REPORT NO.
93

PARLIAMENT OF INDIA
RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE
ON HEALTH AND FAMILY WELFARE

NINETY THIRD REPORT

Demands for Grants 2016-17 (Demand No. 42) of the Department of Health and Family Welfare (Ministry of Health and Family Welfare)

(Presented to the Rajya Sabha on 27th April, 2016)
(Laid on the Table of Lok Sabha on 27th April, 2016)

Rajya Sabha Secretariat, New Delhi
April, 2016/Vaisakha, 1938 (Saka)

Hindi version of this publication is also available

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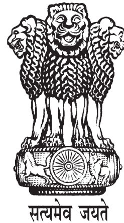

Rajya Sabha Secretariat, New Delhi
April, 2016/Vaisakha, 1938 (Saka)

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COMPOSITION OF THE COMMITTEE
(2015-16)

1. Prof. Ram Gopal Yadav — *Chairman*

RAJYA SABHA

2. Shri Ranjib Biswal
3. Shri Rajkumar Dhoot
4. Dr. Bhushan Lal Jangde

+5. Shrimati B. Jayashree

6. Dr. R. Lakshmanan
7. Shrimati Kahkashan Perween
8. Shri Ambeth Rajan
9. Shri Jairam Ramesh

^10. Dr. T. N. Seema

LOK SABHA

11. Shri Thangso Baite
12. Dr. Subhash Ramrao Bhamre
13. Shrimati Ranjanaben Bhatt
14. Shri Nandkumar Singh Chauhan
15. Dr. Ratna De (Nag)

#16. Shri Devendra *alias* Bhole Singh

17. Dr. (Smt.) Heena Vijay Gavit
18. Dr. Sanjay Jaiswal
19. Dr. K. Kamaraj
20. Shri Arjunlal Meena
21. Shri J. Jayasingh Thiyagaraj Natterjee
22. Shri Chirag Paswan
23. Shri C. R. Patil
24. Shri M. K. Raghavan
25. Dr. Manoj Rajoria
26. Dr. Shrikant Eknath Shinde
27. Shri R. K. Singh
28. Shri Kanwar Singh Tanwar

[+] ceased to be member of the Committee w.e.f. 21st March,2016.

^ ceased to be member of the Committee w.e.f. 2nd April,2016.

[#] ceased to be member of the Committee w.e.f. 18th April,2016.

29. Shrimati Rita Tarai
30. Shri Manohar Untwal
31. Shri Akshay Yadav

SECRETARIAT

Shri P.P.K. Ramacharyulu, *Additional Secretary*

Shri Anil Kumar Gandhi, *Director*

Shri Dinesh Singh, *Joint Director*

Shri Rajesh Kumar Sharma, *Assistant Director*

Shri Pratap Shenoy, *Committee Officer*

INTRODUCTION

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee to present the Report on its behalf, hereby present this 93rd Report of the Committee on the Demands for Grants (Demand No. 42) of the Department of Health and Family Welfare, Ministry of Health and Family Welfare, for the year 2016-17.

2. The Committee held one sitting on 22nd March, 2016 for examination of Demands for Grants (2016-17) of the Department of Health and Family Welfare and heard the Secretary (Ministry of Health and Family Welfare) and other Officers thereon.

3. The Committee considered the Draft Report and adopted the same in its meeting held on 25th April, 2016.

4. The Committee while making its observations/recommendations has mainly relied upon the following documents:–

(i) Address by the President of India to both Houses of Parliament assembled together on 23rd February, 2016;

(ii) Speech of Finance Minister on 28th February, 2016 while presenting the Union Budget 2016-17;

(iii) Implementation of Budget Announcements 2015-16;

(iv) Detailed Demands for Grants of the Department of Health and Family Welfare for the year 2016-17;

(v) Annual Report of the Department for the year 2015-16;

(vi) Outcome Budget of the Department for the year 2016-17;

(vii) Detailed Explanatory Note on Demands for Grants of the Department of Health and Family Welfare for the year 2016-17;

(viii) Physical and financial targets fixed and achievements made so far during the Twelfth Plan period;

(ix) Projection of outlays for the schemes to be undertaken by the Department during the remaining year of the Twelfth Five Year Plan;

(x) Details of under-utilization of the allocations made under different heads during the last four years;

(xi) Written replies furnished by the Department to the Questionnaires sent to them by the Secretariat;

(xii) Presentation made by the Secretary (Ministry of Health and Family Welfare) and other concerned officers; and

(xiii) Written clarifications furnished by the Department, on the points/issues raised by the Members during the deliberations of the Committee.

5. For facility of reference and convenience, observations and recommendations of the Committee have been printed in bold letters in the body of the Report.

PROF. RAM GOPAL YADAV
Chairman,
Department-related Parliamentary
Standing Committee on Health and Family Welfare
Rajya Sabha

NEW DELHI;
25 April, 2016
Vaisakha 5, 1938 (Saka)

ACRONYMS
(NHM SECTOR)

AES	:	Acute Encephalitis Syndrome
ASHAs	:	Accredited Social Health Activists
AS&MD	:	Additional Secretary and Managing Director
BRICS	:	Brazil, Russia, India, China and South Africa
CDs	:	Communicable Diseases
CEmOC	:	Comprehensive Emergency Obstetric Care
CHCs	:	Community Health Centres
CSSM	:	Child Survival and Safe Mother-hood Programme
DEC	:	Diethyl Carbamazine Citrate
EAG	:	Empowered Action Group
EPI	:	Expanded Programme for Immunization
ES	:	Economic Survey
FY	:	Financial Year
GDP	:	Gross Domestic Product
GoI	:	Government of India
Hib	:	Haemophilus Influenza Type b
ICMR	:	Indian Council of Medical Research
IEC	:	Information, Education, Communication
ICT	:	Information Communication Technology
IMR	:	Infant Mortality Rate
IPHS	:	Indian Public Health Standards
IDSP	:	Integrated Disease Surveillance Programme
IPV	:	Inactivated Polio Vaccine
JE	:	Japanese Encephalitis
LF	:	Lymphatic Filarisis

LSAS	:	Life Saving Anesthesia Skills
MDA	:	Mass Drug Administration
MMR	:	Maternal Mortality Ratio
MoHFW	:	Ministry of Health and Family Welfare
MDGs	:	Millennium Development Goals
NACO	:	National AIDS Control Mission
NCDC	:	National Centre for Disease Control
NCDs	:	Non Communicable Diseases
NBSUs	:	New Born Stabilization Units
NHM	:	National Health Mission
NID	:	National Immunization Days
NGO	:	Non-Government Organization
NLEP	:	National Leprosy Elimination Programme
NMR	:	New Born Mortality Rate
NNMR	:	Neo Natal Mortality Rates
NMHP	:	National Mental Health Programme
NMSAP	:	National Multi-Sectoral Action Plan
NTCP	:	National Tobacco Control Programme
NUHM	:	National Urban Health Mission
NIDs	:	National Immunization Days
NPCB	:	National Programme for Control of Blindness
NPHCE	:	National Programme for Health Care of Elderly
NIDSP	:	National Iodine Deficiency Disorders Programme
NCD	:	Non-Communicable Disease
NSSO	:	National Sample Survey Organisation
NOHP	:	National Oral Health Programme
NVBCP	:	National Vector Borne Disease Control Programme
NLEP	:	National Leprosy Eradication Programme
NPCC	:	National Programme Coordination Committee
NTBCP	:	National Trachoma and Blindness Control Programme

NPCDCS	:	National Programme for Prevention and Control Cancer, Diabetes, Cardio- Vascular Diseases and Stroke
NVBDCP	:	National Vector Borne Disease Control Programme
PG	:	Post Graduate
PHCs	:	Primary Healthcare Centres
RBSK	:	Rashtriya Bal Swasthya Karyakaram
RGI - SRS	:	Registrar General of India - Sample Registration System
RKSK	:	Rashtriya Kishore Swasthya Karyakaram
RMNCH+A	:	Reproductive Maternal Newborn Child and Adolescent Health
RCH	:	Reproductive Child Health
RHS	:	Rural Health Statistics
RPD	:	Rapid Diagnostic Test
RSBY	:	Rastriya Swasthya Bima Yojana
SHCs	:	Sub Health Centres
SCs	:	Sub-Centres
SCI	:	State Cancer Institutes
SHS	:	State Health Societies
SLT	:	Smokeless Tobacco Products
TAS	:	Transmission Assessment Survey
TFR	:	Total Fertility Rate
TCCCs	:	Tertiary Care Cancer Centres
TSP	:	Tribal Sub Plan
U5MR	:	Under 5 Mortality Rate
UG	:	Under Graduate
UIP	:	Universal Immunization Programme
UCs	:	Utilization Certificates
UHCs	:	Universal Health Coverage
ULBs	:	Urban Local Bodies
UCHSs	:	Urban Community Health Centres
UPHCs	:	Urban Primary Health Centres

UTs	:	Union Territories
VBD	:	Vector Borne Disease
VBDCP	:	Vector Borne Disease Control Programme
WHO	:	World Health Organisation
WHS	:	World Health Statistics

ACRONYMS
(HEALTH SECTOR)

AIIMS	:	All India Institute of Medical Sciences
BCGVL	:	BCG Vaccine Laboratory
CCA	:	Chief Controller of Accounts
CCEA	:	Cabinet Committee on Economic Affairs
CDSCO	:	Central Drugs Standard Control Organization
cGMP	:	Current Good Manufacturing Practice
CGHS	:	Central Government Health Scheme
CGEPHIS	:	Central Govt. Employees and Pensioners Health Insurance Scheme
CIP	:	Central Institute of Psychiatry
CPWD	:	Central Public Works Department
CRI	:	Central Research Institute
CVC	:	Central Vigilance Commission
DPR	:	Detailed Project Report
DDPRCs	:	Design and Detailed Project Consultants
DUAC	:	Delhi Urban Art Commission
EIA	:	Environmental Impact Assessment
EOT	:	Extension of Terms
FYP	:	Five Year Plan
GFR	:	General Financial Rules
GMCs	:	Government Medical Colleges
HLL	:	Hindustan Latex Limited
HSCCL	:	Hospital Services Consultancy Corporation Limited
IPD	:	In Patient Department
IITs	:	Indian Institutes of Technology
IVF	:	In Vitro Fertilization

IPC	:	Integrated Purchase Committee
JIPMER	:	Jawaharlal Institute of Post Graduate Medical Education and Research
JPNATC	:	Jai Prakash Narayan Apex Trauma Centre
LHMC	:	Lady Harding Medical College
MoH&FW	:	Ministry of Health and Family Welfare
MoUD	:	Ministry of Urban Development
NACO	:	National AIDS Control Programme
NCT	:	National Capital Territory
NDMC	:	New Delhi Municipal Council
NE	:	North East
NITs	:	National Institutes of Technology
NEIGRIHMS	:	North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences
NIMHANS	:	National Institute of Mental Health and Neurosciences
OCT	:	Optical Coherence Tomography
OPD	:	Out Patient Department
OT	:	Operation Theatre
PAO	:	Pay Accounts Office
PGIMER	:	Post-Graduate Institute of Medical Education and Research
PET	:	Position Emission Tomography
PII	:	Pasteur Institute of India
PRO	:	Public Relations Officer
PSA	:	Procurement Support Agent
PMSSY	:	Pradhan Mantri Swasthaya Suraksha Yojana
PSUs	:	Public Sector Undertakings
RECs	:	Regional Engineering Colleges
RIMS	:	Regional Institute of Medical Sciences
RIPANS	:	Regional Institute of Para medical and Nursing Sciences
RML	:	Dr. Ram Manohar Lohia Hospital
SEs	:	Superintendent Engineers

SGPGIM	:	Sanjay Gandhi Post Graduate Institute of Medical Sciences
SVIMS	:	Sree Venkateswara Institute of Medical Sciences
SJH & VMMC	:	Safdarjung Hospital & Vardhman Mahavir Medical College
TCFs	:	Trauma Care Facilities
UCs	:	Utilization Certificates
WHO	:	World Health Organisation

ACRONYMS
(NACO)

AIDS	:	Acquire Immuno deficiency Syndrome
ART	:	Anti-retroviral Therapy
CD4	:	Cluster of Differentiation 4
EFC	:	Expenditure Finance Committee
HIV	:	Human Immunodeficiency Virus
ICTC	:	Integrated Counselling and Testing Centre
MBB	:	Metro Blood Bank
MoU	:	Memorandum of Understanding
NACO	:	National AIDS Control Organisation
NACP	:	National AIDS Control Programme
NGOs	:	Non-Governmental Organisations
PPTCT	:	Prevention of Parent to Child Transmission
SACS	:	State AIDS Control Societies
UCs	:	Utilisation Certificates
WHO	:	World Health Organisation

REPORT

PART-A

National Health Mission (NHM)

I. INTRODUCTION

NATIONAL HEALTH MISSION (NHM)

1.1 The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The main programmatic components include Health system strengthening in rural and urban areas, Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A) and Communicable and Non-Communicable Diseases.

1.2 **Vision and Goal of NHM:** The main Goals of the NHM are "Attainment of Universal Access to Equitable, Affordable and Quality healthcare services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health; to safeguard the health of the poor, vulnerable and disadvantaged and move towards a right based approach to health through entitlements and service guarantees; strengthen public health systems as a basis for universal access and social protection against the rising costs of healthcare; build environment of trust between people and providers of health services; empower community to become active participants in the process of attainment of highest possible levels of health; institutionalize transparency and accountability in all processes and mechanisms; improve efficiency to optimize use of available resource".

NATIONAL RURAL HEALTH MISSION (NRHM)

1.3 National Rural Health Mission (NRHM) seeks to provide quality healthcare to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu & Kashmir and Himachal Pradesh have been given special focus. The thrust of the Mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

NATIONAL URBAN HEALTH MISSION (NUHM)

1.4 National Urban Health Mission (NUHM) seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary healthcare. NUHM covers all State capitals, district headquarters and other cities/ towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will continue to be covered under NRHM.

II. BUDGETARY ALLOCATION

2.1 On being asked whether the plan allocation for different components under NHM for 2016-17 is as

per the projected requirements and if not, the schemes/programmes which would be affected as a result of the shortfall and what measures have been proposed by the Department to offset the effect of shortfall of funds, the Department in its written reply informed that the plan allocation for different components under NHM for 2016-17 is not as per the projected requirements. Against the projected outlay of ₹ 31, 492.95 crore under NHM (Plan) only ₹ 19,000.00 crore has been allocated for the F.Y. 2016-17. The reduction in outlay will affect the following:

(i) Strengthening of District Hospitals including developing them as training sites,

(ii) Scale up of free drugs and free diagnostics initiatives,

(iii) Strengthening of sub Health Centers as 'first port of call' and expanding scope of assured primary healthcare,

(iv) Scaling up new vaccines.

(v) Establishing SHCs, PHCs and CHCs as per the norms,

(vi) Up-scaling of the existing initiatives e.g. strengthening of Health facilities to IPHS standards,

(vii) Implementation of new interventions related to Non Communicable Diseases,

(viii) Roll out and scale up of universal Health Coverage (UHC) pilots,

2.2 On being asked about the funds that are essential to ensure that the Schemes do not suffer due to shortfall in the amount projected and the amount actually allocated, the representatives of the Department during evidence on 22nd March, 2016 submitted that the minimum increase of ₹ 5000 crore would be required for launching free drugs, free diagnostics and free dialysis Initiatives.

2.3 The Department in a written submission has further informed that the following measures have been taken to offset the effect of shortfall of funds:

> After accepting the recommendations of 14th Finance Commission, the Centre-State funding pattern has been revised from 75:25 to 60:40 for all States except NE States and 3 Hill States where it continues to be 90:10. As a result, the State share for 2015-16 increased from ₹ 5,252.59 crore to ₹ 10,522.21 crore.
>
> Similarly, due to the revised Centre-State funding under NHM, the total outlay for Centre and State would be ₹ 29,522.00 crore for the F.Y. 2016-17 with central share of ₹19,000 crore. This enhanced outlay would certainly help in scaling up few more activities under NHM.
>
> Advocating with the States to increase their Health budget. Further, those States that increase their health budget beyond mandatory 10% receive incentive in form of additional fund allocation.
>
> The Fourteenth Finance Commission has more than doubled the grant for local bodies and recommended that nearly all of this money should be spent on improving basic services. The Commission has fixed the grant of ₹ 2.87 lakh crore which should go directly to the Gram Panchayats and Municipalities, without any share for other levels. Under NHM, the local bodies may also be incentivized for spending in the health sector, if proposed by the States in their Programme Implementation Plans (PIPs).

2.4 The Health Secretary during his deposition before the Committee on the 22nd March, 2016, submitted

that the total Plan budget for the Department of Health and Family Welfare for 2016-17 is ₹ 31,000 crore. He also submitted that "On the NHM side, we have got ₹ 19,000.00 crore and the balance is on the Health side. NACO this time has been merged with the Health." He further informed that the Budgetary provision for NHM for 2015-16 was ₹ 18295.00 crore and thus the increase in allocation for NHM for 2016-17 is a little modest.

2.5 The Secretary also submitted that the Centre-State funding pattern has been revised from 75:25 to 60:40 as a result of which the total amount which would become available to the National Health Mission will be in excess of ₹ 31,000.00 crores. Elaborating further, he submitted that "Had it been 75:25, then we would have got something like 24000.00 crore or 25000.00 crore. The decision to increase the funding pattern from 75:25 to 60:40 was taken in November, 2015 and by that time, the States were not in a position to give the extra amount "so, we have informed the Ministry of Finance that in 2015-16, we will be releasing the amount without insisting on the 40% because States have not provided that amount in their Budgets. So, accordingly, have released but the additional amount which the States were supposed to provide in 2015-16, they will be providing in 2016-17."

2.6 Apprising the Committee of the Twelfth Plan approved outlay *vis-a-vis* actual allocation for NHM, the Additional Secretary, Department of Health and Family Welfare in a Power Point Presentation furnished the following information:-

Table No.-1

NHM 12th Plan Outlay *Vs*. Actual Allocation

₹ in crore

12th Plan Outlay	Budgetary Estimates for 2016-17	Budgetary Allocation for 5 years (2012-13 to 2016-17)
1,93,405.71 (NHM)	19,000.00	90,022.82 (46.55% of 12th Plan Outlay)
2,68,551.00 (Depart of H&FW)	31,003.00	1,25,117.00 (46.59% of 12th Plan Outlay)

2.7 The Committee was furnished the following information with regard to the releases made during the 10th, 11th and 12th Plan years:-

Table No.-2

Plan-Wise Allocation & Release under NHM

(₹ in crore)

Sl. No.	Financial Year	B.E.	R.E	Central Release	% Release against R.E
1.	10th Plan	15,424.00	13,951.08	13,771.21	99%

1	2	3	4	5	6
2.	11th Plan	70,030.00	68,063.81	66,131.27	97%
3.	12th Plan	1,00,748.00	71,022.82	70,273.67	96%
4.	2012-13	20,542.00	17,000.00	16,762.77	99%
5.	2013-14	20,999.00	18,100.00	18,215.44	101%
6.	2014-15	21,912.00	17,627.82	18,037.99	102%
7.	2015-16*	18,295.00	18,295.00	17,257.47	94.33%
8.	2016-17	19,000.00	-	-	-
	Total (NHM)		1,53,037.71	150, 176.15	98.13%

*Release updated up to 18-03-2016 (FY 2015-16).

Central share in public spending on health increased from 20% to 32%.

2.8 On being asked whether there has been any increase in State Governments expenditure on health post the 10% increase in transfer of taxes to States from 32% to 42%, as per the Fourteenth Finance Commission's recommendation, the Additional Secretary during the evidence admitted that in the first year of its devolution (*i.e.* in 2015-16) this has not fructified. If it happens in 2016-17, "we would be extremely happy." In reply to another query on whether any State has gone beyond 32% increase in health expenditure, the Joint Secretary who was present during the evidence submitted that States like Assam, Andhra Pradesh, Goa, Maharashtra etc. have done this, but some States have just stayed where they were.

2.9 In reply to another query, the Additional Secretary submitted that "one basic pre-requisite that the NHM has given to the States is that they must increase by at least 10 per cent; otherwise, they will not be eligible to get funding. So, the 10 per cent increase is there. Beyond that, one of the possible ways we are thinking about is that whether we need to further incentivise this kind of a Budget spread in the States."

2.10 Throwing more light on the States spending on Health in 2016-17, the Joint Secretary explained that "Now, that 60:40 decision has been taken, States perforce will be required to raise at least their NHM contribution, from one-third of the Central Government to two-third of the Central Government contribution. So, in that sense, it will have to increase and the next year (*i.e.* 2016-17) releases will not happen to the States unless they have contributed their corresponding State share. So, we will receive State contribution, which will get reflected in a higher budgetary provision for Health, because of this increase in the sharing pattern."

2.11 *On the advanced States making huge investments in health and the laggard States in this regard, the Department in its written reply has informed that as* per the data of F.Y.2013-14, the States that have invested more under the health are Sikkim, Mizoram, Goa, Meghalaya, Himachal Pradesh, Jammu & Kashmir, Kerala etc. These are the States whose public health expenditure per capita is more and the States whose public health expenditure under health is less are Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh**.** The following is the State-wise per capita public health expenditure (PHE);

Table No. 3

Sl.No.	State	PHE (₹ '000)	Population	Per capita PHE
1.	Bihar	26554463	108704374	244
2.	Jharkhand	11492248	34110070	337
3.	Uttar Pradesh	94882241	208706982	455
4.	Odisha	20143774	43222904	466
5.	Madhya Pradesh	34907987	74364445	469
6.	West Bengal	49201561	93472752	526
7.	Assam	17109325	32171441	532
8.	Chhattisgarh	15815142	26548268	596
9.	Maharashtra	74097210	117028284	633
10.	Rajasthan	47956209	71735731	669
11.	Haryana	18948686	26233233	722
12.	Karnataka	46561807	63680117	731
13.	Andhra Pradesh	63727949	86950513	733
14.	Punjab	20984847	28430598	738
15.	Gujarat	51382290	61612488	834
16.	Tamil Nadu	62017984	73962729	839
17.	Uttarakhand	10735329	10415782	1031
18.	Kerala	36380638	34420567	1057
19.	Jammu & Kashmir	13647101	12846237	1062
20.	Tripura	4091047	3752188	1090
21.	Manipur	4121708	2797008	1474
22.	Nagaland	3021764	2046665	1476
23.	Meghalaya	4520667	3042110	1486
24.	Himachal Pradesh	11747197	7124492	1649
25.	Daman & Diu	419885	251629	1669
26.	Dadra & Nagar Haveli	631503	359846	1755
27.	NCT of Delhi	30673563	17277151	1775
28.	Chandigarh	2530652	1081774	2339

1	2	3	4	5
29.	Arunachal Pradesh	3568173	1427786	2499
30.	Puducherry	3611382	1270897	2842
31.	Goa	4631213	1505313	3077
32.	Mizoram	3479035	1127901	3085
33.	Sikkim	2559763	625906	4090
34.	A & N Islands	2018049	391526	5154
35.	Lakshadweep	441341	66218	6665

Source:

1. PHE figures are from "Health Sector financing by Centre and States/UTs in India (2013-14 to 2015-16).
2. State-wise Population figures 2013-14 projected from 2011 census.

2.12 On being asked about the effect of the less budgetary allocation for the Health Sector, the Additional Secretary during his deposition submitted that "There are certain challenges in the health sector which we continue to face. Inadequate financial resources, high out-of-pocket expenditure, even though we have come down from 70 to 58 per cent, it is still very high. Human Resource we will axe. Comprehensive primary care we do not have. These are the challenges which need to be addressed for which we need resources."

2.13 During the Power-Point Presentation, the Additional Secretary also highlighted the following issues:-

Table No.-4

Overview:

Key Indicator	Current Status (2011-12)
Out of Pocket Expenditure	58 % of total health expenditure
Public Health Spending	1.2 % of GDP
Infrastructure	Existing (Shortfall in %)
CHCs	5396 (32%)
PHCs	25308 (22%)
SCs	153655 (20%)

Table No.-5

Low Priority to Public Spending on Health

	Total Expenditure on Health as % of GDP *	Per capita total expenditure on Health, (USD) #	Government expenditure on Health as % of Total Expenditure on Health*	Government expenditure on Health as % of Total Government Expenditure*	Out of Pocket Expenditure as a % of Total Health Expenditure**
India	3.8	61	30.5	4.3	58

1	2	3	4	5	6
Thailand	4.5	264	79.5	16.9	11
China	5.4	367	56	12.5	34
UK	9.3	3598	84	16.2	9
USA	17	9146	47	20	12

* World Health Statistics 2015

** WHO Global Health Repository accessed Jan. 2016

World Bank healthcare expenditure for 2013

2.14 On being asked whether the hindrances coming in the way of speedy transfer of funds to the State Health Societies have been removed, the Department in a written reply has submitted that in the case of NHM, very few States like Madhya Pradesh, Odisha, Tamil Nadu have been able to effectively implement the new mode of transfer of funds from State Treasury to State Health Society. However, there are many States which have not yet received funds even after the lapse of more than three months. The reasons for delay have not been provided by the States, but it may be due to State Finance Departments using these funds to improve their ways and means position.

2.15 The Department has also informed that despite F.Y. 2015-16 being the second year of transfer through Treasury, there are hindrances being faced in the way of speedy transfer of Central funds to the State Health Societies. Uncertainty and lack of timely availability of funds are affecting smooth implementation and timely payments of salaries, beneficiary payments, ASHA incentives, procurement of drugs and supplies etc. Further, lot of time and effort of senior health officials is being wasted in chasing the releases from the State Finance Department leaving less time for monitoring and supervision of NHM by them. The Department is continuously reviewing the fund transfer position and following up with States for early transfer.

2.16 During the financial years 2014-15 and 2015-16 letters were written from Hon'ble Health and Family Welfare Minister to State Chief Ministers, from Union Secretary (H&FW) to State Chief Secretaries and from AS &MD to State Chief Secretaries to ensure timely transfer of funds from State Treasury to State Health Societies account under NHM. The matter is also going to be taken under e- Samiksha.

2.17 Highlighting the delay in transfer of Central funds to the State Health Societies, the Additional Secretary, Department of Health and Family Welfare during evidence made the following submissions:-

> Out of Total Funds released till now under RCH and Health Systems Strengthening *i.e.* ₹ 8,242.78 crore, ₹ 7,460.04 crore were transferred from State Treasury to State Health Society with a delay from 0 to 142 days.
>
> ₹ 782.74 crore (9.5%) is still lying with State Treasury for a period between 90 to 180 days.

2.18 On what are the problem areas identified in implementation of various programmes/components of NRHM and NUHM during 2015-16, the Department in their written reply have informed that the problem areas identified in implementation of various programmes / components of NRHM during 2015-16 are as follows:

> Transfer of Central grants through treasury route has been implemented from the F.Y. 2014-15. It is noted that there have been considerable delays in transferring of funds from State Treasury to State Health Society,

- Public Health being a State subject, implementation of approved plan under NHM depends upon implementation capacities of the State / UT Governments. Implementation capacity of many States is slow particularly in respect of civil construction, procurement of drugs and equipment, engagement and management of human resources, paucity of health human resource such as doctors and specialists etc.
- Poor co-ordination between Urban Local Bodies (ULBs) and State Health Department.

2.19 On what is the quantum of Government expenditure on health as a proportion of GDP, the Department in its written reply informed that the quantum of Government expenditure on health as a proportion of GDP is 1.2%.

2.20 The Committee has also been informed that the Centre-States ratio in total Government health allocations is 28:72. On being asked as to how much Centre's and States health allocations need to grow in order to achieve the goal of raising Government expenditure on health to 2.5% of GDP, the Department has informed that given that Public Health expenditure is approximately ₹152567.00 crore in 2015-16 and GDP is projected at ₹15065010.00 crore, public health expenditure would need to increase by 147% in 2016-17 over 2015-16, for public health spending to touch 2.5% of GDP *i.e.* ₹376625.00 crore.

The Committee's attentions has also been drawn to the following information given in the draft National Health Policy 2015.

Table No.-6

Country	Total Health Exp. per capita (USD) - 2011	Total Health Exp. as % of GDP - 2011	Govt. Health Exp. as % of Total Health Exp. - 2011	Life Expectancy at birth (years) 2012
India	$62	3.9%	30.5%	66
Thailand	$214	4.1%	77.7%	75
Sri Lanka	$ 93	3.3%	42.1%	75
BRIC Countries				
Brazil	$ 1119	8.9%	45.7%	74
China	$ 274	5.1%	55.9%	75
Russia	$803	6.1%	59.8%	69
South Africa	$670	8.7%	47.7%	59
OECD Countries				
USA	$ 8,467	17.7%	47.8%	79
United Kingdom	$ 3,659	9.4%	82.8%	81
Germany	$ 4,996	11.3%	76.5%	81
France	$ 4,968	11.6%	76.8%	82
Norway	$ 9,908	9.9%	85.1%	82
Sweden	$ 5,419	9.5%	81.6%	82
Denmark	$ 6,521	10.9%	85.3%	80
Japan	$ 4,656	10%	82.1%	84

Quantum of savings on Capital Account and Revenue Account

2.21 With regard to the quantum of savings on Capital Account and Revenue Account separately during 2014-15 and 2015-16, the Department in its written reply informed that there are no savings. During the F.Y. 2014-15, not only the entire amount of budgetary outlay has been utilised, rather the savings under Health side was also utilised under NHM. Against the R.E. of ₹17627.82 crore, the Central expenditure was ₹ 18,037.99 crore.

2.22 **The Committee's scrutiny of the total Twelfth Plan approved outlays for the National Health Mission and the whole Department of Health and Family Welfare (Table No.1) is very revealing. The Committee notes that the Planning Commission had approved a total outlay of ₹ 1,93,405.71 crore for the NHM and ₹ 2,68,551.00 crore for the whole Department for the Twelfth Five Year Plan. However, the total budget allocation made by the Union Government in the five years (2012-13 to 2016-17) is ₹ 90,000.82 crore for the NHM and ₹ 1,25,117.00 crore for the Department of Health and Family Welfare, which work out to measly 46.50% of the funding originally envisaged for the NHM as well as the Department under the Twelfth Plan. Table No.2 which compares releases made with Revised Estimates, shows that the overall NHM releases made are as high as 98.13%, implying that the allocated amounts are being utilized effectively. The Committee observes that the avowed vision of the National Health Mission is the attainment of universal access to equitable, affordable and quality healthcare services accountable and responsive to people's needs with effective inter-sectoral convergent action to address the wider social determinants of health and the Mission has huge potential to transform healthcare delivery in the country. If the Government had allocated the entire Twelfth Plan approved outlays, the country would have seen much improved primary healthcare services, fulfillment of the free medicines and diagnostic policy, reduced out-of-pocket expenditure and probably 1.5 per cent of GDP as public health expenditure reached by 2015.**

2.23 **All these facts lead the Committee to believe that the priority for the National Health Mission and the Health Sector as a whole has been a soft target whenever the Government faces a resource crunch. The Committee would like to impress upon the Government that if it wants to enhance access to quality healthcare for the people, it will have to alter the health financing landscape of NHM by allocating adequate financial resources, because if funding for the Mission is inadequate, its implementation would automatically be hampered. The Committee, therefore, recommends that given the need to augment rural health infrastructure and fill in vacancies of various categories of health professionals, this trend of the yawning gap between the approved outlays and sanctioned budget should be reversed and a much higher magnitude of the Union Budget allocation for NHM than what is prevailing should be made so that Central Health spending could be ramped up to boost Indian public health standards. Only then will the NHM be able to guarantee universal access to equitable, affordable and quality healthcare.**

2.24 **The Committee notes that the as against the projected demands of ₹ 31,492.95 crore for the National Health Mission for 2016-17, the allocation made in BE 2016-17 is only ₹ 19000.00 crore, leaving a shortfall of more than ₹12000.00 crore. In comparison to the RE 2015-16 allocation of ₹ 18295.00 crore, the increase in the BE 2016-17 is of ₹ 705.00 crore only, which is grossly inadequate and will be eaten up by inflation. Taking note of the submissions of the representatives of the Department of Health and Family Welfare that in order to undertake new initiatives like free drugs, free diagnostics and free dialysis initiatives, the minimum required increase in allocation**

for 2016-17 would be ₹ 5000.00 crore, the Committee lends its Parliamentary support to the allocation of additional ₹ 5000 crore, if not the full projected amount, for NHM which may be raised at RE stage. The Committee is of the view that with the projection of a promising economic growth which is pegged at 7.5%, the Union Government should have the fiscal space to provide this amount of ₹ 5000.00 crore in 2016-17. The Committee would like the Department to bring this recommendation to the notice of Ministry of Finance and also apprise the Committee of their response thereto.

2.25 **The Committee observes that in its 82nd Report on the Demands for Grants it had apprehended that the 10% increase in devolution of Central tax share to States (*i.e.* from 32% to 42%) post the new devolution formula in the form of untied funds would not compensate for the shortfall in Central Funds for health for 2015-16 in view of the fact that most of the States had already presented their budgets for 2015-16 but not made additional budgetary provisions for meeting the shortfall in Central Plan allocation on Health. The Department's submission that "the decision to increase share of tax pool to States did not lead to increase in health budgets (in 2015-16)....." has validated the Committee's apprehension. The Committee is therefore, concerned that the suddenness with which the changed devolution mechanism has been thrust upon States must have jeopardized the targeted health outcomes in 2015-16. The Committee takes note of the Department's submission that the revised Centre-State funding pattern from 75:25 to 60:40 will ensure increased availability of resources for NHM and that from the Financial Year 2016-17, the Central funds will be released only on clearance of State share as per the new funding pattern. The Committee observes that though the Government has tried to address the reduction in Central Plan allocation for NHM through conditionality, *i.e.* requiring States to raise their own share in Health Care spending by 15 per cent (*i.e.* from 25 to 40 Per cent), there is no mechanism in place to ensure that the additional State health financing indeed gets allocated and spent. The Committee, therefore, recommends that an assessment be made urgently and communicated to the Committee as to what extent the 10% rise in State's revenue is reflected in the allocation of additional resources for health by them during current year.**

2.26 **The Committee would also like to be apprised about the impact of the State Health Budgets, especially on the following 'essential sectors' during 2015-16:-**

(a) Strengthening of Health facilities to IPHS standards,

(b) Establishing new SHCs, PHCs and CHCs as per the norms,

(c) Up-scaling of existing initiatives like Rashtriya Kishore Swasthya Karyakram (RKSK) and Rashtriya Bal Swasthya Karyakram (RBSK),

(d) Implementation of new interventions such as:

(i) Expansion of coverage of Non Communicable Diseases programmes, the screening for which requires intensive resources at district hospitals,

(ii) Strengthening of District Hospitals, especially in High Priority Districts (HPDs),

(iii) Universal Health Coverage (UHC) Pilots,

(iv) Implementation of free drugs and free diagnostics scheme,

(v) Expanding the scope of primary health care to make it comprehensive and develop Sub-Centres as first port of call,

(vi) Increasing availability for Sub-Centres in tribal and hilly areas based on 'time to care' concept.

2.27 **The Committee notes from Table Nos. 4 and 5 that "total health spending in India is at 3.8% of GDP. The Total public expenditure on health (combined spending on health by the Centre and all States) in the country stands at 1.2 per cent of GDP which is 4.3% of total Government expenditure and 30.5% of total health expenditure. Even among the BRICS countries (Brazil, Russia, India, China and South Africa), India spends the least on health. (Table No. 6). The Economic Survey (2015-16) states that according to the Universal Health Coverage (UHC) Index developed by the World Bank to measure the progress made in health sector in select countries of the World, India ranks 143 among 190 countries in terms of per capita expenditure on health ($ 146 PPP in 2011) and 157th position according to per capita spending on health which is just about $44 PPP.**

2.28 **The Committee also notes that the Centre-States ratio in total Government health allocations is 28:72. The Twelfth Five Year Plan Documents had proposed to raise India's overall public spending on health to 2.5% of the GDP by the end of the Twelfth Plan period. With just one year left in the Twelfth Five Year Plan period, there is no possibility of raising public health spending to 2.5 of GDP by 2017 as this would entail increase in the public health allocations at 147% over 2015-16 levels, which is of implausibly high magnitude. According to the Government's draft National Health Policy 2015, global evidence on health spending shows that unless a country spends at least 5-6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Committee is aware that in our federal fiscal structure realising the goal of spending 2.5% of GDP on healthcare would also require States to increase their spending on health and the increase in tax devolution to States from 32% to 42% post the Fourteenth Finance Commission recommendations offers an excellent opportunity for State Governments to step up their spending on health. In its 82nd Report, the Committee had observed that the past experience shows that if the spending is left to State Governments, contractor intensive sectors take priority over non-contractor intensive sectors and Health, not being a contractor intensive sector, would take a backseat in such circumstances. The increase in education expenditure that took place from the mid 80s, in many ways, had forced the State Governments to make an increase in their expenditure commensurately. One of the objectives of the National Health Mission is to spur States to spend more on health. The Committee is, therefore, of the firm opinion that given the dominance of the Centre in the domain collection of tax revenue, increasing public health expenditure to 2.5% of GDP will have to be Centre-led. Despite the policy pronouncement of raising public health expenditure to 2.5% of GDP, as articulated in the Tenth, Eleventh and Twelfth Five Year Plans, the Government spending on health continues to be abysmally low at 1.2% which is insufficient to meet the NHM goals. As per an article titled "Assuring health coverage for all in India" published in the Lancet on the 12th December, 2015, although the Twelfth Five Year Plan had called for a Paradigm shift and recommended the Central Plan expenditure on health to increase by about 34% every year, the Central Government share in public health expenditure has remained less than 30% since 2010 and has reduced progressively, even if marginally. The draft National Health Policy, 2015 recognises the fact that if the target of raising public expenditures on health to 2.5% of the GDP is**

to be achieved, 40% of this would need to come from Central expenditures. The Committee observes that it is a documented fact that low Government expenditure on health leads to high out-of-pocket payments by individual households on healthcare which not only forms a barrier to accessing care, but also leads to households incurring catastrophic expenditure due to health costs which in turn push them into indebtedness and poverty. As per the draft National Health Policy 2015, over 63 million people are pushed below the poverty threshold every year due to healthcare costs alone. As per the NSSO Survey-71st Round (January- June, 2014), the Out-of-Pocket expenditure accounts for 58% of total health expenditure which is one of the highest, even among low income countries. The Committee observes that despite rapid economic growth over the past two decades, successive Union Governments have not made the requisite level of financial investments in health and the growth in the Union health budgets on health have been lower than needed to achieve the 2.5% goal. The Committee observes that acceleration in economic growth by itself will not translate into higher public spending on health. The Government will also have to demonstrate its commitment to ensuring that adequate financial resources for provisioning essential healthcare to all indeed gets allocated and spent. The Committee therefore, recommends that the Central Government should chalk out a solid fiscal roadmap for generating and allocating more financial resources for Health so that the goal of raising Government expenditure on Health to 2.5% of GDP is realised and the vision of moving towards universalization of affordable healthcare is translated into reality. The Committee desires to be furnished with a detailed status note delineating the plan of action for meeting the commitment of earmarking 2.5% of GDP for the Health Sector.

2.29 **The Committee takes note of the written submission of the Department that the transfer of Central grants to State Health Society through treasury route which has been implemented from the financial year 2014-15 has witnessed considerable delays. The Committee also takes note of the submissions made by the Additional Secretary during the evidence on 22nd March 2016 that "out of the total funds of ₹ 8242.78 crore released till now under RCH and Health systems strengthening, ₹ 7460.04 crore were transferred from State Treasury to State Health Society with a delay from 0 to 142 days and ₹ 782.74 crore (9.5%) is still lying with State Treasury for a period between 90 to 180 days." The Committee is extremely concerned to learn that the current fund flow architecture *i.e.* Treasury Route through which funds are flowing to State Health Society is resulting in unnecessary delays in fund transfers and is therefore certain to pose bottlenecks in the smooth implementation of NHM. The Committee observes that timeliness of transfer of funds is extremely important as delayed transfers hamper fund utilization. The Committee, therefore, recommends that the existing fund release mechanism for NHM needs to be reviewed. The Treasury route of transfer of funds should not be allowed to be a constraining factor in speedy transfer of funds and if the delay in funds flow through Treasury mode continues to persist for another three months and the Treasury system fails to address this persisting delay, the Society route of funds should replace the Treasury system of transfer of funds. The Committee desires to be kept updated on the decision taken in the matter.**

2.30 **The Committee while appreciating the States whose public health expenditure is more would like the Department to focus its resources more in the States whose public health expenditure on health is less like Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh, since these States constitute a big chunk both geographically and population-wise and it would require special support and care to ensure that they are able to reach at the average of the States having more public health expenditure per capita.**

2.31 **The Committee is distressed on the reasons spelt out by the Department regarding the problem areas identified in implementation of various components of NHM, such as (i) Public Health being a State subject, implementation of approved plan under NHM depends upon implementation capacities of the State / UT Governments and implementation capacity of many States is slow particularly in respect of civil construction, procurement of drugs and equipment, engagement and management of human resources, paucity of health human resource such as doctors and specialists, etc, and (ii) Poor co-ordination between Urban Local Bodies (ULBs) and State Health Department. The Committee is of the view that the reasons listed out by the Department in its reply point to the fact that there is a wide chasm between the targets set and the actual implementation of the targets in practice. The Committee recommends that the Department take measures to overcome the shortcomings/delays in implementation capacity of States by way of short, medium and long term plans.**

Tribal Sub Plan (TSP)

2.32 During the examination of Demands for Grants (2015-16), the Committee had taken up the issue of the impact of budgetary cuts in the Central Plan allocation on health on the Tribal Sub Plan (TSP). In reply to a question in this regard, the Department in its written submission had furnished the following information:-

> "The allocation under the tribal sub plan will get proportionately reduced due to the cut in the overall allocation under NHM. Under NHM, against stipulated minimum allocation of 8.2% of the total budget / outlay, about 10% has been allocated for Tribal Sub Plan. In addition to above, all tribal districts whose composite health index is below the States' average are classified as High Priority Districts and these are supposed to get 1.3 times higher allocation per capita in comparison to non-High Priority Districts of the State. However, the overall reduction in NHM budget will consequently result in proportionate reduction of tribal sub plan and adversely impact the proposed interventions in tribal areas."

2.33 The Committee in its 82nd Report had recommended to the Department to work out a formula to ensure that "the Tribal Sub Plan is protected from budgetary cuts."

2.34 Responding to the Committee's recommendation, the Department in its Action Taken Note on the 82nd Report had submitted that "to minimise the effect of budgetary cuts on tribal sub plan, it is informed that against the desired contribution of 8.2% of the total outlay for scheduled Tribal Sub Plan (TSP) in the financial year 2015-16, ₹ 2013.02 crore of the total outlay of ₹ 18295.00 crore has been earmarked for TSP *i.e.* 11%.

2.35 **The Committee takes note of the fact that the share of TSP component in the total outlay for NHM for 2015-16 was hiked from 8.2% to 11% and welcomes this hike. The Committee however, desires to be informed as to what has been the experience with addressing health equity concerns in tribal areas.**

2.36 **The Committee observes that Tribal blocks are severely under-served in terms of health infrastructure and workforce, since skilled health workers are often unwilling to move into tribal areas, and quality of services continues to be a concern. The ill-equipped public health system and weak referral linkage often compels poor families to seek care at the private sector. The unregulated private sector tends to be extremely exploitative (in terms of irrational procedures, coercion as well as high out of pocket expenses). Keeping in view the fact that the tribal areas in the country have**

the worst health indicators and are plagued with the stark inequities in access to healthcare, the Committee recommends that mapping of health facilities in tribal areas be carried out to identify the closest facility which is easily accessible based on geographical conditions (specifically in hard-to-reach areas). These facilities like health sub-centers, PHCs, or satellite centers, should be made functional on a priority basis with necessary backup of referral transport facilities and essential medicines.

2.37 **The Committee also recommends that specialists must be recruited and designated FRUs must be urgently operationalized in underserved areas. Since specialists are required for managing emergency care, graduates of Government medical colleges must be provided incentives to work in underserved areas, using a hub-and-spoke model. Training of doctors on CEmOC and LSAS and posting them in tribal areas will ensure continuum of care and prevention of leakage into the private health sector.**

Utilization Certificates(UCs)

2.38 On being asked about the number of pending UCs, year-wise and State-wise and the amount involved therein, for the last 10 years, the Department in its written reply furnished the following information regarding pending UCs since inception of NHM till F.Y. 2014-15 under the two major pools of NHM *i.e.* RCH Flexible Pool and Mission Flexible Pool:

Table No.-7

List of Pendency of Utilization Certificates under RCH Flexible Pool from F.Y. 2005-16 to F.Y. 2014-15

(₹ in crore)

Sl. No.	State / UTs	up to 2014-15	
		No. of Ucs	Amount
	Grand Total	220	3223.72

List of Pendency of Utilization Certificates under Mission Flexible Pool upto the F. Y. 2014-15

(₹ in crore)

Sl. No.	State / UTs	up to 2014-15	
		No. of Ucs	Amount
	Grand Total	307	4302.61

2.39 With regard to the details of the number of utilization certificates pending and the amount involved therein under the various schemes/programmes funded under National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) till date, the Department in their written reply has furnished the following information:

Table No.-8

As on 03/03/2016

Sl.No.	Schemes	No. of Ucs	Amount (₹)
	NRHM-RCH Flexible Pool (2005-2010)	0	0

Sl.No.	Schemes	No. of Ucs	Amount (₹)
	NRHM-RCH Flexible Pool (2010-2015)	58	10.20
	Total	58	102. 09
	RCH Flexible Pool (2005-2010)	2	.21
	RCH Flexible Pool (2010-2015)	86	177.41
	Total	88	17,76,37,80,981

Table No.-9

as on 03/03/2016

Sl.No.	Schemes	No. of Ucs	Amount (₹)
	NRHM-RCH Flexible Pool (2005-2010)	0	0
	NRHM-RCH Flexible Pool (2010-2015)	58	102.09
	Total	58	1020.90
	RCH Flexible Pool (2005-2010)	2	.21
	RCH Flexible Pool (2010-2015)	86	177.41
	Total	88	177.63
	Grand Total	146	279.72

Status of pending UCs under NUHM

(₹ in crore)

Sl. No	2013-14				2014-15				
	Release	Exp	Amount of UC Received	Amount of UC pending	Release	Exp	Amount of UC Received	Amount of UC pending	Total Amount of UC pending
Total	662.23	10.13	10.13	652.10	1345.82	436.31	395.43	954.22	1606.3

2.40 **The Committee observes that 220 Utilization Certificates amounting to ₹ 3223.72 crore and 307 Utilisation Certificates amounting to ₹ 4302.61 crore are pending under the RCH Flexible Pool and Mission Flexible Pool respectively. Similarly, the amount involved in pending UCs pertaining to the National Urban Health Mission is ₹ 1606.32 crore. Time lag in furnishing Utilization Certificates delays transfer of Central Funds which in turn adversely affects capital expenditure to be incurred by States. The Committee notes that the amount involved in pending UCs under RCH Flexible Pool, Mission Flexible Pool and NUHM is quite substantial, and the oldest pending UCs is of the year 2005, which suggests that the problem is endemic. The Committee expresses its displeasure that in spite of the Committee's repeated recommendation to liquidate**

the Pending UCs within a set time-frame, there is lethargy in liquidating the pending UCs. Such a state of affairs goes against the canons of fiscal propriety because on the one hand the Department seeks funds and on the other, it is unable to get the States to provide the Utilisation Certificates (UCs). The Committee fails to comprehend the delay in furnishing UCs when in a digital era, furnishing of UCs can be done at the click of a mouse. The Committee strongly recommends that the Department should put in place a system for smooth and timely furnishing of UCs and also ensure that all pending UCs are liquidated within a period of six months from the date of presentation of this Report.

