays the prescribed number of inspection visits every week as is laid down in this behalf and sends a report of every inspection to higher officers. (S. No. 17)

2·83 The Committee would like that the inspecting officers record their observations in the inspection books of the dispensaries which they visit and ensure that follow-up action is taken by the medical officers incharge of such dispensaries concerned and progress reported to the inspection officers. The inspecting officers should also maintain a proper record of their visits at their level. (S. No. 18)

2·84 The Committee regret to note that even though formal orders were issued in March 1981 to all the supervisory officers of the CGHS that a system of detailed scheduled inspection of every dispensary atleast twice a year should be introduced, the system has not been put into practice so far due to non-availability of transport. The Committee do not accept non-availability of transport as a valid reason for not doing detailed inspections of every dispensary atleast twice a year. The Committee would like that this system of scheduled inspection should be implemented without any further delay and the non-availability of transport should not be allowed to stand in the way of the officers performing this important duty regularly. If Government transport is not available they should be allowed to hire private transport (Taxi) but inspection should not be allowed to suffer. (S. No. 19)

2·85 The Committee observed during on the spot study visits that though the Ministry had laid down a regular system of complaint register and follow-up action on the complaints recorded therein, complaint registers were not readily available in many dispensaries. They were kept in locked almirahs. Either there were no complaints recorded in the registers or where the complaints had been recorded, these had not been investigated fully nor necessary action taken in all the cases. Similar reports have been received from CGHS beneficiaries. The Committee have found that in Bangalore out of 15 complaints received in 1978-79, and 20 received in 1979-80, only 4 were investigated in each year. In Patna only 23 out of 68 such complaints were investigated in 1978-79. In 1979-80, none of the 27 complaints in Patna and the 20 complaints in Allahabad was investigated. Picture in 1980-81 was not very different.

2·86 Health Secretary conceded straight-away in evidence that complaint registers have not been maintained by all the medical officers incharge of CGHS dispensaries. This shows the failure of the system both at ground level and at supervisory level and cannot but be deprecated. The Committee note that the Director, CGHS has issued fresh Instructions in November 1981 directing the Medical Officers Incharge to maintain complaint registers and display notices to this effect at prominent places and has directed the inspecting officers to watch complaints of these instructions. Under the new instructions action taken on a complaint will be recorded in the complaint register itself so that it can be persued by the complainant, if he so likes. To ensure that these fresh instructions do not meet the same fate as in the past, the Ministry will have to keep a constant watch on their observance at all levels. (S. No. 20)

2·87 The Committee feel that it would be desirable if the action taken on a complaint is not only recorded in the complaint register but also communicated to the complainant. (S. No. 21)

2·88 Area Welfare Officers have been appointed by the Ministry of Home Affairs *inter alia*, to function as coordinating officers between the CGHS dispensaries and their beneficiaries and to attend to all emergency hospital work like expeditious hospitalisation of serious cases etc. It has been brought to

the Committee's notice that the approaches by Area Welfare Officers to secure admission of serious cases in recognised hospitals or in similar other matters are not heeded by hospital authorities not the medical officers in-charge of certain CGHS dispensaries have shown due consideration to the suggestions made by Area Welfare Officers.

2·89 The Committee take note of the instructions issued in November, 1981 by the Ministry to the medical officers incharge of the dispensaries to the effect that the names and addresses of Area Welfare Officers should be prominently displayed in each dispensary and that they should extend full cooperation to the Area Welfare Officers in the discharge of their duties towards beneficiaries. (S. No. 22)

2·90 The Committee also take note that the Medical Superintendents of Dr. R. M. L. Hospital and Safdarjung Hospital (Delhi) have been advised that in case they receive any request from Area Welfare Officers about the admission of patients, they should give due and full consideration to it. The observance of this advice will have to be watched. (S. No. 23)

2·91 The Committee regret to note that though meetings of Medical Officers incharge of dispensaries with Area Welfare Officers etc. have been held, no minutes have been kept nor follow-up action watched. The Ministry has now issued instructions that hereafter the minutes of the meetings held in the dispensaries with the Area Welfare Officer or the residents' associations should be duly recorded and the decisions arrived at the meetings followed up and reviewed in the following meetings. This is what should have been done all along. The Committee expect the Ministry to monitor implementation of these instructions. (S. No. 24)

E. Accommodation for C.G.H.S. Dispnesaries

2.92 The number of dispensaries located in Private and Government buildings and the annual rent paid during 1980-81 is given below :—

Sl. No.	Name of City	No. of Dispys. in Govt. Buildings	No. of Dispys. in Private Buildings	Accommodation adequate or not
1	2	3	4	5
1.	Bombay	19	3	adequate
2.	Pune	1	5	Not adequate. arrangements being made for suitable accommodation.
3.	Nagpur	4	5	Do.
4.	Ahmedabad	—	3	Adequate
5.	Madras	2	8	Not adequate arrangements being made for suitable accommodation.
6.	Bangalore	—	7	Adequate.
7.	Hyderabad	6	6	Adequate.
8.	Calcutta	8	4	Do.

1	2	3	4	5
9.	Patna	—	5	Adequate
10.	Jaipur	1	4	Not adequate arrangements being made for suitable accommodation.
11.	Lucknow .	—	3	Do.
12.	Kanpur .	—	8	Do.
13.	Meerut . .	—	5	Do.
14.	Allahabad .	—	5	Do.
15.	Delhi . .	70	29	Private buildings are inadequate.
		111	100	

2.93 The policy of the Government is to accommodate the dispensaries in the Government buildings. Buildings for ten dispensaries are under construction. Efforts are being made to acquire more Government buildings, subject to financial constraints. Government proposes to construct its own buildings subject to availability of land and funds.

2.94 Amplifying the position the Secretary, Ministry of Health during evidence stated that :—

> "Out of the total number of dispensaries under CGHS 111 dispensaries and units are located in Government buildings and 100 dispensaries are located in private buildings. CGHS has paid an annual rent of about Rs. 16 lakhs during 1980-81. Out of these 100, 33 private buildings have adequate accommodation. In the remaining 67 the accommodation is not adequate. Efforts are being made to locate alternative accommodation subject to availability. The general policy of the Government is to locate dispensaries in Government buildings only, but we are not able to achieve this objective because of non-availability of land at suitable locations since dispensaries are to be located as close to the maximum number of beneficiaries as possible. Sometime it is due to inadequacy of funds also. We continue to make efforts to construct dispensaries so that the expenditure on payment of rent is reduced to the minimum."

2.95 At present a number of dispensaries in Delhi are housed in Government quarters, even in newly constructed colonies. The Committee pointed out that housing of a dispensary in a Government quarter could not be considered as an ideal proposition. The Committee asked whether atleast where new colonies have come up, the Ministry should not have thought of constructing a dispensary building according to ideal specifications.

Secretary (Health) stated that :—

> "This is the most desirable suggestion... Whenever future colonies for the Government servants are being planned, we will take it up with the Works and Housing Ministry."

2.96 It was stated in evidence that the Ministry of Health had taken up this question with Delhi Development Authority (DDA) in-so-far-as DDA Colonies were concerned but the Ministry had not taken up with the Ministry

of Works and Housing the question of construction of buildings for dispensaries along with Government quarters in areas where new Government quarters were coming up.

2.97 From the correspondence exchanged between the Ministry and Delhi Development Authority, it is seen that the CGHS had *inter-alia* requested for allotment of accommodations for CGHS dispensaries in Laxmi Nagar, Malviya Nagar, Moti Nagar, Rajouri Garden, Sheikh Sarai, Naveen Shahdara and Karampura.

2.98 It has been stated by the Ministry that DDA has allotted land in the following areas :—

1. Janakpuri—plot has been accepted by CGHS.
2. Paschim Vihar.
3. Tagore Garden (for Rajouri Garden dispensary).
4. Patpar Ganj.

2.99 The plots offered by DDA for Paschim Vihar, Tagore Garden and Patpar Ganj are too small and not adequate for CGHS dispensaries. The matter is still under consideration.

2·100 The Committee find that out of total number of 211 dispensaries under CGHS 111 dispensaries are located in Government buildings and 100 dispensaries are located in private buildings. Accommodation in 67 private buildings is not adequate for the dispensaries. Efforts are being made by the Ministry to locate alternative accommodation. The general policy of the Government is stated to be to locate dispensaries in Government buildings only subject to availability of accommodation.

2·101 There are a large number of dispensaries which are located in residential quarters in Government colonies. In the Committee's opinion residential quarters designed for small families are not at all suitable for locating a dispensary for over 2500 families. In fact, it should not have been difficult for the Ministry to have appropriate buildings with suitable specifications constructed in new Government colonies for dispensaries only if they had taken up the matter with the Ministry of Works and Housing well in advance. It is unfortunate that such a course of action did not occur to the Ministry of Health. The Committee would expect that now onwards the Ministry of Health would establish a regular liaison with the Ministry of Works and Housing and at least in Government residential colonies which may come up hereafter, it would have appropriate buildings for housing Government dispensaries constructed alongwith residential quarters for serving the beneficiaries of those areas. (Sl. No. 25)

2·102 The Committee note that in Delhi the Ministry has taken up the question of allotment of accommodation, plots and flats with the Delhi Development Authority for housing CGHS dispensaries in the newly developing colonies. They find that some progress has been made in getting land allotted in certain colonies for the purpose. The Committee hope that the Ministry would continue to pursue the matter with the DDA with a view to get suitable land allotted and suitable buildings constructed for housing CGHS dispensaries in the new areas. (Sl. No. 26)

F. Statistics regarding Expenditure per beneficiary

2.103 The following table shows the total coverage under CGHS and expenditure per beneficiary and other relevant information for the country as a whole; during the last 3 years :—

	1978-79	1979-80	1980-81	
1. Total number of families beneficiaries	483452	511542	559469	Figures for each year against items 1 & 2 relates to 30th sept. of that yr.
	2051141	2198571	2395799	
2. Total amount of expenditure on CGHS as a whole (in Rs. lakhs)	1127·95	1195·02	1458·93	
3. Per family expenditure (total)	225·32	234·55	271·90	
4. Per family expenditure on medicines (materials & supplies)	109·25	98·59	128·94	
5. Total contribution recd.	1,48,48,747	1,89,44,845	1,58,12,660	
6. Average contributions per family (annual)	Rs. 30/-	Rs. 37/-	Rs. 27/-	

2.104 The following statement gives the range of average cost of medicines issued per beneficiary per year and per beneficiary expenditure per year in respect of dispensaries in 9 cities in 1980-81 :—

Sl. No.	Name of the city	Average cost of medicines issued per beneficiary per year. (Approx.)	Per beneficiary Expenditure per Year. (Approx.)
		Rs.	Rs.
1.	Patna	8—40	31—103
2.	Ahmedabad	38—41	140—213
3.	Nagpur	15—28	42—66
4.	Bombay	Record not maintained	87—249
5.	Lucknow	38—41	116—118
6.	Meerut	21—23	41—48
7.	Allahabad	11—00	30—00
8.	Jaipur	21—31	66—99
9.	Calcutta	6—21	24—73

2.105 It is seen from the information furnished that while the dispensary-wise record of per beneficiary expenditure on medicines of total expenditure per beneficiary has been maintained in 9 cities, such a record has not been maintained in other cities including Nagpur, Bombay, Madras and Delhi. Asked to state the reasons for not maintaining such records in the four cities referred to above, the Ministry stated that there were no specific instructions that cost of expenditure had to be maintained dispensary-wise. Some cities had been maintaining such information on their own initiative.

2.106 The Ministry later furnished overall cost of medicines per beneficiary and total expenditure per beneficiary city-wise as follows :—

Name of city	Average cost of medicines issued per beneficiary per year	Per beneficiary expenditure per year
	Rs.	Rs.
Madras	24·74	63·31
Bombay	16·92	52·31
Nagpur	19·64	48·93
Delhi	27·32	55·72

2.107 The Ministry have informed the Committee that till 1975 the figures used to be compiled dispensary wise in Delhi, later on, it was felt that utility of this information was not commensurate with the effort involved. This compilation was therefore discontinued since 1975.

2.108 Explaining the position further, the representative of the Ministry stated during evidence that—

> "It is a fact that upto 1974 and prior to 1975, the data was being maintained on a dispensary-wise basis. Then, certain administrative problems arose that expenditure in certain dispensaries in Delhi were on the high side per beneficiary whereas in other dispensaries, the expenditure was low. As you know, the dispensaries are located in different category of socio-economic groups. So, these were all got reflected in the dispensary-wise data. Hence, it was decided that the dispensary-wise data should be discontinued. . . This system was discontinued in 1975 and it was a deliberate policy decision."

2.109 The Committee pointed out that a feeling existed in certain quarters that in the dispensaries located in areas where high officials, VIPs resided the medicines of better quality were issued in sufficient quality but in dispensaries in the areas inhabited by lower paid staff, low priced medicines were given. Asked whether this was one of the reasons for discontinuing the system of maintaining the data dispensary wise the witness stated :

> "The various distinctions between one dispensary and the other dispensary and the inferences which could be drawn on the basis of this data, are always, there. In fact, it was the main reason".

2.110 Health Secretary, added during evidence that—

> "The collection of the data dispensary-wise will no doubt generate the actual position and it will bring out the facts..... Our effort would be to see that irrespective of the clientele, whether the dispensary is supposed to cover VIPs or senior officers or low-paid officials all dispensaries should have a stock of at least 80 per cent of all common medicines. It will be our endeavour to see that the treatment given to the beneficiaries is same in all the dispensaries.

2.111 He however assured that "if it is felt that we must have a clear-cut picture as to how much expenditure is involved per beneficiary. We will introduce it".

Expenditure Cost per Family

2.112 The following statement gives city-wise total cost per family during the year 1979-80 :—

	City	Cost per family Rs.
1.	Delhi/New Delhi	315
2.	Bombay	215
3.	Allahabad	164
4.	Meerut	223
5.	Kanpur	252
6.	Calcutta	229
7.	Nagur	262
8.	Madras	229
9.	Bangalore	193
10.	Hyderabad	180
11.	Patna	265
12.	Pune	396
13.	Jaipur	430
14.	Ahmedabad	641
15.	Lucknow	594

2.113 Asked to indicate the reasons for such sharp difference cost per family from city to city, Secretary (Health) informed the Committee during evidence :—

> "Leaving aside Delhi where the cost is high due to various factors, in all other places, except for four cities Pune, Jaipur, Ahmedabad and Lucknow the cost is comparatively low. In those four cities, the CGHS is rather under-utilised.
>
> The P&T Department employees were to come under this scheme but they backed out, that with the result that the facilities which were extended were not utilised adequately. Leaving aside four cities for these reasons, the cost in other cities ranges only from 180 to 265".

2.114 The following Table gives a comperative picture of expenditure incurred by CGHS, the three Public Undertakings and Ministry of Railways on the medical treatment of their employees.

Information has been supplied by the undertakings concerned.

Name of the Undertakings	Per employee expenditure on medical treatment as a whole		Per employee expenditure on medicines	
	1979-80	1980-81	1979-80	1980-81
	Rs.	Rs.	Rs.	Rs.
Air India	496	725	330	532
BHEL	724—23	830—47	—	—
SAIL	574—81	677—93	148—33	179—30
Ministry of Railways	280—40	310—45	49—73	55—98
CGHS	234—55	271—90	98—59	128—94

2·115 In 1980-81, the CGHS served 5,59,469 families incurring an expenditure of Rs. 14·59 crores which came to Rs. 272 per family of which Rs. 129 was the cost per family on medicines (materials and supplies). During that year Rs. 27/- was the average contribution per family, Government thus incurred a net expenditure of Rs. 245 per employee in a year on the medical care and treatment of its employees. Comparing the per family cost with the expenditure incurred on medical treatment of the employees of certain undertakings and the Ministry of Railways, it is seen that in the same year (1980-81) the average cost of medical treatment was Rs. 725/- in Air India, Rs. 830/- in BHEL, Rs. 678/- in SAIL and Rs. 310/- in Ministry of Railways. The Committee do not see any reasons why, even in the matter of medical case, Central Govt. employees should be so poorly served. There is need to augment medical facilities under CGHS and, for this purpose, additional funds should not be grudged. (S. No. 27)

2·116 The Committee find that per family cost in CGHS dispensaries varies from dispensary to dispensary and city to city. In 1979-80 it ranged from Rs. 164/- in Allahabad to Rs. 641 in Ahmedabad. Explaining the reasons for such sharp variation, Secretary (Health) stated in evidence that except in four cities of Pune (Rs. 396/-). Jaipur (Rs. 430/-), Ahmedabad (Rs. 641/-) and Lucknow (Rs. 594/-), where the infrastructure was under-utilised the cost per family in other cities was comparatively low. The Committee are not happy at the admitted under-utilisation of CGHS in certain cities when beneficiaries in other cities are reportedly starving for more facilities. The Committee would like the Ministry to go into the matter and rectify the imbalance without delay. (S. No. 28)

2·117 Information regarding per beneficiary expenditure on medicines and per beneficiary total expenditure under the CGHS has been furnished to the Committee in respect of each dispensary in the nine cities of Patna. Ahmedabad, Nagpur, Pune, Lucknow, Meerut, Allahabad, Jaipur and Calcutta, but similar information, dispensary-wise, in respect of other cities is not available. The Ministry has stated that such information is not required to be kept. The dispensaries which have furnished this information have been doing so on their own. The Ministry added that dispensary-wise information on cost of medicines and total cost used to be maintained till 1975 but because the utility of this information was not commensurate with the effort involved and also because it could lead to an inference that beneficiaries living in certain areas were getting better treatment than those living elsewhere, the system was discontinued in 1975.

2·118 The impression that beneficiaries living in certain areas get preferential treatment and those living in other areas are discriminated against in the matter of treatment and issue of medicines is, in fact, there among beneficiaries and it does not appear to be totally baseless if the information supplied by the Ministry is to be believed. In the Committee's view, dispensary-wise information on per beneficiary cost should be collected and published in the Annual Report of CGHS. It will not only help the Ministry to dispel wrong impressions among beneficiaries (if they are wrong) but also enable the Ministry to enquire into cases of wide imbalance and apply correctives. (S. No. 29)

CHAPTER III

CGHS DISPENSARIES—SYSTEM OF WORKING

A. System of Working

(i) *System of Working*

3.1 In a number of memoranda submitted to the Committee it has been stated that the present system of working of dispensaries is time-consuming and inefficient. Queues have to be formed by patients outside six places in a Dispensary in the following sequence :—

(i) registration window for getting token

(ii) doctor's room.

(iii) Again at the registration window

(iv) for registration of prescription (OPD tickets)

(v) Window for ordinary medicines

(vi) window for special medicines

(vii) window for indenting medicines.

3.2 It has been suggested that the number of queues can be reduced if registration window and counters for issue of medicines (ordinary and special) could be combined and all these activities are handled at one counter.

3.3 In a memorandum submitted to the Committee it has been suggested that the delay can be avoided for patients who have to get medicines repeated or get the medicines prescribed by specialists if they are not required to stand in queues along with other patients.

3.4 Giving its reaction to the aforesaid suggestions the Ministry has stated that instructions already existed to the effect that special and general medicines can be issued from same counter subject to availability of space. The registration counter cannot, however, be combined with the others as the activities are different. The queue outside the registration window for getting priority numbers of doctors (tokens) could be avoided if certain beneficiaries are allotted to each doctor. In that case, the beneficiaries can go directly to the room of the doctor to whom they are attached. After the doctor prescribes medicines, at present he has to go to the registration window. The Ministry is examining if this stage could be eliminated.

3.5 Recommendation to integrate counters for dispensing the restricted as well as general medicines was made by the study teams of National Institute of Health Administration and Education (1975) and Department of Personnel & Administrative Reforms (1977). When asked to state the action taken on these recommendations, the Ministry informed the Committee in a written reply (August 1981) :

> "Already implemented except certain dispensaries, where space does not permit."

3.6 The Study team of the Department of Personnel & Administrative Reforms (1977) had also recommended that the procedure for presenting the prescription at the Registration Counter before it is presented at the

dispensing counter should be discontinued. As regards action taken on this recommendation the Ministry informed the Committee that this procedure had been introduced on experiment basis in two dispensaries in Delhi. The experiment is stated to be "still continuing."

3.7 During evidence Secretary, Ministry of Health, stated that this question had been engaging the attention of the Ministry for quite sometime. In fact as early as in 1975, the Ministry asked the National Institute of Health Administration and Education to undertake a study of time spent at each counter. They had already amalgamated the special and general medicines counters into one counter and issued orders to that effect.

3.8 When the Committee pointed out that they had been told by patients during on-the-spot study visits to dispensaries that counters for special and general medicines were separate and not combined, DGHS stated that the order for amalgamation of the two counters had been issued long ago (1976) but these had been implemented only in six Dispensaries in Delhi (out of 75 dispensaries). These orders could not be implemented in other dispensaries for want of accommodation.

3.9 In a post-evidence reply, the Ministry informed the Committee that the orders for amalgamation of the two counters were issued in pursuance of suggestion made in the report of National Institute of Health Administration and Education, implementation of which was the responsibility of DGHS/CGHS.

3.10 While at many dispensaries the combined counters are functioning but in some of them it has not been possible to enforce these instructions due to inadequacy of sufficient space. It is in the knowledge of the Ministry but as stated above. It was left to DGHS/CGHS to implement these orders subject to the availability of space in individual dispensaries.

(ii) *Waiting Time*

3.11 The Ministry stated that on the recommendations of the Estimates Committee of the Fifth Lok Sabha in their 57th report, a study on waiting time at CGHS dispensaries was carried out by the National Institute of Health Administration and Education in 1975. This study was carried out in two dispensaries. Findings of this study may be seen below :—

	Average Waiting time in Minutes			
	R.K. Puram I Dispensary		Andrews Ganj Dispensary	
	Morning	Evening	Morning	Evening
At the New patients' Registration Counter	0·97	1·10	—	—
At the old patients' Registration Counter	2·19	4·76	—	—
At the common Regn. Counter	—	—	1·18	0·53
At the General medicines Counter	2·40	2·13	0·60	0·27
At the Restricted medicines Counter	2·46	1·94	1·55	1·27

3.12 In reply to a question as to what extent the waiting time spent at the dispensary made inroads into the office hours of the CGHS beneficiaries, the Ministry stated that since the average waiting time (as shown above) was usually less than 2 minutes at each counter, patients did not have to wait for long periods at dispensaries. Moreover, timings of the dispensaries are in the morning and evening i.e. beyond usual office hours. Therefore patients attendance at dispensaries does not make any inroads into their office hours.

3.13 As regards the follow up action taken on the report of the National Institute of Health Administration and Education, the Ministry had stated that "No action was taken presumably because no action was envisaged." A perusal of the report submitted by the National Institute showed that the Study Team had made nine recommendations (page 4 of the Report) suggesting specific measures for reducing waiting time in the dispensaries.

3.14 On being asked as to how the Ministry had come to the conclusion that "no action was envisaged" on these recommendations, the Ministry explained that it may be seen from the foreword to the report, that these studies while specifically relating to waiting time were carried out in two heavy dispensaries having a total workload of about 2900 on an average day. In these dispensaries the average waiting time was just a few minutes. No action was, therefore, considered necessary. However, the specific recommendations of the report are under separate examination."

3.15 During the study visits of the Committee in 1981 it was brought to their notice by the patients that it took them about an hour or so to consult doctor, and get medicines (whatever are available). All the medicines counters were not always working as staff on or one the other counter was not always there. Even when medicines had been prescribed for them by Specialists, the patients had to spend half-an-hour or so at the dispensary to get the prescriptions endorsed by doctors before getting medicines.

(iii) *System of Prior Appointment*

3.16 There is no system of prior appointment for beneficiaries at the dispensary level. Specialists see the patients individually by prior appointment.

3.17 It has been suggested to the Committee that a system of "green line" type of screening and disposal of minor cases requiring medicines for headache, indigestion, sore throat, dressing and injections etc. already prescribed should be introduced. It has been stated that in this way a large number of minor "cough-cold" cases would be separated, and the workload of smaller number of cases requiring more detailed and careful examination would only be left. For cases requiring detailed examination it has been suggested that provision for consultation with the doctor by previous appointment should be made.

3.18 Giving reaction to this suggestion, the Ministry has stated in a written reply that "the need for detailed examination should be left to the discretion of the doctor. Even minor ailments like sore throat may turn out to be diptheria, which is fatal. It would, therefore, not be possible to agree to the above."

3.19 Clarifying the point further Secretary (Health) stated in evidence that the opinion of the DGHS was that it was not proper to have a "green-line" type of disposal of the so called minor "cough-cold" cases. But this suggestion of creating a "green line" for minor troubles could be tried in a few dispensaries.

3.20 As regards the system of prior appointments, Secretary stated that in serious cases, appointments could be given but in their cases, their seeking appointment by telephone might not be possible.

3.21 Subsequently in a post evidence reply, the Ministry furnished the following note on the mechanism of introduction of system of appointments in some selected dispensaries on an experimental basis keeping in view the interests of the low-paid employees as well :

> "The system of giving appointments by the dispensary doctors to the beneficiaries can possibly work out in cases of chronic diseases or such ailments as would require long term continued treatment, in which case one of the doctors of the dispensaries can specify one hour daily at the opening time, for giving appointments to the patients concerned.
>
> It is also felt that consultation for longer period with doctor by the patient in such cases also will be required in the initial visits only. In the subsequent visits the doctor may not have to devote much time as in most of the cases the medicine is only repeated with some changes here or there. As such, the proposed system is not likely to help the low-paid employees. It would be better to try this system on an experimental basis in one or two dispensaries."

(iv) *System of Family Folder*

3.22 The All India CGHS Medical Officers Association in its memorandum to the Committee has suggested that :

> "A system of Family Folder may be introduced so that a lifelong record of every beneficiary is built up. This will not only lead to quicker and more accurate diagnosis but thereby also increase the productivity of employees."

3.23 The All India Central Government Health Scheme Employees Association has also suggested that :

> "The folder system should be introduced in the CGHS dispensaries in place of existing system of prescription/chits because the Folder system ensures clinical advantages to the beneficiaries and financial gains to the Government."

3.24 Similar suggestion has been made in many other memoranda received by the Committee.

3.25 Health Secretary agreed in evidence that the Family Folder had many advantages, but it had certain implications too. The advantages obviously included the availability of total history of a patient at a glance, where a record was available of the past periods of illness, treatment and specialists opinions. It would also be a restraint on malpractices and wastages. These were the positive advantages. The witness, however,

stated that to implement it, they required large documentation and consequently more staff, more filing facilities etc.

3.26 The witness added that they had, on a trial basis, introduced the Folder System in a few dispensaries at Hyderabad, Nagpur, Jaipur and Madras. The results needed to be studied carefully before extending it to all the dispensaries.

3.27 Secretary informed the Committee that according to the Director, CGHS, the financial liability of the implementation of the folder scheme in Delhi would be a recurring expenditure of Rs. 35 lakhs and a non-recurring expenditure of another Rs. 35 lakhs.

3.28 In a post evidence reply the Ministry stated that in order to introduce the system of family folders in CGHS dispensaries the following additional inputs requiring extra expenditure would be required :

Non Recurring

(i) Printing of folders for the card-holders and individual cards for each of the beneficiaries.

(ii) Provision of cabinets (wooden/steel) for keeping the family folders, in case these are to be maintained in the CGHS dispensaries.

Recurring

(i) Creation of additional posts of LDCs at the rate of one LDC for each dispensary for the maintenance of the family folders.

(ii) Printing and supply of cards for continuance use. The estimates relating to expenditure or the introduction of the system are under examination and will become available after evaluation of this system, as adopted in dispensaries at Hyderabad and Nagpur becomes available.

3.29 The Ministry added that "This system has been introduced on experimental basis at Jaipur, Nagpur, Hyderabad and Madras. A fullfledged evaluation of the working of the system has not yet been carried out as it is likely to take some more time to examine all the aspects and implications involved in this system."

(v) *Domiciliary Visits*

3.30 Any patient requiring visit by the doctor at his/her residence makes such a request at the dispensary. For new cases visits are performed by each doctor in rotation and old cases are visited by the doctor under whose treatment a patient is. Though emergency visits are to be performed immediately on call, routine visits are performed beyond dispensary hours. The patients are not required to make any payment for the transport. Doctors are entitled to conveyance allowance and they make their own arrangements for their transport.

3.31 In a written reply, the Ministry explained that "the registers in the dispensaries do not show the number of requests received in the dispensary for domiciliary visits. In other words no request register is maintained. CGHS dispensaries maintain a visit register showing the residence visited by the doctor on each occasion."

3.32 In a number of memoranda submitted to the Committee, it has been stated that the Doctors on some pretext or the other avoid paying visits to the patients at their houses and insist on the patients being brought to the Dispensaries. And in the event of a doctor visiting the patient in his house, the transport is normally paid for by the beneficiary.

3.33 The All India Association of CGHS Doctors has stated that the Medical Officers themselves arrange and pay for the transport. But no association of CGHS beneficiaries appearing before the Committee has accepted this statement of Medical Officers.

3.34 The Ministry informed the Committee that over the past many years of functioning of CGHS, it had not received many complaints where CGHS doctors had not examined patients at their residences.

3.35 The Committee enquired whether any instructions had been issued to the dispensaries to record the requests made by beneficiaries for home visits in a register; if not, how, without such a record, anyone can check as to how many requests for home visits had been turned down or ignored by the doctors.

3.36 Health Secretary stated in evidence that—

> "Presently requests are not registered at the dispensaries. There is no system—I must admit. But a record is being maintained showing the visits made by the doctors. If the suggestion of the Estimates Committee is to maintain such a register, it will be tried out and further action will be taken after evaluating. It is a good suggestion that some system of registration of requests received for domiciliary visits is kept on record."

(vi) *Working Hours*

3.37 Working hours of the dispensaries generally are as follows :

	Morning	*Evening*
Summer	7·00 A M — 10.30 A.M.	5.00 P M. — 7.30 P.M,
Winter	8.00 A.M. — 11.30 A.M.	5·00 P.M. — 7.30 P M.

3.38 On wednesdays the dispensaries function in a single shift for six hours commencing from the start of the dispensary in the morning. On second Saturday the dispensaries work only in the morning shift.

3.39 The following six dispensaries in CGHS, Delhi and all the dispensaries in Calcutta are working in single shift for 12 hours from 7-30 A.M. to 7.30 P.M. on an experimental basis :

Delhi

1. R. K. Puram I
2. Dr. Zakir Hussain Marg
3. New Rajinder Nagar
4. Shahdara
5. Janakpuri 'A' Block
6. Kingsway Camp

Calcutta

Now all dispensaries

3.40 The Ministry has stated that CGHS beneficiaries as well as dispensary staff have welcomed the introduction of the continuous 12 hour shift.

3.41 The main advantage of new system is that working time is stretched to continuous 12 hours. The over crowding during morning and evening is lessened. The house wives and children can attend the dispensary in the vacant time. The dispensary staff have also to attend the duty in single shift. There is less strain on their time and energy.

3.42 As the experiment has evoked a favourable response and has been a success, a proposal to introduce the 12 hours shift in all CGHS Dispensaries is under consideration. As additional staff is required for this purpose, a decision in this regard will depend upon the availability of funds in the Health Budget.

3.43 From the memoranda received by the Committee it is also seen that there is a widespread feeling among CGHS beneficiaries as well as CGHS medical officers and staff that dispensaries should function in single shift from 7 A.M. (or 8 A.M.) to 7 P.M. (or 8 P.M.) instead of two shifts as at present.

3.44 The Committee desired to know whether the system of the 12-hour working of dispensaries which was desired by beneficiaries and welcomed by the Medical Officers and Para-Medical staff should not now be extended to all Dispensaries, Health Secretary stated that :

> "We had earlier extended this experiment to six dispensaries. Now we have further extended to another six dispensaries in Delhi, Bombay and Poona. We are awaiting the report of the Director. We want to evaluate and take a view about it."

3.45 The witness added that "this will involve additional funds because of additional staff."

3.46 With regard to the additional staff required the Ministry has stated that the following additional staff shall be required to run the present 75 allopathic dispensaries in Delhi for 12 hours.

(i) Medical Officer	62
(ii) Pharmacist	83
(iii) Store keeper	16
(iv) Staff Nurse	75
(v) LDC	98
(vi) Dresser	21
(vii) Peon	111
(viii) Female attendant	25
(ix) Safaiwala	1
(x) Chowkidar	1

3.47 The creation of additional posts of the above mentioned categories is likely to involve an extra expenditure of about Rs. 59 lakhs per annum. The Ministry has added that the proposals will be examined in detail after receipt of the Evaluation Report, on the working of experimental dispensaries.

3.48. The Committee agree with CGHS beneficiaries that the present procedures at the dispensaries are too much time consuming. It should not be necessary for a patient to stand in as many as six queues in a dispensary one after the other for consulting a doctor and getting the prescribed medicines, as is the case at present.

3.49. The Committee find that a recommendation to integrate counters for dispensing general and special medicines was made by two different study teams of National Institute of Health Administration and Education and Department of Personnel as far back as 1975 and 1977. The Ministry informed the Committee in August, 1981 that this recommendation had already been implemented except in certain dispensaries where space did not permit. But what the Committee learnt during on-the-spot study visits to various dispensaries in Delhi was different. The counters for special and general medicines were still separate and not combined. It was revealed in evidence that though the order for amalgamation of the two counters had been issued long ago (1976), the orders could not be implemented except in six out of 75 dispensaries in Delhi for lack of accommodation. Issue of orders to amalgamate the two counters in 1976 without first ensuring feasibility and inaction on the part of the Ministry during the five years since the issue of the orders to create conditions conducive for their amalgamation betray and attitude of utter casualness with which the Ministry has dealt with this matter. What is more unfortunate is the misleading reply sent by the Ministry in August, 1981 which gave an impression as if the recommendation regarding amalgamation of the two counters has already been implemented in most of the dispensaries. The Committee hope that counters for general and special medicines will atleast now be amalgamated in all the dispensaries without delay. (Sl. No. 30)

3.50. The Committee find that the Study Team of the Department of Personnel and Administrative Reforms (1977) had also recommended that the procedure for presenting the doctors' prescriptions at the registration counter before these are presented at the dispensing counter should be discontinued. This procedure is stated to have been introduced on an experimental basis in two dispensaries in Delhi were the experiment is still continuing. The Ministry has informed the Committee that the elimination of registration counter is under examination. The Committee feel that the experiment has been continuing for a long time and the Ministry should now be in a position to take a final decision in the matter. (Sl. No. 31)

3.51. The Ministry is of the view that the queue outside the Registration Windows for getting priority numbers of doctors (tokens) could also be avoided. If as discussed above queue for taking tokens and registration window for registering prescriptions are eliminated and counters for general and special medicines are amalgamated there will be a marked improvement in the procedure and considerable relief to the patients. The Committee could like Ministry to take follow-up action in this regard without delay. (Sl. No. 32)

3.52. The Committee also feel that it is absolutely unnecessary for the patients who have to get the medicines 'repeated' or who have got specialists' prescriptions to stand in queue along with other patients merely to have their prescription endorsed before getting medicines. The Ministry should evolve a procedure whereby such patients can get medicines without delay (Sl. No. 33)

3.53. The Committee take note of the findings of the Study Team of National Institute of Health Administration and Education (1975) according to

which the average waiting time was found to be usually less than two minutes at each counter in a dispensary. On the basis of this over 6 years old study the Ministry claims that the patients do not have to wait for long period at dispensary. But the Committee were told by a number of CGHS beneficiaries during their study visits that it took them about an hour or so to consult the CGHS doctors and get medicines. Even after the patients had been to specialists and got prescriptions, they had to spend about half an hour or so at the dispensary to get the prescriptions endorsed by dispensary doctors before getting the medicines. The Committee feel that the study of time taken by patients at CGHS dispensaries conducted in 1975 may not be reflecting the true position as it obtains today. There is need for a fresh study and remedial action to ensure that patients do not have to spend more than the minimum time required to consult a doctor and get medicines. (Sl. No. 34)

3.54. At present there is no system of prior appointment for patients at the dispensary level. The Committee feel that a system of appointment in chronic cases and cases requiring detailed examination can be introduced at the dispensary level also. It should be possible for the patients to fix appointments either on telephones or personally. The appointment system may be tried on an experimental basis at a few dispensaries in Delhi and elsewhere and its usefulness assessed in the light of experience before extending it to other dispensaries. (Sl. No. 35)

3.55. The suggestion to introduce a separate "green channel" type of screening and disposal of minor "cough/cold cases" as distinct from cases requiring careful examination merits consideration. The Committee agree with the Ministry that all seemingly simple cases of sore throat etc. may not be as simple as they may first appear to be. They would, therefore, like the Ministry to give this suggestion a cautious trial in a few dispensaries under careful observation before formulating a view in this regard. (Sl. No. 36)

3.56. The system of family folders for CGHS beneficiaries as suggested by doctors, para-medical staff and CGHS beneficiaries will have numerous advantages. It will make the history of a patient and record of past ailments, treatment and specialists' opinions available at one place. It will also put a restraint on malpractices and wastages. The system is stated to be under trial at a few dispensaries but the evaluation has not yet been carried out. According to Director, CGHS, the folder system if introduced in Delhi will involve an expenditure of Rs. 35 lakhs (recurring) and Rs. 35 lakhs (non-recurring) for printing folders, creating stacking facilities and appointing staff for maintenance of family folders. The Committee are of the view that it will be wrong to keep folders in the dispensary. Besides causing unnecessary expenditure on cabinets, almirahs and the staff and creating problem of additional storage in the already congested dispensaries, it will lead to delays in retrieving the folders and consequently friction and bad blood between the patients and dispensary staff. The family folders should be kept by the CGHS beneficiaries like the CGHS token cards. In case of loss, replacement could be arranged on payment of cost of folder. Once the folders are printed and distributed, there should be no expenditure recurring or non-recurring incurred by the Ministry on this system. The Committee recommend introduction of folder system as suggeste above at the earliest. (Sl. No. 37)

3.57. Though the Ministry has laid down a proper procedure for domiciliary visits by CGHS doctors in certain situations and has also provided for

payment of conveyance allowance to doctors to enable them to keep and use their own conveyance for paying domiciliary visits, the experiences of CGHS beneficiaries are not happy with the working of this system. There was hardly any non-official witness appearing before the Committee who has accepted the claim of the Ministry and the doctors that the charge for transport is paid for by the doctors. It has been represented to the Committee that doctors avoid paying domiciliary visits on some pretext or the other and insist on the patients being brought to the dispensary. And in the event of a doctor paying domiciliary visit, the transport, it is stated, is normally paid for by the beneficiary. It is highly improper if doctors drawing conveyance allowance expect the conveyance charge to be borne by the patients. (S. No. 38)

3.58 The Committee are not happy at the present system of record keeping about domiciliary visits. The register of domiciliary visits maintained in dispensary shows only the number of visits by doctors and not the number of requests received for domiciliary visits. At present it is not possible to know as to how many requests for domiciliary visits were not complied with or ignored and why. The Committee feel that all requests for domiciliary visits made by CGHS beneficiaries either on telephone or in person should be recorded in a regular register, together with time of request, serial number of registered request should be given to the beneficiary for follow-up reference; and the time of domiciliary visit and reasons for not paying the requested visit where such a visit is not considered necessary should be duly recorded in the register. The Committee would like the Ministry to lay down a suitable procedure in this regard and ensure its implementation without delay (S. No. 39)

3.59. There is a general demand for introduction of a single 12-hour shift in the dispensaries in place of the present system of two shifts—one in the morning and other in the evening. The suggestion for 12-hour shift has also been welcomed by CGHS doctors and para-medicial staff. Single 12-hour shift has already been introduced in six dispensaries in Delhi, all dispensaries in Calcutta and in certain dispensaries at other places also and the Ministry is awaiting evaluation report for taking a view in the matter. Introduction of single shift system in all the dispensaries in Delhi alone is estimated to involve an additional expenditure of Rs. 59 lakhs per annum on extra staff that will be required for the purpose.

3.60. The Committee are of the view that a single 12-hour shift in CGHS dispensaries would be ideal both for the patients and the medical and paramedical staff. They also feel that its introduction should be staggered to keep the expenditure under control. This should first be introduced in all these dispensaries where the workload is excessive according to the prescribed norms and thereafter gradually extended to other dispensaries in the light of experience. But they feel that the requirement of additional staff should be worked out carefully and kept to the minimum by arranging duty hours in such a way that manpower does not remain under-utilised as far as possible. (S. No. 40)

SYSTEM OF ISSUE OF MEDICINES TO PATIENTS

(i) *Availability of Medicines in Dispensaries*

3.61 According to the Ministry of Health and Family Welfare the CGHS formularies of different system of medicines contain drugs as shown below :

(a) Allopathic 400 items approx.

