REPORT NO.
96

सत्यमेव जयते

PARLIAMENT OF INDIA
RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING
COMMITTEEON HEALTH AND FAMILY WELFARE

NINETY-SIXTH REPORT

Action Taken by Government on the Recommendations/Observations contained in the Ninety-third Report on 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 15*th December,* 2016*)*
(Laid on the Table of Lok Sabha on 15*th December,* 2016

Rajya Sabha Secretariat, New Delhi
December, 2016/Agrahayana, 1938 (Saka)

Website : *http://rajyasabha. nic. in*
E-mail : *rs-chfw@sansad.nic. in*

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Rajya Sabha Secretariat, New Delhi
December, 2016/Agrahayana, 1938 (Saka)

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COMPOSITION OF THE COMMITTEE
(2016-17)

1. Prof. Ram Gopal Yadav — *Chairman*

RAJYA SABHA

2. Shrimati Renuka Chowdhury
3. Shri Rajkumar Dhoot
4. Dr. R. Lakshmanan
5. Dr. Vikas Mahatme
6. Shri Jairam Ramesh
7. Shri Ashok Siddharth
8. Shri Gopal Narayan Singh
9. Shri K. Somaprasad
10. Dr. C. P. Thakur

LOK SABHA

11. Shri Thangso Baite
[$]12. Shrimati Ranjanaben Bhatt
13. Shri Nandkumar Singh Chauhan
14. Dr. Ratna De (Nag)
15. Dr. (Smt.) Heena Vijay Gavit
16. Dr. Sanjay Jaiswal
17. Dr. K. Kamaraj
18. Shri Arjunlal Meena
19. Shri Anoop Mishra
20. Shri J. Jayasingh Thiyagaraj Natterjee
21. Shri Chirag Paswan
22. Shri C. R. Patil
23. Shri M.K. Raghavan
24. Dr. Manoj Rajoria
25. Dr. Shrikant Eknath Shinde
26. Shri R.K. Singh (Arrah)
27. Shri Bharat Singh

[$] Ceased to be member of the Committee w.e.f 20th October, 2016.

28. Shri Kanwar Singh Tanwar
29. Shrimati Rita Tarai
30. Shri Manohar Untwal
31. Shri Akshay Yadav

SECRETARIAT

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

Shrimati Arpana Mendiratta, *Director*

Shri Rakesh Naithani, *Joint Director*

Shri Dinesh Singh, *Joint Director*

Shrimati Harshita Shankar, *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 Ninety-sixth Report of the Committee on Action Taken by Government on the Recommendations/Observations contained in the Committee's Ninety-third Report on Demands for Grants 2016-17 (Demand No.42) of the Department of Health and Family Welfare, Ministry of Health and Family Welfare for the year 2016-17.

2. The Ninety-third Report of the Department-related Parliamentary Standing Committee on Health and Family Welfare was presented to Rajya Sabha and laid on the Table of Lok Sabha on 27th April, 2016. Replies of the Government on the recommendations contained in the Report, received from the Department of Health and Family Welfare were considered by the Committee at its meeting held on the 14th December, 2016.

3. The Committee considered the Draft Report and adopted the same in its meeting held on the 14th December, 2016.

NEW DELHI;
14*th December,* 2016
Agrahayana 23, 1938 *(Saka)*

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

ACRONYMS

(PART A-NATIONAL HEALTH MISSION)

ASHAs	:	Accredited Social Health Activists
AES	:	Acute Encephalitis Syndrome
AFHCs	:	Adolescent Friendly Health Clinics
ANM	:	Auxiliary Nurse Midwife
ANCDR	:	Annual Case Detection Rate
BCC	:	Behaviour Change Communication
BPL	:	Below Poverty Line
BRICS	:	Brazil, Russia,India, China and South Africa
CHCs	:	Community Health Centres
CHEB	:	Central Health Education Bureau
COTPA	:	Central and Other Tobacco Products(Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act.
DCGI	:	Drug Controller General of India
DEICs	:	District Early Intervention Centres
DFID	:	Department for International Development
DPMR	:	Disability Prevention and Medical Rehabilitation
EAG	:	Empowered Action Group
EmOC	:	Emergency Obstetric Care
FRBM	:	Fiscal Responsibility and Budget Management
FRUs	:	First Referral Units
FY	:	Financial Year
GATS	:	Global Adult Tobacco Survey
GFR	:	General Financial Rules
GDP	:	Gross Domestic Product
HBNC	:	Home Based Newborn Care
HPDs	:	High Priority Districts
HSS	:	Health System Strengthening
IAPPD	:	Integrated Action Plan for Pneumonia and Diarrhoea
ICMR	:	Indian Council of Medical Research