(III). **NRHM-RCH FLEXIBLE POOL**

A. **RCH Flexible Pool**

3.1 On being asked on whether the basic demographic goals set in the National Population Policy have been met and if not, the extent of shortfall *vis-a-vis* goals set for IMR, MMR and TFR, the Department has submitted that India has demonstrated a remarkable progress in some of the crucial health indicators in maternal and child healthcare. The Department has also furnished the following information:-

MMR

3.2 India has registered an impressive decline in Maternal Mortality Ratio (MMR) of 71% from 560 per 100,000 live births, to 167, as compared to the global decline of 45% during 1990-2013. In terms of numbers, this translates into approximately 44,200 maternal deaths as against 2,89,000 on a global scale

U5 Mortality Rate and IMR

3.3 India's under-five mortality rate that stood at 126 against the global average of 90 in 1990, dropped to 49 per 1000 live births, while the global average stood at 46 per 1000 live births in 2013. It reflects that India has registered a sharper and better decline in under-five mortality rate than the global averages. Moreover, the annual rate of decline during 2008-13 has been 6.6% compared to 3.3% compound annual decline observed over 1990-2007.

3.4 The U5MR has declined at a faster pace in the period 2008-2013, registering a compound annual decline of 6.6% per year, compared to 3.3% compound annual decline observed over 1990-2007

3.5 India's IMR has declined from 58 per 1000 live births in 2005 to 40 per 1000 live births in 2013;

3.6 The Newborn Mortality Rate (NMR) in India is 28/1000 live births, which translates into approximately 7.3 lakh deaths annually. After a period of stagnation, from 2003-2007, the decline in Neo Natal Mortality gained pace with a 17% decline recorded in last five years from 2008-2012. More importantly, 6% fall occurred in each of the last two consecutive years(highest so far. Also, during 2008-13, the rate of decline in the Neo Natal Mortality Rates (NMR) was 20% (from 35 to 28), against the global figure of 16.5%.

TFR

3.7 As far as TFR is concerned, it has declined from 3.8 in 1990, to 2.3 in 2013. The rate of decline has accelerated from 1.6% during 1997-2005 to 2.9% during 2005-2013. 24 States, *i.e.* Goa, Manipur, Tamil Nadu,

Tripura, Kerala, Andhra Pradesh, Telangana, Uttaranchal, Himachal Pradesh, Odisha, West Bengal, Punjab, Delhi, Maharashtra, Karnataka, Mizoram, Nagaland, Jammu and Kashmir, Sikkim, and 5 UTs, *i.e.* Andaman and Nicobar Islands, Puducherry, Chandigarh, Daman and Diu and Lakshadweep have already achieved replacement level fertility (2.1 or less).

3.8 On the progress made with regard to Millennium Development Goal (MDG) – Department has *inter alia* furnished the following information **:**

11 States have achieved MDG4 (U5MR <42 per 1000 live births)	Andhra Pradesh, Delhi, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana and West Bengal
7 States have higher U5MR than national average (49)	Assam (75), Madhya Pradesh (69), Odisha (66), Uttar Pradesh (64), Rajasthan (57), Bihar (54) and Chhattisgarh (53)

As per the "The Millennium Development Goals Report, 2015" published by the United Nations, despite the impressive improvements in most regions, current trends are not sufficient to meet the MDG target globally. At today's rate of progress, it will take about 10 more years to reach the global target. The report further States that, the annual rate of reduction in under-five mortality has accelerated since 1995 in countries of all income levels except in high-income countries.

The progress on MDG-4 in some countries of the world as per the "Levels and Trends in Child Mortality Report, 2015" published by United Nations is as stated in the table below:

Table No. 10

Country	U5MR in 1990	U5MR in 2015	MDG-4 target
Bangladesh	144	38	48
Brazil	61	16	20
India*	126	48	42
Nepal	141	36	47
Nigeria	213	109	71
Pakistan	139	81	46
South Africa	60	41	20
South Sudan	253	93	84
Sri Lanka	21	10	7
Thailand	37	12	12

* The U5MR of India as per the latest SRS Report 2013 is 49/1000 live births.

Status Note on Millennium Development Goal -5

Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 556 women dying

during child birth per hundred thousand live births. Approximately 1.38 lakh women were dying every year on account of complications related to pregnancy and child birth.

Millennium Development Goal (MDG) 5 pertains to Maternal Health where target is to reduce the Maternal Mortality Ratio (MMR) by three quarters between 1990 & 2015. Based on the UN Inter–Agency Expert Group's MMR estimates in the publication "Trends in Maternal Mortality: 1990 to 2015", the target for MMR is estimated to be 139 per 1,00,000 live births by the year 2015 taking a baseline of 556 per 100,000 live births in 1990.

Globally, the World's MMR fell by nearly 44% over the past 25 years, to an estimated 216 maternal deaths per 100,000 live births in 2015, from an MMR of 385 in 1990 at an average annual decline of 2.3%.

As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), MMR of India has shown a decline from 178 per 100,000 live births in the period 2010- 12 to 167 per 100,000 live births in the period 2011-13. The annual rate of decline of MMR during the period 2010-12 and 2011-13 is 6.2% registering a decline of 71% since 1990. Assuming, the same pace of decline continues, India's MMR is likely to reach the MDG -5 target of 139.

The progress on MDG-5 in some countries of the world as per the report on Trends in Maternal Mortality Report 1990-2015" as per the UN estimates is as per the table below:

Table No. 11

Country	MDG-5		
	MMR in 1990	MMR in 2015	MDG-5 Target
Bangladesh	569	176	142
Brazil	104	44	26
India*	556	167*	139
Nepal	901	258	225
Nigeria	1350	814	338
Pakistan	431	178	108
South Africa	108	138	27
South Sudan	1730	789	433
Sri Lanka	75	30	19
Thailand	40	20	10

* India MMR is 167 per 100,000 live births as per Registrar General of India- Sample Registration System, RG-SRS (2011-13)

3.9 The representative of the Department during his evidence before the Committee on 22rd March, 2016 informed the Committee that as per the figures available upto 2013, India may reach the Millennium

Development Goals (MDGs) target of 140/lakh live births with regard to Maternal Mortality Rate(MMR).With respect to Under 5 Mortality Rate, India may not achieve the same. He admitted that Bangladesh has a better success rate which was due to better community participation. He further submitted that the community participation method adopted by Bangladesh is worth emulating under the National Health Mission. He further submitted that the Department is confident of achieving Total Fertility Rate (TFR) target of 2.1 by the year 2020. He further submitted that MDG, 2015 had been lapsed last year and new targets have been set under Sustainable Development Goals (SDGs) by United Nations for comity of nations.

3.10 **The Committee observes that despite some important improvements in MMR and IMR, India is behind Brazil, Bangladesh, Nepal, Sri Lanka and Thailand on U5MR and Brazil, Sri Lanka and Thailand on MMR. The Committee would, therefore, like the Department to identify and address the fundamental weaknesses in RCH programme and take credible action towards reducing IMR and MMR to the targeted levels.**

3.11 Responding to a query, the Health Secretary during the evidence submitted that India's population would stabilize by 2045.

3.12 The Additional Secretary who was also present during the evidence submitted that 24 States have already achieved a replacement TFR of 2.1 but the problem is in eight States which have high rate of population growth.

3.13 **The Committee observes that the Health Secretary's submission that population stabilization will happen by 2045 is highly optimistic because experience shows that it takes two generations for the population to stabilize after TFR of 2.1 is reached. The Committee, would, therefore, like to be informed of the strategies adopted to achieve population stabilization by 2045. The Committee also recommends that the Department should adopt innovative strategies including giving financial incentives towards controlling population growth in these States which have high TFR.**

B. **Universal Immunisation Programme (UIP)**

3.14 Immunization Programme is one of the key interventions for protection of children from life threatening condition, which are preventable. Expanded programme for Immunization (EPI) was introduced in 1978 through a World Assembly Resolution. The Universal Immunization Programme (UIP) was launched by the Government of India during 1985. It became the part of Child Survival and Safe Motherhood Programme (CSSM) in 1992 and currently one of the key areas under National Health Mission since 2005.

3.15 Under the Universal Immunization Programme, Government of India is providing vaccination to protect against nine vaccine preventable diseases *i.e.* Tuberculosis; Diphtheria; Pertussis; Tetanus, Polio; Measles; Hepatitis B across the country and Japanese Encephalitis in selected districts and Meningitis/ Pneumonia due to Haemophilus Influenza type B in selected States. Haemophilus Influenza type B (Hib) containing Pentavalent vaccine is introduced in 8 States *viz*. Kerala, Tamil Nadu, Goa, Gujarat, Haryana, Jammu & Kashmir, Karnataka and Puducherry and 12 more States are planned for expansion in 2014-15 and have been expended in all the remaining States in the country except Andhra Pradesh, Maharashtra, Uttar Pradesh, Mizoram, Manipur, Nagaland, Tripura and Lakshadweep which are also being covered during the current year.

3.16 National Technical Advisory Group on Immunization (NTAGI) has recommended introduction of four new vaccines in routine immunization *i.e.* Rubella vaccine, Inactivated Polio Vaccine (IPV), Rota vaccine and Adult JE vaccine which is also being implemented in the country in phased manner.

3.17 **The Committee notes that the National Technical Advisory Group on Immunization (NTAGI) has recommended introduction of new vaccines, namely Rubella vaccine Inactivated Polio Vaccine (IPV), Rotavirus vaccine and Adult JE vaccine which is being implemented in a phased manner. The Committee desires to be apprised of the States where these four vaccines have been introduced and whether any evaluatory studies have been conducted on their efficacy.**

Mission Indradhanush

3.18 The Mission aims to reach out to the children who have been left out or missed out during the routine immunization rounds. The Mission aims to achieve full immunization of at least 90% children by 2020. The first was launched in 210 high focus districts. More than 75 lakh children were vaccinated of which 20 lakh children were fully vaccinated and about 21 lakh pregnant women received tetanus toxoid vaccine. The second phase launched in 352 districts in the country of which 73 are high focus districts of Phase-I. As of January, 2016, more than 75 lakh children were vaccinated, of which more than 15 lakh children were fully vaccinated and more than 14 lakh pregnant women received tetanus toxoid vaccine.

3.19 **The Committee observes that the Department aims to achieve full immunization of 90 % children by 2020. The Committee desires that the target should be achieved without fail and all out efforts may be taken in this direction. The Committee would further like the Department to also apprise the Committee whether the target of 90% immunization would cover all districts of the country by 2020.**

C. **Pulse Polio Immunisation**

3.20 The polio vaccine was initially introduced in 1978 to prevent Polio among children aged 0-5 years. However with the Global resolution in 1988 with aim to eradicate the Polio from the country, Pulse Polio Immunization Programme was launched in India in 1995. Under Pulse Polio Immunization Programme two National Immunization Days (NID) rounds are held in the entire country. During each NID nearly 172 million children are immunized. Nearly 2.3 million vaccinators under the direction of 15500 Supervisors visit 200 million houses to administer Oral Polio vaccine to children up to 0-5 years. Besides, Sub National Immunization Day (SNID) and Mop up rounds are also held in the country to cover Polio endemic States and other areas at risk of importation of Polio virus. The Mobile and transit teams are also deployed at Railway stations, inside running trains and Bus stand, market areas brick kiln, construction sides etc. In addition, Boarder areas are also being covered under Polio campaign. Last Polio case was reported on 13th January, 2011 from Howrah, West Bengal and since then no Polio case has been reported so far. WHO South East Asia – India Region has declared the India Polio free. Further certification from the WHO is in the process.

3.21 During the meeting of the Committee held on 22nd March, 2016 the Secretary, Department of Health and Family Welfare and other of the Department informed that the IPV mode of immunisation had been started and the OPV mode of immunisation would be stopped from 26th April, 2016 (the date set as per global norms). On being queried whether there are adequate companies in India to produce the IPV, it was informed that there are some companies in India that are manufacturing the same.

3.22 **The Committee is of the view that before the Department had enough stock indigenously available in the country because shortage of stock of the IPU available indigenously would in turn require imports. The Committee, therefore, recommends that the Department should ensure that**

there are adequate stocks available in the country and the public sector pharmaceutical companies should also take up production of this vaccine at the earliest so that the Country is insulated from the price and supply shocks concerning IPV.

IV. NATIONAL URBAN HEALTH MISSION (NUHM)- FLEXIBLE POOL

4.1 The Department in a written reply has informed the Committee that the budgetary provision for NUHM for the Financial Year 2016-17 is ₹ 950.00 crore.

4.2 On being asked as to what action has the Department taken on the recommendation of the Committee to urgently take up with the State Governments the matter of recruitment of manpower for NUHM and taking up of various approved activities, the Department in its written reply has informed that since the launch of NUHM in FY 2013-14, so far 993 cities have been covered under NUHM. Support has been provided for strengthening of 4325 facilities in urban areas, construction of 762 new UPHCs and 51 new UCHCs. A total of 2,763 Medical Officers, 18,562 ANMs, 7,597 Staff Nurses, 3,503 Pharmacists and 3,875 Lab Technicians, 213 Program Management Staff (PMS) at State level, 956 Program Management Staff at district level and 414 program management staff at city level have been approved under the Programme. 62,803 ASHAs and 98,128 MAS have also been approved under the Programme.

4.3 The Committee has also been informed that the Ministry is in constant correspondence with the States/UTs regarding implementation of NUHM and the progress made with regard to activities approved under NUHM. The States have been advised to accelerate the program activities in co-ordination with the States Urban Development Department and Municipal Commissioners.

4.4 **The Committee observes that the National Urban Health Mission was launched in 2013 in order to effectively address the healthcare needs of the urban poor population. Though almost three years have elapsed since then, but the NUHM continues to be plagued with underfunding which is evident from the fact that a meagre allocation of ₹ 950.00 crore has been made for NUHM for 2016-17. The Committee observes that the unprecedented urbanization in the country has brought with it rapid growth of populations and a concomitant rise in slum populations and therefore a measly provisioning of ₹ 950.00 crore is grossly inadequate. The Committee, therefore, recommends that greater financial resources be made available for NUHM so that the urban poor are protected against financial risks associated with catastrophic health costs and the urban poor are not excluded from the public healthcare system.**

4.5 **The Committee finds from the information furnished that the in- position manpower *vis-a-vis* the approved staff is tediously slow in spite of all the efforts being put so far. The Committee is of the view that the Department should look at the possibility of creating a monitoring committee in all districts so that regular interface and monitoring of the schemes being implemented including the recruitment position is done.**

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

A. National Vector Borne Disease Control Programme (NVBDCP)

5.1 The Department has informed that Vector borne diseases, *viz.*, Malaria, Dengue, Chikungunya, Japanese Encephalitis (JE) Lymphatic Filariasis and Kala- azar, are major public health concerns and impede

socio-economic development. The National Vector Borne Disease Control Programme (NVBDCP) is implemented for prevention and control of these vector borne diseases under overarching umbrella of National Health Mission. Under the umbrella of NVBDCP, three-pronged strategies are being implemented, namely, disease management including early case detection and prompt treatment, strengthening of referral services; integrated vector management including Indoor Residual Spraying, use of insecticide treated bed nets/ Long lasting insecticidal nets, larvivorous fish and supportive interventions like human resource development, behaviour change communication, monitoring and evaluation, and operational research. The brief situation of the diseases and new initiatives proposed for prevention and control of the Vector Borne Diseases are as below:

Malaria

5.2 The areas vulnerable to malaria are largely tribal, difficult, remote, forested and forest fringe inaccessible areas with operational difficulties. The most malarious areas are NE States, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Andhra Pradesh, Maharashtra, Gujarat, Rajasthan, West Bengal and Karnataka.

5.3 In North Eastern States excluding Sikkim, the Global Fund supported Intensified Malaria Control Project for a period of 5 years (October 2010 – September 2015) is being implemented to scale up preventive and curative interventions for control of malaria. The project area covers a population of 46 million in 86 districts. The goal of the project is to reduce malaria related mortality and morbidity in the area by at least 30% by 2015 as compared to the levels in 2008.

5.4 The five-year World Bank supported project for malaria control and Kala- azar Elimination in 124 malarious districts of nine (9) States namely Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Karnataka & West Bengal and 46 Kala-azar districts in three States namely Bihar, Jharkhand and West Bengal has also been approved by GOI and being implemented from March 2009. Now these districts are being supported with DBS.

5.5 Presently, the malaria incidence reported by States is around 1.50 million cases and deaths below 1000. During 2014, 1.10 million malaria cases with 562 deaths have been reported as compared 1.03 milion case and 273 death till Dec.2015. About 94% of malaria cases and 99% of deaths due to malaria are reported from high disease burden states namely North Eastern (NE) States, Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and West Bengal. However, other States are also vulnerable and have local and focal upsurge. For strengthening surveillance, Rapid Diagnostic Test (RDT) for diagnosis of *P.falciparum* malaria has also been introduced in high endemic areas and being scaled up. Considering that about 50% of the malaria cases are due to *P. vivax* in the country, bivalent RDT (detecting both *Pv* and *Pf* infection) has been introduced in the country at the field level from this year. ASHAs have been trained in diagnosis and treatment of malaria cases and are involved in early case detection and treatment.

5.6 **The Committee observes that Malaria is a public health problem in many parts of the country and anti-malarial drug resistance has emerged as a major challenge. The number of cases is still more than one million and steps need to be taken to address this on a priority basis.**

Dengue

5.7 For control of Dengue fever that is emerging as major threat in urban, peri- urban and rural areas, due to expanding urbanization, deficient water and solid waste management, the emphasis is on avoidance

of mosquito breeding conditions in homes, workplaces and minimizing the man-mosquito contact. During 2014, a total no. of 40571 dengue cases and 137 deaths were reported as compared 97740 dengue cases and 200 death during 2015 (up to 29th Dec. 2015).

Chikungunya

5.8 Chikungunya re-emerged in 2006 and 1.39 million cases of Chikungunya fever were reported. In 2014, 16049 cases of clinically suspected Chikungunya fever were reported as compared 26912 cases of clinically suspected Chikungunya during 2015 (up to 29th Dec. 2015). Improved surveillance, case management and community participation, inter-sectoral collaboration, enactment and enforcement of civic bye-laws and building bye-laws are being emphasized for prevention and control of both Dengue and Chikungunya.

5.9 **The Committee notes from media reports that rapid diagnostic kits for dengue generate upto 50% of false positives for dengue and thus spread panic and are not reliable at all. Experts have favored banning of rapid diagnostic kits. The Committee, desires that necessary action be taken in this regard. Japanese Encephalitis (JE) and Acute Encephalitis Syndrome (AES).**

5.10 JE is reported under Acute Encephalitis Syndrome (AES) from 21 States/UTs in the country. During 2014, 10867 cases and 1719 deaths due to AES including JE were reported as compared to 8405 cases and 1171 deaths due to acute AES/JE during 2015 (up to 29th Dec. 2015).

5.11 In addition to various JE control measures like strengthening of surveillance, case management facilities, vector control and other supportive interventions, JE vaccination programme for children between 1 and 15 years of age under the Universal Immunization Programme, using single dose live attenuated SA-14-14-2 vaccine, has been initiated during 2006 wherein 11 districts from four JE endemic States were covered. However, out of 204 endemic districts, 182 districts have been covered under JE Vaccination till 2015.

5.12 **The Committee notes that out of 204 endemic districts, 182 districts have been covered under JE vaccination till 2015. The Committee recommends that all the remaining endemic districts may be covered under JE vaccination at the earliest to ensure complete elimination of the disease.**

5.13 JE vaccination campaign is done in endemic districts in children 1-15 years of age followed by routine immunization so as to limit the susceptible population who might be affected and spread the disease to nearby newer areas.

5.14 *The vectors of JE, the Culex vishnui* group of mosquitoes is widespread and breed in water with luxuriant vegetation mainly in paddy fields and the abundance is related to rice cultivation, shallow ditches and pools. These vectors are primarily outdoor resting in vegetation and other shaded places but in summer may also rest in indoors. They are principally cattle feeders, though human and pig feeding are also recorded in some areas. The preventive measures are directed at reducing the vector density and in taking personal protection against mosquito bites using insecticide treated mosquito nets. The reduction in mosquito breeding requires eco- management, as the role of insecticides is limited.

5.15 It has been recommended under the programme to keep the piggeries away (4-5 kms.) from human dwellings.

5.16 During the evidence of the Secretary, Department of Health and Family Welfare before the Committee on 22nd March, 2016, it was submitted that the mortality rate from Japanese Encephalitis had actually come down. On the issue of Acute Encephalitis Syndrome (AES) it was submitted that there are two areas of focus. One is the water and the second is point of care. Earlier deaths were occurring because by the time a child fell sick and shifted to a medical college or district hospital, the gap was huge and the child died due to this gap. The Department has informed that in districts of Bihar and Uttar Pradesh, facilities had been created at PHC where the first line of treatment can be given, so that the child is safe.

5.17 **The Committee while appreciating this approach of the Department directs that it should expand such line of treatment to all the districts affected by AES in the country and request the Ministry of Finance to provide adequate funds to support the line of treatment adopted by the Department.**

Lymphatic Filariasis (LF)

5.18 Lymphatic Filariasis is endemic in 250 districts (presently 255) in 16 States and 5 UTs. Targeted for elimination by 2015 (achievement of Mf rate of less than 1% at district level after at least 5 rounds of MDA with minimum 65% population coverage). To achieve the goal of elimination, Government in year 2004, launched the strategy of Annual Mass Drug Administration (MDA) with single dose of Diethyl Carbamazine Citrate (DEC) to population living at the risk of filariasis except children below 2 years, pregnant women and seriously ill persons. The co- administration of DEC + Albendazole were introduced for MDA since 2007.

5.19 The population coverage during MDA has improved from 73% in 2004 to 86.8% in 2014. The overall microfilaria rate has been reduced from 1.24% in 2004 to 0.4% in 2014. Out of 255 LF endemic districts, 222 districts have reported overall microfilaria rate to less than 1%. To achieve high coverage during 2014-15, massive IEC campaign was done involving Global Network for Neglected Tropical Diseases (GNNTD), IEC division of MOH&FW, DAVP, Doordarshan and All India Radio.

5.20 For stoppage of MDA, Transmission Assessment Survey (TAS) using Immuno-Chromatographic Test (ICT) with finger prick blood is done in sampled children of 6-7 years as per WHO method. Till July 2015, a total of 52 districts out of 255 have successfully cleared TAS and during 2015-16, 65 more districts have been targeted for TAS and remaining 137 districts will observe MDA. MDA may continue in about 50-70 districts as TAS will be subjected in 2015 and 2016. Therefore, additional round of MDA in 74 districts have been proposed in 2016 and WHO has been requested to supply 200 million tablets of Albendazole.

5.21 **The Committee recommends that a strategy may be adopted to do community level sensitization and mobilization to maximize coverage of MDA. The Committee desires that the additional round of MDA in 74 districts may be completed as targeted in 2016.**

Kala-Azar

5.22 Kala-azar at present is endemic in 54 districts of four endemic States Bihar (33), Jharkhand (4), West Bengal (11) and Uttar Pradesh (6) about 80% of the total cases are reported from Bihar. The Kala-azar Control Programme was launched in 1990-91. The annual incidence of disease has come down from 77,102 cases in 1992 to 33187 cases in 2011 and deaths from 1,419 to 80 respectively. During 2014, 9241 cases and 11 deaths have been reported and in 2015 as compared 7720 cases and 5 deaths reported till December

2015. The National Health Policy (2002) envisages Kala-azar Elimination by 2015 and Central Govt. provides 100% operational cost to the States besides anti Kala-azar medicine, drugs and insecticides.

5.23 **The Committee notes that though Kala-azar was targeted to be eliminated by 2015, there are no such signs though the cases have come down in 2015. The Committee desires elimination without much delay.**

(B) **National Tuberculosis (TB) Control Programme**

5.24 On being asked regarding the financial performance of National TB Central Programme during 2015-16, the Department in its written reply informed that the financial performance of Revised National Tuberculosis Control Programme (RNTCP) during 2015-16 is as under:

(₹ in crores)

Financial Year	Total Allocation	States Allocation (Cash + Commodity)	Releases (Cash + Commodity)
2015-16	640.00	603.20	516.20 (till 29.02.2016)

5.25 On being asked whether the recommendations of the Expert Committee under the Chairmanship of Secretary and DG, Department of Health and Family Welfare, Indian Council of Medical Research (ICMR) for piloting the feasibility of implementation of daily therapy have been approved by the Ministry of Health and Family Welfare and if so, what action has been taken by the Ministry of Health and Family Welfare on the recommendations of the expert Committee, the Department in its written reply has informed that the recommendations of the Expert Committee for piloting the feasibility of implementation of daily therapy has been approved by the competent authority for implementation of feasibility pilot in five States *i.e.* Sikkim, Bihar, Maharashtra, Himachal Pradesh and Kerala. All the required activities *i.e.* training of personnel States, development of guidelines, recording and reporting systems are being undertaken and procurement of drugs has been initiated. The five States will be in a position to implement on receipt of drugs for daily regimen.

5.26 **The Committee further recommends that if the study is successfully implemented in these five States, the Government should look to expand the study in all States and, if need be, approach the Ministry of Finance for more funds for expansion of this study.**

(C) **National Leprosy Control Programme**

5.27 As per information furnished in the Outcome Budget (2016-17), the National Leprosy Control Programme was launched by the Govt. of India in 1955. Multi Drug Therapy came into wide use from 1982 and the National Leprosy Eradication Programme was introduced in 1983. Since then, remarkable progress has been achieved in reducing the disease burden. India achieved the goal set by the National Health Policy, 2002 of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the National level in December, 2005. The main objective of NLEP is elimination of leprosy less than 1 case per 10,000 population in all the districts of the country by end of 12th Plan and strengthen Disability Prevention and Medical Rehabilitation of persons affected by leprosy.

5.28 **The Committee observes that this is the last year of the 12th Plan and according to the main objective of NLEP, the Department strives to achieve elimination of leprosy less than 1 case per 10,000 population in all the districts of the country by end of 12th Plan and strengthen Disability**

Prevention and Medical Rehabilitation of persons affected by leprosy. The Committee desires to be apprised of the status prevailing as on date within three months of the presentation of this report both in respect of achieving the target set as also the progress made in strengthening Disability Prevention and Medical Rehabilitation of persons affected by leprosy.

(D) **Integrated Disease Surveillance Project (IDSP)**

5.29 As per information furnished in the Outcome Budget (2016-17), Integrated Disease Surveillance Programme (IDSP) was launched with World Bank assistance in November 2004. The project continues in the 12th Plan with domestic budget as Integrated Disease Surveillance Programme under NHM for all States at an outlay of ₹ 640.40 crores. The aims of the programme is to strengthen/maintain a decentralized laboratory based IT-enabled disease surveillance system for epidemic prone diseases to monitor disease trends and to detect and respond to outbreaks in early rising phase through trained Rapid Response Teams and to establish a functional mechanism for inter-sectoral coordination to tackle the Zoonotic diseases.

5.30 Under IDSP data is collected on epidemic prone diseases on weekly basis (Monday–Sunday). The information is collected on three specified reporting formats, namely "S" (suspected cases), "P" (presumptive cases) and "L" (laboratory confirmed cases) filled by Health Workers, Clinicians and Laboratory Staff respectively. The weekly data gives information on the disease trends and seasonality of diseases. Whenever there is a rising trend of illnesses in any area, it is investigated by the Rapid Response Teams (RRT) to diagnose and control the outbreak. Data analysis and actions are being undertaken by respective State/ District Surveillance Units. In the month of September 2015, about 90% districts have reported weekly disease surveillance data from districts.

5.31 The Department has informed the Committee that the Government of India initiated Integrated Disease Surveillance Programme (IDSP) in all States/UTs with the objective to detect and respond to disease outbreaks due to epidemic prone diseases. To support the States/UTs in outbreak investigation, they are provided with additional manpower, training of identified Rapid Response Team (RRT) members for outbreak investigations, strengthening of laboratories for detection of epidemic prone diseases, ICT equipment for data entry, analysis and data transfer, and provision of funds for operationalization.

5.32 IDSP being a programme under NHM and funds are released as part of the total NHM Budget. Actions are taken by NHM Finance division which follows up with the States to reduce the delay in fund release for all programmes including IDSP.

5.33 In the 12th plan, 300 District Public Health Labs were targeted to be strengthened to improve the quality of data and outbreak investigations. Under IDSP, till date (Feb 2016) 111 labs in 29 States have been made functional. Further, A State based referral laboratory network has been established by utilizing the existing functional labs in the identified medical colleges and other major centres in the States and linking them with adjoining districts for providing diagnostic services for epidemic prone diseases during outbreaks. Presently this network is functional in 22 States involving 99 labs. Letters from the Minister, Secretary and AS & MD have regularly been sent to transfer the money from the state treasury to state health societies without delay.

5.34 **The Committee finds, that the progress in strengthening of the District Public Health Labs is at a snail's pace. In the first four years of the Twelfth Plan, the Department has been able to set**

up and make functional only 111 labs against target of 300 set for the Twelfth Five Year Plan. The Committee desires that in the last year efforts should be made to open maximum number of labs.

VI. FLEXIBLE POOL FOR NON-COMMUNICABLE DISEASES, INJURY AND TRAUMA

(A) National Programme for Control of Blindness

6.1 As per information furnished in the Outcome Budget (2016-17), National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. Rapid Survey on Avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence of blindness from 1.1% (2001-02) to 1% (2006-07). The programme continues focus on development of comprehensive eye care services targeting common blinding disorders including Cataract, Refractive Errors, Glaucoma, Diabetic Retinopathy, Childhood Blindness, Corneal Blindness etc.

6.2 The Department have informed the Committee that to improve the operational flexibility of the States/UTs, from 2015-16 the allocation of funds under National Programme for Control of Blindness (NPCB) has been included under the Flexible Pool for Non-Communicable Diseases. The total central allocation under Flexible Pool for Non Communicable Disease which includes NPCB is ₹ 554.50 crore and expenditure reported is ₹ 377.80 crore. During the F.Y. 2015-16, under the NPCB programme, against the approvals of ₹ 169.41 crore, expenditure of ₹ 99.67 crore has been reported by States/UTs till 31.12.2015.

6.3 **The Committee observes that the fund utilisation as reported by States/UTs is very slow as compared to the approvals. The slow utilisation of funds translates into deficient services being provided in the Government settings. The Committee, therefore, recommends that the Department should ensure strict monitoring of allocated funds and ensure that they are evenly utilised during the year as the under-utilisation of funds, reflects poor financial management of resources and also ultimately impacts on the goals of the programme.**

(B) National Mental Health Programme

6.4 As per the Annual Report (2015-16) of the Department of Health and Family Welfare, mental illnesses are emerging as a major cause of morbidity in the country. These illnesses include depression, bipolar mood disorders, anxiety disorders, personality disorders, delusional disorders, substance use disorders, psycho-sexual disorders and sleep disorders among others. It is estimated that at any point of time, 6% to7% population in India suffers from some form of mental illness. WHO estimates that one in four persons will be affected by a mental illness at least once in their lifetime. Addressing mental illnesses by way of prevention, treatment and rehabilitation is necessary for achieving our health objectives. This will simultaneously have a salutary impact on increasing productivity resulting in higher income levels for the economy. Sound mental health will also improve the quality of life. There is a close nexus between poverty and mental illnesses. Hence addressing mental illnesses will also address poverty and deprivation. National Mental Health Programme (NMHP) was started in 1982 with the objectives to ensure availability and accessibility of minimum mental healthcare for all, to encourage mental health knowledge and skills and to promote community participation in mental health service development and to stimulate self-help in the community. Gradually, the approach of mental healthcare services has shifted from hospital based care (institutional) to community based mental

healthcare, as majority of mental disorders do not require hospitalization and can be managed at community level.

6.5 On being asked as to what concrete measures have been taken to ensure optimum utilization of funds allocated under the head - National Mental Health Programme, the Department has informed that the States/UTs are required to submit utilization certificates along with audited statement of accounts every year in respect of the funds released to them under the NMHP. Additionally, the National Health Mission has a strong financial management mechanism to ensure optimum utilization of funds allocated under the head – National Mental Health Programme along with other programmes of this Ministry. As a response of these measures, the States/UTs are monitoring the pace of expenditure and optimum utilization of funds by various implementing agencies and projecting their funds requirement in a more realistic manner.

6.6 In reply to another query, the Department has informed that the National Mental Health Programme (NMHP) has become a part of the Flexible Pool for Non Communicable Diseases from F.Y. 2015-16 and the funds are released in a pool instead of programme-wise. The allocation of ₹ 377.80 crore has been utilized against the Plan funds allocation of ₹ 554.50 crore upto 17.03.2016 under Flexible Pool for Non Communicable Diseases.

6.7 **The Committee recommends that even though the funds are released pool-wise, the Department should also keep a track of status of expenditure under the Programme separately to allow an assessment of the actual progress being made under the pool.**

(C) **National Programme for the Health Care of Elderly (NPHCE)**

6.8 As per information furnished in the Outcome Budget (2016-17), the Ministry launched the "National Programme for the Health Care of Elderly" (NPHCE) in 2010 to provide dedicated health care facilities to the elderly people through the State health delivery system at primary, secondary and tertiary levels including outreach services. The basic aim of the NPHCE programme is to provide separate, specialized and comprehensive health care to the elderly people in the country. The major objectives of the NPHCE are establishment of Department of Geriatric in identified Medical Institutions as Regional Geriatric Centres for different regions of the country and to provide dedicated health facilities in District Hospitals, CHCs, PHCs and Sub Centres levels.

6.9 As on now, a total of 104 districts of 24 States/UTs and 8 Regional Geriatric Centres (RGCs) have been covered under the Programme.

6.10 The Department has also informed that the National Programme for Healthcare of Elderly (NPHCE) has now become a part of Flexible Pool for Non Communicable Diseases. No separate funds are allocated for the Plan Activities under NPHCE. The utilization under Plan Activities is ₹ 377.80 crore against the Plan funds allocation of ₹ 554.50 crore upto 17.03.2016 under Flexible Pool for Non Communicable Diseases. During the financial year 2015-16 under NPHCE against the approvals of ₹ 132.47 crore the States/UTs have reported utilization of ₹10.21 crore till 31.12 2015.

6.11 **The Committee finds that during the financial year 2015-16 under NPHCE against the approvals of ₹ 132.47 crore the States/UTs have reported utilization of ₹10.21 crore till 31.12 2015, which is a very poor record , in light of the fact that by the Department's reply "that in order to improve the operational flexibility of the States/UTs, the allocation of funds under Flexible Pool for**

Non Communicable Diseases have been made pool-wise instead of scheme wise-from 2015-16 and therefore, no separate allocation has been done for the programme in 2016-17" which is a contra-indication of the above statement. The Committee feels that factual statements should be borne by results in form of healthy utilisation of funds allocated and recommends that the operational flexibility does not mean abnegation of responsibility. The Committee, therefore, exhorts the Department to ensure strict monitoring for optimum utilisation of allocated funds.

(D) **National Tobacco Control Programme (NTCP)**

6.12 As per information furnished in the Outcome Budget (2016-17), India is the second largest consumer of tobacco in the world. The tobacco epidemic in India is notable for the variety of smoked and smokeless tobacco products that are used and for their production by entities ranging from the loosely organized manufacture of bidi and smokeless products to multinational corporations. An estimated one million Indians die annually from tobacco-related diseases. Globally, tobacco consumption kills nearly 6 million people in a year. The Global Adult Tobacco Survey India - GATS 2010 - found that 35% of Indian adults in the age group, 15 years and above use tobacco in one form or the other. The extent of use of smokeless tobacco products (SLT) is particularly alarming - about 33% adult males and 18% adult females in the country consume SLT. The mean age at initiation of daily tobacco use in India for those aged 20–34 years is as low as 17.8 years. According to the Global Youth Tobacco Survey - GYTS 2006, 14.6% of students aged 13-15 years in India use some form of tobacco - 4.4% smoke cigarettes and 12.5% use other forms of tobacco.

6.13 In order to protect the youth and masses from the adverse effects of tobacco usage and second hand smoke (SHS), the Government of India enacted the "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA-2003)".

6.14 A committee was constituted to review and suggest amendments to the Tobacco Control Laws - "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA-2003)". Based on its recommendations, a draft note for the cabinet has been prepared and circulated for inter-ministerial consultations. As per the advice of the Ministry of Law, the Amendment Bill has been placed in the public domain, as part of the pre-legislative consultations, to elicit comments of all the stakeholders, including the general public. At present, the Ministry is in the process of examining the comments that have been received.

6.15 **The Committee notes that - "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA-2003)" has been placed in the public domain, as part of the pre-legislative consultations. The Department should complete the process of reviewing and finalizing the Amendment Bill and bring it forward in the Parliament at the earliest.**

(E) **National Oral Health Programme (NOHP)**

6.16 As per the Annual Report (2015-16), National Oral Health Programme (NOHP) is a new initiative by Government of India with the following objectives:-

Improvement in the determinants of oral health e.g. healthy diet, oral hygiene improvement etc. and to reduce disparity in oral health accessibility in rural and urban population;

Reduce morbidity from oral diseases by strengthening oral health services at sub-district/district hospital to start with;

Integrate oral health promotion and preventive services with general healthcare system and other sectors that influence oral health; namely various National Health Programmes; and

Promotion of Public Private Partnerships (PPP) for achieving Public Health Goals.

6.17 The programme constitutes two separate activities *i.e.* (i) activities up to district level which is under the umbrella of NHM and (ii) tertiary level activities (containing State Level and Central Level activities).

6.18 On being asked as to what has been the actual impact of integration of NOHP on ensuring better financial management under Health System Strengthening, the Department in its written reply has informed that in the beginning of F.Y. 2015-16, the BE for NOHP was ₹ 2.00 crore. There was a total demand of ₹ 67.85 crore from the States and UTs in the current F.Y. 2015-16 including the supplementary proposals. It would not have been possible to give approvals amounting to ₹ 14.34 crore to 28 States/UTs if the programme had not been integrated under Health System Strengthening under NRHM.

6.19 **Since there is a higher demand from States/UTs, the Committee desires that more amount may be sanctioned under this programme. More publicity campaign is necessary under this programme and efforts may be made in this direction**.

F. **Burn Injuries Scheme**

6.20 In the Twelfth Five Year plan, under the Scheme, burns unit shall be established in 67 Medical Colleges. The programme will be part of "Human resource in Health and Medical Education Scheme". Apart from this, the development of burn units in 19 district Hospitals under NHM umbrella shall also be taken up and assistance to be provided to the States will be governed by the norms set under this parent Scheme. One of the important criteria under the Scheme is that the assistance proposed under the programme for various components will be shared between the Centre and State Governments in the ratio of 75:25 (for North-Eastern and Hill States the ratio will be 90:10).

6.21 As per the status note for 'National Programme for Prevention & Management of Burn Injuries' (NPPMBI) (as on 20th November, 2015), the following is the status of Burns Injury Scheme:

As of now, 43 Burn Units (including 13 burn units in district hospitals) have been approved by Screening Committee – Trauma and Burns.

The IEC material utilized during the pilot phase of this programme has been modified and updated for greater reach out and awareness. Activity of dissemination of information through train rapping is under taken in 5 trains. IEC plan for burn scheme primarily focuses on the preventive aspect of burn injuries.

A training of 20 Medical Officers/Surgeons from State Government Medical Colleges identified during the Twelfth Five Year Plan is proposed from 30th November, 2015 to 5th December, 2015 at Dr. RML Hospital and Safdarjung Hospital. A sum of ₹ 2,31,250/- to each hospital has been sanctioned for this purpose.

The Draft IEC action plan on Burn Injuries scheme for year 2015-16 has been requested from CHEB.

6.22 **The Committee hopes that the Draft IEC action plan on Burn Injuries Scheme would have been finalized by now and recommends that the Department should put the action plan into implementation without much delay.**

(G) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS)

6.23 On whether the Multi-Sector Plan has been prepared for effective strategy for prevention and control of NCDs and whether the nation-wide survey being planned to be done by Indian Council of Medical Research (ICMR) to estimate the burden and prevalence of major risk factors of NCDs has been initiated, the Department in its written reply has informed that the Draft National Multi-Sectoral Action Plan (NmSAP) for prevention and control of NCDs has been prepared and circulated to 39 Central Ministries/Departments for their comments. 31 Departments have nominated their Nodal Officers for coordination in the subject whereas 7 Departments have furnished their comments on the NmSAP. Further, Indian Council of Medical Research (ICMR) has been assigned the work to conduct the following Study/Survey:-

(a) Survey for Monitoring the Non-Communicable Diseases (NCD) Targets 2014-15 with a total cost of ₹ 8.90 crore; and

(b) Burden of Non-Communicable Diseases and Associated Risk Factors for India (BOD-NCD) a total cost of ₹ 2.48 crore.

6.24 The Department has also informed that a meeting of all Nodal Officers/representatives of concerned Ministries/Departments was held on 19th February, 2016 to discuss/deliberate upon the draft National Multi-Sectoral Action Plan for Prevention and Control of Non-Communicable Diseases (NCDs). The Nodal Officers have been requested to take appropriate steps on the action points of respective Ministries and furnish comments for finalization of the NmSAP road map. Funds to the tune of ₹ 3.56 crore and ₹ 0.99 crore respectively have been released to Indian Council of Medical Research (ICMR) for initiating activities in respective studies *i.e.* (i) Survey for Monitoring the Non-Communicable Diseases (NCD) Targets 2014-15 and (ii) Burden of Non-Communicable Diseases and Associated Risk Factors for India (BOD-NCD).

6.25 **The Committee would like to be apprised of the results of the Study/Survey carried out by ICMR and would also like to be apprised of the action, if any, being taken by the Department on the basis of the results of the Study/Survey.**

6.26 On being asked about the utilization status of Plan funds allocated for NPCDCS in 2015-16, the Department in its written reply has informed that the NPCDCS programme has become a part of the Flexible Pool for Non Communicable Diseases from F.Y. 2015-16 and the funds are released in a pool instead of programme-wise. The amount of ₹ 377.80 crore has been utilized against the Plan funds allocation of ₹ 554.50 crore upto 17.03.2016 under Flexible Pool for Non Communicable Diseases.

6.27 As per the outcome Budget (2016-17), the programme is proposed to be expanded to all the districts across the country by March 2017, with focus on strengthening of infrastructure, human resource development, health promotion, early diagnosis, treatment and referral for prevention and control of cancer, diabetes, cardiovascular diseases and stroke. During the FY 2014-15, funds have been released to the 36 States/UTs to the tune of ₹ 210.40 crore under NCD Flexi Pool and 351.90 crore for 5 State Cancer Institutes (SCI) and 2 Tertiary Care Cancer Centre (TCCCs) Under Health Budget. From 2015-16 the

budget of the Programme has been subsumed under NCD Fexi Pool for district and below level activities. During the Financial Year 2015-16 funds to the tune of ₹ 269.17 crore have been released so far under NCD Flexi Pool and ₹ 76.63 crore for 1 SCI and 3TCCs under Health Budget.

6.28 **The Committee observes that India is experiencing a rising burden of Non-Communicable diseases (NCDs). As per the information given in the Annual Report 2015-16 of the Department, NCDs are estimated to account for about 60% of all deaths in India. The Committee would, therefore, urge upon the Department to adopt a comprehensive strategy to address NCD challenges and also explore the option of mainstreaming AYUSH therapy as part of medical care for effective prevention.**

H. **Thalesemia**

6.29 **The Committee finds that a genetically inherited disease called Thalesemia is also prevalent in our country and lakhs of Thalesemia patients are there in the country and ignored by the Government because they too belong to small pool of patients. In this disease the body of the patient does not produce blood and they require blood transfusion from time to time. Majority of them are children. The Committee is therefore of the opinion that intervention of Government becomes very necessary to save the lives of Thalesemic patients. The Committee accordingly recommends that Thalesemia should also be included in list of various diseases and budgetary allocations should be made for this disease as well.**

VII. **Establishment of new Medical Colleges attached with existing district/referral hospitals (Upgradation of District Hospitals to Medical Colleges)**

7.1 As per the Outcome Budget 2016-17 of the Department, in order to meet the shortfall of human resource in health, the Government is implementing a Centrally Sponsored Scheme for "Establishment of new medical colleges attached with existing district/referral hospitals" with fund sharing between the Central Government and States in the ratio of 90:10 for NE/special category States and 60:40 (revised) for other States. The total cost of establishment of one Medical College under the scheme is ₹ 189 crore. A total of 58 district/referral hospitals have been approved under the Scheme and funds to the tune of ₹ 228.53 crore have been released to the States/UTs. The objectives of the Scheme are:

To establish 58 medical colleges with intake capacity of 100 in each to increase 5800 seats at the undergraduate level in Government sector.

To bridge the gap in number of seats available in government and private sector to ensure availability of more MBBS seats for students who cannot afford costly medical education in private sector.

To mitigate the shortage of doctors by increasing the number of undergraduate seats in the country for equitable health care accessibility across the States.

To utilise the existing infrastructure of district hospitals for increasing undergraduate seats in a cost effective manner by attachment of new medical college with existing district/referral hospitals. Additional human resource in health generated by the scheme would meet the health care needs of the growing population and ensure that doctors are available at PHC/CHC/District level to ensure service guarantee under NRHM.