(b) Homoeopathic 800 items approx.

(c) Unani 280 items approx.

(d) Ayurvedic 350 items approximately.

3.62 Ministry has stated that all total CGHS stocks about 2800 different types of medicines. These items are generally available in the dispensary, except when they go out of stock in the Medical Stores. Since CGHS formulary is quite exhaustive it is possible to treat all sorts of diseases from drugs within this formulary. In case, however, any particular drugs is not available for reasons mentioned above, a suitable substitute of equal therapeutic effect is usually available which is issued so that the patient is not put to any inconvenience.

3.63 The Ministry has further stated that in case a particular medicine is essential, the same is obtained against local purchase indents. The normal time lag between the supply and demand for such medicines is usually for 24 hours in Delhi, and 6-8 hours outside. In case, however, a medicine prescribd is urgently required the same can be obtained by the patient without pre-payment after obtaining an emergent requisition which is issued by the Medical Officers of every dispensary round the clock.

(ii) *Issue of Medicines to Patients*

3.64 In numerous memoranda received by the Committee, the present system of issue of medicines has been severely criticised. Comments made in some of the memoranda are reproduced/summarised below :—

> "50% of medicines are not normally available at the dispensary. The time lag between indentation and supply is 4 to 7 days. It may be more if the medicine is not available immediately at the central store or in the Super Bazar."
>
> "the supply of medicines, the procedural formalities, the delays involved in procurement, the quality of drugs etc. constitute one of the most serious causes of dissatisfaction and complaint. The mechanical approach in this matter ignores the patients' need and psychology with the result that the patients have to go without medicines for varying periods to make do with substitutes or purchases from the market."
>
> "one of the major bottlenecks or problem faced by the CGHS dispensaries is with regard to inadequate and timely supply of medicines including the common ones, not to speak of those to be obtained by special indent. There is a growing feeling of frustration as regards the long delays between the examination of the patient and his getting the proper medicines. The lapse of 7–10 days is not uncommon. Secondly, even some of the medicines are not available. More than that, there is a greater degree of uncertainty as to when the medicines would be available. The problem is all the more acute with regard to special medicines which are not commonly used. The inordinate delays in the supply of medicines not only adds to the anxiety of the patients but creates financial strain on the patients."

3.65 M.P.s too face difficulties in timely supply of medicines by Doctors or in the re-imbursement in case they are compelled to purchase

from open market. At times, there is break of 5 to 7 days between two instalments of supply of same medicines. A number of Members of Parliament have pointed out that the system of supply of medicines in CGHS is very unsatisfactory Medicines are hardly available in the dispensary and patients have to move from place to place for medicines.

3.66 In the event of non-availability of medicines, "in the interregnum patients have either to purchase medicines locally at their own cost or go without it, depending upon the individual situations. Where condition is critical or immediate administration of the medicine is required, one has to purchase medicines at one's own cost."

3.67 "C.G.H.S. dispensaries do not get all types of medicines in sufficient quantities as are required on the basis of last consumption. The doctors are told that due to shortage of funds full quantities of all medicines are not purchased. Hence demands of dispensaries are invariably cout."

3.68 The Ministry has stated that local purchase is resorted to through approved local chemists, if (a) the medicine prescribed is outside CGHS formularly and/or (b) it has gone out of the stock of the Medical Store Depot. In every city there is an approved chemist for this purpose. In Delhi, M/s Super Bazar has been appointed as approved chemist. So far as local purchase indents are concerned, the Ministry has added that after placing such an indent, supplies are made by the approved chemist either the same afternoon or the next morning.

3.69 The claim of the Ministry of Health that the normal time lag between the demand and supply of indented medicines is usually 24 hours in Delhi and 6–8 hours outside Delhi was challenged by all the non-officials/Organisations who tendered evidence before the Committee.

3.70 Relevant Extracts from evidence are given below :—

"as far as we have been able to find out, there is a lot of room for improvement and the claim that medicines are invariably supplied within 24 hours would be a little difficult to swallow. There are a large number of cases in which the waiting for the medicines is much longer than 24 hours."

[A Public Organisation]

"It is a fact that when my wife was ill and she was treated in the Willingdon Hospital by a Specialist. The Specialist prescribed certain medicines but we could get the medicine only after 15 days. During this period had to visit the hospital four times."

[Rep. of Central Sectt. Services Association]

"The statement of the Health Ministry is absolutely incorrect. In most of the cases it does not take less than four to five days while in some other cases it takes even a fortnight."

[Rep. of a Central Sectt. Officers Association]

"This is not correct. Our estimate of 36 to 48 hours is more correct and it is based on our actual experience. When medicines are not available in the dispensary, they have to end an indent to the central indenting office. I have a personal experience when I was able to get the medicine only after 7 days."

[Rep. of CGHS beneficiaries in Bombay]

"I am very sorry to state that my experience in Delhi is that even after 3 or 4 or 5 days we have not been able to get the medicines. Outside Delhi at least for 7 days I could not get medicines. So, this statement is totally incorrect."

[An M.P.]

3.71 A representative of the CGHS Medical Officers Association stated in evidence before the Committee that :

"It is a fact that medicines are not available—if not 50% of them, but it may be 40%. The factors may be different. There is a short supply of medicines .... that there is a shortage of medicines in CGHS. There is no doubt about it."

3.72 The Ministry has, however, stated that in most of the cases local purchase of medicines, the Chemists have supplied the indented medicines on time. In rare cases, however, local chemists are unable to supply on the specific due date. But such cases are extremely rare. Whenever such an incidence occurs, it is impressed on the chemists to be more prompt.

3.73 In reply to a query whether any study had been made into the working of indenting units attached to dispensaries, the Minister stated that no such study had been carried out.

3.74 As regards time-lag between indentation and supply of medicines by chemists, the representative of the Ministry stated in evidence that many a time certain indented medicines were not supplied by chemists. For example, out of a total of 277 indent slips issued from Moti Bagh dispensary (New Delhi) on 3 days in July, August and September 1981, 232 medicines were supplied within 24 hours and 45 could not be supplied for various reasons like, go-slow and strike in manufacturing units discontinuance of or interruption in production by manufacturers, non-availability in ready stock, inability of producers to cope with demand.

The witness said that :

"shortages have arisen from time to time. Let us not try to gloss over the problems. There are problems of adequate stocks at the Central Depot and adequate stocks at the dispensaries. We are trying to make up. I am only trying to say that it has to be viewed against the general context of periodical shortages arising from time to time."

3.75 The Ministry informed the Committee that "efforts are being made to ensure that such shortages are not recurrent."

3.76 The witness denied medicines indented on the depot were supplied with a delay of a week or more than that.

3.77 The Times of India in its issue dated 18-9-1981 reported :—

"Drug supplies to the dispensaries (in Delhi) have been extremely erratic and some of them do not even have enough stocks of basic medicines like Aspirin, Crocin, Analgin and Baralgan. While the worst suffers have been the lower and middle class localities like Sewa Nagar, as their needs are always accorded low priority, residents of the VIP colonies like Pandara Park, Bapa Nagar and South Avenue too have had an equally trying time getting medicines from their dispensaries. The dispensaries catering to the top brass are better maintained and equipped and their needs are looked into

immediately. The quality of drugs available here is far superior and the attendance by doctors more regular."

3.78 Referring to this press report the Ministry stated that :—

"Admittedly there has been shortage of drugs at times in CGHS Dispensaries. Efforts are being made to streamline the purchase and other procedures. CGHS is not providing superior quality of drugs to dispensaries catering to VIPs."

(iii) *Buffer stock of Medicines in Dispensaries*

3.79 Director General, Indian Council of Medical Research in his memorandum submitted to the Committee suggested that prompt measures should be taken to provide every dispensary with adequate buffer stock of the common medicines. The moment the buffer stocks are drawn upon there should be a feed system by which such drugs are immediately supplied.

3.80 Elaborating his view-point, the Director General, who appeared before the Committee as non-official witness stated in evidence :—

"The alternative that I have suggested is that we improve our drug purchase, drug management, drug supply position within the CGHS itself through a proper management technology. It should be possible to ensure a continuous supply of drugs and medicines through a proper mechanism of a buffer stocks. If you had a buffer stock and you kept an eye on how it is being depleted, there should be a replacement in a continuous manner, I see no difficulty in this at all. If the patient gets his drug at the place where he has been examined and where he has been prescribed a medicine, it would help him. So you don't have to go to another place".

3.81 Giving its reaction to the above suggestion, the Ministry stated that the CGHS dispensaries are expected to stock drugs on the formulary. In view of wide variety of medicines, it would be impractical for the CGHS to stock all of them. The Ministry conceded that due to administrative reasons some medicines do run out of stock. On such occasions every effort is made to supply suitable substitute or procure the appropriate medicine in the shortest possible time.

3.82 Secretary (Health) in his evidence before the Committee stated :—

"We have our Central Stores for medicines. At Karnal also we have a centralised stores. We have asked the CGHS dispensaries to replenish the stocks from nearby stores rather than depending only upon the CGHS supplies or direct purchases. This has somewhat improved the position. I would say, the position has improved substantially. This is one step we have taken in this regard ..... We have asked them to keep buffer stocks of commonly required drugs."

(iv) *Cuts in Indents*

3.83 It was reported in The Times of India, Delhi, (18-9-81) that :—

"The Kidwai Nagar dispensary for instance had last indented for about 350 items but only 150 were received from the Central Depot. The others were merely marked 'not available' with no further ex-

planation. The dispensary did not have adequate staff of drugs for hypertension, tubercolosis, asthama and diarrhoea and at one stage even aspirin and throatpaint were not available. This forced the authorities to put up a notice admitting the shortage of drugs and asking the people to bear with this inconvenience. The other dispensaries too have been facing a similar crisis."

3.84 Referring to the phenomenon of cuts in indents by Central Medical Depot, the Study Team of the Department of Personnel and Administrative Reforms had recommended in their report (April 79) :

"The store depot should not, unless absolutely necessary because of the low level of stock make any cuts in the quantities indented in the regular indents by the dispensaries."

3.85 During surprise visits paid by Study Group of Estimates Committee to certain dispensaries, it was noticed that full quantities of medicines indented by dispensaries were not supplied by the Central Store. There were blanket cuts and no reasons were given.

3.86 On the question of cuts made by the Central Stores, the representative of the Ministry stated in evidence that :—

"When the Central Store gets an indent for an item of which the stocks in the Central Stores are very limited, then they effect a prorate cut."

3.87 In order to make a case study of the magnitude of cuts applied to indents placed by dispensaries on Central Medical Store the Committee asked for information regarding the medicines indented by four dispensaries in Delhi (S. N. Market, R. K. Puram-III, Rajpura Road and Moti Bagh) in January, February and March, 1981 and the quantities supplied by Central Medical Store. From the information furnished by the Ministry it was seen that in large number of cases medicines were either not available in the Central Store or substantial cuts were applied, as will be seen from the following statement :—

	No. of medicines indented	No. of medicines in which substantial cuts were applied	No. of medicines which were not supplied at all
Jan. 81 . .	293	30	32
Feb. 81 . .	192	37	21
March, 81 . .	294	150	87
	779	217	140

[Low or no stock and high demand were stated to be the reason for apply the cuts in indents].

(v) *New System of Supply of Medicines*

3.88 From the memoranda received and the evidence heard by the Committee, it was seen that perhaps the weakest and most criticised area of working of CGHS is the present system of dispensing medicines. Medicines are not readily available in many cases; indented medicines take many days to arrive; quality of medicines does not inspire confidence; patients have to stand in long queues; they have to pay repeated visits; pharmacists behaviour and efficiency is far from satisfactory. If only the medicines distribution system is streamlined and modernised; much of the cause of dissatisfaction with CGHS would vanish.

3.89 The following suggestions have been made to place the supply of medicines on a more systematic and satisfactory footing :—

1. (a) CGHS dispensaries should confine themselves to "prescribng" medicines and the prescribed medicines should be allowed to be purchased without cash payment by CGHS beneficiaries from Super Bazar Branches and certain other Chemists to be recognised by the CGHS Directorate and they may seek payment from Government direct for the supplies made.

   (b) The existing Dispensing Units in the Dispensaries should be converted into mini-chemist-shops to be run by Super Bazar or other 'recognised' chemists.

2. Pending the aforesaid arrangement, the prescribed medicines which are not available in ready stock in a dispensary should straight-away be authorised to be purchased, without cash payment, from Super Bazar Units or other "recognised" chemists. Consequently the indentation system in the Dispensary would be discontinued.

3.90 Giving its reaction to the suggestions, the Ministry stated that Super Bazar will not be able to open branches to cover all the CGHS dispensaries. The medicines as purchased by CGHS are about 20% cheaper than the rates of Super Bazar and thus, the proposal will involve heavier financial outlays. The advantages of bulk planned purchases would thus be denied to Government.

3.91 The Secretary, Ministry of Health during evidence stated that :

"The suggestion of permitting the CGHS beneficiaries to purchase medicines prescribed by doctors from recognised chemists was tried..... sometime. But this system had to be given up because of heavy misuse, because of the collusion between the beneficiaries and the chemists and all that."

3.92 The Committee point out that the proposal will involve following savings which will more than off-set the higher cost of medicines :—

(i) There will be no leakage of Government moneys in the shape of pilferage, wastage and time-barring of medicines.

(ii) CGHS will not have to employ para medical staff for distribution of medicines.

(iii) CGHS will not have to hire accommodation for keeping and distributing medicines.

3.93 The Ministry stated in a note submitted after the evidence :

"At present the medicines are procured and issued through dispensaries so that the beneficiaries do not have to waste much time in getting the prescribed drugs. The consultation with Medical Officer and dispensing of the medicines is completed at the same place.

The system proposed by Estimates Committee, was taken up with the Super Bazar. They have categorically intimated that it will not be possible for them to open more branches and also to issue medicines to the patients."

3.94 The Study Team of the Department of Personnel and Administrative Reforms had also made a similar recommendation in Report (1977). It recommended :

(i) Opening of Chemist units in as many branches of Super Bazar as possible may be expedited;

(ii) In respect of non-listed medicines and medicines out of stock in the Central Stores Depot, the beneficiary, if so desired may be authorised to procure the medicines directly from the Super Bazar.

3.95 The Ministry's reaction to these recommendation were as follows :—

(i) "M/S Super Bazar has not agreed. For administrative reasons, private chemists were not considered for this.

(ii) For life saving medicines, patients can get emergency slips round the clock. For other categories supervision and control is necessary, in order to maximise resource utilization."

(vi) *Medicines prescribed by specialists and Endorsement on the Specialists slip*

3.96 It has been represented to the Committee that patients referred to specialists in far off hospitals or polyclinics should not be required to go back to their own dispensaries for collecting medicines. This procedure is time-consuming, unnecessary and inconvenient.

3.97 Asked whether patients referred to the Specialists have to go back to the referring dispensary and seek an endorsement on the specialists' prescriptions from Dispensary doctors to get the medicines prescribed by the Specialists, if so, the underlying idea in laying down such a time-consuming procedure.

3.98 Stating that the procedure was as stated above, the Ministry explained that it is the dispensary doctor working as the family physician who knows the full individual history, family history, social background etc. and it is he who can offer a comprehensive treatment to any patient. The duty of the specialists is to give consultation and advice regarding diagnosis of the disease. The treatment is to be prescribed by the Dispensary doctor. After Specialist consultation, therefore, the patients are expected to go back to dispensary for continued medical care and issue of medicines.

3.99 The Study Team of the Department of Personnel and Administrative Reforms and recommended in their Report on the working of CGHS dispensaries (September, 1977) that :

> "The medicines prescribed by the Specialists may be dispensed from the CGHS Hospitals or the nodal dispensary where the consultation is taken. The procedure that the patient should obtain the same from his parent dispensary may accordingly be modified".

3.100 The Ministry stated that "this interferes with the patient doctor-relationship. Moreover, medicines are issued only from the dispensary in which a Token Card is entered. This procedure is likely to lead to misuse".

3.101 The Study Team of Department of Personnel and Administrative Reforms had also recommended that—

> "The medicines prescribed by specialists may be dispensed for the total specified period of the treatment. If it is not practicable, the period may at least be increased to two weeks from one week as at present".

3.102 The Ministry had not accepted this recommendation either. The Ministry stated that "for administrative reasons, and also in the interest of patients who would take medicine for long without medical supervision, this has not been found practicable".

3.103 The Committee asked the Ministry whether it was a fact that, even where Specialists prescribed medicines for a long period of one month or two months, the medicines (which were not available in dispensary's stock) were indented for a week or maximum a fortnight at a time with the result that after every week or fortnight, the patients had to wait upon the doctors to get the medicines indented again and in this process they had to go without medicines between the date of indentation and the date of receipt of indented medicines.

3.104 The Ministry stated that frequent follow-up checks are necessary to evaluate the response of the patients to the treatment and if necessary to modify the treatment accordingly. It is, therefore, in the patient's own interest that medicines for long duration are not supplied when he can keep on consuming a fixed dose without frequent medical supervision. However, as per existing procedure, the patients are expected to present their prescriptions for a subsequent indent about 2-3 days before the next supply in due. Quite often, however, the patients come to the dispensary only after they have consumed the full quantity. This results in a gap in the treatment. Efforts are, however, made in such cases to always advise the patient to attend the dispensary about two days prior to the due date of the next supply.

3.105 Explaining the reasons why the medicines are not, indented for the full period for which these had been prescribed by the Specialists, the Ministry added that "if the medicine prescribed by Specialist is indented for the full period and it is subsequently found that the doses have to be reduced or particular medicine has to be discontinued altogether, this will lead to non-utilisation of the medicine and waste of public money".

(vii) *Role of Director, CGHS vis-a-vis medicines prescribed by Specialists*

3.106 The Committee enquired whether prescriptions given by Specialists to CGHS beneficiaries were required to be submitted to Director, CGHS for approval, if so whether he approved of this practice, the Secretary (Health) stated in evidence that—

> "The practice is not that the Director approves the prescription of the Specialists. The practice is that if the medicine is to be issued for more than a week, then the prescription had to be sent for clearance. According to the orders issued on 7th December 1981 we have now done away with this practice."

3.107 In a note submitted after evidence, the Ministry clarified that according to the procedure introduced w.e.f. February 1981 counter signatures of the Director General of Health Services and not Director, CGHS, were required for procurring medicines on local purchase for a period over one week. This was only an administrative measure to be followed by the CGHS Dispensary to ensure that the local purchase of items certified as inescapable by the Specialists only was made to avoid any irregularity or wastage

3.108 This procedure should not, in any account, be construed as the Director, CGHS sitting in judgment over the medicines prescribed by a Specialist. The Ministry stated that these orders had, however, been withdrawn since 8th December 1981.

(viii) *Substitute Medicines*

3.109 It has been brought to the Committee's notice in a number of memoranda that in place of medicines prescribed by specialists, the medical officers' of the dispensaries issue 'substitutes' in many cases. These substitutes, it is stated, are not of the required standard.

3.110 In another memorandum it has been stated that "Doctors making endorsement generally give cheap substitutes and that system of issuing cheap substitutes is dangerous particularly in case of serious ailments".

3.111 The Ministry stated that if a Specialist prescribed a particular brand of a drug, then generic product was supplied in pursuance of the Government decision on the Hathi Committee Report.

3.112 The Ministry added that it is not correct to say that the substitutes are not of the required standard nor is it correct to say that cheap substitutes are generally given. Substitutes of equal therapeutic effect are given. Specialists, by and large, prescribe medicines by generic names. When Specialists feel that the supply of a drug by brand name is inescapable it is certified as such, in which case the supply is made by brand name and in other cases a suitable substitute of equal therapeutical value is provided".

(ix) *Change of Brands of Drugs*

2.113 A Member of Parliament, who has been a Minister of Health in a State, in his memorandum to the Committee stated as follows :

> "I am a patient of Hypertension and, as such, have been taking suitable drugs prescribed by competent physicians here. The main difficulty in getting the drugs timely has been that from time to time they continue to change the brands of the drugs. This sort of change almost regularly proves to be highly irritating, mainly because human nature being what it is, one gets used to certain drugs and no substitute, is psychologically readily acceptable. Another reason is that, at times, the substitutes prove to be comparatively less effective and highly unsatisfactory."

3.114 Giving its reaction the Ministry stated that this point seems to imply that the brand name drugs are most satisfactory than generic name drugs. This is a fallacious argument, merely because the generic prepara-

tion is not psychologically acceptable. If brand name drugs are to be purchased in every case, the expenditure on drugs will escalate to a high degree and in the present financial constraints in the country, it is not economically desirable.

(x) *Duties of Medical Officer Incharge*

3.115 The duties of the Medical Officer-In-charge are as follows :—

(1) He is incharge of the dispensary and responsible for its proper running.

(2) General administration to ensure (a) punctuality among staff, their cordial and helpful attitude towards patients, (b) Cleanliness of dispensary, (c) Maintenance of dispensary building, furniture, fixtures etc. (d) discipline among the staff (e) availability of medicines.

(3) Correspondence with offices and Headquarters of CGHS.

(4) Ensure timely preparation and submission of various reports and returns.

(5) He is to listen to, and remove any grievance of the beneficiaries as well as of the staff.

(6) He is to ensure equitable distribution of patients' workload among all doctors, and to regulate his own workload commensurate with his other duties. He also ensures that requests for domiciliary visits are complied with timely.

(7) He is to maintain liaison with Residents' Welfare Associations, and Area Welfare Officer, and attend their meetings whenever convened.

(8) He may delegate some of the less important administrative duties among other medical officers to enable him to devote more time to professional matters.

3.116 The Committee enquired whether it had come to the Ministry's notice that in a number of dispensaries, under the pretext of attending to administrative work, Medical Officers Incharge did not see patients at all and whether the Medical Officer Incharge were justified in refusing to see patients in the name of administrative work.

3.117 The Ministry stated that Medical Officers saw patients apart from attending to administrative duties. No specific case where the Medical Officers Incharge had not attended to patients and devoted time exclusively to administrative duties had come to the notice of the Ministry.

3.118 From the memoranda received and the evidence heard by the Committee, it appears that perhaps the weakest and the most criticised area of CGHS is the present system of dispensing medicines. Medicines are not readily available; indented medicines take a few days, sometimes upto 7 days, to arrive, the Ministry's claim that these are made available within 24 hours in Delhi and 6-8 hours outside Delhi has been challenged by the beneficiaries; patient have to go without medicines for varying periods. Quality of medicines does not inspire confidence. Patients have to stand in long queues for cellecting medicines and they have to pay repeated visits to the dispensary for the purpose. Pharmacists behaviour and efficiencg are far from satisfactory. The Com-

mittee feel that if only the medicines distribution system is streamlined and modernised, much of the cause of the dissatisfaction of CGHS would vanish. (S. No. 41)

3.119 Though the Ministry has tried to explain the reasons, which it says are beyond its control, for non-availability of medicines in ready stock and also for delayed supply of indented medicines by Super Bazar or other approved chemists, the fact remains that medicines are not available in dispensaries and patients do not get medicines on time in many cases. The CGHS beneficiaries dissatisfaction, therefore, is not without basis. Even a representative of the CGHS Medical Officers Association stated before the Committee that upto 40% of the medicines prescribed by doctors are not available in ready stock.

3.120 The Committee feel that there is need to have a fresh look at the organisational set-up of the CGHS dispensaries entirely from a different angle It has been suggested to the Committee that the two functions at present performed by CGHS dispensaries, namely, consultation with and prescription by doctors and the issue of medicines, should be separated. The CGHS dispensaries should confine themselves only to consultation with doctors and prescribing of medicines by them. The dispensing units of the CGHS dispensaries should be converted into commercial units which should supply medicines to CGHS beneficiaries on the basis of doctors' prescription but without cash payment and settle accounts directly with CGHS Directorate. These commercial units may be run by Super Bazar or any other public sector agency. Only a commercially run dispensing unit can be expected to strive for customer satisfaction. This system will make dispensers and pharmacists accountable for pilferage, wastage and leakage of public funds. Staff costs, rent of accommodation and other overheads will not rise unrelated to sales, and sales need not be confined merely to CGHS beneficiaries. The Committee feel that this suggestion deserves a dispassionate consideration and trial on an experimental basis in a few selected dispensaries and its results evaluated after sometime before coming to a conclusion. (S. No. 42)

3.121 Where and so long as the organisational set up of the dispensaries is not altered as suggested above, the present system of supplying medicines should be overhauled on the following lines:—

(a) Whatever medicines prescribed by doctors are not available in ready stock in a dispensary, these should be straightway and on the spot authorised to be purchased locally on indents from approved chemists;

(b) Where the patient offers to collect the indented medicine himself, he should be given the authority to collect it from the approved chemist directly. This will avoid delays in urgent cases;

(c) In other cases, the dispensary may place indent on the approved chemist and issue to the patient as at present;

(d) It should be made the responsibility of the approved chemist to supply the indented medicine either from its own stock or with arrangement with same other chemist, without cash payment.

(e) The number of approved chemists in each city should be increased so that patients do not have to go far to collect their medicines. If super Bazar does not agree to open more branches, other chemists should be approved.

3.122 Similar recommendations were made by the Study Team of the Department of Personnel and Administrative Reforms (1977) but it is unfortunate that the Ministry held the age-old cancepts of supervision, central and administrative procedures too sacrosanct to be discarded in favour of the new approach. The Committee would urge the Ministry not to lose any more time to bring about changes in the system of issuing medicines with a view to meeting the CGHS/beneficiaries' needs and expectations. (S. No. 43)

3.123 The propossal of bufferstocks of common medicines in dispensaries coupled with a system of replenishment of stocks as they get depleted is a very sound proposal. It can ward off situations which at present arise quite frequently when dispensaries suddenly find common medicines out of stock to the discomfiture of patients. Health Secretary has informed the Committee that they have asked the dispensaries to keep buffer stocks of commonly required drugs. It is a step in the right direction. But unless the size and composition of buffer stock are clearly defined and a proper feed system is developed the desired results may not flow. The Committee, therefore, suggest to the Ministry to draw up a comprehensive scheme of buffer stocks and implement it under proper guidance. (S. No. 44)

3.124 Shortage of drugs in the CGHS dispensaries have been endemic and persistent. Though central medical store is supposed to maintain adequate stocks of medicines included in CGHS formularies, it has not been able to meet the requirements of the dispensaries. Reports that indents placed by dispensaries on central depot are either slashed subsequently or not complied with at all are not unfounded. The Study Group of the Committee observed this phenomenon during their study visits. Later after a case study of the indents placed by four disponsaries in Delhi (S. N. Market, R. K. Puram III, Moti Bagh and Rajpur Road) in January, February and March, 1981 and supplies made by the central store, it was confirmed that the central store has not been able to make adequate supplies of the needed medicines to the dispensaries on the ground of low or no stocks or higher demand. In January 1981, out of 293 medicines requisitioned by these four dispensaries, the central store applied sharp cuts in the case of 30 medicines and made no supply at all of 32 other medicines. The position worsend in February and March, 1981 when out of 192 and 294 medicines indented by these dispensaries, supplies of 37 and 150 medicines, respectively, were substantially cut and in the case of 21 medicines in February and 87 in March, 1981, no supplies, whatsoever, were made. All this cannot be explained away by some shortages, hare and there, of drugs in the country.

3.125. From what the Committee has heard, seen and studied, one conclusion is irresistable the central store has failed in the matter of timely and adequate supply of meeicines to dispensaries and for many of the ills of the dispensaries it is the central store which is chiefly responsible.

3.126 The Committee would like the Ministry to enquire into the working of the Central Medical Store and take immediate measures to streamline its working so as to make it a well-stocked reservoir of medicines to be able always to meet the dispensaries' needs regularly and without delay. For this purpose, among other things, inventory control procedures will have to be modernised and personnel with adequate training and experience in materials management will have to be deployed to handle its affairs efficiently and systematically. (S. No. 45)

3.127 The Committee do not approve of the present procedure under which patients referred by dispensaries to the specialists have to go back to the referring dispensary to get endorsement on the specialists' prescriptions' from dispensary doctors and then collect their medicines from the dispensary. This procedure is time consuming, unnecessary and inconvenient. The Committee are of the view that, as recommended by the Study Team of the Department of personnel and Administrative Reforms (September, 1977) the medicines prescribed by specialists should be dispensed from the CGHS hospitals or the nodal dispensaries where the consultation is taken and the patients should not be required to shuttle between the specialists and the referring dispensaries on this account unnecessarily. The Ministry's objection to this recommendation that this would interfere with patient-doctor relationship or that this is likely to load to misuse, hardly carries conviction. The Committee strongly urge that CGHS beneficiaries should be issued medicines prescribed by specialists from the hospitals or nodal dispensaries where the consultation takes place and pending setting up of dispensing units in the hospitals, the prescribed medicines should be allowed to be purchased from the Super Bazar units already working in the CGHS hospitals on credit. (S. No. 46)

3.128 The Committee also feel that the recommendation of Study Team of the Department of Personnel and Administrative Reforms that the medicines prescribed by specialist should be disposed for the total period recommended by the specialist. The Committee recommended that it should be implemented without any further delay. This procedure will not only save the patients of the botheration of visiting dispensary and standing in long queues every week but also reduce crowding and pressure in the dispensaries and should be introduced without any further delay.

3.129 Even when a specialist prescribes a medicines for a period of one month or so and when the medicine is not available in dispensaries' stock and has to be indented from Super Bazar or other local chemist the dispensary indents medicines only for a week or so at a time. The result is that the patient has to get the medicine indented every week and come again to collect the week's supply. This is a waste of time. The Committee do not see any reason why a medicine if it has to be indented, cannot be indented and issued for the full period for which it has been prescribed by the specialist. This will avoid gaps in treatments. Hypothetical fear of non-utilisation of a part of the purchased medicine should not be held against the introduction of this procedure. (S. No. 48)

3.130 The Committee are happy to note that the practice introduced in February, 1981 under which counter signature of Director-General of Health Services were required for procuring a medicines on local purchase for a period over one week, has been discontinued with effect from December 1981. There was no particular advantage nor any *rationale* in routing the specialists' prescriptions through D. G. H. S. It only resulted in delays and immense harassment to patients. (S. No. 49)

3.131 The Committee take note of the circumstances in which medicines with brand names, prescribed by specialists are not issued by the dispensary doctors and in their place generic products are supplied in pursuance of Government decision on the Hathi Committee Report. The Committee, however, cannot but also take note of a general scepticism among CGHS beneficiaries that substitute medicines given in lieu of brand names are not of the required standard and comparable therapeutic value. This scepticism is further ac-

centuated when they find different substitutes with different colours and shape given on different occasions in lieu of the same brand name. What is important is the quality of medicines and not merely the brand name. The Committee do not see any objection in supplying medicines by generic names in lieu of brand names provided the substitutes have been found to be of proven quality and same therapeutic value after scientific tests. It will be wrong in the Committee's opinion to prescribe any untested substitutes in lieu of brand name. The Committee would like the Ministry to review the generic name medicines in the CGHS formularie from this angle and intimate to the Committee whether all of these generic name medicines have been found to be of required standard and therapeutic value, and also ensure that no new name may be added to formulary before subjecting it to quality test. (S. No. 50)

3.132 The Committee also feel that in sensitive and chronic cases in which treatment with brand names medicines has been able to control or stabalise the problems, and where a switch-over to generic name substitute is likely to create a psychological effect or introduce an element of risk or slow down recovery, it will be advisable not to insist on issue of substitute medicines in lieu of brand names regardless of cost implications. Doctors should have no fetish either for generic names or for brand names. Each case should be treated on merits with due regard to the psychology of the patient and the state of ailment (S. No. 51)

3.133 The Committee take note that Medical Officers Incharge of the dispensaries are required to see patients apart from attending to administrative duties. This is as it should be as otherwise Medical Officers will be reduced to merely administrative officers. The Ministry should, however, ensure that this happens in actual practice. (S. No. 52)

C—Specialits Services

3.134 In Delhi C.G.H.S. Specialists in various disciplines are posted at Dr. Ram Manohar Lohia Hospital, Safdarjang Hospital, C.G.H.S. Polyclinics etc. These Specialists are borne on the strength of C.G.H.S. and are under the administrative control of Director (CGHS). The patients referred by the C.G.H.S. dispensaries may have the consultation and advice of the Specialists in the OPDs of the hospitals and C.G.H.S. Polyclinics. The Specialists pay visit to the dispensaries of different areas according to a Schedule approved by Director (CGHS).

3.135 The patients of certain specified diseases are referred to the other Government, Municipal and Private hospitals recognised for the purpose.

3.136 In Delhi Specialists Services have been decentralised and are provided in different areas in Polyclinics or Specialists Centres attached to certain dispensaries. Due to financial constraints, it has not been possible to open Polyclinics in all the areas though it is desirable to do so.

(i) *Availability of specialists services in CGHS dispensaries*

3.137 In some of the memoranda received by the Committee, it has been stated that :

> "Specialist services should be made available in all major dispensaries. There should be no restriction on the specialists to write prescriptions."
>
> ".... The Specialists should visit a dispensary atleast once in a week."

3.138 In a number of memoranda received from outside Delhi also, it has been complained that Specialist services are not adequate.

3.139 The Ministry has stated that it is not possible to send these specialists to all CGHS dispensaries, because there will not be sufficient work-load to keep them occupied for the whole time. Much time will also be wasted in travelling from one dispensary to another. There are nodal points where specialists visit and patients from neighbouring dispensaries consult the specialists at the nodal dispensary according to a time schedule. The specialists do visit nodal dispensaries at regular intervals. The Ministry has added that this arrangement is more convenient to CGHS beneficiaries. Besides, there are two Polyclinics in Delhi at Kasturba Nagar and Pusa Road where specialists services are available.

3.140 The Ministry has further stated that in cities outside Delhi it may not be possible to provide specialists services in every speciality, because the total number of patients referred for consultation may not be sufficient. The question of opening Polyclinics in cities other than Delhi is, however, under consideration.

3.141 Explaining the present arrangements in Delhi, the representative of the Ministry of Health stated in evidence :—

> "So far as Delhi is concerned, I have to furnish the number of visits made by Specialists as follows :—

Specialists	No. of dispensaries being visited
Medical	35 out of 75
Surgical	5
ENT	6
Eye	8
Skin	32

> Besides, we have got four polyclinics all over India where Specialists are available. We propose to open 12 more polyclinics in all the Centres during the Sixth Plan.
>
> The question of providing Specialists' services in all the Dispensaries will have to be looked into and solved with adequate care because it may ultimately result in a situation where the Specialists do not have enough work. So, necessarily the Specialist' attention has to be concentrated on a given number of Dispensaries and the present system in Delhi, in our view, provides adequate coverage."

(ii) *Visit of Specialists to Dispensaries in Bombay*

3.142 It has been stated in a memorandum received from the residents in Central Government Quarters, Koliwada, Bombay that :—

> "The drugs which are to be prescribed by the Specialists who is supposed to visit the Dispensary once a week invariably visits the dispensary twice a month and the patients have to wait for his next visit as the essential medicines are not prescribed by the doctors other than the specialists. Therefore, the patient has to purchase medicines at his own cost to save himself from the agonies.

Can the sickness wait till the arrival of the Specialists ?

Can the sickness wait till the medicines arrive from the Central Stores which takes atleast two days."

3.143 In this connection, the Ministry has stated that the Specialist is expected to visit CGHS dispensary, Koliwada once a week and normally does so. Patients are given attention and medicine in time. The patients who need immediate special attention can go to CGHS Polyclinic at Ballard Estate, Bombay or can be referred to any one of the recognised hospitals. The need for such action is to be decided by the Medical Officer, on medical grounds depending on the condition of the patient.

3·144 In Delhi the CGHS beneficiaries requiring specialists attention are referred to Dr. Ram Manohar Lohia Hospital, Safdarjang Hospital and Poly-Clinics where CGHS specialists are posted. Specialists also visit nodal dispensaries in Delhi numbering 35, where patients from neighbouring dispensaries come to consult them. Specialists, however, do not go to all the dispensaries because there may not be sufficient workload to keep them fully occupied. In the memoranda submitted to the Committee by associations of CGHS beneficiaries in Delhi and elsewhere a need for providing specialists in more dispensaries has been expressed. According to the Ministry the present arrangement is quite adequate. Whether the number of specialists appointed in various disciplines has been determined after a scientific survey or on an *ad hoc* basis is not clear. Nor has the criterion adopted to declare a dispensary as 'nodal' dispensary been explained.

3·145 The Committee would suggest that workload for specialists consultation in each branch should be systematically assessed *vis-a-vis* the existing capacity of the specialists available and shortage in any particular branch made good. Needless to say, adequate number of specialists should be available to cope with the demand not only in Delhi but also in other cities. The Committee would like to be apprised of the outcome of assessment city-wise. (Sl. No. 53)

3.146 Decentralisation of specialists services is a step in the right direction. The Committee agree that it is not necessary to provide specialists in each dispensary. But it should be the objective of the Ministry to provide specialists for a group of dispensaries at least in areas which are far off from Dr. Ram Manohar Lohia Hospital and Safdarjung Hospital. It is unfair to make patients living in far off colonies to go all the way to the aforesaid hospitals when beneficiaries living nearby may be enjoying the specialists facilities in nodal dispensaries. The Committee would like the Ministry to review the present location of nodal dispensaries and their linkage with other dispensaries and inform the Committee of the steps necessary to augment and rationalise the present facilities. (Sl. No. 54)

3·147 The Committee also suggest that the availability periodicity and efficiency of specialist services provided in Bombay and other cities outside Delhi should be appraised in the light of the experiences of CGHS beneficiaries there and remedial action taken to place these services on a reasonable level of efficiency. (Sl. No. 55)

CHAPTER IV

CGHS MEDICAL STORE DEPOT

A. Stores Organisation and Functions

4.1 The CGHS Medical Stores Depot which works under the overall control of a Deputy Director caters to the requirements of CGHS Allopathic Dispensaries in Delhi/New Delhi. In addition, requirements of CGHS Maternity Centres and Hospitals in R. K. Puram, Kalkaji and Srinivaspuri and also of Delhi Police Hospitals at Kingsway Camp and Rajpur Road, which are under the control of CGHS, are met by this Depot. It also caters to the requirements of medicines of two mobile dispensaries which serve far-flung areas in the city.

4.2 Supply of non-drug items to Ayurvedic, Homoeopathic and Unani Dispensaries is also the responsibility of this Depot.

(i) *Procedure of Purchase and Stocking of Medicines*

4.3 It has been stated in a memorandum that the whole system relating to the procurement/supply of medicines is highly defective and the beneficiaries have a genuine ground for complaint about the shortage of medicines in the dispensaries. The functioning of CGHS medical Stores Depot needs to be streamlined immediately as the very reputation of CGHS is at stake due to malfunctioning of the CGHS Medical Stores Depot. To streamline the supply of medicines to more than 90 dispensaries/Units and to strengthen the functioning of Medical Stores Depot, it has been suggeted that in addition to one main CGHS Medical Store Depot three sub-Depots, one for each CGHS Zone, may be set up to feed the dispensaries under their charge.

4.4 Giving their reactions to the above suggestions the Ministry stated that the purchase/procurement/shortage and issue procedures have already been examined in detail, by the Deptt. of Personnel and Administrative Reforms.

(ii) *Procurement of Medicines*

4.5 The procedure for purchase and storage of medicines for use in CGHS dispensaries and their distribution to various dispensaries has been explained in the succeeding paragraphs. Purchases procedure for each system are not identical for practical reasons.

4.6 The Ministry have stated that on 1st of April each year, based on the consumption trend of the past three years, and after allowing for sufficient buffer stock to be maintained, and balance held in stock on that day, requirements of each item of drug for the next year are worked out. The total value of each item is worked out and total requirement in money terms is arrived at. If it is found to exceed the budget provisions, pro-rata cut is imposed on all non-life saving items so as to bring down the proposed expenditure within the funds available. This however, reduces the actual requirement.

(iii) *Method of Purchase*

4.7 DGS&D have concluded rate contracts for about 30 Allopathic drugs with different firms. These drugs are purchase from these firms against rate contracts. Purchases of items outside these contracts are improper.

4.8 Following procedure is followed in respect of items not covered under rate contracts :

(i) *Items exceeding Rs. 1 lakh in value*

Indents are placed with DGS&D after the quantity has been worked out. They float tenders and place orders with firms as they consider fit. Government departments placing indents have no say in this.

(ii) *Items less than Rs. 1 lakh in value*

Firms are registered by the High Power Committee (Drugs) of the DGS&D. CGHS also follows this list and floats tenders to them. Lowest tender offered which conforms to the specifications in the tender are always approved. Rates are approved by CGHS Medical Stores in Delhi and the same rates are applicable throughout India.