IDSP	:	Integrated Disease Surveillance Programme
IEAG	:	India Expert Advisory Group
IEC	:	Information, Education, Communication
IFA	:	Iron and Folic Acid Supplementation
IMR	:	Infant Mortality Rate
IPHS	:	Indian Public Health Standards
IPV	:	Inactivated Polio Device
IUCD	:	Intrauterine Contraceptive Device
IYCF	:	Infant and Young Child Feeding Practice
JE	:	Japanese Encephalitis
JPHNs	:	Junior Public Health Nurses
JSY	:	Janani Suraksha Yojana
JSSK	:	Janani Shishu Suraksha Karyakaram
KA	:	Kala Azar
KMC	:	Kangaroo Mother Care
KTS	:	Kala-azar Technical Supervisor
LCDC	:	Leprosy Care Detection Campaign
LSAS	:	Life Saving Anaesthesia Skills
MCI	:	Medical Council of India
MDA	:	Mass Drug Administration
MDGs	:	Millennium Development Goals
MDR	:	Maternal Death Review
MIS	:	Management Information System
MMR	:	Maternal Mortality Ratio
MoWCD	:	Ministry of Women and Child Development
MR	:	Measles Rubella
NBSUs	:	New Born Stabilization Units
NDD	:	National Deworming Day
NFHS	:	National Family Health Survey
NFPIS	:	National Family Planning Indemnity Scheme
NGO	:	Non-Governmental Organization

NHM	:	National Health Mission
NIDSP	:	National Iodine Deficiency Disorders Programme
NIMR	:	National Institute of Malaria Research
NLEP	:	National Leprosy Eradication Programme
NMSOP	:	National Multisectoral Action Plan
NMHP	:	National Mental Health Programme
NOHP	:	National Oral Health Programme
NPCB	:	National Programme for Control of Blindness
NPCDCS	:	National Programme for Prevention and Control Cancer, Diabetes, Cardio Vascular Diseases and Stroke
NPHCE	:	National Programme for Healthcare of Elderly
NRCs	:	Nutritional Rehabilitation Centres
NRHM	:	National Rural Health Mission
NSSO	:	National Sample Survey Organisation
NTAGI	:	National Technical Advisory Group on Immunization
NTCP	:	National Tobacco Control Programme
NUHM	:	National Urban Health Mission
NVBCP	:	National Vector Borne Disease Control Programme
PHCs	:	Primary Healthcare Centres
PHE	:	Public Health Expenditure
PKDL	:	Post-Kala-azar- Dermal Leishmaniasis
PMO	:	Prime Minister's Office
PMSSY	:	Prandhan Mantri Swasthya Suraksha Yojana
POP	:	Progesterone Only Pill
PPFP	:	Postpartum Family Planning
PPI	:	Pulse Polio Immunisation
RCS	:	Reconstructive Surgery
RDTS	:	Rapid Diagnostic Kits
RBSK	:	Rashtriya Bal Swasthya Karyakaram
RCHP	:	Reproductive and Child Health Project
RG-SRS	:	Registrar General of India- Sample Registration System
RKSK	:	Rashtriya Kishore Swasthya Karyakram