7.2 During the oral evidence of representative of the Department of Health and Family Welfare with the Committee on 22nd March, 2016, the Health Secretary informed the Committee that forty seven of the proposals have been approved under this Scheme and construction has been started in twelve of them. On being asked whether this Scheme would be carried forward, the Health Secretary submitted that the Department is moving a proposal for adding 82 more colleges in the Scheme. He further informed that since this Scheme can only be started in districts which do not have a medical college, either in private sector or in Government sector, it is tailor made for those areas where there is under representation. The plan is to map the medical colleges and to see that at least for two or three districts there is one medical college which roughly will cover one- third districts which would amount to 133 districts. Since 58 districts are already covered and 82 will be in the near future it would cover 140 districts. The Health Secretary also submitted that roughly, ₹ 120 crore has to be given by the Central Government but the additional 82 medical colleges being proposed would find difficulty in funding and it would be difficult to get funds for 82 districts.

7.3 **The Committee welcomes the proposal of the Department for addition of 82 district hospitals to the Scheme which will go a long way in removing the regional imbalance in terms of medical colleges. The Committee recommends that while working out the proposal for the additional 82 districts, utmost care and caution should be taken to ensure that only un-served regions find their place in the list of 82 district hospitals which are to be upgraded. The Committee further recommends that the Department should quickly move towards firming up the proposal of up-gradation of 82 more district hospitals as medical colleges and an early decision may be taken.**

VIII. RASHTRIYA SWASTHYA BIMA YOJANA

8.1 As per the information furnished, the Rashtriya Swasthya BimaYojana (RSBY) is a centrally sponsored scheme to provide health insurance coverage to Below Poverty Line (BPL) families and including other 11 categories of Unorganized Workers (UOWs) (MGNREGA Workers, Construction Workers, Domestic workers, Sanitation Workers, Mine Workers, licensed Railway Porters, Street Vendors, Beedi Workers, Rickshaw Pullers, Rag Pickers and Auto/Taxi drivers).

8.2 Each family enrolled in the scheme is entitled to hospitalization benefits of upto ₹ 30,000 per annum including maternity benefits on a family floater basis (a unit of five) in government empanelled hospitals (includes both private and public). Pre-existing conditions are covered from day one and there is no age limit. Transportation Cost upto ₹ 100 is also provisioned under the scheme.

8.3 During the year 2015-16, the RSBY scheme is implemented in 19 States/UTs, across 397 Districts with a target of around 7.31 crore families, covering around 4.22 crore families.

8.4 The Sharing pattern for RSBY scheme is as under:

(a) In case of North Eastern States, Jammu & Kashmir and 3 Himalayan States the Central Government bears 90% of insurance premium cost.

(b) Union Territories - the Central Government share is 100% on case to case basis

(c) For remaining other States Central Government bears 60%. of premium cost.

8.5 Apart from above, Central Government also bear ₹ 60 as smart card cost.

8.6 The State Governments are required to release their requisite state share before claiming release of Central share of premium.

8.7 In RE 2015-16, this Division has been allocated ₹ 650/- crore. In addition to RE 2015-16, Ministry of Labour and Employment (MoLE) has also provided ₹ 50/- crore out of which ₹ 41.70 Crore has been released to the States.

8.8 Out of ₹ 650/- crores (RE), an amount of ₹ 519.86 crore as on 11.03.2016 have been utilized by way of releasing grant-in-aid to States implementing RSBY. The proposal for release of central share amounting to ₹ 125.23 crore is in pipeline. Details of state-wise release of grant-in-aid (Central Share) are given below:-

Table No. 12

STATEMENT OF RELEASE OF GRANT-IN-AID TO STATES/UTs IN 2015-16

Sl. No.	Name of State	2015-16
1	Assam	23.24
2	Bihar	-
3	Chhattisgarh	51.12
4	Gujarat	74.24
5	Haryana	4.67
6	Himachal Pradesh	12.35
7	Jharkhand	-
8	Karnataka	81.40
9	Kerala	112.37
10	Madhya Pradesh (*)	1.00
11	Manipur	0.54
12	Meghalaya	4.10
13	Mizoram	9.43
14	Odisha	18.48
15	Puducherry (*)	0.17
16	Punjab	2.80
17	Rajasthan	-
18	Tripura	15.64
19	Uttar Pradesh	4.73
20	Uttarakhand	10.20
21	West Bengal	93.38
	Grand Total	519.86

(*) Grant-in-Aid released in Madhya Pradesh and Puducherry in 2015-16, but the RSBY Scheme is not being implemented in 2015-16.

8.9 **The Committee notes that Rashtriya Swasthya Bima Yojana aims to provide health insurance coverage to all BPL families including 11 categories of informal sector workers. Financial constraint is a major barrier to access to healthcare by poor households. The Committee would therefore like the Department to evaluate as to what extent the RSBY has been able to promote access to healthcare and provide financial protection to the targeted beneficiaries. The Committee would also like to know whether any mechanism is in place to regulate and oversee the insurers and healthcare providers under the RSBY.**

IX. STERILIZATION DEATHS IN CHHATTISGARH

9.1 A mass sterilization camp conducted in Takhatpur, Chhattisgarh in November, 2014 had resulted in 13 deaths and 65 injuries. In an article titled "Victims of the numbers game" published on March 2016 in the Hindu, it has *inter- alia* been reported that "the deaths in Takhatpur camp reveal that on paper, the policy might have evolved but the programme still continues to be driven by targets, threats and coercion. The stress of targets brought to bear upon government doctors is immense." The article also states that a situational report authored by experts from population Foundation of India, Family Planning Association of India and Parivar Sewa Sanstha has established that the premises where the tubectomies were conducted had not been disinfected properly.

9.2 **The Committee is greatly anguished to take note of the revelation that the Sterilization Programme "still continues to be driven by targets, threats and coercion." Now that the Report of the Chhattisgarh Government Enquiry Commission is out, the Committee would like to be apprised of the following:-**

What lessons have been learned from the Takhatpur sterilization deaths and what course corrections have been taken by Ministry of Health and Family Welfare to prevent any such incident in future.

How will Informed Choice be monitored to ensure that health workers are not functioning under the pressure of targets? Have any independent evaluations/commissions, Community Monitoring/Social Audit efforts been instituted?

What is the proportion of budget allocation for female sterilization as compared to male methods, spacing methods, information services/counselling? Have Provider Incentives been removed for female sterilizations?

What changes have been brought about in budget allocations to ensuring Informed Choice (as opposed to targets), provision of spacing contraceptive methods, resources for quality monitoring and to promoting men's responsibility for contraception?

X. DEFICIENCY OF HEALTH INFRASTRUCTURE AND MANPOWER IN RURAL AREAS

10.1 As per the Rural Health Statistics, 2015, the health care infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:

Population Norms

Centre	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

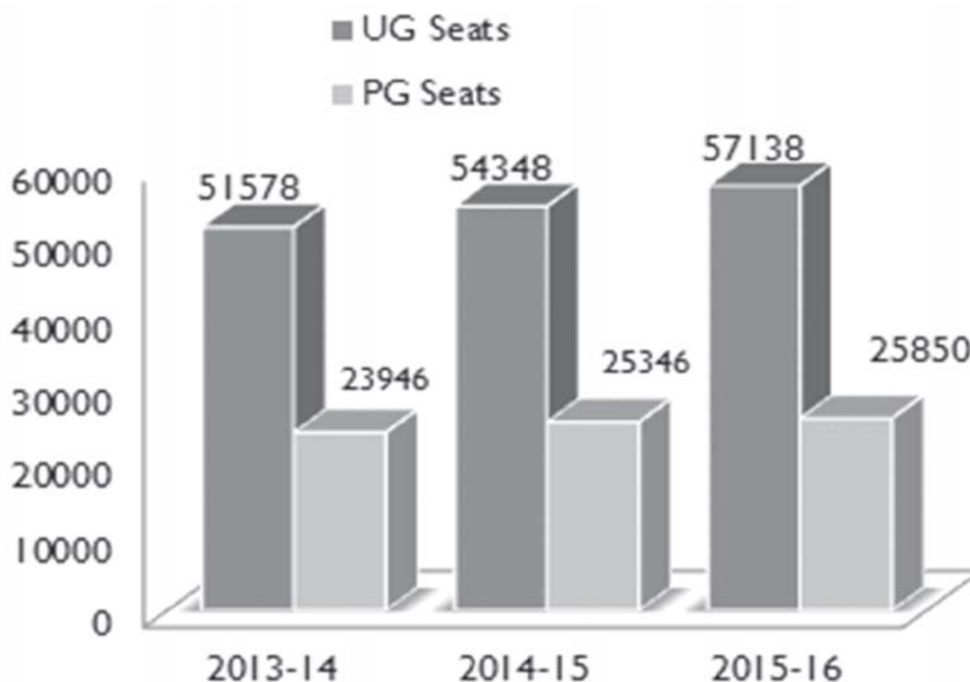
10.2 Further as per Rural Health Statistics, 2015, the number of Sub-Centres, Primary Health Centres and Community Health Centres is 153655, 25308 and 5396 respectively. The Additional Secretary during his deposition before the Committee on 22nd March, 2016 informed the Committee that the shortfall for Sub-Centres, Primary Health Centres and Community Health Centres is 35145 (20%), 6556(22%) and 2316 (32%) respectively.

Manpower shortfall

10.3 Further as per Rural Health Statistics, 2015, as on 31st March, 2015, the overall shortfall of allopathic Doctors at PHCs, is 11.9% of the total requirement for existing infrastructure as compared to manpower in position. The specialist doctors at CHCs have increased from 3550 in 2005 to 4078 in 2015. However, as compared to requirement for existing infrastructure, there is a shortfall of 83.4% of Surgeons, 76.3% of Obstetricians and Gynaecologists, 83.0% of Physicians and 82.1% of Paediatricians. Overall, there is a shortfall of 81.2% specialists at the CHCs as compared to the requirement for existing CHCs.

10.4 Apprising the Committee of the increase in Undergraduate and Post-graduate seats, the Additional Secretary, Department of Health and Family Welfare during his deposition before the Committee on the 22nd March, 2016 furnished the following information:-

Table No. 13



10.5 **This Committee notes that there is a steady increase in the shortfall of doctors, specialists and surgeons in the rural settings because as compared to the requirement for existing infrastructure, there is a shortfall of 83.4% of Surgeons, 76.3% of Obstetricians and Gynecologists, 83.0% of Physicians and 82.1% of Paediatricians. Overall, there is a shortfall of 81.2% specialists at the CHCs as compared to the requirement for existing CHCs. One implication of this is that people in the rural areas have little access to quality medical services which in turn compels them to travel**

to the nearest city on bumpy roads entailing high cost of transport and challenging journeys. The Committee, therefore, recommends that the Department should direct its focused attention to addressing this skew in availability of Health Care Services in our rural health system.

10.6 **The Committee notes that the number of UG and PG seats during 2015-16 was 57138 and 25850 respectively. The Committee observes that one of the most important constraints plaguing our healthcare system is related to retention and skilling of health work force in rural areas and ensuring equity in distribution of skilled work force. A number of States do not produce the requisite number of doctors, nurses or paramedics and nor do they have the requite budget to recruit quality human resources for health. A consequence of this is that many of the appointments are restricted to being contractual in nature. The absence of good contractual arrangements is a big constraining factor in attracting or retaining good quality manpower. The Committee would, therefore, like to be apprised of the measures taken or contemplated to be taken to overcome the above problem.**

10.7 **The Committee also observes that there are 25308 Primary Health Centres (as per Rural Health Statistics 2015) and if the 57000 + doctors being produced every year are compulsorily placed in Primary Health Centres for two years then each year every PHC would have 2 allopathic doctors. Similarly, if the PHC service could be made a conditionality to access PG medical education, over 25000 PG doctors would be more than enough for our Community Health Centres (5396 CHCs as per Rural Health Statistics 2015). The Committee would, therefore, recommend that the Department should formulate an appropriate strategy to ensure that the graduate and post-graduate doctors from medical colleges are required compulsorily to join government facilities, especially in rural areas. Otherwise, production of health workforce by presenting figures about medical colleges seats would prove fallacious.**

PART - B

(Health Sector)

(Health Side)

I. BUDGETARY PROVISIONS HEALTH

1.1 The Ministry of Health and Family Welfare presented its detailed Demands for Grants in Lok Sabha on 11th March, 2016. A perusal of Demand No. 42 which pertains to the Department of Health and Family Welfare, reveals that the total approved Annual Plan Outlay 2016-17 (*i.e.* Budget Estimates) for the health sector is ₹ 10800 crore out of which ₹ 9100 crore is for Health Sector and ₹ 1700 crore for National AIDS Control Programme (NACO).

1.2 On being asked about the projected demand of the Department of Health and Family Welfare for Health Sector for 2016-17 on the plan and non-plan side, the extent of shortfall *vis-à-vis* the projected demand, the programmes/schemes likely to be affected as a result of the shortfall and the measures envisaged to be taken to offset the effect of the shortfall, the Department in a written reply has submitted the following information:-

Table No. 1

(₹ in crore)

	Demand Projected		Funds allocated		Shortfall	
	Plan	Non-Plan	Plan	Non-Plan	Plan	Non-Plan
HEALTH	17962.50	7093.85	9100.00	5724.55	8862.50	1369.30
NACO	2550.00	-	1700.00	-	850.00	-

1.3 The major schemes where allocation is less are:-

Pradhan Mantri Swasthya Suraksha Yojana

Human Resources for Health and Medical Education

All India Institute of Medical Sciences, New Delhi.

Tertiary Care Schemes (National Programme for Prevention and Control of Cancer, Diabetes Cardio-Vascular Disease and Stroke, Health Care for the Elderly, Assistance for Capacity Building for Trauma Centres, National Mental Health Programme, Tobacco Control etc.)

JIPMER, Puducherry

PGIMER, Chandigarh

1.4 To meet the shortfall, the matter will be taken up with Ministry of Finance at the appropriate time to seek additional funds as also efforts will be made to reappropriate savings available from other programmes/schemes.

1.5 In reply to another question regarding the total approved outlay for Twelfth Plan for Health Sector and the actual expenditure incurred, the Department has submitted the following information :-

Table No. 2

(₹ in Crores)

Years	**XIIth Plan Outlay for Health Sector**	**Funds allocated**			**Expenditure incurred during 2012- 13 to 2015-16 (as on 17.3.2016)**		
		Plan	**Non-Plan**	**Total**	**Plan**	**Non-Plan**	**Total**
2012-13	75145.29	6585.00	3596.00	10181.00	4145.43	4069.67	8215.10
2013-14		8166.00	4131.70	12297.70	4261.22	4653.59	8914.81
2014-15		8733.00	4813.45	13546.45	5645.36	5003.98	10649.34
2015-16		6254.00	5345.61	11599.61	6216.48	5128.92	11345.40
2016-17		10800.00	6020.92	16820.92	-	-	-
Total	75145.29	40538.00	23907.70	64445.68	20268.50	18856.20	39124.65

1.6 Twelfth Plan Outlay for Health Sector of Department of Health & Family Welfare (Plan) is ₹ 75145.29 crore. Non-Plan funds are allocated year-wise by Ministry of Finance.

1.7 When asked as to why there was a big gap between the allocations and the Actual Expenditure, during 2012-13 to 2016-17, the Secretary during his evidence before the Committee on 22-3-2016 explained that though BE of 2016-17 had been included in the total allocations made during the Twelfth Plan period, the corresponding expenditure figures were not reflected due to which the shortfall in expenditure was getting reflected more than what actually is.

1.8 During the course of Health Secretary's deposition, the Committee was informed that during financial year 2015-16 the following additional funds were received by the Department over B.E. 2015-16:-

Table No. 3

Scheme	B.E. 2015-16		Additional Funds	
	Plan	Non-Plan	Plan	Non-Plan
HRH	0.00	0.00	387.00	0.00
Tertiary Care	0.00	0.00	337.20	0.00
AIIMS, New Delhi	550.00	920.00	150.00	95.00
Jipmer, Puducherry	200.00	240.00	150.00	11.00
Safdarjang Hospital	357.00	300.00	150.00	0.00
PORB (CGHS)	0.00	965.00	0.00	100.00
Pgimer Chandigarh	160.00	490.00	0.00	95.00
Total	1267	2915	1174	301

1.9 The details of actual expenditure under Plan and Non Plan for 2014-15 and 2015-16, as supplied by the Department is given in Annexure - I

1.10 In reply to a query regarding the amount surrendered during 2014-15 and 2015-16, the Department has furnished the following information:-

1.11 The Major Head-wise amount surrendered during 2014-15 and 2015-16 both in figures and percentage terms are given below:-

Table No. 4

HEALTH *(₹ in crores)*

Major Head	B.E. 2014-15			Surrenders		
	Plan	Non- Plan	Total	Plan	Non-Plan	Total
MH-2251	10.00	68.13	78.13	-	0.56	0.56
MH-2013	-	2.50	2.50	-	-	-
MH-2071	-	875.00	875.00	-	-	-
MH-2210	3134.53	3644.61	6779.14	21.14	17.74	38.88
MH-2211	665.75	211.71	877.46	1.40	1.40	2.80
MH-2552	812.91	-	812.91	160.55	-	160.55
MH-3601	2118.95	11.00	2129.95	1178.96	-	1178.96
MH-3602	26.37	0.50	26.87	25.65	-	25.65
TOTAL	**6768.51**	**4813.45**	**11581.96**	**1387.70**	**19.70**	**1407.40**
% of surrender w.r.t. BE 2014-15				**20.50%**	**0.41%**	**12.15%**
MH-4210	1829.34	-	1829.34	990.99	-	990.99
MH-4211	0.27	-	0.27	-	-	-
MH-4216	89.88	-	89.88	26.01		26.01
MH-4552	45.00		45.00	45.00	-	45.00
TOTAL	**1964.49**	**-**	**1964.49**	**1062.00**	**-**	**1062.00**
% of surrender w.r.t. BE 2014-15				**54.06%**		**54.06%**
TOTAL - Health	**8733.00**	**4813.45**	**13546.45**	**2449.70**	**19.70**	**2469.40**
% of surrender w.r.t. BE 2014-15				**28.05%**	**0.40%**	**18.23%**
NHM						
MH-2210	187.34	1579.45	1766.79	28.32	210.57	238.89

Major Head	B.E. 2014-15			Surrenders		
	Plan	Non- Plan	Total	Plan	Non-Plan	Total
MH-2211	78.17	683.29	761.46	4.18	-	4.18
MH-2552	2206.59	-	2206.59	497.28	-	497.28
MH-3601	19178.13	-	19178.13	3210.82	-	3210.82
MH-3602	261.77	-	261.77	68.80	-	68.80
MH-3606	-	724.60	724.60	-	564.30	564.30
Total - NHM	**21912.00**	**2987.34**	**24899.34**	**3809.40**	**774.87**	**4584.27**
% of surrender w.r.t. BE 2014-15				**17.38%**	**25.94%**	**18.41%**
Grand Total	**30645.00**	**7800.79**	**38445.79**	**6259.11**	**794.57**	**7053.68**
% of surrender w.r.t. BE 2014-15				**20.42%**	**10.19%**	**18.35%**

1.12 The Department has informed that out of total surrender of ₹ 7053.68 crores during 2014-15, ₹ 6245.00 crore was surrendered due to reduction of the Plan outlay from ₹ 30,645.00 crore to ₹ 24,400.00 crore at RE 2014-15 stage by the Ministry of Finance by imposing financial cut. The remaining surrender of ₹ 808.68 crore was due to non-receipt of adequate number of proposals for financial assistance from some of the State and Union Territory Governments, slow pace of expenditure on procurement of equipment and capital works, non-finalisation of proposals for procurement of equipments, vehicles, non-taking off the schemes and low absorption of funds by some of the NE States. Saving was also due to non-filling up of vacant posts, economy in expenditure on administrative heads, non-materialisation of works, slow progress in works by the executing agency. The funds were surrendered on 31st March, 2015.

1.13 The Department has also informed that as far as year 2015-16 is concerned, there was an increase at the RE stage by ₹ 1250.00 cr. under Plan and ₹ 301.00 cr. under Non-Plan. It is expected that majority of the funds will be utilized. A saving of ₹ 97.25 cr. (approx..) is likely under Capital Head, due to slow progress in execution of works by the executing agency, non-finalisation of proposals for procurement of machinery and equipments etc.

1.14 On being asked about the quarterly break-up of expenditure under Health Sector, the Department has furnished the following information:-

Table No. 5

(₹ in Crores)

Quarter	Expenditure as per booked figure of PAO	Percentage of RE
1st	3416.29	26.85
2nd	2054.16	16.14
3rd	2320.28	18.24
4th	4638.35*	36.45*

* As on 31st March, 2016

1.15 **As regards the details of savings on Capital and Revenue Accounts of Health Sector, the Committee has been supplied the following information:-**

Table No. 6

Sector	Year	Savings in crores of ₹	Date of surrender	Percentage of Surrender of BE
Revenue	2014-15	1407.40	31/3/15	12.15
	2015-16	-	-	N.A.
Capital	2014-15	1062.00	31/3/2015	54.06
	2015-16	97.75	31/3/16	9.6

1.16 On the issue of pending UCs under Health Sector and the amount involved therein, the Department of Health & Family Welfare has informed the Committee that as a result of emphasis placed on settling of pending UCs, there has been substantial reduction in the pendency. For D/o Health, as on 31st March 2015, there were 3090 UCs pending amounting to ₹ 6834.59 crores which has been reduced to 1929 UCs pending amounting to ₹ 2862.45crores as on 26.2.2016.

1.17 The Committee has been informed that following action is taken to settle the pending UCs.

(i) A software was developed by office of CCA to monitor the pending UCs. The software facilitates monitoring of UCs year-wise, scheme-wise and institution-wise.

(ii) Rules of GFR with respect to Grants in Aid *vis a vis* the pendency of UCs are strictly followed. It is ensured that before any grant is released, no UCs are pending against the institution by strictly adhering to OM no. 7(1)E-Coord/2012 dated 14th November, 2012.

(iii) Monthly report on the pendency of UCs is reviewed by office of CCA.

1.18 The oldest UCs date back to 2005-06 and the amount involved therein is ₹ 67.40 crore.

1.19 On being asked as to how many projects of Health Sector (Central Sector) have witnessed time overruns and cost escalation, the Department has furnished the following information:-

1.20 Construction work of Hospital Block buildings consisting of Academic Block, OPD Block, IPD Block, Oncology Block, Student's Hostel, etc. with associated Services under Comprehensive Redevelopment Plan of Lady Hardinge Medical College and Associated Hospitals was awarded to M/s. Unity Infraprojects Limited with value of award work of ₹ 393.98 crore in the Month of February, 2012. The work was started in the month of March, 2012 and was to be completed within 20 months. However, the construction work could not be completed as per time schedule as the contractor *i.e.* M/s. Unity Infraproject faced financial crunch and the contractor abandoned the work at site.

1.21 A series of meetings were held in the Ministry with contractor and Project Management Consultant to review the progress of work wherein the contractor accepted the delay because of their financial crunch.

1.22 Despite repeated consultation process, the contractor miserably failed to fulfill any commitment. In view of the inability of Unity Infraprojects to restart the work, the contract for subject works as stipulated in the General Conditions of Contract of the Agreement with M/s unity Infraprojects Ltd. was terminated.

Table No. 7

Sl. No.	Institute	Project	Initial cost of Project	Initial targeted date of Completions	Work completed (%)	Estimated Cost Over-run	Estimated Time Over-run	Remarks
1.	RIMS, Imphal	**Package-I** Construction of PG-Gents and Ladies hostel, UG-Ladies hostel, Nursing Hostel and Internee hostel	75.96 Crore	October, 2013	35%	Appx. 10% of the initial cost	Around 4 years	The construction agency M/s RDB Reality and Infrastructure Ltd. could not complete the project despite repeated discussions/meetings and grant of extension of time to complete the project. Therefore, contract with the Agency had to be terminated for non-performance and contractor black-listed. Re-tendering process for completion of the project is under process.
2.	RIMS, Imphal	**Package-II** Construction of OPD Block	35.58 crore	August, 2013	35%	Appx. 10% of the initial cost	Around 4 years	
3.	RIPANS, Aizwal	Construction of additional facilities, *viz.*, Boys hostel, Library, Academic Block and	68.69 crore	July, 2015	46%	Expected to be completed within the initial cost	Around 15 months	Work on the project has slowed-down due to difficult terrain, landslides and rains. Though the contractor is behind the schedule due to

Sl. No.	Institute	Project	Initial cost of Project	Initial targeted date of Completions	Work comple ted (%)	Estimated Cost Over-run	Estimated Time Over-run	Remarks
		Girls' hostel, etc.						above reasons, by regular monitoring and persuasion, the pace and progress of work has improved. Two Blocks of Library and Boys Hostel have been substantially completed, and are likely to be handed over shortly.

1.23 **The Committee is concerned that there is a significant gap between the total Twelfth Plan approved outlays for Health sector and the sanctioned Budgets in the five years of the Twelfth Plan Period (2012-13 to 2016-17). As against the total approved plan outlays of ₹ 75145.29 crore for Health Sector, the total allocation made by the Government till date is ₹ 40,538/- crore which is only 53.95 % of the total quantum of funds recommended originally. It is true that it is always prudent to generate more value for the funds provided but it would be unrealistic to expect to achieve key health outcomes and objectives of Health Sector with only 53.95% of the approved outlays. The Government, therefore, owes an explanation on the reasons behind such a huge gap between the budgetary allocations made for Health Sector from 2012-13 to 2016-17 *vis-à-vis* the total approved outlays for the Twelfth Five Year Plan and its impact on the goals and objectives of Health Sector.**

1.24 **The Committee notes that the projected demand of Department of Health and Family Welfare for Health Sector for Plan funds for 2016-17 was ₹ 17962.50 crore against which actual allocation made is ₹ 9100 crore, leaving a shortfall of ₹ 8862.50 crore. The major schemes to be adversely affected as a result of less allocation include among others, Pradhan Mantri Swasthya Suraksha Yojanja; Human Resources for Health and Medical Education; AIIMS, New Delhi and Tertiary care schemes. Almost all of these schemes have the objective of correcting the imbalances in availability of affordable and quality tertiary level healthcare in the country. Given the disturbing scenario in which availability of tertiary care is skewed towards private domain *vis-à-vis* public sector; and the costs of private tertiary care is prohibitive, these schemes which are oriented towards facilitating an equitable access to adequate and quality tertiary care and ensuring appropriate manpower mix of different categories of health professionals, assume added significance. Lack of expansion of public sector hospitals in proportion to population growth and health needs is making healthcare out of the reach of people, especially the poorer sections of the Country. Hence the role of the Government in this sector has to be increased substantially to provide adequate healthcare to needy. The**

Committee is, therefore, of the firm opinion that the Plan allocation of ₹ 9100.00 crore for the Health Sector for 2016-17 is not sufficient and needs to be raised so that the burden of high out-of Pocket healthcare expenditure of people could be reduced.

1.25 **The Committee simultaneously observes that since realistic allocation of funds is a reflection of prudent need-based planning, the requirement of funds for Health Sector in 2016-17 may be subjected to periodic review so that there is no scope of fiscal profligacy or idle parking of funds and timely action takes place for its optimal and judicious utilization in consonance with established principles of financial propriety.**

1.26 **While the Committee is all for enhancing the magnitude of allocations for the Health Sector Schemes, it is constrained to observe that out of allocated plan funds of ₹ 29,738.00 crore for the first four years of the Twelfth Plan, only ₹ 20268.50 crore has been utilized as on 17.03.16, leaving a huge shortfall of ₹ 9469.50 crore in the plan expenditure during the first four years of the Twelfth Plan period.**

1.27 **The Committee is also dismayed to note that there is a substantial shortfall of the budgeted expenditure of the Department of Health and Family Welfare in 2014-15 and 2015-16. The shortfall witnessed in the Plan expenditure as compared to the Revised Estimates is to the extent of ₹ 1126.82 crore in 2014-15 and ₹ 1557.87 crore in 2015-16, because as against the RE of ₹ 6772.18 crore in 2014-15 which was reduced from BE of ₹ 8733.00 crore, the Department could only expend ₹ 5645.36 crore. In the year 2015-16, as against RE of ₹ 7504.00 crore which was increased from BE of ₹ 6254.00 crore, the Department ended up utilizing ₹ 7106.64 crore only. The Committee's scrutiny also reveals that substantial variations have occurred between the sanctioned budgetary provisions and the actual expenditure incurred by the Department under several heads of the Grants operated by it during 2014-15 and 2015-16. For example, despite the budgetary provisions of ₹ 197.75 crore and ₹ 294.78 crore obtained as Revised Estimates for "Strengthening/Creation of Paramedical Institute (RIPS/NIPS)" and "Upgradation of State Government Medical Colleges (PG seat)" during 2014-15, respectively, not a single rupee was spent under these heads. Similarly, the Department had obtained ₹ 87.65 crore as RE 2015-16 for Central Drugs Standard Control Organisation, but has spent only ₹ 55.11 crore as on 31st March, 2016, thus registering unspent provisions of ₹ 32.54 crore. It is thus obvious that these instances portray an absence of a sound budgetary mechanism for assessing the actual requirement of funds and give an impression that the budgetary requirements are being projected by the Department more on the basis of theoretical anticipation rather than on actual requirements. The Committee emphasizes the fact that it is necessary on the part of the Department to avoid large variations in the Budget Estimates, Revised Estimates and Actuals to ensure that the budgeted funds are not locked up and surrendered later. The Committee would like to impress upon the Department that non-utilization should be a rare exception instead of being a recurring feature as has been witnessed year after year. The Committee therefore, recommends that at least from now onwards, definite yardsticks be devised and adhered to for the purpose of projecting realistic budgetary assumptions and balanced utilization thereof so that the sanctioned Budgets for the Health Sector do not remain idly parked.**

1.28 **The Committee is dismayed to note that huge savings to the tune of ₹ 1062.00 crore and ₹ 97.75 crore have been registered in the Capital Account during 2014-15 and 2015-16 respectively. Such gross under-utilization of funds under Capital Section of the Demands for Grants points to the**

fact that development oriented activities have been curtailed. The reasons adduced by the Department mainly relate to slow pace of expenditure on procurement of equipments and Capital works, non-finalization of machinery and proposals for procurement of machinery equipments, slow progress in execution of works by the executing agency etc. The Committee deprecates the Department for such an erratic expenditure management, especially at a time when the Government is striving for fiscal consolidation. The Committee, therefore, recommends that the occurrence of huge quantum of savings on the Capital Account warrants special attention and proactive steps by the Department so that this pernicious trend could be tackled in an effective manner.

1.29 **The Committee also notes that unspent budgetary provisions were kept till the close of the respective financial years and surrendered on the 31st March in both the years. The Committee is constrained to observe that had the Department exercised rigorous monitoring of the progress of expenditure to determine the nature of spending on a periodic basis and well spaced the spending pattern, it would have been able to foresee the quantum of unspent budgetary provisions in time and would have surrendered the same much before, without waiting for the fiscal end. The Committee observes that a resource constrained country like India cannot afford to keep a vast chunk of its financial resources locked up and surrendered towards the end of financial year and recommends that the provisions of General Financial Rules be adhered to scrupulously and unspent budgetary provisions may be surrendered timely for their gainful utilization for other fund starved projects/ schemes.**

1.30 **The Committee notes from the information furnished that as many as 1929 utilization certificates are pending as on 26.02.2016 under Health Sector and a substantial amount to the tune of ₹ 2862.45 crore is involved therein. The oldest pending U.C. dates as far back as 2005-06. Since pending UCs impede further release of funds and thus poses bottlenecks in the effective implementation of schemes, the Committee recommends that liquidation of pending UCs be accorded utmost priority and a dedicated mechanism be put in place to ensure that all pending UCs are liquidated within a designated timeline. The Committee desires to be kept apprised of the action taken and the success achieved in this regard.**

1.31 **The Committee is also concerned to note that one project in North Eastern Region of India, namely RIMS, Imphal has experienced cost overrun of 10% and time overrun of 4 years while RIPANS, Aizwal has time overrun of 15 months. The Committee's concern in regard to delay in these projects mainly centres on the fact that access to quality health services remains low in the N.E. Region and the inordinate delay in execution of the projects would further accentuate this disequilibrium in the healthcare domain in North East Region. The Committee, therefore, recommends that all hindrances in operationalization of the projects may be ironed out within a designated time-frame. The Committee wishes to be kept apprised of the progress of operationalizing the projects.**

II. SAFDARJUNG HOSPITAL AND VARDHAMAN MAHAVIR MEDICAL COLLEGE (SJH AND VMMC), NEW DELHI

2.1 Safdarjung Hospital is a Central Government Hospital providing services in various specialties and super-specialties in almost all major disciplines. The Hospital has a medical college associated with it, named Vardhman Mahavir Medical College. A Homoeopathy OPD and Ayurvedic OPD are also running within the premises of this Hospital.

2.2 As per information furnished in the Outcome Budget 2016-17, the approved outlay for SJH and VMMC for the Twelfth Plan is ₹ 2468.00 crore. In reply to a question, it has been informed that the Plan Budget Estimates (BE), Revised Estimates (RE) and Actual Expenditure (AE) for 2015-16 is as follows:-

Table No. 8

(₹ in crore)

BE	RE	AE
357.00	511.00	507.00*
BE	RE	AE
357.00	511.00	507.00*

*As on 31st March, 2016 (provisional)

2.3 On a query regarding the progress made towards re-development plan of the Hospital and revision of its cost, if any, the Committee has been informed that the redevelopment plan consists of Super-specialty cum paid ward and emergency ward. The Government has approved this redevelopment plan with the estimated cost of ₹ 1333 crore. The original cost of the redevelopment plan has not been revised.

The updated status of the redevelopment project is given below:-

(i) Civil Works

(a) Civil work of Emergency Block is substantially completed as per the timeline and it is likely to be completed by 31st March 2016.

(b) SSB and Paid ward block: civil work is progressing as per schedule and is likely to be complete by June-July 2016.

(ii) Machinery & Equipment

The Government has approved medical equipments including lab furniture at the cost of ₹ 396 crores. The tendering process is in advance stage. The equipments are likely to be in place before October 2016.

(iii) Manpower

2.4 The manpower requirment has been finalised and submitted to the Ministry of Finance for seeking their approval.

2.5 The project is scheduled to be completed by March, 2017 and it is going on as per time line.

2.6 On being asked about the projected demand of fund requirements for VMMC and the approved allocation for 2015-16, the Department has informed that against plan projection of ₹ 18.30 crore, ₹ 12.00 crore has been allocated in BE 2016-17. The Committee has also been informed that the project of expansion of the College building and auditorium is delayed as requisite permissions could not be obtained by CPWD.

2.7 The Committee has noted from the information furnished that following is the vacancy position in VMMC and SJH:-

Table 9

Group	Sl.No.	Name of Group	Sanction	In position		Vacant	Remarks
	1	Medical Superintendent	1		1	0	
	2	Addl. M.S.- Teaching	1		2	-1	
	3	Addl. M.S.- GDMO	4		3	1	
Group A Distribution - Type I	4.	Specialist of Teaching Sub Cadre inclu-ding Principal (SJH/VMMC)	175	Regular - 148, on Contract - 13, Total- 161	161	14	13 (Doctors are on Contract basis)
	5.	CHS Specialist Non Teaching	140		137	3	
	6	GDMOs with PG Qualification	73		60	13	
	7	Public Helath Sub Cadre (Epidoimelogist)	1		1	0	
		Total (Group A)	**395**		**365**	**30**	
Group	Sl.No.	Name of Group	Sanction	In position		Vacant	Remarks
Group A Distribution - Type II	1	Medical	395	365	30		
	2	Group - A Non Medical (including college of Nursing)	67	10	57		
		Total (Group A)	**462**	**375**	**87**		
Group	Sl.No.	Group - B Gazetted Non Medical	Sanction	In position		Vacant	Remarks
Group B	1	Technical / Para Medical	22	4		18	

Group	Sl.No.	Group - B Gazetted Non Medical	Sanction	In position	Vacant	Remarks
	2	Technical / Para Medical (Nursing)	10	9	1	
	3	Technical	1	0	1	
	4	Ministerial / Non technical	32	13	19	
		Total Gr. B	**65**	**26**	**39**	
		Grand Total	**527**	**401**	**126**	

2.8 On being asked about the progress made towards making IVF lab of Safdarjung Hospital operational, the Department has supplied the following information: -

2.9 "The details of progress made with respect to making IVF lab at Safdarjung Hospital operations is as under:–

The civil work is almost complete. The work of modular OT is near completion. The delay in making OT was due to cancellation of the tender due to single vendor. It was retendered and awarded. The anaesthetic pipelines have been laid and ducting of centralised A/C is underway. This will be followed by final painting and white washing and should be completed within a month.

Sanction of various posts has been given in consultation with the Department of Expenditure.

To procure the equipment and reagents in turnkey basis, a notice inviting tender (NIT) of tender enquiry was published *vide* notice No. Y- 11016/199/IVF Centre/SJH/2015-PC dated 23.10.2015 in National Newspaper and ITJ. Closing date and time for receipt of bids was 16.12.2015. There was a pre-bid meeting with companies for discussing technical specifications at 16.11.2015, wherein some changes in the specification were suggested.

The Directorate General of Health Services directed Safdarjung Hospital to review the specifications as new concept and new equipment are available for IVF at present.

Consequently, a meeting was held in the office of Medical Superintendent, Safdarjung Hospital with IVF experts on 29.12.2015 to discuss their views on changes in technical specifications. Specifications were reviewed and a few new equipments were added. The revised specifications have been submitted for seeking approval of Directorate General of Health Services on 21.1.2016."

2.10 **The Committee notes the submission of the Department that the redevelopment Plan of Safdarjung Hospital is going as per timeline and there is no escalation in the original estimates of ₹ 1333.00 crore. The Committee also notes that the manpower requirement has been submitted to the Ministry of Finance for seeking their approval. The Committee would expect the Department to proactively pursue the approval of the manpower requirement with the Ministry of Finance so that**

there are no instances of tardiness and inefficiencies in executing the redevelopment plan and the funds earmarked for the project do not remain idly parked for want of necessary approvals. The Committee wishes to be updated in this regard.

2.11 **The Committee has been impressing upon the Department to obtain necessary approvals on time and to ensure that the project is taken up for implementation without delay. The Committee is, therefore, anguished to note that the project of expansion of VMMC building and auditorium is delayed because the requisite permission could not be obtained by CPWD. Delay in obtaining approvals often proves to be contributory factor for under-utilization of budgeted funds. It is, therefore, imperative on the part of the Department to aggressively take up the matter of delay with CPWD for the purpose of expediting the requisite permissions/approvals so that the expansion of VMMC does not lead to delays and under-utilization of budgeted funds and cost escalations.**

2.12 **The delay in operationalization of In-Vitro Fertilization lab at Safdarjung had found mention in the Committee's 39th, 54th and 82nd Reports presented to Parliament on 28th April 2010, 26th April 2012 and 24th April 2015 respectively. In the 82nd Report, the Committee had recommended that the setting up IVF lab should not be delayed beyond 2015-16. The Committee is, however, constrained to observe that this project is still hanging fire. The Committee, therefore, expresses its displeasure at the snail's pace of progress made towards making the IVF lab operational and recommends that stringent measures be taken for addressing the recurrent problem of delay in implementing the project and expediting operationlization of the IVF lab at Safdarjung Hospital.**

2.13 **The Committee notes with dismay that out of 527 sanctioned posts, as many as 126 vacancies are in Group 'A' and 'B' category. The Committee observes that such a large number of vacancies would eventually impact on the functioning of the Hospital. The Committee, therefore, recommends that an action plan be drawn up and vacancies be filled in a time-bound manner. The Committee desires to be apprised of the Department's plan of action for filling up the vacancies.**

III. DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

3.1 Dr. Ram Manohar Lohia Hospital (RML Hospital), New Delhi is a centre of excellence in healthcare under Central Sector Hospitals.

3.2 The Plan funds allocated to the Hospital in 2015-16 was ₹ 175 crore and the actual expenditure incurred as on 15.03.2016 was ₹ 163.44 crore which work out to 88.05% of the allocated funds for the financial year 2016-17.

3.3 BE of ₹ 182.00 crore has been earmarked for the Hospital for 2016-17.

3.4 In reply to a question the Committee has been informed that the following projects of the Hospital are under way:-

(i) **Construction of Super Specialty Block:**

Revised DPR for land measuring 2.45 Acres at G-Point adjacent to Dr. RML Hospital has been prepared and is under examination by a Committee constituted under Senior Architect, Central Design Bureau comprising members from Technical experts from PMSSY, HSCC. Once it is approved by the Committee, it will be processed for seeking approval of competent authority.

(ii) **Constructions of Dharamshala**

A four storeyed new building for Dharamshala with 42 rooms and covered area has been constructed. This will provide accommodation to the attendants of patients coming from different parts of the country for treatment in the RML Hospital, New Delhi. However, the completion certificate is awaited from local authorities, which is likely to be received soon.

(iii) **Modern Maternal Care Centre**

The land measuring 2.01 acre at Old R.K.Ashram Marg is heavily occupied by the Jhuggies dwellers. Government of NCT of Delhi has been requested for eviction.

3.5 **The Committee observes that two critical projects, namely construction of Super-Specialty Block and Modern Maternal Care Centre have been conceptualized. The Committee is, however, concerned to note that the land allotted for the purpose of constructing Maternal Care Centre is occupied by the Jhuggy dwellers. The Committee expects the Department to vigorously pursue the matter of eviction with the Government of NCT of Delhi so that this important project is not delayed further. The Committee desires to be apprised of the outcome of the request made to the Government of NCT of Delhi.**

3.6 In response to a query regarding the updated vacancy position in respect of various cadres in the Hospital the Department has furnished the following status:-

Table No. 10

Dr. Ram Manohar Lohia Hospital, New Delhi (Group A)

Sl.No.	Name of the Post	Sanctioned Strength	In position	Vacant	Number of posts deemed abolished	Reasons	Remarks
1.	Jt. Director (Admin.)	1	0	1	The Post vacant since creation *i.e.* 1992		Group A non CHS post to be filled by Ministry
2.	Dy. Director (Admin.)	3	1	2			
3.	Dy. Labour Welfare Commissioner	1	1	1			

Table No. 11

Dr. Ram Manohar Lohia Hospital, New Delhi (Group A) Tenure post

Sl.No.	Name of Department	Sanctioned Strength	In position	Vacant	Number of posts deemed abolished	Reasons	Remarks
1	Dr. R.M.L. Hospital	2927	2097	826	209		Expert Group A posts as mentioned above and CHS posts

Table No. 12

Dr. Ram Manohar Lohia Hospital, New Delhi

Sl.No.	Name of the Post	Sanctioned Strength	In position	Vacant	Number of posts deemed abolished	Reasons	Remarks
1.	Junior Resident Doctors	231	155	76			Tenure Post
2.	Senior Resident	270	244	26			

3.7 The Department has also stated that Dr. RML Hospital is paying adequate attention for filling up the vacant posts in order to facilitate the medical care to the patient. The recruitment process for filling up the post of 187 Staff Nurses on contract basis has been completed and 165 Staff Nurses have already joined and for the remaining vacant posts, the offer of appointment is under process. The recruitment process for filling up the posts of Jr. ECG Technician, Speech Therapist, Physiotherapist, Occupational Therapist, OT Assistant, Radiographer, LDCs have already been initiated and proposals are at advanced stage and likely to be completed very soon. Further, the recruitment process has also been initiated with regard to the posts likely to be occurred from 1st April, 2016 to 31st March, 2017.

3.8 **The Committee would also like to be apprised of the sanctioned, and in- position strengths of doctors, nurses, and other categories of officers and staff of Dr. Ram Manohar Lohia Hospital.**

3.9 In reply to a question regarding the actual expenditure incurred *vis-à-vis* allocation of funds made in 2015-16 in respect of Post Graduate Institute of Medical Education and Research (Dr. Ram Manohar Lohia Hospital) New Delhi, the Department has furnished the following information:-

Table No. 13

Statment Showing Plan Budget Allocation of 2015-2016

(₹ in lakhs)

Sl. No.	Head Code 2210 (Plan)	Object Head	B.E	R.E	Expe. Upto 14-03-2016
1	2	3	4	5	6
1	400001	Salary	1.9	1.90	1.79
2	400013	OE	.50	.60	.51
3	400027	MW	.30	0.22	.15
4	400031	Grants-in-Aid	.01	.010	0
5	400050	Other Charges	.020	.20	0
6	400006	Medical Treatment	.030	.015	0
7	400011	TA	.030	.020	.013

1	2	3	4	5	6
8	400028	Professional Service	.020	.020	0
9	400020	Other Admn. Expenses	.015	.01	0
10	400021	Supply & Materials	.075	.075	.040
		TOTAL	2.90	2.90	2.51
		4210 (Plan)			
		Machinary & Eqiupment	.10	.10	.001

3.10 **The Committee's scrutiny reveals significant absence of correlation between BE, RE and AE under various heads. For example against the BE and RE allocation of ₹ .01 lakh under the head - Grants-in-Aid, ₹ .02 lakh under the head - other charges and ₹ .03 lakh under the head - medical treatment, ₹ .02 lakh under the head - Professional Service and ₹ .015 lakh under the head - other Admin. Expenses, nothing has been spent till 14.03.2016. Similarly, the PGIMER, New Delhi was able to expend ₹ .001 lakh only against the BE and RE allocation of ₹ .10 lakh for Machinery and Equipment. The Committee observes that such an erratic trend of expenditure is indicative of shortcomings in formulating the Budget Estimates and lack of effective monitoring of utilization of budgeted funds. The Committee would therefore, like the Department to explain the reasons behind the mismatch between the BE, RE and the Actual Expenditure of PGIMER, New Delhi in the year 2015-16.**

IV. LADY HARDINGE MEDICAL COLLEGE & (LHMC) SMT. SUCHETA KRIPLANI HOSPITAL, NEW DELHI

4.1 Lady Hardinge Medical College & Smt. Sucheta Kriplani Hospital provides medical education for under-graduate and post graduate courses, along with hospital services while Kalawati Saran Children's Hospital provides medical care services exclusively for paediatric patients. As per information given in the Annual Report, Gynaecology Department of LHMC is on 5th position among Best Hospitals of India as judged by The Week.

4.2 During the course of examination of Demands for Grants (2015-16) , the Department had furnished the following information regarding the Redevelopment Plan of LHMC and its associated hospitals:-

(a) It was decided that the redevelopment of the LHMC and associated hospitals should be done in phased manner.

(b) Phase I was for implementation of the 'Central Educational Institution (Reservation in Admission) Act–2006' to create additional infrastructure for additional admissions and manpower pertaining to 27% OBC reservation. The CCEA approved a budget of ₹ 586.49 crore for Phase I of Comprehensive Redevelopment Plan.