(iv) *Storage*

4.9 Medicines procured are stored in a central place in the Central Medical Store Depot in the premises of Dr. R. M. L. Hospital. There are separate depots in respect of other systems of medicine. Cities other than Delhi also have their depots.

(v) *Distribution*

4.10 The medicines are distributed to various dispensaries on demand according to the prescribed procedure.

4.11 Local purchase is resorted to through approved local chemist, if (a) the medicine prescribed is outside CGHS formulary and/or (b) it has gone out of the stock at the Medical Store Depot. In every city there is an approved chemist for this purpose. In Delhi, M/s Super Bazar has been appointed as approved chemist.

4.12 From the information furnished by the Ministry regarding the indents placed by CGHS Directorate on DGS&D during the years 1978-79, 1979-80 and 1980-81 and the dates of placing orders by DGS&D on suppliers and the actual dates of supplies of medicines, it is seen that in almost all cases the supplies were made long after the targets dates by which the drugs were required by the CGHS. The delay ranged from 3-12 months. Even the orders placed by DGS&D on the suppliers after receipt of indents from CGHS were in most cases considerably delayed. The Committee found that normally indents are placed by CGHS Directorate on DGS&D towards the end of May and mostly in June and July of a year.

4.13 The representative of the Ministry informed the Committee during evidence that indent is sent to the DGS&D early in a financial year. The witness added that "the position is kept under constant watch although the arrivals from the DGS&D rate contracts and ATS are very often delayed."

4.14 The witness further stated that "we are the largest consumer. The Medical Stores are competent to purchase medicines. So, exemption could be granted from the stipulation that we should buy up from the DGS&D as this is not going to affect the overall cost of purchase. We are able to get at competitive price the medicines as the DGS&D is able to get ..... 50% of our medicines we buy ourselves. If we buy another fifty per cent, it may not be much of a burden."

4.15 The witness admitted during the course of evidence that because of lack of funds, their supply position was bad and the dispensaries were facing the difficulties on this account.

4.16 Asked if within the existing procedure of indenting through DGS&D the process could be expedited, the representative of the Ministry explained that "considerable refinement in the procedure can be brought about. Indenting now takes place after the Budget is passed. Then indenting can take place early. Financial availability certificate can be given at the time of placement of tender three to four months ahead."

4.17 As regards quality, the witness added that "DGS&D is obliged—as they have to support the small scale sector—to issue tenders to firms which are registered with them and firms not registered with them. In the drug industry quality is very very important. So, our suggestion to DGS&D has been that firms registered with DGS&D alone should be tendered for."

B Quality Control of Medicines

(i) *Procedure for Quality Control followed by CGHS Medical Store Depot in respect of Allopathic Drugs*

4.18 All supplies are covered by warranty certificate in the proforma prescribed with each consignment by the firms. On receipt of supplies, they are compared with the control samples received at the time of tenders before acceptance. Since rates are valid for whole of India, control samples of accepted firm are sent to all units outside Delhi for their comparison.

(ii) *Chemical analysis before acceptance*

4.19 Due to limited facilities for testing available batches of all supplies are not subjected to chemical tests. Test is carried out on set of priorities listed below :—

(i) Supplies from unregistered firms or firms from whom supplies have not been received in the past, all such supplies are subjected to chemical tests before accepting them—exception is made in case the item has gone out of stock and local purchase is being made at much higher rates. In these cases also if there are more than one batch supplied at a time the minimum number of batches necessary are used, on the basis of warranty and remaining are sent for testing.

(ii) All other firms : Random sampling is done for testing of products including brand products of renowned firms. When supplies from the firms falling in the first category are found to be consistently of acceptable quality, they are also brought down to the second category.

(iii) *Chemical tests after acceptance*

4.20 Whenever there is reaction to a drug or whenever there are complaints of quality or whenever it is suspected that drug may have deteriorated, in quality, the concerned drug is sent for testing.

4.21 Following action is taken subsequent to rejection of medicines found substandard :—

(i) Firm is asked to replace the rejected, stores with stores of acceptable quality, if stock level permits, such replacements are again got tested.

(ii) Copies of test reports are forwarded to

(a) All State Drug Controllers.

(b) Drug Controller (India).

(c) All CMOs of CGHS throughout India.

(iii) Performance of firms whose supplies are repeatedly rejected is also forwarded to DGS&D recommending deregistration and/or suitable action.

4.22 In a number of memoranda received by the Committee, complaints were made that medicines supplied by the CGHS were sometimes sub-standard, and of cheap quality.

4.23 It was stated in a memorandum that "the problem of quality of drug supplied is often raised from time to time. This needs periodical check up at several levels and different times and situations. There should be built-in-mechanism for prompt action against the defaulting persons.

4.24 The Para-medical staff Association in their memorandum stated that "the medicines supplied to the beneficiaries from the CGHS dispensaries have little curative effect as proved from the repeat visits of patients".

4.25 The Ministry had admitted that "due to limited facilities for testing available, batches of all supplies are not subjected to chemical tests" and that "circumstances may not permit all the batches to be tested".

4.26 The Committee asked whether in view of the widespread dissatisfaction with the quality of drugs issued through CGHS, the Ministry did not feel the necessity of taking immediate and foolproof measures to ensure that the drugs purchased by CGHS were of the standard quality and not a single supply was accepted and used without prior quality test ?

4.27 The Ministry stated that "the medicines for CGHS are purchased from firms which are registered by DGS&D after ensuring the quality of their products. Purchase from unregistered firms is done only through DGS&D. Secondly drugs produced and marketed by firms are subject to the provision of Drug Control Act. Besides, this, ample check is made under CGHS where possible. As such it is not correct to say that medicines given to patients are not tested for quality".

4.28 Referring to the procedure for quality control as mentioned above, the Ministry added "every effort is being made to ensure that only quality drugs are supplied. In this connection, it may be added that adoption of

recommendations of Hathi Committee report regarding the supply of drugs under their generic names rather than brand names is being followed generally by the CGHS. Such of a popular brand name by generic drugs of equal therapeutic value is often construed as supply of substandard drugs. This unfortunate impression does not appear to have any proper scientific basis".

4.29 The Ministry further added that "at present, the testing procedure followed by CGHS is by and large satisfactory".

4.30 The following statement shows the position regarding quality tests carried out on medicines purchased during the last three years :—

Sl. No.	Name of city	The value of medicines purchased	The inspections carried out to check quality	The value of medicines purchased	The inspection carried out to check quality	The value of medicines purchased	The Inspections carried out to check quality
		1978-79		1979-80		1980-81	
1.	Nagpur	14,48,000	Not done	11,64,000	5	29,32,000	Nil
2.	Ahmedabad	3,19,489·13	100%	2,45,809·67	—	2,92,818·96	Nil
3.	Jaipur	6,12,000	5	10,90,000	1	13,16,383	5
4.	Kanpur	16,94,671	Nil	16,90,720	Nil	24,23,823	Nil
5.	Patna	16,99,954·71	Nil	22,50,052·96	Nil	19,97,434·91	Nil
6.	Meerut	16,08,951	Nil	20,00,000	1	16,27,594	Nil
7.	Hyderabad	28,66,343	—	31,27,926	4	34,02,118·00	Yes
8.	Madras	18,82,674	5	22,56,630	10	20,65,417	Nil
9.	Calcutta	48,40,000	Nil	54,21,000	Nil	47,27,000	Nil
10.	Allahabad	18,95,102	1	13,81,663	3	15,50,233	2
11.	Lucknow	1,72,751·22	Nil	10,58,913·64	Nil	10,05,999·64	3
12.	Pune	5,41,660	Nil	7,64,778·62	1	11,24,469·42	4
13.	Bangalore	14,17,245·75	Nil	13,88,841·39	Nil	13,50,436·05	1
14.	Bombay	34,29,158,82	17	37,774,055·36	30	40,90,682·42	4
15.	Delhi	3,08,90,000	81	3,72,60,000	145	2,66,20,000	100
	Total Purchases without quality tests.	Rs. 1,34,23,232		Rs. 1,18,09,526		Rs. 1,60,66,085	

(iv) *Guidelines for selecting drugs for quality checks*

4.31 The Committee asked whether any guidelines/norms had been laid down for selecting drugs for quality checks, if so what, percentage of batches/drugs/supplies are required to be subjected to quality cheks, the Ministry informed the Committee that "drugs are generally received from unregistered firms on the basis of orders placed through DGS&D. These are generally tested prior to acceptance except where the need is urgent in which case reliance is placed on warranty clause till subsequent batches are tested. Sometimes purchase of drugs from new unregistered firms has to be resorted to through Super Bazar. In such cases also testing cannot be done because of paucity of time".

4.32 The Committee further asked as to how many batches/drugs/supplies obtained by the Central Medical Store Depot and the Medical Store Depots in each other city where CGHS is working, were to be quality checked and how many were actually so checked. In how many cases the quality checking was made before the drugs were used. In how many cases the quality was found to be not upto the mark and what precise action was taken in the matter. The Ministry gave information only in respect of Delhi, as follows :

Number of batches received from firms : 100
with whom CGHS had no past experience of supply. (1980-81)
Number of batch sought of these 100=46
on which quality test were not performed :

4.33 According to the Ministry, all these tests were carried out before acceptance of supplies. Out of the batches sent for test, 8 batches were found not of required standard. Following action was taken in respect of these batches :

(i) Firms was asked to replace with stores of standard quality.

(ii) Performance of the firm was reported to DGS&D.

(iii) Results of the test was communicated to all CGHS Units outside Delhi, all State Drug Controller and Drug Controller (India).

4.34 The value of drugs purchased through DGS&D and directly by CGHS during the last 3 years, is stated to be as follows :—

Year	Direct purchases	Through DGS&D
1978-79	Rs. 147·1 lakhs	Rs. 155·0 lakhs
1979-80	Rs. 150·8 lakhs	Rs. 221·0 lakhs
1980-81	Rs. 110·0 lakhs	Rs. 150·02 lakhs

4.35 Asked to state the percentage of batches of drugs purchased through DGS&D which were tested before/after purchase and the percentage of such batches of drugs found to be sub-standard, the Ministry stated that "there are no fixed percentage prescribed. Since, only a few of the orders placed by the DGS&D are with unregistered firms, all of them are not subjected to test. 100 batches were received in 1980-81 in Delhi from unregistered firms, or firms with which CGHS had not past experience. Out of these 54 batches were subjected to test. Out of these 8 batches failed in test".

4.36 Regarding the drugs purchased direct by CGHS, the Committee enquired whether the orders were placed with lowest tenderers only or whether quality was also taken into consideration the Ministry stated that "at the tender stage, it cannot be presumed that the supply shall be sub-standard. As such lowest tenders as per specification are accepted."

4.37 The number of batches of drugs subjected to tests in Delhi in 1979-80 and 1980-81 were as follows :—

	1979-80	1980-81
Total consignments subjected to test L (Delhi) .	145	100
No. of consignments failed	10	13

4.38 Asked to state whether the drugs were dispensed to patients before the tests results were received, the Ministry stated that the drugs were not accepted unless satisfactory test results were received.

4.39 The Ministry further stated that following action is taken against manufacturers of sub-standard drugs :

(i) Firm is asked to replace the substandard stores.

(ii) Performance of the firm is reported to DGS&D.

(iii) Copies of test reports are sent to Drugs Controller (India), all State Drug Controllers, and all Chief Medical Officers of CGHS outside Delhi.

(iv) As already stated, manufacturers are required to get each batch tested before release to consumers. State drug controller also see that this is done. CGHS only carried out a counter check. It may therefore, be seen that none of the batches are dispensed without any quality control test.

(v) Medicines are purchased by CGHS only from registered firms. Matter has also been taken up with the Secretary (Supply) to see that DGS&D also does not place orders with unregistered firms.

4.40 It would be impracticable to carry out cross check of every batch which may run into thousands.

4.41 With regard to the testing of medicines, Secretary (Health) informed the Committee in his evidence that —

"the overall responsibilities of Quality Control for drugs are that of the State Drug Controllers who enforce the Drug and Cosmetics Control Rules. The manufacturing firms have to get each batch tested.——— Then, the Inspector of the State Drug Controller are there. They have to keep a regular check. The check by the CGHS is essentially a cross-check. The check has already taken place. We purchase medicines through DGS&D, as also direct. With regard to the purchases through DGS&D, there are two categories of suppliers, one the registered suppliers and the other unregistered suppliers, we can have a limited check; they are the proven suppliers. The other is purchased from the unregistered suppliers. That is mainly to encourage the small scale industries. Out of 100 batches supplied by them, 54% have been subjected to check. With regard to registered suppliers, our percentage of checking is 6.7. We have taken up with the Ministry of Supply on 11-12-81 that we are not in favour of supplies by the unregistered suppliers".

4.42 From the information furnished by the Ministry, it was seen that direct purchases worth lakhs of rupees were resorted to in a number of cities where CGHS was in operation. The total value of medicines purchased by CGHS directly without any quality test, whatsoever, was Rs. 1.34 crores in 1978-79, Rs. 1.8 crores in 1979-80 and Rs. 1.60 crores in 1980-81. Patna Rs. 59 lakhs; Bangalore Rs. 41 lakhs (during last 3 years 1978–81) without carrying out any quality checks whatsoever.

When the Committee pointed this out the heavy purchases made in Patna (Rs. 59 lakhs) and Bangalore (Rs. 41 lakhs) in evidence, the representative of the Ministry stated that "These are all purchases by CGHS from registered suppliers..... and in such cases only very random checks are necessary".

4.43 Asked why even random checks were not done in Ahmedabad, Patna and Bangalore, the witness added —

> "In Patna the difficulty is that there is no a proved testing house. In Bangalore there are approved testing houses, but are very very few in number".

4.44 The Committee could not appreciate the idea of making purchases to the tune of lakhs of rupees directly by CGHS without some sort of quality checks, the witness stated that "under the Drugs Control Act, the drugs are subjected to rigid test at manufacturing stage and there are very severe and stringent specifications in the rules", Secretary (Health), however, stated in his evidence that "I accept that when we purchase drugs, we also have a responsibility to do some cross-checks. It was as a part of that responsibility that so far as registered, proven suppliers were concerned, we made 6.75% checks. As regards unregistered suppliers, 54% were submitted to check".

4.45 As the hon. member mentioned "with regard to Patna and other places, we must create our own testing facilities as early as possible, because we cannot afford to have isolated pockets without any check. We will soon make provisions for this".

4.46 In this context of huge purchases of drugs made in Patna, Ahmedabad and Bangalore without quality tests, the Committee also raised the question of financial powers of CGHS officers to make direct purchases of drugs.

4.47 The representative of the Ministry stated that the Chief Medical officers of the aforesaid places as heads of offices, have full financial powers to make purchases subject to budget allocations.

4.48 In a note submitted after evidence the Ministry informed the Committee as follows in regard to purchases of medicines in Patna and Bangalore during the last 3 years —

> "CGHS Medical Stores Depot, floats tenders to registered firms. After the quotations have been approved, rate agreements, valid for one year from 1st April each year, are entered into, with the firms. Copies of these rate agreements are sent to all Chief Medical Officer's outside Delhi including Bangalore and Patna. They purchase items only in accordance with these rate agreements. For items which have suddenly gone out of stock, each C.M.O. appoints a local chemist for purchases from local firms after floating tenders. Such items are purchased from these local sources. The Chief Medical Officers of CGHS have been declared "Head of Office" and enjoy the powers of "Head of Office". They are empowered to purchase medicines subject to budget provision with the further

provision, that if the value of any items exceeds Rs. 1 lakhs, the papers are sent to D.G.S. & D. for placement of orders. It has been ascertained from Chief Medical Officers of Patna and Bangalore, that during the last 3 years, no item costing more than one lakh was purchased by the Chief Medical Officer. There are about 2700 medicines in the formularies of different systems taken together, and the value of purchases made is as given below :—

Value of Purchases in lakhs other than through local chemist

	1978-79	1979-80	1980-81
CGHS Bangalore . .	13·09	12·20	11·70
CGHS Patna . . .	12·95	17·24	11·83

There is no approved laboratory at Patna. As such no tests were carried out. As regards CGHS Bangalore, one batch in 1978-79 and 1980-81 was got tested from the Government Analyst of the Drugs Control Department. It may, however, be stated that there are no regular arrangements for cross-checking of all the consignments received by CGHS. It is the responsibility of the State Drug Controllers to ensure that the Drugs which are marketed are of the desired and prescribed standard".

(v) *Purchase of Medicines from Unregistered Firms*

4.49 The Ministry stated that in the case of Allopathic drugs, since original enlistment is done by DGS&D, only that department is competent for blacklisting. Whenever drugs are found to be substandard supplied by firms registered with DGS&D, suitable information is sent to DGS&D to take action.

4.50 Asked why purchases were made from such firms again 1980-81, the representative of the Ministry stated—

"E. Merck is a multinational company. A batch of their product was not up to the mark. But Merck supply very essential medicines and if we stop buying from them, we cannot get same essential medicines. There are other firms also—Hindustan Antibiotics Ltd., Poona. It is a public sector company producing penicillin and streptomycin. If we discontinue purchases from them, we would not get penicillin".

Names of Firms whose supplies of medicines have been found to be sub-standard

4.51 The Ministry supplied the following statement showing names of firms whose supplies were found to be sub-standard in 1980-81 and whose names were recommended to the DGS&D for suitable action.

4.52 The firms whose names were forwarded to the DGS&D during 1979-80 recommending de-registration or any other suitable action are mentioned below. As far as the Ministry was aware value of purchasers

made from these firms during 1980-81 are shown against them, none of these firms had been blacklisted (Position as in August, 1981)—

Sl. No.	Name of the firms	Purchased through DGS&D during 80-81	Purchase made through local order
1.	M/s. Tablet Ltd., Madras	5,10,640—40	Nil
2.	M/s International Chemical Cor. Amritsar	Nil	46,239—64
3.	M/s Tabsules Isomers (1) Pvt.	Nil	Nil
4.	M/s Trroks Pherma, Bahadurgarh	Nil	Nil
5.	M/s E. Merck	Nil	58,045—55,
6.	M/s Becon Pharmacutical, Bombay	Nil	21,243—75
7.	M/s C. I. Lab. Calcutta	2,74,417—00	Nil
8.	M/s Tamil Nadu Dhadha, Madras	Nil	Nil
9.	M/s Sigma Laboratories, Bombay	1,15,915—00	Nil
10.	M/s P.G.I., Bombay	2,43,167—20	Nil
11.	M/s British Pha, Lab, Bombay	Nil	49.440-00
12.	M/s Hindustan Antibiotic, Poona	56,732—40	Nil
13.	M/s India Chemical New Delhi	Nil	Nil
14.	M/s Nectarine Pharma, New Delhi	2,38,190—26	94,880—96

Statement for purchases made during 1981-82, upto 31-12-1981 from firms. (Figures relates to Delhi only)

Sr. No.	Name of firms	Value of order placed
		Rs.
Allopathy		
1.	M/s. International Chemical Corpn. Amritsar	73,313·76
2.	M/s. Viper Chemcials, Baroda	17,316·00
3.	M/s. Tabsules Iseners Ltd. Bombay	Nil
4.	M/s. Sigma Laboratories, Bombay	Nil
5.	M/s. Spencer & Co. Madras	Nil
Ayurvedic		
6.	M/s. Himachal Drugs, Pharma, Amritsar	24·55
7.	M/s. Raj Vaidya Shital Prasad, Delhi	389·97
8.	M/s. Nav Shakti Ayurvedic Pvt. Ltd. Bhusaval	412·59
9.	M/s. Dhanwantri Lab. Bhagalpur	2,096·74
10.	M/s. Petlad Moahal Aregya Mandal, Gujarat	285·58
11.	M/s. Shivalik Drugs, Madras	51·48
12.	M/s. Dogra Kayakalp, Jullundur	182·58
13.	M/s. Maxe Laboratories, Delhi	927·81
14.	M/s. Madhava Pharmaceuticals, Cochin	27·56
15.	M/s. Haryana Pharmacy, Jhajjar	5·37
16.	M/s. Swastika Drug Pharma, Amritsar	19·78
17.	M/s. Kamal Ayurvedic Pharmacy, Hardwar	2·96
18.	M/s. Deshrakshak Ausadhalaya, Hardwar	351·10
19.	M/s. Naveen Ayurvedic Bhavan, Delhi	Nil

Explanatory Note

In case of other systems of medicines, registration is done by CGHS. However, in case of SSI Units, registration is taken as automatic, under the newly introduced single-point registration scheme. Under this scheme, registration with NSIC is enough. No further registration with any other department is necessary.

4.53 As already stated by the Ministry 100 batches were received in 1980-81 from such firms. 54 batches were subjected to test. 8 batches were found sub-standard. Purchases were made in 1981-82 from some of the firms whose supplies were not found upto the mark in 1980-81. The value of orders placed with such firms in 1981-82 (upto end of December 1981) is also shown in the statement.

C. Stock Verification of Medicines.

(i) *Stock verification of the Central Medical Store Depot*

4.54 Stock verification in the Central Medical Store Depot is carried out in the following manner and frequency :—

(i) By the stock holder i.e. person having the charge on the first two working days of each month. A certificate to these effect is submitted through the store Supdt. and the Store Manager within seven days to the DAD (Store) for further follow up action. There have not been any large scale discrepancy during the last three years.

(ii) Annually, during the first seven working days of April each year by the stock holders and cross checked by the Store Supdt. and the Store Manager.

(iii) Random check by the Store Supdt./Store Manager.

(iv) The general financial rules lay down that the store should also be checked by an agency other than the person holding the charge. Such a check was carried out from 8-3-78 to 2-5-78 by the internal audit unit under the Director, CGHS.

4.55 Rule 116 of the General Financial Rules which is reproduced below lays down that physical verification of all stores shall be made at least once in every year :—

"A physical verification of all stores shall be made at least once in every year under rules prescribed by the competent authority, and subject to the condition that the verification is not entrusted to a person :

(i) who is the custodian, the ledger-keeper or the accountant of the stores to be verified, or who is a nominee of, or is employed under the custodian, the ledger-keeper or the accountant; or

(ii) who is not conversant with the classification, nomenclature and technique of the particular classes of stores to be verified. The verification shall never be left to low paid subordinates and in the case of large and important stores, it shall be as far as possible, entrusted to a responsible officer, who is independent of the subordinate authority in charge of the stores".

4.56 The Ministry has stated that the CGHS Medical Store Depot handles 400 drugs and 4000 non-drugs items, including various forms and stationery, Liveries, laboratory chemicals, surgical instruments etc. The value of stock at any given time is approximately Rs. one crores. According to the Ministry the physical verification of the entire stores is, therefore, a time consuming process, running into 8 to 10 weeks.

4.57 The Ministry has stated in reply to a question that "it is a fact that audit has not been done after 1978. Efforts are being made to ensure annual verification as per General Financial Rules. Dates of stock verification prior to 1978, have not become available inspite of best efforts".

4.58 Explaining the position the Director General Health Service in evidence stated that :—

> "The discrepancies in 1978-79 in the CGHS Medical Stores were to the tune of Rs. 19,336.42. During the years 1979-80 and 1980-81 no discrepancy has been found but 5 must also add that no verification was carried out in these two years by any outside agency. This is only Internal Audit; no outside agency did it".

4.59 Asked to explain the reasons as to why stock verification was not done after 1978-79, the witness stated :—

> "Stock of 4,000 items in the depot at any time is involved. It is worth more than a crore. Physical verification takes 8 to 10 weeks. Meanwhile depot cannot be closed also. The limited number of verifiers were to carry out verification at the dispensaries. They have to find out whether there was any defect or any irregularity etc. They could not make themselves available for verification work in stores depot".

Secretary (Health) stated—

> "No verification of stock in Central Stores has taken place after 1978, by outside agencies. This was not done by persons other than those holding stocks. I admit that. We have not followed the General Financial Rules strictly which provide for annual verification. This must be admitted. Now we have issued orders that this stock verification should take place within 15 days."

These orders were issued on 7-12-1981.

4.60 The Ministry has added that Medical officers Incharge, or any other officer deputed by him on his behalf, is required to carry out surprise physical verification twice a week of not less than 5 items. Scheduled verification without prior notice, is also to be carried out by Internal Audit Unit of Zones, at about 6 month by intervals.

(ii) *Stock verification in the Dispensaries*

4.61 The Ministry has furnished the following information with

regard to the particulars of stock verifications done in the Dispensaries during the year 1978-79 to 1980-81 in fourteen cities :—

Sl. No.	City	Frequency of verification in 1978-79.		Frequency of verification in 1979-80.		Frequency of verification in 1980-81.	
		Central Stores.	Dispensaries.	Central Stores.	Dispensaries.	Central Stores.	Dispensaries.
1.	Bombay	—	—	—	—	—	—
		(Information not available.)					
2.	Bangalore	1	10	1	11	1	11
3.	Pune	(Information not available.)					
4.	Lucknow	1	1	1	1	1	1
5.	Allahabad	(Information not available.)					
6.	Kanpur	1	6	1	6	1	8
7.	Calcutta	nil.	12	1	12	nil	22
8.	Madras	1	10	1	10	1	10
9.	Hyderabad	1	13	1	15	1	15
10.	Meerut	—	—	—	8	—	9
11.	Patna	nil	7	1	7	nil	7
12.	Jaipur	(Information not available.)					
13.	Ahmedabad	nil	3	1	3	nil	3
14.	Nagpur	1	11	1	20	nil	nil

4.62 The inspections were carried out by Medical Officers Incharge of Dispensaries, and no shortage or excess was discovered except in the case of Bangalore during the year 1978-79 where a shortage of Rs. 7586 was discovered. The amount was reported to have been recovered from the Officer concerned.

4.63 In so far as Delhi is concerned, the conflicting information has been supplied by the Ministry regarding the number of dispensaries where stock verification was hold during last three years. From the Preliminary Material furnished to the Committee it is seen that out of 75 dispensaries, inspections were carried out only in 24 dispensaries in 1978-79, 15 dispensaries in 1979-80 and 10 dispensaries in 1980-81. Shortages of varying amounts found during stock verification have been reconciled in some cases and are due to be reconciled in some other cases.

4.64 But from the written replies to questions submitted by the Ministry later, it is seen that stock verification was not done in 16 dispensaries in 1979-80 and in 29 dispensaries in 1980-81, implying that in the remaining dispensaries, it was done.

4.65 A detailed procedure has been laid down by the Ministry for procurement of medicines by CGHS. Items exceeding Rs. one lakh in value are procured by CGHS through DGS&D and those less than Rs. one lakh in value are obtained direct from firms registered with DGS&D through a system of tenders. Urgent needs are met by local purchase through approved local chemists.

4.66 The Committee regret to note that supplies through DGS&D are very of ten delayed. The delays which range from 3 months to 12 months dislocate the supply mechanism in dispensaries and cause a great inconvenience to CGHS patients. The Committee learn that delays can be avoided if the indents,

instead of being placed on DGS&D in a new financial year, are placed well before the end of the previous financial year. The representative of the Ministry told the Committee that this is possible. If that is so, the Committee see no reason why annual indents should not be placed by CGHS well before the commencement of relevent financial year. (S. No. 56)

4·67 The Committee find that DGS&D takes considerable time after receipt of indents from CGHS to place orders on the suppliers for supply of medicines. This should be looked into and time lag between receipt of indents and placement of orders should be reduced as far as possible. (S. No. 57)

4.68 Lack of funds for purchase of medicines at the time when these are required shows poor budget planning. The Committee urge that adequate funds should be provided to CGHS at the right time to enable it to procure and maintain stocks of medicines at optimum level. (S. No. 58)

4.69 Though the Ministry has laid down an elaborate system of quality tests on medicines purchased by CGHS, this is not properly observed in actual practice. All supplies of medicines from unregistered or new firms are required to be subjected to chemical tests but it is a matter of deep regret that this is not being done. In Delhi only 54% of such medicines were checked for quality in 1980-81. The Committee cannot but deplore such gross negligence on the part of CGHS management in such a serious mater. The explanation given by the Ministry that supplies from unregistered firms are arranged by DGS&D and that the responsibility of quality control for drugs is that of the State Drugs Controller does not absolve the CGHS of its responsibility to make cross-checks.

4.70 It is stated that purchases from unregistered firms are made by DGS &D mainly to encourage small scale industries. The Committee do not consider it proper to purchase medicines from firms whose standing and standards have net been tested and accepted. Helping Small Scale Industries is a noble aim but not at the cost of CGHS beneficiaries' health. The Committee would like the Ministry to drive this point home to DGS&D and dissuade it from purchasing medicines from unproven suppliers. (S. No. 59)

4.71 As resgrds supplies from registered suppliers, the percentage of checking for quality is stated to be 6·7%. The basis on which 6·7% checking in respect of supplies by registered suppliers and 54% of checking in respect of supplies by unregistered suppliers are considered adequate, has not been explained by the Ministry. In fact, the Ministry had stated in reply to a question that there were no fixed percentages prescribed for quality checks. This is a big flaw. The Committee would like that norms in percentage terms for quality tests for medicines received from different sources should be prescribed and enforced. (S. No. 60)

4.72 The Committee find that even 6-7% quality checks have not been performed in all cases of supplies from registered suppliers. Medicines amounting to Rs. 1·34 Crores in 1978-79, Rs. 1·18 crores in 1979-80 and Rs. 1·60 crores in 1980-81 were purchased direct by Chief Medical Officers in the various cities, where CGHS is in operation, without any check whatsoever, That there was no approved testing house in Patna which accounted for Rs. 59 lakhs worth of such purchases is a lame excuse. No check was made in Bangalore either even though approved testing houses were there. The direct purchases made there amounted to Rs. 41 lakhs in 3 years. This is negligence of a high order which deserves to be condemned.

4.73 The Committee take note of Health Scretary's statement that when CGHS purchases medicines, it has a responsibility to do some cross-checks.

If testing facilities are lacking at any place, the Ministry would soon provide them there. The Committee would like to be apprised of the action taken in pursuance of Helath Secretary's assurance. (S. No. 61)

4.74 The Committee cannot but take note of the heavy purchases of medicines made directly by Chief Medical Officers of Patna, Bangalore and other cities during the last 3 years. Even though the purchases are stated by the Ministry to have been made according to the prescribed procedures and within their financial poweres there is need to keep a watch on direct purchases of such high magnitude. (S. No. 62)

4.75 The Committee find that, while purchasing medicines, lowest tenders as per specimens are accepted as, according to the Ministry, at that stage it cannot be presumed that the supply may be substandard. In the Committee's opinion this is not a correct approach. The Ministry should consider whether some sort of screening of the tenders cannot be done at tender stage to minimise the likelihood of sub-standard madicines being supplied to CGHS under the cover of lowest tenders. (S. No. 63)

4.76 In view of utter disregard for quality tests of medicines which the CGHS has displayed, the widespread reports that medicines available in CGHS are sub-standard and have little curative effect appear to have a ring of reality even though it may be difficult to quantify this phenomenon. The Ministry's statement that "at present the testing precedure followed by CGHS is by and large satisfactory" when actually it is not so in actual practice, betrays an attitude of callousness and casualness which is deplorable. If beneficiaries are losing faith in medicines supplied by CGHS dispensaries, the CGHS authorities are themselves to blame. The Ministry too cannot escape its share of blame in this regard. The importance of quality control over medicines procured by CGHS, whether through DGS&D or directly should have required no emphasis but seeing the sorry state of things in CGHS the Committee have no alternative but to emphasize that medicines purchased from unrecognised and unproven suppliers should in no case be used without prior quality tests. And even in respect of supplies from proven suppliers, experience has shown that quality cannot be taken for granted. Random chacks of a prescribed percentage of such drugs must be carried out as a rule. Any disregard for qualitycontrol at any level should be dealt with sternly and attract deterrent punishment. (Sl. No. 64)

4.77 Out of 100 batches of drugs purchased by CGHS in Delhi from unregistered and new suppliers in 1980-81, only 54 were subjected to quality checks. And of these 54 batches, 8 (i.e. about 15%) failed in the stests. This is not a small number.This shows the risk taken by CGHS in using 46 other batches of medicines without any test that year. The Committee feel that where supplies procured from unregistered firms are found to be not upto the mark, no future purchases should be made from them till they get themselves registered with the competent authority after going through the prescribed procedure. This is the minimum that should be done, even if they are not black listed. (S. No. 65)

4·78 The names of firms whose suppliers are not found up to the mark are sent to DGS&D for suitable action and black listing. There were 14 such allopathic firms in 1979-80 and 5 in 1980-81. It is unfortunate that a public sector undertaking is also there in the list of units whose supplies were not upto the mark. None of them, so far as Ministry is aware, has been black-listed. Purchases were made by CGHS in the following years also from some of such firms due to compulsion of circumstances. There was no alternative according to the Ministry.

4·79 It is a serious matter for the Ministry to consider as to whether such firms should be allowed to get away with impunity because of their dominent role in the field of production of specific drugs. The Committee do not think Government should helplessly watch such a thing happening from year to year. At least those firms whose supplies are found spurious or adulterated or harmful should not be shown any mercy. (S. No 66)

4·80 The Committee would suggest that the case of the public sector undertaking whose supplies were found to be not up to the mark should be brought to the notice of the administrative Ministry concerned for corrective action. (S. No. 67)

4.81 According to the extent procedure stocks in the Central Medical Store Depot are supposed to be checked every month and every year by the stockholders and cross-checked by supervisory officers. Besides, random checks are also supposed to be done by the supervisory officers. It is not clear from the information furnished by the Ministry whether supervisory officers did conduct scheduled and random checks and cross-checks as prescribed; and if so, with what results. The Committee would like to have this information in a precise form in respect of 1981-82. (S. No. 68)

4.82 A very serious lapse that has come to the Committee's notice is in regard to stock verification of the Central Medical Store Depot by an independent agency as required under the General Financial Rules. The Rules provide that the stocks in the Central Store should be checked atleast once every year by a responsible officer who is independent of the authority incharge of the store. The Committee fined evidence of only one such check having been carried out in March/May. 1978. The Ministry has admitted that no such independent check has been carried out after that period, and dates of stock verification done prior to 1978 are not available. What has pained the Committee more is that senior officers have sought to justify this laps by playing up the magnitude of the work involved and the shortage of staff to do it. If senior officers take such an attitude, subordinate officers are sure to neglect their duties with impunity. And this is what appears to have happened. The Committee cannot too strongly deplore this lapse. They would like that this lapse may be enquired into, the responsibility fixed and the Committee informed of the outcome. (S. No. 69)

4.83 The Committee appreciate that the Health Secretary has admitted the fact that the management has not followed the General Finance Rules in the matter of annual stock verification of the Central Store. Orders are stated to have been issued on 7th December, 1981 to conduct the stock verification within 15 days. The Committee would like to know the outcome of this stock verification. (S. No. 70)

4·84 The Committee hope that the Ministry will not allow any remissness in future in regard to the timely and regular stock verification of stores, annual, monthly and random, and keep itself informed of the progress in this regard. (S. No. 71)

4.85 The picture in regard to stock verification of stores in the dispensaries is also not very clear. The dispensary stocks are required to be verified in a limited way twice a week by the Medical Officer Incharge and once every six months by the Internal Audit Unit of the Zone. From the information furnished by the Ministry it is seen that in many cities even the information in regard to stock verifications of dispensary stocks is not kept and in other cities the number of stock verifications has been fewer than scheduled or expected. This

shows the laxity of supervision on the part of Chief Medical Officers in the respective cities and deserves to be deplored.

4.86 The position in respect of dispensaries in Delhi is also confusing. In the beginning the Ministry informed the Committee that out of 75 dispensaries stock verifications had not been done in 24 dispensaries in 1978-79, 15 dispensaries in 1979-80, and 10 dispensaries in 1980-81, but subsequently it was stated by the Ministry that the stock verification had not been done in 16 dispensaries in 1979-80 and 29 dispensaries in 1980-81, thus implying that in the remaining dispensaries it had been done. Whichever statement be correct, the fact stands out that here too the supervisory authorities have failed to enforce departmental instructions in regard to stock verification. That such a thing should be happening under the vary nose of CGHS headquarters, is indeed deplorable.

4.87 The Committee expect that atleast now the Ministry would lay down a clear schedule of surprise and scheduled stock verification outlining in unequivocal terms the authorities who will do these stock verifications and their frequency so that the officers concerned can be held accountable for their lapses, if any, in future. (S. No. 72)

D. Purchase of Medicines from Public Sector Organisations and Private Sector Organisations

4.88 The following statement shows the value of drugs purchased from the Public Sector Organisations and Private Sector Organisations during the last three years (i.e. 1978-79, 1979-80 and 1980-81) :

Year	Qty. purchased through public enterprises.	Qty. purchased through private enterprises.
1978-79	27,04,664-65	1,43,77,426-22
1979-80	38,57,232-83	2,20,58,463-02
1980-81	19,32,140-29	1,39,06,821-35

4.89 From the information furnished by the Ministry it is seen that 18 drugs in 1978-79, 20 in 1979-80, and 27 in 1980-81 were purchased from private sector even when they were also manufactured in and available from Public Sector enterprises.

4.90 Asked to state the reasons why these medicines were not purchased from Public Sector Organisations, the Ministry stated that according to the purchase policy, Public Sector undertakings are entitled to a price preference of 10%, over private sector. But, a small scale Industrial (SSI) Unit is entitled to a price preference of 15%. Following examples may be seen :—

	Product A	Product B	Product C	Product D
1. Price quoted by a private firm	100·00	100·00	100·00	100·00
2. Price quoted by Public Sector	112·00	112·00	108·00	108·00
3. Price quoted by SSI Unit .	114·00	120·00	96·00	117·00

Product A —Price of S. S. I. Unit is eligible for consideration. Price of Public Sector unit is not.

Product B —Both Public Sector and S.S.I. Unit are to be ignored.

Product C and D —Both S.S.I. and Public Sector are eligible.

4.91 These criteria only make them eligible. This preference is not mandatory. Economy has also to be looked after.

4.92 As desired by the Committee the Ministry in a post evidence note stated that the value of savings in expenditure by C.G.H.S. Delhi by purchasing medicines from Private Sector in preference over Public Sector during the last three years was as follows :—

Summary of the Year-wise savings

Year	Savings
1978-79	Rs. 8,53,461·62
1979-80	Rs. 2,50,289·96
1980-81	Rs. 2,82,416·59
Total savings :	Rs. 13,86,168·17

4.93 Explaining the position further, Secretary (Health) stated in evidence that :—

> "In 1978-79, the quantity purchased through public sector was about Rs. 27 lakhs. In 1979-80, it went upto Rs. 38.57 lakhs. In 1980-81, it went down to Rs. 19.32 lakhs.
>
> There is a reason. It must be understood that before the previous Janta Government came over, there was a system till 1977 that the public sector undertakings will have a preference for purchase. For example, medicines should be bought from public sector, even if the prices of medicines from public sector undertakings were 10% higher. It was made compulsory that we should buy from them.
>
> Now this policy was changed. There would be no price preference. That was the first step taken in 1977. Subsequently, even purchase preference was left with the result that there was an increase in the purchase from the private sector.
>
> But the present Government has again re-introduced the old system in October, 1980. The price as well as the purchase preference should be for the public sector. Its impact will really be felt in 1982-83. Some increase will be there in 1981-82 also. The real impact would be there during the year 1982-83. Our effort is to buy more and more medicines from the public sector."

4.94 Secretary assured the Committee that "in keeping with the Government policy of purchases from the public sector, now that the preference has been given, we will buy, as far as possible, from the public sector subject to the range of production being available."

4·95 The Committee are very unhappy to note that during the years 1978-79, 1979-80 and 1980-81 the Ministry purchased a number of drugs from private sector even when the same drugs were produced in and were available from the public sector. The purchases from private sector in preference over public sector are stated to have been made for the reasons that during these years the price preference and purchase preference which were earlier given to public sector for making purchases on behalf of Government had been withdrawn. Price and purchase preferences in favour of public sector have been re-introduced by Government in October 1980. The Ministry has stated that

same impact of these orders will be discernible in 1981-82 and full impact will be there fron the year 1982-83. The Committee expect that Government policy of purchases from public sector units in preference over private sector will be followed in latter and spirit consistent with the over-riding consideration of quality. Where, however, drugs available in public sector are not purchased from public sector for any reason, the comparative volume of such purchases with reasons therefor should be clearly mentioned in the Annual Report of the Ministry. (S. No. 73)

E. Lack of Funds for Medicines

4.96 It has been reported in the Times of India (18-9-81) that :—

> "While some pharmaceutical companies are believed to be withholding supplies to the CGHS because their earlier dues have not been cleared, the CGHS budget for medicines, it has been found, is inadequate in any case because of the mounting cost of drugs. The budget has just not kept pace with the inflation".