RMNCH+A	:	Reproductive Maternal Newborn Child and Adolescent Health
RNTCP	:	Revised National TB Control Programme
RI	:	Routine Immunization
RSBY	:	Rashtriya Swasthya Bima Yojana
RTIs	:	Reproductive Tract Infections
SHCs	:	Sub Health Centres
SHS	:	State Health Societies
SNCUs	:	Special New Born Care Units
SNID	:	Sub National Immunization Days
STIs	:	Sexually Transmitted Infections
TB	:	Tuberculosis
TFR	:	Total Fertility Rate
TSP	:	Tribal Sub Plan
UCs	:	Utilization Certificates
UHC	:	Universal Health Coverage
ULBs	:	Urban Local Bodies
UOWs	:	Unorganised Workers
VHNDs	:	Village Health Nutrition Days
WHO	:	World Health Organisation
WIFS	:	Weekly Iron and Folic Acid Supplementation

ACRONYMS

(PART B-HEALTH SECTOR)

ADs	:	Additional Directors
ADIs	:	Assistant Drug Inspectors
AIDS	:	Acquired Immuno Deficiency Syndrome
AIIMS	:	AH India Institute of Medical Sciences
ANM/GNM	:	Auxiliary Nursing Midwifery / General Nursing & Midwifery
A/C	:	Airconditioning
AE	:	Actual Expenditure
BE	:	Budget Estimates
BG	:	Bank Guarantee
BCG	:	Bacille Calmette Guerin
BOQ	:	Bill of quantities
CRI	:	Central Research Institute
CDSCO	:	Central Drugs Standard Control Organization
cGMP	:	Current Good Manufacturing Practice
CGHS	:	Central Government Health Scheme
CGEPHIS	:	Central Government Employees and Pensioners Health Insurance Scheme
CIP	:	Central Institute of Psychiatry
CCEA	:	Cabinet Committee on Economic Affairs
CCA	:	Chief Controller of Accounts
CHS	:	Central Health Service
CVC	:	Central Vigilance Commission
CPWD	:	Central Public Works Department.
COCT	:	CARDIAC Optical Coherence Tomography
DSR	:	Delhi Schedule of Rates
DNEA	:	Diploma in Nursing Education and Administration
DPT	:	Diptheria Pertusis Tetanus
DPR	:	Detailed Project Report
DDC	:	Deputy Drugs Controller
DUAC	:	Delhi Urban Art Commission

DUSIB	:	Delhi Urban Shelter Improvement Board
DNITs	:	Detailed Notice of Inviting Tenders
EAP	:	Externally Aided Project
EIA	:	Environmental Impact Assessment
EFC	:	Expenditure Finance Committee
EOT	:	Extension of Terms
ECG	:	Electrocardiography
ERC	:	Empowered Review Committee
EEG	:	Electroencephalogram
FE	:	Final Estimate
FNIRS	:	Functional Near-Infrared Spectroscopy
FP for CD	:	Flexible Pool for Communicable Diseases
FP for NCD	:	Flexible Pool for Non-Communicable Diseases
GIA	:	Grants-in-aid
GFR	:	General Financial Rules
GDMOs	:	General Duties Medical Officer
GMC	:	Government Medical colleges
HRH	:	Human Resource for Health
HQ	:	Headquaters
HSCC	:	Hospital Services Consultancy Corporation
HFW	:	Health & Family Welfare
HVAC	:	Heating, Ventilation and Air Conditioning
IFD	:	Integrated Finance Division
IPD	:	In-patient Department
ICU	:	Intensive Care Unit
ITJ	:	Indian Trade Journal
IVF	:	In Vitro Fertilization
IVF-ET	:	In Vitro Fertilization-Embryo Transfer
INC	:	Indian Nursing Council
IPC	:	Integrated Purchase Committee
JIPMER	:	Jawaharlal Institute of Postgraduate Medical Education & Research