(c) The activities under Phase I of the Comprehensive Redevelopment Plan of LHMC and associated hospitals comprises following activities:

(i) Civil work including electrical, AC and furnishing work etc.

(ii) Procurement of the machines and equipment

(d) The construction of hospital and residential buildings was initiated in March 2012 by M/s Unity Infraprojects Ltd. and M/s SAM Built Well (I) Ltd. respectively.

(i) The civil work was to be completed in 20 months *i.e.* in Nov. 2013 and the whole project by May/June 2014.

(ii) However the construction work by M/s Unity Infraprojects Ltd. is at standstill.

(iii) This was reviewed by Secretary (HFW) in the meeting held on 11.11.2014 and it was decided that HSCC would issue a show cause notice to M/s Unity Infraprojects Limited and initiate the process for termination of contract.

(iv) Accordingly, HSCC issued a show cause notice to Unity Infraprojects on 8.12.2014 with the instruction to M/s Unity Infraprojects Ltd. to give the reply in 7 days *i.e.* by 15.12.2014.

(v) In their reply M/s Unity Infraprojects Ltd. requested that the show cause notice be withdrawn and project completion duration be extended.

4.3 Subsequently, the Department in its Action Taken Notes on the 82nd Report of the Committee furnished the following information:-

Action Taken

"3.34 HSCC(I) Ltd., the Project Consultant has informed that the construction work by the contractor, M/s Unity Infraprojects is at standstill for more than a year due to financial crunch and the contractor, M/s Unity Infraprojects has stopped the work at the site. The Ministry has been regularly monitoring the work of redevelopment and also exploring other ways and means or alternates to get the redevelopment work expedited. A meeting was convened in the M/o Health and Family Welfare on 18.02.2015, to review the progress of works which was attended by senior officers of HSCC(I) Ltd. (Project consultant), Representatives of M/s Unity Infraprojects Ltd. (Contractor) and LHMC. M/s Unity Infraprojects Ltd. accepted the delay because of their financial crunch. Further, various commitments were made by M/s Unity Infraproject in the meeting.

3.35 A meeting was again convened in the M/o Health and Family Welfare on 10.03.2015 to review the progress of works wherein, it was observed that M/s Unity Infraprojects Ltd. has not fulfilled any of its commitments made by them during the meeting held on 18.02.2015. In this meeting, M/s Unity Infraprojects Ltd. again requested for 15 days' time period and committed that they shall take up the works in all fronts and shall fulfil all commitment made by them during the meeting dated 18.02.2015, by 25th March, 2015. It was also assured that UG hostel shall be completed and handed over to LHMC by 15th March, 2015. However, M/s Unity Infraprojects Ltd. failed to fulfil any commitment.

3.36 Accordingly, proposal for termination of contract for subject works as stipulated in the General conditions of contract of the agreement with M/s Unity Infraprojects Ltd. by issuance of termination notice is under consideration.

Recommendation/Observation

3.37 The Committee would also like to be informed of the financial implications of potential termination of contract awarded to M/s Unity Infraprojects Ltd., for the delay in completion of the Redevelopment Plan including the cost escalation involved.

Action Taken

3.38 As Project Consultant, HSCC (I) Ltd. has informed that, the tender for subject works was called in February, 2011 based on estimate prepared on DSR 2007 with cost index of 136%. The current cost index over DSR 2007 is 178%. The increase in cost index to the tune of 30.88% would be on balance works amounting to ₹ 393.98 crore (tendered)- ₹ 127.00 crore (executed) = ₹ 266.98 crore. However, actual cost implication would only be known after invitation of tenders for balance works which would be initiated subsequent to the termination of contract. Further, as per term of contract upon determination, the security deposit (Retention money) already recovered in the form of Retention money Bank guarantee amounting to ₹ 7,25,84,000/- and Performance Guarantee amounting to ₹ 19,69,90,943/- under the contract shall be liable to be forfeited and shall be absolutely at the disposal of LHMC."

4.4 Apprising the Committee of the latest developments in this regard, the Department has made the following written submissions:-

4.5 Due to breaches of terms and conditions of Contract and delay on the part of M/s Unity Infraprojects Ltd., the Contract was determined on 19.08.2015 by LHMC on the recommendation of HSCC with approval of the Ministry of Health and Family Welfare. On the recommendation of HSCC, the 'Termination Notice' was issued to M/s Unity Infraprojects Ltd. on 20.08.2015 in terms of Contract and immediately on 21.08.2015 notice for encashment of Bank Guarantees (BG) was served on the Banks and the proceeds of encashment of BG have been taken by LHMC.

Mobilization Advance	₹ 30,73,40,000/-
Retention money	₹ 7,25,84000/-
Performance BG	₹ 19,69,90,943/-
Operation & maintenance	₹ 75,62,404/-

Status of arrangement being made to award the contract to a new Contractor and the time limit within which the same would be completed

Subsequent to determination of contract of M/s Unity Infraprojects Ltd. (Contractor) by the competent authority for subject works on 19.08.15, a meeting was convened by the Ministry on 27.08.15, wherein a schedule for activities to be undertaken till award of balance works, left out by M/s Unity Infraprojects Ltd. were finalized. However, HSCC informed that M/s GD Sambhre (Architectural consultant) showed inability to complete the activities of preparation of tender documents including BOQ, estimate, specifications etc. for subject works, resulting in delay in taking up of other activities like approval of estimate by the Ministry and subsequent floating of tenders by HSCC.

Accordingly, HSCC was asked to submit their proposal for taking up the activities pertaining to preparation of estimate, BOQ, specifications etc. of balance works left out by M/s Unity Infraprojects Ltd.

The proposal for executing balance works along with cost implication and estimated cost of balance works left out by M/s Unity including 5 years annual operation & maintenance has been prepared and is under examination of the Ministry.

HSCC has informed that the process for tendering and execution of works will be initiated after approval of cost estimates by Ministry and will take around 24 months after the approval of cost estimates.

4.6 **The Committee observes that the originally approved cost of the Redevelopment Plan of LHMC and associated hospitals was ₹ 586.49 crore and the project was targeted to be completed by May/June 2014. But due to breaches of terms and conditions and delay on the part of M/s Unity Infraprojects Ltd., the contract has been terminated. Much delay has already taken place and it is, therefore, imperative on the part of the Department to resolve at the highest level all procedural and operational matters including approval of cost estimates expeditiously, and execute the Redevelopment Plan within the approved cost and shortest possible time-frame. The Committee also recommends that a fool-proof mechanism be devised to address operational performance of the contractor and take appropriate policy decision to address the critical issues concerning the execution of the Redevelopment Plan. The Committee desires to be kept apprised of the progress made towards executing the Redevelopment Plan.**

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

5.1 The Committee has been informed that the AIIMS had been allocated ₹ 700.00 crore for 2015-16 and the entire allocation has been utilized. The Institute has been allocated ₹ 1000.00 crore for the financial year 2016-17 which is almost double of BE 2015-16 allocation of ₹ 550.00 crore and is 43% higher than RE of ₹ 700.00 crore for 2015-16.

5.2 On being asked about the utilization status of the Plan allocation of ₹ 700.00 crore for 2015-16 and the status of physical targets set and success achieved in 2015-16, the Committee has been informed that the amount will be fully utilized during the said financial year. It has also been informed that the main works initiated during 2015-16 are as follows:-

(i) New OPD Block (Cost: ₹ 573 crore)

(ii) New Mother & Child Block (Cost: ₹ 204. crore

(iii) National Cancer Institute (Cost: ₹ 505 crore)

(iv) New Private Ward (Cost: ₹ 92 crore)

5.3 All works have been awarded and physical construction initiated.

5.4 Asked about the adequacy of the funds allotted to AIIMS, the Director, AIIMS, during evidence before the Committee submitted that ₹ 1000.00 crore has been allocated in BE 2016-17 which would be sufficient for AIIMS, additional funds are required for executing and operationlizing the Jhajjar Campus of AIIMS.

5.5 During the examination of Demands for Grants (2015-16) of the Department of Health and Family Welfare, the Committee had been informed that a major development work in the form of expansion of OPD Block at AIIMS had been planned with the estimated cost of ₹ 573.00 crore out of which ₹ 4.02 crore had been spent. Subsequently, it was informed that OPD Civil construction works had been awarded and would be completed by 30th May, 2017.

5.6 The Department in its Action Taken Notes on the 82nd Report had *inter-alia* informed that out of the 22 projects targeted to be completed in the Eleventh Plan, the updated status of the projects *vis-à-vis* their completion were as below:-

Table No. 14

Total Projects	22
Completed	12
In progress	01
Tendering/Award Stage	04
Shelved	02
Held up on account of low priority	01
Held up on account of non-clearance of statutory bodies	01

5.7 On being asked about the progress made towards implementation of pending development projects, the Department has informed that every effort is being made to resolve the issues related to the implementation of different development projects with timely completion of projects with no time and cost overruns subsequently. Meetings with NDMC and coordination meeting with Ministry of Urban Development are being held on regular basis.

5.8 As regards starting a Burns Unit at JPNATC, the Department in a written reply submitted that proposal for starting of Burn and Plastic Surgery Block at AIIMS Trauma Centre was cleared by the SFC on 13.08.2015. Tender has been invited, financial bids opened and awaited for approval for next Standing Finance Committee. Building plans have been submitted to all statutory bodies. Approval received from DUAC, approval from EIA & NDMC is under process. It is proposed to have 100 beds including 30 beds for ICU care along with five operation theatres. The proposed facility will provide comprehensive 24x7 emergency patient care.

5.9 In reply to a query regarding vacancies in the faculty posts, the Department has informed that 232 faculty posts are vacant as on 14.04.2016:

Table No. 15

Vacancies (Post-Wise as well as Cadre-Wise in Faculty Position) as on 11.04.2016

Sl.No.	Name of the post	Vacant
1	Director	–
2	Medical Superintendent	–
3	Professor	66
4	Additional Professor	10
5	Associate Professor	23
6	Assistant Professor	131
7	Principal, College of Nursing	–
8	Lecturer in Nursing	002
	TOTAL	232

5.10 Recruitment process for the vacant faculty posts of Assistant Professor/ Lecturer in Nursing has already been initiated and vacant posts of Assistant Professor/Lecturer in Nursing are going to be advertised soon to fill up the same.

5.11 **The Committee notes that in the Action Taken Notes on the 89th Report, it had been submitted by the Department that as against the allocation of ₹ 343.00 crore in RE 2014-15 for creation of Capital Assests, total expenditure of ₹ 191.69 crore (*i.e.* 55.96%) was incurred in the month of March 2014 despite stipulated ceiling of 30% as per the provisions of General Financial Rules. The Committee expects the authorities concerned to show proper fiscal discipline and responsibility by evenly laying out expenditure for which quarterly targets may be fixed.**

5.12 **The Committee notes that the expansion of OPD Block at AIIMS has been planned with the estimated cost of ₹ 573.00 crore out of which a meager ₹ 4.02 crore has been spent and the targeted date of completion of the project is 30th May 2017. Going by the persistent problems of time and cost overruns in the infrastructure projects of AIIMS in the past, the Committee apprehends that the possibility of occurrence of fiscal and physical slippages in the execution of the project is distinct. The Committee, therefore, recommends that intensive monitoring of the execution of the expansion work of OPD at AIIMS be done so that the project is executed within the approved cost and designated time-line.**

5.13 **The Committee in Para 5.16 of its 82nd Report had sought to be apprised of time overrun and cost escalation, if any, of the 12 completed projects and the reasons behind the shelved projects. The Committee is, however, constrained to observe that instead of giving specific information as asked for, the Department in the Action Taken Notes on the 82nd Report has merely supplied number of projects completed, in-progress, at tendering/award stage, etc. The Committee reiterates recommendation made in Para 5.16 of its 82nd Report and desires to be apprised of time overrun and cost escalation, if any, of the 12 completed projects. The Committee also desires to be kept apprised of the approved cost of the projects in progress and tendering/award stage and the designated time-line for their execution and operationalization.**

5.14 **The Committee also takes serious view of the fact that when asked to indicate the progress made towards implementation of pending development projects at AIIMS, the Department has merely stated that "every effort is being made to resolve the issues related to the implementation of different development projects with timely completion of projects with no time and cost overruns...". The Committee had expected the Department to apprise it of the status of completion of all pre-project formalities, approved cost of the projects and set time-frame of their implementation and expenditure incurred, if any. The Committee, while strongly disapproving of the fashion with which the Department has responded to the query of the Committee, urges the Department to furnish the above details in connection with all pending/on- going Development Projects at AIIMS.**

5.15 **The Committee notes that the setting up of a Burns Unit at AIIMS has been approved by the Standing Finance Committee on 13.08.2015. The Committee would now like the Department to play a proactive role in moving the AIIMS administration towards quickly completing all pre-project formalities in a time bound manner and implement the project within a stipulated timeframe.**

5.16 **It is a matter of great concern that a whopping 232 faculty posts are vacant at AIIMS. The Committee observes that teachers/doctors are the most important cog in the delivery of quality**

healthcare and imparting of quality education at AIIMS. One of the prime reasons of high burden of clinical services on AIIMS is its repute for high quality care. The Committee therefore, recommends that the faculty shortage at AIIMS must be squarely addressed without further delay as it has a direct bearing on the delivery of quality healthcare and imparting of quality education.

VI POST GRADUATE INSTITUTE OF MEDICAL EDUCATION AND RESEARCH, CHANDIGARH

6.1 The Post-Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, is a premier national centre of medical education, research, post-graduate medical education and is also a specialized hospital.

6.2 The Institute is fully funded by the Government of India. The main objectives of the Institute are :-

- To develop patterns of teaching of under-graduate and post-graduate medical education in all its branches so as to demonstrate a high standard of medical education;
- To bring together as far as possible in one place educational facilities of the highest order for training of personnel in important branches of health activity; and
- To attain self-sufficiency in post-graduate medical education to meet the country's need for specialists and medical teachers.

6.3 In reply to a question, the Committee has been informed that the allocation of ₹ 170.00 crore made in BE 2016-17 for the Institute is ₹ 10.00 crore higher than BE 2015-16 allocation of ₹ 160.00 crore. It has also been informed that the allocation for 2015-16 will be utilized fully.

6.4 On being asked about the status of on-going projects at PGIMER, Chandigarh, the Department has furnished the following information:-

Table No. 16

Sl. No.	Name of Project	Project Outlay /Estimated Cost (₹ in crore)	Time line for execution	Cost Overrun	Expenditure upto January 2016 (₹ in crore)	Remarks
1	2	3	4	5	6	7
1	Advanced Cardiac Centre (Phase-II)	13.67	Work was to be completed in 11th Five year Plan	Nil	2.82	The civil, Electrical and HVAC components pertaining to this work has already been completed and put use. Tenders for the Lifts shall be opened on 22.3.2016. Scheme for Medical Gases is being revised as per requirement of user department and the tenders shall be floated within one month.

1	2	3	4	5	6	7
2	Modernization of Research A and B Block	48.33	Work was to be completed in 11th Five year Plan		4.83	Two Separate Monitoring Committees have been constituted by Director, PGIMER to look after Modernization. As regards to the scheme submitted by NBCC for upgradation of External Engineering services of Research Block A&B, the scheme has been finalized in meeting of the Monitoring Committee held on 24.2.2016. Accordingly, the tender document and estimate are being prepared by NBCC. The same are expected to be finalized within one month.
3	Modernization of Nehru Hospital	87.82	Work was to be completed in 11th Five year Plan		8.78	After the approval of SFC in its meeting held on 3.12.2015 for the work of modernization of Nehru Hospital, the revised scheme prepared by NBCC for Nehru Hospital is under scrutiny. The same shall be finalized in the forthcoming meeting of Monitoring Committee expected to be held in next fortnight.

Table No. 17

Updated Progress report in respect of Pending Projects which are under Implementation as desired under issue no. 64 of Questionnaires Set-I based on the 89th report of the Departmental Related Parliamentary Standing Committee on Health and Family Welfare.

Sl. No.	Name of Project	Project Outlay /Estimated Cost (₹ in crore)	Time line for execution	Expenditure upto January 2016 (₹ in crore)	Cost Overrun	Remarks
1	2	3	4	5	6	7
1	Setting up of Satellite	449.00	within 34 months	28.20	N/A	The present status of work is as under:

1	2	3	4	5	6	7
	Centre of PGIMER at Sangrur (Punjab)		*i.e.* 31st December 2016. A start up OPD facility was to be started before commis-sioning of Satellite Centre.			**Phase I-A** **Temporary OPD, Guest House & Boundary wall:** The work of temporary OPD is approx. 95% completed. Aluminum, Fire Fighting, Electrical wiring and road work in progress. The work of Guest House is approx. 85% completed. Aluminum, flooring, plumbing and firefighting work in progress. The work of boundary wall is approx. 98% completed except front side wall which is held up in lack of approval from NHAI for freezing the boundary line. **Phase I-B** **Hospital, Administrative Block, OPD and Residential Complex** HSCC has floated tender for the composite work including HVAC and external electrical works for ₹157.18 crores. HSCC has opened the Technical Bid on 14.01.2016 and submitted the Technical Evaluation Bid to the Institute on 15.02.2016 and further clarifications given by HSCC on 1.03.2016. The Technical Bid is under scrutiny with the Institute and the same shall be completed within a week for opening of price bid by HSCC. Following approvals are still awaited from HSCC

1	2	3	4	5	6	7
						Approval of Master Plan & Building Plans. Approval from NHAI
2.	Expansion of Nehru Hospital (250 bedded) at PGIMER, Chandigarh (under OBC).	182.05	–	47.16	N/A	As the original estimate did not include the essential services and there has been cost escalation during this period, the revised cost estimate amounting to ₹ 182.05 cr. (₹ 92.97 cr.) was put up before the Standing Finance Committee meeting he1d on 19.08.2015. The committee approved the proposal and directed the agency (CPWD) to expedite the work. The Revised Cost Estimate amounting to ₹ 182.05 cr. is being put up before the Standing Finance Committee of Ministry for appraisal and Hon'ble Minister for approval. As per present status at site, all the Reinforced Cement Concrete (RCC) structure work has been completed except a part of Terrace floor. At all the floors, work of outer envelope wall with Aerated Cement Concrete Blocks is in progress. The internal brick work partitions have been completed at all the floors except on 4th floor where it is in final stage. The Reinforced Cement Concrete walls of linear accelerator have been casted upto bottom of roof level and the roof is also ready for casting. Works

1	2	3	4	5	6	7
						for installation of Elevators and connection of 11 KV to 66KV sub-station have been awarded and the tenders for sub-station are under process in CPWD. The DNITs of remaining services are under preparation at CPWD.
3.	Supply Installation Testing & Commission-ing (SITC) of Heating Ventilation and Air Conditioner (HVAC) system in New OPD work.	33.00	–	0.14	N/A	The consultancy work for various Engineering Services has been awarded amounting to ₹ 60.00 lacs. The Consultant has started the work.
4.	Up–gradation and Special Repair of Residential houses of PGIMER, Sector 12, Chandigarh	3.93	–	Nil	N/A	Detailed Estimate & Detailed Notice of Inviting Tender (DNIT) to be put up before Engineering Sub-Committee.
5.	Revised Estimate for Construction of Residential Complex & Hostels at PGIMER Campus, Sector-12, Chandigarh under OBC Implementa-tion Scheme	211.34	–	Nil	N/A	PMC/DPR Consultant to be appointed. Revised Cost Estimate to be put up for EFC approval as per revised powers.

1	2	3	4	5	6	7
6.	Re- construction/raising of Boundary Wall, Replacement of Entry Gate & Reconstruction of Driveway etc. in Type- VI & VII houses, Sector-24, Chandigarh.	3.40	–	Nil	N/A	The detailed estimate is being prepared for approval of the authority.
7.	Expansion of existing Multi-level Parking, Construction of new Multi-level parking and connecting passage from Multi-level Parking to New OPD, PGIMER, Sector-12 Chandigarh	63.08	–	Nil	N/A	The agenda was put up in the Standing Finance Committee meeting he1d on 19.08.2015 The Committee approved the proposal of construction of Multi-level Parking and connecting passage. The case is being prepared for appointment of consultant.
8.	Upgradation and Special Repair of Residential houses of PGIMER, Sector 24, Chandigarh (Module-I, II & III)	17.85	–	Nil	N/A	Detailed Estimate & Detailed Notice of Inviting Tender (DNIT) to be put up before Engineering Sub Committee
9.	Upgradation of HVAC System of Operation Theater Complex, Nehru Hospital, PGIMER, Chandigarh	6.53	–	Nil	N/A	Heating Ventilation and Air Conditioner (HVAC) Consultant to be appointed for upgradation

6.5 **The Committee is constrained to observe that all the three projects, *i.e.* Advance Cardiac Centre (Phase II), Modernisation of Research 'A' and 'B' Block and Modernisation of Nehru Hospital were targeted to be completed during the Eleventh Five Year Plan but are nowhere close to execution even after the lapse of four years of the Twelfth Plan period. The Committee expresses its displeasure at the tardy progress of implementation of the above projects and recommends that the factors responsible for the inordinate delay in the implementation of the projects may be gone into in detail and corrective measures taken accordingly so that the implementation of projects is speeded up with sustained monitoring.**

6.6 **The Committee notes that nine other projects, namely, (i) setting up of Satellite Centre of PGIMER at Sangrur, (ii) expansion of Nehru Hospital at PGIMER; (iii) Supply, Installation and Commissioning of Heating, Ventilation and Air Conditioner (HVAC) system in new OPD (iv) upgradation and Special Repair of Residential Houses of PGIMER, Sector-12, Chandigarh, (v) Construction of Residential Complex & Hostel in PGIMER (vi) Re- construction/raising of Boundary Wall, Replacement of Entry Gate & Reconstruction of Driveway (vii) Expansion of existing multi-level parking (viii) Upgradation and Special Repair of Residential house of PGIMER in Sector-24, Chandigarh and (ix) Upgradation of HVAC system of operation Theatre Complex are under implementation. The Committee would like to be kept apprised of the progress towards their implementation.**

VII. JAWAHARLAL INSTITUTE OF POST-GRADUATE MEDICAL EDUCATION AND RESEARCH (JIPMER), PUDUCHERRY

7.1 As per the information given in the Annual Report 2015-16, Jawaharlal Institute of Post-Graduate Medical Education and Research (JIPMER) has emerged as one among the top best five medical institutes in the country and is poised to become the global giant in health sector. JIPMER is unique in providing best healthcare facilities of all broad specialties and super specialties free of cost to the community. It caters to the need of all strata of the society, from the poorest of the poor to the most affordable one. The Committee has been informed that Plan allocation of ₹ 600.00 crore has been made for JIPMER for the financial year 2016-17, which is three times more than the BE 2015-16 allocation of ₹ 200.00 crore and 70% higher than the RE of ₹ 350.00 crore for 2015-16. It has also been informed that the allocation of ₹ 350.00 crore for 2015-16 will be utilized fully.

7.2 In reply to a query, it has been informed that the following main works were initiated during 2015-16:-

(i) Modernization of Old Hospital & Institute Buildings, Expansion of SSB, Screening OPD with Geriatric & Dental Units-(Cost ₹ 237.68 crore)

(ii) Construction of Staff Quarters-(Cost ₹ 21.39 crore)

(iii) Re-laying of Roads-(Cost ₹ 18.92 crore)

(iv) Construction of 2.4 MLD Capacity Sewage Treatment Plant-(Cost ₹ 02.64 crore)

(v) Multi-Disciplinary Establishment of Robotic Surgery -(Cost ₹ 25.00 crore)

(vi) Modernization of Administrative Block -(Cost ₹ 0.94 crore)

(vii) Construction of Compound Wall for JIPMER Campus -(Cost ₹ 04.08 crore).

7.3 **The Committee welcomes the initiation of the infrastructure projects at JIPMER. The Committee's only advice would be to obtain all project-related clearances in advance and address procedural issues at the project conceptualization and approval stage so that these development projects don't witness time overruns and concurrent cost overruns as compared to the initially estimated project costs.**

7.4 The Committee has also been informed that the following new projects/initiatives are proposed to be undertaken in 2016-17:-

(i) Establishment of JIPMER-II at Karaikal

(ii) Setting up of Multi-Disciplinary Advanced Research Centre

(iii) Construction of Urban Health Centre at Kuruchikuppam

(iv) Augmentation works at PET-CT

(v) Up-gradation of Regional Cancer Centre.

7.5 **The Committee observes that the Establishment of JIPMER-II at Karaikal; and construction of Urban Health Centre at Kuruchikuppam may involve issues like land acquisition, rehabilitation and settlement, forest/wildlife clearances and therefore proper cooperation of and coordination with the State Government of Puducherry is of prime importance. The Committee would, therefore, like the JIPMER to put in place a robust coordination mechanism with the State Government so that regular and periodic follow-up action can be taken with the State Government for the purpose of timely resolution of all issues concerning the State.**

VIII. NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (NIMHANS), BENGALURU

8.1 As per the information given in the Annual Report 2015-16, the Central Government and State Government of Karnataka finance the National Institute of Mental Health and Neurosciences, Bengaluru. NIMHANS was declared as an Institute of National Importance in September, 2012.

8.2 NIMHANS is a tertiary care hospital in the fields of psychiatry, neurology and neurosurgery with their allied fields and teaching, research and community oriented activities are the main thrust of the Institute. The objective of the Institute is to promote the growth and development of Mental Health and Neuro Sciences.

8.3 On being asked about the actual expenditure incurred, both Plan and Non- Plan, in 2015-16, the Committee has been given following information:-

Table No. 18

(₹ in crore)

Head	BE 2015-16	RE 2015-16	Expenditure (As on 15.03.2016)*
PLAN			
Grants in aid General	23.00	23.00	18.5283
Grants for creation of Capital Assets	79.00	79.00	63.9596

(₹ in crore)

Head	BE 2015-16	RE 2015-16	Expenditure (As on 15.03.2016)*
Grant in aid salaries	38.00	38.00	43.1275
Total	140.00	140.00	125.6154
NON PLAN			
Grant in aid General	25.00	25.00	74.5410
Grant in aid salaries	110.00	110.00	94.9591
Total	135.00	135.00	169.5001

* Expenditure over and above the grants released by Government of India includes utilization of funds received from Government of Karnataka and Institute's own revenue earnings.

8.4 As per the information furnished, NIMHANS had projected a fund requirements of ₹ 199.31 crore under plan for BE 2016-17, against which it has been allocated ₹ 140.00 crore.

8.5 It has been informed that the following major capital works and procurement of equipments have been planned for 2016-17:-

a) **Capital Works:**

Construction of sub-specialty block

Construction of building for housing Medical Cyclotron equipment

Construction of building for housing Intra-operative MRI

Construction of Annexe building for Sub-specialty block for Psychiatry Department

Construction of building for common laboratories

b) **Major Equipments:**

MR gFUS

Upgradation of Achieva 3T equipment

Live Cell Imaging coupled with patch clamp Electrophysiology setup

FNIRS and E-Prime Equipment

Transmission Electron Microscope.

Auto analyzer with Accessories

Ultra Centrifuge

Upgrade of Confocal microscope FV 1000

Intra operative electrophysiology

Upright Fluorescence Microscope

Vestibular Evaluation Systems

8.6 **The Committee observes that NIMHANS has planned to implement some major projects and procure major equipments during 2016-17 for augmenting the facilities in the fields of psychiatry, neurology and neurosurgery. The Committee, therefore, recommends that the Department should ensure that these projects are not hamstrung by lack of funds as they relate to capacity building. Adequate budgetary requirements may be projected at RE stage on the basis of trend of expenditure and actual requirement. The Committee also expects the Department to anticipate the procedural/ administrative constraints in the implementation of the projects and address them well in time. The Committee desires to be apprised of the quantum of allocation and adequacy of funds for carrying out the Major Works and procuring Major Equipments and whether allocation of funds under these heads of the Grants have been made prior to obtaining pre-project clearances.**

8.7 On being asked about the updated status of filling up of vacant posts of faculty, Senior Resident and Junior Resident, the Committee has been furnished the following information :-

Faculty: There are 48 vacant faculty posts at the Institute as on date. The posts have been notified for filling up vide notification dated 05.01.2016. The last date for submission of applications was 20.02.2016. The applications received till 20.02.2016 are being scrutinized by the Institute and the posts will be filled up shortly.

Senior Resident/Junior Resident: There are 2 vacant posts each of Senior Resident and Junior Resident at the Institute. The posts have been notified for filling up *vide* notification dated 01.01.2016. The last date for submission of applications was 16.01.2016. The applications received till 16.01.2016 are being scrutinized by the Institute and the posts will be filled up shortly.

8.8 **The Committee notes that as many as 48 faculty posts are vacant and the process of filling them up is underway. Such a high vacancy situation in faculty posts is certain to impair on the functioning of NIMHANS. The Committee, therefore, recommends that the filling up of faculty posts be completed in a time bound manner and the Committee updated in this regard.**

IX. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH AND MEDICAL SCIENCES (NEIGRIHMS), SHILLONG

9.1 As per information given in the Annual Report 2015-16 of the Department, North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences was envisaged as a Post Graduate Medical Institute on the lines of AIIMS, New Delhi and PGIMER, Chandigarh.

9.2 With regard to the actual expenditure figures *vis-à-vis* the allocation made in 2015-16, the following information has been furnished:-

Table No. 19

(₹ in crore)

GIA	Allocation	Expenditure (As on January,2016)
Grant in Aid(Capital)	47.00	16.77
Grant in Aid (Salary)	88.00	67.77
Grant in Aid(General)	65.00	35.04
TOTAL:	200.00	119.58

9.3 An allocation of ₹ 300.00 crore has been made for the Institute on the plan side in BE 2016-17. The Committee has been informed that the allocation of Plan Budget for 2016-17 is as per projected demand of the Institute.

9.4 **The Committee observes that as against the allocation of ₹ 47.00 crore as Grant-in-Aid (capital), only ₹ 16.77 crore has been expended till January 2016. Since not more than 33% in the last quarter and 15% in the month of March can be spent, the possibility of under-utilization of budgeted funds is distinct. What is more worrisome is that the under-utilization of the budgeted plan funds for NEIGRIHMS may occur on the Capital Account, thereby impacting developmental activities. This calls for serious introspection so that such instances of blockage of funds earmarked for development activities do not recur.**

9.5 The Committee has been informed that the following projects are on-going at NEIGRIHMS:-

Department of Neuro-Surgery is being augmented during the current Financial Year 2015-16 with the addition of Neuro-Navigation compatible C- Arm image Intensifier; one unit of Operating Microscope and Image guided system for cranial and spinal application at a sanctioned cost of ₹ 3.91 crore.

The Cardiac Optical Coherence Tomography(OCT) has been made operational in the Department of Cardiology at a cost of ₹1.05 crore.

The Department of Radio-Diagnosis is being strengthened with the addition of 1000 mA Digital Fruoroscopyststem with flat panel detector at a total turnkey cost of ₹3.53 crore.

9.6 The following projects are in the pipeline :-

Expansion of Nursing College and Hostel (from 50 to 100 intake) at a total cost of ₹ 61.89 crore.

Establishment of Under Graduate Medical College with Hostel for 100 intake and Regional Cancer Centre with 252 bed capacity with Patient Guest House of 28 rooms at a total cost of ₹ 474.24 crore (₹ 249.54 crore and ₹ 224.70 crore respectively).

9.7 On line e-tenders were invited in November, 2015,Technical bids of the eligible bidders were opened on 2nd March,2016 and the case is being processed for award of contract.

9.8 **The Committee observes that the projects like (i) Expansion of Nursing College and Hostel and (ii) Establishment of Undergraduate Medical College and Regional Cancer Centre at NEIGRIHMS have significant bearing on improving the delivery of healthcare services in a region which is deficient in healthcare delivery and therefore needs greater attention. These projects had been hanging fire for quite some time and figured in the 82nd Report of the Committee also. The Committee is, therefore, happy to note that some forward movement has been reported towards their implementation. The Committee, therefore, desires that undertaking these projects for implementation be taken up in right earnest and the pending issues pertaining to them may be addressed with clarity and all necessary approvals obtained. The Committee also recommends that an effective monitoring mechanism be put in place to obviate any possibility of time overruns and cost escalation of these projects.**

X. **CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI**

10.1 Central Institute of Psychiatry is a leading organization in the country providing diagnostic and treatment facilities in mental health apart from conducting post-graduate courses in psychiatry.

10.2 As per the information furnished by the Department, the fund allocation and actual expenditure in respect of CIP for 2015-16 are as follows:-

Table No. 20

(₹ in crore)

Component	BE 2015-16	RE 2015-16	Expenditure (as on 11.02.2016)
Plan Revenue	19.50	17.65	16.68
Non Plan Revenue	40	40	38.35
Plan Capital	30.5	27.5	27.21
TOTAL	90	85.15	82.24

- A total number of 52761 patients in OPD, 12896 in Special Clinics, 2259 in Extension Clinics and 2918 in IPD have utilized the clinical services during the current year.
- Major equipments such as Bio-Neuro feedback system, mechanized laundry equipments, Automatic Elisa Analyser and rTMS with EEG were procured by the Institute.
- Order for Purchase of fMRI Equipment has been placed.

10.3 The Committee has *inter-alia* been informed that the proposal for re- development of the Institute at a cost of ₹ 279.00 crore and for construction of 90 residential quarters at a cost of ₹ 34.65 crore are under consideration. It has also been informed that the proposal for re-development of the Institute has been revised upward due to the increase in plinth area from 31,882 sqm (as originally approved in 2008) to 45,000 sqm as the existing infrastructure capacity is insufficient to meet the increasing requirements of the Institute.

10.4 Proposal for grant of status of an autonomous institution to CIP, Ranchi is also under consideration.

10.5 **The Committee observes that the Central Institute of Psychiatry provides comprehensive services for all psychiatric patients, including those requiring care for concurrent medical disorders and patient care research and manpower development are the main objectives of the Institute. The Committee, therefore, extends its support to the re-development plan of the Institute, which in the opinion of the Committee, would enhance access to quality psychiatric treatment to more patients. The Committee would, however, recommend to the Department to proactively pursue the finalization of the re-development plan of CIP and take appropriate measures to eradicate deficiencies in project formulation and implementation so that there are no cost and time overruns. The Committee desires to be kept apprised of the progress of implementation of the re-development plan of CIP.**

10.6 **The Committee takes note of the fact that the grant of status of autonomous institution to the Central Institute of Psychiatry is also under consideration. The Committee is of the opinion**

that with the according of status of autonomous institution, the CIP would get adequate operational flexibility to pursue its own ideas without hindrance and therefore keeping CIP tied down to the Department in Delhi may not be warranted. The Committee, therefore, recommends that the CIP may be made autonomous consistent with the precedents of other autonomous institutions that are funded by the Department and appropriate Paradigm may be put in place to enforce financial and performance accountability in the autonomous structure of CIP.

XI. REGIONAL INSTITUTE OF MEDICAL SCIENCES (RIMS), IMPHAL

11.1 Regional Institute of Medical Sciences was set up in 1976 and has been functioning under the Ministry of Health and Family Welfare since 1st April, 2007. RIMS is an Institute of regional importance catering to the needs of the North Eastern Region in the field of medical education by providing under-graduate and post-graduate courses. RIMS is a 1,074 bedded teaching Hospital equipped with modern state-of-the-art equipment and teaching facilities. The Hospital provides services to a large number of patients both outdoor as well as indoor patients and admits over four thousand patients in a year. The institute has an intake capacity of 100 Under-graduate and 150 Post-graduate students every year. It also runs the Ph. D. Courses in various subjects and M. Phil in Clinical Psychology.

11.2 As per information given in the Annual Report 2015-16 of the Department, the following two major projects are under implementation:-

(i) The Project for upgradation of RIMS to bring it at par with AIIMS, New Delhi (Phase-II) at an estimated cost of ₹ 129.00 crore is under implementation. As the progress of work allocated to M/s RDB Ltd., Kolkata was very slow in-spite of repeated extensions of time granted to them, their contract has been terminated and the firm has been blacklisted. Project Consultants M/s HSCC Ltd. has retendered the work.

(ii) Government has approved the proposal for creation of additional infrastructure for increasing the number of MBBS seats from 100 to 154 per annum at a total cost of ₹ 202 crore. The project is proposed to be executed in two packages.

11.3 **The Committee obverses that RIMS caters to the healthcare needs of North Eastern Region including providing medical education. Given the fact that the North Eastern Region has weak public health indicators and weak health infrastructure, strengthening and capacity building of RIMS is of vital importance. The Committee is, however, anguished to note that the progress of upgradation of RIMS has been tardy due to inefficiency on the part of the contractor whose contract stands terminated now. The Committee would expect that Project Consultant M/s HSCC would quickly select a new contractor and lay emphasis on completion of the project within the approved cost and time-frame. The Committee desires to be apprised of the total approved cost, expenditure incurred so far and the time-line fixed for execution of the project.**

XII. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

12.1 As per the information made available to the Committee, Pradhan Mantri Swasthya SurakshaYojana (PMSSY) under MoH&FW was launched in 2006 with the objectives of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and also to augment facilities for quality medical education in the country.

12.2 PMSSY, a Central Sector Scheme, has two components –

(i) Setting up of AIIMS-like institutions; and

(ii) Upgradation of existing State Government Medical College/Institutions. Upgradation programme broadly envisages improving health infrastructure through construction of Super Speciality Blocks/Trauma Centres etc. and procurement of medical equipment for existing as well as new facilities on Central and State share basis.

12.3 As per information furnished by the Department, the Twelfth Plan Approved Outlay for PMSSY is ₹ 12000.00 crore allocation of funds and amount spent during the last two years, as intimated by the Department, are as under :-

Table No. 21

(₹ in crore)

Year	BE	RE	Expenditure
2014-15	1956	891.00	822.03
2015-16	2206	1646.03	1384.44

12.4 In reply to a question, the Department has informed the Committee that as against the projected demand of ₹ 4344.76 crore for PMSSY, a plan allocation of ₹ 2450.00 crore has been made for 2016-17.

12.5 On being asked about the updated status of the establishment of AIIMS-like Institutions, and upgradation of State Government Medical Colleges/Institutions, it has been informed that there has been some delay in construction of AIIMS like institutions at Bhopal, Bhubaneswar, Patna, Jodhpur, Raipur, Rishikesh and Rae Bareli. The delay can mainly be attributed to site specific issues and unforeseen circumstances. These mainly relate to delays in supply of drawings by Design DPR Consultants, obtaining of local body approvals and finalization of revised cost estimates, inadequate bid responses in some cases etc. The status of construction related activities of all the AIIMS like institutions is as given below.

Table No. 22

Phases and Components under PMSSY

	AIIMS like Institutions	Upgradation of State Govt. Med. Colleges
Phase - I	Bhopal, Bhubaneshwar, Jodhpur, Patna, Raipur, Rishikesh (06 AIIMS)	Thirteen (13) Med. Colleges. List given in Annexure-II
Phase - II	AIIMS in West Bengal shifted to Phase IV and Rae Bareli, Uttar Pradesh (01 AIIMS)	Six (06) Govt. Govt. Med. Colleges. List in Annexure-II
Phase - III		Thirty nine (39) Govt. Med. Colleges. List in Annexure-II

	AIIMS like Institutions	Upgradation of State Govt. Med. Colleges
Phase - IV	West Bengal, Andhra Pradesh, Maharashtra and Purvanchal, Uttar Pradesh (04 AIIMS)	Twelve (12) Govt. Med. Colleges. List in Annexure-II
Phase - V	Jammu, Kashmir, Punjab, Tamil Nadu, Himachal Pradesh, Assam, Bihar (07 AIIMS)	

12.6 The AIIMS like institutions at Bhopal, Bhubaneswar, Patna, Jodhpur, Raipur, Rishikesh have become operational. Regular MBBS batches have started since 2012 in these new AIIMS and regular Nursing courses have started since 2013. The IPD, OPD OT Services in all six new AIIMS are functional. No definite timelines can be envisaged on full operationalisation of these AIIMS like institutions as these involve complex contractual issues even though the Ministry has taken several concrete steps to resolve them.

12.7 The steps taken to avoid recurrence of events leading to delay in constructions of AIIMS are detailed below:-

(a) In the earlier system the Ministry involved itself directly with award of contract as well as contractual management with the help of in house consultant and the Superintendent Engineers (SEs) in the site. However, it has been seen that the Ministry does not have a strong technical cell to take care of the complete gamut of activities associated in this approach. The Ministry also found itself ill equipped to handle day to day contractual workers such as considering variation/deviations, granting extension of Terms (EOT), payment of RA bills etc. Further, the system of having a private player as PC without a strong technical set up to manage and monitor it at Ministry level turned out to be problemsome.

In consideration of above, the Ministry has considered and put in place following system as are being followed by several other Ministries like MoUD, Ministry of Railway, Defence Ministry etc. for its new projects under PMSSY.

(i) The new works/projects would be awarded to the Executing agencies of the Ministry and CPWD etc in terms of GFR 26 on turnkey basis. While doing so, the Ministry will ensure that these executing agencies follow GFR/CVC and other guidelines in the contractual matters etc. Administrative approval of Ministry will, however, be requested on the DPR and before award of works to consultant/construction agency.

(ii) Also on independent agency will be deployed for quality assurance on the works carried out by the executing agencies.

(iii) Adoption of Primavera software by Oracle for Project Management would be insisted for all works above ₹ 20 crores as per CPWD guidelines.

b. With respect to the existing six AIIMS, following measures have been taken/initiated

(i) The ERC at local AIIMS level, chaired by Director of respective AIIMS have been empowered to sanction EOT, variation, deviation etc and the activity of payment of RA bills has also been transformed to the six AIIMS.

(ii) AIIMS have been authorized to take required technical inputs from the nearby RECs/NITs/IITs in case the DDPRCs do not respond. However, efforts are also on to get DDPRCs back on board.

(iii) The Ministry, with approval of Hon'ble HFM has decided to assign the job of PC for the balance construction work at the AIIMS to Ministry's own PSUs, HSCC and HLL on nomination basis to strengthen the hands of SEs at the local level. Ministry's own PSU were taken as it was viewed that in the view of various complications such as of DDPRCS, site related other contractual issues with construction agencies, including arbitration cases with them, complexity of assessment of balance work, no private Consulting Firm would come forward. In fact, the Ministry's PSUs have also agreed only very reluctantly after sort of coercing them.

(iv) PSA for procurement of equipment has been advised to ascertain preparedness of sites/work spaces at each AIIMS and obtain comment of respective Director before placing order for equipment so that the equipment delivery can be synchronized with the space readiness and equipment do not lie uninstalled/uninitialized.

12.8 The Committee has been informed that there has been no substantial cost overrun at present.

12.9 **Legislative Position** AIIMS Amendment Act, 2012 has been enacted amending the All India Institute of Medical Sciences Act, 1956 to provide autonomous status to the six AIIMS. The societies formed earlier have been incorporated as corresponding Institutes. Institute body for each new AIIMS has also been constituted in July, 2013. Besides, Governing Body, Standing Finance Committee and Academic Committee for six new AIIMS have also been constituted.

STATUS OF PROJECTS TAKEN UNDER PHASE I OF PMSSY

12.10 **Status of Six AIIMS :** Construction activities for various components of new AIIMS projects such as Medical College, Hospital, Housing, Hostels, etc. were undertaken at six sites at Jodhpur, Bhopal, Patna, Rishikesh, Bhubaneswar and Raipur. The physical progress (in %) as on 29.02.2016 of six new AIIMS is as under:

Table No. 23

Name of site	Medical College	Hospital Complex	Residential Complex	Electrical Services	Estate Services
Bhopal	91.16	81.07	98.66	84.25	45.20
Bhubneswar	94.28	86.70	35.00(Ph.I) & 85.00 (Ph.II)	98.36	52.47
Jodhpur	91.85	92.93	100.00	99.50	98.80
Patna	97.20	69.00	100.00	94.00	36.00
Raipur	89.51	73.49	100.00	95.86	50.09
Rishikesh	89.58	96.03 & 66.10 (False ceiling & fire door)	100.00	98.00	68.66
Weighted Progress	92.66	82.44	85.71	94.85	57.69

12.11 **Status of Manpower Recruitment**

Creation of posts: 4089 posts of various categories including faculty and nursing have been created for each of the six AIIMS. Recruitment to various positions is made in phased manners on need basis.

Table No. 24

Status of Manpower Recruitment is as Under:

AIIMS	Faculty Posts					Non- Faculty Posts		
	Sanct- ioned	In position	Vacancy	Post Advertised	Inter- view held	Sanctioned	Regular	Contractual
Bhopal	305	54	251	251	-	3776	3	158
Bhubaneswar	305	61	244	244	215	3776	179	90
Jodhpur	305	59	246	221	29	3776	00	264
Patna	305	57	248	195	25	3776	291	190
Raipur	305	62	243	133	77	3776	0	413
Rishikesh	305	49	256	256	256	3776	6	205

Advertisements for filling up remaining faculty posts have been issued by all AIIMS and the selection process has been planned to be completed by March, 2016 in all AIIMS.

The recruitment rules for non-faculty posts have been finalized and been sent to six new AIIMS.

12.12 **Upgradation of Government Medical Colleges (PMSSY Phase-I) :** Out of 13 GMCs in Phase I; 10 involve civil work & procurement of medical equipment while 3 GMCs only procurement of medical equipment.

Civil works at the following eight medical college institutions *viz.* Trivandrum Medical College; Salem Medical College; Bangalore Medical College; SGPGIMS, Lucknow; NIMS, Hyderabad; Jammu Medical College; RIMS, Ranchi; and IMS, BHU, Varanasi has been completed

Kolkata Medical College - Construction of OPD Block Academic Block has been completed and Super Speciality Block is in progress.

Srinagar Medical College – 99.5% completed.

With regard to three colleges where upgradation involves procurement of medical equipment only, *viz.* SreeVenkateswara Institute of Medical Sciences (SVIMS), Tirupati; Grant Medical College, Mumbai and B.J. Medical College, Ahmedabad the procurement process likely to be completed by March, 2016.

STATUS OF PROJECTS TAKEN UNDER PHASE-II OF PMSSY

12.13 Government approved establishment of AIIMS in Uttar Pradesh and West Bengal. Present position as below:-

AIIMS, Rae Bareli

The Government of Uttar Pradesh has transferred the land to Central Government for establishment of AIIMS at Rae Bareli.

The Ministry has appointed M/s. HSCC (I) Ltd. as Project Management Consultant for the Project.

Construction of housing complex is in progress.