4.97 Asked to state the budget provisions made for medicines during the last three years and the actual expenditure on medicines during the period, the Ministry furnished the following information :—

Year	*Budget for Medicines in lakhs. (Rs.)	Actual Expenditure on Medicines.
1978-79	452·00	49462557
1979-80	536·43	57728897
1980-81	510·07	54584993

(*) The figures refer to provision under the Materials Supplies since there is no separate budget head for Medicines.

4.98 Asked further whether it was a fact that the CGHS was unable to procedure the required quantity and quality of drugs at the right time for lack of adequate funds or that the pharmaceutical companies had refused or delayed the supply of indented medicines.

4.99 The Ministry stated that it was a fact that there was a gap between the projected requirement and actual purchases ultimately made. This was because of budgetary constraints. As regards payment of bills, the Ministry added that "the procedure of settlement of bills takes on an average 3-4 months from the date of supply. Admittedly there have been complaint of delayed payment but considering the size of the organisation which deals with about 1000 suppliers, the number of complaints cannot be considered excessive. All efforts are being made to improve the system while it is a fact that the allocations of funds to CGHS has gone up this increased provision has been neutralised by increased needs which is due to (i) increase in coverage of the scheme (ii) general rise in price of drugs (iii) increased cost of services.

4.100 Explaining the position further, the representative of the Ministry stated in evidence (Dec. 1981) that :—

> "We are dealing with about 1,000 pharmaceutical companies. In 1981 only one pharmaceutical company in Madras has suspended supplies on account of not having received payment of bills preferred by it. All the other pharmaceutical firms have continued the

supplies. It is, however, a fact that the amount which we could allocate in the Budget for pharmaceuticals, as far as CGHS was concerned, fell short of the demand of CGHS due to budgetary reasons. So there has been an accumulation of liabilities to pharmaceutical firms. This year we propose to move a supplementary grant in the Lok Sabha to clear this accumulation."

4.101 Elaborating the position, Secretary (Health) stated that :—

"The point is that at the end of the year bills accumulate and the funds are exhausted in the first few months of the next year. We have to get more funds to clear the backlog. I think it is possible to make timely payments when we get the supplementary demands. Then we will be able to make the payments as quickly as possible."

LACK OF FUNDS FOR MEDICINES

4.102 The Committee asked the Ministry to furnish a statement showing bills pending for more than six months as on 1-12-1981 and reasons therefor.

4.103 Instead of supplying the information asked for, the Ministry furnished information in respect of 1980-81. During this year, the Ministry stated there was no bill which was paid after a lapse of 6 months from the date of receipt.

4·104 The Committee find (atleast from the figure of last 3 years) that budget allocation for purchase of medicines in a year falls short of actual requirements. The result is that the budget funds are exhausted in the first few months of a financial year and the Ministry has to wait for supplementary demands till the end of the financial year for clearing the back-long of payments. The Ministry has admitted that there have been complaints of delayed payments. This is no consolation that in 1981 only one pharmaceutical company in Madras suspended supplied to CGHS on account of not having received payments of bills. Others too could not but be sore at inordinate delays in payment even though they did not, for the present, choose to go to the extent of stopping supplies. It will be tantamount to exploitation if the suppliers' patience is tested so long year after year. The present system, under which the Ministry takes 3-4 months to pay bills for the supplies of medicines even when funds are available and, in other cases, the suppliers have to be kept waiting for payments till supplementary funds become available at the end of the financial year, shows administrative inefficiency and poor budget planning. If suppliers are expected to honour supply orders of CGHS with promptitude to enable the Central Medical Store to comply with dispensaries' indents without delay, adequate funds should be provided in the budget right at the beginning and payment procedure should be streamlined so as to ensure payments within a maximum period of one month or so. The Committee would like the Ministry to go into the present system and inform them of the steps taken to make it efficient. (S. No. 74)

F Time Barred Medicines

4.105 The Committee enquired whether there was any system of reviewing the stocks of medicines in Central Store and Dispensaries with a view to isolating timebarred medicines and whether during 1980-81 any of the Dispensaries in Delhi returned time-barred medicines to the Central Store.

4.106 The Ministry stated that CGHS Medical Store Depot maintains Registers showing details of drugs of definite shelf life. These are reviewed from time to time (6 months advance) and drugs whose life is short are circulated to dispensaries to make efforts to utilise them with in their life. Such Registers are also maintained at dispensary level. Efforts are also made to consume the stores by supplying the same through Medical Store Depots functioning under the DGHS and also to local Government Hospitals such as Safdarjung/Dr. R.M.L. Hospitals.

4.107 It has been stated by the Ministry that no time barred medicine was used.

4.108 Asked to state whether the system of review was adequate and fool proof and whether the Ministry could say that time-barred medicines were not issued to patients, D.G.H.S. informed the Committee in evidence that "no time-barred medicines were returned to the Central Stores Depot during 1980-81. The total value of the drugs (time-barred) during the year 1980-81 was Rs. 4090.70 as compared to the total turnover of Rs. 3 crores in Delhi."

4.109 When the Committee pointed out that fear had been expressed in certain circles that time-barred medicines were consumed by patients or sold in the market, the witness assured that "we take every precaution to see that such medicines are not misused."

4.110 The system of dealing with medicines of definite shelf life in CGHS does not inspire confidence. It is stated that the Central Medical Store issues stocks of all such medicines to the dispenseries, etc. well before due dates and dispensaries, in turn manage to consume all such supplies within the validity period. The Ministry has informed the Committee that no time-barred medicines have been found to have been returned by the dispensaries to the Central Store. How the appropriate number of patients with ailments matching such drugs appear on the scene to consume all such medicines is something which is, to say the least, quite bewildering. Different stories are, however, in circulation about time-barred medicines in the CGHS dispensaries but for abvious reasons, the Committee are not in a position to go into the matter in depth. The Committee call upon the Ministry to look into this problem more critically, and make case studies at field level to ensure that precautions taken by CGHS against the use of time-barred drugs are adequate to guard against their misuse either on the patients or otherwise. (Sl. No. 75)

G. Sale of Drugs in India which are Banned in Developed Countries

4.11 In reply to Unstarred Question No. 436 in Lok Sabha regarding selling of drugs in India which are banned in developed countries the Minister of Health & Family Welfare stated on 20 November 1980 that under the Drugs and Cosmetics Act and the Rules thereunder no new drug can be imported into or manufactured in the country without the permission of the Drugs Controller, India. Permission for the import of new drugs is granted only after it is ensured on the basis of the data furnished that the drug is safe and efficacious for the conditions indicated. New Drugs are not permitted to be imported unless they have been approved in the country of origin and are being marketed in a number of countries.

4.112 If subsequent to the introduction of drug, reports of toxic effects come to notice, action for banning its import, manufacture or sale

is taken in consultation with medical experts in the country. During recent years, reports of toxic effects, lack of therapeutic efficacy/carcinogenicity in animals have come to notice in respect of six drugs. The drugs involved are (1) Practolol, (2) Nialamide, (3) Methapyrilene Fumerate, (4) Amidopyrine, (5) Halogenated Oxyquinolines and (6) Phenformin. Action to ban the import and manufacture has been taken in the case of first 4 drugs.

4.113 In the case of Phenformin and Halogenated Oxyquinolines, the medical experts including the Indian Council of Medical Research who were consulted were not in favour of banning the use of these drugs as the toxic effects reported with these drugs had not been observed in this country although these drugs have been in use for many years. Manufacturers marketing preparations containing these drugs have been instructed to incorporate suitable cautionery statements on the side effects of these drugs in their package and promotional literature.

4.114 It was reported in the Financial Express of (August 19, 1980) that "the country's pharmaceutical manufacturers are continuing to produce and market no fewer than 33 formulations containing amidopyrine, a controversial pain-killer now in the process of being banned.

4.115 It was reported in the Hindustan Times (November 7, 1981) Shri P. N. Haskar, Chairman of the Delhi Science Forum said on November 6, 1981 that "nearly two dozen drugs which are banned in several advanced countries are sold in India without any check".

4.116 The Director General, Indian Council of Medical Research, New Delhi, who appeared before the Committee as an expert witness stated in his evidence :

> "I have been interested in this problem and I have been studying it. It is true that some drugs which are not permitted for use in the countries in which the drugs are manufactured do come into—I may use the word—developing countries. Then there are many examples of this. But in our country this is not really a significant feature because we have a pretty tight system of control before a drug is allowed to be used in India.
>
> Although I am not connected with either drug control or such things. I know we have a fairly tight control over the drugs to be used in this country. Every drug, before it is certified for human use here, even though there is evidence submitted by the manufacturer of its freedom from toxicity etc., is again tested in this country on our people, before it is allowed to be used.
>
> What you say, Sir, is a problem of great importance to the developing world as a whole. I think, we amongst the develoing countries, are in a somewhat happier position, in the sense that we do exercise a great deal of control."

4.117 Asked to explain the position, the Ministry stated in their note after evidence that according to the information provided by W.H.O. a number of products produced by manufacturers of drugs are withdrawn in U.S.A. and other developed or developing countries. There is, however,

no uniformity on the action taken by various countries about the withdrawal of these drugs for being marketted due to various reasons such as the extent of the use of the drugs or availability of safer substitutes in that country or benefit risk ratio etc. In India, on receipt of the information about withdrawal of drugs from W.H.O., the Drugs Controller of India consults Indian Council of Medical Research and other experts about the necessity or desirability of withdrawal of drugs or otherwise. It will be appreciated that the conditions of medical practice, disease pattern or availability of substitutes in India are quite different with those, prevailing in the developed countries. As such, the decision taken by the Government of U.S.A., etc. cannot always be followed in India also. According to the information available, out of 17 drugs reported by W.H.O., seven were withdrawn from market in India, while five drugs were not approved or even applications seeking permit to market them were not received.

4.118 The Ministry has further stated that under the provisions of the Drugs and Cosmetics Act, the State Drugs Controllers are the licensing authorities for manufacture, sale and distribution of drugs in India, no drug can be imported into India or manufactured unless it has been approved by the Drugs Controller of India, who has to satisfy himself/herself that the drugs to be imported/manufactured are safe and efficacious for use. The permission, on various occasions and in respect of many drugs had been with-held or withdrawn whenever any defect in the efficacy of the products has been found. For instance, names of a few drugs not approved during the past few years are given below (the names of the countries where they had been withdrawn are mentioned in the bracket :—

1. Nialamide (U.S.A.)
2. Practolol (U.K.)
3. Sodium Berate (Berax) (Korea, Costa Rica, Canada)
4. Aminophenazene (Amidepyrine) (Australia, Denmark)
5. Phenacetin (U.K.)
6. Triazolam (Netherland)
7. Methapyrlene (USA, Canada, Australia)
8. Alclofenec (Italy)
9. Tetracycline Liquid orgal desage preparations (U.S.A.)

4.119 It is not possible to give any categorical information that none of the drug produced by multinationals or foreign companies and sold India is banned in developed countries. As stated above, judicious decision is taken on merits in respect of each of the drugs banned in the developed countries keeping in view its efficacy and utility in India.

4·120 Widely circulating reports that a number of drugs which are banned in several advanced countries are sold in India without any check, have reached the Committee. Director General of Indian Council of Medical Research is of the opinion that in our country this is really not a significant feature because we have pretty tight system of control before a drug is allowed to be used in india. According to the Ministry no drug can be imported into India or manufactured unless it has been approved by the drugs Controler of India. The permission on various occasions and in respect of many drugs had been withheld or withdrawn whenever any defect in the efficacy of the product has been found. The Committee are disturbed to note that

"it is not possible for the Ministry to give any categorical information that none of the drugs produced by multinationals or foreign companies and sold in India is banned in developed countries," WHO, it is stated furnished information to authorities in India about the drugs withdrawn in USA and other developed or developing countries. The conditions of medical practices, disease pattern or availability of substitutes in India are stated to be different from those prevailing in the developed countries. As such, according to the Ministry, the decision taken by developed countries cannot always be followed in India. On receipt of the information from WHO, the Indian authorities examine the matter in depth and take judicious decision on merits in respect of each of the drug so reported to have been banned in the developed countries. The Ministry informed the Committee that out of 17 such drugs reported by WHO, 7 were withdrawn from market in India while five drugs were not approved or even application seeking permission to market them were not received. The Ministry has not given any explanation in respect of the five remaining drugs. The Committee would like to be informed about them. (Sl. No. 76)

4.121 The Committee cannot overemphasise the need to act without delay on receipt of such reports and to exercise the most careful examination of such drugs with a view to ensuring that the drugs which are harmful or have deleterious side effects are not in any circumstances allowed to be marketed or remain in circulation. In order to prevent any alarm in the general public in regard to such drugs it would be desirable if the Ministry, through official handouts, gives out the considered views of the expert bodies on such drugs as are reportedly banned or are in the process of being banned in developing or developed countries. The Ministry's silence in the face of reports of any of such suspected drug can be a serious omission if not dereliction of duty. (Sl. No. 77).

CHAPTER V

HOSPITALISATION

A. Hospitalisation

5.1 The experiences of the CGHS beneficiaries about hospitalisation as stated in some of the Memoranda submitted to the Committee are as follows :—

"The services provided are very poor. The emergency cases are not admitted without delay."

"There is no difference between CGHS beneficiary and general public so far as admission in the hospital and emergency cases are concerned."

"Step-motherly treatment is being given to the CGHS patients."

In other memorandum it has been stated that :—

"There is no CGHS Hospital in Delhi. No special treatment is provided to CGHS beneficiaries and they are treated as general patients. The conditions at CGHS recognised hospitals are appalling. Government is spending large amount of money on these hospitals but due to lack of proper supervision and administration, red-tape and out-dated procedures, general public particularly CGHS beneficiaries do not get the desired benefities."

5.2 It has been stated before the Committee that "it seems anamolous that a CGHS beneficiary in Delhi should be debarred from availing of facilities in Government institutions like the All India Institute of Medical Sciences, the G. B. Pant Hospital etc. With the overcrowding of Safdarjung and Willingdon Hospitals, hospitalisation of CGHS beneficiaries in hospitals like the Mool Chand, Holy Family, Heart Foundation and St. Stephens should be permitted. Likewise medicines prescribed by these institutions should be made available to the beneficiaries."

5.3 In view of congestion in Dr. R. M. Lohia Hospital and Safdarjung Hospital that Committee enquired as to why more Government, semi-government of private hospitals should not be recognised for hospitalisation of CGHS beneficiaries, the Ministry stated in a note that it has not been possible to approve more hospitals on account of financial contraints. As regards arriving at some understanding with hospitals like AIIMS, Jai Prakash Narain Hospital and other similar hospitals in Delhi to extend hospital facilities to CGHS beneficiaries, it stated that "reference to AIIMS is considered unnecessary for ordinary ailments. However, CGHS beneficiaries are allowed to avail the facilities in AIIMS in complicated cases. It is considered that reference to LNJPN Hospital may not help as that hospital is as busy as other Government hospitals. Some institutions and even state hospitals are not agreeable to take on CGHS cases".

5.4 The Ministry added that "whereas separate OPD Wing existed for CGHS in Safdarjung Hospitals we have not been able to provide such facility in all Government hospitals due to financial constraints".

5.5 In another note, the Ministry stated that on the advice of specialists patients' requested for reference to AIIMS and Lok Nayak Jai Prakash Narain Hospitals is considered for availing facilities of super specialists. Hospitals like Moolchand, Holy Family, Heart Foundation etc. are private hospitals, where treatment is costly. When facilities at Dr. R. M. L. Hospital and Safdarjang Hospitals are available to Government, it would be against economic consideration to allow CGHS beneficiaries to go to these institutions.

5.6 Emphasising the point, subsequently, Secretary (Health) stated during evidence :—

> "So far as Delhi is concerned Dr. R. M. L. Hospital and Safdarjang Hospital are more or less functioning as CGHS Hospitals with separate inputs by way of staff, equipment etc. having been provided. In the CGHS Wing of these hospitals, no instance of refusal for admission to any CGHS emergency case has been reported. In Dr. R. M. L. Hospital 90% of the beds in the Nursing Home are reserved for the CGHS patients and adequate arrangements for admission to CGHS patients in General Wards of both the hospitals exist and have been filled up."

5.7 Secretary added :

> "In 1980-81, 33406 admissions were there in Dr. R. M. L. Hospital, out of which 16157 were the CGHS admissions. If we go to the earlier years, the ratio is more or less the same. This ratio almost comes to 50% in 1980-81. In Safdarjang Hospital the ratio is not that high. These hospitals are functioning as CGHS recognised hospitals."

5.8 In reply to the point raised by the Committee whether in view of congestion in these two hospitals it would not be advisable to provide more beds in other hospitals, Secretary (Health) elaborated as follows :

> "In Dr. R. M. L. Hospital the admissions are given to 50% of the CGHS beneficiaries. Nobody has been turned back for want of beds. In addition, for the specialist treatment we have other hospitals and people are becoming more and more medical treatment oriented, though for certain of the diseases they could be treated elsewhere. Yet the patients prefer to go to these hospitals, keeping this aspect in mind, namely the increase in population of Delhi, we have already two hospitals of 500 beds each which are in the advanced stage—one is coming up—the OPD and the Casualty Ward are to come up in April, 1982, while in an other they are expected to come up in April, 1983. The number of three one-hundred bedded hospitals is also likely to go up in the Governmental sector alone. Naturally they will take care of the CGHS patients as well."

5.9 The Committee pointed out that while the number of CGHS beneficiaries admitted in the two hospitals in Delhi was known and this number might have goneup, the number of beneficiaries who might have been denied admission was not known. According to the reports received by the Committee, there was quite a good number of beneficiaries who had been denied admission to these hospitals.

(i) *Recognition of Hospitals in Bombay*

5.10 In a memorandum submitted by an association of Central Government Employees in Bombay, it was stated that "Facilities of hospitalisation are totally inadequate. In cities like Bombay, CGHS itself shall have their own hospitals."

5.11 In another memorandum received from Bombay, it was stated that—

> "Generally the hospital authorities are giving admission to the patients from the dispensary only when beds are available, otherwise they have to come back to the dispensary for endorsement to some other hospitals which is harassment to the patients. If a hospital owned by the CGHS is available somewhere in Central Bombay, with all the necessary equipment and sufficient beds, it will be a great help to the patients."

5.12 It has been stated in a memorandum received from Bombay that, "Pending construction of the CGHS Hospital at Haji Ali, Bombay arrangement may be made to reserve at least 100 beds in the All India Institute of Physical Medicine and Rehabilitation Hospital at Haji Ali, Bombay exclusively for the use of Central Government servants retired and serving, and their families, as was done for employees of the Bhabha Atomic Research Centre, Bombay in Hospitals like the J.J. Hospital, Bombay. It is also felt that the Municipal Hospitals like the K. F. M. Hospital, B. L. Nayar Hospitals and Co-oper Hospital in Bombay which are well equipped and which have facilities for hospitalisation and advanced treatment, should also be recognised for providing hospitalisation and treatment for Central Government servants in addition to the Public and Private hospitals which are recognised at present. It will also be desirable for CGHS to negotiate with the Bombay Municipal Corporation for extending special facilities for Central Government Servants on payment of additional charges to be reimbursed by the CGHS".

5.13. In evidence before the Committee the representative of the Central Government Officers Association, Bombay, stated :

> "The facilities for hospitalisation are very poor and inadequate. Some hospitals have been recognised for admission of CGHS patients. They are the National Hospital, Dadra, the Bombay Hospital and the State Government Hospitals. In Bombay, even the Municipal Hospitals, which are very well equipped, are not recognised CGHS Hospitals."

5.14 The Ministry has stated that CGHS has already recognised 5 Government Hospitals and 8 Private Hospitals at Bombay. Mobay Municipal Corporation has not so far been agreeable to provide special facilities to CGHS beneficiaries though they have been contacted on several occassions.

5.15 As regards construction of a new hospital in Bombay, the Ministry stated in a note that Planning Commission were not in favour of further hospital construction in the urban areas."

5.16 On the question of recognising more hospitals in Bombay for the convenience of CGHS beneficiaries, Secretary (Health) stated during evidence :—

> ".....CGHS has already recognised a sufficient number of hospitals in Bombay, 5 Government hospitals and 8 private hospitals and it is felt that no difficulty is being experienced by any of the CGHS beneficiaries over there. Recently an additional hospital has also been recognised.....we had a proposal of putting up a CGHS hospital at Bombay and we intended to include it in the Sixth Five Year Plan, but because of overall availability of funds, it has not been possible to include it."

(ii) *Hospital Rates at Bombay*

5.17 It has been stated in a memorandum submitted to the Committee that for hospitalisation and treatment State Government/Municipal/Private hospital, rates have been fixed by Central Government for each item like bed facility according to status, X-ray facility etc., these rates were prescribed long time back and have remained unrevised since then. The hospitals concerned are unable to provide the required facilities within the prescribed rates due to all round increase in cost of materials and service. Government servants and their families are thereby put to a lot of inconvenience. These rates, therefore, require immediate revision.

5.18 The Ministry stated in a note that "It is a fact that rates as approved by CGHS are either same or lower than the rates paid by private individuals. These rates cannot always be compared with rates for private individuals, as CGHS provide a large and steady clientele, and should expect some concession in the rates. The rates are also under periodic review."

5.19 In this regard, Health Secretary stated in evidence that rates were revised from time to time keeping in view the services given by the hospitals and taking their various factors into consideration.

5.20 During the study visit of the Committee to Bombay, it had been brought to their notice by CGHS beneficiaries that the rates of various services in private hospitals, as approved by CGHS, were so low as compared to the general rates of these hospitals that they do not readily agree to admit CGHS beneficiaries in these hospitals for treatment or for extending other services. They were told that "these rates are too low" when the Committee invited attention to these difficulties of the beneficiaries, the representative of the Ministry stated that "If proposals come from the hospitals, such revisions are considered".

5.21 Clarifying the position further, the Ministry stated in a note submitted after the evidence that "the rates of charges for services provided by the private hospitals are decided by mutual agreement between the Ministry of Health and F.W. and the management of the hospitals which have been approved under CGHS. As such, the question of charging the rates which may be much lower than the current rates of the hospitals does not arise. In fact, the rates are constantly reviewed from time to time and the proposals received from the hospitals for their revision are considered promptly. Only during the last 6 months the rates of the following hospitals of Bombay have been increased by 25% on the basis of the proposals

sent by them after they had decided to increase the rates for the general public.

1. Nanavati Hospital
2. National Hospital
3. Bombay Hospital
4. Shushrusha Hospital

5.22 It will be appreciated that CGHS is a bulk consumer and it cannot be expected to pay exhorbitantly high rates as are sometimes charged by the private organisations from the individuals. None of the hospitals have declined to offer services to the CGHS beneficiaries because of the so-called low rates."

(iii) *Hospitals in Calcutta and Other State Capitals*

5.23 In a memorandum submitted to the Committee it was stated that :

> "For treatment of indoor patients of CGHS the standard of hospitals in Calcutta and other State Capitals is not upto the mark. It must be ensured that the standard of hospitals where CGHS indoor patients are admitted, should be at least of the standard of Dr. Ram Manohar Lohia Hospital at Delhi. At present it is not so."

5.24 The Ministry stated that hospitals in Calcutta and other State Capitals as recognised under CGHS are run either by State Government or by other agencies, where bulk of the patients do not belong to CGHS. Those hospitals are under the control of the State Government, Central Government do not own hospitals in places out-side Delhi and cannot provide their own facilities under the existing constraints.

5.25 Clarifying the position Health Secretary stated in evidence that ".... State hospitals in Calcutta is attached to Medical Colleges. There are differences in facilities offered depending upon local conditions. We cannot compare them and say something is inferior and something is superior." Health Secretary agreed to depute the Director General Health Services to inspect the Calcutta Hospitals and report on the standard of services provided in the hospitals there and the improvement that could be made therein.

5.26 Subsequently the Ministry furnished the following note on the DGHS's view on the standard of Medical facilities available in Calcutta hospitals :—

> "DGHS has reported that the standard of medical facilities available in the Calcutta hospitals which have been recognised under CGHS is not in any way inferior. In fact, only those State Governments and private hospitals are approved for CGHS beneficiaries which are run by the State Government or by the organisation of repute and have already been recognised for treatment under CS (MA) Rules. In fact, the State Governments hospitals are attached to the medical colleges and the question of their standard, not being upto the mark, does not arise. There might, no doubt, be slight variation in the availability of the facilities in the different hospitals due to certain local conditions, but this does not

adversely tell upon the standard of the services provided in these hospitals. It may be pertinent to mention that except in Delhi, there are no Central Government hospitals in any other city where CGHS dispensaries are functioning which could be utilised for providing medical facilities to the beneficiaries. The hospitals under CGHS are recognised after assessing the services, both quantitatively and qualitatively, provided by them apart from their being easily accessible to the beneficiaries."

5.27 Health Secretary informed the Chairman after evidence (February, 1982) as follows :—

I. *Treatment at All India Institute of Medical Sciences.*

It has now been decided that the All India Institute of Medical Sciences may be treated as a referral institute/hospital in respect of persons covered under CS(MA) Rules, 1944.

II. *Super Specialist Treatment.*

(i) Proposals are in hand to strengthen the facilities available to Central Government Health Employees for availing super specialist treatment in Areas like coronary bye pass in AIIMS, Railway Hospital, Perambur (Madras), Christian Medical College, Vellore, etc. so that the need for going abroad for such treatments can be minimised.

(ii) Proposals are under consideration to identify more hopsitals/private clinics where specialised facilities are available, especially for treatment of the type of diseases for which normally requests are received from Central Government employees for treatment abroad and in respect of which treatment facilities in ordinary Government hospitals are still in-adequate.

III. *Recognition of new hospitals.*

The list of recognised hospitals in cities covered by Central Government Health Scheme is kept under review to consider recognition of more private hospitals.

(iv) *Ambulance Service*

5.28 From the numerous memoranda received by the Committee from the beneficiaries. It is seen that there is utter dis-satisfaction with the Ambulance service in Delhi and outside. Ambulance Service, it is stated, is rarely available to transport emergent cases to hospitals. CGHS does not have its own Ambulance service. It depends on the Ambulance vans maintained in hospitals.

5.29 It has been brought to the Committee's notice that, in Ahmedabad, Ambulance vans are stationed in Fire Stations and because of this, Ambulance Service is available day and night and is working better than that in Delhi.

5.30 Health Secretary informed the Committee in evidence that the Municipal Corporation of Ahmedabad were maintaining fire stations in Ahmedabad; they also maintained separate ambulances inaddition to the hospitals and medical colleges. In Delhi, the position was quite different. Here apart from 74 ambulances based in hospitals there were 15 ambulances with the Delhi Police to which another 10 would be added during this year. In the 6th Plan the Delhi Police would get 100 ambulances

more to take care of the road accident Cases. They would be provided with wireless equipment etc.

5.31 The witness could not say as to how many of 74 ambulances based in hospitals were in working condition. The Committee felt that the existing arrangement was not upto the mark. When the Committee observed that there should be a proper arrangement to make ambulance available for emergent cases and the arrangement should be made widely known, the representative of the Ministry stated that the Delhi administration was working on a proposal to have ambulances based centrally with wireless system so that inter-communication was possible.

(v) *Health Check up Clinic*

5.32 The Health Check-up Clinic in Delhi started functioning in 1969. From the Annual Report on the working of CGHS for the year 1979-80, it was seen that even after 11 years of its working, this clinic did not have facilities for X-ray examination, ECG and other specialised diagnostic techniques. The beneficiaries are directed to Willington and Safdarjung Hospitals for these check ups. There was about 2.5 lakh families with nearly 11 lakh beneficiaries in Delhi under CGHS in 1979-80. Of that, only 8 availed of the Health check up facility per day.

5.33 On being asked whether the Ministry had ever analysed the reasons for the health check-up clinic not becoming popular in Delhi Health Secretary stated in evidence that the Ministry had not carried out any detailed review about this Health Clinic. According to the witness, there are three main reasons as to why it has not been popular. Firstly it is located near the offices, if it were located near residential areas, it might have been more popular for the Government servants to make use of it. Secondly it is also not having all the facilities which it should have, like X-Ray and other facilities. Thirdly it is not functioning only as a check up unit. It is also functioning as a First-Aid Unit. A proposal to have one more such clinic in Sixth Plan fell through due to lack of funds. Secretary (Health) stated that "I must admit that we have been largely giving attention to curative aspect and not to Healh Check up".

5.34 The Committee pointed out that either the Health Check-up Clinic should have all the facilities like X-Ray, ECG and other up-to-date instrument, if it was to provide complete health-check-up at one place, or it should be done away with.

5.35 When asked to comment on this, Health Secretary stated that "I agree" with this view.

(vi) *Clinical Laboratories functioning under CGHS*

5.36 It is stated in a number of memorandum received by the Committee that for getting different tests done a patient has to go on different days and get all results after making several visits. Reports are found to be often unreliable, and there are inordinate delays.

5.37 It has been suggested by a number of CGHS beneficiaries that if not in each dispensary, there should be a clinical laboratory unit in each area where there is concentration of Government servants. A few such laboratories exist already.

5.38 In a memorandum from an organisation from Bombay it has been stated that the quality of clinical reports obtained from CGHS clinical laboratories is very poor.

5.39 The representatives of the Para Medical Staff Association who appeared before the Committee to give evidence, stated that no attention had been paid towards the improvement of clinical laboratories. They were inadequately staffed. Equipment was outdated and outmoded. It had not kept pace with the technological advancements. New techniques were not known to the technicians. There were no refresher courses for the technicians. Doctors did not visit the laboratories. Reports were prepared by technicians but there was no check. The impression that the results of the clinical laboratories wanting in dependability was not wrong.

5.40 According to the Ministry some of the clinical laboratories are now well-equipped and updated. The remaining laboratories are being modernised. The strength of the technicians working in all the laboratories located in all C.G.H.S. Organisations except at Bombay, Madras and Patna are adequate. Steps are being taken for providing adequate technicians to the above cities. None of the technicians have, however, undergone any refresher course. The Ministry is also not aware of the institute imparting the refresher course for the technicians. The Ministry admitted that "the laboratories are not all equipped with modern equipment."

5.41 Referring to the reports of quality of testing not being good, Health Secretary stated in evidence that—

> "Off hand it is difficult to accept it unless there is a clear-cut evidence to this effect. Just saying that all tests are not good is over simplifying the problem".

5.42 Health Secretary accepted that they had no facility now for any system of refresher courses for technicians working in clinical laboratories. He assured that they would try to have a system of refresher courses from time to time. One difficulty which the witness apprehended in arranging refresher courses was that there was shortage of technicians and posts were already vacant. If technicians were posted for refresher courses, shortage would increase. Ministry's efforts were to fill up the vacant posts and "We can then adopt this system."

5.43 Health Secretary further stated that there were two pathologists located in poly-clinics in Delhi. "It is their function to visit the clinical laboratories and see the quality of the tests carried out and exercise some technical supervision over the work of laboratory assistants".

5.44 As regards the adequacy of clinical laboratories and need for upgradation of equipment, the witness stated that :

> "In Delhi out of 75 dispensaries, 23 have clinical laboratories. In Bombay also out of 22, 8 have. Similarly in some other cities also we have got such clinical laboratories. As it is almost one-third dispensaries are covered. Out effort is no doubt that the equipment is continued to be reviewed and replaced where replacement is necessary and it is kept uptodate.

5.45 As regards equipping each dispensary with a laboratory, the witness added that—

> "It may not be advisable because when you put so much money and equipment, it must be adequately utilised. Otherwise, on account of under-utilisation, the cost will go up on unit basis. Our experience is that in 1979-80 as many as 7,03,521 tests were carried out in these laboratories and in 1980-81, the number is 7,98,003. The yearly increase is thus not perceptible. This is with regard to Delhi only. We have already in Delhi one out of 3 dispensaries equipped with a laboratory unit. Our considered view is that it is perhaps not necessary to have a laboratory in every dispensary".

5·46 The experiences of CGHS beneficiaries in hospitals recognised for their treatment in Delhi, Bombay, Calcutta and other cities do not appear to be very happy. The hospitals are stated to be over-crowded, services poor and admissions even in emergency cases not always prompt; and no special consideration is shown to CGHS beneficiaries.

5·47 There are two hospitals in Delhi, namely, Dr. R. M. L. Hospital and Safdarjung Hospital which are CGHS hospitals where 50% or slightly less than 50% admissions are of CGHS patients. According to the Ministry, nobody has been turned back by these hospitals for want of beds. But according to the reports received by the Committee quite a good number of CGHS beneficiaries are not able to get admissions to these hospitals in Delhi. As the Ministry do not have any system of monitoring demand and availability of admissions in these hospitals, the Committee are unable to accept the Ministry's claim that none has been denied admission in these hospitals. (Sl. No. 78)

5·48 Two 500-bed hospitals are stated to be under construction in Delhi and are expected to be ready within a year or two. Besides three more 100-bed hospitals are expected to come up in Government sector. These hospitals will take care of CGHS patients also. But, in the Committee's view this does not do away with the necessity of opening out the doors of more Government hospitals (other than Dr. R. M. L. Hospital and Safdarjung Hospital CGHS patients to meet the growing demand. Nor does the plea of financial constraint advanced by the Ministry in support of its stand not to recognise more hospitals stands to reason. The demand for more beds is there today and this cannot wait till five more hospitals which would be open to all and not merely to CGHS beneficiaries, come up. When the new hospitals come up the demand will also go up further.

5·49 The Committee strongly feel that there is an immediate need to recognise more hospitals like Lok Nayak Jai Prakash Narain Hospital, Govind Ballabh Pant Hospital, for the purpose of treatment of CGHS beneficiaries. Besides Government hospitals certain private hospitals of repute should also be recognised for the purpose. (S. No. 79)

5·50 The Committee are glad to learn that the Ministry has now decided to treat All-India Institute of Medical Sciences as a referral institute/ hospital in respect of persons covered under Central Services (Medical Attendance) Rules, 1944. The Committee would like that similar facility should be extended to persons covered under the Central Government Health Scheme also. (S. No. 80)

5·51 In Bombay too, 5 Government hospitals and 8 private hospitals, which are recognised under CGHS are stated to be inadequate to meet the needs of CGHS beneficiaries. The proposal for construction of a CGHS hospital at Haji Ali, Bombay has been shelved on account of financial constraint. Here again, though the Ministry feels that "difficulty is being experienced by any of the CGHS beneficiaries over there," the CGHS beneficiaries feel otherwise and the Committee have no reasons to brush aside the views of the CGHS beneficiaries in this regard in the absence of any systematic study of demand and availability of beds in recognised hospitals. The Committee recommend that the need for recognising a few more hospitals of State Government or Bombay Municipal Corporation or even private hospitals or reserving beds in such hospitals should be seriously considered in relation to the population of Central Government employees in Bombay and their dispersal over a vast area with a view to providing adequate hospital facilities for them. (S. No. 81)

5·52 Hospital rates in Bombay are fixed by Central Government for various services and these are revised from time to time in the light of proposals made by the recognised hospitals. The Committee have been informed by CGHS beneficiaries in Bombay that the rates of various services in these hospitals, as approved by CGHS, are so low as compared to the general rates of these hospitals, that these hospitals do not readily agree to admit CGHS beneficiaries for treatment and other services. The Ministry's stand is that CGHS being a bulk consumer and providing steady clientele it should expect some concession in the rates, which admittedly, are lower for CGHS beneficiaries in many cases than these paid by private individuals. But whether the hospitals admit CGHS beneficiaries, who pay lower rates, as readily as they do others who pay more, is a matter on which the beneficiaries' experience deserves to be given more weight than the Ministry's expectation.

5·53 The Committee feel that the Ministry should monitor the experiences of CGHS beneficiaries in Bombay in this regard and review the position in the light of the actual facts as may come to their notice in this exercise. If lower rates make CGHS beneficiaries unwelcome patients in the recognised hospitals, the remedy lies in revising rates upward and not expecting altruistic approach from hospitals managements in dealing with Central Government employees. (Sl. No. 82).

5·54 The standard of hospitals in Calcutta and other cities is stated to be not upto the mark though the Ministry denies that there is any such thing. Health Secretary agreed in evidence to depute the Director General of Health Services to observe the services provided in Calcutta hospitals and report on the standard of services there and the improvements that could be made. The Committee would like the report together with the action taken by the Government to be communicated to them within six months. (Sl. No. 83.)

5·55 The Committee would also recommend that a similar report by Director-General Health Services, should also be submitted to them in respect of hospital in other cities where CGHS is in operation. (S. No. 84)

5·56 The Committee are happy to learn that proposals are under consideration to make CGHS beneficiaries eligible for super specialist treatment in areas like coronary bye pass in AIIMS, Railway Hospital, Perambur (Madras) Christian Medical College, Vellore, etc., so that the need for their going abroad for such treatment can be minimised. The Committee learn that the Ministry is also trying to identify more hospitals and private clinics where specialised facilities are available, especially for treatment of the type of diseases for

which normal requests are received from Central Government employees for treatment abroad and in respect of which treatment facilities in ordinary Government hospitals are still in adequate. These are welcome developments. The Committee would urge the Ministry that these proposals should be finalised and treatment facilities in all such specialised hospitals extended to CGHS beneficiaries at the earliest. (S. No. 85).

5·57 There is Disatisfaction with ambulance services in Delhi and outside. These services are, however, not under the control of CGHS authorities. The Ministry has informed the Committee that ambulance service in Delhi will be considerably augmented by the end of the Sixth Five Year Plan. Delhi Administration is reportedly working on a scheme to have centrally based ambulance vans with wireless system of inter-communication. Ambulance service may not be the direct responsibility of CGHS authorities but, surely, the Ministry of Health and Family Welfare cannot show complete unconcern about this service. In Delhi, the Ministry is directly concerned with this. The need for having an efficient ambulance service in a city cannot be disputed. For this purpose, adequate number of ambulance vans should be available; their location should be known to the people; and they should be available on telephone. The Committee expect that the Ministry will use its good offices to arrange for an efficient ambulance service in Delhi and other cities where CGHS is in operation for the benefit of CGHS beneficiaries. (S. No. 86)

5·58 It was really a good idea to set up a Health Check-up Clinic in Delhi in 1969 but it is unfortunate that this clinic has not been able to become popular even after 11 years of its working. In 1979-80 for which information is available, only 8 persons availed of the health check-up facility in this clinic every day on an average. The main reasons for this clinic not becoming popular are—(1) non-availability of facilities for X-ray examination, ECG and other specialised diagnostic equipment because of which CGHS beneficiaries are made to go from one place to another to have all check-ups done; and (2) its location away from residential areas. It is regrettable that the Ministry even though fully aware of the position, did not choose to take remedial measures all these years.

5·59 The Committee feel, and the Health Secretary also agrees, that it is no use keeping an ill-equipped health check-up clinic. It should be fully equipped for giving complete service under one roof and located at a place where its popularity can grow. (S. No. 87)

5·60 The working of clinical laboratories under CGHS had also come in for severe criticism. The users have exprssed their dissatisfaction with the quality of tests done in these laboratories which, they say are, often unreliable. There are also delays and mix-ups.

5·61 At present there is one clinical laboratory for three dispensaries in Delhi and Bombay. The Committee agree with the Ministry that for the present it is not necessary to have a clinical laboratory attached to each dispensary. But what has disturbed the Committee is the lack of faith of users in the quality of tests done in these laboratories. The Ministry is not prepared to accept the general reports of poor quality of testing unless "there is a clear cut evidence to this effect." It is not understand how a patient can provide "clear cut evidence" of poor quality of tests. It should before the Ministry to advise a system by which it can have sample and cross checking of results to satify itself that the quality of tests is of the required standard. (S. No. 88).

5·62 The reasons for the unsatisfactory working of clinical laboratories are not too difficult to know. All the laboratories are not equipped with modern equipment. Technicians' skill has not been updated since their recruitment. Staff-at Bombay, Patna and Madras is short of requirements. The Ministry has also admitted these shortcomings.