JPNATC	:	Jai Prakash Narayan Apex Trauma Center
LC	:	Letter of Credit
LHMC	:	Lady Harding Medical College
LRHS	:	Lady Reading Health School
METI	:	Monitoring, Evaluation and Technical Cell of India
MH	:	Major Head
MoU	:	Memorandum of Understanding
NACO	:	National AIDS Control Programme
NE	:	North-eastern
NHM	:	National Health Mission
NECB	:	New Emergency Care Building
NIMHANS	:	National Institute of Mental Health and Neurosciences
NEIGRIHMS	:	North Eastern Indira Gandhi Regional Institute of Health And Medical Sciences
NHAI	:	National Highway Authority of India
NCDC	:	National Center for Disease Control
NDMC	:	New Delhi Municipal Council
NCT	:	National Capital Territory
NIT	:	Notice Inviting Tender
NBCC	:	National Buildings Construction Corporation
OBC	:	Other Backward Castes
OPD	:	Out-patient Department
OM	:	Office Memorandum
OT	:	Operation Theater
PAO	:	Pay and Accounts office
PGIMER	:	Post-Graduate Institute of Medical Education and Research
PG	:	Post Graduate
PII	:	Pasteur Institute of India
PMSSY	:	Pradhan Mantri Swasthaya Suraksha Yojana
PMC	:	Project Management Committee
PORB	:	Pensions and Other Retirement Benefits
PRO	:	Public Relation Officer

RCC	:	Reinforced Cement Concrete
RE	:	Revised Estimate
RDs	:	Regional Directors
RCH	:	Reproductive Child Health
RIMS	:	Regional Institute of Medical Sciences
RIPANS	:	Regional Institute of Paramedical and Nursing Sciences
RIPS/NIPS	:	Regional Institutes of Paramedical Sciences/National Institute of Paramedical Sciences
RML	:	Dr. Ram Manohar Lohia Hospital
RSBY	:	Rashtriya Swasthya Bima Yojana
RNTCP	:	Revised National Tuberculosis Control Program
SITC	:	Supply Installation Testing & Comissioning
SFC	:	Standing Finance Committee
SSB	:	Super Specialty Block
SOE	:	Statement of Expenditure
SJH & VMMC	:	Safdarjung Hospital & Vardhman Mahavir Medical College
TCFs	:	Trauma Care Facilities
UCs	:	Utilization Certificates
UG	:	Undergraduate
UT	:	Union Territory
UIP	:	Universal Immunization Programme
UPSC	:	Union Public Service Commission

REPORT

PART A-NHM SECTOR

The Report of the Committee deals with the Action taken by the Government on the recommendations contained in the Ninety-third Report of the Committee on Demands for Grants (Demand No. 42) of the Department of Health and Family Welfare for the year 2016-17.

2. Action Taken Notes (ATNs) have been received from the Government in respect of the recommendations contained in the 93rd Report. They have been categorized as follows:

(i) Recommendations/Observations in respect of which replies of the Government have been accepted by the Committee: 2.29, 2.30, 3.19, 5.9, 5.12, 5.21, 5.22, 5.25, 5.26, 5.28, 6.6, 6.7, 6.21, 6.22, 6.28, 6.29, 10.5, 10.6, 10.7

TOTAL – 19 (Chapter-I)

(ii) Recommendations/Observations which the Committee does not desire to pursue in view of the Government's replies: 2.26, 2.27, 2.28, 2.31, 2.33, 2.34, 2.35, 2.36, 2.37, 2.38, 2.39, 2.40, 3.8, 3.9, 3.10, 3.11, 3.12, 3.13, 3.16, 3.17, 4.4, 4.5, 5.16, 5.17, 6.19, 7.1, 7.2, 7.3, 8.9, 9.1, 9.2

TOTAL – 31 (Chapter-II)

(iii) Recommendations/Observations in respect of which replies of the Government have not been accepted by the Committee: 2.22, 2.23, 2.25, 3.21, 3.22, 5.33, 5.34, 6.2, 6.3, 6.10, 6.11, 6.13, 6.14, 6.15

TOTAL – (Chapter-III)

(iv) Recommendations/Observations in respect of which final replies of the Government are still awaited: 2.24, 6.24, 6.25

TOTAL – (Chapter-IV)

3. The details of the ATNs are discussed in various Chapters in the succeeding pages.

CHAPTER-I

Part A- (NHM Sector)

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE BEEN ACCEPTED BY THE COMMITTEE

II. BUDGETARY ALLOCATION

Recommendation/ Observation

1.1 *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)

Action Taken

1.2 The observations of the Committee have been noted for compliance and the Committee will be kept updated on the matter.