Initially, an amount of ₹ 823 crore was approved for the project.

AIIMS, West Bengal

Earlier, a location was proposed at Raiganj, Uttar Dinajpur.

Now, Kalyani, as offered by Government of West Bengal has been finalized for setting up of new AIIMS under PMSSY Phase-IV.

12.14 **UPGRADATION OF EXISTING GOVERNMENT MEDICAL COLLEGES (PMSSY PHASE-II)**

06 Government Medical Colleges (GMCs) covered.

Civil work started at the following four medical colleges and progress at these institutes is given below:

(i) R.P. Government Medical College, Tanda – Civil work completed and new SSB inaugurated on 1.3.14.

(ii) Jawaharlal Nehru Medical College of AMU, Aligarh (99.5%)

(iii) Government Medical College, Amritsar (99.5%); and

(iv) Pt. B.D. Sharma Postgraduate Institute of Medical Sciences, Rohtak (67%)

(v) Government Medical College, Madurai – Due to change in location for the new Super Speciality Block, plan had to be modified. The civil work has started and 18% of its work has completed.

(vi) Government Medical College, Nagpur – Upgradation programme involves only procurement of equipment and entire procurement work is being undertaken by the Institute/State Government.

STATUS OF PROJECTS TAKEN UNDER PHASE-III OF PMSSY

Cabinet Committee on Economic Affairs (CCEA) has approved on 7.11.2013, the proposal for upgradation of the 39 medical colleges/institutions, at an approved cost of ₹150 crore (Central Contribution - ₹ 120 crore and State Share – ₹ 30 crore) each.

HSCC/HLL/CPWD have been selected as executive agencies for civil work at 39 medical colleges.

DPR of 37 GMCs has been approved and tenders have been floated for 32 colleges.

STATUS OF PROJECTS TAKEN UNDER PHASE-IV OF PMSSY

12.15 **AIIMS announced in 2014-15**: Four (4) new AIIMS have been announced during Budget Speech 2014-15 one each in Andhra Pradesh, Maharashtra, West Bengal and Poorvanchal in U.P. Out of these, the Cabinet approved Three (03) new **AIIMS at Mangalagiri, A.P. Nagpur, Maharashtra and Kalyani, W.B.** on 07th October, 2015. The progress on these is brought out below:

HSCC India Ltd. a PSU of MoH&FW has been appointed as Executing Agency on turnkey basis.

The pre-investment activities like Soil survey/Topographical survey have been completed.

Construction of boundary wall will be started shortly.

MoU between MoH&FW and Government of Andhra Pradesh/Maharashtra/West Bengal had been signed.

Taking over land at Kalyani (West Bengal) and Mangalagiri (Andhra Pradesh) has been done.

EOI for design and architecture has been invited.

12.16 **AIIMS in Purvanchal, U.P. :** Government of Uttar Pradesh had offered sites but MoH&FW has requested them to provide four lane connectivity to the proposed site.

12.17 On being asked as to what steps have been taken to avoid recurrence of events leading to delay in construction of AIIMS-like Institutions, the Department has made the following written submissions:-

c. In the earlier system the Ministry involved itself directly with award of contract as well as contractual management with the help of inhouse consultant and the Superintendent Engineers (SEs) in the site. However, it has been seen that the Ministry does not have a strong technical cell to take care of the complete gamut of activities associated in this approach. The Ministry also found itself ill equipped to handle day to day contractual workers such as considering variation/deviations, granting Extension of Terms (EOT), payment of RA bills etc. Further, the system of having a private player as PC without a strong technical set up to manage and monitor it at Ministry level turned out to be problemsome.

In consideration of above, the Ministry has considered and put in place following system as are being followed by several other Ministries like MoUD, Ministry of Railways, Defence Ministry etc. for its new projects under PMSSY.

iv. The new works/projects would be awarded to the Executing agencies of the Ministry and CPWD etc. in terms of GFR 26 on turnkey basis. While doing so, the Ministry will ensure that these executing agencies follow GFR/CVC and other guidelines in the contractual matters etc. Administrative approval of Ministry will, however, be requested on the DPR and before award of works to consultant/construction agency.

v. Also on independent agency will be deployed for quality assurance on the works carried out by the executing agencies.

vi. Adoption of Primavera software by Oracle for Project Management would be insisted for all works above ₹ 20 crores as per CPWD guidelines.

d. With respect to the existing six AIIMS, following measures have been taken/initiated.

v. The ERC at local AIIMS level, chaired by Director of respective AIIMS have been empowered to sanction EOT, variation, deviation etc. and the activity of payment of RA bills has also been transformed to the six AIIMS.

vi. AIIMS have been authorized to take required technical inputs from the nearby RECs/ NITs/IITs in case the DDPRCs do not respond. However, efforts are also on to get DDPRCs back on board.

vii. The Ministry, with approval of Hon'ble HFM has decided to assign the job of PC for the balance construction work at the AIIMS to Ministry's own PSUs, HSCC and HLL on nomination basis to strengthen the hands of SEs at the local level. Ministry's own PSU were taken as it was viewed that in the view of various complications such as of DDPRCs, site related other contractual issues with construction agencies, including arbitration cases with them, complexity of assessment of balance work, no private Consulting Firm would come forward. In fact, the Ministry's PSUs have also agreed only very reluctantly after sort of coercing them.

viii. PSA for procurement of equipment has been advised to ascertain preparedness of sites/work spaces at each AIIMS and obtain comment of respective Director before placing order for equipment so that the equipment delivery can be synchronized with the space readiness and equipment do not lie uninstalled/uninitialized.

ix. AIIMS have also been directed for processing and payment of RA bills of smaller values of ₹ 30 lakhs to allow for quicker circulation of money.

x. The progress is also reviewed periodically.

12.18 Updating the Committee on establishing a monitoring cell for the upgradation work under PMSSY, the Department has submitted that Project Management Committee (PMC) has been constituted as an apex steering and monitoring body for the entire duration of the PMSSY projects; and also for finalisation/ approval of concept plan and Detailed Project Report along with tendered cost for civil work. The PMC comprises of Secretary (Health) as Chairman; and Director General of Health Services, Director (AIIMS), Director (PGIMER), Addl. Secretary (Health), Special Secretary & FA/Addl. Secretary & FA, MoH&FW, Director General (CPWD), Advisor (Health-NITI Ayog- erstwhile Planning Commission), Joint Secretary (PMSSY), MoH&FW, a representative each from Ministry of Statistics and Programme Implementation, Ministry of Railways, Ministry of Defence, Airport Authority of India, National Highway Authority of India as members.

12.19 In reply to a query as to whether the Government has the fiscal strength to make investments on PMSSY, the Department has replied that the fresh impetus on part of the PMSSY Division regarding adherence to timelines *w.r.t.* procurement and construction of AIIMS and upgradation, is beginning to show results. There has been substantial shift in momentum of completion of pending works and initiation of new works. Hence it should not be difficult to absorb and utilize further allocation of funds in this regard. In the year 2015-16, ₹ 2206.00 crore was provided for PMSSY. The utilization as on 09.03.2016 is 1384.44 crore.

Table No. 25

State-Wise List of AIIMS and Hospitals /Medical Colleges under Upgradation of PMSSY

Sl.	State	New AIIMS	Upgradation of State Government Medical Colleges / Hospitals				
			Phase I	Phase II	Phase III	Phase IV	Phase V
1	Andhra Pradesh	AIIMS Mangalapuri (Ph-IV)	SVIMS, Tirupati		SMC, Vijayawada GMC, Anantpur		
2	Assam	AIIMS Guwahati (Ph-V)			GMC, Guwahati AMC, Dibrugarh		
3	Bihar	AIIMS Patna (Ph-I) AIIMS Declared (Ph-V)			SMC, Muzaffarapur GMC, Darbhanga	PMCH, Patna GMC, Bhagalpur GMC, Gaya	
4	Chhattisgarh	AIIMS, Raipur (Ph-I)				GMC, Bilaspur	
5	Goa				GMC, Panaji		
6	Gujarat		BJMC, Ahmedabad		GMC, Rajkot	GMC, Surat GMC, Bhavnagar	
7	Haryana			PDSIMS, Rohtak			
8	Himachal Pradesh	AIIMS Declared (Ph-V)		GMC Tanda	I.G. GMC, Shimla		
9	Jammu & Kashmir	AIIMS, Jammu (Ph-V) AIIMS, Kashmir (Ph-V)	GMC, Jammu GMC, Kashmir				
10	Jharkhand		RIMS, Ranchi		PMC, Dhanbad		

Sl.	State	New AIIMS	Upgradation of State Government Medical Colleges / Hospitals				
			Phase I	Phase II	Phase III	Phase IV	Phase V
11	Karnataka		BMC, Bangalore		VMC, Bellary KIMS, Hubli		
12	Kerala		MC, Thiruvanan-thapuram		MC, Kozhikode TDMC, Alappuzha		
13	Madhya Pradesh	AIIMS, Bhopal (Ph-I)			GMC, Rewa NSCB, MC, Jabalpur GRMC, Gwalior	GMC, Indore	
14	Maharashtra	AIIMS, Nagpur (Ph-IV)	Grants, MC + JJ Hospitals	GMC, Nagpur	GMC, Aurangabad GMC, Latur GMC, Akola SVK, GMC, Yavatmal		
15	Odisha (Orissa)	AIIMS, Bhubaneshwar (Ph-I)			MKCG MC, Behrampur VSS MC, Burla	GMC, Cuttack	
16	Punjab	AIIMS, Bhatinda (Ph-V)		GMC, Amritsar	GMC, Patiala		
17	Rajasthan	AIIMS, Jodhpur (Ph-I)			SP MC, Bikaner RNT MC, Udaipur GMC, Kota	GMC, Jaipur	
18	Tamil Nadu	AIIMS Declared (Ph-V)	GMC, Salem	GMC, Madurai	TMC, Thanjavur TMC, Tirunelveli		
19	Telangana		NIMS, Hyderabad		R.G. IMS, Adilabad KMC, Warangal		

Sl.	State	New AIIMS	Upgradation of State Government Medical Colleges / Hospitals				
			Phase I	Phase II	Phase III	Phase IV	Phase V
20	Tripura				AMC, Agartala		
21	Uttar Pradesh	AIIMS, Rae Bareli (Ph-II) AIIMS, Purbanchal (Ph- IV)	S.G.PGIMS, Lucknow IMS, Varanasi	JNMC, AMU, Aligarh	GMC, Jhansi GMC, Gorakhpur MLN MC, Allahabad LLR MC, Meerut	GMC, Agra GMC, Kanpur	
22	Uttarakhand	AIIMS, Rishikesh (Ph-I)					
23	West Bengal	AIIMS, Kalyani (Ph-IV)	KMC, Kolkata		BS MC, Bankura GMC, Malda NBMC, Darjeeling		
24	Delhi					UCMS- GTB Hospital	
		18 AIIMS	13	06	39	12	No GMC

12.20 Total of 18 AIIMS and 70 State Government Medical Colleges / Hospitals under different phases of PMSSY.

12.21 **The Committee observes that there has been huge shortfall in utilization of the budgeted expenditure of PMSSY in the last two years. The shortfall witnessed in the Plan expenditure as compared to the Budget Estimates has been to the extent of 1133.97 crore in 2014-15 and ₹ 821.56 crore in 2015-16. ₹ 2450.00 crore has been allocated in BE 2016-17 on the plan side against the projected demand of ₹ 4344.76 crore. Acknowledging that the Department had faced difficulties in absorbing the allocated funds, the Health Secretary during the course of his deposition before the Committee in connection with examination of Demands for Grants (2015-16) had submitted that the Department did not have the requisite experience of having that kind of structure constructed and procurements made but a strong mechanism had been put in place and in the coming years things would witness better performance. But given the trend of utilization of funds witnessed in the year 2015-16, the Committee apprehends that there would be less utilization of Plan funds in 2016-17 as well. The Committee, therefore, recommends that the Department should address the issue of under-utilization of budgeted funds for PMSSY with all seriousness so that realistic projection of fund requirement is made and such instances of blockage of funds do not recur. The Committee would also urge the Department to avoid making ritualistic allocations, which remain on paper only.**

The Committee would further like the Department to ensure that the implementing agencies of PMSSY at the ground level have the requisite machinery and skilled manpower to fully utilize the allotted sums.

12.22 **The Committee gathers from the information furnished that full operationlisation of six AIIMS-like Institutions is yet to be realized. The Department has informed that the delay in operationlization is mainly due to site specific issues such as delays in supply of drawings by Design DPR Consultants, obtaining of local body approvals and finalization of revised cost estimates, inadequate bid responses in some cases, etc. The Committee is distressed to observe that the long persisting delay in full operationalization of six AIIMS-like institutions is impacting their defined objectives. The Committee is of the firm opinion that the issues which have been mentioned as contributory factors to the delay in full operationalization of AIIMS-like Institutions could have been tackled in an effective manner had the Department been to able to ensure effective monitoring and initiated appropriate remedial measures on time. Evidently, the Department has been lagging behind on effective and sustained monitoring and there are also serious shortcomings in inter-agency coordination for resolving the problems in a timely manner. The Committee, therefore, desires that appropriate corrective measures be taken for addressing issues contributing to delays and cost escalation in full operationalization of six AIIMS-like Institutions.**

12.23 **It is a matter of serious concern that all the six AIIMS are facing shortage in faculty and non-faculty posts. Considering the critical role the faculty plays in training of graduating doctors, the Committee observes that the quality of doctors produced by AIIMS-like Institutions will be far from desirable unless urgent measures are taken to overcome the deficiency of faculty in AIIMS-like institutions. The Committee has learnt from media reports that the interview for recruitment of faculty positions at AIIMS, Patna which is reeling under acute faculty shortage, was concluded on the 11th February, 2016 but the selections are yet to be ratified by the GB/IB of the Institute despite the Departments written assurance to the Committee that the selection process has been planned to be completed by March 2016 in all AIIMS. This, in the opinion of the Committee, speaks volumes of the inertia and indifference of the Department in the matter. The Committee observes that it is imperative on the part of the Department to accord utmost priority to completing the selection process within the designated time-frame so as to ensure optimal functioning of AIIMS-like institutions. The Committee, therefore, recommends that the meeting of the GB/IB may be called immediately and the selections made may be ratified within one mouth from the presentation of this Report.**

12.24 **The Committee notes from the information supplied that PMSSY Phase- I also envisages upgradation of 13 existing medical colleges/institutions. Out of the 13 Government Medical Colleges Institutions identified for upgradation in the first phase, civil works at eight medical colleges/ institutions have been completed and with regard to three medical colleges where upgradation involves procurement of medical equipments only, the procurement process was targeted to be completed by March 2016. Though the Committee welcomes upgradation of existing Government Medical Colleges/Institutions under PMSSY, it desires to know the criteria for selection of these Government Medical Colleges for upgradation and whether socio-economic and health indicators had been taken into account while selecting them for upgradation.**

12.25 **The Committee observes that though the Government of Uttar Pradesh had offered sites for establishment of AIIMS in Poorvanchal, U.P, the Department is insisting on providing a four-lane connectivity by the State Government before undertaking the project. The Committee is astonished**

to note that despite a motorable road being available and the State Government giving written assurance for the construction of a four-lane road at a later stage, the Department is not budging from its stated demand, which in the opinion of the Committee, is not reasonable and may lead to delays and resultant cost escalation. The Committee, therefore, recommends that the Department immediately move towards initiating pre-project activities for establishment of AIIMS in Poorvanchal so that the objective of correcting the imbalances in availability of affordable/reliable tertiary level healthcare in Poorvanchal, Uttar Pradesh can be corrected.

12.26 **The Committee notes from the information furnished that the Cabinet Committee on Economic Affairs (CCEA) had approved on 7.11.2013 proposal for upgradation of 39 medical colleges/ institutions in Phase III, at an approved cost of ₹ 150.00 crore each (Central Contribution ₹ 120 crore and State share - ₹ 30.00 crore). Detailed Project Reports of 37 colleges have been approved and tenders floated for 32 colleges. Almost two and a half years have lapsed since the proposal for upgradation was accorded approval, but the execution activities are yet to commence on the ground. The Committee would, therefore, like to be apprised of the time-frame within which the upgradation is targeted to be started; whether there has been any upward revision of the approved cost; and the reasons behind non-approval of the remaining two Government medical colleges.**

12.27 **The Committee observes that a new governance structure has been put in place to facilitate faster execution of AIIMS - like Institutions. The Committee hopes that the new governance and management structure would eradicate deficiencies in implementation of six AIIMS-like Institutions and facilitate their greater autonomy. The Committee would however, like the Department to carry out an appraisal of the efficacy of the new governance and management structure. The Committee also recommends that a robust mechanism be put in place to ensure adequate accountability of the local AIIMS, both in financial terms and by way of performance.**

12.28 **The Committee observes that the expansion of tertiary care institutions is an essential requirement in the country and it is, therefore, important that the adequate finances are made available to PMSSY. Needless to emphasize that lack of financial resources should not be allowed to plague PMSSY and the Central Government should mobilize additional resources for PMSSY.**

VII. CENTRAL DRUGS STANDARD CONTROL ORGANISATION (CDSCO)

13.1 The Central Drugs Standard Control Organiation (CDSCO) headed by the Drug Controller General (India) is the Central Authority for regulating the quality of drugs marketed in the country under the Drugs and Cosmetics Act, 1940 and Rules framed thereunder.

13.2 In reply to a query, the Department has informed the Committee that the expenditure incurred during 2015-16 in respect of CDSCO is as below:-

Table No. 26

Revenue Expenditure

(Figures in Crores)

Major Head 2210	BE 2015-16	RE 2015-16	Expenditure Incurred upto Jan.'16	Committed Expenditure for 2015-16	Total
Plan	67.00	56.15	40.77	12.93	53.70
Non-Plan	24.00	21.00	15.53	03.18	18.79
Total	91.00	77.15	51.85	16.11	72.49

13.3 The Committee has also been informed that major portion of saving is under "salaries" head due to the following reasons:-

(i) Recruitment process for 147 Drug Inspectors has been initiated by UPSC and after the written examination, interviews are pending. Budgetary provisions had been made for their salary during latter half of 2015-16.

(ii) CDSCO has received dossiers of 50 candidates for appointment as Assistant Drugs Inspectors (ADIs). Fifteen ADIs have already joinedand two are expected to join soon. 15 candidates have been sent for medical examination. Police verification is pending in respect of remaining 18 candidates. Budgetary provisions made for their salary for 2015-16 could not be utilised fully.

Table No. 27

Capital Expenditure

(Figures in Crores)

Major Head 4210	BE 2015-16	RE 2015-16	Expenditure Incurred upto Jan.'16	Committed Expenditure For 2015-16	Total
Plan	31.50	31.50	12.86	18.64	31.50

13.4 It has also been informed that the scheme for strengthening the Central Drug Regulatory Structure has been approved on 12.08.2015. 'Major works' proposals in Delhi, Indore, Chennai, Goa and Noida are in the pipeline and the residual amount will be spent on these projects. The up-gradation of CDSCO labs and offices has already been taken up at Hyderabad, Guwahati and Chandigarh.

13.5 The Committee has also been informed that the total budgetary allocation to the Central Drugs Standard Control Organisation for 2016-17 is ₹ 184.70 crore as given below:-

Table No. 28

(₹ in crore)

Budgetary Allocations	Plan	Non-Plan	Total
Revenue (Major Head 2210)	80.00	25.70	105.70
Capital (Major Head 4210)	79.00	-	79.00
TOTAL	159.00	25.70	184.70

13.6 The Department has stated that the Capital Outlay of ₹ 79.00 crore would be utilized in terms of approval accorded by the Cabinet Committee on Economic Affairs towards strengthening of the drug regulatory system in the country, including laboratories under Central Drugs Standard Control Organisation. The proposed activities are as below:-

Table No. 29

(₹ in crore)

Sl.No.	Activity	Amount	
1.	Civil works for	45.00	The current allocation will meet only part of

Sl.No.	Activity	Amount	
	Construction of 6 new labs (drugs-2, medical devices-2, diagnostics-1, cosmetics-1		the expenditure and part of it will be incurred in subsequent years
	Upgradation of 7 existing labs		
	Construction/upgradation of new offices		
	Physical infrastructure for new labs		
2	New equipment for 7 existing labs, 6 new labs and 8 new Mini-labs	34.00	
TOTAL		79.00	

13.7 Throwing more light on the status of the Centrally Sponsored Scheme for upgradation of State Drug Testing Laboratories, the Department in a written reply has made the following submissions:-

> "The Cabinet Committee on Economic Affairs (CCEA) has approved the proposal for strengthening the drug regulatory system in the country, both under the Central and the State Governments at a total expenditure of ₹ 1,750 crores. Out of this, ₹ 900 crore has been approved for strengthening the Central structures and ₹ 850 crore is the Central Government's share for upgrading and strengthening the Drug Regulatory system in the States. The share of the Centre and the States in case of State component will be in the ratio of 60:40 for all States except Jammu and Kashmir, Himachal Pradesh, Uttarakhand, Sikkim and Seven North-Eastern States for which the ratio will be 90:10. One of the major components of the State scheme is to upgrade State Drug Testing Laboratories. Accordingly, the activities planned in the States and the Union Territories include setting up of 10 drug testing labs and upgradation of 31 existing drug testing labs by the end of 2017-18. Proposals for such strengthening have been requested from all the States and 14 States have since forwarded their proposals."

13.8 Updating the Committee on the status of filling up of vacant categories of regulatory and laboratory staff at CDSCO, the Department has furnished the following information:-

Table No. 30

Status of Vacant Posts in CDSCO

Sl. No.	Name of the post/Mode of Recruitment	No. of Sanctioned Posts as on 29.02.2016	In Position as on 29.02.2016	Vacant Posts as on 29.02.2016	Present Status
1.	DCG(I) 100% by deputation including short-term contract	1	1	0	The position is currently filled up on additional charge basis due to litigation.

Sl. No.	Name of the post/Mode of Recruitment	No. of Sanctioned Posts as on 29.02.2016	In Position as on 29.02.2016	Vacant Posts as on 29.02.2016	Present Status
2.	Director (Vigilance)	01	Newly created post	01	Recruitment Rules are being finalized in consultation with DoPT.
3.	JDC(I) Promotion failing which by Deputation (including short-term contract) failing both by direct recruitment	2	2	0	-
4.	DDC(I) (i) 50% by promotion failing which by direct recruit (ii) 50% by direct recruitment	23	15	08	Four posts each are likely to be filled up through promotion and by direct recruitment in 2016-17.
5.	ADC(I) 100% by promotion failing which by deputation (including short-term contract) failing both by direct recruitment.	41	26 (25 regular + 1 on deputation)	15	The result of direct recruitment against the 10 posts of ADC(I) has been declared. Remaining 05 posts under promotion quota will be filled up after approval by UPSC.
6.	Drugs Inspector Direct Recruitment	279	135	144	The UPSC has conducted the written examination and declared the result of written test and final result is awaited. 147 posts will be filled up.
7.	Assistant Drug Inspector 100% by direct recruit	81	46	37	Against 50 vacancies for which SSC recommended candidates, 15 candidates have joined and 02 are expected to join shortly. 15 candidates have been referred to Dr. RML Hospital for medical examination. Police Verification is pending for 18 candidates.

Sl. No.	Name of the post/Mode of Recruitment	No. of Sanctioned Posts as on 29.02.2016	In Position as on 29.02.2016	Vacant Posts as on 29.02.2016	Present Status
8.	Sr. Biomedical Engineer. By Composite method (Deputation including short-term contract/ promotion)	1	-	1	This will take time as Recruitment Rules are proposed to be revised. Further, we are separately seeking approval for creation of posts for regulating medical devices with qualifications in relevant disciplines.
9.	Biomedical Engineer. By deputation (including short-term contract) failing which by direct recruitment	1	-	1	This will take time as Recruitment Rules are proposed to be revised. Further, we are separately seeking approval for creation of posts for regulating medical devices with qualifications in relevant disciplines.
10.	T.O. (i) 50% by promotion failing which by deputation (ii) 50% by deputation	24	10	14	It is a dying cadre and the posts will be gradually phased out. Further, direct recruitment has been stopped. These vacant posts will be filled up by promotion of eligible candidates as and when they become eligible.
11.	S.T.A. (i) 33.33% by promotion failing which by deputation failing both by direct recruitment. (ii) 66.66% by Direct Recruitment	15	02	13	It is a dying cadre and the posts will be gradually phased out. Further, direct recruitment has been stopped. These vacant posts will be filled up by promotion of eligible candidates as and when they become eligible.
12.	T.A. Direct Recruitment	6	04	02	It is a dying cadre and the posts will be gradually phased out. Further, direct recruitment has been stopped. These vacant posts will be filled up by promotion of eligible candidates as and when they become eligible.
	TOTAL	475	239	236	

13.9 **The Committee notes that as against the allocation of ₹ 31.50 crore provided in RE 2015-16, the actual expenditure upto January 2016, is ₹ 12.86 crore only (i.e. approximately 41%) leaving around 59% to be expended in the last two months of the financial year 2015-16. Shockingly, the Department claims that the residual amount will be spent on 'major works' proposals which are in the pipeline. The Committee strongly conveys its disapproval of such an erratic expenditure management. The Committee is unable to comprehend as to how the CDSCO would be able to spend nearly 59% of the allotted sums in the last two months of the financial year 2015-16 on major works proposals which are still in the pipeline. The Committee, therefore, deprecates the CDSCO for such a casual and desultory reply as the reasons given by the Department are not in-line with the extent of under-utilisation.**

13.10 **The Committee also observes that as per the norms stipulated by the Ministry of Finance, not more than 33% and 15% can be spent in the last quarter and last month respectively of the financial year. The Committee therefore wonders as to how the CDSCO would be able to achieve the feat of spending the remaining amount of ₹ 18.64 crore (i.e. 59%) in the last two months of 2015-16 without violating the provisions of General Financial Rules. The Committee would, therefore, like the Department to explain in this regard.**

13.11 **The Committee notes that the Cabinet Committee on Economic Affairs has approved the proposal for strengthening the drug regulatory system in the country at total expenditure of ₹ 1750 crore with the Central and State share being ₹ 900.00 crore and ₹ 850.00 crore respectively and the targeted period for completion of the project being the end of 2017-18. The Committee observes that the quality of drugs is of critical importance not only for the well-being of the people of the country but also for our economy as it earns a substantial amount in foreign exchange through export of drugs. The Committee through its reports on Demands for Grants has been exhorting the Department to iron out the issues concerning the proposal for strengthening of the drug regulatory system in the country. The Committee is, therefore, relieved that this project has been approved by the CCEA. It is now an imminent necessity on the part of the Department to undertake concerted action for ensuring timely completion of all project-related formalities and address the pending issues pertaining to this project with a sense of urgency and promptitude. The Committee also recommends that a dedicated monitoring mechanism be put in place for planning, coordination and timely completion of various components of the project. The Committee desires to be kept apprised of the progress made towards implementing the project.**

13.12 **The Committee notes that there are eight, fifteen, one forty four and thirty seven vacant posts of Deputy Drug Controller, Assistant Drug Controller, Drug Inspector and Assistant Drug Inspector respectively. The Committee is alarmed at such a high vacancy position which will seriously undermine the performance and goals of the CDSCO. The Committee wonders as to what could be the reasons behind such a time lag of filling up the vacancies. The Committee expects the Department to take up the matter of filling up the vacancies with appropriate agency.**

Upgradation of Sera and Vaccine Manufacturing Units.

13.13 The Committee had made an extensive study on the various issues connected with the three vaccine manufacturing producing PSUs, namely, the Central Research Institute (CRI), Kasauli, the Pasteur Institute of India (PII), Conoor and the BCG Vaccine Laboratories, Guindy, Chennai and presented to the Parliament

four Reports i.e., 34th Report on 18th February, 2009, 38th Report on 18th December, 2009, 43rd Report on 4th August, 2010 and 52nd Report on 4th March, 2011 dealing with issues like the problems ailing them; their revival; effect of the closure of the three PSUs on the Universal Immunization Programme, resultant spiralling vaccine prices in the country, status of making them current Good Manufacturing Practice (cGMP) compliant etc. The Committee has since been calling for progress reports on bi-monthly basis on the status of progress made towards making them cGMP compliant.

13.14 On being asked about the updated status of progress made towards making the three sera and vaccine producing units GMP compliant, the Department has furnished the following information:-

1. **BCG Vaccine Laboratory, Guindy:-**
    - Civil & Modular Works: All the work completed.
    - HVAC: All validation activities completed.
    - Electrical System: All Electrical & cabling work completed.
    - Water System: All Equipment erection with operational qualification completed.
    - Mechanical & other allied Works: - All major work completed.
2. **Pasteur Institute of India, Coonoor:-**
    - Civil work for the new GMP project was initiated in the month of June, 2013. All major work of DP block & meet extraction Block completed.
    - Major works of Sterility and Microbiology completed.
    - 95% of the work for the Utility Block has been completed. Painting white wash work in progress.
3. **Central Research Institute, Kasauli:-**
    - cGMP compliance achieved for DPT group of vaccines.
    - Commercial batches of DPT vaccines commence.

13.15 The financial performance of the three sera and vaccine units, as informed by the Department, is as follows:-

Table No. 31

SERA and Vaccine Manufacturing Units - Financial Performance : 2015-16

CRI, Kasauli

(₹ in lakhs)

Head	BE 2015-16	RE 2015-16	Actual Exp. 03.03.2016	Estimated Exp. Upto 31.03.2016
Plan Expenditure	1600.00	1458.00	793.59	1065.09
Non-Plan Expenditure	3800.00	3800.00	2874.77	3800.00
TOTAL	5400.00	5258.00	3668.36	4865.09

BCG VL, Guindy

(₹ in lakhs)

Head	BE 2015-16	RE 2015-16	Actual Exp. 03.03.2016	Estimated Exp. Upto 31.03.2016
Plan Expenditure	1240.00	864.00	646.62	725.36
Non-Plan Expenditure	1075.00	900.00	680.15	900.00
TOTAL	2315.00	1764.00	1326.77	1625.36

PII, Coonoor

(₹ in lakhs)

Head	BE 2015-16	RE 2015-16	Actual Exp. 03.03.2016	Estimated Exp. Upto 31.03.2016
Plan (Capital) GIA-Capital	2000.00	2000.00	2000.00	200.00
Plan (Revenue) GIA-Salaries	1400.00	900.00	900.00	900.00
Plan (Revenue) GIA-General	1100.00	700.00	700.00	700.00
TOTAL	4500.00	3600.00	3600.00	3600.00

13.16 **The Committee observes that the work of upgradation of the three sera and vaccine manufacturing units, i.e. CRI, Kasauli, PII, Conoor and BCGVL, Guindy has been going on since long and the Committee has been urging upon the Department to expedite completion of work regarding cGMP compliance and enable the vaccine manufacturing PSUs to contribute their mite to the Universal Immunization Programme and insulate the Universal Immunization Programme from price and supply uncertainty. The Committee notes that CRI, Kasauli has been made cGMP compliant and commercial batches of DPT group of vaccines have commenced. However, BCGVL, Guindy and PII, Conoor are yet to commence commercial batches of vaccines. The Committee hopes that the full operationalization of BCGVL and PII would be realized within the time-line indicated. The Committee desires to be kept apprised of the full operationalization of BCGVL and PII.**

13.17 **The Committee observes that significant budgetary provisions made for CRI, Kasauli, and BCGVL, Guindy for 2015-16 remained grossly under- utilized and later surrendered. The Committee would, therefore, like the Department to chalk out the fiscal roadmap of the vaccine producing PSUs in concrete terms and avoid recurrence of huge financial under performance of the units in future.**

XIV. CENTRAL GOVERNMENT HEALTH SCHEME

14.1 As per information given in the Annual Report 2015-16, Central Government Health Scheme is a health scheme mainly for serving/retired Central Government employees and their families. The Scheme

was started in 1954 in Delhi. Over the time, it has spread to 26 cities and 12 more cities will be covered soon.

14.2 In reply to a Question, the Department has furnished the following information regarding the actual expenditure vis-à-vis the funds earmarked for CGHS in 2015-16 :

Table No. 32

(₹ in Crore)

Head Account	B.E.	R.E.	Actual
NON-PLAN	815.00	815.00	673.53
PLAN	111.00	139.00	85.36
PORB	965.00	1065.00	922.72
TOTAL	1891	2019	1683.61

14.3 The revision under PORB Head is due to meet the committed liabilities of expenditure on medicines for pensioners and hospital bills.

14.4 It has also been informed that the revision under Plan Head is mainly on account of committed expenditure for following head :

- Construction of CGHS, HQ building in Delhi - ₹ 6.00 Cr.
- Expenditure for payment of medicines bills - ₹ 11.55 Cr
- Expenditure on contractual staff - ₹ 1.00 Cr
- Expenditure under NER for salaries, medicines, etc., - ₹ 9.00 Cr.

14.5 Plan allocation of ₹115.00 crore has been made for CGHS in BE 2016-17.

14.6 **The Committee in its 82nd Report on the Demands for Grants 2015-16 of the Department had observed that the plan allocations made for CGHS in BEs of 2012-13, 2013-14 and 2014-15 had been revised upwards at RE stage but the actuals were less than the BEs and REs in all the three years and advised the Department to exercise greater fiscal discipline and make realistic projection of fund requirements. The Committee is, therefore, concerned to note that the year 2015-16 is no different when it comes to under-utilisation of plan funds. The Committee, therefore, recommends that the Department should take tangible measures for reversing this recurrent trend of under-utilisation of plan funds under CGHS head and subject the utilization of funds to periodic review.**

14.7 **The Committee in its 88th Report on the action taken by the Government on the 71st Report of the Committee on the functioning of CGHS had noted that a large number of posts of General Duty Medical Officers and Specialists were lying vacant and the Department had appointed some doctors and specialists on contract basis as a stop gap arrangement. The Committee had also observed that even if UPSC makes selection of doctors, very few join CGHS. The Committee had, therefore, recommended to find out the reasons behind doctors not joining CGHS post their selection by UPSC and take remedial measures. The Committee desires to be apprised of the developments in this regard. The Committee also desires to be apprised of the updated status of vacancies across all categories of posts.**

14.8 **In its 71st Report, the Committee had *inter alia* recommended to explore the feasibility of appointing a PRO at the Medical Centre, PHA for the convenience of Members of Parliament. The Department in its Action Taken Notes on the 71st Report furnished in January 2014 had assured that necessary action would be taken in this regard. More than 2 years have elapsed since then but no action has been taken by the Department to translate the assurance into reality. The Committee recommends that immediate action may be taken to appoint a PRO at the Medical Centre, Parliament House Annexe for the convenience of Members of Parliament.**

14.9 During the course of evidence of the Health Secretary before the Committee on 22nd March, 2016 the issue of opening more CGHS wellness centres in Kerala came up for discussion. One Member of the Committee pointed out that at present there was only one CGHS wellness Centre at Thiruvananthapuram which is far away from the north part of Kerala. He suggested that a CGHS Wellness Centre may be opened at Calicut which is situated in northern part of Kerala. Responding to the issue Sh. N.S. Kang, Additional Secretary in the Department submitted that the House Committee had recommended opening a CGHS Wellness Centre at Cochin, which is under consideration. He also stated that "If there is a recommendation for Calicut also, we can compare the two."

14.10 Subsequently, the Member *vide* his letter addressed to the Chairman of the Committee made the following submission:

> "There has been a long pending demand to cover the city of Calicut (Kozhikode) with CGHS facility. One of the oldest city in the world, Calicut has been the capital of the then Madras presidency or the Malabar region covering 6 districts in the present dispensation.
>
> The city/district has a large number of Central Government establishments including railways, postal, central police organizations, income tax offices, and many other establishments of the Central Government. Apart from these, the city/district has over 1 lakh pensioners who have been availing CGHS facilities during their career.
>
> Establishing a CGHS centre at Calicut would help not only the people of Calicut city/district the neighbouring 5 districts will also be benefitted. At present the beneficiaries are required to travel up to Trivandrum which is unviable to most of the patients."

14.11 **The Committee observes that the Department should adopt a general principle that regional distribution of CGHS Wellness Centre will be ensured. Kerala already has one CGHS Wellness Centre at Thiruvananthapuram and starting a second centre in Kerala should be done in a manner that regional disparities in terms of access to CGHS Wellness Centre are resolved. The Committee, therefore, recommends that the Department should consider opening the second CGHS Wellness Centre at Calicut, based on the above principle.**

XV. ASSISTANCE FOR CAPACITY BUILDING FOR TRAUMA CARE FACILITIES IN GOVERNMENT HOSPITALS

15.1 As per information given in the Annual Report 2015-16, road traffic injuries are one of the leading causes of deaths and disabilities. According to WHO "Global Status Report on Road Safety 2013", more than 1.2 million people die in road accidents every year and as many as 50 million are injured. Deaths due to road accidents are in the eight leading causes of death globally which is expected soon to be the fifth common cause of death by the year 2030 unless the problem is addressed urgently. As far as India is concerned, death and disabilities due to accidents are gradually rising. During the year 2011, there were

around 4.98 lakhs road accidents which killed 1.42 lakh people and more than 5 lakh were injured. During 11th Five Year Plan the Government of India initiated a scheme on trauma care with an outlay of ₹ 732.75 crore with 100 % central funding provision to develop a network of 140 trauma care facilities in the Government Hospitals along the Golden-Quadrilateral highway corridor. Out of the identified 140 hospitals, the trauma centres in 118 hospitals were funded under the trauma scheme, 20 hospitals were funded under PMSSY scheme and 2 trauma centres in Delhi's Dr. RML Hospital & AIIMS were developed with their own funds. The trauma care network was so designed that no trauma victim has to be transported for more than 50 kms to a designated hospital having trauma care facilities. For this purpose an equipped basic life support ambulance was to be deployed by National Highway Authority of India (NHAI) (Ministry of Road Transport and Highways) at a distance of 50 KMs on the designated National Highways. Ministry of Road Transport and Highways has supplied these ambulances on National Highways. An amount of ₹ 352.69 crore was released during the 11th plan.

15.2 The Committee has been informed that the scheme has been extended to the 12th plan period and has already been approved by CCEA with total budget outlay of ₹ 899.29 crore. The proposal has been approved for development of another 85 new Trauma Care Centres on the same pattern with following minor variations:-

a. The criteria for identification of State Government hospitals on the national highways will be as follows:-

Connecting two capital cities;

Connecting major cities other than capital city;

Connecting ports to capital city;

Connecting industrial townships with capital city and

Accidental black spot data.

The identification of the hospitals for development of 85 trauma centres will be done in consultation with all the stakeholders. Preference will be given to States which are not covered during 11th plan and hilly and North Eastern States.

b. Unlike the 11th plan, the scheme is not 100% centrally sponsored. Now the amount of assistance will be shared between Central and State Governments in a ratio of 60:40 w.e.f. 2015-16. The ratio of sharing for North Eastern States and hill States of Himachal Pradesh, Uttarakhand and Jammu & Kashmir this ratio will be 90:10.

c. The scheme earlier merged within the ambit of "Human Resource in Health and Medical Education Scheme". However, as per the recommendations of sub-group of Chief Minister on rationalization of Centrally Sponsored Schemes, this scheme is subsumed in NHM, it is presumed that the component of the scheme for Medical Colleges would be taken care as these are tertiary care institutions and as such are not supported under NHM till date.

d. National Injury Surveillance, Capacity Building and Trauma Registry Center have been established at Dr. RML Hospital.

e. Funds will be released to L-II Trauma Care Facilities of 11th FYP and 12th FYP for establishing rehabilitation units.

f. National conferences will be conducted during the 12th FYP under the programme.

g. Trainings are being provided to the Doctors and Nurses working in Trauma Care centers and to the Para-medics to be posted in the ambulances.

In reply to a question, the Department has informed that there was no fund allocation at BE-2015-16 stage. However, funds of ₹ 100.00 crore were provided through supplementary grants and at RE stage. Out of ₹ 100.00 crore funds to the tune of ₹ 81.00 crore have already been released. The Department expects that the funds earmarked for this project will be utilized fully.

15.3 An allocation of ₹ 200.00 crore has been made for Assistance for Capacity Building (Trauma Care) in 2016-17.

15.4 Intimating the Committee of the progress made towards construction/upgradation of Trauma Care Facilities (TCFs) the Department has submitted that

> "The construction activities have been completed in 99 trauma care facilities (TCF) out of 116 TCFs identified during 11th FYP. Construction activities are also in progress in other 11 TCFs.
>
> As reported by the implementing agencies, 57 Trauma Care Facilities have become fully functional in terms of construction/renovation, extension, equipments and manpower."

15.5 **The Committee is concerned to note that the Scheme for Capacity Building for Trauma Care Facilities is no longer a 100% Centrally Sponsored Scheme and the amount of assistance will be shared between Central and State Governments in the ratio of 60:40 w.e.f. 2015-16. The Committee is highly sceptical of the success of this scheme, in the changed scenario of alteration in the funding pattern because there are competing demands on the resources of the states and their additional fiscal space for mobilizing resources is also limited. The Committee would, therefore, strongly recommend to the Government to have a re-look into the funding pattern so as to suitably enhance central assistance provided under the scheme for Capacity Building for Trauma Care to cover the entire cost of capacity building.**

PART-C

NACO

I. BUDGETARY ALLOCATION

1.1 The Department has informed the Committee that as against the projected demand of ₹ 2550.00 crore for 2016-17, NACO has been allocated ₹ 1700.00 crore.

1.2 In reply to a query regarding the status of NACO Budgetary provisions utilization of plan funds allocated for NACO in 2014-15 and 2015-16 and whether any evaluatory study has been conducted on whether the states have the additional fiscal space for allocating resources for the AIDS Control Programme, the Committee has been furnished the following information:-

Table No. 33

Year	Allocated ₹ in crores		Utilization
	B E	R E	₹ In Crores
2014-15	1785.00	1300.00	1287.39
2015-16	1397.00	1615.00	1516.00*

* Figures till 18th March 2016.

1.3 The Department has also submitted that there would be savings/lapse of only meager amount.

1.4 The State Governments were requested to contribute to the programme during 2015-16. A few State Governments agreed to contribute partly to the scheme. But the matter was not pursued due to (i) Grant of additionality of ₹ 218.00 crores to National AIDS Control Organization at RE stage under 2nd Batch of Supplementary Demand 2015-16 and (ii) Declaration of the Central Sector Status to National AIDS & STD Control Programme by Ministry of Finance. In light of this, there was no requirement for any evaluatory study on whether all states have the additional fiscal space for allocating the resources for the AIDS Control Programmes.

1.5 Regarding the extent of savings and unspent balances during 2014-15 and 2015-16 under NACO, the Department has supplied the following information:

Table No. 34

₹ in crores

Year	Savings	Unspent Balances	Reasons
2014-15	497.61	12.61	Savings were due to mandatory cut imposed by M/o Finance at RE stage (BE 1785.00 crore, RE 1300.00.crores), whereas the unspent balance is less than

Year	Savings	Unspent Balances	Reasons
			1% of expenditure permissible with in RE ceiling. The same was due to non booking of the amounts authorized to Union UTs and in case of some bills of procurement, the observations could not be addressed due to closure of account of FY 2014-15.
2015-16	Nil	Updated figures are being collected.	At RE stage Supplementary Grant of 218.00crores has been given to National AIDS Control Organization with RE of1615.00 crores against BE of 1397.00 crores.The same is likely to be utilized with expenditure sanction of ₹ 1548.00 crores already issued till 18th March, 2016.

1.6 On being asked about the steps taken to utilize the unspent balances available with State AIDS Control Societies (SACS), the Department has submitted that close monitoring of cash balances with SACS is under taken and the position is reviewed to direct the SACS to liquidate the cash balances with them. Review meeting with SACS officials/personal intervention with SACS Project Directors inter alia for liquidating the cash balances were held. Releases made to SACS from NACO were after adjusting the unspent balance pending with them. The position of the unspent balances during **2014-15 and 2015-16 is** as under :-

Table No. 35

Consolidated Year-wise statement for the release, expenditure and unspent balance (cash-in hand) with all SACS as on 29th Feb. 2016

** Figures in Lacs*

Years	Release	Expenditure	Unspent Balance (Cash in Hand)	Expenditure increase in 2014-15 over 2013-14	Unspent Balance Increase/ Decrease in 2014-15 over 2013-14
2013-14	69059.66	86068.39	10572.15		
2014-15	93587.00	92385.69	13685.47	6317.30	3113.32
2015-16#	76739.00	50240.13			

Figures as on 29-02-2016

1.7 The Committee has been informed that from 2014-15 the releases of GIA have been done through State Treasury routes rather than prevailing direct transfer to SACS. The increase in unspent balance (cash in hand) during 2014-15 was primarily due to delay in transfer of money from State Treasury to SACS. The money received late by SACS was also disbursed late, thereby resulting in late adjustment thereof. However, with direct release to SACS w.e.f. FY 2016-17 position of unspent balance will improve and due care will be taken to ensure timely utilisation of funds.

1.8 The position of the funds released by National AIDS Control Organization, funds received by SACS and funds pending with State Treasuries was periodically reviewed after every release and matter was taken up with States and was pursued regularly to intervene and resolve the pendency of the funds released for SACS, lying undisbursed with treasuries.

1.9 Ministry of Finance in the month of January 2015 consented to the proposal for direct releases to SACS, rather than through the State Treasury. With the release of almost all state plan funds of the year 2015-16 already made, the releases in next financial year will be made under direct disbursement method to SACS with provisioning thereof under relevant Major Head."

1.10 Regarding the quantum of grants made to SACS during 2014-15 and 2015-16 and the expenditure figures thereof, the following information was supplied to the Committee:-

Table No. 36

Consolidated Year-wise position of funds released to SACS during 2014-15 and 2015-16

* Figures in Lacs

Year	Funds Released to SACS	Expenditure Figure
2014-15	93587.00	92385.69
2015-16#	76739.00	50240.13

Figures as on 29-02-2016

1.11 The Committee has also been informed that NACO had initiated and followed up with SACS to recover the unspent balances with discontinued TIs. The actions initiated for recovery of unspent balances against the defaulting NGOs has shown results in decrease of unspent amount in 68 NGOs spread over 10 States.

1.12 From last time the unspent balances with the defaulting NGOs has further declined to ₹ 72.07 lakhs from 352.00 lakhs. SACS-wise detail is given below.