5·63 The Committee would like the Ministry to accept the widespread feeling of dissatisfaction with the working of these laboratories as only then can it seriously set out to tone up their efficiency and quality. In this age of the fast changing technology techncians, should have periodical refresher courses if they have to remain abreast with newer techniques. The equipments in the clinical laboratories should be modernised in all the laboratories. The two Pathologists located in Delhi Polyclinic whose function is to visit the clinical laboratories and supervise the quality of tests, should be required to bestir themselves and be more active and vigilant. They should have random checks carried out under their direct supervision to cross-check results. Unless a multipronged attack is made on this problem as suggested above, it will not be possible to bring about the desired improvement in the working of these laboratories. The Committee would like the Ministry to report the progress of action taken in this direction within six months. (Sl. No. 89)

B. POLYCLINICS

5.64 In their Fifty-seventh Report on Central Government Health Scheme the Estimates Committee (1973-74) had noted that with a view to avoid rush and over-crowding at Willingdon Hospital (now Dr. R M L Hospital) and Safdarjung Hospital in Delhi for specialist consultation, Government had set up five polyclinics at Pusa Road, Lajpat Nagar, Daryaganj, Tilak Nagar and R. K. Puram. The Committee had recommended that each of the five polyclinics should have the following facilities (i) Beds for emergency cases; (ii) Oxygen cylinder facilities; (iii) Specialised laboratory examination; (iv) Radiological examination and electrotherapy; (v) Specialist services; (vi) Initial supply of medicines; and (vii) E.C.G. etc. The Committee also expressed the view that facilities for specialities like medicine, surgery, dentistrly, ear, nose and throat opthalmology, gynaecology and paediatrics should also be provided at these polyclinics. The surgical specialist should be in a position to do minor operation at the polyclinic itself. The Committee also, suggested periodical evaluation of the working of polyclinics to bring about the required improvements in the interest of efficient service to the beneficiaries.

5.65 In its action taken replies (november, 1974) the Ministry stated that, "in view of the inadequate space and resources, it is not possible to provide additional facilities in the existing Polyclinics. When the polyclinics are housed in Government buildings to be constructed for the purpose and when funds become available, additional facilities will be provided."

5.66 In their Report (September 1977) on the Working of C.G.H.S. Dispensaries the Study Team of the Department of Personnel and Administrative Reforms, Ministry of Home Affairs, observed as follows :—

> "The existing poly-clinics provide only some specialised medical services which include medical and ENT. Dentistry and Ophthalmological services have been provided only in some of them. Due to absence of technical personnel to operate the machines, no polyclinic at present offers ECG facility. In the absence of these facilities, majority of beneficiaries have to visit only Willingdon or Safdarjung Hospitals. As these hospitals are also open to general public,

there are long waiting periods for the CGHS beneficiaries. The Estimates Committee (1973-74) of the Fifth Lok Sabha had recommended that the poly-clinics should have the following facilities :

(i) Beds for emergency cases.

(ii) Oxygen cylinder facilities.

(iii) Specialised laboratory examinations.

(iv) Radiological examination and Electrotherapy.

(v) E.C.G.

(vi) Minor surgical operation.

(vii) Gyneocology and Paediatrics.

5.67 The Study Team recommended that the afforesaid facilities along with adequate technical staff should be provided for in all the CGHS poly-clinics as soon as possible. X-ray facilities, too, should be decentralised and the poly-clinics should be equipped with the machine and staff for the purpose.

5.68 Asked to state the action taken on the Study Team's recommendations, the Ministry of Health & Family Welfare stated :—

"Not practicable in view of lack of larger accommodation and financial constraints. This will amount to converting them into "Mini Hospitals". Planning Commission is opposed to more hospitals in Urban areas."

5.69 It is seen that a Committee of the Joint Consultative Machinery had also recommended that clinics should be opened at all places at least where they would be administratively and financially viable so that proper consultation was available to beneficiaries.

5.70 Asked to state the progress made in this regard, the Ministry stated that wherever, administratively and financially viable Polyclinics were being opened subject to financial constraints.

5.71 The present position of Polyclinics in different cities is as follows :—

City	Existing	Proposed in 1981-82
Delhi	2	1
Bombay	1	1
Calcutta	1	—
Madras	—	1
Nagpur	—	1
Hyderabad	—	1

5.72 Demands for opening more polyclinics with full laboratory and X-ray facilities and specialists from all common disciplines have been voiced again in memoranda submitted to the Estimates Committee (1981-82).

5.73 A non-official witness stated before the Committee that the specialists work should be de-linked from hospitals and there should be poly-clinics where neighbouring dispensaries could have specialists facilities as well as clinical facilities.

5.74 An eminent Doctor and a medical administrator of repute and experience stated in his evidence before the Committee that—

> "the whole movement in the world of health services is to take the services out to the different classes of people as far as your resources permit. I think just to have 80 dispensaries around Delhi and then feed the whole lot to two main hospitals is not rational. It is known that only a few people make their way there. I do not have to mention how they do it. The poor Class IV, and Class III people, are the sufferers. I would say that increasing the number of dispensaries may not be of much use, but establishing an intermediate health station between the dispensary and the referral hospital will be of value. In that case nearly 99 per cent of the cases need not be referred to the hospitals but only one percent will be sent to the major hospitals, and more time can be devoted for them."

5.75 Giving his views on the question of opening of more Poly-clinics, the representatives of the Ministry of Health & Family Welfare stated in his evidence (December, 1981) that—

> "In the 6th Plan, we have provided for a total of 12 new polyclinics in addition to the four that we have. Each will cost Rs. 16.5 lakhs, 13 lakhs for equipment and 3.5 lakhs for staff and each is expected to cover 50,000 card holders. These are referal point where the specialist consultation is available. X-ray facilities and clinical laboratory facilities are also provided. So far as psychiatry is concerned, we have got psychiatrists in Safdarjung Hospital and Ram Manohar Lohia Hospital. To provide a psychiatrist in all these polyclinics will not be worth it because there would not be required load. The orthopaedic services are hospital based; that will not make much meaning. We, of course, agree that we should have more and more polyclinics.

5·76 The importance of polyclinic an intermediate health station between the dispensary and the referal hospital—has been highlighted and the need for setting up more polyclinics emphasized by CGHS beneficiaries as well as medical experts. Government had also realised its importance and it has already set up 4 polyclinics in Delhi. 12 more are proposed to be set up in the Sixth Five Year Plan of which 5 were to be set up in 1981-82. The Committee have not been informed whether any one of these polyclinics has been established in the first two years of the Sixth Plan. If not, the Committee wonder how target would be achieved in the remaining three years of the plan. Seeing the advantages of polyclinics especially to lower paid staff and their popularity, it will be unfortunate if the 12 polyclinics or proposed for the Sixth Five Year Plan do not come up as targeted. The Committee would like the Ministry to avoid such a thing happening at any cost. (S. No. 90)

5·77 The Estimates committee (1973-74) had recommended in their 57th Report that polyclinic should provide all types of specialised medical services if they have to fulfil the objectives for which they were intended. The Study Team of the Department of Personnel and Administrative Reforms (1977) had also supported the Committee's recommendation and recommended provision of all specialist services in the polyclinics. The Committee are disappointed to note that the Ministry's re action to these recommendations has not been encouraging at all. It has

Table II

Para Medical Staff

Units	No. of posts sanctioned	No. of posts filled	No. of posts lying vacant.
1	2	3	4
1. Bombay	253	253	—
2. Lucknow	57	48	9
3. Madras	115	103	12
4. Bangalore	188	162	26
5. Hyderabad	215	213	2
6. Patna	61	58	3
7. Ahmedabad	40	37	3
8. Jaipur	98	83	15
9. Meerut	67	59	8
10. Allahabad	64	52	12
11. Nagpur	72	67	5
12. Calcutta	154	104	50
13. Pune	65	65	—
14. Kanpur	91	84	7
15. Delhi	1282	1209	73
	2822	2597	225

6.4 During evidence, a representative of the Ministry furnished the latest position regarding sanctional posts of medical officers and the number in position :—

Mediaal Officers

	Sanctioned	In positioned
Bombay	97	87
Ahmedabad	25	16
(In Ahmedabad P & T opted out : that was one of the reasons)		
Meerut	33	30
Nagpur	34	30
Pune	29	27
Bangalore	49	49
Kanpur	46	30
Lucknow	27	23
Hyderabad	54	52
Allahabad	35	22
Jaipur	28	24
Patna	27	23
Madras	63	60
Calcutta	84	84
Delhi	753	709

As against 1388 sanctioned posts of M. Os., 1266 are in position today.

6.5 The witness admitted that "We cannot say that the position is that unsatisfactory."

6.6 From above, it is seen that two sets of figures supplied by the Ministry in writing in August, 1981 do not tally with each other. In evidence (Dec. 1981) a representative of the Ministry gave figures regarding the posts of doctors which tallied with neither of the figures given earlier.

6.7 It is also seen from the information furnished by the Minister that in the case of Medical Officers at Hyderabad, Jaipur, Pune and Kanpur, the dates since when the posts have been lying vacant have not been furnished. In the case of Ahmedabad, 3 posts have been lying vacant since creation; whereas 5 have been filled on monthly wages. In certain other places, the posts have been lying vacant since 2-9-1976 (Bangalore); 23-10-78 (Lucknow); 1978 (Calcutta) and 21-8-1979 (Bombay).

6.8 Similarly, in the case of Para-Medical staff, posts have been lying vacant in Ahmedabad since creation and in Nagpur for an unspecified period. In the case of 73 posts in Delhi, the exact dates since when they have been lying vacant are not readily available with the Ministry. In certain other cases the posts have been lying vacant for a period of 5 to 12 years e.g. Meerut—since 1970, in Bangalore since October, 1975, and in Calcutta since 1973.

6.9 The Committee regret to observe that the figures of total strength of doctors and para-medical staff furnished by the Ministry are quite confusing. The Ministry has supplied three different sets of figures which do not tally with one another.

6.10 Taking the best figures, the Committee find that over 100 posts of doctors and nearly 225 posts of para-medical staff are lying vacant. At certain places vacancies in the case of doctors have been there for over five years and in the case of para-medical staff for over 10 years. The reasons given by the Ministry for these shortages, such as long time taken in making recruitment of doctors through UPSC and non-availability of para-medical staff, do not carry conviction with the Committee. It only shows that the Ministry has no proper system of perspective planning and initiating action for recruitment of Medical Officers well in advance. Such a large number of vacancies are bound to effect adversely the working of CGHS dispensaries on the one hand and aggravate unemployment position in the country on the other. The Committee cannot but hold the Ministry responsible for the failure in providing full contingents of doctors and para-medical staff in the CGHS dispensaries. The Committee would like the Ministry to remove weaknesses in personnel planning and management to avoid such serious short-comings as high-lighted above. They would also like the Ministry to fill up all the vacancies without delay and report progresses within three months. (S. No. 93)

B. Confirmation of Medical Officers and Staff in CGHS

6.11 From the information furnished to the Committee, it is seen that out of 1052 Medical Officers in position on 31-3-1981 in various cities (excluding Bombay), where CGHS is operating, 231 Medical Officers not been confirmed. Information about Bombay was not available with the Ministry. Out of these 231 Officers, 50 had put in more 10 years of service.

Table II

Para Medical Staff

Units	No. of posts sanctioned	No. of posts filled	No. of posts lying vacant.
1	2	3	4
1. Bombay	253	253	—
2. Lucknow	57	48	9
3. Madras	115	103	12
4. Bangalore	188	162	26
5. Hyderabad	215	213	2
6. Patna	61	58	3
7. Ahmedabad	40	37	3
8. Jaipur	98	83	15
9. Meerut	67	59	8
10. Allahabad	64	52	12
11. Nagpur	72	67	5
12. Calcutta	154	104	50
13. Pune	65	65	—
14. Kanpur	91	84	7
15. Delhi	1282	1209	73
	2822	2597	225

6.4 During evidence, a representative of the Ministry furnished the latest position regarding sanctional posts of medical officers and the number in position :—

Mediaal Officers

	Sanctioned	In positioned
Bombay	97	87
Ahmedabad	25	16
(In Ahmedabad P & T opted out : that was one of the reasons)		
Meerut	33	30
Nagpur	34	30
Pune	29	27
Bangalore	49	49
Kanpur	46	30
Lucknow	27	23
Hyderabad	54	52
Allahabad	35	22
Jaipur	28	24
Patna	27	23
Madras	63	60
Calcutta	84	84
Delhi	753	709

As against 1388 sanctioned posts of M. Os., 1266 are in position today.

6.5 The witness admitted that "We cannot say that the position is that unsatisfactory."

6.6 From above, it is seen that two sets of figures supplied by the Ministry in writing in August, 1981 do not tally with each other. In evidence (Dec. 1981) a representative of the Ministry gave figures regarding the posts of doctors which tallied with neither of the figures given earlier.

6.7 It is also seen from the information furnished by the Minister that in the case of Medical Officers at Hyderabad, Jaipur, Pune and Kanpur, the dates since when the posts have been lying vacant have not been furnished. In the case of Ahmedabad, 3 posts have been lying vacant since creation; whereas 5 have been filled on monthly wages. In certain other places, the posts have been lying vacant since 2-9-1976 (Bangalore); 23-10-78 (Lucknow); 1978 (Calcutta) and 21-8-1979 (Bombay).

6.8 Similarly, in the case of Para-Medical staff, posts have been lying vacant in Ahmedabad since creation and in Nagpur for an unspecified period. In the case of 73 posts in Delhi, the exact dates since when, they have been lying vacant are not readily available with the Ministry. In certain other cases the posts have been lying vacant for a period of 5 to 12 years e.g. Meerut—since 1970, in Bangalore since October, 1975, and in Calcutta since 1973.

6.9 The Committee regret to observe that the figures of total strength of doctors and para-medical staff furnished by the Ministry are quite confusing. The Ministry has supplied three different sets of figures which do not tally with one another.

6.10 Taking the best figures, the Committee find that over 100 posts of doctors and nearly 225 posts of para-medical staff are lying vacant. At certain places vacancies in the case of doctors have been there for over five years and in the case of para-medical staff for over 10 years. The reasons given by the Ministry for these shortages, such as long time taken in making recruitment of doctors through UPSC and non-availability of para-medical staff, do not carry conviction with the Committee. It only shows that the Ministry has no proper system of perspective planning and initiating action for recruitment of Medical Officers well in advance. Such a large number of vacancies are bound to effect adversely the working of CGHS dispensaries on the one hand and aggravate unemployment position in the country on the other. The Committee cannot but hold the Ministry responsible for the failure in providing full contingents of doctors and para-medical staff in the CGHS dispensaries. The Committee would like the Ministry to remove weaknesses in personnel planning and management to avoid such serious short-comings as high-lighted above. They would also like the Ministry to fill up all the vacancies without delay and report progresses within three months. (S. No. 93)

B. Confirmation of Medical Officers and Staff in CGHS

6.11 From the information furnished to the Committee, it is seen that out of 1052 Medical Officers in position on 31-3-1981 in various cities (excluding Bombay), where CGHS is operating, 231 Medical Officers not been confirmed. Information about Bombay was not available with the Ministry. Out of these 231 Officers, 50 had put in more 10 years of service.

6.12 As regards Para-medical staff, out of 2597 persons in position on 31-3-1981, 619 persons who had put in more than 5 years' service had not been confirmed. Out of these 619 persons, 249 had put in more than 10 years of service.

6.13 In Delhi alone, out of 204 Medical Officers, Grade I and 419 Medical Officers Grade II, as many as 94 Medical Officers (Grade I) and 66 Medical Officers (Grade II) who had put in more than 3 years service in the Grade had not been made permanent.

6.14 As regards the Para-medical staff in Delhi, out of a total of 1209 persons, 353 persons with more than 3 years service had not been confirmed (Aug., 1981). Of them 142 had put in (5—10 years) service, 94 (10—15 years) service and 6 persons (over 15 years) service. The main reasons attributed for not making the aforesaid staff permanent were stated to be as follows :—

(i)	Due to non-availability of permanent posts	33 persons
(ii)	Due to administrative reasons	140 persons
(iii)	Due to delay in convening meeting of D.P.C.	180 persons
	Total	353 persons

6.15 The Ministry has stated that the two pre-requisites for making the medical staff permanent in the CGHS are (i) the availability of permanent posts and (ii) suitability of the persons for confirmation. Temporary staff are made permanent as and when there conditions are fulfilled.

6.16 Explaining this position further a representative of the Ministry stated in evidence that :—

> "There is no prescribed time limit for any category of Government employees which stipulates that after such and such period, an employee should be made permanent. The confirmation depends upon the availability of permanent posts from time to time. The DPC meetings are held and the employees are confirmed accordingly.
>
> So far as the CHS Officers are concerned, the process of reviewing the posts and converting them into permanent posts is done by the Directorate of CGHS and the confirmation is done by the CGHS cadre authority which is also under the Ministry of Health. I must admit that the process of getting the posts reviewed and made permanent has not been quick enough. We are at it. So far as the para-medical staff is concerned, the position is better. Even here, one problem is that there is no unified cadre."

6.17 The Committee pointed out that the CGHS Scheme is a permanent one, but the doctors are not permanent and in 180 cases of paramedical staff, the Ministry had delayed the holding of DPC meetings.

6.18 The witness stated :—

> "It is a matter of concern which we also share. Before the DPC meeting is held, the confidential reports of the doctors have to be written down and there are other formalities to be gone into. We assure you that all this will be gone into."

6.19 On the Committee's expressing serious concern at the long delays in confirming eligible officers and asking why the past omissions cannot be rectified by completing the process of confirmation for all eligible officers and staff, the witness assured the Committee that :—

> "We given you an assurance that, both with reference to the posts of Medical Officers and with reference to the para-medical posts, we will have a special drive organized and see to it that the conversion is expedited."

6.20 Asked to indicate a specific target date by which this process would be completed, Health Secretary assured the Committee that confirmation cases of all eligible medical officers and para-medical staff would be processed and completed by the 31 March, 1982.

C. Promotional Avenues

6.21 It has been brought to the Committee's notice that :—

> "There is practically no promotion from Senior Class I to Supertime Grade II. There being only 43 posts of Supertime Grade II sanctioned against a total of about 2700 Junior and Senior Class One Officers resulting in stagnation of about 500 Doctors in the maximum of Senior Class I."

6.22 The All India Central Government Health Scheme Employees Association, in their memorandum submitted to the Committee, stated that :—

> "Besides other considerations, absolute lack of incentive/promotional avenues for the Medical Officers, Para-medical and clerical staff in the CGHS Organisation leads to feelings of frustrating among them and this stagnation in service career reflects in their attitude/behaviour towards the beneficiaries.
>
> CGHS was introduced in July, 1954, and a person who is Pharmacist/LDC/Staff Nurse/Dresser/Peon/Lab. Techn./Sweeper or a Female Attendant is still in the same post since the beginning of the Scheme. No promotional avenues are there. A person who is serving Govt. of India for the last 28 years without any incentive, how can you expect courtesy from him. He or she is not rude but he is frustrated."

6.23 An eminent medical administrator of high Standing and experience stated in a note submitted to the Committee that :

> "One of the problems facing the CGHS is how to attract talented medical personnel to the CGHS Cadre and having attracted them how to retain them.
>
> I realise that these problems are not unique to this cadre alone but are more widespread phenomena. Nevertheless, since the issues involved here relate to public health and since the training of a doctor takes a considerably longer time than the training of other personnel in the service, especially if they take postgraduate qualifications, it would be appropriate if the problems of the CGHS are given special attention.
>
> It is well-known that the avenues for promotion are very limited within the CGHS. A number of officers get stuck in

the same pay scale for 10—15 years and several officers are known to have retired on the same scale of pay as at the beginning of their services.

There are also no incentives for good work and there is no question of merit promotion. Under these circumstances it will be difficult to attract to retain talented officers within the cadre. It would be helpful if the CGHS can be made more flexible to overcome these difficulties. Within reasonable limits the number of higher positions can be increased."

6.24 The Ministry stated that there are large number of categories of Medical and para-medical posts under CGHS. For all these posts, recruitment rules are prepared and got approved from the competent authority, keeping in view the requirements of the post, job description and career aspirations of the incumbants of the posts in the particular line or grade. Medical Officers are considered for promotion to higher grades namely, M.O. Gr. I, Specialist Grade I etc.

6.25 The para-medical staff are promoted to higher grade wherever available such as Nursing Orderly to dresser. It is admitted that in many of these categories like Pharmacist etc. there are only meagre chances of promotion. However, selection grade is being provided.

6.26 As far as Medical posts are concerned, the Junior Medical Officer should put in 5 years of service for promotion to Senior Class I Officer. The Senior Class I Officer is required to put in a minimum of 10 years service for becoming eligible for promotion to the post of Super time Grade II.

6.27 As regards the para-medical staff, there are no fixed minimum period of service which could be made universally applicable to all the posts. The period of service is prescribed in the recruitment rules of the higher posts where officers of the lower grade are to be considered for appointment to these posts.

6.28 With regard to the Para-medical staff the Committee find from the information furnished by the Ministry that out of 47 various categories of Para-Medical and other staff, promotional avenues are not there for 38 categories comprising 1907 posts out of a total of 2601 and only 9 categories of staff (694 posts) have prospects of promotion.

6.29 It was stated by the Ministry that "it is true that the chances of promotion from Senior Grade I to super time Grade II are not commensurate with the large number of posts. But restructuring of the Central Health Service is in the last stage of finalisation. It is anticipated that additional promotion avenues will then become available."

6.30 The Ministry furnished (Aug. 1981) the following statement showing the number of medical officers in CGHS (Delhi) who fulfilled all conditions for promotion but had not been promoted to the next grade even after they had put in service for the period given below :

S. No.	Period of Service	Medical Officers
1.	more than 15 years	31
2.	10—15 years	30
3.	5—10 years	169

6.31 The Ministry admitted that "at present a large number of Senior Class I Officers are stagnating at the maximum of the pay-scale. However, the precise number of such officers and the dates from which they are stagnating are not readily available. In this context it is pertinent to point out that in majority of cases, the officers have reached the maximum of their pay-scales due to substantial increase/raise in the emoluments as a result of application of the concordance - table. All the same this Ministry is taking steps to mitigate this hardship by restructuring the service."

Medical Officer Incharge

6.32 In reply to a question, the Ministry stated that it was a fact that in a number of dispensaries, Medical Officers Incharge of dispensaries were holding posts in the same scale in which a number of other doctors in those dispensaries were working.

6.33 But the Ministry did not agree that it created administrative problem for a Medical Officer Incharge to enforce discipline and carry out supervisory duties in such dispensaries where other doctors might also be in the same grade of pay.

6.34 The Ministry stated that "the medical officers in charge of the dispensary has no functional supervision over other medical officers of an equivalent scale of pay working in a dispensary. The supervisory duties of the Medical Officer incharge of the dispensary are of an administrative nature which the senior most officer among them is performing. However, in order to strengthen the administrative set up of the Service and to increase promotion avenues for C.H.S. officers of various grades, it is proposed to upgrade posts in various grades of the service."

D. Cadre Review

6.35 The Committee's attention was drawn to the following recommendation of the Third Pay Commission :

> "It seems to us that a structural reorganisation of cadre is necessary to get over these difficulties and to ensure that the GDO's Grade I, Hospital Specialities, and Teaching Specialists have reasonable promotion opportunities in their respective fields."

6.36 It was stated in a memorandum that even before Third Pay Commission Report, the Department of Personnel and AR *vide* their O. M. No. 5/1/71-PP Vol. VI, dt. 6-5-78 had asked ever cadre controlling authority to constitute a cadre Review Committee under the Chairmanship of the Cabinet Secretary to meet at least once in every three years. While in respect of other Central Servicesi n Group A, the Ministries set up Cadre Review Committee and cadre reviews had been undertaken periodically and posts upgraded wherever necessary, but no cadre review had taken placed in case of Central Health Service with the result that promotional avenues beyond senior Class-I scale were almost non existent.

6.37 Asked as to why the Cadre review in the case of Central Health Service or CGHS had not taken place inspite of the clear instructions by

the Department of Personnel and AR on the subject, the Ministry of Health stated that :—

> "Restructuring of Central Health Service, which includes G.D.O. Grade I, hospital specialists and Teaching specialists, is in last stage of finalisation. It is anticipated that additional promotion avenues will then become available. Recommendations of Third Pay Commission in respect of Pharmacists have been implemented.
>
> Recommendations regarding other categories of para-medical staff working under C.G.H.S. are under consideration."

6.38 The Ministry in a subsequent note informed the Committee that the instructions referred to were received from the Department of Personnel and Administrative Reforms is 1972. While action was being taken to undertake cadre review as per the instructions, the recommendations of the Third Pay Commission were received in the meantime, which necessitated to restructure the entire service and the revision of the CHS Rules 1963, as amended from time to time. It was considered that the proposed restructure of the service would serve the purpose of the cadre review and may create more avenues of promotion for senior medical officers. However, the proposed restructuring is still under consideration in consultation with the UPSC, Department of Personnel and Administrative Reforms and Ministry of Finance, etc., and is likely to be finalised shortly alongwith the cadre Review of the Service."

6.39 Explaining the position further, Secretary (Health) stated in evidence :—

> "The Central Health Service was initially constituted in 1963 and then the Service was reorganised with effect from September 1966 to provide for better service conditions.
>
> The service was converted into Class I service with effect from 1973. There are certain aspects of this service which must be understood-stagnation, etc. It is not a compact service like most of the other services. This services has four streams—1. teaching. 2. non-teaching, 3. general duty, 4. public health. This is a service where there is a large element of direct recruitment almost at all levels. There is existence of officers belonging to different specialities and super-specialities. There are thirty specialities and super-specialities in the service. The presence of specialities and super-specalities makes the task difficult.
>
> The officers of the service enjoy benefit of non-practising allowance in addition to their basic pay. This kind of facility is not available to many other highly technical services. The allowance some times ranges from Rs. 150/- to .Rs. 600/- (non-practising allowance). Even the Third Pay Commission observed that this service does not conform to a single service, common qualification, common gradation and inter-changability. Inspite of all these difficulties it was decided to review the cadre management of this service in 1979. It has taken considerable time because of complexities. Since I joined this Ministry, I along with my colleagues have been able to push this proposal which has been going on in a major and expeditious way and we have come to a very advance stage of its being approved. I can only mention at each level we

have provided so much additional facilities. This has been largely agreed at official level between our Ministry, Ministry of Finance and Department of Personnel and that it is now only the formality to take the proposal forward. CGHS officers Association met me They expressed their satisfaction."

6.40 The witness added—

"Both the associations of Central Health Officers and C.G.H. Medical Officers called on me. I assured them and now they are aware of the steps being taken by us.....We are taking the total cadre and reviewing it to ensure quite adequate promotion opportunities are available from one cadre to another. For example, a G.D.O. Grade II takes a considerable period to become G.D.O. Grade I. They are stagnating. But we are providing that after six years of service, he should have almost an automatic opportunity to go. If suficient posts have once been sanctioned, it will generate considerable and substantial opportunities of promotion to the medical officers. We expect to have it through".

6.41 Asked to state the percentage of promotion from GDO Grade II to GDO Grade I, the witness replied that :

"We have taken the review of promotion prospects of various services keeping in view a broad percentage.....It will not be proper for me to disclose actually the measures which are being considered till the Cabinet takes a view. But we are hopeful that within two month this proposal should be through."

6.42 In a post evidence note the Ministry has stated that while it is admitted that the cadre review of the C.H.S. was not taken up immediately on receipt of instructions from the D.P.A.R., it has already been taken up. There are a large number of doctors of different grades in the Central Health Services from whom Medical Officers are provided to numerous organisations under the Ministry of Health and Family Welfare and the large number of Departments of Government of India needing the services of such officers. As such, the process of review in the different levels of the cadre could not be completed quickly. A cadre Review of Central Health Service has since been undertaken and the Departments final proposals are at present receiving the attention of the Department of Personnel and Administrative Reforms. However, the restructuring of the cadre is in the last stage of finalisation.

6·43 Stagnation and lack of adequate promotion prospects have created widespread frustration in CGHS doctors and para-medical staff of which the Committee cannot but take a note. The Ministry has admitted that chances of promotion from Senior Grade I to Supper-time Grade-II are not commensurate with the large number of posts and a large number of them are stagnating at the maximum of their pay-scale. Medical Officers incharge of dispensaries and a number of other doctors in each dispensary are in the same scale and this surely cannot be conducive to proper administrative control and discipline. In Delhi alone 169 Medical Officers with 5-10 years' service in CGHS who fulfil all conditions of promotion have not got promotion; 30 eligible officers are stuck in their posts even after having put in 10-15 years of service and 31

officers with more then 15 years service have been without any opening. Figures about doctors outside Delhi are not available.

6·44 Position of para-medical staff is no better and the Ministry is aware of it. The very structure of service in their case is disappointing. Out of 47 categories of para-medical posts having a sanctioned strength of 2601 personnel, 38 categories of posts comprising 1907 personnel have no promotion prospects whatsoever. It is difficult to envisage an organisation which provides no avenue of upward mobility for its technically qualified staff and still expects them to run its services efficiently. This is a sad reflection on the personnel management of the Ministry. The Committee would like the Ministry to give this matter an urgent thought and speedy action. (S. No. 94)

6·45 Restructuring of Central Health Service and cadre review in respect of Medical Officers of all grades, as recommended by Third Pay Commission, is stated to be nearing finalisation. Recommendations of the Pay Commission in respect of Pharmacists have been implemented and those regarding other categories of para-medical staff are stated to be under consideration. But the unconscionable delay of nearly 10 years in undertaking this much needed exercise resulting in irreparable harm to Medical and para-medical staff, for which the Committee hold the Ministry responsible, cannot but be deplored. (S. No. 95)

6·46 The Committee are glad to learn that the Health Secretary alongwith his colleagues have now been able to "push" the proposals regarding cadre review and restructuring of CGHS which, it is stated, are now at a very advanced stage of being approved. When these are finalised, additional promotional avenues are expected to become available for medical officers of all grades and stagnation is expected to end. The Committee would like that these welcome but hitherto much delayed measures should not be delayed any further. They would like to be apprised of the outcome of these exercises in concrete terms. (S. No. 96)

6·47 The Committee would also like that the Third Pay Commission's recommendations in respect of para-medical staff other than pharmacists (in whose case action has already been taken) should also be processed and implemented without dealy. (S. No. 97)

6·48 The Committee would like to observe in this context that while the Ministry has a right to expect the most efficient performance from Medical and para-medical staff in CHGS to be able to provide satisfactory service to CGHS boneficiaries, it also has a responsibility towards them to ensure reasonably good career prospects and service conditions to avoid frustration creeping into their ranks. The Committee would advise the Ministry to keep this aspect under its constant watch and not to delay remedial action wherever and whenever it becomes necessary in the future. (S. No. 98)

6·49 Even in the matter of confirmation of Medical Officers and paramedical staff the position was very unsatisfactory. 23. Medical Officers who had put in more than five years' of service had not been confirmed upto March 1981. Of them 50 had put in more than 10 years' of service and were still awaiting confirmation. In Delhi alone, 94 out 204 Medical Officer Grade I and 66 out of 419 Medical Officer Grade II had put in more than three years' of service in the grade and had not been made permanent.

6·50 The position in regard to para-medical staff is no better. Out of 2597 such staff in position on 31-3-1981, as many as 619 persons had not been confirmed even though they had put in more than five years' of service; 249 of them had put in more than 10 years of service. In Delhi, out of 1209 para-medical staff, 353 persons having more than three years service, 142 with 5-10 years service, 94 with 10-15 years of service and 6 with over 15 years of service had not been confirmed.

6·51 After going into the reasons for the non-confirmation of Delhi based para-medical staff, the Committee find that except in the case of 33 persons for whom permanent posts were not available, in 320 other cases administrative delays on the part of the Ministry were responsible for not processing their conformation cases. The Committee would like the cases of administrative delay to be enquired into at appropriate level with a view to learning lessons for the future. (S. No. 99)

6·52 Even though, as the Ministry states, there is no prescribed time-limit after which a Government employee should be made permanent, it does not mean that the employee should be left in suspense beyond a reasonable period if permanent posts are available. Any delay in this behalf amounts to harassment which must be avoided. The Committee, in fact, would like the Ministry to examine in consultation with the Department of Personnel the desirability of laying down a rule that if after three years' of satisfactory service a Medical Officer or para-medical staff is not confirmed by the appropriate authority, his/her case together with the reasons therefor should be placed before the next higher authority or Health Secretary to unable the latter to judge whether the discretion not to confirm the employee has been exercised judiciously. (S. No. 100)

6·53 The Committee take note of the admission of Health Secretary that the process of getting the posts reviewed and made permanent has not been quick enough. The Committee had during evidence expressed serious concern at the long delays in this regard and had observed that the Ministry should complete the process of confirmation in respect of all eligible officers and staff without delay. At the Committee's instance, the Health Secretary was good enough to assure the Committee that the case of all eligible medical officers and staff would be processed and completed by 31st March, 1982. The Committee trust that the Ministry will fulfil its assurance and earn the goodwill of officers and staff. (S. No. 101)

6·54 The Committee find that a major impediment in the way of processing confirmation cases in respect of Medical Officers has been the delay in convening DPC (Department Promotion Committee). They also understand that UPSC has to be consulted before the confirmation cases of medical officers who have been recruited through UPSC, are decided. The Committee feel that this is cumbersome and time-consuming procedure. Once a doctor has been recruited through UPSC his confirmation should be decided by the Ministry in the light of his performance and it need not await formal approval by UPSC. Only in cases where the Ministry chooses not to confirm an eligible doctor after he has put in prescribed length of service, the Ministry should be required to place the matter together with the reasons for not confirming him before the UPSC for the latter's satisfaction and review. This will avoid delays and also chances of harassment. (S. No. 102)

6·55 There are three zones namely Northern Zone, Central Zone and Southern Zone in which CGHS set up in Delhi has been divided. It has come

to the Committee's notice that a number of Medical Officers have been working in the same place and in the same zone for the last many years. In the Committee's opinion a medical officer should not remain in the same place and same zone for more than 4 years or so in the interest of efficiency of service to CGHS beneficieries. The Committee would like the Ministry to examine the question of devising a suitable scheme on postings and transfers to ensure periodical rotation of medical officers from one place to another and from one zone to another. (S. No. 103)

E. Ad-Hoc Medical Officers

6.56 It was brought to the notice of the Committee that "some of the medical officers in the CGHS had been working in ad-hoc capacity for as long as 10 years without having regularised even though their services have been found entirely satisfactory. In the meantime, the recruitment rules and the methods of recruitment have changed, placing these officers in a comparatively higher age group at the relative disadvantage in the matter of competing in written tests with younger age groups fresh from the medical colleges.

6.57 The Ministry was asked to state (i) the number of such Doctors and para-medical staff as on 1-10-1981, who have put in more than 10 years service and between 5-10 years of service but have not been regularised so far, and what are the reasons therefor;

(ii) the changes that have been made in the recruitment rules;

(iii) steps proposed to be taken to regularise the appointments of ad-hoc doctors and para-medical staff.

6.58 The Ministry informed the Committee that the number of doctors as on 1-10-1981 who have put in more than 10 years service and between 5-10 years service but have not been regularised so far is 12 and 79, respectively.

6.59 In the CGHS rules, there is no provision for induction of such officers in the CGHS unless they come through the UPSC. The doctors were informed at the time of their initial appointment itself that ad-hoc appointment does not bestow any right or claim on them for absorption in the CHS on a regular basis.

6.60 The Ministry further stated that "prior to 1976, selections for Junior Class I posts of CHS were held by the UPSC on the basis of interview only. The system of holding a written examination followed by interview was introduced by the UPSC from 1977 onwards. However, keeping in view the grievances of these ad-hoc doctors, a special examination was conducted in the year 1977-78 by the UPSC in which the selection was made only on the basis of interview. In another examination held in 1978, such doctors were given a choice to qualify in any one of the following subjects : (i) Surgery (ii) Medicine (iii) Obstetrics and Gynaecology (iv) Preventive and Social Medicine. But a very few of the ad-hoc appointees could qualify for regular appointment in the examinations. Age is also being relaxed upto 58 years for such doctors. It is proposed to amend the CHS rules so as to prepare for the selection on the basis of interview only which could enable all the ad-hoc doctors to get themselves regularised."

6.61 Clarifying the position in evidence, Health Secretary stated that :—

"Under the CGHS scheme doctors are appointed on an ad-hoc basis in order to fill up leave or short-term vacancies of regular incumbents of posts. Normally we do not want to do on an ad-hoc basis, but we have necessarily to do because the posts cannot be left vacant. The regular doctors are recruited through the UPSC and no doctor can be regularised without the approval of the UPSC. The time taken by the UPSC is always quite long—the post has to be advertised and there are so many other things. Not only that, even selected people were not available. I may mention that 500 persons were selected but hardly 300 came ultimately to take up the appointment. The reason is that doctors have so many other opportunities."

6.62 Health Secretary added that :

"Quite a few go for post-graduate degree also. But one thing I want to make clear. If the *ad hoc* appointments continue for a period of time, this is due to reasons which are not in our control. But the doctor who has been taken on an *ad hoc* basis should not also think that a right has been created for him in that appointment; he is there because we have not been able to recruit regular doctors."

6.63 The witness further stated that :

"According to the latest information, the number of ad hoc doctors under CGHS today is 131 : the number of those who have put in more than ten years of service as ad hoc doctors and the number of those who have put in five to ten years of service but have not been regularised are 12 and 79, respectively. But there are various reasons for it."

6.64 A representative of the Ministry further stated that :

"In order to give an opportunity to the ad hoc doctors to get regularised, we arranged for special selection through the UPSC in the year 1978. We requested the UPSC to dispense with the competitive examination and allow a higher age limit—45 years of age instead of 35—and conduct an interview—not only for those people but also for others because they cannot discriminate between ad hoc doctors working in the CGHS and the doctors working outside the CGHS but within the age limit of 45. In this interview we were able regularise only very few doctors, about 100 and old doctors we were able to regularise. At that time, the total number of doctors appointed or ad hoc basis way very large. The representation has been received time and again from those who have put in more than five years of service on an ad hoc basis that they should be screened for regularisation. We have taken up the matter with the UPSC and the Commission, on principle, have agreed to again conduct an interview for such people who have put in more than five years service in the CGHS. But, this will be done after.

the re-structuring of the CGHS. In these rules we are now bringing this out, that ad hoc doctors may be regularised by calling them for an interview. The moment this is done—some of the doctors who are really good will certainly be regularised."

6·65 The recruitment of doctors for CGHS is required to be made through UPSC. *Ad hoc* appointments are, however, made to fill up leave or short term vacancies of regular incumbents. Their appointments cannot be regularised without the approval of the UPSC. Such doctors are informed at the time of their initial appointment that *ad hoc* appointment does not bestow any right or claim on them for absorption in CGHS on regular basis. The Committee take note of the various measures including relaxation in recruitment procedures and rules taken by the Ministry to regularise *ad hoc* appointments with the approval of UPSC. After all this there are still at present 131 *ad hoc* doctors in CGHS who have not so far been regularised. 12 of them have put in more then 10 years service and 79 between 5-10 years service.

6·66 The Ministry is at present restructuring the medical cadre in the CGHS with a view, *inter alia*, to giving opportunities to *ad hoc* doctors who have put in more than 5 years service to get regularised. The Committee feel that the *ad hoc* doctors who have already put in satisfactory service for more than 5 years deserve to be considered more sympathetically for the purpose of regularisation and in this process, it should be ensured that they do not suffer any loss in the matter of emoluments on account of delay in regularisation. They hope that the Ministry would continue with the process initiated by it in this regard till all the *ad hoc* doctors who have put in satisfactory service are regularised. (Sl. No. 104)

F. Conveyance Allowance

6.67 The orders regarding grant of conveyance allowance to Medical Officers/Specialists under the CGHS are contained in the Department of Health letter No. F.4-11/72 CGHS(P) dated the 18th July, 1974 and the 21st May, 1980. The orders were reviewed and revised last in May 1980. For paying domiciliary visits and performing other official duties, with effect from May, 1980, Medical officers including Ayurvedic/Homoeopathic/Unani Physicians/Specialists employed under the Central Government Health Scheme are eligible to draw conveyance allowance at the following rates :

(i) For these who maintain their own motor cars . . .	Rs.	275·00
(ii) For those who maintain Scooter/motor cycle . . .	Rs.	90·00
(iii) For those who do not maintain either car or motor cycle/ scooter	Rs.	60·00

6.68 Conveyance allowance is admissible to every doctor for having performed a minimum of 60 visits per quarter. In case the average number of visits per month falls between 6 and 19, the conveyance allowance is paid on pro-rata basis. No conveyance allowance is paid if the number of visits falls below an average of 6 visits per month.

6.69 The Ministry informed the Committee (January 1982) that the question of upward revision of conveyance allowance was under Ministry's active examination.

6.70 Asked about the rates of conveyance allowance the representative of the Medical Officers Association stated in evidence as follows :—

"What we suggest is that the visits are always for emergencies and the doctor has to reach at the shortest possible period. Therefore,

the Doctors should be encouarged to maintain their own conveyance and for that we say that a minimum maintenance expenditure be given as conveyance allowance and then the running expenditure can be linked with the amount of visits paid by him. The maintenance allowance should be Rs. 350/- to cover depreciation, insurance road tax etc. Thereafter we must give the doctors on the kilometre run. If we calculate on the cost of petrol, it will not come to less than fifty paise a kilometre at the moment".