Table No. 37

SACS-wise details of amount pending with TIs, amount recovered, and actions initiated

Sl. No.	State	Total Amount pending as on 1st June 2015	Amount recovered till Dec 2015	Total Amount pending till Dec 2015	Action Initiated
1	Andhra Pradesh	538,588		538,588	Issued notice to FIVE NGOs / CBOs by consulting Government Pleader. Revenue act letter is in process.
2	Assam	143,260		143,260	RTI is filed against the only pending NGO, but NGO is not traceable.
3	Chhattisgarh	188,449		188,449	Released Legal Notice, 2nd notice will be issued to one pending NGO

Sl. No.	State	Total Amount pending as on 1st June 2015	Amount recovered till Dec 2015	Total Amount pending till Dec 2015	Action Initiated
4	Gujarat	98,591		98,591	Follow up letters has been sent to one NGO, no reply received.
5	Haryana	91,000		91,000	Notice has been issued to the One Pending NGO regarding balance recovery amount
6	Karnataka	102,034	102,034	0	All the amount recovered by SACS
7	Jharkhand*	2,228,973		2,228,973	Reminder Letter sent to all 20 NGOs. Regular follow up done under SACS Finance division for further action.
8	Madhya Pradesh	3,400,035	75,237	3,324,798	Letter is given to 28 NGOs. An Auditors compliance committee has been formulated to resolve the dispute with 28 NGOs and further updates on progress will be shared.
9	Odisha	314,153		314,153	Again letter is issued to 4 NGOs to return assets and balance amount If no revert happens the issue would be escalated to Planning & Coordination Department, Government of Odisha for blacklisting.
10	Tamil Nadu	279,221		279,221	As per TANSACS legal advisor opinion, recovery letter sent to DACO-DAPCU for identifying the where about details of the 15 NGOs, based on the details submitted by DACO-DAPCU, Legal notice yet to be issued to the NGOs.
	TOTAL	**7,384,304**	**177,271**	**7,207,033**	

*Jharkhand unaudited amount

1.13 Out of the pending amount of ₹ 72.07 lakhs, ₹ 55.53 lakhs (77% of the outstanding amount) is pending with two states viz. Madhya Pradesh SACS (₹ 33.24 lakhs for 28 NGOs) and Jharkhand SACS (₹ 22.29 lakhs for 12 NGOs). Remaining 7 states have 16.54 lakhs pending (23%).

1.14 **The Committee notes that an additional amount of ₹ 218.00 crore was granted to National AIDS Control Organisation at RE stage of 2015-16, raising the total allocation for NACO to ₹ 1615.00 crore. NACO has incurred expenditure of ₹ 1515.46 crore till 18th March 2016. Keeping**

in view the submissions made by NACO, the Committee expects NACO to fully utilize the allocated funds. The Committee also notes that as against the projected demand of ₹ 2550 crore for 2016-17, NACO has been allocated ₹ 1700.00 crore on the plan side, leaving a shortfall of ₹ 850.00 crore. As per the recently released India HIV Estimation 2015 Report, National adult (15-49 years) HIV prevalence in India is 0.26%. As per information given in the Annual Report 2015-16 of Department of Health and Family Welfare, the adult HIV prevalence at national level has continued its steady decline from an estimated peak of 0.38% in 2001-03 to 0.26% in 2015. The Committee feels that this is due to the effective implementation of the various interventions of NACP and scaled up prevention strategies. In view the good track record of NACO in utilizing the earmarked funds, the Committee lends support to infusing more money, if needed, into NACO at the RE 2016-17 stage.

1.15 **The Committee notes from the information given in the Outcome Budget 2016-17 of the Department of Health and Family Welfare that as on 31.01.2016 ninety three Utilization Certificates amounting to ₹ 147.93 crore pertaining to NACO are pending. The Committee observes that if there is time lag in submission of UCs, it delays release of central funds which in turn impinges on the implementation of various programmes of NACO. The Committee, therefore, recommends that sustained efforts be made to liquidate the pending UCs within a period of six months. The Committee desires to be kept apprised of the efficacy of measures taken in liquidating pending UCs.**

1.16 **The Committee observes that in spite of action taken by NACO to recover the unspent balances with discontinued NGOs, availability of unspent balances with some SACS is still quite high. The Committee, therefore, recommends that a multi-pronged strategy of liquidating the unspent balances with SACS be adopted and emphasis be laid on intensive monitoring at various levels.**

1.17 **The Committee notes that at its behest the direct release of funds to SACS has been restored w.e.f. 2016-17, which would help in reducing the time- lag in release of funds. The Committee would suggest that the e-transfer system may be put in place to obviate delays in the flow of funds to SACS. The Committee also would like to be informed of the extent to which these allocations to SACS are translated into health outputs and services rendered by SACS in 2016-17.**

II. METRO BLOOD BANKS

2.1 On being asked about the physical and financial performance of the project concerning establishment of Metro Blood Banks, the Department in a written reply has informed that "The Metro Blood Bank (MBB) Project is conceived to create Regional Centers of Excellence (CoE) in Transfusion Medicine so as to complement the entire Blood Transfusion Service efforts. EFC concurred the project as central sector scheme with budget outlay of ₹ 404 crores over seven years. Hon'ble HFM (Union of India) approved the project in June 2015. MoU, to be signed with states, was revised as per EFC recommendations and vetting by Ministry of Law and Justice. After obtaining approvals, revised MoU has been shared with states in Dec 2015. It is expected that MoU with respective states should be signed shortly and expenditure made accordingly. Financial outflow shall start soon after signing of MoU with States".

2.2 **The Committee observes that the budgetary provisions to the tune of ₹ 83.00 crore had been made in BE-2014-15 for setting up of Metro Blood Banks, but the entire amount had to be surrendered**

due to non-approved of the project by Expenditure Finance Committee (EFC). The EFC has now approved the Project as Central Sector Scheme with budget outlay of ₹ 404.00 crore to be implemented over 7 years. The Committee notes the assertion made by the Department that MoUs with States should be signed shortly and financial outflow shall start soon after. However, given the fact that the revised MoU was shared with States in December 2015, the Committee doubts that the funds would be drawn from this head in financial year 2015-16. Evidently, the NACO appears to be oblivions to the ground reality on the implementation of this project. There should be no further delay in implementing this programme.

III. **HIV PREVALENCE**

3.1 The Committee notes from the information given in the Annual Report 2015- 16 of the Department, that as per the recently released, India HIV Estimation 2015 report, National adult (15–49 years) HIV prevalence in India is estimated at 0.26% (0.22%– 0.32%) in 2015. In 2015, adult HIV prevalence is estimated at 0.30% among males and at 0.22% among Females.

3.2 The steps taken by the NACO to keep strict vigil on the rising trends of HIV prevalence in the low prevalence states and specific efforts made to contain this trend are following:

Regular review meeting at national and state level for scaling –up of the coverage of the programme and improve the quality of services

There has been scale-up of facility-integrated counseling and testing services across the country including in low provenance states to augment coverage of the programme during NACP-IV period. These facilities integrated ICTC are under the general health system at PHC and CHC level.

NACO decided to initiate lifelong ART (using the triple drug regimen) for all pregnant and breastfeeding women living with HIV, regardless of CD4 count or WHO clinical stage, both for their own health and to prevent vertical HIV transmission and for additional HIV prevention benefits. This benefits all states including low prevalence rising HIV prevalence among pregnant women states

For the year 2015, India has created a standardized PPTCT Information and Management system. Standardised data collection tools have been developed for improving the quality of data collected. A National PPTCT Core Group has been constituted with the support of development partners for monitoring and supervision of the implementation of the national PPTCT strategy and strengthening the implementation of PPTCT services in the Country."

3.3 During the course of oral evidence of the Health Secretary on 22nd March, 2016, a query was raised whether there was underreporting of AIDS/HIV cases because a large number of people go to private clinics as they don't want their names to be disclosed. But private practitioners often don't inform the authorities concerned about the positive HIV/AIDS cases. Responding to the query, the Additional Secretary who was present during the evidence stated that "at the testing stage, people do go to private clinics. But for treatment, because Government treatment is free, a very large majority of the people come to us. So the Government figures are reasonably accurate."

3.4 **It is a matter of serious concern for the Committee that some states are showing trend of HIV prevalence. Though the NACO has taken steps to contain this trend, the Committee would**

like the NACO to improve the implementation aspects of this Scheme in the high HIV prevalence states. The NACO should also ensure that the benefits of the specific measures percolate down to all the intended beneficiaries.

3.5 **The Committee notes that because of the taboo of HIV/AIDS, a large number of patients go to private clinics for the simple reason that they want their privacy maintained. The Committee apprehends that the data concerning number of HIV/AIDS cases are being collected from Government hospitals/health institutions and a lot of data from private clinics and private hospitals is not being captured. The Committee would, therefore, like the Department to ensure that no under-reporting of HIV/AIDS cases takes place.**

OBSERVATIONS/RECOMMENDATIONS - AT A GLANCE

PART-A

National Health Mission (NHM)

II. BUDGETARY ALLOCATION

The Committee's scrutiny of the total Twelfth Plan approved outlays for the National Health Mission and the whole Department of Health and Family Welfare (Table No.1) is very revealing. The Committee notes that the Planning Commission had approved a total outlay of ₹ 1,93,405.71 crore for the NHM and ₹ 2,68,551.00 crore for the whole Department for the 12th Five Year Plan. However, the total budget allocation made by the Union Government in the five years (2012-13 to 2016-17) is ₹ 90,000.82 crore for the NHM and ₹ 1,25,117.00 crore for the Department of Health and Family Welfare, which work out to measly 46.50% of the funding originally envisaged for the NHM as well as the Department under the 12th Plan. Table No.2 which compares releases made with Revised Estimates, shows that the overall NHM releases made are as high as 98.13%, implying that the allocated amounts are being utilized effectively. The Committee observes that the avowed vision of the National Health Mission is the attainment of universal access to equitable, affordable and quality healthcare services accountable and responsive to people's needs with effective inter-sectoral convergent action to address the wider social determinants of health and the Mission has huge potential to transform healthcare delivery in the country. If the Government had allocated the entire Twelfth Plan approved outlays, the country would have seen much improved primary healthcare services, fulfillment of the free medicines and diagnostic policy, reduced out-of-pocket expenditure and probably 1.5 percent of GDP as public health expenditure reached by 2015. (Para 2.22)

All these facts lead the Committee to believe that the priority for the National Health Mission and the Health Sector as a whole has been a soft target whenever the Government faces a resource crunch. The Committee would like to impress upon the Government that if it wants to enhance access to quality healthcare for the people, it will have to alter the health financing landscape of NHM by allocating adequate financial resources, because if funding for the Mission is inadequate, its implementation would automatically be hampered. The Committee, therefore, recommends that given the need to augment rural health infrastructure and fill in vacancies of various categories of health professionals, this trend of the yawning gap between the approved outlays and sanctioned budget should be reversed and a much higher magnitude of the Union Budget allocation for NHM than what is prevailing should be made so that Central Health spending could be ramped up to boost Indian public health standards. Only then will the NHM be able to guarantee universal access to equitable, affordable and quality healthcare. (Para 2.23)

The Committee notes that as against the projected demands of ₹ 31,492.95 crore for the National Health Mission for 2016-17, the allocation made in BE 2016-17 is only ₹ 19000.00 crore, leaving a shortfall of more than ₹ 12000.00 crore. In comparison to the RE 2015-16 allocation of ₹ 18295.00 crore, the increase in the BE 2016-17 is of ₹ 705.00 crore only, which is grossly inadequate

and will be eaten up by inflation. Taking note of the submissions of the representatives of the Department of Health and Family Welfare that in order to undertake new initiatives like free drugs, free diagnostics and free dialysis initiatives, the minimum required increase in allocation for 2016-17 would be ₹ 5000.00 crore, the Committee lends its Parliamentary support to the allocation of additional ₹ 5000 crore, if not the full projected amount, for NHM which may be raised at RE stage. The Committee is of the view that with the projection of a promising economic growth which is pegged at 7.5%, the Union Government should have the fiscal space to provide this amount of ₹ 5000.00 crore in 2016-17. The Committee would like the Department to bring this recommendation to the notice of Ministry of Finance and also apprise the Committee of their response thereto. (Para 2.24)

The Committee observes that in its 82nd Report on the Demands for Grants it had apprehended that the 10% increase in devolution of Central tax share to states (*i.e.* from 32% to 42%) post the new devolution formula in the form of untied funds would not compensate for the shortfall in Central Funds for health for 2015-16 in view of the fact that most of the States had already presented their budgets for 2015-16 but not made additional budgetary provisions for meeting the shortfall in Central Plan allocation on Health. The Department's submission that "the decision to increase share of tax pool to States did not lead to increase in health budgets (in 2015-16)....." has validated the Committee's apprehension. The Committee is therefore, concerned that the suddenness with which the changed devolution mechanism has been thrust upon states must have jeopardized the targeted health outcomes in 2015-16. The Committee takes note of the Department's submission that the revised Centre-State funding pattern from 75:25 to 60:40 will ensure increased availability of resources for NHM and that from the Financial Year 2016-17, the Central funds will be released only on clearance of State share as per the new funding pattern. The Committee observes that though the Government has tried to address the reduction in Central Plan allocation for NHM through conditionality, *i.e.* requiring States to raise their own share in Health Care spending by 15 percent (*i.e.* from 25 to 40 Percent), there is no mechanism in place to ensure that the additional state health financing indeed gets allocated and spent. The Committee, therefore, recommends that an assessment be made urgently and communicated to the Committee as to what extent the 10% rise in State's revenue is reflected in the allocation of additional resources for health by them during current year. (Para 2.25)

The Committee would also like to be apprised about the impact of the State Health Budgets, especially on the following 'essential sectors' during 2015-16:-

(a) Strengthening of Health facilities to IPHS standards,

(b) Establishing new SHCs, PHCs and CHCs as per the norms,

(c) Up-scaling of existing initiatives like Rashtriya Kishore Swasthya Karyakram (RKSK) and Rashtriya Bal Swasthya Karyakram (RBSK),

(d) Implementation of new interventions such as:

(i) Expansion of coverage of Non Communicable Diseases programmes, the screening for which requires intensive resources at district hospitals

(ii) Strengthening of District Hospitals, especially in High Priority Districts (HPDs)

(iii) **Universal Health Coverage (UHC) Pilots,**

(iv) **Implementation of free drugs and free diagnostics scheme,**

(v) **Expanding the scope of primary health care to make it comprehensive and develop Sub-Centres as first port of call,**

(vi) **Increasing availability for Sub-Centres in tribal & hilly areas based on 'time to care' concept.** (Para 2.26)

The Committee notes from Table Nos. 4 and 5 that "total health spending in India is at 3.8% of GDP. The Total public expenditure on health (combined spending on health by the Centre and all States) in the country stands at 1.2 percent of GDP which is 4.3% of total Government expenditure and 30.5% of total health expenditure. Even among the BRICS countries (Brazil, Russia, India, China and South Africa), India spends the least on health. (Table No. 6). The Economic Survey (2015-16) states that according to the Universal Health Coverage (UHC) Index developed by the World Bank to measure the progress made in health sector in select countries of the World, India ranks 143 among 190 countries in terms of per capita expenditure on health ($ 146 PPP in 2011) and 157th position according to per capita spending on health which is just about $44 PPP. (Para 2.27)

The Committee also notes that the Centre-States ratio in total Government health allocations is 28:72. The 12th Five Year Plan Documents had proposed to raise India's overall public spending on health to 2.5% of the GDP by the end of the 12th Plan period. With just one year left in the 12th Five Year Plan period, there is no possibility of raising public health spending to 2.5 of GDP by 2017 as this would entail increase in the public health allocations at 147% over 2015-16 levels, which is of implausibly high magnitude. According to the Government's draft National Health Policy 2015, global evidence on health spending shows that unless a country spends at least 5-6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Committee is aware that in our federal fiscal structure realising the goal of spending 2.5% of GDP on healthcare would also require States to increase their spending on health and the increase in tax devolution to states from 32% to 42% post the Fourteenth Finance Commission recommendations offers an excellent opportunity for State Governments to step up their spending on health. In its 82nd Report, the Committee had observed that the past experience shows that if the spending is left to State Governments, contractor intensive sectors take priority over non-contractor intensive sectors and Health, not being a contractor intensive sector, would take a backseat in such circumstances. The increase in education expenditure that took place from the mid 80s, in many ways, had forced the State Governments to make an increase in their expenditure commensurately. One of the objectives of the National Health Mission is to spur States to spend more on health. The Committee is, therefore, of the firm opinion that given the dominance of the Centre in the domain collection of tax revenue, increasing public health expenditure to 2.5% of GDP will have to be Centre-led. Despite the policy pronouncement of raising public health expenditure to 2.5% of GDP, as articulated in the 10th, 11th and 12th Five Year Plans, the Government spending on health continues to be abysmally low at 1.2% which is insufficient to meet the NHM goals. As per an article titled "Assuring health coverage for all in India" published in the Lancet on the 12th December, 2015, although the Twelfth Five Year Plan had called for a Paradigm shift and recommended

the Central Plan expenditure on health to increase by about 34% every year, the Central Government share in public health expenditure has remained less than 30% since 2010 and has reduced progressively, even if marginally. The draft National Health Policy, 2015 recognises the fact that if the target of raising public expenditures on health to 2.5% of the GDP is to be achieved, 40% of this would need to come from Central expenditures. The Committee observes that it is a documented fact that low government expenditure on health leads to high out-of-pocket payments by individual households on healthcare which not only forms a barrier to accessing care, but also leads to households incurring catastrophic expenditure due to health costs which in turn push them into indebtedness and poverty. As per the draft National Health Policy 2015, over 63 million people are pushed below the poverty threshold every year due to healthcare costs alone. As per the NSSO Survey-71st Round (January- June, 2014), the Out-of-Pocket expenditure accounts for 58% of total health expenditure which is one of the highest, even among low income countries. The Committee observes that despite rapid economic growth over the past two decades, successive Union Governments have not made the requisite level of financial investments in health and the growth in the Union health budgets on health have been lower than needed to achieve the 2.5% goal. The Committee observes that acceleration in economic growth by itself will not translate into higher public spending on health. The Government will also have to demonstrate its commitment to ensuring that adequate financial resources for provisioning essential healthcare to all indeed gets allocated and spent. The Committee therefore, recommends that the Central Government should chalk out a solid fiscal roadmap for generating and allocating more financial resources for Health so that the goal of raising Government expenditure on Health to 2.5% of GDP is realised and the vision of moving towards universalization of affordable healthcare is translated into reality. The Committee desires to be furnished with a detailed status note delineating the plan of action for meeting the commitment of earmarking 2.5% of GDP for the Health Sector. (Para 2.28)

The Committee takes note of the written submission of the Department that the transfer of Central grants to State Health Society through treasury route which has been implemented from the financial year 2014-15 has witnessed considerable delays. The Committee also takes note of the submissions made by the Additional Secretary during the evidence on 22nd March 2016 that "out of the total funds of ₹ 8242.78 crore released till now under RCH and Health systems strengthening, ₹ 7460.04 crore were transferred from State Treasury to State Health Society with a delay from 0 to 142 days and ₹ 782.74 crore (9.5%) is still lying with State Treasury for a period between 90 to 180 days." The Committee is extremely concerned to learn that the current fund flow architecture *i.e.* Treasury Route through which funds are flowing to State Health Society is resulting in unnecessary delays in fund transfers and is therefore certain to pose bottlenecks in the smooth implementation of NHM. The Committee observes that timeliness of transfer of funds is extremely important as delayed transfers hamper fund utilization. The Committee, therefore, recommends that the existing fund release mechanism for NHM needs to be reviewed. The Treasury route of transfer of funds should not be allowed to be a constraining factor in speedy transfer of funds and if the delay in funds flow through Treasury mode continues to persist for another three months and the Treasury system fails to address this persisting delay, the Society route of funds should replace the Treasury system of transfer of funds. The Committee desires to be kept updated on the decision taken in the matter. (Para 2.29)

The Committee while appreciating the States whose public health expenditure is more would like the Department to focus its resources more in the States whose public health expenditure on

health is less like Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh, since these States constitute a big chunk both geographically and population-wise and it would require special support and care to ensure that they are able to reach at the average of the States having more public health expenditure per capita. (Para 2.30)

The Committee is distressed on the reasons spelt out by the Department regarding the problem areas identified in implementation of various components of NHM, such as (i) Public Health being a State subject, implementation of approved plan under NHM depends upon implementation capacities of the State/UT Governments and implementation capacity of many States is slow particularly in respect of civil construction, procurement of drugs and equipment, engagement and management of human resources, paucity of health human resource such as doctors & specialists, etc., and (ii) Poor co-ordination between Urban Local Bodies (ULBs) and State Health Department. The Committee is of the view that the reasons listed out by the Department in its reply point to the fact that there is a wide chasm between the targets set and the actual implementation of the targets in practice. The Committee recommends that the Department take measures to overcome the shortcomings/delays in implementation capacity of States by way of short, medium and long term plans. (Para 2.31)

Tribal Sub Plan (TSP)

The Committee takes note of the fact that the share of TSP component in the total outlay for NHM for 2015-16 was hiked from 8.2% to 11% and welcomes this hike. The Committee however, desires to be informed as to what has been the experience with addressing health equity concerns in tribal areas. (Para 2.35)

The Committee observes that Tribal blocks are severely under-served in terms of health infrastructure and workforce, since skilled health workers are often unwilling to move into tribal areas, and quality of services continues to be a concern. The ill-equipped public health system and weak referral linkage often compels poor families to seek care at the private sector. The unregulated private sector tends to be extremely exploitative (in terms of irrational procedures, coercion as well as high out of pocket expenses). Keeping in view the fact that the tribal areas in the country have the worst health indicators and are plagued with the stark inequities in access to healthcare, the Committee recommends that mapping of health facilities in tribal areas be carried out to identify the closest facility which is easily accessible based on geographical conditions (specifically in hard-to-reach areas). These facilities like health sub-centers, PHCs, or satellite centers, should be made functional on a priority basis with necessary backup of referral transport facilities and essential medicines. (Para 2.36)

The Committee also recommends that specialists must be recruited and designated FRUs must be urgently operationalized in underserved areas. Since specialists are required for managing emergency care, graduates of Government medical colleges must be provided incentives to work in underserved areas, using a hub-and-spoke model. Training of doctors on CEmOC and LSAS and posting them in tribal areas will ensure continuum of care and prevention of leakage into the private health sector. (Para 2.37)

Utilization Certificates(UCs)

The Committee observes that 220 Utilization Certificates amounting to ₹ 3223.72 crore and

307 Utilisation Certificates amounting to ₹ 4302.61 crore are pending under the RCH Flexible Pool and Mission Flexible Pool respectively. Similarly, the amount involved in pending UCs pertaining to the National Urban Health Mission is ₹ 1606.32 crore. Time lag in furnishing Utilization Certificates delays transfer of Central Funds which in turn adversely affects capital expenditure to be incurred by States. The Committee notes that the amount involved in pending UCs under RCH Flexible Pool, Mission Flexible Pool and NUHM is quite substantial, and the oldest pending UCs is of the year 2005, which suggests that the problem is endemic. The Committee expresses its displeasure that in spite of the Committee's repeated recommendation to liquidate the Pending UCs within a set time-frame, there is lethargy in liquidating the pending UCs. Such a state of affairs goes against the canons of fiscal propriety because on the one hand the Department seeks funds and on the other, it is unable to get the States to provide the Utilisation Certificates (UCs). The Committee fails to comprehend the delay in furnishing UCs when in a digital era, furnishing of UCs can be done at the click of a mouse. The Committee strongly recommends that the Department should put in place a system for smooth and timely furnishing of UCs and also ensure that all pending UCs are liquidated within a period of six months from the date of presentation of this Report. (Para 2.40)

(III). NRHM-RCH FLEXIBLE POOL

The Committee observes that despite some important improvements in MMR and IMR, India is behind Brazil, Bangladesh, Nepal, Sri Lanka and Thailand on U5MR and Brazil, Sri Lanka and Thailand on MMR. The Committee would, therefore, like the Department to identify and address the fundamental weaknesses in RCH programme and take credible action towards reducing IMR and MMR to the targeted levels. (Para 3.10)

The Committee observes that the Health Secretary's submission that population stabilization will happen by 2045 is highly optimistic because experience shows that it takes two generations for the population to stabilize after TFR of 2.1 is reached. The Committee, would, therefore, like to be informed of the strategies adopted to achieve population stabilization by 2045. The Committee also recommends that the Department should adopt innovative strategies including giving financial incentives towards controlling population growth in these states which have high TFR. (Para 3.13)

B. Universal Immunisation Programme(UIP)

The Committee notes that the National Technical Advisory Group on Immunization (NTAGI) has recommended introduction of new vaccines, namely Rubella vaccine Inactivated Polio Vaccine (IPV), Rotavirus vaccine and Adult JE vaccine which is being implemented in a phased manner. The Committee desires to be apprised of the States where these four vaccines have been introduced and whether any evaluatory studies have been conducted on their efficacy. (Para 3.17)

Mission Indradhanush

The Committee observes that the Department aims to achieve full immunization of 90 % children by 2020. The Committee desires that the target should be achieved without fail and all out efforts may be taken in this direction. The Committee would further like the Department to also apprise the Committee whether the target of 90% immunization would cover all districts of the country by 2020. (Para 3.19)

C. Pulse Polio Immunisation

The Committee is of the view that before the Department had enough stock indigenously available in the country because shortage of stock available indigenously would in turn require imports. The Committee, therefore, recommends that the Department should ensure that there are adequate stocks available in the country and the public sector pharmaceutical companies should also take up production of this vaccine at the earliest so that the Country is insulated from the price and supply shocks concerning IPU. (Para 3.22)

IV. NATIONAL URBAN HEALTH MISSION (NUHM)- FLEXIBLE POOL

The Committee observes that the National Urban Health Mission was launched in 2013 in order to effectively address the healthcare needs of the urban poor population. Though almost three years have elapsed since then, but the NUHM continues to be plagued with underfunding which is evident from the fact that a meagre allocation of ₹ 950.00 crore has been made for NUHM for 2016-17. The Committee observes that the unprecedented urbanization in the country has brought with it rapid growth of populations and a concomitant rise in slum populations and therefore a measly provisioning of ₹ 950.00 crore is grossly inadequate. The Committee, therefore, recommends that greater financial resources be made available for NUHM so that the urban poor are protected against financial risks associated with catastrophic health costs and the urban poor are not excluded from the public healthcare system. (Para 4.4)

The Committee finds from the information furnished that the in-position manpower *vis-a-vis* the approved staff is tediously slow in spite of all the efforts being put so far. The Committee is of the view that the Department should look at the possibility of creating a monitoring committee in all districts so that regular interface and monitoring of the schemes being implemented including the recruitment position is done. (Para 4.5)

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

A. National Vector Borne Disease Control Programme (NVBDCP)

Malaria

The Committee observes that Malaria is a public health problem in many parts of the country and anti-malarial drug resistance has emerged as a major challenge. The number of cases is still more than one million and steps need to be taken to address this on a priority basis. (Para 5.6)

Dengue

The Committee notes from media reports that rapid diagnostic kits for dengue generate upto 50% of false positives for dengue and thus spread panic and are not reliable at all. Experts have favored banning of rapid diagnostic kits. The Committee, desires that necessary action be taken in this regard. (Para 5.9)

Japanese Encephalitis (JE) and Acute Encephalitis Syndrome (AES)

The Committee notes that out of 204 endemic districts, 182 districts have been covered under JE vaccination till 2015. The Committee recommends that all the remaining endemic districts

may be covered under JE vaccination at the earliest to ensure complete elimination of the disease. (Para 5.12)

The Committee while appreciating this approach of the Department directs that it should expand such line of treatment to all the districts affected by AES in the country and request the Ministry of Finance to provide adequate funds to support the line of treatment adopted by the Department. (Para 5.17)

Lymphatic Filariasis (LF)

The Committee recommends that a strategy may be adopted to do community level sensitization and mobilization to maximize coverage of MDA. The Committee desires that the additional round of MDA in 74 districts may be completed as targeted in 2016. (Para 5.21)

Kala-Azar

The Committee notes that though Kala-azar was targeted to be eliminated by 2015, there are no such signs though the cases have come down in 2015. The Committee desires elimination without much delay. (Para 5.23)

(B) National Tuberculosis (TB) Control Programme

The Committee further recommends that if the study is successfully implemented in these five States, the Government should look to expand the study in all states and, if need be, approach the Ministry of Finance for more funds for expansion of this study. (Para 5.26)

(C) National Leprosy Control Programme

The Committee observes that this is the last year of the 12th Plan and according to the main objective of NLEP, the Department strives to achieve elimination of leprosy less than 1 case per 10,000 population in all the districts of the country by end of Twelfth Plan and strengthen Disability Prevention & Medical Rehabilitation of persons affected by leprosy. The Committee desires to be apprised of the status prevailing as on date within three months of the presentation of this report both in respect of achieving the target set as also the progress made in strengthening Disability Prevention & Medical Rehabilitation of persons affected by leprosy. (Para 5.28)

(D) Integrated Disease Surveillance Project(IDSP)

The Committee finds, that the progress in strengthening of the District Public Health labs is at a snail's pace. In the first four years of the 12 Plan, the Department has been able to set up and make functional only 111 labs against target of 300 set for the Twelfth Five Year Plan. The Committee desires that in the last year efforts should be made to open maximum number of labs. (Para 5.34)

VI. FLEXIBLE POOL FOR NON-COMMUNICABLE DISEASES, INJURY AND TRAUMA

(A) National Programme for Control of Blindness

The Committee observes that the fund utilisation as reported by States/UTs is very slow as compared to the approvals. The slow utilisation of funds translates into deficient services being

provided in the Government settings. The Committee therefore recommends that the Department should ensure strict monitoring of allocated funds and ensure that they are evenly utilised during the year as the underutilisation of funds, reflects poor financial management of resources and also ultimately impacts on the goals of the programme. (Para 6.3)

(B) National Mental Health Programme

The Committee recommends that even though the funds are released pool wise, the Department should also keep a track of status of expenditure under the Programme separately to allow an assessment of the actual progress being made under the pool. (Para 6.7)

(C) National Programme for the Health Care of Elderly (NPHCE)

The Committee finds that during the financial year 2015-16 under NPHCE against the approvals of ₹ 132.47 crore the States/ UTs have reported utilization of ₹10.21 crore till 31.12 2015, which is a very poor record , in light of the fact that by the Department's reply "that in order to improve the operational flexibility of the States/UTs, the allocation of funds under Flexible Pool for Non Communicable Diseases have been made pool wise instead of scheme wise from 2015-16 and therefore, no separate allocation has been done for the programme in 2016-17" which is a contra-indication of the above statement. The Committee feels that factual statements should be borne by results in form of healthy utilisation of funds allocated and recommends that the operational flexibility does not mean abnegation of responsibility. The Committee, therefore, exhorts the Department to ensure strict monitoring for optimum utilisation of allocated funds. (Para 6.11)

(D) National Tobacco Control Programme (NTCP)

The Committee notes that - "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA-2003)" has been placed in the public domain, as part of the pre-legislative consultations. The Department should complete the process of reviewing and finalizing the Amendment Bill and bring it forward in the Parliament at the earliest. (Para 6.15)

(E) National Oral Health Programme (NOHP)

Since there is a higher demand from States/UTs, the Committee desires that more amount may be sanctioned under this programme. More publicity campaign is necessary under this programme and efforts may be made in this direction. (Para 6.19)

(F) Burn Injuries Scheme

The Committee hopes that the Draft IEC action plan on Burn Injuries Scheme would have been finalized by now and recommends that the Department should put the action plan into implementation without much delay. (Para 6.22)

(G) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke(NPCDCS)

The Committee would like to be apprised of the results of the Study/Survey carried out by

ICMR and would also like to be apprised of the action, if any, being taken by the Department on the basis of the results of the Study/Survey. (Para 6.25)

The Committee observes that India is experiencing a rising burden of Non-Communicable diseases (NCDs). As per the information given in the Annual Report 2015-16 of the Department, NCDs are estimated to account for about 60% of all deaths in India. The Committee would, therefore, urge upon the Department to adopt a comprehensive strategy to address NCD challenges and also explore the option of mainstreaming AYUSH therapy as part of medical care for effective prevention. (Para 6.28)

H. Thalesemia

The Committee finds that a genetically inherited disease called Thalesemia is also prevalent in our country and lakhs of Thalesemia patients are there in the country and ignored by the Government because they too belong to small pool of patients. In this disease the body of the patient does not produce blood and they require blood transfusion from time to time. Majority of them are children. The Committee is therefore of the opinion that intervention of Government becomes very necessary to save the lives of Thalesemic patients. The Committee accordingly recommends that Thalesemia should also be included in list of various diseases and budgetary allocations should be made for this disease as well. (Para 6.29)

VII. ESTABLISHMENT OF NEW MEDICAL COLLEGES ATTACHED WITH EXISTING DISTRICT/ REFERRAL HOSPITALS (UPGRADATION OF DISTRICT HOSPITALS TO MEDICAL COLLEGES)

The Committee welcomes the proposal of the Department for addition of 82 district hospitals to the Scheme which will go a long way in removing the regional imbalance in terms of medical colleges. The Committee recommends that while working out the proposal for the additional 82 districts, utmost care and caution should be taken to ensure that only un-served regions find their place in the list of 82 district hospitals which are to be upgraded. The Committee further recommends that the Department should quickly move towards firming up the proposal of up-gradation of 82 more district hospitals as medical colleges and an early decision may be taken. (Para 7.3)

VIII. RASHTRIYA SWASTHYA BIMA YOJANA

The Committee notes that Rashtriya Swasthya Bima Yojana aims to provide health insurance coverage to all BPL families including 11 categories of informal sector workers. Financial constraint is a major barrier to access to healthcare by poor households. The Committee would therefore like the Department to evaluate as to what extent the RSBY has been able to promote access to healthcare and provide financial protection to the targeted beneficiaries. The Committee would also like to know whether any mechanism is in place to regulate and oversee the insurers and healthcare providers under the RSBY. (Para 8.9)

IX. STERILIZATION DEATHS IN CHHATTISGARH

9.2 **The Committee is greatly anguished to take note of the revelation that the Sterilization Programme "still continues to be driven by targets, threats and coercion." Now that the Report of**

the Chhattisgarh Government Enquiry Commission is out, the Committee would like to be apprised of the following:-

What lessons have been learned from the Takhatpur sterilization deaths and what course corrections have been taken by Ministry of Health and Family Welfare to prevent any such incident in future.

How will Informed Choice be monitored to ensure that health workers are not functioning under the pressure of targets? Have any independent evaluations/commissions, Community Monitoring/Social Audit efforts been instituted?

What is the proportion of budget allocation for female sterilization as compared to male methods, spacing methods, information services/counselling? Have Provider Incentives been removed for female sterilizations?

What changes have been brought about in budget allocations to ensuring Informed Choice (as opposed to targets), provision of spacing contraceptive methods, resources for quality monitoring and to promoting men's responsibility for contraception? (Para 9.2)

X. DEFICIENCY OF HEALTH INFRASTRUCTURE AND MANPOWER IN RURAL AREAS

This Committee notes that there is a steady increase in the shortfall of doctors, specialists and surgeons in the rural settings because as compared to the requirement for existing infrastructure, there is a shortfall of 83.4% of Surgeons, 76.3% of Obstetricians & Gynecologists, 83.0% of Physicians and 82.1% of Paediatricians. Overall, there is a shortfall of 81.2% specialists at the CHCs as compared to the requirement for existing CHCs. One implication of this is that people in the rural areas have little access to quality medical services which in turn compels them to travel to the nearest city on bumpy roads entailing high cost of transport and challenging journeys. The Committee, therefore, recommends that the Department should direct its focused attention to addressing this skew in availability of Health Care Services in our rural health system. (Para 10.5)

The Committee notes that the number of UG and PG seats during 2015- 16 was 57138 and 25850 respectively. The Committee observes that one of the most important constraints plaguing our healthcare system is related to retention and skilling of health work force in rural areas and ensuring equity in distribution of skilled work force. A number of States do not produce the requisite number of doctors, nurses or Paramedics and nor do they have the requite budget to recruit quality human resources for health. A consequence of this is that many of the appointments are restricted to being contractual in nature. The absence of good contractual arrangements is a big constraining factor in attracting or retaining good quality manpower. The Committee would, therefore, like to be apprised of the measures taken or contemplated to be taken to overcome the above problem. (Para 10.6)

The Committee also observes that there are 25308 Primary Health Centres (as per Rural Health Statistics 2015) and if the 57000 + doctors being produced every year are compulsorily placed in Primary Health Centres for two years then each year every PHC would have 2 allopathic doctors. Similarly, if the PHC service could be made a conditionality to access PG medical education, over 25000 PG doctors would be more than enough for our Community Health Centres (5396 CHCs as

per Rural Health Statistics 2015). The Committee would, therefore, recommend that the Department should formulate an appropriate strategy to ensure that the graduate and post graduate doctors from medical colleges are required compulsorily to join government facilities, especially in rural areas. Otherwise, production of health workforce by presenting figures about medical colleges seats would prove fallacious. (Para 10.7)

PART - B

(HEALTH SECTOR)

I. BUDGETARY PROVISIONS

The Committee is concerned that there is a significant gap between the total Twelfth Plan approved outlays for Health sector and the sanctioned Budgets in the five years of the 12th Plan Period (2012-13 to 2016-17). As against the total approved plan outlays of ₹ 75145.29 crore for Health Sector, the total allocation made by the Government till date is ₹ 40,538/- crore which is only 53.95 % of the total quantum of funds recommended originally. It is true that it is always prudent to generate more value for the funds provided but it would be unrealistic to expect to achieve key health outcomes and objectives of Health Sector with only 53.95% of the approved outlays. The Government, therefore, owes an explanation on the reasons behind such a huge gap between the budgetary allocations made for Health Sector from 2012-13 to 2016-17 *vis-à-vis* the total approved outlays for the Twelfth Five Year Plan and its impact on the goals and objectives of Health Sector. (Para 1.23)

The Committee notes that the projected demand of Department of Health and Family Welfare for Health Sector for Plan funds for 2016-17 was ₹ 17962.50 crore against which actual allocation made is ₹ 9100 crore, leaving a shortfall of ₹ 8862.50 crore. The major schemes to be adversely affected as a result of less allocation include among others, Pradhan Mantri Swasthya Suraksha Yojanja; Human Resources for Health and Medical Education; AIIMS, New Delhi and Tertiary care schemes. Almost all of these schemes have the objective of correcting the imbalances in availability of affordable and quality tertiary level healthcare in the country. Given the disturbing scenario in which availability of tertiary care is skewed towards private domain *vis-à-vis* public sector; and the costs of private tertiary care is prohibitive, these schemes which are oriented towards facilitating an equitable access to adequate and quality tertiary care and ensuring appropriate manpower mix of different categories of health professionals, assume added significance. Lack of expansion of public sector hospitals in proportion to population growth and health needs is making healthcare out of the reach of people, especially the poorer sections of the Country. Hence the role of the Government in this sector has to be increased substantially to provide adequate healthcare to needy. The Committee is, therefore, of the firm opinion that the Plan allocation of ₹ 9100.00 crore for the Health Sector for 2016-17 is not sufficient and needs to be raised so that the burden of high out-of Pocket healthcare expenditure of people could be reduced. (Para 1.24)

The Committee simultaneously observes that since realistic allocation of funds is a reflection of prudent need-based planning, the requirement of funds for Health Sector in 2016-17 may be subjected to periodic review so that there is no scope of fiscal profligacy or idle parking of funds and

timely action takes place for its optimal and judicious utilization in consonance with established principles of financial propriety. (Para 1.25)

While the Committee is all for enhancing the magnitude of allocations for the Health Sector Schemes, it is constrained to observe that out of allocated plan funds of ₹ 29,738.00 crore for the first four years of the Twelfth Plan, only ₹ 20268.50 crore has been utilized as on 17.03.16, leaving a huge shortfall of ₹ 9469.50 crore in the plan expenditure during the first four years of the 12th Plan period. (Para 1.26)

The Committee is also dismayed to note that there is a substantial shortfall of the budgeted expenditure of the Department of Health and Family Welfare in 2014-15 and 2015-16. The shortfall witnessed in the Plan expenditure as compared to the Revised Estimates is to the extent of ₹ 1126.82 crore in 2014-15 and ₹ 1557.87 crore in 2015-16, because as against the RE of ₹ 6772.18 crore in 2014-15 which was reduced from BE of ₹ 8733.00 crore, the Department could only expend ₹ 5645.36 crore. In the year 2015-16, as against RE of ₹ 7504.00 crore which was increased from BE of ₹ 6254.00 crore, the Department ended up utilizing ₹ 7106.64 crore only. The Committee's scrutiny also reveals that substantial variations have occurred between the sanctioned budgetary provisions and the actual expenditure incurred by the Department under several heads of the Grants operated by it during 2014-15 and 2015-16. For example, despite the budgetary provisions of ₹ 197.75 crore and ₹ 294.78 crore obtained as Revised Estimates for "Strengthening/Creation of Paramedical Institute (RIPS/NIPS)" and "Upgradation of State Government Medical Colleges (PG seat)" during 2014-15, respectively, not a single rupee was spent under these heads. Similarly, the Department had obtained ₹ 87.65 crore as RE 2015-16 for Central Drugs Standard Control Organisation, but has spent only ₹ 55.11 crore as on 31st March, 2016, thus registering unspent provisions of ₹ 32.54 crore. It is thus obvious that these instances portray an absence of a sound budgetary mechanism for assessing the actual requirement of funds and give an impression that the budgetary requirements are being projected by the Department more on the basis of theoretical anticipation rather than on actual requirements. The Committee emphasizes the fact that it is necessary on the part of the Department to avoid large variations in the Budget Estimates, Revised Estimates and Actuals to ensure that the budgeted funds are not locked up and surrendered later. The Committee would like to impress upon the Department that non-utilization should be a rare exception instead of being a recurring feature as has been witnessed year after year. The Committee therefore, recommends that at least from now onwards, definite yardsticks be devised and adhered to for the purpose of projecting realistic budgetary assumptions and balanced utilization thereof so that the sanctioned Budgets for the Health Sector do not remain idly parked. (Para 1.27)

The Committee is dismayed to note that huge savings to the tune of ₹ 1062.00 crore and ₹ 97.75 crore have been registered in the Capital Account during 2014-15 and 2015-16 respectively. Such gross underutilization of funds under Capital Section of the Demands for Grants points to the fact that development oriented activities have been curtailed. The reasons adduced by the Department mainly relate to slow pace of expenditure on procurement of equipments and Capital works, non-finalization of machinery and proposals for procurement of machinery equipments, slow progress in execution of works by the executing agency etc. The Committee deprecates the Department for such an erratic expenditure management, especially at a time when the Government is striving for

fiscal consolidation. The Committee, therefore, recommends that the occurrence of huge quantum of savings on the Capital Account warrants special attention and proactive steps by the Department so that this pernicious trend could be tackled in an effective manner. (Para 1.28)

The Committee also notes that unspent budgetary provisions were kept till the close of the respective financial years and surrendered on the 31st March in both the years. The Committee is constrained to observe that had the Department exercised rigorous monitoring of the progress of expenditure to determine the nature of spending on a periodic basis and well spaced the spending pattern, it would have been able to foresee the quantum of unspent budgetary provisions in time and would have surrendered the same much before, without waiting for the fiscal end. The Committee observes that a resource constrained country like India cannot afford to keep a vast chunk of its financial resources locked up and surrendered towards the end of financial year and recommends that the provisions of General Financial Rules be adhered to scrupulously and unspent budgetary provisions may be surrendered timely for their gainful utilization for other fund starved projects/ schemes. (Para 1.29)

The Committee notes from the information furnished that as many as 1929 utilization certificates are pending as on 26.02.2016 under Health Sector and a substantial amount to the tune of ₹ 2862.45 crore is involved therein. The oldest pending U.C. dates as far back as 2005-06. Since pending UCs impede further release of funds and thus poses bottlenecks in the effective implementation of schemes, the Committee recommends that liquidation of pending UCs be accorded utmost priority and a dedicated mechanism be put in place to ensure that all pending UCs are liquidated within a designated timeline. The Committee desires to be kept apprised of the action taken and the success achieved in this regard. (Para 1.30)

The Committee is also concerned to note that one project in North Eastern Region of India, namely RIMS, Imphal has experienced cost overrun of 10% and time overrun of 4 years while RIPANS, Aizwal has time overrun of 15 months. The Committee's concern in regard to delay in these projects mainly centres on the fact that access to quality health services remains low in the N.E. Region and the inordinate delay in execution of the projects would further accentuate this disequilibrium in the healthcare domain in North East Region. The Committee, therefore, recommends that all hindrances in operationalization of the projects may be ironed out within a designated time- frame. The Committee wishes to be kept apprised of the progress of operationalizing the projects. (Para 1.31)

II. SAFDARJUNG HOSPITAL AND VARDHAMAN MAHAVIR MEDICAL COLLEGE (SJH AND VMMC), NEW DELHI

The Committee notes the submission of the Department that the redevelopment Plan of Safdarjung Hospital is going as per timeline and there is no escalation in the original estimates of ₹ 1333.00 crore. The Committee also notes that the manpower requirement has been submitted to the Ministry of Finance for seeking their approval. The Committee would expect the Department to proactively pursue the approval of the manpower requirement with the Ministry of Finance so that there are no instances of tardiness and inefficiencies in executing the redevelopment plan and the funds earmarked for the project do not remain idly parked for want of necessary approvals. The Committee wishes to be updated in this regard. (Para 2.10)

The Committee has been impressing upon the Department to obtain necessary approvals on time and to ensure that the project is taken up for implementation without delay. The Committee

is, therefore, anguished to note that the project of expansion of VMMC building and auditorium is delayed because the requisite permission could not be obtained by CPWD. Delay in obtaining approvals often proves to be contributory factor for under utilization of budgeted funds. It is, therefore, imperative on the part of the Department to aggressively take up the matter of delay with CPWD for the purpose of expediting the requisite permissions/approvals so that the expansion of VMMC does not lead to delays and under-utilization of budgeted funds and cost escalations. (Para 2.11)

The delay in operationalization of In-Vitro Fertilization lab at Safdarjung had found mention in the Committee's 39th, 54th and 82nd Reports presented to Parliament on 28th April 2010, 26th April 2012 and 24th April 2015 respectively. In the 82nd Report, the Committee had recommended that the setting up IVF lab should not be delayed beyond 2015-16. The Committee is, however, constrained to observe that this project is still hanging fire. The Committee, therefore, expresses its displeasure at the snail's pace of progress made towards making the IVF lab operational and recommends that stringent measures be taken for addressing the recurrent problem of delay in implementing the project and expediting operationlization of the IVF lab at Safdarjung Hospital. (Para 2.12)

The Committee notes with dismay that out of 527 sanctioned posts, as many as 126 vacancies are in Group 'A' and 'B' category. The Committee observes that such a large number of vacancies would eventually impact on the functioning of the Hospital. The Committee, therefore, recommends that an action plan be drawn up and vacancies be filled in a time-bound manner. The Committee desires to be apprised of the Department's plan of action for filling up the vacancies. (Para 2.13)

III. DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

The Committee observes that two critical projects, namely construction of Super-Specialty Block and Modern Maternal Care Centre have been conceptualized. The Committee is, however, concerned to note that the land allotted for the purpose of constructing Maternal Care Centre is occupied by the Jhuggy dwellers. The Committee expects the Department to vigorously pursue the matter of eviction with the Government of NCT of Delhi so that this important project is not delayed further. The Committee desires to be apprised of the outcome of the request made to the Government of NCT of Delhi. (Para 3.5)

The Committee would also like to be apprised of the sanctioned, and in-position strengths of doctors, nurses, and other categories of officers and staff of Dr. Ram Manohar Lohia Hospital. (Para 3.8)

The Committee's scrutiny reveals significant absence of correlation between BE, RE and AE under various heads. For example against the BE and RE allocation of ₹ .01 lakh under the head - Grants-in-Aid, ₹ .02 lakh under the head - other charges and ₹ .03 lakh under the head - medical treatment, ₹ .02 lakh under the head - Professional Service and ₹ .015 lakh under the head - other Admin. Expenses, nothing has been spent till 14.03.2016. Similarly, the PGIMER, New Delhi was able to expend ₹ .001 lakh only against the BE and RE allocation of ₹ .10 lakh for Machinery and Equipment. The Committee observes that such an erratic trend of expenditure is indicative of shortcomings in formulating the Budget Estimates and lack of effective monitoring of utilization of budgeted funds. The Committee would therefore, like the Department to explain the reasons behind

the mismatch between the BE, RE and the Actual Expenditure of PGIMER, New Delhi in the year 2015-16. (Para 3.10)

IV. LADY HARDINGE MEDICAL COLLEGE & (LHMC) SMT. SUCHETA KRIPLANI HOSPITAL, NEW DELHI

The Committee observes that the originally approved cost of the Redevelopment Plan of LHMC and associated hospitals was ₹ 586.49 crore and the project was targeted to be completed by May/June 2014. But due to breaches of terms and conditions and delay on the part of M/s. Unity Infraprojects Ltd., the contract has been terminated. Much delay has already taken place and it is, therefore, imperative on the part of the Department to resolve at the highest level all procedural and operational matters including approval of cost estimates expeditiously, and execute the Redevelopment Plan within the approved cost and shortest possible time frame. The Committee also recommends that a fool-proof mechanism be devised to address operational performance of the contractor and take appropriate policy decision to address the critical issues concerning the execution of the Redevelopment Plan. The Committee desires to be kept apprised of the progress made towards executing the Redevelopment Plan. (Para 4.6)

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

The Committee notes that in the Action Taken Notes on the 89th Report, it had been submitted by the Department that as against the allocation of ₹ 343.00 crore in RE 2014-15 for creation of Capital Assests, total expenditure of ₹ 191.69 crore (*i.e.* 55.96%) was incurred in the month of March 2014 despite stipulated ceiling of 30% as per the provisions of General Financial Rules. The Committee expects the authorities concerned to show proper fiscal discipline and responsibility by evenly laying out expenditure for which quarterly targets may be fixed. (Para 5.11)

The Committee notes that the expansion of OPD Block at AIIMS has been planned with the estimated cost of ₹ 573.00 crore out of which a meager ₹ 4.02 crore has been spent and the targeted date of completion of the Project is 30th May 2017. Going by the persistent problems of time and cost overruns in the infrastructure projects of AIIMS in the past, the Committee apprehends that the possibility of occurrence of fiscal and physical slippages in the execution of the Project is distinct. The Committee, therefore, recommends that intensive monitoring of the execution of the expansion work of OPD at AIIMS be done so that the Project is executed within the approved cost and designated time-line. (Para 5.12)

The Committee in Para 5.16 of its 82nd Report had sought to be apprised of time overrun and cost escalation, if any, of the 12 completed projects and the reasons behind the shelved projects. The Committee is, however, constrained to observe that instead of giving specific information as asked for, the Department in the Action Taken Notes on the 82nd Report has merely supplied number of projects completed, in-progress, at tendering/award stage, etc. The Committee reiterates recommendation made in Para 5.16 of its 82 Report and desires to be apprised of time overrun and cost escalation, if any, of the 12 completed projects. The Committee also desires to be kept apprised of the approved cost of the projects in progress and tendering/award stage and the designated time-line for their execution and operationalization. (Para 5.13)

The Committee also takes serious view of the fact that when asked to indicate the progress

made towards implementation of pending development projects at AIIMS, the Department has merely stated that "every effort is being made to resolve the issues related to the implementation of different Development Projects with timely completion of projects with no time and cost overruns...". The Committee had expected the Department to apprise it of the status of completion of all pre-project formalities, approved cost of the projects and set time-frame of their implementation and expenditure incurred, if any. The Committee, while strongly disapproving of the fashion with which the Department has responded to the query of the Committee, urges the Department to furnish the above details in connection with all pending/on-going Development Projects at AIIMS. (Para 5.14)

The Committee notes that the setting up of a Burns Unit at AIIMS has been approved by the Standing Finance Committee on 13.08.2015. The Committee would now like the Department to play a proactive role in moving the AIIMS administration towards quickly completing all pre-project formalities in a time bound manner and implement the project within a stipulated timeframe. (Para 5.15)

It is a matter of great concern that a whopping 232 faculty posts are vacant at AIIMS. The Committee observes that teachers/doctors are the most important cog in the delivery of quality healthcare and imparting of quality education at AIIMS. One of the prime reasons of high burden of clinical services on AIIMS is its repute for high quality care. The Committee therefore, recommends that the faculty shortage at AIIMS must be squarely addressed without further delay as it has a direct bearing on the delivery of quality healthcare and imparting of quality education. (Para 5.16)

VI. POST GRADUATE INSTITUTE OF MEDICAL EDUCATION AND RESEARCH, CHANDIGARH

The Committee is constrained to observe that all the three projects, *i.e.* Advance Cardiac Centre (Phase II), Modernisation of Research 'A' and 'B' Block and Modernisation of Nehru Hospital were targeted to be completed during the Eleventh Five Year Plan but are nowhere close to execution even after the lapse of four years of the 12th Plan period. The Committee expresses its displeasure at the tardy progress of implementation of the above projects and recommends that the factors responsible for the inordinate delay in the implementation of the projects may be gone into in detail and corrective measures taken accordingly so that the implementation of projects is speeded up with sustained monitoring. (Para 6.5)

The Committee notes that nine other projects, namely, (i) setting up of Satellite Centre of PGIMER at Sangrur, (ii) expansion of Nehru Hospital at PGIMER; (iii) Supply, Installation and Commissioning of Heating, Ventilation and Air Conditioner (HVAC) system in new OPD (iv) upgradation and Special Repair of Residential Houses of PGIMER, Sector-12, Chandigarh, (v) Construction of Residential Complex & Hostel in PGIMER (vi) Re- construction/raising of Boundary Wall, Replacement of Entry Gate & Reconstruction of Driveway (vii) Expansion of existing multi-level parking (viii) Upgradation and Special Repair of Residential house of PGIMER in Sector-24, Chandigarh and (ix) Upgradation of HVAC system of operation Theatre Complex are under implementation. The Committee would like to be kept apprised of the progress towards their implementation. (Para 6.6)

VII. JAWAHARLAL INSTITUTE OF POST-GRADUATE MEDICAL EDUCATION AND RESEARCH (JIPMER), PUDUCHERRY

The Committee welcomes the initiation of the infrastructure projects at JIPMER. The Committee's only advice would be to obtain all project-related clearances in advance and address procedural issues at the project conceptualization and approval stage so that these development projects don't witness time overruns and concurrent cost overruns as compared to the initially estimated project costs. (Para 7.3)

The Committee observes that the Establishment of JIPMER-II at Karaikal; and construction of Urban Health Centre at Kuruchikuppam may involve issues like land acquisition, rehabilitation and settlement, forest/wildlife clearances and therefore proper cooperation of and coordination with the State Government of Puducherry is of prime importance. The Committee would, therefore, like the JIPMER to put in place a robust coordination mechanism with the State Government so that regular and periodic follow-up action can be taken with the State Government for the purpose of timely resolution of all issues concerning the State. (Para 7.5)

VIII. NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (NIMHANS), BENGALURU

The Committee observes that NIMHANS has planned to implement some major projects and procure major equipments during 2016-17 for augmenting the facilities in the fields of psychiatry, neurology and neurosurgery. The Committee, therefore, recommends that the Department should ensure that these projects are not hamstrung by lack of funds as they relate to capacity building. Adequate budgetary requirements may be projected at RE stage on the basis of trend of expenditure and actual requirement. The Committee also expects the Department to anticipate the procedural/administrative constraints in the implementation of the projects and address them well in time. The Committee desires to be apprised of the quantum of allocation and adequacy of funds for carrying out the Major Works and procuring Major Equipments and whether allocation of funds under these heads of the Grants have been made prior to obtaining pre-project clearances. (Para 8.6)

The Committee notes that as many as 48 faculty posts are vacant and the process of filling them up is underway. Such a high vacancy situation in faculty posts is certain to impair on the functioning of NIMHANS. The Committee, therefore, recommends that the filling up of faculty posts be completed in a time bound manner and the Committee updated in this regard. (Para 8.8)

IX. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH AND MEDICAL SCIENCES (NEIGRIHMS), SHILLONG

The Committee observes that as against the allocation of ₹ 47.00 crore as Grant-in-Aid (capital), only ₹ 16.77 crore has been expended till January 2016. Since not more than 33% in the last quarter and 15% in the month of March can be spent, the possibility of under-utilization of budgeted funds is distinct. What is more worrisome is that the under-utilization of the budgeted plan funds for NEIGRIHMS may occur on the Capital Account, thereby impacting developmental activities. This calls for serious introspection so that such instances of blockage of funds earmarked for development activities do not recur. (Para 9.4)

The Committee observes that the projects like (i) Expansion of Nursing College and Hostel and (ii) Establishment of Undergraduate Medical College and Regional Cancer Centre at NEIGRIHMS have significant bearing on improving the delivery of healthcare services in a region which is deficient in healthcare delivery and therefore needs greater attention. These projects had been hanging fire for quite some time and figured in the 82nd Report of the Committee also. The Committee is, therefore, happy to note that some forward movement has been reported towards their implementation. The Committee, therefore, desires that undertaking these projects for implementation be taken up in right earnest and the pending issues pertaining to them may be addressed with clarity and all necessary approvals obtained. The Committee also recommends that an effective monitoring mechanism be put in place to obviate any possibility of time overruns and cost escalation of these projects. (Para 9.8)

X. CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI

The Committee observes that the Central Institute of Psychiatry provides comprehensive services for all psychiatric patients, including those requiring care for concurrent medical disorders and patient care research and manpower development are the main objectives of the Institute. The Committee, therefore, extends its support to the re-development plan of the Institute, which in the opinion of the Committee, would enhance access to quality psychiatric treatment to more patients. The Committee would, however, recommend to the Department to proactively pursue the finalization of the re-development plan of CIP and take appropriate measures to eradicate deficiencies in project formulation and implementation so that there are no cost and time overruns. The Committee desires to be kept apprised of the progress of implementation of the re-development plan of CIP. (Para 10.5)

The Committee takes note of the fact that the grant of status of autonomous institution to the Central Institute of Psychiatry is also under consideration. The Committee is of the opinion that with the according of status of autonomous institution, the CIP would get adequate operational flexibility to pursue its own ideas without hindrance and therefore keeping CIP tied down to the Department in Delhi may not be warranted. The Committee, therefore, recommends that the CIP may be made autonomous consistent with the precedents of other autonomous institutions that are funded by the Department and appropriate Paradigm may be put in place to enforce financial and performance accountability in the autonomous structure of CIP. (Para 10.6)

XI. REGIONAL INSTITUTE OF MEDICAL SCIENCES (RIMS), IMPHAL

The Committee obverses that RIMS caters to the healthcare needs of North Eastern Region including providing medical education. Given the fact that the North Eastern Region has weak public health indicators and weak health infrastructure, strengthening and capacity building of RIMS is of vital importance. The Committee is, however, anguished to note that the progress of upgradation of RIMS has been tardy due to inefficiency on the part of the contractor whose contract stands terminated now. The Committee would expect that Project Consultant M/s HSCC would quickly select a new contractor and lay emphasis on completion of the project within the approved cost and time-frame. The Committee desires to be apprised of the total approved cost, expenditure incurred so far and the time-line fixed for execution of the project. (Para 11.3)

XII. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

The Committee observes that there has been huge shortfall in utilization of the budgeted expenditure of PMSSY in the last two years. The shortfall witnessed in the Plan expenditure as compared to the Budget Estimates has been to the extent of 1133.97 crore in 2014-15 and ₹ 821.56 crore in 2015-16. ₹ 2450.00 crore has been allocated in BE 2016-17 on the plan side against the projected demand of ₹ 4344.76 crore. Acknowledging that the Department had faced difficulties in absorbing the allocated funds, the Health Secretary during the course of his deposition before the Committee in connection with examination of Demands for Grants (2015-16) had submitted that the Department did not have the requisite experience of having that kind of structure constructed and procurements made but a strong mechanism had been put in place and in the coming years things would witness better performance. But given the trend of utilization of funds witnessed in the year 2015-16, the Committee apprehends that there would be less utilization of Plan funds in 2016-17 as well. The Committee, therefore, recommends that the Department should address the issue of under-utilization of budgeted funds for PMSSY with all seriousness so that realistic projection of fund requirement is made and such instances of blockage of funds do not recur. The Committee would also urge the Department to avoid making ritualistic allocations, which remain on paper only. The Committee would further like the Department to ensure that the implementing agencies of PMSSY at the ground level have the requisite machinery and skilled manpower to fully utilize the allotted sums. (Para 12.21)

The Committee gathers from the information furnished that full operationlisation of six AIIMS-like Institutions is yet to be realized. The Department has informed that the delay in operationlization is mainly due to site specific issues such as delays in supply of drawings by Design DPR Consultants, obtaining of local body approvals and finalization of revised cost estimates, inadequate bid responses in some cases, etc. The Committee is distressed to observe that the long persisting delay in full operationalization of six AIIMS-like institutions is impacting their defined objectives. The Committee is of the firm opinion that the issues which have been mentioned as contributory factors to the delay in full operationalization of AIIMS-like Institutions could have been tackled in an effective manner had the Department been to able to ensure effective monitoring and initiated appropriate remedial measures on time. Evidently, the Department has been lagging behind on effective and sustained monitoring and there are also serious shortcomings in inter-agency coordination for resolving the problems in a timely manner. The Committee, therefore, desires that appropriate corrective measures be taken for addressing issues contributing to delays and cost escalation in full operationalization of six AIIMS-like Institutions. (Para 12.22)

It is a matter of serious concern that all the six AIIMS are facing shortage in faculty and non-faculty posts. Considering the critical role the faculty plays in training of graduating doctors, the Committee observes that the quality of doctors produced by AIIMS-like Institutions will be far from desirable unless urgent measures are taken to overcome the deficiency of faculty in AIIMS-like institutions. The Committee has learnt from media reports that the interview for recruitment of faculty positions at AIIMS, Patna which is reeling under acute faculty shortage, was concluded on the 11th February, 2016 but the selections are yet to be ratified by the GB/IB of the Institute despite the Departments written assurance to the Committee that the selection process has been planned to be completed by March 2016 in all AIIMS. This, in the opinion of the Committee, speaks volumes of the inertia and indifference of the Department in the matter. The Committee observes that it is

imperative on the part of the Department to accord utmost priority to completing the selection process within the designated time-frame so as to ensure optimal functioning of AIIMS-like institutions. The Committee, therefore, recommends that the meeting of the GB/IB may be called immediately and the selections made may be ratified within one mouth from the presentation of this Report. (Para 12.23)

The Committee notes from the information supplied that PMSSY Phase- I also envisages upgradation of 13 existing medical colleges/institutions. Out of the 13 Government Medical Colleges Institutions identified for upgradation in the first phase, civil works at eight medical colleges/ institutions have been completed and with regard to three medical colleges where upgradation involves procurement of medical equipments only, the procurement process was targeted to be completed by March 2016. Though the Committee welcomes upgradation of existing Government Medical Colleges/Institutions under PMSSY, it desires to know the criteria for selection of these Government Medical Colleges for upgradation and whether socio-economic and health indicators had been taken into account while selecting them for upgradation. (Para 12.24)

The Committee observes that though the Government of Uttar Pradesh had offered sites for establishment of AIIMS in Poorvanchal, U.P, the Department is insisting on providing a four-lane connectivity by the State Government before undertaking the project. The Committee is astonished to note that despite a motorable road being available and the State Government giving written assurance for the construction of a four-lane road at a later stage, the Department is not budging from its stated demand, which in the opinion of the Committee, is not reasonable and may lead to delays and resultant cost escalation. The Committee, therefore, recommends that the Department immediately move towards initiating pre-project activities for establishment of AIIMS in Poorvanchal so that the objective of correcting the imbalances in availability of affordable/reliable tertiary level healthcare in Poorvanchal, Uttar Pradesh can be corrected. (Para 12.25)

The Committee notes from the information furnished that the Cabinet Committee on Economic Affairs (CCEA) had approved on 7.11.2013 proposal for upgradation of 39 medical colleges/ institutions in Phase III, at an approved cost of ₹ 150.00 crore each (Central Contribution ₹ 120 crore and State share - ₹ 30.00 crore). Detailed Project Reports of 37 colleges have been approved and tenders floated for 32 colleges. Almost two and a half years have lapsed since the proposal for upgradation was accorded approval, but the execution activities are yet to commence on the ground. The Committee would, therefore, like to be apprised of the time-frame within which the upgradation is targeted to be started; whether there has been any upward revision of the approved cost; and the reasons behind non-approval of the remaining two Government medical colleges. (Para 12.26)

The Committee observes that a new governance structure has been put in place to facilitate faster execution of AIIMS - like Institutions. The Committee hopes that the new governance and management structure would eradicate deficiencies in implementation of six AIIMS-like Institutions and facilitate their greater autonomy. The Committee would however, like the Department to carry out an appraisal of the efficacy of the new governance and management structure. The Committee also recommends that a robust mechanism be put in place to ensure adequate accountability of the local AIIMS, both in financial terms and by way of performance. (Para 12.27)

The Committee observes that the expansion of tertiary care institutions is an essential requirement in the country and it is, therefore, important that the adequate finances are

made available to PMSSY. Needless to emphasize that lack of financial resources should not be allowed to plague PMSSY and the Central Government should mobilize additional resources for PMSSY. (Para 12.28)

XIII. CENTRAL DRUGS STANDARD CONTROL ORGANISATION (CDSCO)

The Committee notes that as against the allocation of ₹ 31.50 crore provided in RE 2015-16, the actual expenditure upto January 2016, is ₹ 12.86 crore only (*i.e.* approximately 41%) leaving around 59% to be expended in the last two months of the financial year 2015-16. Shockingly, the Department claims that the residual amount will be spent on 'major works' proposals which are in the pipeline. The Committee strongly conveys its disapproval of such an erratic expenditure management. The Committee is unable to comprehend as to how the CDSCO would be able to spend nearly 59% of the allotted sums in the last two months of the financial year 2015-16 on major works proposals which are still in the pipeline. The Committee, therefore, deprecates the CDSCO for such a casual and desultory reply as the reasons given by the Department are not in-line with the extent of under-utilisation. (Para 13.9)

The Committee also observes that as per the norms stipulated by the Ministry of Finance, not more than 33% and 15% can be spent in the last quarter and last month respectively of the financial year. The Committee therefore wonders as to how the CDSCO would be able to achieve the feat of spending the remaining amount of ₹ 18.64 crore (*i.e.* 59%) in the last two months of 2015-16 without violating the provisions of General Financial Rules. The Committee would, therefore, like the Department to explain in this regard. (Para 13.10)

The Committee notes that the Cabinet Committee on Economic Affairs has approved the proposal for strengthening the drug regulatory system in the country at total expenditure of ₹ 1750 crore with the Central and State share being ₹ 900.00 crore and ₹ 850.00 crore respectively and the targeted period for completion of the project being the end of 2017-18. The Committee observes that the quality of drugs is of critical importance not only for the well-being of the people of the country but also for our economy as it earns a substantial amount in foreign exchange through export of drugs. The Committee through its reports on Demands for Grants has been exhorting the Department to iron out the issues concerning the proposal for strengthening of the drug regulatory system in the country. The Committee is, therefore, relieved that this project has been approved by the CCEA. It is now an imminent necessity on the part of the Department to undertake concerted action for ensuring timely completion of all project-related formalities and address the pending issues pertaining to this project with a sense of urgency and promptitude. The Committee also recommends that a dedicated monitoring mechanism be put in place for planning, coordination and timely completion of various components of the project. The Committee desires to be kept apprised of the progress made towards implementing the project. (Para 13.11)

The Committee notes that there are eight, fifteen, one forty four and thirty seven vacant posts of Deputy Drug Controller, Assistant Drug Controller, Drug Inspector and Assistant Drug Inspector respectively. The Committee is alarmed at such a high vacancy position which will seriously undermine the performance and goals of the CDSCO. The Committee wonders as to what could be the reasons behind such a time lag of filling up the vacancies. The Committee expects the Department to take up the matter of filling up the vacancies with appropriate agency. (Para 13.12)

Upgradation of Sera and Vaccine Manufacturing Units

The Committee observes that the work of upgradation of the three sera and vaccine manufacturing units, *i.e.* CRI, Kasauli, PII, Conoor and BCGVL, Guindy has been going on since long and the Committee has been urging upon the Department to expedite completion of work regarding cGMP compliance and enable the vaccine manufacturing PSUs to contribute their mite to the Universal Immunization Programme and insulate the Universal Immunization Programme from price and supply uncertainty. The Committee notes that CRI, Kasauli has been made cGMP compliant and commercial batches of DPT group of vaccines have commenced. However, BCGVL, Guindy and PII, Conoor are yet to commence commercial batches of vaccines. The Committee hopes that the full operationalization of BCGVL and PII would be realized within the time-line indicated. The Committee desires to be kept apprised of the full operationalization of BCGVL and PII. (Para 13.16)

The Committee observes that significant budgetary provisions made for CRI, Kasauli, and BCGVL, Guindy for 2015-16 remained grossly under-utilized and later surrendered. The Committee would, therefore, like the Department to chalk out the fiscal roadmap of the vaccine producing PSUs in concrete terms and avoid recurrence of huge financial under performance of the units in future. (Para 13.17)

XIV CENTRAL GOVERNMENT HEALTH SCHEME

The Committee in its 82nd Report on the Demands for Grants 2015-16 of the Department had observed that the plan allocations made for CGHS in BEs of 2012-13, 2013-14 and 2014-15 had been revised upwards at RE stage but the actuals were less than the BEs and REs in all the three years and advised the Department to exercise greater fiscal discipline and make realistic projection of fund requirements. The Committee is, therefore, concerned to note that the year 2015-16 is no different when it comes to under-utilisation of plan funds. The Committee, therefore, recommends that the Department should take tangible measures for reversing this recurrent trend of under-utilisation of plan funds under CGHS head and subject the utilization of funds to periodic review. (Para 14.6)

The Committee in its 88th Report on the action taken by the Government on the 71st Report of the Committee on the functioning of CGHS had noted that a large number of posts of General Duty Medical Officers and Specialists were lying vacant and the Department had appointed some doctors and specialists on contract basis as a stop gap arrangement. The Committee had also observed that even if UPSC makes selection of doctors, very few join CGHS. The Committee had, therefore, recommended to find out the reasons behind doctors not joining CGHS post their selection by UPSC and take remedial measures. The Committee desires to be apprised of the developments in this regard. The Committee also desires to be apprised of the updated status of vacancies across all categories of posts. (Para 14.7)

In its 71st Report, the Committee had *inter alia* recommended to explore the feasibility of appointing a PRO at the Medical Centre, PHA for the convenience of Members of Parliament. The Department in its Action Taken Notes on the 71st Report furnished in January 2014 had assured that necessary action would be taken in this regard. More than two years have elapsed since then but no action has been taken by the Department to translate the assurance into reality. The Committee

recommends that immediate action may be taken to appoint a PRO at the Medical Centre, Parliament House Annexe for the convenience of Members of Parliament. (Para 14.8)

The Committee observes that the Department should adopt a general principle that regional distribution of CGHS Wellness Centre will be ensured. Kerala already has one CGHS Wellness Centre at Thiruvananthapuram and starting a second centre in Kerala should be done in a manner that regional disparities in terms of access to CGHS Wellness Centre are resolved. The Committee, therefore, recommends that the Department should consider opening the second CGHS Wellness Centre at Calicut, based on the above principle. (Para 14.11)

XV. ASSISTANCE FOR CAPACITY BUILDING FOR TRAUMA CARE FACILITIES IN GOVERNMENT HOSPITALS

The Committee is concerned to note that the Scheme for Capacity Building for Trauma Care Facilities is no longer a 100% Centrally Sponsored Scheme and the amount of assistance will be shared between Central and State Governments in the ratio of 60:40 w.e.f. 2015-16. The Committee is highly sceptical of the success of this scheme, in the changed scenario of alteration in the funding pattern because there are competing demands on the resources of the states and their additional fiscal space for mobilizing resources is also limited. The Committee would, therefore, strongly recommend to the Government to have a re-look into the funding pattern so as to suitably enhance central assistance provided under the scheme for Capacity Building for Trauma Care to cover the entire cost of capacity building. (Para 15.5)

PART-C

NACO

I. BUDGETARY ALLOCATION

The Committee notes that an additional amount of ₹ 218.00 crore was granted to National AIDS Control Organisation at RE stage of 2015-16, raising the total allocation for NACO to ₹ 1615.00 crore. NACO has incurred expenditure of ₹ 1515.46 crore till 18th March 2016. Keeping in view the submissions made by NACO, the Committee expects NACO to fully utilize the allocated funds. The Committee also notes that as against the projected demand of ₹ 2550 crore for 2016-17, NACO has been allocated ₹ 1700.00 crore on the plan side, leaving a shortfall of ₹ 850.00 crore. As per the recently released India HIV Estimation 2015 Report, National adult (15-49 years) HIV prevalence in India is 0.26%. As per information given in the Annual Report 2015-16 of Department of Health and Family Welfare, the adult HIV prevalence at national level has continued its steady decline from an estimated peak of 0.38% in 2001-03 to 0.26% in 2015. The Committee feels that this is due to the effective implementation of the various interventions of NACP and scaled up prevention strategies. In view the good track record of NACO in utilizing the earmarked funds, the Committee lends support to infusing more money, if needed, into NACO at the RE 2016-17 stage. (Para 1.14)

The Committee notes from the information given in the Outcome Budget 2016-17 of the Department of Health and Family Welfare that as on 31.01.2016 ninety three Utilization Certificates

amounting to ₹ 147.93 crore pertaining to NACO are pending. The Committee observes that if there is time lag in submission of UCs, it delays release of central funds which in turn impinges on the implementation of various programmes of NACO. The Committee, therefore, recommends that sustained efforts be made to liquidate the pending UCs within a period of six months. The Committee desires to be kept apprised of the efficacy of measures taken in liquidating pending UCs. (Para 1.15)

The Committee observes that in spite of action taken by NACO to recover the unspent balances with discontinued NGOs, availability of unspent balances with some SACS is still quite high. The Committee, therefore, recommends that a multi-pronged strategy of liquidating the unspent balances with SACS be adopted and emphasis be laid on intensive monitoring at various levels. (Para 1.16)

The Committee notes that at its behest the direct release of funds to SACS has been restored w.e.f. 2016-17, which would help in reducing the time-lag in release of funds. The Committee would suggest that the e-transfer system may be put in place to obviate delays in the flow of funds to SACS. The Committee also would like to be informed of the extent to which these allocations to SACS are translated into health outputs and services rendered by SACS in 2016-17. (Para 1.17)

II. METRO BLOOD BANKS

The Committee observes that the budgetary provisions to the tune of ₹ 83.00 crore had been made in BE-2014-15 for setting up of Metro Blood Banks, but the entire amount had to be surrendered due to non-approved of the project by Expenditure Finance Committee (EFC). The EFC has now approved the Project as Central Sector Scheme with budget outlay of ₹ 404.00 crore to be implemented over 7 years. The Committee notes the assertion made by the Department that MoUs with States should be signed shortly and financial outflow shall start soon after. However, given the fact that the revised MoU was shared with States in December 2015, the Committee doubts that the funds would be drawn from this head in financial year 2015-16. Evidently, the NACO appears to be oblivions to the ground reality on the implementation of this project. There should be no further delay in implementing this programme. (Para 2.2)

III. HIV PREVALENCE

It is a matter of serious concern for the Committee that some states are showing trend of HIV prevalence. Though the NACO has taken steps to contain this trend, the Committee would like the NACO to improve the implementation aspects of this Scheme in the high HIV prevalence states. The NACO should also ensure that the benefits of the specific measures percolate down to all the intended beneficiaries. (Para 3.4)

The Committee notes that because of the taboo of HIV/AIDS, a large number of patients go to private clinics for the simple reason that they want their privacy maintained. The Committee apprehends that the data concerning number of HIV/AIDS cases are being collected from Government hospitals/health institutions and a lot of data from private clinics and private hospitals is not being captured. The Committee would, therefore, like the Department to ensure that no under-reporting of HIV/AIDS cases takes place. (Para 3.5)

MINUTES

IX

*NINTH MEETING

The Committee met at 10.30 A.M. on Tuesday, the 22nd March, 2016 in Main Committee Room, Ground Floor, Parliament House Annexe, New Delhi.

MEMBERS PRESENT

1. Prof. Ram Gopal Yadav — *Chairman*

RAJYA SABHA

2. Dr. Bhushan Lal Jangde
3. Shrimati Kahkashan Perween
4. Shri Ambeth Rajan
5. Shri Jairam Ramesh

LOK SABHA

6. Dr. Subhash Ramrao Bhamre
7. Shrimati Ranjanaben Bhatt
8. Dr. Ratna De (Nag)
9. Shri Devendra *alias* Bhole Singh
10. Dr. (Shrimati) Heena Vijay Gavit
11. Shri J.Jayasingh Thiyagaraj Natterjee
12. Shri C.R. Patil
13. Shri M.K. Raghavan
14. Dr. Manoj Rajoria
15. Dr. Shrikant Eknath Shinde
16. Shri Kanwar Singh Tanwar
17. Shrimati Rita Tarai
18. Shri Manohar Untwal

SECRETARIAT

Shri Pradeep Chaturvedi, *Director*

Shri Dinesh Singh, *Joint Director*

Shri Rakesh Kumar Sharma, *Assistant Director*

Shri Pratap Shenoy, *Committee Officer*

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* Minutes of First to Eight Meetings relate to other matters.

WITNESSES

Representatives from the Department of Health and Family Welfare
Health Sector

1. Shri B.P. Sharma, Secretary
2. Dr. Jagdish Prasad, Director General of Health Services
3. Ms. Vijaya Srivastava, Additional Secretary & Financial Advisor
4. Shri N.S. Kang, Additional Secretary & Director-General,CGHS
5. Shri K.B. Aggarwal, Additional Secretary
6. Dr. Arun Panda, Additional Secretary
7. Shri C.R.K. Nair, Additional Director General (Statistics)
8. Ms. Bharati Das, Chief Controller of Accounts
9. Shri Anshu Prakash, Joint Secretary
10. Shri A.R. Rizvi, Joint Secretary
11. Ms. Dharitri Panda, Joint Secretary
12. Shri Sunil Sharma, Joint Secretary
13. Shri K.L. Sharma, Joint Secretary
14. Shri K.C. Samaria, Joint Secretary
15. Ms. Sheela Prasad, Economic Advisor
16. Shri M.C. Misra, Director(AIIMS)
17. Shri G.N. Singh, Drugs Controller General (India)
18. Shri Bimal Dubey, Director, Food Safety and Standards Authority of India
19. Dr. D.C. Joshi, Director, CGHS,
20. Dr. Neeraj Dingra, Deputy Director General
21. Shri P. Ravindren, Director (Emergency Medical Relief)
22. Dr. Venkatesh, Director (National Centre for Disease Control)
23. Md. Shaukat, Deputy Director General (Non-communicable disease)

National Health Mission

1. Shri B.P. Sharma, Secretary
2. Dr. Jagdish Prasad, Director General of Health Services
3. Ms. Vijaya Srivastava, Additional Secretary & Financial Advisor
4. Dr. Arun Panda, Additional Secretary
5. Shri A.K. Mishra, Additional Secretary & Managing Director (National Health Mission)
6. Shri C.R.K. Nair, Additional Director General (Statistics)
7. Ms. Bharati Das, Chief Controller of Accounts
8. Shri Anshu Prakash, Joint Secretary
9. Shri Manoj lhalani, Joint Secretary
10. Ms. Dharitri Panda, Joint Secretary
11. Dr. Rakesh Kumar, Joint Secretary
12. Ms. Vandana Gumani, Joint Secretary

13. Ms. Sheela Prasad, Economic Advisor
14. Dr. A.C. Dhariwal, Director (National Vector Borne Disease Control Programme)
15. Dr. Ajay Khera, Deputy Commissioner

I. **Opening Remarks**

2. At the outset, the Chairman welcomed Members of the Committee and briefed them about the agenda of the meeting *i.e.*, examination of Demands for Grants (2016-17) of the Department of Health and Family Welfare pertaining to Health Sector and National Health Mision (NHM) (Ministry of Health and Family Welfare) and taking of oral evidence of the Secretary of the Department of Health and Family Welfare.

II. **Oral Evidence of the Secretary, Department of Health and Family Welfare**
Health Sector

3. The Committee heard the Secretary and other representatives of the Department of Health and Family Welfare (2016-17) pertaining to Health Sector. At the outset, the Secretary presented an overall micro-picture of the Department before the Committee, stating that during the year 2015-16, BE of ₹ 24549.00 crore was allocated under NHM and Heath Sector which is 53.16 % of the Twelfth Plan Outlays. He also informed that the budget lines had been restored in 2015-16 under the following schemes (a) contraceptive (b) cancer care and (c) mental health. Further, he stated that during the year 2016-17, total ₹ 31300 crore has been allocated under Health Sector, NACO and NHM. In November, 2015, the funding pattern between Centre and State had been fixed in 60:40 ratio which was earlier 75:25. Thereafter, Dr. Arun Panda, Additional Secretary made a power-point presentation and acquainted the Committee with the progress of various schemes of the Department pertaining to Health Sector. His presentation included (i) Twelfth Plan financing status including Plan outlay of NHM and Health; (ii) Budgetary Plan allocation and expenditure of the Twelfth Plan; (iii) additional funds received over BE 2015-16 for the health schemes; (iv) Budget allocation (2016-17) of the Health and NHM sectors; (v) Budgetary Plan allocation and expenditure of NACO; (vi) Tertiary care and human resources; (vii) big thrust to hospitals, AIIMS, PGIMER, JIPMER, Safdarjung Hospital, Dr. Ram Manohar Lohia Hospital, Lady Hardinge Medical College, *etc*.; (viii) PMSSY/ New Delhi, AIIMS and upgradation of super specialities in phases; (ix) Focus on Non Communicable Diseases (NCDs); (x) human resources in medical colleges and nursing institutions; (xi) e-initiatives (xii) food regulation (xiii) Drug regulation; (xiv) tertiary care, etc.

National AIDS Control Organisation (NACO)

4. Shri N.S. Kang, Additional Secretary & DG, CGHS made power-point presentation relating to NACO highlighting the following points (i) the Plan Budget of NACO in 2015-16 and 2016-17; and (ii) achievements and initiatives of NACO.

5. During the course of power-point presentations, the Members raised queries regarding adequacy or otherwise of the approved budget for Health Sector; trend of utilisation of budgeted funds during the first-four years of the 12th Plan; Schemes/programmes likely to be impacted due to the shortfall in the allocated budget; the bare minimum amount of funds required to bridge the shortfall and implement schemes/ programmes in an effective manner; *etc*. Some of the queries were answered. The Chairman asked the Secretary to furnish written replies to the queries orally unanswered within a week.

(The Committee then adjourned at 12.09 P.M. for tea break to meet again at 12.30 P.M.)

National Health Mission (NHM)

5. Shri A.K. Mishra, AS&MD (NHM) gave a power-point presentation on National Health Mission (NHM). His presentation included (i) Plan-wise allocation and release under NHM; (ii) Augmentation of Human resources; (iii) strengthening of community processes; (iv) e-health and management information system; (v) achievements under NHM sector; (vi) India's progress on MDG-4, *i.e.*, under 5 mortality ratio and MDG-5, *i.e.*, maternal morality ratio; (vii) Decline in infant mortality rate (IMR) and total fertility rate (TFR); (viii) Disease control programmes including malaria, tuberculosis, leprosy, Kala Azar, Filariasis, Japanese Encephalitis and blindness control; (ix) improved service delivery; (x) National Urban Health Mission; (xi) key programmes under NHM; (xii) Communicable diseases control programmes and non-communicable diseases control programmes; (xiii) initiatives in 2015-16 including Mission Indradhanush ; (xiv) recent e-health initiatives; (xv) NHM Twelfth Plan outlay *vs*. actual allocation, etc.

6. Thereafter, Members raised certain queries on the Demands for Grants (2016-17) pertaining to NHM. The issues raised included - whether States had allocated additional resources for health post the 10% increase in devolution of central tax share to States; additional resources for NHM raised through supplementary grants in 2015-16; current spending on health as a proportion of GDP; the minimum level of additional funds required to carry out the schemes/programmes of NHM without compromising health goals and outcomes; time-frame for population stabilization; *etc*. The Secretary, Department of Health and Family Welfare and other officials replied to some of the queries raised by the Members. He was then requested by the Chairman to furnish detailed written replies to the queries orally unanswered within a week.

7. A verbatim record of the proceedings of the meeting was kept.

8. The Committee then adjourned at 1.47 P.M.

X

TENTH MEETING

The Committee met at 3.00 P.M. on Monday, the 25th April, 2016 in Committee Room 'E', Basement, Parliament House Annexe, New Delhi.

MEMBERS PRESENT

1. Dr. Sanjay Jaiswal — *In the Chair*

RAJYA SABHA

2. Dr. Bhushan Lal Jangde
3. Shri Ambeth Rajan
4. Shri Jairam Ramesh

LOK SABHA

5. Shri Thangso Baite
6. Shrimati Ranjanaben Bhatt
7. Dr. (Shrimati) Heena Vijay Gavit
8. Dr. Manoj Rajoria
9. Shri R.K. Singh
10. Shri Kanwar Singh Tanwar
11. Shrimati Rita Tarai

SECRETARIAT

Shri P.P.K. Ramacharyulu, *Additional Secretary*
Shri Anil Kumar Gandhi, *Director*
Shri Dinesh Singh, *Joint Director*
Shri Rajesh Kumar Sharma, *Assistant Director*
Shri Pratap Shenoy, *Committee Officer*

1. **Opening Remarks**

2. In the absence of Chairman, the Committee elected Dr. Sanjay Jaiswal to preside over the meeting. He apprised Members of the agenda of the meeting, *i.e.*, to consider and adopt draft 93rd and 94th Reports of the Committee on Demands for Grants (2016-17) of Ministry of Health and Family Welfare pertaining to Departments of Health and Family Welfare and * * *.

*** Relate to other matter.

Consideration and adoption of draft 93rd and * * * Reports of the Committee

3. The Committee then considered and discussed the draft 93rd and 94th Reports of the Committee on Demands for Grants (2016-17) of the Ministry of Health and Family Welfare pertaining to Departments of Health and Family Welfare and * * * respectively. After some discussions, the Committee adopted the said Reports. The Committee, thereafter, decided that the Reports may be presented to the Rajya Sabha and laid on the Table of the Lok Sabha on Wednesday, the 27th April, 2016. The Committee authorized the Chairman of the Committee, and in his absence Shri Jairam Ramesh and in their absence, Dr. Bhushan Lal Jangde to present the Reports in Rajya Sabha, and Shrimati Ranjanaben Bhatt and in her absence, Dr. (Shrimati) Heena Vijay Gavit to lay the Reports on the Table of the Lok Sabha.