6.71 It has been suggested in a memorandum that instead of fixed conveyance allowance as at present admissible to the doctors, payment of allowance on the basis of home visits made by them would be an incentive to them.

6.72 Asked to state its views on the suggestion to link conveyance allowance to the number of visits paid by the Doctors, the Ministry stated that minimum of 20 domiciliary visits in a month entities of medical officer for grant of conveyance allowance at the rates prescribed. A proportionate reduction in conveyance allowance is made if the number of domiciliary visits falls short of the minimum visits of 20 but not below 6.

CGHS dispensaries are primarily meant to provide service at the dispensary. However, in certain situations both emergent and routine domiciliary visits are also made at the discretion of the doctor. Over the past many years of cautioning of CGHS, we have not received many complaints where CGHS doctors have not examined patients, at their residence. Therefore, a change in the system does not seem necessary.

6.73 The Committee pointed out that many suggestions have been thrown up. Some say that conveyance allowance should be linked to number of visits paid by doctor. Others say that it should be a lumpsum amount paid under two heads, *viz.*, a basic minimum for all doctors maintaining vehicles and an additional amount related to the distance travelled by doctors on such visits. Still others feel that there should be a pool of official vehicles at the disposal of dispensaries regionwise from which the doctors in that region might be able to requisition one for paying home visits and in that case conveyance allowance would not be required to be paid to doctors. The Ministry was asked to look into these suggestions in depth and furnish a note to the Committee. The note was not received till end of February, 1982.

6·74 Conveyance allowance at the following rates under certain conditions is paid to Medical Officers to enable them to pay domiciliary visits : those maintaining their own motorcars—Rs. 275/- PM, those maintaining scooters/motorcyclos Rs. 90/-PM and those not maintaining either cars or scooters—Rs. 60/- PM. The Committee have gone into this matter in the light of the views of CGHS beneficiaries and doctors. They wonder how in present times a doctor of Grade-I or Grade-II can buy a car and maintain it with the meagre allowance paid to him. The Committee also wonder what a doctor not maintaining car or scooter would be doing with Rs. 60/- PM which is paid to him as conveyance allowance. Such a doctor cannot afford to hire a taxi or other vehicle for paying home visits and most probably may not be taking the trouble of travelling by public bus for which along the meagre allowance of Rs. 60 may be adequate. In the Committee's opinion, doctors not owning cars or scooters should be given options either to draw conveyance

allowance as at present or to claim re-imbursement of taxi or auto-rickshaw hire charges for paying home visits as the case may be, with suitable safeguards against misuse. (Sl. No. 105)

6·75 The Committee also feel that it is rather too much to expect a doctor of Grade-I or Grade-II to maintain a car and use it for official purposes on payment of a meagre conveyance allowance. Either the conveyance allowance should be adequate to pay for the basis maintenance of car or scooter and the fuel consumed in the course of travelling on official duty, or the CGHS should maintain a pool of official vahicles in each city, region-wise, from which the doctors in that region might be able to requisition one for paying home visits. In the latter case the payment of conveyance allowance to the doctors would not be necessary. The Committee would like the Ministry to consider the entire question of conveyance allowance realistically and evolve a system which would be most convenient to doctors and would also lead to a better service to CGHS beneficiaries. (S. No. 106)

6·76 It is surprising that the Ministry has received no complaints over the past many years from CGHS beneficiaries regarding the reluctance of doctors to pay home visits. The Committee has received many such reports and they would advise the Ministry not to take the absence of formal complaints from CGHS beneficiaries as a proof of their satisfaction with the prevailing system of domiciliary visits. Unless the Ministry finds a practical solution to the problem of conveyance for doctors, it would not be able to provide an efficient system of home visits to the satisfaction of CGHS beneficiaries. (S. No. 107)

G. Service Conditions for Doctors

6.77 It was stated in a memorandum that only 50% of doctors selected by UPSC joined duty. Even among them, the resignation rate was quite high. This called for urgent remedies to make the jobs more attractive for Doctors. Most of the doctors do not possess Post-Graduate qualifications. They may be permitted to do the Post-Graduate Course after 3 years of service. Certain percentage of seats may be reserved for the CGHS doctor to do the Post Graduate Courses in the corresponding City Hospital or Central Medical Institutions like, JIPMER, AIIMS, etc. This will not only bring down the resignation rate but also create job satisfaction among the doctors.

6.78 Replying to these points, the Ministry furnished the following statement :—

Number of Doctors Recruited/Resigned during the last 10 *Years*

	Number of doctors recruited during the last 10 years.	Number of doctors who resigned during the last ten years.	The number of doctors who applied for permission to do post graduation courses and who were permitted to do the courses during last 10 years.	
Year		Yearwise	Yearwise	Applied	Permitted
1		2	3	4	5
1971	. . .	29	—	—	—
1972	. . .	38	17	1	1
1973	. . .	94	25	15	15

1	2	(3)	4	5
1974	50	28	8	8
1975	46	28	4	4
1976	207	47	1	1
1977	138	44	8	8
1978	56	51	9	9
1979	293	95	11	11
1980	136	34	7	7
TOTAL	1087*	369	64	64

*Information regarding Pune, Bangalore not readily available.

6.79 The Ministry added that the doctors desirous of improving their educational attainments, while remaining in service are eligible for applying for study leave for a maximum period of two years, after putting in a minimum of regular service of five years.

6.80 According to the Ministry it is neither possible nor administratively desirable to reserve seats for a group of officers like the one belonging to CGHS for undertaking post graduate studies in selected hospitals. By virtue of working in CGHS, the Medical Officers do not earn any special right in the matter of Post Graduate studies. In any case, the selection of candidates for post Graduate Studies is an academic matter and all post Graduate hospitals/Institutions have to follow certain criteria for selecting Post Graduate studies".

6.81 Clarifying the position regarding post Graduate Courses for CGHS doctors, the Ministry added that the admission for the Post-graduate qualifications is mostly done in the medical institutions run by the State Governments and other organisations At present the Central Government is not having any quote of allotment of seats for the post-graduate admissions in these colleges/institutions. But in so far as All India Institute of Medical Education and Research, Chandigarh, which are run by the Central Government are concerned there is already a provision for admission of sponsored candidates to post-graduate courses. The CGHS doctors can also be considered for being sponsored for admission to such courses, but they will have to compete among the other sponsored candidates. A Medical Education Review Committee set up by the Government of India is also reviewing the current admission procedures and the case of CGHS doctors will also be placed before it."

6.82 When asked to furnish information regarding the number of doctors offered appointment under CGHS during the last 5 years and the number who joined or resigned during this periods, year-wise, the Ministry informed the Committee that information was not available (year 1982) and would be sent shortly (The information was not received till and of February, 1982).

6.83 From the information given above the Committee observed that during the years 1972-80, as many as 369 doctors resigned their jobs under CGHS.

6.84 Asked to state the reasons for such a large number of doctors resigning from CGHS, the Ministry stated that the number of resignations was not high and it was a normal feature of any establishment, the Ministry

added that "The reasons usually given in the applications for resignation are domestic grounds or person reasons. As in all other professions, doctors also change their employers and jobs for the sake of better prospects and this aspect does not need any special study or a remedial measure".

6·85 There is a feeling in certain quarters that only 50% of the doctors selected by UPSC for CGHS join duty. The Ministry unfortunately does not maintain data from which one could know as to how many doctors were offered appointments by UPSC and how many of them accepted them. It would be interesting to make a study of this phenomenon, say, for a period of last five years and draw meaningful conclusions. (S. No. 108)

6·86 The Committee find that incidence of resignations among CGHS doctors is quite high. In an organisation which has a strength of about 1300 doctors, as many as 369 doctors had resigned between 1972—1980 as against a little over 1000 new doctors recruited during this period. The Ministry surprisingly does not consider the number of resignations high. The Ministry even does not consider it necessary to make any study of the phenomenon of resignations to know the real reasons hehind the resignation.

6·87 The Committee feel that the high resignation rate could be due to the reasons that service conditions and career prospects in CGHS may not be as good as in some other organisations to which CGHS doctors might be attracted. The Committee would like the Ministry to make a case study of the doctors who resigned their jobs under CGHS during a particular period to find out the real reasons for their resignations and see what it can do to prevent such a large scale eflodus of doctors from CGHS. (S. No. 109)

6·88 The suggestion made in a memorandum to permit liberally the CGHS doctors to do postgraduate courses and no provide the necessary facilities for the purpose, merits consideration. If this is done atleast a certain percentage of doctors who might think of resigning their jobs under CGHS for the purpose of doing postgraduate courses, may stay back. (S. No. 110)

H. Residential Accommodation

6.89 The following Table shows the number of Doctors and Para-medical staff who have been allotted Government accommodation (in Delhi) :—

Number of Doctors and para-medical staff who have been allotted government residential accommodation		Percentage of Dctors and para medical staff who have been allotted Government residential accommodation	
Doctors	Para-medical staff	Doctors	Para-medical staff
222	258	31·93	21·34

6.90 The following Table shows the break-up of the periods for which Doctors and Para-medical staff (Delhi) who have not been allotted Government accommodation, have been waiting for allotment :

	More than 15 years	10—15 years	5—10 years	Less than 5 years	Total
(i) Doctors . .	23	25	111	328	487
(ii) Para-medical staff . .	197	174	115	465	951
					1438

6.91 Asked whether any special consideration was shown to doctors and para medical staff in the matter of allotment of Government residential accommodation, the Ministry informed the Committee that the allotment of residential accommodation was controlled by the Directorate of Estates. No separate norms had been laid down for doctors and para-medical staff. A separate pool of accommodation has been placed at the disposal of the CGHS in Delhi by the Directorate of Estates, for the purpose of allotment to doctors and para-medical staff. Allotment from the CGHS pool is made on the basis of seniority in service except in exigencies of Government work.

6.92 Clarifying the position in evidence, Secretary (Health) stated that :

> "The CGHS doctors and para-medical staff fall in two categories, one, those who perform emergency duties and the other, who perform the normal duties. The staff employed on emergency duties are eligible for allotment of residential accommodation from three sources: one, CGHS have their own buildings and residences for persons who have to perform emergency duties; two, residences set aside by the Directorate of Estates as CGHS pool, three, they compete with others in the normal quota. The satisfaction level of this category is slightly more. As regards the present percentage of satisfaction of residential accommodation in respect of doctors in Delhi, who are generally eligible for Type D, it comes to 32%. For para-medical staff it is 21.34%. This is an area in which the level of satisfaction, I think, should be more than other employees. I would seek the indulgence of the hon. Chairman and Members that if they could give a special recommendation for this, that would be very much helpful."

I. Retirement Age

6.93 It has been stated in the memorandum submitted by CGHS Medical Officers' Association that :

> 'Medical offictrs enter late in service than others and they retire at the prescribed age thus putting in less number of years in service and earning less pension, gratuity, and other benefits. So the age of retirement of doctors be enhanced to 63 years to compensate them for their late entry."

6.94 The Committee asked the Ministry about the age composition of CGHS doctors recruited during the last five years; the retirement age, the retirement age of doctors in States and Railways; The Ministry stated that 23 to 36 years was the age composition of doctors recruited during the last 5 years. The retirement age for them is 58 years. The Ministry further stated that in order to compensate the CHS Officers (which terms includes CGHS doctors also) to enable them to earn maximum pension due to their late entry in service, a provision has been made in the CHS Rules for affording them the benefit of added years of service. This benefit is, however, admissible to officers of specialist grade II and and above.

6.95 The Ministry did not furnish information regarding retirement age of Doctors in States. The retirement age for doctors in Railways was stated to be 58 years.

6.96 Explaining the position Secretary (Health) stated in evidence that :

> "The retirement age of a CGHS doctor is 58 years. It is not a fact that a large number of these doctors will retire without earning their

full pension. To a specialist who enters at an advanced age the benefit of added years of service upto 5 years is allowed. Basically no doctor whether general duty or a specialist retire without earing a pension...."

6.97 The witness added that it was not the Government's intention to change the retirement age.

6.98 The Committee find that as against 222 doctors, who have been provided Government accommodation, 487 are without it. In para-medical staff category, as against 258 such staff who have Government accommodation, 951 have not got Government accommodation so far. The degree of satisfaction is 32% for Doctors and 21% for para-medical staff. It is, in the Committee's opinion, very essential to provide residential accommodation at least to all key personnel close to the dispensary to which they are attached, in the interest of a more effcient service to patients at odd hours. The Committee would like the Ministry to identify the doctors and para-medical staff who are holding key positions in each dispensary and arrange, in consultation with the Ministry of Works and Housing, to provide them suitable accommodation within easy distance from the respective dispansaries. (S. No. 111)

6.99 The Committee have no comments to make on the retirement doctors. But they do feel for the doctors who, because of their late entry into service-in some cases as late as 30-36 years—would retire without adequate pension. Specialists doctors have been given the benefit of added years of services of upto 5 years for the purpose of pension. But there is no such consideration for other doctors. The Committee see no logic in discriminating between specialists and other doctors under pension rules. They would like all doctors to be treated alike in this matter. (S. No. 112)

J. Foreign assignments for Central Health Service Doctors

6.100 In their memorandum submitted to the Committee, the All India Medical Officers Association stated that :—

> "Foreign assignments to friendly countries is banned to CHS Doctors though it is open to others which is not fair to CHS doctors."

6.101 Asked to state whether Foreign assignments to friendly countries were banned to CGHS Doctors the Ministry stated (August, 1981) that :—

> "There is a complete ban on foreign assignments in respect of CHS officers (including CGHS officers) since 1975. This Ministry was compelled to impose this ban due to the fact that a large number of officers who initially went on foreign assignment for specific period did not return after completion of the period of assignment. This resulted in a lot of administrative difficulties in as much as resultant vacancies could not be filled on regular basis, because posts had to be kept reserved for men in the event of their repatriation. On the whole the experience of this Ministry in regard to getting more officers back through personal letters, through our embassies abroad has been sad and unsatisfactory. In order not to perpetuate this insoluble problem, a complete ban was invoked in 1975."

6.102 The Committee learn that Ministry of Health and Family Welfare has since reviewed the matter and has decided (22 February, 1982) to relax

the existing ban or the forwarding the applications of CHS officers for empanelment in the "Foreign Assignment Panel" maintained by the Department of Personnel and Administrative Reforms and to their release to take up assignments abroad on deputation on arestrictive basis.

6.103 The Committee take note of the recent decision of the Ministry of Health and Family Welfare relaxing the existing ban on the forwarding of applications of CGHS officers for empanelment in the "Foreign Assignment Panel" maintained by the Department of Personnel and Administrative Reforms and to their release to take up assignments abroad on deputation on a restrictive basis. (S. No. 113)

K. Behaviour of Doctors & Para-Medical Staff

6.104 In almost all the memoranda received by the Committee, complaints of rudeness, curtness and callousness of dispensers and para-medical staff have been made in open or veiled language.

6.105 Similar feelings were expressed by a number of patients whom the Study Group of the Committee met during on-the-spot study visits to dispensaries in Delhi. They also stated that complaints against doctors were no needed by doctors.

6.106 Complaints against doctors' behaviour, though less numerous than those against para-medical staff, have also been made in a number of memoranda. The following extract from a memorandum reflects the feeling prevailing among many sections of CGHS beneficiaries :—

> "Generally medical officers are not courteous and sometimes rude with CGHS beneficiaries. They often gossip with other doctors, dispensary staff while patients are waiting shivering with fever, pain, bodyache, in queue outside their rooms. There is complete absence of personal touch in the behaviour of these doctors. They hardly use stethoscope, BP Instrument, measure pulse etc."

6.107 Patients' dissatisfaction with the doctors behaviour and approach also came to the Committee's notice during their on-the-spot study visits.

6.108 Medical officers Association has admitted that doctors do not devote as much time to a patient as they should.

> "The reason is that they do not have enough time for this purpose. The staff inspection unit of the Ministry of Finance in 1977 carried out study and decided on an average a Doctor should take four minutes per patient.....then norms laid down by the SIU should be decided....on an average a doctor should not take less than five minutes per patient. The norms should be based on the average attendance in peak months only. During the lean months, the extra staff can be utilised for imparting in service refresher course training."

6.109 It is also stated in their memorandum that "there is frustration among Medical Officers as there are no promotional avenues for them. They have suggested that Medical Officers should be spared from as much clerical work as possible so that they can devote their energy to diagnose and treat the patients....."

6.110 Giving its comments, the Ministry furnished the following information in regard to the number of complaints received against medical

officers, dispensers and other staff during the years 1978-79, 1979-80 and 1980-81 :—

Details of Complaints received during 1978-79, 1979-80 *and* 1980-81 *against the Medical Officers and Para-Medical Staff and Others.*

S. No.	City	No. of complaints			Break-up of complaints					
									1980-81 M.Os.	
		1978-79.	1979-80	1980-81	1978-79		1979-80			
					M.Os.	Others	M.Os.	Others		Others
1.	Lucknow	15	7	32	6	9	4	3	8	24
2.	Jaipur	Total information in 1980-81.		33	—	—	—	—	6	27
3.	Madras	41	22	33	16	25	8	14	11	22
4.	Pune	13	20	18	3	10	1	19	1	17
5.	Bangalore	15	20	18	5	10	1	19	2	16
6.	Bombay	12	10	9	2	10	6	4	4	5
7.	Meerut	Not recorded		13	—	—	—	—	3	10
8.	Ahmedabad	—	1	4	—	—	—	1	—	4
9.	Kanpur	9	21	29	4	5	5	16	8	21
10.	Calcutta	22	17	13	15	7	10	7	8	5
11.	Patna	68	27	23	15	53	4	23	5	18
12.	Hyderabad	Not received		19	—	—	—	—	3	16
13.	Allahabad	27	20	24	6	21	5	15	10	14
14.	Nagpur	15	7	32	6	9	4	3	8	24
15.	Delhi	325	269	282	86	239	82	187	85	197

6.111 The Ministry stated that out of 28.5 lakh beneficiaries, the number of complaints received did not relate to rude behaviour of para-medical staff.

6.112 As regards Medical Officers the Ministry stated that change in norms would involve substantial financial outlays and would not be possible in the present economic condition. The Ministry added that the number of complaints against CGHS staff as a whole, were comparatively few as compared to the large number of its clientele. However, when ever complaints of rude behaviour came to notice, these were suitably dealt with.

6.113 A representative of the Confederation of CSS Associations, in his evidence stated :

> "....the behaviour of the dispensers and other para-medical staff is just an imitation of the behaviour of the doctors. When they find that the behaviour of the doctors themselves is not as it should be, they take the cue, and because they are less educated and less refined they become worse. We support this contention that, at present, the behaviour of the para-medical staff and dispensers towards the patients is not as it should be. In certain cases they behave as if they are giving something in charity."

6.114 A representative of the Section Officers' Association of the Central Secretariat Services stated in his evidence :—

> "They (doctors) have become actually indifferent towards the needs or difficulties of the CGHS beneficiaries that they do not even apply their mind to examined them. The stagnation in their case is much more."

6.115 As regards para-medical Staff, the witness stated :

> "They are supposed to reach there by 7 in the morning. Then again they have to come at 5 p.m. That is why their behaviour is not proper. Their working conditions should be improved."

6.116 A representative of a Residents' Association from Bombay spoke in the following words :

> "There have been some complaints that the doctors have been a little rude or unsympathetic to patients."

> "They are indifferent; they usually do not come in right time.... and they are not always cooperative."

6.117 When confronted with the patients' views about their behaviour, a representative of the Para-medical staff Association in their evidence before the Committee stated :

> "There is no question of rudeness in this. The reason is that it is not possible to satisfy all the patients within a limited time at our disposal. That is why these things arise. There is rush of patients in dispensaries and the staff is inadequate. Most of the employees are stagnating because there are no avenues of promotion for them."
>
> (English translation of original in Hindi)

6.118 About the rude behaviour of Doctors towards patients, a representative of Medical Officers Association stated in evidence as follows :

> "As far as Medical Officers are concerned, there is no question of rude behaviour; they are meant for them and they have to satisfy the patients. The patients want that the doctors should listen to them while they have got no time. The doctors should be given a proper place and only a limited number of patients should be there so that they can examine them properly. Then they should get all the medicines. If this is done, then there cannot be a single complaint against the Medical Officers."

Patient Satisfaction

6.119 The Ministry was asked to state the level of patient satisfaction according to its own assessment and whether it had any proposal to ensure greater patient satisfaction than at present, the Ministry informed the Committee that no study had been made of the level of patient satisfaction. However, out of 28.5 lakhs beneficiaries concerned in all the cities combined, the number of complaints received were only about 1.46 per day. Most of these complaints, on investigation, had been found to be incorrect. The Ministry added that it may, therefore. be seen that the level of patient satisfaction is very high.

6.120 Dealing with the question of rude behaviour of Medical Officers and Para-medical Staff, Secretary (Health) stated in his evidence :

> ".....the CGHS has been extended to 15 cities covering over 22 lakh beneficiaries. The number of allopathic dispensaries

is 183 and a large number of Medical Officers and Para-Medical staff are employed under the Scheme. In such a big area, there could be some such examples. By and large, we do not accept that doctors behave like that. There may be some isolated cases. Whenever it is brought to our notice, we take action against them. I have already submitted to you that we intend to have another study made through the S.I.U. about the workload in the dispensaries, about the doctor—patient ratio and things like that. We intend to make it service oriented scheme and run it as efficiently as possible. Secondly, our effort is also not to expand the service, rather to consolidate first and then expand it later on. This is the general policy."

6.121 Reacting to the Committee's feelings that low-paid employees and like were the worst sufferers in this context, Secretary (Health) assured that—

"We will again issue our instructions on the point that you have brought to our notice, that they should be polite and attend to the patients of whichever category they come from most quickly and expenditiously. We will also mention that if any lapses are found we will resort to a deterrent action."

6·122 CGHS beneficiaries dissatisfaction with the behaviour of doctors and para-medical staff at the dispensary level has been brought to the Committee's notice in writing and in person. Many doctors, it is stated, are rude, keep patients waiting unnecessarily and do not see the patients carefully. The Committee do not want to convey an impression that CGHS beneficiaries consider all or most of the doctors or para-medical staff rude. But even if a small minority behaves improperly, the image of the entire class gets tarnished. It is against this danger that the Committee wish to warn the community of doctors and para-medical staff. (S. No. 114)

6·123 Doctors and para-medical staff have not accepted the charge of rude behaviour. According to them, heavy workload and too inadequate a strength do not permit them to give proper attention to each patient to his/her satisfaction. Besides, they say, there is great frustration in the medical and para-medical staff due to stagnation and stenuous working schedule. The Committee feel deeply pained at the doctors' and para-medical staff's attempt to plead heavy work load and frustration in extenuation of the charge of rude and indifferent behaviour. The medical and para-medical staff may have problems (and have problems which the Committee have dealt with elsewhere in this report); but this cannot be a justification for the curtness in their behaviour or casualness in their approach. (S. No. 115)

6·124 Like CGHS beneficiaries, the Committee expects from the doctors a standard of conduct consistent with the high traditions of the noble profession to which they have the privilege to belong. Patients look to doctors not merely as writers of prescriptions but also as dispensers of health for which, doctors know more than anybody else, a patient has to be treated not only medically but also psychologically. The Committee would, therefore, call upon the doctors to live upto the expectations of their patients even under testing circumstances and deal with all of them, high or low, with patience, understanding, smile and human touch. (S. No. 116)

6·125 The Committee expect that the dispensers and other para-medical staff will also take note of the CGHS beneficiaries' feelings about their behaviour and do everything possible not to give them and cause of complaint on this account. (S. No. 117)

6.126 The Ministry has tried to counter the charge of rudeness of the dispensary staff on the basis of statistical data, according to which the number of complaints from all cities comes to only 1·46 complaints a day. The Committee have not gone into statistical aspect of complaints but from what they have heard and read, this appears to be too good to be true. In any case, the Committee do not agree with the Ministry's approach to measure the patients' satisfaction on statistical scale. It will be a pity if on statistical basis the Ministry, doctors and para-medical staff delude themselves into believing that CGHS beneficiaries are satisfied with the behaviour of dispensary staff or if they adopt an attitude of self-righteousness or complacence in this regard. (S. No. 118)

6·127 The Committee are conscious of the fact that in a matter like this, it is the doctors and the para-medical staff themselves who can really help. The Ministry can only issue and re-issue appeals to them to be courteous and considerate, which the Committee have no doubt, they will do. But unless the Ministry can successfully bring home to the doctors and para-medical staff the desirability of attending to patients with smile and sweetness, regardless of their personal problems of stagnation and heavy workload, the problem will not be solved. For this the Ministry on the one hand will have to be firm in dealing with instances of callous and curt behaviour, and on the other, show sympathetic understanding of legitimate problems of doctors and other staff. (S. No. 119)

CHAPTER VII

MISCELLANEOUS

A. ORGANISATIONAL SET-UP

(i) *Organisational set up in the Ministry*

7.1 All the matters requiring Government sanction and policy decisions regarding Central Government Health Scheme are submitted by the Director-General Health Services to the Ministry of Health and Family Welfare. A separate section namely CGHS (Policy) has been established in the Ministry to deal with all the matters relating to the CGHS.

7.2 The existing organisational set up for the CGHS which functions under DGHS is headed by Director, CGHS who is also ex-officio DDG. Director, CGHS is assisted by two DDAs, one ADG, two Desk Officers and one Medical Statistician.

(ii) *Role of Ministry*

7.3 The Committee asked the Ministry to spell out in concrete terms the role played it during 1979-80 and 1980-81 in the field of Supervision, Control, Monitoring and review the Ministry stated that it takes decisions on policy matters relating to CGHS. The Directorate General Health Services is an attached office providing technical advice to the Ministry and guidance to the CGHS organisations in Delhi and outside Delhi. CGHS is a subordinate office entrusted with the implementation of the policies and is functioning in 15 cities including Delhi. Ministry exercises overall control and takes policy decisions. Inspection is conducted by Director, CGHS and other senior officers in the CGHS.

7.4 The Committee pointed out that whether it was a fact that, when the committee started examining the working of CGHS and asked for information on various aspects of the scheme, most of the information was not readily available with the Ministry and they had to send special despatches to all the 15 centres to collect information and still could not supply complete information in time.

7.5 The Secretary, Ministry of Health stated during evidence :—

"the role of the Ministry of Health and Family Welfare relates to the following activities :—

(1) General policy;

(2) Laying down of norms through Staff Inspection Unit (SIU);

(3) Creation of posts;

(4) Budgetary control and allocation of funds;

(5) Formulation and processing of Plan proposals for CGHS;

(6) Review of functioning through various agencies like National Institute of Health and Family Welfare or Department of Personnel;

(7) Periodic review of functioning and framing of rules.

As regards day-to-day supervision, control, monitoring and staffing, it is being exercised by the Director (CGHS), who in turn is under the Director General of Health Services. The Director General of Health Services is an attached office of the Ministry. The Director (CGHS) is also assisted by the Deputy Director and Assistant Director General.

As for the second part of the question relating to information system, I may submit that we have, at present, two types of information system. One information system relates to regulatory expenditure under sub-heads salary, payment of special services etc. Rent rates taxes etc., relating largely to the budgetary and financial aspects also come under this. The other system of information is looking after the Medical Statistical Cell with regard to CGHS. This is a functional information system. It relates to dispensary-wise attendance of patients, number of card-holder per dispensary and doctors attached and number of cases attended during normal hours and emergencies. Information under these two heads are continuously received fom various dispensaries by the headquarters.

Now, when we were to be examined by the Committee, naturally we obtained information for the first 78 points (raised by the Committee). But on the supplimentaries on certain questions relating to items like quantity of petrol used in dispensary, mileage covered by the vehicles, details of schedule inspections dispensary-wise, details of various categories of staff, information may be available with the dispensary but not on regular basis conveyed to the headquarters because they are largely related to the local administration. So when we were to supply the information within the stipulated date, we did send the officers to various places so that we could collect this information."

7.6 The Committee pointed out that, in his statement, Health Secretary mentioned about functional review system. The Committee asked him to produce before the Committee the last three reports regarding the Ministry's visit to dispensaries to make functional review of the CGHS, Delhi for our record ?

7.7 Health, Secretary stated in evidence that "these reports are not received in the Ministry". He added that "these functional review reports are received not by the Ministry but by the Directorate who is supposed to supervise and monitor the functioning of the CGHS dispensaries."

7.8 During the course of discussions, the committee enquired about the aspects of (i) supervision (ii) control; and (iii) monitoring.

7.9 In reply to another questions Health Secretary admitted :

"that is largely true", that supervision, Control and monitoring of the working of CGHS has left to the Director General Health Services (DGHS). When asked whether the 'review' was also left to the DGHS, the witness stated that "the periodic review is done by the Ministry through these agencies."

7.10 Asked to state whether there was any system under which periodic review of CGHS was done compulsory, say, every three months or six months or twelve months, the witness replied :

> "As regards certain functional review like supply of medicines, there is no system laid down as such but, we are keeping a watch from time to time whether the medicines of the right type are available in adequate quantity. We pursue the matter with the CGHS."

7.11 The Committee observed whether from the Secretary's statement it might be concluded that ".....no system of review is there. Only a watch-dog system is there whereby you will see whether the supply of medicines is adequate or not and whether there is any deficiency." The witness stated "that is, with the Ministry."

7.12 A representative of the Ministry (Additional Secretary) added that "we are keeping a close watch on the supply of medicines and I hold meetings." The last meeting was stated to have been held hardly a week ago (from the date of evidence i.e. 10-12-1981) when asked when the meeting was held prior to the Committee taking up the subject, the witness said, "sometime in October-November last year when the budget year of CGHS was gone through."

7.13 When further asked whether there was any review of it, the representative (Addl. Secy.) stated :

> "No systematic review."

7.14 From the statement showing the recommendations made by the Study Team of Department of Personnel and Administrative Reforms on the working of CGHS dispensaries (1977) and the action taken thereon, it is seen that out of 33 recommendations and observations, only 17 were accepted by the Ministry. The 16 recommendations which were not accepted by the Ministry included some which were innovative and went to the root of many of the problems.

(iii) *Management Exports*

7.15 The Committee enquired whether the CGHS Directorate had on its rolls experts or consultants on the following subjects :

Finance
Management
Medical Administration
Personnel
Inventory Control
Purchase

7.16 The Ministry stated that there were no experts or consultants of Finance etc. on the rolls of CGHS. But as in other Govt. organisations, there are officers of disciplines like Deputy Directors (Admn.), Administrative Officers, Accounts Officer, S.A.S. Accountants, Section Officers and Depot Managers, who have training and experience in the various lines of administration.

7.17 Elaborating the point in evidence Secretary (Health) stated that :—

> "With regard to any organisation, there are always specific officers to take care of specific jobs, say, somebody to take care of purchase of medicines, somebody to take care of accounts, somebody to take care of the overall stock of stores. So far as the specialised services are concerned it is not practicable for every organisation in the Government to have its own specialised services. They are provided by specific departments; for instance, the Department of Personnel and Administrative Reforms is supposed to provide specialised advice on management techniques and inventory control. They keep on issuing various circulars on the ABC system of control. Similarly, the Controller of Accounts gives advice on the maintenance aspects of accounts. DGS&D takes care of the purchase of medicines. It is not practicable for each organisation to have its own specialist service."

7.18 The role of the Ministry of Health in relation to CGHS is to lay down general policy and staff norms and attend to matters relating to creation of posts, budgetary control, plan proposals and periodic review of functioning of CGHS. The task of supervision, control, monitoring and staffing is taken care of by the Director, CGHS who works under the superintendence and control of Director-General, Health Services. The Ministry, the Committee were told, did not do anything directly in the field of supervision, control and monitoring which were left to the Director-General, Health Services. Even in regard to periodic review of functioning of CGHS, Secretary (Health) frankly confessed in evidence that "as regards certain functional review like supply of medicines, there is no system laid down as such" under which periodic review of CGHS is to be done compulsorily every three months or six months or 12 months.

7.19 The Ministry, it was stated, kept a watch from time to time over the supply of right type of medicines in adequate quantity. However, even in this field, it was confessed, there was no systematic review by the Ministry.

7.20 The Committee cannot too strongly deplore the attitude of unconcern prevailing in the Ministry in the past towards the working of CGHS, The Committee do not think it proper for the Ministry to wash its hands completely of the important tasks of general supervision, control and monitoring of the overall performance of CGHS and pass them on to a subordinate authority. Unless the Ministry actively oversees the activities of CGHS at macro level as an apex body should do, it will not be possible for it to know the shortcomings of the scheme or the problems of CGHS beneficiaries. Nor will it be possible for the Ministry to do any meaningful review of the working of the scheme. The Committee would, therefore, strongly urge that the Ministry should shed the ivory-tower attitude it has had so far and play an active role in exercising effective supervision and control over the scheme and in carrying out periodic reviews of its working. (Sl. No. 120)

7.21 The Committee were, however, glad to see that, notwithstanding the past record of the Ministry, the attitude of the Health Secretary during evidence was refreshingly responsive and encouragingly positive. The Committee

were informed during and after evidence that action in various directions had already been initiated by the Ministry in the light of the Committee's observations. The Committee expect that similar sensitivity and alarcrity to act, as seen in evidence, would continue to be shown hereafter by the Ministry in streamlining the working of the CGHS with a view to giving maximum satisfaction to the beneficiaries and living up to their expectations. (Sl. No. 121)

7.22 On distinct impression which the Committee have acquired in the process of examination of the working of CGHS is that the Ministry lacks an efficient information system. The Committee would advise the Ministry to organise a proper management information system and a matching apparatus to analyse the information to be able to know the weak spots in the working of the CGHS and to apply correctives without delay. (Sl. No. 122)

7.23 The Committee find that out of 33 recommendations and observations made by the Study Team of Department of Personnel and Administrative Reforms on the Working of CGHS dispensaries (1977) only 17 were accepted by the Ministry. The remaining 16 recommendations which were not accepted included some which were original and went to the root of many problems. The Committee feel that the purpose of appointing an expert body to look into any problem is defeated if the controlling authority does not take the expert views seriously. The Committee would like the Ministry to have an innovative approach and open mind in dealing with the problems of CGHS. (Sl. No. 123)

7.24 Neither the Ministry nor the CGHS Directorate has on its roles experts or consultants in the sphere of Finance, Personnel Management, Material Management, Medical Administration, Inventory Control and Purchase. These areas of responsibility are handled by common run of beaurocrats as anywhere else in the Government Secretariats. This is the Committee's view is not a very happy situation. The Committee do not agree with the Health Secretary that "It is not practicable for each organisation to have its own specialist service." The Committee feel that in view of the fact that the CGHS is running over 210 dispensaries and units of all types in 15 cities and dealing with nearly 24 lakh beneficiaries (over 5½ lakh families) and spending over Rs. 14 crores per annum towards purchase of medicines and administration, it is of paramount importance that the CGHS Directorate should have on its roles experts at least in personnel management, finance, purchase and inventory control to ensure efficiency with economy in the administration of the scheme. Such a vast network of dispensaries and related services is difficult for the generalists alone to manage competently. The Committee expect the Ministry to bestow attention to these areas of administration which have remained neglected over two decades. (Sl. No. 124)

B. Definition of Family

7.25 It has been stated in a memorandum submitted to the Committee that the definition of 'family' in CGHS is strictly on European family pattern. The Indian concept of family should be adopted and if necessary extra premium may be imposed.

7.26 The Ministry informed the Committee that the scheme of CGHS was introduced in replacement of medical reimbursement provided under CS(NA) rules and therefore, the definition of the term Family remained the same. This scheme is heavily subsidized. Enlargement of the term

Family will have for reaching financial repurcussions, which cannot be anticipated in absence of adequate statistical data.

7.27 At present, under CGHS, rules 'Family' includes husband/wife of the CGHS card holder, wholly dependent children or step-children and parents who are mainly dependent on and residing with the Government servant. For this purpose, parents are considered dependent if their monthly income from all sources does not exceed Rs. 350. Female Government employees have the option to treat either their parents or parents-in-law as dependents. Married, widowed and divorced daughters are not treated as members of family.

7.28 Sisters (unmarried or widowed or separated) parents-in-law and brothers dependent on the CGHS card holders and living with them are not entitled to CGHS benefits with or without payment of extra charges, as they are not covered by the aforesaid definition. Sons of the CGHS card holders are, however, members of 'family' if they are wholly dependent on the Card Holders.

Extension of CGHS to Servants and Drivers of MPs

7.29 Asked to comment on a suggestion that guests, servants and drivers of Members of Parliament should also be given CGHS facility on payment of nominal monthly subscription, the Ministry stated that all the dispensaries in areas where normally Member of Parliament reside have a facility of enrolling members of general public as CGHS beneficiaries. The category of persons stated above can avail of this facility on payment of prescribed charges.

7.30 CGHS Scheme, is intended for Central Government employees and has been extended to the M.Ps. It is highly subsidized scheme and therefore, further extension of the scheme to other categories would require substantial financial outlay and would also promote other similarly placed categories for inclusion in the scheme.

7.31 Dealing with the question of enlargement of the definition of 'family', the representative of the Ministry informed the Committee in evidence that there was a demand in the general Consultative Machinery which deals with the Central Government employees that unmarried sisters and brothers who are dependent on the card holders should be treated as members of the card holders' family.

7.32 The demand was examined by a sub-committee headed by Health Secretary which came to the conclusion that it was not possible to accept the demand. The employees side accepted this formulation.

7.33 He added that in 14 dispensaries in Delhi i.e. Laxmibai Nagar, Motibagh, Kidwai Nagar, Andrews Ganj, North Avenue, South Avenue, Constitution House, Chankayapuri, Hauz Khas, Pandara Road, Nauroji Nagar, Telegraph Lane, Dr. Zakir Hussain Road, R. K. Puram II, the members of the general public residing in these areas are also permitted to avail themselves of the CGHS facility on payment of a given amount. If the non-entitled member of the CGHS card holders' families reside in these areas, they can avail of this facility.

7.34 The term "family" under the CGHS includes husband/wife of the CGHS card-holder, wholly dependent children or step children and parents (or parents-in-law in certain circumstances) who are mainly dependent on and

are residing with the Government servant. The Ministry is not agreeable to extend the scheme to persons not covered under the present definition of "family" except in areas under the jurisdiction of certain dispensaries in Delhi where already the members of general public are permitted to avail themselves of the CGHS facility on payment of a given amount. The Committee feel that the case of wholly dependent sisters who are unmarried or widowed or separated and of daughters who are widowed or separated and who are living with the Government servants stands on a special footing in Indian social system and deserves to be considered with sympathy for extension of CGHS facilities, if not on subsidised rates, at least on normal rates. (Sl. No. 125)

C. Vehicles

7.35 The following statement shows the number of vehicles mileage covered, petrol consumed, repairs cost etc. in so far as Delhi is concerned.

S. No.	Year	No. of vehicles	Mileage covered (kms.)	Quantity of Petrol consumed (Litres)	Over-time Drivers	Maintenance & Repairing etc.
1.	2.	3.	4.	5.	6.	7
1.	1976-77	14	78,581	24052	No record	33441.07
2.	1977-78	16	79,622	23282	Do.	54372·48
3.	1978-79	16	69,085	21795	Do.	112178·93
4.	1979-80	16	83,724	22514	Do.	43666·54
5.	1980-81	16	84,581	23071	Do.	87609·76

7.36 The Ministry has stated that no record of overtime allowance paid to Drivers is maintained separately.

7.37 From the aforesaid statement, it is seen that the CGHS set-up in Delhi had 16 vehicles which covered a total distance of 84,581 k.m. in 1980-81 consuming 23071 litres of petrol. A sum of Rs. 87,610 was spent on their maintenance and repairing etc. during that year. A vehicle thus consumed one litre of petrol for every 3.66 Km. of journey and the maintenance and repair cost amounted to Rs. 5,475 per year per vehicle.

7.38 The Committee asked whether it was not something abnormal for a vehicle to consume so much of petrol and cost so much on its maintenance and repairs.

7.39 The Ministry stated that there were 13 vehicles under the control of CGHS, Delhi. Out of these 10 were more than 16 years old. 6 vehicles of these had been condemned 5 or 6 years ago. 12 out of the 13 vehicle were petrol driven. 9 out of the 13 vehicles were trucks/heavy wagons and they consumed petrol at a high rate and thus the average consumption was more. The prescribed life of the vehicles is 10 years or 1,20,000 kms. whichever is later. In the circumstances, the Ministry added, the expenditure on consumption of petrol and also repairs on these vehicles was bond to be high Action is being taken to replace the old vehicles with new ones.

7.40 The Ministry further stated that no norms had been laid down by the Mnistry on the petrol cosumption and/or maintenance.

7.41 Secretary, Ministry of Health, explained during evidence that :—

"On account of the age of the vehicles petrol consumption is on the high side. Secondly, 9 out of the 13 vehicles are trucks/heavy wagons and these consume petrol at a fairly high rate. We have not been able to replace these vehicles due to paucity of funds. If lighter vehicles are there, petrol expenditure on the vehicle would be iess. But all these are very old."

7.42 CGHS set up in Delhi has been incurring an unduly heavy expenditure on petrol for its vehicles and on their maintenance and repair. The average consumption of petrol was 3.66 K.M. per litre during 1980-81 and the maintenance and repair cost amounted to an average of Rs. 5475/- per vehicle during that year. The explanation given by the Ministry in support of such an abnormally high expenditure that most of the vehicles are very old, and heavy, like trucks and wagons, does not carry conviction with the Committee. The Ministry should have replaced the old vehicles progressively instead of running and maintaining them so uneconomically. The Committee would like the Ministry to enquire as to whether any serious attempt was ever made and pursued to provide funds for the replacement of at least the condemned vehicles and why the attempt did not succeed and furnish a report to them within six months. (Sl. No. 126)

D. General

New 20-Point Programme

7.43 There are two particular points in the New 20-Point Programme of the Government of India to which the Committee would like to draw the attention of the Ministry of Health and CGHS authorities in particular, namely, family planning and control of tuberculosis and blindness.

7.44 The people now realise the benefits of a small family. The Government's role is to educate them in the methods of contraception so that they are motivated to accept, on their own, any one of them. It is very necessary that a voluntary effort is intensified at every level and every possible opportunity utilised in the process of educating the CGHS beneficiaries in the reproductive group and making them adopt the small family norm. The Committee would urge the Ministry to ensure that it provides every possible facility, particularly Laproscopy which is proving popular, in the CGHS poly-clinics and hospitals and if possible in the dispensaries to make family planning more attractive so that the targets set down in the Sixth Five Year Plan to raise the percentage of couples practising family planning from 22.5% to 36.5% by 1984-85 are fully met. (S. No. 127)

7.45 The incidence of Tuberculosis is still high in India. The Committee are not aware whether the Ministry has organised any campaign to screen all CGHS beneficiaries with a view to detecting signs of Tuberculosis at the earliest stage. They should strongly recommend that the screening of government employees and their families should be organised by CGHS expeditiously and suspected cases of Tuberculosis identified for an intensive treatment and care in specialised hospitals. The Committee would also like the Ministry to ensure that adequate number of beds for Tuberculosis patients covered by CGHS are available in specialised hospitals and the patients do not have any

difficulty in getting the prescribed medicines. In Delhi and other places where there is large concentration of Government employees the Ministry should consider providing special wings worth adequate number of TB specialists in the existing hospitals. (S. No. 128)

7.46 There is a good deal of preventable blindness in the country due to nutritional deficiency, disease or cataract. The Committee would suggest CGHS should organise an intensive programme of examining the eyes of CGHS beneficiaries, particularly the children and the old men and women, and undertake without delay preventive, promotive and curative measure of eye health care. (S. No. 129)

7.47 The Committee would also like that the Ministry should review the present capacity for dealing with cataract cases in the hospitals and polyclinics set up or recognised under the CGHS and augment the capacity wherever necessary. They would like the Ministry to take stock of the backlog of cataract cases among CGHS beneficiaries and draw up a time bound programme to clear them, within one year. (S. No. 130)

7.48 It should also be ensured by the Ministry that CGHS beneficiaries requiring glasses under the eye health care programme should be able to get good quality glasses at reasonable prices. (S. No. 131)

NEW DELHI :
March 22, 1982
Chaitra 1904(*S*)

S. B. P. PATTABHI RAMA RAO,
Chairman
Estimates Committee

APPENDICES

APPENDIX I

Statement showing the number of families (No. of Cardholders) registered with the dispensaries in each of the 15 cities during the year 1980-81

S. No.	Name of the City	Name of the dispensary	No. of card holder	No. of beneficiaries	Average attendance per day	Average number of doctor attending dispensary per day	Average number of para-medical staff attaching dispensary per day
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	AHMEDABAD	Shahpur Dispy.	763	3243	72	6	8
		Saraspur	467	2232	76	3	7
		Navrangpur Dispy.	1094	4116	76	3	7
2.	BANGALORE	Union Street	4003	17239	315	7	9
		Malleswaram	4031	14662	221	6	9
		Basavanagundi	3364	13729	268	6	9
		Ulsoor	3833	18486	265	5	9
		Rajaji Nagar	2680	11905	233	5	9
		Jaya Nagar	2988	11343	181	5	9
		Sadhachivangar	2654	11486	205	5	8
3.	LUCKNOW	CGHS Dispy. No. I (Krishna Colony)	2675	8050	180·32	5	10
		Lal Bagh Dispy. No. 2	3450	7528	175·8	5	11
		Aish Bagh Dispy. No. 3	978	4589	85·52	4	10
4.	MEERUT	Abu Lane	4000	19000	292·2	4·88	9
		Mohan Puri	1600	8000	234·6	3·60	7
		Vijay Nagar	2500	12000	254·2	3·00	8
		Kankar Khera	1600	8000	303·0	3·60	7
		Ishwar Puri	1500	7401	176·2	2·70	6
		Ayurvedic Unit	—	—	161·1	2·00	2
		Homoeopathic Unit	—	—	74·4	2·00	2

5. MADRAS	Mylapore	4201	16488	321	7	8·0
	Vepery	3798	15247	427	7	5·5
	Nunganbakkan	3031	11755	277	7	9·5
	George Town	1782	7389	215	5	7·0
	Triplicane	4247	15810	363	7	5·4
	T. Nagar	3702	13130	223	4	7·0
	Perambur	2696	11387	347	4	8·8
	K. K. Nagar	2355	9662	318	4	8·5
	Adyar	1053	4334	182	3	7·6
	Roy Puram	—	—	—	—	6·5
	Homoeopathic Unit	—	—	28	2	0·9
	Dental Unit	—	—	28	1	0·9
	Ayur. Unit	—	—	88	2	1·7
	Siddha Unit	—	—	15	1	0·1
6. BOMBAY	C.G.O.	3241	11660	144	3	17
	Pedder Road	990	3807	70	2	17
	N.S. Road	447	1663	49	1	7
	Worli	4075	16884	265	4	18
	Mahim	3053	11125	171	2	24
	Santacruz	7430	28837	327	8	24
	Juhu	672	2394	61	1	7
	Ghat Keper	4624	19048	311	6	23
	Wadala	4806	18218	354	5	20
	Kaliwada	5566	20140	563	8	27
	Chembur	3409	13207	290	4	16
	Bandra	3142	11814	209	4	16
	Byculla	2760	9845	121	2	15
	Opera House	2117	6779	92	2	14
	Colaba	3192	11425	251	3	17
	Vakola	1912	8032	208	3	14
	Deonar	2045	8937	185	3	13
	Matunga	1358	5081	154	2	13

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Bhandup	2321	10397	220	3	13
		Vikhroli	1052	4930	141	3	13
		Mulund	868	3590	79	1	12
		Goregaon	312	1291	33	1	12
7.	PUNE	Disp. No. 1 (D.G.)	1632	5952	146	5	9
		Disp. No. 2 City	3253	10143	242	4	15
		Disp. No. 3 (Cantt.)	2258	8069	260	4	12
		Disp. No. 4 (Rasta)	2832	10603	282	5	16
		Disp. No. 5 (Range hills)	104	466	37	3	2
8.	JAIPUR	I. Janta Colony	1910	9527	322	3	8
		II. Bajaj Nagar	1759	8207	229	2·5	6
		III. Station Rd.	1523	7978	246	2·5	8
		IV. Choura Rasta	2843	13214	310	3	8
9.	NAGPUR	Katol Road Dispy.	1775	8288	297	2·5	5
		Civil Lines Dispy.	1179	5610	109	1·5	6
		Seminary Hills Dispy.	854	2305	106	1	—
		Pachpaoli Dispy.	2417	13986	399	3	6
		Itwari Dispy.	1503	7599	222	2	7
		Medical College Dispy.	3163	16496	559	3·5	6
		Dharmapath Dispy.	2870	16996	290	3	7
		Sitabuldi Dispy.	26588	11588	241	5	12
		Khamla Dispy.	1388	6371	180	1·5	4
10.	HYDERABAD	Charminar	7081	35672	359	5	10
		Humayun Nagar	7453	34604	493	5	19
		Secunderabad (Fun)	8075	37950	413	8	22
		Begumpet	2192	10145	169	3	15
		Himayathnagar (Fun)	2216	8788	222	6	19

	Kachiguda	2798	13876	352	5	18	
	Malakpet	1723	7533	362	5	16	
	Kanchanbagh	594	2563	190	2	3	
	Alwal	2565	12247	234	3	10	
	Ameerpet	721	3492	125	3	11	
	Ist Aid Post	—	—	48	1	3	
	Ayurvedic	—	—	47	2	3	
	Homoeopathic	—	—	59	2	3	
	Unani Dispy.	—	—	50	2	4	
	Dental Unit	—	—	13	1	1	
11. ALLAHABAD	Liddle Road	4591	238000	72	8	5 Cent per	
	Civil Lines	3500	17635	79	4	4 centage	
	Kalyani Devi	5043	25713	39	8	4 except un-	
	Bank Road	2898	18688	73	4	4 avoidable	
	Kaladhanda	2133	10719	82	4	4 circums-	
						tances.	
12. CALCUTTA	Belevedere	3800	14300	290	5	13	
	Lake Area	4600	17000	325	4	12	
	Dover Lane	4121	18763	290	5	11	
	Narkeldanga	3214	18901	300	5	16	
	Shyambazar	3069	15869	169	6	17	
	Regent Estate	2595	10682	240	5	17	
	Bhowanipore-Kalighat	3714	13130	256	5	12	
	Bidhansarani	5303	19812	291	5	12	
	Mint Colony	5759	21270	392	6	12	
	B.B. D. Bag	4709	19950	250	6	15	
	Santragachi	342	1494	68	3	10	
	Salt-Lake	575	2857	52	4	13	
	Ayurvedic	—	—	79	2	2	
	Homoeopathic Unit	—	—	56	2	2	
	Dental Unit.	—	—	52	2	2	

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
13.	PATNA	Budhmarg Dispy. No. 1	3040	12379	398	9	13
		Kankarbagh Dispy. No. 2	3146	18676	234	4	7
		Kadam Kuan Dispy. No. 3	1948	12726	156	3	8
		Boring Canal No. 4	2757	12934	161	3	10
		Sub-Dispensary, Patna City	762	9293	148	3	9
		Homoeopathic Unit	—	—	98	2	2
		Ayurvedic Unit	—	—	67	2	2
		Dental Unit	—	—	9	1	1
14.	KANPUR	Juhi	3277	16002	202	5	9
		R.K. Nagar	3484	14220	342	6	10
		Civil Lines	2267	11335	184	5	9
		Khapra Mahal	2337	11582	236	4	9
		Kidwai Nagar	3153	16053	209	4	9
		Gandhi Gram	2653	13760	187	4	8
		Pandu Nagar	2674	14368	85	3	8
		Azad Nagar	1006	5030	16	3	8
15.	DELHI	Andrews Ganj	4128	20567	392	8	12
		Ashok Vihar	3255	14101	326	5	15
		Chandni Chowk	3717	16185	419	4	8
		Chitra Gupta Road	4341	19941	277	6	19
		Chankya Puri	1736	5983	161	3	4
		Constitution House	3152	13161	238	3	4
		Derya Ganj	3152	17497	380	6	11
		Delhi Cantt	3409	13437	314	8	3
		Dev Nagar	6097	24961	451	4	3
		Gole Market	4620	20095	494	4	3
		G.K.G.	7847	39235	594	6	9
		Hauz Khas	4659	17667	433	5	7
		Hari Nagar	4180	17859	448	4	16

Inder Puri	2238	11554	277	3	17
Janak Puri	5071	21245	565	9·2	13
Jangpura	2319	11098	307	4	8
Kalkaji	6375	25385	587	9	8
Karol Bagh	2774	12450	279	3	3
Kidwai Nagar	5667	25363	495	10	11
Kasturba Nagar I	3234	16221	615	5	10
Kingsway Camp	13391	41776	743	11	8
Laxmibai Nagar	3241	14982	454	8	11
Lajpat Nagar	3937	13285	460	8	11
Lodi Road I	4893	21017	452	6	8
Lodi Road II	2553	11966	432	7	9
Malviya Nagar	2855	11996	232	4	7
Minto Road	3785	13384	584	4	17
Moti Bagh	3385	14069	339	8	10
Moti Nagar	4328	19992	4	4	5
Nanak Pura	4491	20243	405	5	9
Naraina	3274	13607	—	3	5
Nangal Raya	5219	24280	—	6	10
Nauroji Nagar	4318	17384	418	8	10
Netaji Nagar	5816	26322	—	3	6
North Avenue	2123	8252	—	6	5
New Rajinder Nagar	3450	14448	412	8	4
Pandara Road	2844	14947	236	5	7
Paharganj	3919	10792	433	4	5
Patel Nagar I	4320	14947	—	6	4
Patel Nagar II	3892	1884	430	6	—
President Estate	1711	8088	223	3	4
Pulbangash	3205	16660	—	5	N.A.
Pusa Road	2990	12449	253	3	5
Palam Colony	2905	17596	—	4	13
Rajouri Garden	5659	26589	472	5	7·5
R. K. Puram I	4519	17776	451	9	12

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		R.K. Puram II	4322	13828	448	5	9
		R. K. Puram III	4830	20910	471	6	10
		R.K. Puram IV	4813	18159	—	8	10
		R. K. Puram V	3707	14847	380	5	9
		Rajpur Road	2566	12488	—	3	11
		Sarojini Nagar I	2842	13226	384	4	7
		Sarojini Nagar II	2128	9355	—	4	8
		Sarojini Nagar Market	2795	10750	—	6	9
		Shahdra	6683	31733	693	11	31
		Shakur Basti	4605	19109	—	5	14
		Srinivas puri	7045	27489	—	9	13
		Subzi Mandi	4626	22789	384	3 to 5	22—25
		South Avenue	2141	9157	294	6	4
		Sadiq Nagar	7497	15056	369	6	8
		Tilak Nagar	1952	36242	718	6	13
		Telegraph Lane	2058	77333	—	9	5
		Timarpur	2944	16517	443	7 to 8	9
		Zakir Hussain Road	2453	9122	395	3	6
		Tri Nagar	1207	6022	370	4	6
		Laxmibai Nagar	962	4692	429	5	4
		M. B. Road	1402	5309	—	7	10
		Ghaziabad	1002	4599	—	4	4
		Faridabad	1881	10130	—	4	4
		Kasturba Nagar II	1784	8315	—	4	8
		R. K. Puram VI	3610	20056	—	3	8
		Gurgon	—	—	—	3	5
		Central Sectt. F. Aid Post	—	—	—	5	5
		Nirman Bhavan F. Aid Post	—	—	—	2	3
		Parliament F. Aid Post	—	—	—	2	1
		Parliament Annexe	—	—	—	4	3

V. B. D. House Ist Aid Post	—	—	—	2	1
Ay. Disp. Dev Nagar	—	—	240	2	3
Ay. Disp. Gole Market	—	—	227	2	3
Ay. Disp. Kidwai Nagar	—	—	253	3	5
Ay. Disp. North Avenue	—	—	135	3	2
Ay. Disp. R. K. Puram	—	—	283	3	3
Ay. Disp. Delhi Cantt (Unit)	—	—	141	1	3
Ay. Disp. Gorgon (Unit)	—	—	—	1	1
Ay. Disp. Hari Nagar (Unit)	—	—	85	1	1
Ay. Disp. M. B. Road	—	—	—	1	1
Ay. Disp. Jangpura	—	—	52	1	1
Ay. Disp. Kingsway Camp	—	—	77	1	1
Ay. Disp. Laxmi Nagar	—	—	—	1	1
Ay. Disp. Lodi Road	—	—	—	9	9
Homo. Dev Nagar	—	—	164	2	2
Homo. Gole Market	—	—	139	5	5
Homo. R. K. Puram	—	—	364	3	3
Homo. Darya Ganj (Unit)	—	—	50	1	1
Homo. Hari Nagar (Unit)	—	—	76	1	1
Homo. Kalkaji (Unit)	—	—	144	1	1
Homo Kasturba Nagar	—	—	117	2	1
Homo. Raja Garden	—	—	149	2	1
Homo. Shadhra (Unit)	—	—	94	1	1
Homo. Timarpur (Unit)	—	—	49	2	1
Unani Sarojini Nagar	—	—	222	1	3
Unani Darya Ganj	—	—	53	1	1

APPENDIX II

Summary of Recommendations/Observations

Sl. No.	Para No. of Report	Recommendations/Observations
1	2	3
1.	1·18 to 1·22	The Ministry has made no assessment or evaluation of the CGHS Scheme with reference to its objectives. There is no independent feedback system through which it can know the experiences of the beneficiaries. In this context Health Secretary admitted that "there are possibly no clear indicators by which one could base any clear-cut claim" (that the objectives of the Scheme had been fulfilled by and large). After an in-depth study of the working of the CGHS in the light of the memoranda received from CGHS beneficiaries and the material placed before them by the Ministry and also after paying on-the-spot study visits to various CGHS dispensaries in and outside Delhi, the Committee have come to the conclusion that the working of CGHS leaves much to be desired; it has failed to provide facilities for medical care and treatment to the satisfaction of the beneficiaries and so has not by and large achieved its objectives.
2.	1·23	The Ministry of Health would do well to shed the complacence under which it appears to be labouring at present about the working of the Scheme, and accept the bitter fact that CGHS has not come upto the expectations of its beneficiaries. Unless the Ministry sees the Scheme through the eyes of its beneficiaries, it will not be able to get the true picture and will lose one more opportunity to set things right.
3.	1·24	The Comittee recommend that working of the Scheme as a whole should be evaluated at periodical intervals through an independent institution in the context of the objectives of the Scheme. Unless the Ministry organises such an evaluation, it cannot know the shortcomings of the scheme and will not be able to take corrective action in time.
4.	1·25	The Committee would like the Ministry to evolve a proper feedback system to invite reactions of a cross-section of beneficiaries from time to time and take serious note of their views and problems.
		Workload in CGHS Dispensaries
5.	2·33 to 2·37	The workload of 2000-2500 families is the desired scale prescribed by the Ministry for a dispensary. But in a large number of dispensaries the workload is much in excess of the prescribed scale. 56 out of 72 dispensaries in Delhi and 60 out of 108 dispensaries elsewhere had more than the prescribed workload in 1980-81. In 46 dispensaries in Delhi, Bangalore, Madras, Bombay, Hyderabad, Allahabad and Calcutta workload was more than 4000 families per dispensary, the maximum number being 13391 families in Kingsway Camp dispensary (Delhi). There is no uniformity in the scale of doctors sanctioned for the various dispensaries. The doctor-patient ratio in almost all the cities varies sharply from dispensary to dispensary. While in certain dispensaries a doctor examines only 5 patients a day, in a number of other dispensaries he has to attend to 100-159 patients a day. The maximum number that a doctor can examine is 90 according to SIU norms and the ideal according to the Ministry as well as others is 75 per day per doctor.

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		The Committee would like the Ministry to review the workload region-wise in each city (not merely dispensary-wise) and see if the workload can be re-distributed among neighbouring dispensaries evenly without causing inconvnnience to card holders. The outcome of the review may be communicated to the Committee.
6.	2·38	The Committee recommend that, in the first phase, the workload in dispensaries with more than 4000 families should be brought down to the desirable level by opening more dispensaries and re-adjusting the workload. The Committee would like the Ministry to draw up a concrete programme, city-wise, to achieve this end and inform the committee.
		Doctor-Patient ratio
7.	2·39	The Committee do not consider doctor-beneficiary ratio to be a scientific method of fixing staff norm. The present norm has created an absurd situation in which doctors in some dispensaries with doctor-patient ratio of 1:5 sit almost idle throughout the day, while in other dispensaries with doctor-patient ratio of 1 : 100-159, they have too much work to be able to see patients carefully. Strength of doctors in each dispensary should be related to the average number of patients visiting the dispensary and it should be reviewed periodically in the light of variation in attendance over a period.
8.	2·40	The Committee would urge the Ministry to rationalise the workload of doctors in dispensaries not only in Delhi ubt also elsewhere keeping in view the average attendance in each dispensary so as to ensure that, as far as possible, no doctor remains under-utilised or over-burdened. The Committee would expect this rationalisation to be done without delay.
9.	2·41	Under-utilisation of professionally qualified manpower of such a high order as 5 patients per doctor per day or even a few more at certain places in CGHS which is already short of staff of this category is a culpable waste of medical personnel and funds. It should stop. (Sl. No. 9)
		Opening of CGHS Dispensary at Port-Blair
9A	2·41A	Fifteen cities are at present covered under the Central Government Health Scheme. The Ministry, it appears has no proposal to extend Central Government Health Scheme to more cities during Sixth Five Year Plan. Its aim is stated to be to consolidate the existing service before extending it further. Taking note of the Ministry's approach in this regard, the Committee would like to point out that Port Blair stands on a special footing for the reason that it being a Union Territory, there is a large concentration of Central Government Employees there with the Medical facilities not quite adequate to cope with the demand. They feel that the case of Port Blair deserves to be considered sympathetically and Central Government Health Scheme extended there at the earliest.
		CGHS Dispensaries in Ghaziabad/Gurgaon
10.	2·46	The Committee take note that the Ministry is already considering a proposal to set up another dispensary in Ghaziabad to cater for the CGHS beneficiaries who are living for away from the present dispensary there. As regards the dispensary in Gurgaon, the Ministry is already making search for alternative accommodation in the area where there is large concentration of Central Government employees. The Committee hope that the Ministry's efforts in both these cities will bear fruit soon.

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11.	2·47	It has been brought to the Committee's notice that though a large number of Central Government employees are living in Gurgaon, only a small part of them have chosen to avail of the CGHS services there because of the location of dispensary at an inconvenient place. CGHS authorities do not have any census of the total strength of Central Government employees living in Gurgaon. It will be worthwhile to take a census of Central Government employees living in Gurgaon and other peripheral cities around the capital to find out the real position. The census will enable the Ministry to take stock of CGHS facilities in these cities.
12.	2·48	The Committee hope the present difficulties of CGHS beneficiaries in Gurgaon in getting medical aid outside the dispensary hours will be solved to their satisfaction when the dispensary will start functioning round the clock.
13.	2·49	The Committee would like the Ministry to look into the matter of providing ordinary amenities like drinking water, fans, shelter, etc. in the Gurgaon dispensary.
14.	2·50	The Committee also hope that a telephone would soon be installed in the Gurgaon dispensary for the benefit of CGHS beneficiaries.
15.	2·51	The arrangements for dealing with Gynaecological problems of CGHS beneficiaries at Gurgaon are reported to be inadequate. The Committee suggest that the Ministry should take up the question of recognition of Govt. Hospital at Gurgaon with the Government of Haryana at higher level so as to provide all kinds of medical facilities for CGHS beneficiaries in Gurgaon city itself.
16.	2·52	The Committee would like to impress upon the Ministry that unless proper medical facilities are made available to the Central Government employees living in peripheral cities of Delhi, the employees would have no other alternative but to go to the already congested hospitals in the capital. Provision of adequate medical facilties in Gurgaon, Ghaziabad and other peripheral towns is absolutely essential.
		Inspections
17.	2·80	The Committee find that in 1980-81 Director, CGHS did not visit any dispensary in 9 out of 15 cities where CGHS is in operation. The Committee were informed in evidence that the Director General, Health Services visited dispensaries off-and-on, once a month or twice in two months, but he did not keep any record of his visits as he was not required to keep any such record. The Committee appreciate that surprise visits are paid to dispensaries by Director General, Health Services and Director, CGHS at their convenience. Such visits can prove more productive if the officers concerned record their observations in the inspection books of the dispensaries or in their own records to enable the CGHS directorate to watch the follow-up action on their observations. Health Secretary was frank enough in evidence to admit that the number of surprise inspections paid by officers in Delhi was less than the norm and that the Ministry was not satisfied that sufficient number of inspections had been made. The Committee expect that the Ministry would tighten their control to ensure that each zonal officer in Delhi as well as outside Delhi pays the prescribed number of inspection visits every week as is laid down in this behalf and sends a report of every inspection to higher officers.

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18.	2·83	The inspecting officers should record their observations in the inspection books of the dispensaries which they visit and ensure that follow-up action is taken by the medical officers incharge of such dispensaries concerned and progress reported to the inspection officers. The inspecting officers should also maintain a proper record of their visits at their level.
19.	2·84	The Committee regret to note that even though formal orders were issued in March 1981 to all the supervisory officers of the CGHS that a system of detailed scheduled inspection of every dispensary atleast twice a year should be introduced, the system has not been put into practice so far due to non-availability of transport. The Committee do not accept non-availability of transport as a valid reason for not doing detailed inspections of every dispensary atleast twice a year. The Committee would like that this system of scheduled inspection should be implemented without any further delay and the non-availability of transport should not be allowed to stand in the way of the officers performing this important duty regularly. If Government transport is not available they should be allowed to hire private transport (Taxi) but the inspection should not be allowed to suffer.
20.	2·85	Health Secretary conceded straight-away in evidence that complaint registers have not been maintained by all the medical officers incharge of CGHS dispensaries. This shows the failure of the system both at ground level and at supervisory level and cannot but be deprecated. The Director, CGHS has issued fresh instructions in November, 1981 directing the Medical Officers incharge to maintain complaint registers and display notices to this effect at prominent places and that inspecting officers should watch compliance of these instructions. Under the new instructions action taken on a complaint will be recorded in the complaint register itself so that it can be perused by the complainant, if he so likes. The Ministry should keep a constant watch on their observance at all levels.
21.	2·87	The Committee feel that it would be desirable if the action taken on a complaint is not only recorded in the complaint register but also communicated to the complainant.
		Area Welfare Officers
22.	2·88 & 2·89	Instructions issued in November, 1981 by the Ministry to the medical officers incharge of the dispensaries to the effect that the names and addresses of Area Welfare Officers should be prominently displayed in each dispensary and that they should extend full cooperation to the area Welfare Officers in the discharge of their duties towards beneficiaries.
23.	2·90	The Committee also take note that the Medical Superintendents of Dr. R.M.L. Hospital and Safdarjung Hospital (Delhi) have been advised that in case they receive any request from Area Welfare Officers about the admission of patients, they should give due and full consideration to it. The observance of this advice will have to be watched.
24.	2·91	The Ministry has now issued instructions that here after the minutes of the meetings held in the dispensaries with the Area Welfare Officer or the residents' associations should be duly recorded and the decisions arrived at the meetings followed up and reviewed in the following meetings. This is what should have been done all along. The Committee expect the Ministry to monitor implementation of these instructions.

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		Accommodation for CGHS Dispensaries
25.	2·100 & 2·101	There are a large number of dispensaries which are located in residential quarters in Government colonies. In the Committee's opinion residential quarters designed for small families are not at all suitable for locating a dispensary for over 2500 families. The Committee would expect that now on wards the Ministry of Health would establish a regular liaison with the Ministry of Works and Housing and at least in Government residential colonies which may come up hereafter, it would have appropriate buildings for housing Government dispensaries constructed alongwith residential quarters for serving the beneficiaries of these areas.
26.	2·102	The Committee note that in Delhi the Ministry has taken up the question of allotment of accommodation, plots and flats with the Delhi Development Authority for housing CGHS dispensaries in the newly developing colonies. The Committee hope that the Ministry would continue to pursue the matter with the DDA with a view to get suitable land allotted and suitable buildings constructed for housing CGHS dispensaries in the new areas.
		Statistics regarding expenditure per beneficiary
27.	2·115	In 1980-81, the CGHS served 5,59,469 families incurring an expenditure of Rs. 1·59 crores which came to Rs. 272 per family of which Rs. 129 was the cost per family on medicines (materials and supplies). During that year Rs. 27/- was the average contribution her family, Government thus incurred a net expenditure of Rs. 245 per employee in a year on the medical care and treatment of its employees. Comparing the per family cost with the expenditure incurred on medical treatment of the employees of certain undertakings and the Ministry of Railways, it is seen that in the same year (1980-81) the average cost of medical treatment was Rs. 725/- in Air India, Rs. 830/- in BHEL, Rs. 678/- in SAIL and Rs. 310/- in Ministry of Railways. The Committee do not see any reasons why, even in the matter of medical case, Central Govt. employees should be so poorly served. There is need to augment medical facilities under CGHS and, for this purpose, additional funds should not be grudged.
28.	2·116	The Committee find that per family cost in CGHS dispensaries varies from dispensary to dispensary and city to city. In 1979-80 it ranged from Rs. 164/- in Allahabad to Rs. 641/- in Ahmedabad. Explaining the reasons for such sharp variation, Secretary (Health) stated in evidence that except in four cities of Pune (Rs. 396/-). Jaipur (Rs. 430/-), Ahmedabad (Rs. 641/-) and Lucknow (Rs. 594/-), where the infrastructure was under-utilised the cost per family in other cities was comparatively low. The Committee are not happy at the admitted under-utilisation of CGHS in certain cities when beneficiaries in other cities are reportedly starving for more facilities. The Committee would like the Ministry to go into the matter and rectify the imbalance without delay.
29.	2·117 & 2·118	In the Committee's view, dispensary-wise information on per beneficiary cost should be collected and published in the Annual Report of CGHS. It will not only help the Ministry to dispel wrong impressions among beneficiaries (if they are wrong) but also enable the Ministry to enquire into cases of wide imbalance and apply correctives.

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		System of Working
30.	3·48 & 3·49	The Committee agree with CGHS beneficiaries that the present procedures at the dispensaries are too much time consuming. It should not be necessary for a patient to stand in as many as six queues in a dispensary one after the other for consulting a doctor and getting the prescribed medicines, as is the case at present.
		The Committee find that a recommendation to integrate counters for dispensing general and special medicines was made by two different study teams of National Institute of Health Administration and Education and Department of Personnel as far back as 1975 and 1977. The Ministry informed the Committee in August, 1981 that this recommendation had already been implemented except in certain dispensaries where space did not permit. But what the Committee learnt during on-the-spot study visits to various dispensaries in Delhi was different. The counters for special and general medicines were still separate and not combined. The Committee hope that counters for general and special medicines will atleast now be amalgamated in all the dispensaries without delay.
31.	3·50	The Committee find that the Study Team of the Department of Personnel and Administrative Reforms (1977) had also recommended that the procedure for presenting the doctors' prescriptions at the registration counter before these are presented at the dispensing counter should be discontinued. This procedure is stated to have been introduced on an expermimental basis in two dispensaries in Delhi were the experiment is still continuing. The Committee feel that the experiment has been continuing for a long time and the Ministry should now be in a position to take a final decision in the matter.
32.	3·51	The Ministry is of the view that the queue outside the Registration Windows for getting priority numbers of doctors (tokens) could also be avoided. If above queue for taking tokens and registration window for registering prescriptions are eliminated and counters for general and special medicines are amalgamated there will be a marked improvement in the procedure and considerable relief to the patients. The Committee would like the Ministry to take follow-up action in this regard without delay.
33.	3·52	The Committee also feel that it is absolutely unnecessary for the patients who have to get the medicines 'repeated' or who have got specialists' prescriptions to stand in queue along with other patients merely to have their prescription endorsed before getting medicines. The Ministry should evolve a procedure whereby such patients can get medicines without delay.
34.	3·53	The Committee were told by a number of CGHS beneficiaries during their study visits that it took them about an hour or so to consult the CGHS doctors and get medicines. Even after the patients had been to specialists and got prescriptions, they had to spend about half an hour or so at the dispensary to get the prescriptions endorsed by dispensary doctors before getting the medicines. There is need for a fresh study and remedial action to ensure that patients do not have to spend more than the minimum time required to consult a doctor and get medicines.

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		System of Prior Appointment
35.	3·54	The Committee feel that a system of appointment in chronic cases and cases requiring detailed examination can be introduced at the dispensary level also. It should be possible for the patients to fix appointments either on telephones or personally. The appointment system may be tried on an experimental basis at a few dispensaries in Delhi and elsewhere and its usefulness assessed in the light of experience before extending it to other dispensaries.
36.	3·55	The suggestion to introduce a separate "green channel" type of screening and disposal of minor "cough/cold cases" as distinct from cases requiring careful examination merits consideration. The Committee agree with the Ministry that all seemingly simple cases of sore throat etc. may not be as simple as they may first appear to be. They would, therefore, like the Ministry to give this suggestion a cautious trial in a few dispensaries under careful observation before formulating a view in this regard.
		System of Family Folders
37.	3·56	The system of family folders for CGHS beneficiaries as suggested by doctors, para-medical staff and CGHS beneficiaries will have numerous advantages. It will make the history of a patient and record of past ailments, treatment and specialists' opinions available at one place. It will also put a restraint on malpractices and wastages. The Committee are of the view on that it will be wrong to keep folders in the dispensary. Besides causing unnecessary expenditure on cabinets, almirahs and the staff and creating problems of additional storage in the already congested dispensaries, it will lead to delays in retrieving the folders and consequently friction and bad blood between the patients and dispensary staff. The family folders should be kept by the CGHS beneficiaries like the CGHS token cards. In case of loss, replacement could be arranged on payment of cost of folder. The Committee recommend introduction of folder system as suggested above at the earliest.
		Domiciliary Visits
38.	3·57	It has been represented to the Committee that doctors avoid paying domiciliary visits on some pretext or the other and insist on the patients being brought to the dispensary. And in the event of a doctor paying domiciliary visit, the transport, it is stated, is normally paid for by the beneficiary. It is highly improper if doctors drawing conveyance allowance expect the conveyance charge to be borne by the patients.
39.	3·58	The Committee are not happy at the present system of record keeping about domiciliary visits. The Committee feel that all requests for domiciliary visits made by CGHS beneficiaries either on telephone or in person should be recorded in a regular register. The Committee would like the Ministry to lay down a suitable procedure in this regard and ensure its implementation without delay.
		Working Hours
40.	3·59 & 3·46	The Committee are of the view that a single 12-hour shift in CGHS dispensaries would be ideal both for the patients and the medical and para-medical staff. They also feel that its introduction should be staggered to keep the expenditure under control. This should first be introduced in all

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		those dispensaries where the workload is excessive according to the prescribed norms and thereafter gradually extended to other dispensaries in the light of experience. But they feel that the requirement of additional staff should be worked out carefully and kept to the minimum by arranging duty hours in such a way that manpower does not remain under-utilised as far as possible.
		System of Issue of Medicines
41.	3·118	From the memoranda received and the evidence heard by the Committee, it appears that perhaps the weakest and the most criticised area of CGHS is the present system of dispensing medicines. Medicines are not readily available; indented medicines take a few days, sometimes upto 7 days, to arrive; patients have to go without medicines for varying periods. Quality of medicines does not inspire confidence. Patients have to stand in long queues for collecting medicines and they have to pay repeated visits to the dispensary for the purpose. Pharmacists behaviour and efficiency are far from satisfactory. The Committee feel that if only the medicines distribution system is streamlined and modernised, much of the cause of the dissatisfaction of CGHS would vanish.
42.	3·119 & 3·120	The Committee feel that there is need to have a fresh look at the organisational set-up of the CGHS dispensaries entirely from a different angle. It has been suggested to the Committee that the two functions at present performed by CGHS dispensaries, namely, consultation with and prescription by doctors and the issue of medicines, should be separated. The CGHS dispensaries should confine themselves only to consultation with doctors and prescribing of medicines by them. The dispensing units of the CGHS dispensaries should be converted into commercial units which should supply medicines to CGHS beneficiaries on the basis of doctors' prescription but without cash payment and settle accounts directly with CGHS Directorate. These commercial units may be run by Super Bazar or any other public sector agency. Only a commercially run dispensing unit can be expected to strive for customer satisfaction. This system will make dispensers and pharmacists accountable for pilferage, wastage and leakage of public funds. Staff costs, rent of accommodation and other overheads will not rise unrelated to sales, and sales need not be confined merely to CGHS beneficiaries. The Committee feel that this suggestion deserves a dispassionate consideration and trial on an experimental basis in a few selected dispensaries and its results evaluated after sometime before coming to a conclusion.
43.	3·121 & 3·122	Where and so long as the organisational set up of the dispensaries is not altered as suggested above, the present system of supplying medicines should be overhauled on the following lines :— (a) Whatever medicines prescribed by doctors are not available in ready stock in a dispensary, these should be straightway and on the spot authorised to be purchased locally on indents from approved chemists; (b) Where the patient offers to collect the indented medicine himself, he should be given the authority to collect it from the approved chemist directly. This will avoid delays in urgent cases; (c) In other cases, the dispensary may place indent on the approved chemist and issue to the patient as at present;

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		(d) It should be made the responsibility of the approved chemist to supply the indented medicine either from its own stock or with arrangement with some other chemist, without cash payment.
		(e) The number of approved chemists in each city should be increased so that patients do not have to go far to collect their medicines. If Super Bazar does not agree to open more branches, other chemists should be approved.
		Similar recommendations were made by the Study Team of the Department of Personnel and Administrative Reforms (1977) but it is unfortunate that the Ministry held the age-old concepts of supervision, control and administrative procedures too sacrosanct to be discarded in favour of the new approach. The Committee would urge the Ministry not to lose any more time to bring about changes in the system of issuing medicines with a view to meeting the CGHS/beneficiaries' needs and expectations.
		Buffer stock of medicines in Dispensaries
44.	3·123	The proposal of buffer stocks of common medicines in dispensaries coupled with a system of replenishment of stocks as they get depleted is a very sound proposal. The committee suggest to the Ministry to draw up a comprehensive scheme of buffer stocks and implement it under proper guidance.
		Cuts in Indents placed at the Central Medical Store
45.	3·124 to 3·126	Shortage of drugs in the CGHS dispensaries have been endemic and persistent. Though central medical store is supposed to maintain adequate stocks of medicines included in CGHS formularies, it has not been able to meet the requirements of the dispensaries. Reports that indents placed by dispensaries on central depot are either slashed subsequently or not complied with at all are not unfounded. The Study Group of the Committee observed this phenomenon during their study visits.
		From what the Committee has heard, seen and studied, one conclusion is irresistable the central store has failed in the matter of timely and adequate supply of medicines to dispensaries and for many of the ills of the dispensaries it is the central store which is chiefly responsible.
		The Committee would like the Ministry to enquire into the working of the Central Medical Store and take immediate measures to streamline its working so as to make it a well-stocked reservoir of medicines to be able always to meet the dispensaries' needs regularly and without delay.
46.	3·127	The Committee are of the view that, as recommended by the Study Team of the Department of Personnel and Administrative Reforms (September 1977) the medicines prescribed by specialists should be dispensed from the CGHS hospitals or the nodal dispensaries where the consultation is taken and the patients should not be required to shuttle between the specialists and the referring dispensaries on this account unnecessarily. The Committee strongly urge that CGHS beneficiaries should be issued medicines prescribed by specialists from the hospitals or nodal dispensaries where the consultation takes place and pending setting up of dispensing units in the hospitals, the prescribed medicines should be allowed to be purchased from the Super Bazar units already working in the CGHS hospitals on credit.