8. The Committee then adjourned at 3.40 P.M.

*** Relate to other matters.

ANNEXURES

1	2	3	4	5	6	7	8	9	10
5.2 Capital Section	27.45		27.45	35.00		35.00	18.40		18.40
5.3 N.E.R	11.28		11.28	23.87		23.87			
Hospitals and Dispensaries									
6. **Safdarjang Hospital, New Delhi.**	330.00	271.00	601.00	580.90	271.00	851.90	562.57	269.68	832.25
6.1. Main Hospital	180.00	271.00	451.00	215.90	271.00	486.90	212.50	269.68	482.18
6.2 SJH Capital Section	145.00		145.00	364.00		364.00	349.32		349.32
6.3 SJH Capital Section	5.00		5.00	1.00		1.00	0.75		0.75
7. **Dr. RML Hospital, New Delhi**	176.00	185.00	361.00	175.60	192.17	367.77	155.43	193.08	348.51
7.1. Main Hospital	122.00	185.00	307.00	130.60	192.17	322.77	121.99	193.08	315.07
7.2 RML Capital section	52.00		52.00	45.00		45.00	33.44		33.44
7.3 RML Capital section	2.00		2.00						
8. **Central Institute of Psychiatry, Ranchi**	40.00	35.00	75.00	49.78	37.89	87.67	26.21	37.49	63.70
8.1 Revenue	16.00	35.00	51.00	16.95	37.89	54.84	15.67	37.49	53.16
8.2 Capital	22.00		22.00	31.73		31.73	10.49		10.49
8.3 Capital	2.00		2.00	1.10		1.10	0.05		0.05
9. **All India Institute of Physical Medicine & Rehab., Mumbai**	6.00	13.20	19.20	6.90	13.31	20.21	5.03	12.71	17.74
9.1 Revenue	5.00	13.20	18.20	5.20	13.31	18.51	4.02	12.71	16.73

9.2 Capital	1.00		1.00	1.70		1.70	1.01		1.01
10. **Kalawati Saran Children's Hospital, New Delhi**	38.50	35.00	73.50	38.57	34.97	73.54	29.65	32.84	62.49
10.1 Revenue Section	32.00	35.00	67.00	32.47	34.97	67.44	27.73	32.84	60.57
10.2 Capital Section	6.00		6.00	6.00		6.00	1.88		1.88
10.3 Capital Section	0.50		0.50	0.10		0.10	0.04		0.04
11. **Medical Treatment of CGHS Pensioners**		875.00	875.00		875.00	875.00		948.81	948.81
Total-Hospitals and Dispensaries	590.50	1414.20	2004.70	851.75	1424.34	2276.09	778.89	1494.61	2273.50
Medical Education, Training & Research									
12. **VallabhBhai Patel Chest Institute, Delhi University**	16.90	26.50	43.40	16.90	28.70	45.60	16.30	28.70	45.00
13. **Lady Hardinge Medical College & Smt. S.K. Hospital New Delhi**	95.00	155.00	250.00	93.20	163.05	256.25	81.20	156.36	237.56
13.1. Main Institution	65.00	155.00	220.00	75.10	163.05	238.15	68.17	156.36	224.53
13.2 Capital Section	25.00		25.00	15.60		15.60	11.96		11.96
13.3 Capital Section	5.00		5.00	2.50		2.50	1.07		1.07
14. **All India Institute of Medical Sciences (AIIMS), New Delhi**	550.00	815.00	1365.00	700.00	865.00	1565.00	621.00	1001.00	1622.00

1	2	3	4	5	6	7	8	9	10
15. **National Institute of Mental Health & N.S., Bangalore**	132.80	110.00	242.80	158.46	120.17	278.63	143.22	120.17	263.39
16. **All India Institute of Speech & Hearing, Mysore**	81.14	14.50	95.64	50.00	15.41	65.41	41.93	14.46	56.39
17. **PGIMER, Chandigarh**	200.00	440.00	640.00	160.00	460.00	620.00	135.00	555.00	690.00
18. **Jawaharlal Institute of PG Medical Education & Res., Puducherry**	160.00	190.00	350.00	220.00	196.51	416.51	185.45	190.98	376.43
19. **Kasturba Health Society, Wardha**	50.00		50.00	55.55		55.55	45.98		45.98
21. **North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences, Shillong**	160.00		160.00	177.00		177.00	159.76		159.76
21. **Vardhman Mahaveer Medical College, New Delhi**	9.50		9.50	9.50		9.50	9.46		9.46
21.1 Revenue Section	9.50		9.50	9.50		9.50	9.46		9.46
21.2 Capital Section									
22. **Dr. Ram Manohar Lohia PG Institute of Medical Education & Research, New Delhi**	24.00		24.00	26.00		26.00	22.42		22.42

22.1 Revenue Section	21.00	21.00	24.50	24.50	22.07	22.07
22.2 Capital Section	3.00	3.00	1.50	1.50	0.35	0.35
23. **Establishment of AIIMS Type Super Speciality Hospitals-cum- Teaching Institutions and Upgrading of State Govrnment Hospitals (PMSSY)**	1456.00	1456.00	891.00	891.00	812.03	812.03
Revenue	550.00	550.00	530.00	530.00	505.05	505.05
Capital	844.00	844.00	301.00	301.00	247.50	247.50
Capital	62.00	62.00	60.00	60.00	59.48	59.48
23.1 Setting up of new AIIMS	500.00	500.00			10.00	10.00
24. **Regional Instt. Of Medical Sciences, Imphal**	230.00	230.00	280.00	280.00	280.00	280.00
Revenue					280.00	280.00
NE	230.00	230.00	280.00	280.00		
Capital						
25. **Lokpriya Gopinath Bordoloi Reg. Instt. of Mental Health, Tejpur**	66.00	66.00	66.00	66.00	66.00	66.00

1	2	3	4	5	6	7	8	9	10
Revenue							66.00		66.00
NE	66.00		66.00	66.00		66.00			
Capital									
26. **Regional Instt. Of Paramedical and Nursing Sciences, Aizwal**	60.00		60.00	63.00		63.00	46.70		46.70
Revenue							46.70		46.70
NE	60.00		60.00	63.00		63.00			
Capital									
27. **Other Educational Institutions**	5.46	11.00	16.46	4.49	11.58	16.07	2.94	9.62	12.56
27.1. RAK College of Nursing, New Delhi	1.80	7.00	8.80	2.33	7.78	10.11	1.26	6.92	8.18
27.1.1 RAK College of Nursing, New Delhi Capital									
27.2. Grants to Medical Council of India	1.10	0.20	1.30	0.50	0.20	0.70	0.50		0.50
27.3. Lady Reading Health School and RC Lohia Infant Welfare Centre	0.85	2.70	3.55	0.91	2.50	3.41	0.58	1.85	2.43
27.4. Grants to National Academy of Medical Sciences, N.Delhi	1.10	0.55	1.65	0.35	0.55	0.90	0.60	0.55	1.15

27.4.1 Lady Reading Health School and RC Lohia Infant Welfare Centre (Capital)	0.20		0.20	0.20		0.20			
27.5. Grants to National Board of Examination	0.01		0.01						
27.6. Grants to Dental Council of India		0.20	0.20		0.20	0.20		0.10	0.10
27.7. Grants to Pharmacy Council of India		0.20	0.20		0.20	0.20		0.20	0.20
27.8. Grants to Indian Nursing Council	0.40	0.15	0.55	0.20	0.15	0.35			
27.9. Medical Grants Commission									
28. **CNCI Kolkata**	100.00	18.00	118.00	36.00	18.00	54.00	33.20	18.00	51.20
TOTAL-Medical ***Education, Training & Research***	3896.80	1780.00	5676.80	3007.10	1878.42	4885.52	2712.59	2094.29	4806.88
PUBLIC HEALTH									
29. **Port/Airport Health Organisations/ Establishment (including De-ratisation of Ships)**	10.00	25.00	35.00	17.08	28.33	45.41	3.82	21.23	25.05

1	2	3	4	5	6	7	8	9	10
29.1 Port Health Establishment including APO	0.50	25.00	25.50	7.06	28.33	35.39	2.64	21.23	23.87
29.2 Port Health office, J.N.Port, NhavaSheva	0.75		0.75	1.27		1.27	0.79		0.79
(Capital)	8.75		8.75	8.75		8.75	0.39		0.39
30. **TB/Leprosy Training Institutes**	10.07	26.25	36.32	17.22	26.06	43.28	8.62	24.19	32.81
30.1. National TB Training Institute, Bengaluru (Revenue)	1.65	8.00	9.65	1.36	8.00	9.36	1.28	7.95	9.23
30.2 National TB Training Institute, Bengaluru (Capital)	1.00		1.00	1.00		1.00	0.88		0.88
30.3 Central Leprosy Teaching and Research Institute, Chengalpattu (Revenue)	1.50	11.00	12.50	1.61	11.35	12.96	1.27	10.60	11.87
30.4 Central Leprosy Teaching and Research Institute, Chengalpattu (Capital)	0.55		0.55	1.20		1.20	0.65		0.65
30.4.1 Central Leprosy Teaching and Research Institute, Chengalpattu (Capital)	0.20		0.20	0.30		0.30			

30.5 Regional Leprosy Training and Research Institute, Aska (Revenue)	0.25	3.25	3.50	0.14	3.11	3.25	0.08	2.49	2.57
30.5 Regional Leprosy Training and Research Institute, Aska (Capital)	0.05		0.05	5.60		5.60			
30.6 Regional Leprosy Training and Research Institute, Raipur Revenue	0.50	4.00	4.50	0.59	3.60	4.19	0.51	3.15	3.66
Capital	0.20		0.20	0.20		0.20	0.19		0.19
Capital									
30.7 Regional Leprosy Training and Research Institute, Gauripur Revenue	3.97		3.97	4.21		4.21	3.74		3.74
Capital	0.15		0.15	0.96		0.96	0.02		0.02
Capital	0.05		0.05	0.05		0.05			
31. **Development of Nursing Services**	10.00		10.00	10.00		10.00	0.63		0.63
31.1 Other than N.E.R	10.00		10.00	10.00		10.00	0.63		0.63
31.2 N.E.R									
32. **National Institute of Communicable Diseases, New Delhi**	13.00	30.00	43.00	12.95	29.12	42.07	9.69	23.05	32.74

1	2	3	4	5	6	7	8	9	10
32.1. Main Institution	12.70	30.00	42.70	12.45	29.12	41.57	9.42	23.05	32.47
32.2. Guniea-worm Eradication Programme									
32.3. Yaws Eradication Programme	0.30		0.30	0.40		0.40	0.27		0.27
33. **Prevention of Food Adulteration (including Project of Feasibility Testing Scheme of Vitamins and Mineral Fortification of Staple Food)**	62.92	4.37	67.29	62.92	7.19	70.11	41.63	3.63	45.26
33.1 Admn.& Prev. of Food Adulteration (GC)	2.92	4.00	6.92	2.92	6.96	9.88	0.52	3.50	4.02
33.2 Food Safety and Standards Authority of India	60.00		60.00	60.00		60.00	41.11		41.11
33.3 Project of Feasibility Testing Schemes of Vitamins & Mineral…….		0.37	0.37		0.23	0.23		0.13	0.13

34. **Central Drugs Standard Control Organisation**	85.00	22.00	107.00	50.00	22.00	72.00	37.28	17.43	54.71
Rev.	60.00	22.00	82.00	40.00	22.00	62.00	34.32	17.43	51.75
Capital	25.00		25.00	10.00		10.00	2.96		2.96
34.1 Indian Pharma-copoeia Commission	10.00	3.75	13.75	12.00	3.75	15.75	10.00	3.75	13.75
34.2 National Pharma-covigilance Programme	5.00		5.00	5.00		5.00	4.82		4.82
TOTAL	100.00	25.75	125.75	67.00	25.75	92.75	52.10	21.18	73.28
35. **Manufacture of Sera & Vaccine**	144.02	12.32	156.34	92.64	10.77	103.41	88.68	6.31	94.99
35.1. BCG Vaccine Laboratory, Guindy, Madras (Revenue)	4.38	12.32	16.70	5.00	10.77	15.77	1.08	6.31	7.39
Investment in Public Sector & Other Undertakings (Hindustan Latex Limited)	7.64		7.64	7.64		7.64	7.60		7.60
35.2. Pasteur Institute of India, Coonoor	40.00		40.00	40.00		40.00	40.00		40.00
35.3. IVC Chengalpattu & Medi Park-HLL	92.00		92.00	40.00		40.00	40.00		40.00
36. **Public Health Laboratories**	41.50	38.60	80.10	37.73	37.87	75.60	36.17	34.58	70.75

1	2	3	4	5	6	7	8	9	10
36.1. Central Research Institute, Kasauli (Revenue)	5.15	33.00	38.15	4.07	33.00	37.07	3.65	30.14	33.79
Capital	4.85		4.85	2.20		2.20	1.20		1.20
36.2. Institute of Serology, Kolkata	0.50	5.60	6.10	0.46	4.87	5.33	0.32	4.44	4.76
36.3. National Institute of Biological Standardisation & Quality Control, Noida	31.00		31.00	31.00		31.00	31.00		31.00
37. **Public Health Education**	13.00	41.40	54.40	13.20	38.99	52.19	9.60	35.41	45.01
37.1. All India Institute of Hygiene & Public Health, Kolkata	10.00	22.40	32.40	10.20	19.91	30.11	8.04	17.61	25.65
37.2 AIIH&PH, Kolkata (Capital)	3.00		3.00	3.00		3.00	1.56		1.56
37.3 Child Care & Training Centre, Singur		19.00	19.00		19.08	19.08		17.80	17.80
38. **Health Sector Disaster Preparedness & Management Including Emergency Medical Relief.(Including Avian Flu)**	27.00		27.00	11.50		11.50	1.21		1.21

38.1 Other than N.E.R.	15.00		15.00	8.00		8.00			
38.2 Emergency Medical Releief (Avian Flu)	1.50		1.50	1.50		1.50	1.21		1.21
Capital	10.00		10.00	2.00		2.00			
39. **Lala Ram Swarup Inst. of TB and Allied Diseases, N.Delhi**	35.00	15.75	50.75	42.28	21.47	63.75	39.92	17.45	57.37
40. **Procurement of Meningitis Vaccine for Inoculation of**		6.50	6.50		6.50	6.50		3.29	3.29
41. **Haj Pilgrims**									
42. **Rashtriya Arogya Nidhi**		27.50	27.50		30.50	30.50		30.90	30.90
42.1 (National Illness Assistance Fund)		16.00	16.00		19.00	19.00		20.90	20.90
42.2 Assistance towards hosp. of poor		11.00	11.00		11.00	11.00		10.00	10.00
		0.50	0.50		0.50	0.50			
Other Health Schemes									
43. Oversight Committee (Revenue)	100.00		100.00	170.43		170.43	137.12		137.12
Oversight Committee (Capital)	80.00		80.00	35.50	35.50				
Oversight Committee (Capital)	3.13		3.13						
TOTAL	183.13		183.13	205.93		205.93	137.12		137.12

1	2	3	4	5	6	7	8	9	10
44. **Institute of Public Health (PHFI)**	0.30		0.30	0.30		0.30			
45 **New Initiatives**									
45.1 National Organ Transplant Programme (Revenue)	3.00		3.00	1.80		1.80	0.53		0.53
Capital	2.00		2.00	0.43		0.43	0.22		0.22
TOTAL	5.00		5.00	2.23		2.23	0.75		0.75
45.2 National Centre for Disease Control (Revenue)	4.00		4.00	3.40		3.40	0.86		0.86
(Capital)	71.00		71.00	51.00		51.00	70.71		70.71
TOTAL	75.00		75.00	54.40		54.40	71.57		71.57
45.3 National Advisory Board for Standards	2.00		2.00	1.00		1.00	0.27		0.27
TOTAL-New Initiatives	82.00		82.00	57.63		57.63	72.59		72.59
46. **Other Schemes**	1.96	6.58	8.54	2.25	7.02	9.27	1.16	6.06	7.22
46.1 Central Health Education Bureau, New Delhi	0.25	2.76	3.01	0.55	3.35	3.90	0.25	2.68	2.93
46.2. Institute of Human Behaviour and Allied Sciences, Shahdara, Delhi	0.01		0.01						

46.3. Grants to New Delhi TB Centre		3.30	3.30		3.15	3.15		2.95	2.95
46.4 Strengthening of Health Information and Monitoring System (including Model Vital Health Statistical Unit, Nagpur)	1.70		1.70	1.70		1.70	0.91		0.91
46.5 Award of Prizes to Authors of Original Books in Hindi		0.08	0.08		0.08	0.08		0.03	0.03
46.6 Grants to Indian Red Cross Society		0.40	0.40		0.40	0.40		0.36	0.36
46.7 Grants to St. John's Ambulance		0.04	0.04		0.04	0.04		0.04	0.04
47 **New Schemes - CS (New)**	67.00		67.00	10.40		10.40	0.28		0.28
(i) Strengthening of existing branches and establishment of 27 branches of NCDC	1.00		1.00						
Capital	1.00		1.00						
(ii) Strengthening intersectoral coor-dination of preven-tionand control of Zoontic diseases	1.00		1.00				0.06		0.06

1	2	3	4	5	6	7	8	9	10
(iii) Viral Hepatitis	2.00		2.00	0.10		0.10	0.07		0.07
(iv) Anti-Micro Resistance	2.00		2.00	0.20		0.20	0.15		0.15
(v) Health Insurance (CGEIPS)	50.00		50.00	10.00		10.00			
(vi) Emergency Medical Services	10.00		10.00	0.10		0.10			
Total- Other Health Schemes	334.39	6.58	340.97	276.51	7.02	283.53	211.15	6.06	217.21
48. **Medical Stores Organisation**		50.00	50.00		50.93	50.93		47.46	47.46
49. **Centre Sector - Family Welfare - Schemes of NHM**									
(1) Social Marketing of Area Projects	0.04		0.04						
(2) Social Marketing of Contraceptives	75.00		75.00	101.00		101.00	76.69		76.69
(3) Funding to Institution	43.58	66.73	110.31	41.13	65.28	106.41	33.93	60.78	94.71
(i) Population Research Centre	15.00		15.00	16.50		16.50	14.82		14.82
(ii) National Institute of Health and Family Welfare, New Delhi	15.00	32.60	47.60	14.9	32.05	46.95	13.90	32.05	45.95

(iii) International Institute for Population Sciences, Mumbai	10.00	16.75	26.75	5.57	15.17	20.74	4.74	11.70	16.44
(iv) National Commission on Population	2.00		2.00	2.59		2.59	0.27		0.27
(v) Funding to Training Institution	1.58	17.38	18.96	1.57	18.06	19.63	0.20	17.03	17.23
(a) Family Welfare Training and Research Centre, Mumbai	0.57	3.63	4.20	0.57	3.63	4.20	0.17	3.36	3.53
(b) Rural Health Training Centre, Najafgarh	0.01	13.75	13.76		14.43	14.43		13.67	13.67
(c) Travel of Experts/ Conference/Meetings etc.	1.00		1.00	1.00		1.00	0.03		0.03
(4) Central Procurement Agency	0.01		0.01						
(5) Contribution to International Organisation	4.98		4.98	9.70		9.70	3.57		3.57
(6) Family Welfare Linked Health Insurance plan	1.00		1.00	3.00		3.00			
(7) Free Distribution of Contraceptives	75.00		75.00	153.30		153.30	147.74		147.74
(8) Procurement of Supplies and Materials	50.00		50.00	20.00		20.00	18.94		18.94

1	2	3	4	5	6	7	8	9	10
(9) IEC (Information, Education and Communication)	252.00	9.33	261.33	281.38	9.33	290.71	261.05	5.94	266.99
(10) USAID assisted Project - SIFPSA, U.P, Lucknow									
(11) Forward Linkage to NRHM									
(12) Strengthing national Porg. Management of the NRHM	40.00		40.00	94.19		94.19	60.85		60.85
(13) National Drug De- Addication Programme	35.00		35.00	37.27		37.27	31.91		31.91
Other CS Activities									
(i) Other Family Welfare Activities	3.10		3.10	3.65		3.65	2.05		2.05
(a) Male Participation	1.00		1.00	1.00		1.00	0.45		0.45
(b) Training in Sterilisation/Recana-lisation	0.05		0.05	0.05		0.05	0.04		0.04
(c) Family Welfare Prog. In Other Ministries	0.55		0.55	1.10		1.10	0.34		0.34

(d) Technology in Family Welfare	1.50		1.50	1.50		1.50	1.22		1.22
(ii) Gandhigram Institute	2.70		2.70	2.72		2.72	2.18		2.18
(iii) Assistance to IMA.	0.01		0.01	0.01		0.01			
(iv) Expenditure at Headquarters (RCH)	0.01		0.01						
(v) Research and Study activities in RCH	0.10		0.10						
(vi) Regional Health Office	27.65	10.65	38.30	29.48	12.81	42.29	22.70	9.85	32.55
(vii) Training in RCH	11.50		11.50	12.00		12.00	10.69		10.69
(viii) Technical Wing at Headquarters	2.50		2.50	2.50		2.50	2.08		2.08
(ix) Involvement of NGOs in FP Prog. Under Public-Private Partnership (PPP)	0.85		0.85	0.85		0.85			
(x) Management Information system	90.00		90.00	80.00		80.00	66.03		66.03
Total- Other CS Activities	138.42	10.65	149.07	131.21	12.81	144.02	105.73	9.85	115.58
Total- CS - Family Welfare - Schemes of NHM	715.03	86.71	801.74	872.18	87.42	959.60	740.41	76.57	816.98

1	2	3	4	5	6	7	8	9	10
50. **Membership for International Organisations**	7.19	28.76	35.95	11.19	28.76	39.95	11.97	21.56	33.53
	7.19		7.19	11.19		11.19	11.97		11.97
Contribution to IRCS		0.06	0.06		0.06	0.06			
Contribution to WHO		22.00	22.00		22.00	22.00		19.42	19.42
Delegation to International Conference		4.00	4.00		4.00	4.00		1.30	1.30
International Conference on Medical and Public Health		2.60	2.60		2.60	2.60		0.84	0.84
Codex Trust Fund (CTF)		0.10	0.10		0.10	0.10			
Total - Public Health	1523.12	425.49	1948.61	1544.40	436.68	1981.08	1255.60	372.87	1628.47
State/UT Plan									
51. **Cancer Control**	73.00		73.00	40.00		40.00	27.30		27.30
Tobacco Control									
52. **National Mental Health Programme**	200.00		200.00	15.00		15.00			
53. **Assistance for Capacity Building for Trauma Centers**	70.00		70.00	40.00		40.00	33.52		33.52
54. **Prevention of Burn injury**	28.00		28.00	10.00		10.00	7.86		7.86

55. **National Programme for Prevention and Control of Cancer, Diabetes, Cardiova-scular Diseases**	680.00		680.00	360.00		360.00	352.02		352.02
56. **Health Care for the Elderly**	157.00		157.00	5.00		5.00			
57. **National Programme for Control of Blindness**	70.00		70.00	70.00		70.00	67.75		67.75
58. **Telemedicine**	44.77		44.77	11.00		11.00	8.21		8.21
59. **Human Resources for Health**									
(i) Upgrd./Streng. of Nursing Services (ANM/GNM)	197.80		197.80	91.00		91.00	112.59		112.59
(ii) Strengthening/ Upgrd. of Pharmacy Sch./Coll.	5.00		5.00	5.00		5.00			
(iii) Streng./Creation of Paramedical Instt. (RIPS/NIPS)	197.75		197.75	197.75		197.75			
(iv) District Hospital - Upgradation of State Government Medical Colleges (PG Seats)	295.28		295.28	8.76		8.76	10.00		10.00

1	2	3	4	5	6	7	8	9	10
(v) Strengthening Government Medical Colleges (UG Seats) and Central Govt. Health Institutions	325.00		325.00	294.78		294.78			
(vi) Establishing new Medical Colleges (Upgrading District Hospitals)	145.17		145.17	8.17		8.17	128.53		128.53
(vii) Setting up of State institutions of Paramedical sciences in States and Setting up of College of Paramedical Education	20.00		20.00						
(viii) Setting up of College of pharmacy in Govt. Medical colleges	26.00		26.00						
(ix) Strengthening District hospitals for providing advanced secondary care	31.11		31.11						
(x) Innovation based schemes	1.00		1.00						

60. Human Resources for Health and Medical Education UT/s without legislature	12.00		12.00	6.54		6.54			
Total - Human Resources for Health	1256.11		1256.11	612.00		612.00	251.12		251.12
Total - State/UTs Plan	2578.88		2578.88	1163.00		1163.00	747.78		747.78
Grnad Total									
Part 1 Health	8733.00	4486.71	13219.71	6772.18	4609.21	11381.39	5645.36	4798.76	10444.12

(₹ in Crores)

Scheme/Programme/ Institutions	2015-16 (BE)			(RE) 2015-16			Expenditure Statement up to 31st March 2016		
	Plan	Non- Plan	Total	Plan	Non- Plan	Total	Plan	Non- Plan	Total
1. **Secretariat**	5.35	71.00	76.35	14.67	73.13	87.80	13.42	65.36	78.78
1.1. Health establishment	3.33	42.71	46.04	12.45	46.04	58.49	11.72	44.58	56.30
1.2. Information Technology (Health)	1.70		1.70	1.90		1.90	1.70	0.00	1.70
1.3. FW establishment		15.25	15.25		15.63	15.63	0.00	13.60	13.60
1.4. Pr.AO establishment	0.32	12.68	13.00	0.32	11.10	11.42	0.00	7.18	7.18
1.5. Departmental Canteen		0.36	0.36		0.36	0.36	0.00	0.00	0.00
2. **Discretionary Grant**	0.00	2.50	2.50	0.00	2.50	2.50	0.00	2.18	2.18
3. **Director General of Health Services**	5.00	42.00	47.00	4.89	40.65	45.54	3.05	35.43	38.48
3.1 Director of CGHS	0.00	2.15	2.15		2.15	2.15	0.00	1.32	1.32
4. **National Medical Library**	29.62	5.43	35.05	29.62	5.43	35.05	26.11	4.39	30.50
5. **Central Govt. Health Scheme (Incl *Health Insurance)***	111.00	815.00	926.00	139.00	815.00	954.00	109.76	788.37	898.13
Hospitals and Dispensaries									
6. **Safdarjang Hospital, New Delhi**	357.00	300.00	657.00	511.00	290.00	801.00	507.53	287.51	795.04

7.	**Dr. RML Hospital, New Delhi**	175.0 0	260.00	435.00	175.00	230.00	405.00	164.81	212.25	377.06
8.	**Central Institute of Psychiatry, Ranchi**	50.00	40.00	90.00	45.15	40.00	85.15	20.57	35.63	56.20
9.	**All India Institute of Physical Medicine & Rehab., Mumbai**	8.00	14.00	22.00	6.85	13.65	20.50	4.80	13.35	18.15
10.	**Kalawati Saran Children's Hospital, New Delhi**	40.00	40.00	80.00	37.04	37.94	74.98	31.69	35.46	67.15
11.	**Medical Treatment of CGHS Pensioners**	0.00	965.00	965.00		1065.00	1065.00	0.00	1049.70	1049.70
	TOTAL-Hospitals and Dispensaries	630.00	1619.00	2249.00	775.04	1676.59	2451.63	729.40	1633.90	2363.30
	Medical Education, Training & Research									
12.	**Vallabh Bhai Patel Chest Institute, Delhi University**	17.60	30.00	47.60	17.60	30.00	47.60	17.60	30.00	47.60
13.	**Lady Hardinge Medical College & Smt. S.K. Hosp., New Delhi**	100.00	175.00	275.00	100.00	175.00	275.00	79.91	174.91	254.82
14.	**All India Institute of Medical Sciences (AIIMS), New Delhi**	550.00	920.00	1470.00	700.00	1027.00	1727.00	700.00	1120.00	1820.00
15.	**National Institute of Mental Health & N.S., Bangalore**	140.00	135.00	275.00	140.00	135.00	275.00	149.00	135.00	284.00

1	2	3	4	5	6	7	8	9	10
16. **All India Institute of Speech & Hearing, Mysore**	55.00	18.00	73.00	33.40	17.42	50.82	33.38	15.72	49.10
17. **PGIMER, Chandigarh**	160.00	490.00	650.00	160.00	490.00	650.00	125.00	650.00	775.00
18. **Jawaharlal Institute of PG Medical Education & Res., Puducherry**	200.00	240.00	440.00	350.00	249.00	599.00	350.00	248.77	598.77
19. **Kasturba Health Society, Wardha**	60.00		60.00	60.00		60.00	60.00	0.00	60.00
20. **North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences, Shillong**	200.00	0.00	200.00	200.00	0.00	200.00	178.98	0.00	178.98
				0.00			178.98	0.00	178.98
	200.00		200.00	200.00		200.00			0.00
21. **Vardhman Mahaveer Medical College, New Delhi**	11.50	0.00	11.50	11.50	0.00	11.50	11.42	0.00	11.42
22. **Dr. Ram Manohar Lohia PG Institute of Medical Education & Research, New Delhi**	26.00	0.00	26.00	30.00	0.00	30.00	27.21	0.00	27.21
		0.00	0.00		0.00	0.00		0.00	

23. **Establishment of AIIMS Type Super Speciality Hospitals-cum- Teaching Institutions and Upgrading of State Govt. Hospitals (PMSSY)**	2206.00	0.00	2206.00	1646.03	0.00	1646.03	1568.67	0.00	1568.67
23.1 **Setting up of new AIIMS**	0.00		0.00	0.00		0.00	0.00		0.00
24. **Regional Instt. Of Medical Sciences, Imphal**	250.00	0.00	250.00	250.00	0.00	250.00	243.69	0.00	243.69
25. **Lokpriya Gopinath Bordoloi Reg. Instt. Of Mental Health, Tejpur**	70.00	0.00	70.00	35.00	0.00	35.00	32.13	0.00	32.13
26. **Regional Instt. Of Paramedical and Nursing Sciences, Aizwal**	65.00	0.00	65.00	29.00	0.00	29.00	29.00	0.00	29.00
27. **Other Educational Institutions**	5.84	12.30	18.14	4.79	11.96	16.75	4.16	9.50	13.66
27.1. RAK College of Nursing, New Delhi	2.70	8.00	10.70	2.38	8.00	10.38	1.44	6.83	8.27
27.1.1 RAK College of Nursing, New Delhi Capital			0.00			0.00	0.00		0.00

1	2	3	4	5	6	7	8	9	10
27.2. Grants to Medical Council of India	0.80	0.20	1.00	0.80	0.20	1.00	0.45	0.00	0.45
27.3. Lady Reading Health School and RC Lohia Infant Welfare Centre	1.13	3.00	4.13	0.60	2.66	3.26	0.61	1.84	2.45
27.4. Grants to National Academy of Medical Sciences, N.Delhi	1.00	0.55	1.55	1.00	0.55	1.55	1.66	0.53	2.19
27.4.1 Lady Reading Health School and RC Lohia Infant Welfare Centre (Capital)			0.00			0.00	0.00		0.00
27.5. Grants to National Board of Examination	0.01		0.01	0.01		0.01	0.00	0.00	0.00
27.6. Grants to Dental Council of India		0.20	0.20		0.20	0.20	0.00	0.20	0.20
27.7. Grants to Pharmacy Council of India		0.20	0.20		0.20	0.20	0.00	0.10	0.10
27.8. Grants to Indian Nursing Council	0.20	0.15	0.35		0.15	0.15	0.00	0.00	0.00
27.9. Medical Grants Commission		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

28. **CNCI Kolkata**	49.00	18.00	67.00	19.00	18.00	37.00	19.00	18.00	37.00
TOTAL-Medical Education Training & Research	4165.94	2038.30	6204.24	3786.32	2153.38	5939.70	3629.15	2401.90	6031.05
Public Health									
29. **Port/Airport Health Organisations/Establishment (including De- ratisation of Ships)**	11.50	33.00	44.50	13.47	33.00	46.47	2.91	21.30	24.21
29.1 Port Health Establishment including APO	1.86	33.00	34.86	3.80	33.00	36.80	2.11	21.30	23.41
29.2 Port Health office, J.N.Port, Nhava Sheva	1.57		1.57	1.57		1.57	0.70	0.00	0.70
(Capital)	8.07		8.07	8.10		8.10	0.10	0.00	0.10
30. **TB/Leprosy Training Institutes**	20.50	27.84	48.34	19.68	27.24	46.92	8.21	24.77	32.98
30.1. National TB Training Institute, Bangalore (Revenue)	1.65	8.34	9.99	1.65	8.34	9.99	1.48	8.35	9.83
30.2 National TB Training Institute, Bangalore (Capital)	1.10		1.10	1.10		1.10	0.29	0.00	0.29
30.3 Central Leprosy Teaching and Research Institute, Chengalpattu (Revenue)	1.75	12.00	13.75	1.75	12.00	13.75	1.24	11.00	12.24

1	2	3	4	5	6	7	8	9	10
30.4 Central Leprosy Teaching and Research Institute, Chengalpattu (Capital)	1.10		1.10	1.10	0.00	1.10	0.20	0.00	0.20
30.4.1 Central Leprosy Teaching and Research Institute, Chengalpattu (Capital)	0.25		0.25	0.25		0.25	0.00	0.00	0.00
30.5 Regional Leprosy Training and Research Institute, Aska (Revenue)	0.25	3.50	3.75	0.25	3.25	3.50	0.08	2.37	2.45
30.5 Regional Leprosy Training and Research Institute, Aska (Capital)	7.05		7.05	7.05		7.05	0.00	0.00	0.00
30.6 Regional Leprosy Training and Research Institute, Raipur Revenue	0.75	4.00	4.75	0.75	3.65	4.40	0.70	3.05	3.75
30.7 Regional Leprosy Training and Research Institute, Gauripur Revenue	5.30		5.30	4.48		4.48	3.98	0.00	3.98
Capital	1.05		1.05	1.05		1.05	0.00	0.00	0.00
31. **Development of Nursing Services**	13.00	0.00	13.00	13.00	0.00	13.00	1.03	0.00	1.03

32. **National Institute of Communicable Diseases, New Delhi**	17.10	31.50	48.60	14.17	28.91	43.08	10.85	23.74	34.59
32.1. Main Institution	16.70	31.50	48.20	13.90	28.91	42.81	10.63	23.74	34.37
32.3. Yaws Eradication Programme	0.40		0.40	0.27		0.27	0.22	0.00	0.22
33. **Prevention of Food Adulteration (including Project of Feasibility Testing Scheme of Vitamins and Mineral Fortification of Staple Food)**	75.00	8.40	83.40	74.57	6.55	81.12	54.96	4.13	59.09
33.1 Admn.& Prev. of Food Adulteration (GC)	3.00	8.00	11.00	2.57	6.15	8.72	0.08	3.97	4.05
33.2 Food Safety and Standards Authority of India	72.00		72.00	72.00		72.00	54.88	0.00	54.88
33.3 Project of Feasibility Testing Schemes of Vitamins & Mineral…….		0.40	0.40		0.40	0.40	0.00	0.16	0.16
34. **Central Drugs Standard Control Organisation**	98.50	24.00	122.50	87.65	21.00	108.65	55.11	17.65	72.76
Rev.	67.00	24.00	91.00	56.15	21.00	77.15	46.29	17.65	63.94
Capital	31.50		31.50	31.50		31.50	8.82	0.00	8.82

1	2	3	4	5	6	7	8	9	10
34.1 Indian Pharma-copoeia Commission	17.00	4.00	21.00	19.85	4.00	23.85	20.86	3.88	24.74
34.2 National Pharma-covigilan ce Programme	6.00		6.00	6.00		6.00	5.75	0.00	5.75
TOTAL	121.50	28.00	149.50	113.50	25.00	138.50	81.72	21.53	103.25
35. **Manufacture of Sera & Vaccine**	117.40	10.75	128.15	110.52	9.00	119.52	99.71	6.61	106.32
35.1. BCG Vaccine Laboratory, Guindy, Madras (Revenue)	3.75	10.75	14.50	3.75	9.00	12.75	2.28	6.61	8.89
Investment in Public Sector & Other Undertakings (Hindustan Latex Limited)	8.65		8.65 ***0.00***	4.89		4.89 ***0.00***	4.55	0.00	4.55
35.2. Pasteur Institute of India, Coonoor	45.00		45.00	45.00		45.00	36.00	0.00	36.00
35.3. IVC Chengalpattu & Medi Park-HLL	60.00	0.00	60.00	56.88		56.88	56.88	0.00	56.88
36. **Public Health Laboratories**	51.55	43.75	95.30	49.73	42.81	92.54	42.75	33.42	76.17
36.1. Central Research Institute, Kasauli (Revenue)	11.15	38.00	49.15	11.15	38.00	49.15	6.33	29.11	35.44
Capital	4.85		4.85	3.43		3.43	1.60	0.00	1.60

36.2. Institute of Serology, Kolkata	0.55	5.75	6.30	0.55	4.81	5.36	0.22	4.31	4.53
36.3. National Institute of Biological Standardisation & Quality control, Noida	35.00		35.00	34.60		34.60	34.60	0.00	34.60
37. **Public Health Education**	16.00	47.40	63.40	16.00	42.93	58.93	5.61	38.35	43.96
37.1. All India Institute of Hygiene & Public Health, Kolkata	13.00	26.40	39.40	13.00	21.93	34.93	3.87	21.06	24.93
37.2 AIIH&PH, Kolkata (Capital)	3.00		3.00	3.00		3.00	1.74	0.00	1.74
37.3 Child Care & Training Centre, Singur		21.00	21.00		21.00	21.00	0.00	17.29	17.29
38. **Health Sector Disaster Preparedness & Management Including Emergency Medical Relief. (Including Avian Flu)**	27.00	0.00	27.00	7.97	0.00	7.97	1.53	0.00	1.53
38.1 Other than N.E.R.	15.00	0.00	15.00	5.47	0.00	5.47	1.51	0.00	1.51
38.2 Emergency Medical Releief (Avian Flu)	1.50	0.00	1.50	1.50	0.00	1.50	0.02	0.00	0.02
39. **Lala Ram Swarup Inst. of TB & Allied Diseases, N.Delhi**	40.00	22.85	62.85	40.00	21.43	61.43	40.00	19.93	59.93

1	2	3	4	5	6	7	8	9	10
40. **Procurement of Meningitis Vaccine for Inoculation of Haj Pilgrims**	0.00	6.50	6.50	0.00	6.50	6.50	0.00	6.16	6.16
41. **Rashtriya Arogya Nidhi**	0.00	31.75	31.75	0.00	31.75	31.75	0.00	31.75	31.75
Other Health Schemes									
42. **Oversight Committee (Revenue)**	80.00		80.00	73.00		73.00	41.00	0.00	41.00
Oversight Committee (Capital)	20.00		20.00	6.00		6.00	0.00	0.00	0.00
TOTAL	100.00	0.00	100.00	79	0	79	41	0	41
43. **Institute of Public Health (PHFI)**	0.01		0.01	0.01		0.01	0.00	0.00	0.00
44 **New Initiatives**									
44.1 National Organ Transplant Prog-ramme (Revenue)	9.50		9.50	9.50		9.50	6.29	0.00	6.29
44.2 National Centre for Disease Control (Revenue)	3.60		3.60	1.00		1.00	0.26	0.00	0.26
(Capital)	46.40		46.40	70.00		70.00	69.99	0.00	69.99
TOTAL	50.00	0.00	50.00	71.00	0.00	71.00	70.25	0.00	70.25
44.3 National Advisory Board for Standards	2.00		2.00	2.00		2.00	0.12	0.00	0.12
Total- New Initiatives	62.00	0.00	62.00	83.00	0.00	83.00	76.66	0.00	76.66

45. **Other Schemes**	3.15	7.63	10.78	3.83	7.63	11.46	1.31	6.09	7.40
45.1 Central Health Education Bureau, New Delhi	1.15	3.70	4.85	1.83	3.70	5.53	0.33	2.62	2.95
45.2. Institute of Human Behaviour & Allied Sciences, Shahdara, Delhi			0.00			0.00	0.00	0.00	0.00
45.3. Grants to New Delhi TB Centre		3.41	3.41		3.41	3.41	0.00	3.37	3.37
45.4 Strengthening of Health Infor-mation & Moni-toring System (including Model Vital Health Statistical Unit, Nagpur)	2.00		2.00	2.00		2.00	0.98	0.00	0.98
45.5 Award of Prizes to Authors of Original Books in Hindi		0.08	0.08		0.08	0.08	0.00	0.03	0.03
45.6 Grants to Indian Red Cross Society		0.40	0.40	0.00	0.40	0.40	0.00	0.06	0.06
45.7 Grants to St. John's Ambulance		0.04	0.04		0.04	0.04	0.00	0.01	0.01

1	2	3	4	5	6	7	8	9	10
46. **New Schemes - CS (New)**	60.00	0.00	60.00	6.56	0.00	5.06	0.00	0.00	0.00
(i) Strengthening of existing branches & establishment of 27 branches of NCDC			0.00	1.50			0.00		0.00
(ii) Strengthening intersectoral coor-dination of preven-tion and control of Zoontic diseases			0.00	0.06		0.06	0.00		0.00
(iii) Viral Hepatitis			0.00			0.00	0.00		0.00
(iv) Anti-Micro Resistance			0.00			0.00	0.00		0.00
(v) Health Insurance (CGEIPS)	50.00		50.00			0.00	0.00		0.00
(vi) Emergency Medical Services	10.00		10.00	5.00		5.00	0.00		0.00
47. **Rashtriya Swasthya Bima Yojna (RSBY)**	100.00	0.00	100.00	660.00	0.00	660.00	634.46	0.00	634.46
TOTAL- Other Health Schemes	325.16	7.63	332.79	832.40	7.63	838.53	753.43	6.09	759.52
48. **Medical Stores Organisation**	0.00	51.73	51.73	0.00	51.73	51.73	0.00	46.10	46.10
49. **Central Sector - Family Welfare - Schemes of NHM**									

(1) Social Marketing of Area Projects			0.00				0.00		0.00
(2) Social Marketing of Contraceptives	50.00	0.00	50.00	80.00		80.00	75.66	0.00	75.66
(3) Funding to Institution	43.11	70.26	113.37	43.45	67.17	110.62	32.26	62.06	94.32
(i) Population Research Centre	15.70	0.00	15.70	15.70	0.00	15.70	15.63	0.00	15.63
(ii) National Institute of Health and Family Welfare, New Delhi	15.00	33.60	48.60	15.00	33.60	48.60	10.29	30.37	40.66
(iii) International Institute for Population Sciences, Mumbai	10.00	17.50	27.50	10.00	15.00	25.00	5.15	14.31	19.46
(iv) National Commission on Population	1.00		1.00	0.35		0.35	0.34		0.34
(v) Funding to Training Institution	1.41	19.16	20.57	2.40	18.57	20.97	0.85	17.38	18.23
(a) Family Welfare Training and Research Centre, Mumbai	1.01	4.00	5.01	2.00	4.00	6.00	0.51	3.43	3.94
(b) Rural Health Training Centre, Najafgarh		15.16	15.16		14.57	14.57	0.00	13.95	13.95
(c) Travel of Experts/ Conference/Meetings etc.	0.40		0.40	0.40		0.40	0.34		0.34
(4) Central Procurement Agency			0.00			0.00	0.00		0.00

1	2	3	4	5	6	7	8	9	10
(5) Contribution to International Organisation	5.00		5.00	7.63		7.63	7.28		7.28
(6) Family Welfare Linked Health Insurance plan			0.00			0.00	0.00		0.00
(7) Free Distribution of Contraceptives	50.00	0.00	50.00	110.00	0.00	110.00	101.53	0.00	101.53
(8) Procurement of Supplies & Materials	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(9) IEC (Information, Education and Communication)	150.00	10.18	160.18	264.53	8.63	273.16	200.46	6.04	206.50
(10) USAID assisted Project - SIFPSA, U.P., Lucknow			0.00				0.00		0.00
(11) Forward Linkage to NRHM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(12) Strengthing National Prog. Manage- ment of the NRHM	30.00		30.00	65.00		65.00	51.44		51.44
(13) National Drug De- Addication Programme	35.00	0.00	35.00	35.00	0.00	35.00	26.00	0.00	26.00
Other CS Activities									0.00
(i) Other Family Welfare Activities	3.50	0.00	3.50	3.50	0.00	3.50	1.47	0.00	1.47
(a) Male Participation	0.95		0.95	0.95		0.95	0.43		0.43

(b) Training in Sterilisation/ Recanalisation	0.05		0.05	0.05		0.05	0.04		0.04
(c) Family Welfare Prog. in Other Ministries	1.00		1.00	1.00		1.00	0.00		0.00
(d) Technology in Family Welfare	1.50		1.50	1.50		1.50	1.00		1.00
(ii) Gandhigram Institute	2.75		2.75	2.75		2.75	2.56		2.56
(iii) Assistance to IMA	0.01		0.01	0.01		0.01	0.00		0.00
(iv) Expenditure at Headquarters (RCH)			0.00			0.00	0.00		0.00
(v) Research & Study activities in RCH			0.00			0.00	0.00		0.00
(vi) Regional Health Office	30.00	14.86	44.86	30.00	13.67	43.67	21.41	10.12	31.53
(vii) Training in RCH	11.50		11.50	11.50		11.50	8.63		8.63
(viii) Technical Wing at Headquarters	2.50		2.50	12.50		12.50	1.65		1.65
(ix) Involvement of NGOs in FP Prog. Under Public-Private-Partnership (PPP)	0.01	0.00	0.01	0.01	0.00	0.01	0.00	0.00	0.00
(x) Management Information system	50.00		50.00	50.00		50.00	43.49		43.49
TOTAL- Other CS Activities	100.27	14.86	115.13	110.27	13.67	123.94	79.21	10.12	89.33

1		2	3	4	5	6	7	8	9	10
	TOTAL- CS - Family Welfare - Schemes of NHM	463.38	95.30	558.68	715.88	89.47	805.35	573.84	78.22	652.06
50.	**Membership for International Organisations**	8.00	28.76	36.76	9.37	28.76	38.13	5.44	27.49	32.93
	Contribution to IRCS		0.06	0.06		0.06	0.06		0.00	0.00
	Contribution to WHO		22.00	22.00		22.00	22.00		24.92	24.92
	Delegation to International Conference		4.00	4.00		4.00	4.00		1.80	1.80
	International Conference on Medical & Public Health		2.60	2.60		2.60	2.60		0.77	0.77
	Codex Trust Fund (CTF)		0.10	0.10		0.10	0.10		0.00	0.00
	TOTAL- Public Health	1307.09	475.16	1782.25	2030.26	452.71	2481.47	1681.99	389.59	2071.58
	State/UT Plan									
51.	**Cancer Control**	0.00	0.00	0.00	13.20	0.00	13.20	10.39	0.00	10.39
	Tobacco Control		0.00			0.00			0.00	
52.	**National Mental Health Programme**	0.00	0.00	0.00	35.00	0.00	35.00	35.42	0.00	35.42

53. Assistance for Capacity Building for Trauma Centers	0.00	0.00	0.00	100.00	0.00	100.00	91.03	0.00	91.03
54. Prevention of Burn injury	0.00	0.00	0.00	15.00	0.00	15.00	13.31		13.31
55. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovas-cular Diseases	0.00	0.00	0.00	130.00	0.00	130.00	130.28	0.00	130.28
56. Health Care for the Elderly	0.00	0.00	0.00	28.00	0.00	28.00	35.43	0.00	35.43
57. National Programme for Control of Blindness	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
58. Telemedicine	0.00	0.00	0.00	16.00	0.00	16.00	16.70	0.00	16.70
59. Human Resources for Health									
(i) Upgradation/ Strengthening of Nursing Services (ANM/GNM)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(ii) Strengthening/ Upgradation of Pharmacy Sch./ Coll.	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(iii) Strengthining/ Creation of Paramedical Instt. (RIPS/NIPS)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

1	2	3	4	5	6	7	8	9	10
(iv) District Hospital - Upgradation of State Government Medical Colleges (PG Seats)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(v) Strengthening Government Medical Colleges (UG Seats) and Central Government Health Institutions	0.00	0.00	0.00	50.00	0.00	50.00	50.00	0.00	50.00
(vi) Establishing new Medical Colleges (Upgrading District Hospitals)	0.00	0.00	0.00	337.00	0.00	337.00	531.20	0.00	531.20
(vii) Setting-up of State Institutions of Paramedical Sciences in States and Setting-up of College of Para-medical Education	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(viii) Setting-up of College of Pharmacy in Government Medical Colleges	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(ix) Strengthening of District hospitals for providing advanced secondary care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

(x) Innovation based schemes			0.00				0.00		0.00
60. **Human Resources for Health & Medical Education UTs without legislature**			0.00			0.00	0.00		0.00
TOTAL - Human Resources for Health	0.00	0.00	0.00	387.00	0.00	387.00	581.20	0.00	581.20
TOTAL - State/UT Plan	0.00	0.00	0.00	724.20	0.00	724.20	913.76	0.00	913.76
GRAND TOTAL Part 1 Health	6254.00	5070.54	11324.54	7504.00	5221.54	12724.04	7106.64	5322.44	12429.08

State-wise list of AIIMS and Hospitals/Medical Colleges under upgradation of PMSSY

Sl.	State	New AIIMS	Upgradation of State Govt. Medical College/Hospitals			
			Phase I	Phase II	Phase III	Phase IV
1	2	3	4	5	6	7
1.	Andhra Pradesh	AIIMS Mangalapuri (Ph-IV)	SVIMS, Tirupati		SMC, Vijayawada GMC, Anantpur	
2.	Assam	AIIMS Guwahati (Ph-V)			GMC, Guwahati AMC, Dibrugarh	
3.	Bihar	AIIMS Patna (Ph-I) AIIMS Declared (Ph-V)			SMC, Muzaffarpur GMC, Darbhanga	PMCH, Patna GMC, Bhagalpur MC, Gaya
4.	Chhattisgarh	AIIMS, Raipur (Ph-I)				GMC Billaspur
5.	Goa				GMC, Panaji	
6.	Gujarat		BJMC, Ahmedabad		GMC, Rajkot	GMC, Surat GMC, Bhavnagar
7.	Haryana			PDSIMS, Rohtak		

8.	Himachal Pradesh	AIIMS Declared (Ph-V)		GMC Tanda	I.G. GMC, Shimla	
9.	Jammu & Kashmir	AIIMS, Jammu (Ph-V) AIIMS, Kashmir (Ph-V)	GMC, Jammu GMC, Kashmir			
10.	Jharkhand		RIMS, Ranchi		PMC, Dhanbad	
11.	Karnataka		BMC, Bangalore		VMC, Bellary KIMS, Hubli	
12.	Kerala		MC, Thiruvananthapuram	TDMC, Alappuzha	MC, Kozhikode	
13.	Madhya Pradesh	AIIMS, Bhopal (Ph-I)			GMC, Rewa NSCB, MC, Jabalpur GRMC, Gwalior	GMC, Indore
14.	Maharashtra	AIIMS, Nagpur (Ph-IV)	Grants, MC + JJ Hospitals	GMC, Nagpur	GMC, Aurangabad GMC, Latur GMC, Akola SVK, GMC, Yavatmal	
15.	Odisha (Orissa)	AIIMS, Bhubaneshwar (Ph-I)			MKCG MC, Behrampur VSS MC, Burla	GMC, Cuttack
16.	Punjab	AIIMS, Bhatinda (Ph-V)		GMC, Amritsa	GMC, Patiala	

1	2	3	4	5	6	7
17.	Rajasthan	AIIMS, Jodhpur (Ph-I)			SP MC, Bikaner RNT MC, Udaipur GMC, Kota	GMC, Jaipur
18.	Tamil Nadu	AIIMS, Declared (Ph-V)	GMC, Salem	GMC, Madurai	TMC, Thanjavur TMC, Tirunelveli	
19	Telangana		NIMS, Hyderabad	R.G. IMS, Adilabad KMC, Warangal		
20.	Tripura			AMC, Agartala		
21.	Uttar Pradesh	AIIMS, Rae-bareli (Ph-II) AIIMS, Purbanchal (Ph-IV)	S.G.PGIMS, Lucknow IMS, Varanasi	JNMC, AMU, Aligarh	GMC, Jhansi GMC, Gorakhpur MLN MC, Allahabad LLR MC, Meerut	GMC, Agra GMC, Kanpur
22.	Uttarakhand	AIIMS, Rishikesh (Ph-I)				

23.	West Bengal	AIIMS, Kalyani (Ph-IV)	KMC, Kolkata		BS MC, Bankura GMC, Malda NBMC, Darjeeling		
24.	Delhi						GMC
	TOTAL	18 AIIMS	13	06	39	12	

Total of 18 AIIMS and 70 State Government Medical Colleges/Hospitals under different phases of PMSSY.