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47.	3·128	The Committee also feel that the recommendations of Study Team of the Department of Personnel and Administrative Reforms that the medicines prescribed by specialist should be dispensed for the total period recommended by the specialist. The Committee recommended that it should be implemented without any further delay.
48.	3·129	The Committee do not see any reason why a medicine if it has to be indented, cannot be indented and issued for the full period for which it has been prescribed by the specialist.
49.	3·130	The Committee are happy to note that the practice introduced in February, 1981 under which counter signature of Director-General of Health Services were required for procuring a medicines on local purchase for a period over one week, has been discontinued with effect from December 1981. There was no particular advantage nor any rationale in routing the specialists' prescriptions through D.G.H.S. It only resulted in delays and immense harassment to patients.
		Change of Brand of Drugs
50.	3·131	The Committee take note of the circumstances in which medicines with brand names prescribed by specialists are not issued by the dispensary doctors and in their place generic products are supplied in pursuance of Government decision on the Hathi Committee Report. The Committee do not see any objection in supplying medicines by generic names in lieu of brand names provided the substitutes have been found to be of proven quality and same therapeutic value after scientific tests. It will be wrong in the Committee's opinion to prescribe any untested substitutes in lieu of brand name. The Committee would like the Ministry to review the generic name medicines in the CGHS formularies from this angle and intimate to the Committee whether all of these generic name medicines have been found to be of required standard and therapeutic value, and also ensure that no new name may be added to formulary before subjecting it to quality test.
51.	3·132	The Committee also feel that in sensitive and chronic cases in which treatment with brand names medicines has been able to control or stabilise the problems, and where a switch-over to generic name substitute is likely to create a psychological effect or introduce an element of risk or slow down recovery, it will be advisable not to insist on issue of substitute medicines in lieu of brand names regardless of cost implications. Doctors should have no fetish either for generic names or for brand names.
		Duties of Medical Officer Incharge
52.	3·133	Medical Officers Incharge of the dispensaries are required to see patients apart from attending to administrative duties. The Ministry should, however, ensure that this happens in actual practice.
		Specialists Services
53.	3·144 & 3·145	The Committee suggest that workload for specialists consultation in each branch should be systematically assessed *vis-a-vis* the existing capacity of the specialists available and shortage in any particular branch made good. Needless to say, adequate number of specialists should be available to cope with the demand not only in Delhi but also in other cities. The Committee would like to be apprised of the outcome of assessment city-wise.
54.	3·146	Decentralisation of specialists services is a step in the right direction. The Committee agree that is is not necessary to

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		provide specialists in each dispensary. But it should be the objective of the Ministry to provide specialists for a group of dispensaries at least in areas which are far off from Dr. Ram Manohar Lohia Hospital and Safdarjung Hospital. The Committee would like the Ministry to review the present location of nodal dispensaries and their linkage with other dispensaries and inform the Committee of the steps necessary to augment and rationalise the present facilities.
55.	3·147	The Committee also suggest that the availability periodicity and efficiency of specialist services provided in Bombay and other cities outside Delhi should be appraised in the light of the experiences of CGHS beneficiaries there and remedial action taken to place these services on a reasonable level of efficiency.
		CGHS MEDICAL STORE DEPOT
		Procedure of Purchase and Stocking of Medicines
56.	4·65 & 4·66	A detailed procedure has been laid down by the Ministry for procurement of medicines by CGHS. Items exceeding Rs. one lakh in value are procured by CGHS through DGS&D and those less than Rs. one lakh in value are obtained direct from firms registered with DGS&D through a system of tenders. Urgent needs are met by local purchase through approved local chemists.
		The Committee regret to note that supplies through DGS&D are very often delayed. The delays which range from 3 months to 12 months dislocate the supply mechanism in dispensaries and cause a great inconvenience to CGHS patients. The Committee learn that delays can be avoided if the indents, instead of being placed on DGS&D in a new financial year, are placed well before the end of the previous financial year. The representative of the Ministry told the Committee that this is possible. If that is so, the Committee see no reason why annual indents should not be placed by CGHS well before the commencement of relevant financial year.
57.	4·67	The Committee find that DGS&D takes considerable time after receipt of indents from CGHS to place orders on the suppliers for supply of medicines. This should be looked into and time lag between receipt of indents and placement of orders should be reduced as far as possible.
		Lack of Funds
58.	4·68	Lack of funds for purchase of medicines at the time when these are required shows poor budget planning. The Committee urge that adequate funds should be provided to CGHS at the right time to enable it to procure and maintain stocks of medicines at optimum level.
		System of Quality Tests
59.	4·69 & 4.70	Though the Ministry has laid down an elaborate system of quality tests on medicines purchased by CGHS, this is not properly observed in actual practice. All supplies of medicines from unregistered or new firms are required to be subjected to chemical tests but it is a matter of deep regret that this is not being done.
		The Committee do not consider it proper to purchase medicines from firms whose standing and standards have not been tested and accepted. Helping Small Scale Industries is a noble aim but not at the cost of CGHS beneficiaries' health. The Committee would like the Ministry to drive this point

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		home to DGS&D and dissuade it from purchasing medicines from unproven suppliers.
60.	4·71	There were no fixed percentages prescribed for quality checks of medicines received from different sources. This is a big flaw. The Committee would like that norms in percentage terms for quality tests for medicines should be prescribed and enforced.
61.	4·72 & 4·73	Medicines amounting to Rs. 1·34 crores in 1978-79, Rs. 1·18 crores in 1979-80 and Rs. 1·60 crores in 1980-81 were purchased direct by Chief Medical Officers in the various cities, where CGHS is in operation, without any check whatsoever. That there was no approved testing house in Patna which accounted for Rs. 59 lakh worth of such purchases is a lame excuse. No check was made in Bangalore either even though approved testing houses were there. The direct purchases made there amounted to Rs. 41 lakhs in 3 years. This is negligence of a high order which deserves to be condemned. The Committee take note of Health Secretary's statement that when CGHS purchases medicines, it has a responsibility to do some cross-checks. If testing facilities are lacking at any place, the Ministry would soon provide them there. The Committee would like to be apprised of the action taken in pursuance of Health Secretary's assurance.
62.	4·74	The Committee cannot but take note of the heavy purchases of medicines made directly by Chief Medical Officers of Patna, Bangalore and other cities during the last 3 years. Even though the purchases are stated by the Ministry to have been made according to the prescribed procedures and within their financial powers there is need to keep a watch on direct purchases of such high magnitude.
63.	4·75	The Ministry should consider whether some sort of screening of the tenders cannot be done at tender stage to minimise the liklihood of sub-standard medicines being supplied to CGHS under the cover of lowest tenders.
64.	4·76	The Committee have no alternative but to emphasize that medicines purchased from unrecognised and unproven suppliers should in no case be used without prior quality tests. And even in respect of supplies from proven suppliers, experience has shown that quality cannot be taken for granted. Random checks of a prescribed percentage of such drugs must be carried out as a rule. Any disregard for quality control at any level should be dealt with sternly and attract deterrent punishment.
65.	4·77	Out of 100 batches of drugs purchased by CGHS in Delhi from unregistered and new suppliers in 1980-81, only 54 were subjected to quality checks. And of these 54 batches, 8 (i.e. about 15%) failed in the tests. This is not a small number. This shows the risk taken by CGHS in using 46 other batches of medicines without any test that year. The Committee feel that where supplies procured from unregistered firms are found to be not upto the mark, no future purchases should be made from them till they get themselves registered with the competent authority after going through the prescribed procedure. This is the minimum that should be done, even if they are not black listed.
66.	4·78 & 4·79	The names of firms whose suppliers are not found up to the mark are sent to DGS&D for suitable action and black listing. There were 14 such allopathic firms in 1979-80 and 5 in 1980-81. It is unfortunate that a public sector undertaking is also there in the list of units whose supplies were not upto the mark.

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		None of them, so far as Ministry is aware, has been blacklisted. Purchases were made by CGHS in the following years also from some of such firms due to compulsion of circumstances. There was no alternative according to the Ministry.
		It is a serious matter for the Ministry to consider as to whether such firms should be allowed to get away with impunity because of their dominant role in the field of production of specific drugs. The Committee do not think Government should helplessly watch such a thing happening from year to year. At least those firms whose supplies are found spurious or adulterated or harmful should not be shown any mercy.
67.	4·80	The Committee would suggest that the case of the public sector undertaking whose supplies were found to be not up to the mark should be brought to the notice of the administrative Ministry concerned for corrective action.
68.	4·81	According to the extant procedure stocks in the Central Medical Store Depot are supposed to be checked every month and every year by the stockholders and cross-checked by supervisory officers. Besides, random checks are also supposed to be done by the supervisory officers. It is not clear from the information furnished by the Ministry whether supervisory Officers did conduct scheduled and random checks and cross-checks as prescribed; and if so, with what results. The Committee would like to have this information in a precise form in respect of 1981-82.
69.	4·82	A very serious lapse that has come to the Committee's notice is in regard to stock verification of ethe Central Medical Store Depot by an independent agency as rquired under the General Financial Rules. The Rules provide that the stocks in the Central Store should be checked atleast once every year by a responsible officer who is independent of the authority incharge of the store. The Committee find evidence of only one such check having been carried out in March'May, 1972. The Ministry has admitted that no such independent check has been carried out after that period, and dates of stock verification done prior to 1978 are not available. What has pained the Committee more is that senior officers have sought to justify this lapse, by playing up the magnitude of the work involved and the shortage of staff to do it. If senior officers take such an attitude, subordinate officers are sure to neglect their duties with impunity. And this is what appears to have happened. The Committee cannot too strongly deplore this lapse. They would like that this lapse may be enquired into, the responsi bility fixed and the Committee informed of the outcome.
70.	4·83	The Committee appreciate that the Health Secretary has admitted the fact that the management has not followed the General Finance Rules in the matter of annual stock verification of the Central Store. Orders are stated to have been issued on 7th December, 1981 to conduct the stock verification within 15 days. The Committee would like to know the outcome of this stock verification.
71.	4·84	The Committee hope that the Ministry will not allow any remissness in future in regard to the timely and regular stock verification of stores, annual, monthly and random, and keep itself informed of the progress of this regard.
72.	4·85 to 4·87	The picture in regard to stock verification of stores in the dispensaries is also not very clear. The dispensary stocks are required to be verified in a limited way twice a week by the Medical Officer Incharge and once every six months by the Internal Audit Unit of the Zone.

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		The Committee expect that atleast now the Ministry would lay down a clear schedule of surprise and scheduled stock verifications outlining in unequivocal terms the authorities who will do these stock verifications and their frequency so that the officers concerned can be held accountable for their lapses, if any, in future.
		Purchase of Medicines from Public Sector
73.	4·95	The Committee expect that Government policy of purchases from public sector units in preference over private sector will be followed in latter and spirit consistent with the over-riding consideration of quality. Where, drugs available in public sector are not purchased from public sector for any reason, the comparative volume of such purchases with reasons therefor should be clearly mentioned in the Annual Report of the Ministry.
		Budget Allocation
74.	4·104	The Committee find (atleast from the figure of last 3 years) that budget allocation for purchase of medicines in a year falls short of actual requirements. The result is that the budget funds are exhausted in the first few months of a financial year and the Ministry has to wait for supplementary demands till the end of the financial year for clearing the back-log of payments. The Ministry has admitted that there have been complaints of delayed payments. The present system, under which the Ministry takes 3-4 months to pay bills for the supplies of medicines even when funds are available and, in other cases, the suppliers have to be kept waiting for payments till supplementary funds become available at the end of the financial year, shows administrative inefficiency and poor budget planning. If suppliers are expected to honour supply orders of CGHS with promptitude to enable the Central Medical Store to comply with dispensaries' indents without delay, adequate funds should be provided in the budget right at the beginning and payment procedure should be streamlined so as to ensure payments within a maximum period of one month or so.
		Time barred Medicines
75.	4·110	Different stories are in circulation about time-barred medicines in the CGHS dispensaries but for obvious reasons, the Committee are not in a position to go into the matter in depth. The Committee call upon the Ministry to look into this problem more critically, and make case studies at field level to ensure that precautions taken by CGHS against the use of time-barred drugs are adequate to guard against their misuse either on the patients or otherwise.
		Drugs banned in advanced Countries
76.	4·120	Widely circulating reports that a number of drugs which are banned in several advanced countries are sold in India without any check, have reached the Committee. Director General of Indian Council of Medical Research is of the opinion that in our country this is really not a significant feature because we have pretty tight system of control before a drug is allowed to be used in India. According to the Ministry no drug can be imported into India or manufactured unless it has been approved by the Drugs Controller of India. According to the Ministry, the decision taken by developed countries cannot always be followed in India. On receipt of the information from WHO, the Indian authorities examine the matter in depth and take judicious decision on merits in respect of each of the drug so reported to have been banned in the developed coun-

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		tries. The Ministry informed the Committee that out of 17 such drugs reported by WHO, 7 were withdrawn from market in India while five drugs were not approved or even application seeking permission to market them were not received. The Ministry has not given any explanation in respect of the five remaining drugs. The Committee would like to be informed about them.
77.	4·121	The Committee cannot over emphasise the need to act without delay on receipt of such reports and to exercise the most careful examination of such drugs with a view to ensuring that the drugs which are harmful or have deleterious side effects are no in any circumstances allowed to be marketed or remain in circulation. In order to prevent any alarm in the general public in regard to such drugs it would be desirable if the Ministry, through official handouts, gives out the considered views of the expert bodies on such drugs as are reportedly banned or are in the process of being banned in developing or developed countries. The Ministry's silence in the face of reports of any of such suspected drug can be a serious omission if not dereliction of duty.
78.	5·46 & 5·47	The experiences of CGHS beneficiaries in hospitals recognised for their treatment in Delhi, Bombay, Calcutta and other cities do not appear to be very happy. The hospitals are stated to be over-crowded, services poor and admissions even in emergency cases not always prompt; and no special consideration is shown to CGHS beneficiaries. The Ministry do not have any system of monitoring demand and availability of admissions in these hospitals, the Committee are unable to accept the Ministry's claim that none has been denied admission in these hospitals.
		Recognition of hospitals
79.	5·48 & 5·49	The Committee strongly feel that there is an immediate need to recognise more hospitals like Lok Nayak Jai Prakash Narain Hospital, Gobind Ballabh Pant Hospital, for the purpose of treatment of CGHS beneficiaries. Besides Government hospitals certain private hospitals of repute should also be recognised for the purpose.
80.	5·50	The Committee are glad to learn that the Ministry has now decided to treat All-India Institute of Medical Sciences as a referral institute/hospital in respect of persons covered under Central Services (Medical Attendance) Rules, 1944. The Committee would like that similar facility should be extended to persons covered under the Central Government Health Scheme also.
81.	5·51	In Bombay too, 5 Government hospitals and 8 private hospitals, which are recognised under CGHS are stated to be inadequate to meet the needs of CGHS beneficiaries. The proposal for construction of CGHS hospital at Haji Ali, Bombay has been shelved on account of financial constraint. The Committee recommended that the need for recognising a few more hospitals of State Government or Bombay Municipal Corporation nor even private hospitals or reserving beds in such hospitals should be seriously considered in relation to the population of Central Government employees in Bombay and their dispersal over a vast area with a view to providing adequate hospital facilities for them.

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		Hospital rates in Bombay
82.	5.52 & 5.53	The Committee have been informed by CGHS beneficiaries in Bombay that the rates of various services in these hospitals, as approved by CGHS, are so low as compared to the general rates of these hospitals, that these hospitals do not readily agree to admit CGHS beneficiaries for treatment and their services. The Committee feel that the Ministry should monitor the experiences of CGHS beneficiaries in Bombay in this regard and review the position in the light of the actual facts as may come to their notice in this exercise. If lower rates make CGHS beneficiaries unwelcome patients in the recognised hospitals, the remedy lies in revising rates upward and not expecting altruistic approach from hospitals managements in dealing with Central Government employees.
		Standard of Hospitals in Calcutta
83.	5.54	The standard of hospitals in Calcutta and other cities is stated to be not upto the mark though the Ministry denies that there is any such thing. Health Secretary agreed in evidence to depute the Director General of Health Services to observe the services provided in Calcutta hospitals and repott on the standard of services there and the improvements that could be made. The Committee would like the report together with the action taken by the Government to be communicated to them within six months.
84.	5.55	The Committee would also recommend that a similar report by Director-General Health Services, should also be submitted to them in respect of hospitals in other cities where CGHS is in operation.
		Super Specialist Treatment
85.	5.56	The Committee are happy to learn that proposals are under consideration to make CGHS beneficiaries eligible for super specialist treatment in areas like cornary bye pass in AIIMS, Railway Hospital, Parambur (Madras), Christian Medical College, Vellore, etc. so that the need for their giving abroad for such treatment can be minimised. The Committee learn that the Ministry is also trying to identify more hospitals and private clinics where specialised facilities are available, especially for treatment of the type of diseases for which normal requests are received from Central Government employees for treatment abroad and in respect of which treatment facilities in ordinary Government hospitals are still inadequate. These are welcome developments. The Committee would urge the Ministry that these proposals should be finalised and treatment facilities in all such specialised hospitals extended to CGHS beneficiaries at the earliest.
		Ambulance Services
86.	5.57	There is dissatisfaction with ambulance services in Delhi and outside. These services are, however, not under the control of CGHS authorities. The need for having an efficient ambulance service in a city cannot be disputed. For this purpose, adequate number of ambulance vans should be available; their location should be known to the people; and they should be available on telephone. The Committee expect that the Ministry will use its good offices to arrange for an efficient ambulance service in Delhi and other cities where CGHS is in operation for the benefit of CGHS beneficiaries.

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		Health Check-up Centre
87.	5·58 & 5·59	It was really a good idea to set up a Health Check-up Clinic in Delhi in 1969 but it is unfortunate that this clinic has not been able to became popular even after 11 years of its working. In 1979-80 only 8 persons availed of the health check-up facility in this clinic every day on an average. The main reasons for this clinic not becoming popular are—(1) non-availability of facilities for X-ray examination, ECG and their specialised diagnastic equipment and (2) its location away from residential areas. It is regrettable that the Ministry even though fully aware of the position, did not choose to take remedial measures all these years. The Committee feel, and the Health Secretary also agrees, that it is no use keeping an ill-equipped health check-up clinic. It should be fully equipped for giving a complete service under one roof and located at a place where its popularity can grow.
		Clinical Laboratories
88.	5·60 & 5·61	The working of clinical laboratories under CGHS had also come in for severe criticism. The users have expressed their dissatisfaction with the quality of tests done in these laboratories which, they say, are, often unreliable. What has disturbed the Committee is the lack of faith of users in the quality of tests done in these laboratories. The Ministry is not prepared to accept the general reports of poor quality of testing unless "there is a clear cut evidence to this effect." It is not understand how a patient can provide "clear cut evidence" of poor quality of tests. It should be for the Ministry to devise a system by which it can have sample and cross checking of results to satisfy itself that the quality of tests is of the required standard.
89.	5·62 & 5·63	The reasons for the unsatisfactory working of clinical laboratories are not to difficult to know. All the laboratories are not equipped with modern equipment. Technicians' skill has not been updated since their recruitment. Staff at Bombay, Patna and Madras is short of requirements. The Committee would like the Ministry to accept the widespread feeling of dissatisfaction with the working of these laboratories as only then can it seriously set out to tone up their efficiency and quality. The equipments in the clinical laboratories should be modernised in all the laboratories. The two Pathologists located in Delhi Polyclinic whose, function, it is to visit the clinical laboratories and supervise the quality of tests, should be required to bestir themselves and be more active and vigilant. They should have random checks carried out under their direct supervision to cross-check results. Unless a multipronged attack is made on this problem as suggested above, it will not be possible to bring about the desired improvement in the working of these laboratories. The Committee would like the Ministry to report the progress of action taken in this direction within six months.
		Polyclinics
90.	5·76	The importance of polyclinic an intermediate health station between the dispensary and the referral hospital—has been highlighted and the need for setting up more polyclinics emphasized by CGHS beneficiaries as well as medical experts. Government had also realised its importance and it has already set up 4 polyclinics in Delhi. 12 more are proposed to be set

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		up in the Sixth Five Year Plan of which 5 were to be set up in 1981-82. Seeing the advantages of polyclinics especially to lower paid staff and their popularity, it will be unfortunate if the 12 polyclinics proposed for the Sixth Five Year Plan do not come up as targeted. The Committee would like the Ministry to avoid such a thing happening at any cost.
91.	9·77	The Estimates Committee (1973-74) had recommended in their 57th Report that polyclinic should provide all types of specialised medical services if they have to fulfil the objectives for which they were intended. The Study Team of the Department of Personnel and Administrative Reforms (1977) had also supported the Committees' recommendation and recommended provision of all specialist services in the polyclinics. The Committee are disappointed to note that the Ministry's reaction to these recommendations has not been encouraging at all. It has pleaded its inability to implement these recommendations on the ground of paucity of accommodation and financial constraint. The Committee feel that it is very shortsighted view as in the absence of these facilities at polyclinics the entire burden falls on referral hospitals to the detriment of their efficiency and ability to provide good quality services in really serious cases. Instead of burdening these hospitals any further, the Ministry should provide at least all such specialised services in polyclinics as are in wide demand and equip them with all the necessary equipments and staff with a view to making them useful intermediate health stations between the dispensaries and hospitals and relieving pressure on referral hospitals.
		Physiotherapy Units
92.	5·82	The Ministry may, consider the feasibility and desirability of setting up a few more Physiotherapy units outside the hospitals for the benefit of beneficiaries residing far away from these hospitals.
		Staff Strength
93.	6·9 & 6·10	The Committee regret to observe that the figures of total strength of doctors and para-medical staff furnished by the Ministry are quite confusing. The Ministry has supplied three different sets of figures which do not tally with one another.
		Taking the best figures, the Committee find that over 100 posts of doctors and nearly 225 posts of para-medical staff are lying vacant. At certain places vacancies in the case of doctors have been there for over five years and in the case of paramedical staff for over 10 years. The reasons given by the Ministry for these shortages, such as long time taken in making recruitment of doctors through UPSC and non-availability of para-medical staff, do not carry conviction with the Committee. It only shows that the Ministry has no proper system of perspective planning and initiating action for recruitment of Medical Officers well in advance. Such a large number of vacancies are bound to affect adversely the working of CGHS dispensaries on the one hand and aggravate unemployment position in the country on the other. The Committee cannot but hold the Ministry responsible for the failure in providing full contingents of doctors and paramedical staff in the CGHS dispensaries. The Committee would like the Ministry to remove weaknesses in personnel planning and management to avoid such serious short-comings as highlighted above. They would also like the Ministry to fill up

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		all the vacancies without delay and report progress within three months.
		Promotional Avenues
94.	6·43 & 6·44	Stagnation and lack of adequate promotion prospects have created widespread frustration in CGHS doctors and para-medical staff of which the Committee cannot but take a note. The Ministry has admitted that chances of promotion from Senior Grade I to Super-time Grade-II are not commensurate with the large number of posts and a large number of them are stagnating at the maximum of their pay-scale. Medical Officers in charge of dispensaries and a number of other doctors in each dispensary are in the same scale and this surely cannot be conducive to proper administrative control and discipline. Position of para-medical staff is no better and the Ministry is aware of it. The very structure of service in their case is disappointing. Out of 47 categories of para-medical posts having a sanctioned strength of 2601 personnel, 38 categories of posts com prising 1733 personnel have no promotion prospects whatsoever. It is difficult to envisage an organisation which provides no aveue of upward mobility for its technically qualified staff and still expects them to run its services efficiently. This is a sad reflection on the personnel management of the Ministry. The Committee would like the Ministry to give this matter an urgent thought and speedy action.
		Cadre Review
95	6·45	Restructuring of Central Health Service and cadre review in respect of Medical Officers of all grades, as recommended by Third Pay Commission, is stated to be nearing finalisation. Recommendations of the pay Commission in respect of Pharmacists have been implemented and those regarding other categories of para-m edical staff are stated to be under consideration. But the unconscionable delay of nearly 10 years in undertaking this much needed exercise resulting in irreparable harm to Medical and para-medical staff, for which the Committee hold the Ministry responsible, cannot but be deplored.
96.	6·46	The Committee are glad to learn that the Health Secretary alongwith his colleagues have now been able to "push" the proposals regarding cadre review and restructuring of CGHS which, it is stated, are now at a very advanced stage of being approved. When these are finalised, additional promotional avenues are expected to become available for medical officers of all grades and stagnation is expected to end. The Committee would like that these welcome but hitherto much delayed measures should not be delayed any further. They would like to be apprised of the outcome of these exercises in concrete terms.
97.	6·47	The Committee would also like that the Third Pay Commission's recommendaitions in respect or para-medical staff other than pharmaciss in whose case action has already been taken) should also be processed and implemented without delay.
98.	6·48	The Committee would like to observe in this context that while the Ministry has a right to expect the most efficient performance from Medical and para-medical staff in CGHS to be able to provide satisfactory service to CGHS beneficiaries, it also has a responsibility towards them to ensure reasonably good career prospects and service conditions to avoid

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		frustration creeping into their ranks. The Committee would advise the Ministry to keep this aspect under its constant watch and not to delay remedial action wherever and where ever becomes necessary in the future.
		Confirmation of Medical Officers & Staff in CGHS
99.	6.49 to 6.51	Even in the matter of confirmation of Medical Officers and para-medical staff the position was very unsatisfactory. 231 Medical Officers who had put in more than five years' of service had not been confirmed upto March 1981. Of them 50 had put in more than 10 years' of service and were still awaiting confirmation. In Delhi alone, 94 out 204 Medical Officer Grade I and 66 out of 419 Medical Officer Grade II had put in more than three Years' of service in the grade and had not been made permanent.
		The position in regard to para-medical staff is no better. Out of 2597 such staff in position on 31-3-1981, as many as 619 persons had not been confirmed even though they had put in more than five years' of service; 249 of them had put in more than 10 years of service. In Delhi, out of 1209 para-medical staff, 353 persons having more than three years service, 142 with 5-10 years service, 94 with 10-15 years of service and 6 with over 15 years of service had not been confirmed. After going into the reasons for the non-confirmation of Delhi based para-medical staff, the Committee find that except in the case of 33 persons for whom permanent posts were not available, in 320 other cases administrative delays on the part of the Ministry were responsible for not processing their conformation cases. The Committee would like the cases of administrative delays to be enquired into at appropriate level with a view to learning lessons for the future.
100.	6.52	The Committee, in fact, would like the Ministre to examine in consultation with the Department of Personnel the desirability of laying down a rule that if after three years' of satisfactory service a Medical Officer or para-medical staff is not confirmed by the appropriate authority, his/her case together with the reasons therefor should be placed before the next higher authority or Health Secretary to enable the latter to judge whether the discretion not to confirm the employee has been exercised judiciously.
101.	6.53	The Health Secretary was good enough to assure the Committee that the case of all eligible medical officers and staff (for confirmation) would be processed and completed by 31st March, 1982. The Committee trust that the Ministry will fulfil its assurance and earn the goodwill of officers and staff.
102.	6.54	The Committee find that a major impediment in the way of processing confirmation cases in respect of Medical Officers has been the delay in convening DPC (Department Promotion Committee). They also understand that UPSC has to be consulted before the confirmation cases of medical officers who have been recruited through UPSC, are decided. The Committee feel that this is cumbersome and time-consuming procedure. Once a doctor has been recruited through UPSC his confirmation should be decided by the Ministry in the light of his performance and it need not await formal approval by UPSC. Only in cases where the Ministry chooses not to confirm an eligible doctor after he has put in prescribed length of service, the Ministry should be required to place the matter together with the reasons for not confirming him be-

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		fore the UPSC for the latter's satisfaction and review. This will avoid delays and also chances of harassment.
		Transfer of medical Offices
103.	6·55	In the Committee's opinion a medical officer should not remain in the same place and same zone for more than 4 years or so in the interest of efficiency of service to CGHS beneficiaries. The Committee would like the Ministry to examine the question of devising a suitable scheme of postings and transfers to ensure periodical rotation of medical officers from one place to another and from one zone to another.
		Ad-hoc Medical Officers
104.	6·65 & 6·66	The recruitment of doctors for CGHS is regquired to be made through UPSC. *Ad hoc* appointments are, however, made to fill up leave or short term vacancies of regular incumbents Their appointments cannot be regularised without the approval of the UPSC.
		The Ministry is at present restructuring the medical cadre in the CGHS with a view, *inter alia*, to giving opportunities to *ad hoc* doctors who have put in more than 5 years service to get regularised. The Committee feel that the *ad hoc* doctors who have already put in satisfactory service for more than 5 years deserve to be considered more sympathetically for the purpose of regularisation and in this process it'should be ensured that they do not suffer any loss in the matter of emoluments an account of delay in regularisation. They hope that the Ministry would continue with the process initiated by it in this regard till all the *ad hoc* doctors who have put in satisfactory service are regularised.
		Conveyance Allowance
105.	6·74	Conveyance allowance at the following rates under certain conditions is paid to Medical Officers to enable them to pay domiciliary visits : those maintaining their own motorcars— Rs. 275/- PM, those maintaining scooters/motorcycles Rs. 90/- PM and those not maintaining either cars or scooters Rs. 60/- PM. In the Committee's opinion, doctors not owning cars or scooters should be given options either to draw conveyance allowance as at present or to claim re-imbursement of taxi or auto-rickshaw hire charges for paying home visits as the case may be, with suitable safeguards against misuse.
106.	6·75	The Committee would like the Ministry to consider the entire question of conveyance allownace realistically and evolve a system which would be most convenient to doctors and would also lead to a better service to CGHS beneficiaries.
107.	6·76	The Committee has received many such reports and they would advise the Ministry not to take the absence of formal complaints from CGHS beneficiaries as a proof of their satisfaction with the prevailing system of domiciliary visits. Unless the Ministry finds a practical solution to the problem of conveyance for doctors, it would not be able to provide an efficient system of home visits to the satisfaction of CGHS beneficiaries.

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		Service Conditions for Doctors
108.	6·85	There is a feeling in certain quarters that only 50% of the doctors selected by UPSC for CGHS join duty. The Ministry unfortunately does not maintain data from which one could know as to how many doctors were offered appointments by UPSC and how many of them accepted them. It would be interesting to make a study of this phenomenon, say, for a period of last five years and draw meaningful conclusions.
109.	6·86 & 6·87	The Committee find that incidence of resignations among CGHS doctors is quite high. In an organisation which has a strength of about 1300 doctors, as many as 369 doctors had resigned between 1972—1980 as against a little over 1000 new doctors recruited during this period. The Committee feel that the high resignation rate could be due to the reasons that service conditions and career prospects in CGHS may not be as good as in some other organisations to which CGHS doctors might be attracted. The Committee would like the Ministry to make a case study of the doctors who resigned their jobs under CGHS during a particular period to find out the real reasons for their resignations and see what it can do to prevent such a large scale exodus of doctors from CGHS.
110.	6·88	The suggestion made in a memorandum to permit liberally, the CGHS doctors to do postgraduate courses and to provide the necessary facilities for the purpose, merits consideration. If this is done atleast a certain percentage of doctors who might think of resigning their jobs under CGHS for the purpose of doing postgraduate courses, may stay back.
		Residential Accommodation
111.	6·98	The Committee find that as against 222 doctors, who have been provided Government accommodation, 487 are without it. In para-medical staff category, as against 258 such staff who have Government accommodation, 951 have not got Government accommodation so far. The degree of satisfaction is 32% for Doctors and 21% for para-medical staff. It is, in the Committee's opinion, very essential to provide residential accommodation at least to all key personnel close to the dispensary to which they are attached, in the interest of a more efficient service to patients at odd hours. The Committee would like the Ministry to identify the doctors and para-medical staff who are holding key positions in each dispensary and arrange, in consultation with the Ministry of Works and Housing, to provide them suitable accommodation within easy distance from the respective dispensaries.
		Retirement Age
112.	6·99	The Committee have no comments to make on the retirement age of doctors. But they do feel for the doctors, who because of their late entry into service in some cases as late as 30-36 years—would retire without adequate pension. Specialists doctors have been given the benefit of added years of service of upto 5 years for the purpose of pension. But there is no

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		such consideration for other doctors. The Committee see no logic in discriminating between specialists and other doctors under pension rules. They would like all doctors to be treated alike in this matter.
		Foreign assignments for Central Health Service Doctors
113.	6·103	The Committee take note of the recent decision of the Ministry of Health and Family Welfare relaxing the existing ban on the forwarding of applications of CHS officers for empanelment in the "Foreign Assignment Panel" maintained by the Department of Personnel and Administrative Reforms and to their release to take up assignments abroad on deputation on a restrictive basis.
		Behaviour of Doctors and para-medical Staff
114.	6·122	CGHS beneficiaries dissatisfaction with the behaviour of doctors and para-medical staff at the dispensary level has been brought to the Committee's notice in writing and in person. The Committee do not want to convey an impression that CGHS beneficiaries consider all or most of the doctors or para-medical staff rude. But even if a small minority behaves improperly, the image of the entire class gets tarnished. It is against this danger that the Committee wish to warn the community of doctors and para-medical staff.
115.	6·123	Doctors and para-medical staff have not accepted the charge of rude behaviour. According to them, heavy workload and too inadequate a strength do not permit them to give proper attention to each patient. The Committee feel deeply pained at the doctors' and para-medical staff's attempt to plead heavy workload and frustration in extenuation of the charge of rude and indifferent behaviour. The medical and para-medical staff may have problems (and they have problems which the Committee have dealt with elsewhere in this report); but this cannot be a justification for the curtness in their behaviour or casualness in their approach.
116.	6·124	Like CGHS beneficiaries, the Committee expects from the doctors a standard of conduct consistent with the high traditions of the noble profession to which they have the privilege to belong. The Committee would, call upon the doctors to live upto the expectations of their patients even under testing circumstances and deal with all of them, high or low with patience, understanding, smile and human touch.
117.	6·125	The Committee expect that the dispensers and other para-medical staff will also take note of the CGHS beneficiaries' feelings about their behaviour and do everything possible not to give them any cause of complaint on this account.
118	6·126	The Committee do not agree with the Ministry's approach to measure the patients' satisfaction on statistical scale. It will be a pity if on statistical basis the Ministry, doctors and para-medical staff delude themselves into believing that CGHS beneficiaries are satisfied with the behaviour of dispensary xtaff or if they adopt an attitude of self-righteousness or complacence in this regard.
119.	6·127	The Committee are conscious of the fact that in a matter like this, it is the doctors and the para-medical staff themselves who can really help. Unless the Ministry can successfully bring home to the doctors and para-medical staff the desirability of attending to patients with smile and sweetness, regardless of their personal problems of stagnation and heavy workload, the problems will not be solved.

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		For this the Ministry on the one hand will have to be firm dealing with instances of callous and curt behaviour, and on the other, show sympathetic understanding of legitimate problems of doctors and other staff.
		Role of Ministry
120.	7·18 to 7·20	The role of the Ministry of Health in relation to CGHS is to lay down general policy and staff norms and attend to matters relating to creation of posts, budgetary control, plan proposals and periodic review of functioning of CGHS. The task of supervision, control, monitoring and staffing is taken care of by the Director, CGHS who works under the superintendence and control of Director-General, Health Services. The Ministry, the Committee were told, did not do anything directly in the field of supervision, control and monitoring which were left to the Director-General, Health Services. The Ministry, it was stated, kept a watch from time to time over the supply of right type of medicines in adequate quantity. However, even in this filed, it was confessed, there was no systematic review by the Ministry. The Committee cannot too strongly deplore the attitude of unconcern prevailing in the Ministry in the past towards the working of CGHS. The Committee do not think it proper for the Ministry to wash its hands completely of the important tasks of general supervision, control and monitoring of the overall performance of CGHS and pass them on to a subordinate authority. Unless the Ministry actively oversees the activities of CGHS at macro level as an apex body should do, it will not be possible for it to know the shortcomings of the scheme or the problems of CGHS beneficiaries. Nor will it be possible for the Ministry to do any meaningful review of the working of the scheme. The Committee would, therefore strongly urge that the ministry should shed the ivory-tower attitude it has had so far and play an active role in effective supervision and control over the scheme and in carrying out periodic reviews of its working.
121	7·21	The Committee were, however, glad to see that, notwithstanding the past record of the Ministry, the attitude of the Health Secretary during evidence was refreshingly responsive and encouragingly positive. The Committee were informed during and after evidence that action in various directions had already been initiated by the Ministry in the light of the Committee's observations. The Committee expect that similar sensitivity and alacrity to act, as seen in evidence would continue to be shown hereafter by the Ministry in streamlining the working of the CGHS with a view to giving maximum satisfaction to the beneficiaries and living up to their expectations.
		Management Information System
122	7·22	The Committee would advise the Ministry to organise a proper management information system and a matching apparatus to analyse the information to be able to know the weak spots in the working of the CGHS and to apply correctives without delay.
123.	7·23	Out of 33 recommendations and observations made by the Study Team of Department of Personnel and Administrative Reforms on the Working of CGHS dispensaries (1977) only 17 were accepted by the Ministry. The remaining 16 recommendations which were not accepted included

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		some which were original and went to the root of many problem. The Committee feel that the purpose of appointing an expert body to look into any problems is defeated if the controlling authority does not take the expert views seriously. The Committee would like the Ministry to have an innovative approach and open mind in dealing with the problems of CGHS.
		Management Experts
124.	7·24	Neither the Ministry nor the CGHS Directorate has on its roles experts or consultants in the sphere of Finance, Personnel Management, Material Management, Medical Administration, Inventory Control and Purchase. These areas of responsibility are handled by common run of beaurocarts as anywhere else in the Government Secretariats. This in the Committee's view is not a very happy situation. The Committee do not agree with the Health Secretary that "It is not practicable for each organisation to have its own specialist service." The Committee feel that in view of the fact that the CGHS is running over 210 dispensaries and units of all types in 15 cities and dealing with nearly 24 lakh beneficiaries (over 5-1/2 lakh families) and spending over Rs. 14 crores per annum toward purchase of medicines and administration, it is of paramount importance that the CGHS Directorate should have on its roles experts at least in personnel management, finance, purchase and inventory control to ensure efficiency with economy in the administration of the scheme. Such a vast network of dispensaries and related services is difficult for the generalists alone to manage competently. The Committee expect the Minstry tobestow attention to these areas of administration which have remained neglected over two decades.
		Definition of Family.
125.	7·34	The term "family" under the CGHS includes husband/wife of the CGHS cardholder, wholly dependent children or step children and parents (or parents-in-law in certain circumstances) who are mainly dependent on and are residing with the Government servant. The Committee feel that the case of wholly dependent sisters who are unmarried or widowed or separated and of daughters who are widowed or separated and who are living wih the Government servants stands on a special footing in Indian social system and deserves to be considered with sympathy for extension of CGHS facilities, if not on subsidised rates, at least on normal rates.
		Vehicles
126.	7·42	CGHS set up in Delhi has been incurring an unduly heavy expenditure on petrol for its vehicles and on their maintenance and repair. The average consumption of petrol was 3·66 K.M. per litre during 1980-81 and the maintenance and repair cost amounted to an average of Rs. 5475/- per vehicle during that year. The explanation given by the Ministry in support of such an abnormally high expenditure that most of the vehicles are very old, and heavy, like trucks and wagons, does not carry conviction with the Committee. The Ministry should have replaced the old vehicles progressively instead of running and maintaining them so uneconomically. The Committee would like the Ministry to enquire as to whether any serious attempt was ever made and pursued to provide funds for the replacement of at least the condemned vehicles and why the attempt did not succeed and furnish a report to them within six months.

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		New 20 Point Programme
127	7·44	The people now realise the benefits of a small family. The Government's role is to educate them in the methods of contraception so that they are motivated to accept on their own, any one of them. It is very necessary that a voluntary effort is intensified at every level and every possible opportunity utilised in the process of educating the CGHS beneficiaries in the reproductive group and making them adopt the small family norm. The Committee would urge the Minstry to ensure that it provides every possible facility, particularly Laproscopy which is proving popular, in the CGHS poly-clinics and hospitals and if possible in the dispensaries to make family planning more attractive so that the targets set down in the Sixth Five Year Plan to raise the percentage of couples practising family planning from 22·5% to 36·5% by 1984-85 are fully met.
128.	7·45	The incidence of Tuberculosis is still high in India. The Committee are not aware whether the Ministry has organised any campaign to screen all the CGHS beneficiaries with a view to detecting signs of Tuberculosis at the earliest stage. They would strongly recommend that the screening of government employees and their families should be organised by CGHS expeditiously and suspected cases of Tuberculosis identified for an intensive treatment and care in specialised hospitals. The Committee would also like the Ministry to ensure that adequate number of beds for Tuberculosis patients covered by CGHS are available in specialised hospitals and the patients do not have any difficulty in getting the prescribed medicines. In Delhi and other places where there is large concentration of Government employees the Ministry should consider providing special wings worth adequate number of TB specialists in the existing hospitals.
129.	7·46	There is a good deal of preventable blindness in the country due to nutritional deficiency, disease or cataract. The Committee would suggest that CGHS should organise an intensive programme of examining the eyes of CGHS beneficiaries, particularly the children and the old men and women, and undertake without delay preventive, promotive and curative measure of eye health care. (S. No. 129)
130.	7·47	The Committee would also like that the Minstry should review the present capacity for dealing with cataract cases in the hospitals and poly-clinics set up or recognisaed under the CGHS and augment the capacity wherever necessary. They would like the Ministry to take stock of the backlog of cataract cases among CGHS beneficiaries and draw up a time-bound programme to clear them, within one year.
131.	7·48	It should also be ensured by the Ministry that CGHS beneficiaries requiring glasses under the eye health care programme should be able to get good quality glasses at reasonable prices.

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