Recommendation/ Observation

1.3 *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)

Action Taken

1.4 Under NHM, the annual resource envelope of a State is based on its population, area and a weightage factor which depends on the health lag and socio-economic backwardness. In view of this, the States *viz.*

Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh which are part of high focus states, are given enhanced resources by giving a weightage of 1.3 to 1.5 for their population while allocating the Central Grants and consequently receive more Central allocation per capita in comparison to more developed States.

III. NRHM-RCH FLEXIBLE POOL

Mission Indradhanush

Recommendation/ Observation

1.5 *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)

Action Taken

1.6 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 phase was launched in 201 high focus districts. The second phase launched in 352 districts in the country of which 73 are high focus districts of Phase-I. The survey result shows that Mission Indradhanush has led to 5-9% increase in full immunization coverage. The third phase has been launched in 216 high focus districts of the country. Till now (as on 14th May 2016) 173.3 lakh children were reached out of which 45.29 lakh children were fully immunized. In addition, 45.36 lakh pregnant women vaccinated against tetanus.

1.7 All the efforts are being made to achieve 90% full immunization coverage by 2020. Special attention is being given to low immunization coverage pockets like urban slums, tribal areas, brick kilns, migratory population etc. Following each monthly round, rigorous reviews are being undertaken to identify the gaps and plug them before commencement of the next round. The target of 90% full immunization coverage is for the whole country.

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

A. National Vector Borne Disease Control Programme (NVBDCP)

Recommendation/ Observation

1.8 *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)

Action Taken

1.9 The observations of the Committee have been noted. In this connection, it is stated that ICMR has taken a decision in its meeting held on 3rd May, 2016 under the Chairmanship of Dr. D.A. Gadkari, former Director, NIV, Pune to evaluate the DCGI approved RDTs for its sensitivity and specificity.

LYMPHATIC FILARIASIS (LF)

Recommendation/ Observation

1.10 *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)

Action Taken

1.11 The recommendations of the Committee have been noted. JE Vaccination campaign (1-15 Yrs) has been completed in 197 endemic districts. To further strengthen the JE prevention NTAGI has recommended two doses of JE vaccine under Routine Immunization, 1 at 9 months of age and 2nd at 16-24 months of age to protect children. The same has been incorporated under Routine Immunization (RI) *w.e.f.* April, 2013.

LYMPHATIC FILARIASIS (LF)

Recommendation/ Observation

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

Action Taken

1.13 The strategy of community level sensitization and mobilization is being adopted for maximizing the coverage of Mass Drug Administration (MDA). The states have been regularly advised to emphasize on the strategy. The component of community level snensitization and mobilization includes:

1. Inter personal communication
2. Group discussion
3. Melas, drum beatings, nukkad nataks, miking etc.
4. Radio and TV advertisement
5. Banners, handbills, posters and newspaper advertisement

1.14 The analysis of districts revealed that all the 74 districts have been targeted in addition to 5 more districts to ensure reduction in microfilaria prevalence as Mass Drug Administration (MDA) impact.

KALA-AZAR

Recommendation/ Observation

1.15 *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 Decenmber 2015. The National Health Policy (2002) envisages Kala-azar Elimination by 2015 and Central Government provides 100% operational cost to the States besides anti Kala-azar medicine, drugs and insecticides. (Para 5.22)

1.16 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.

Action Taken

1.17 Kala-azar (Visceral Leishmaniasis) is at present endemic in 33 districts of Bihar, 4 districts of Jharkhand, 11 districts of West Bengal besides occurance of sporadic cases in 6 districts of eastern Uttar Pradesh. The state of Bihar alone is contributing >80% of total KA reported from four states. An estimated 130 million population is exposed to the risk of Kala-azar in the endemic districts of four states. Kala-azar affects the socially marginalized and the poorest communities. The peak annual incidence of Kala-azar was seen in 1992, when 77102 cases and 1419 deaths were reported from the endemic states. A vigorous campaign of case detection and indoor residual spraying with DDT was taken up resulting in sharp decline within a period of 2 years. The reported cases of 44533 in 2007 were reduced to 24212 in 2009. In 2015, Kala-azar cases reduced by 10.8% (8243) & death by 54.5% (5) in comparison to the corresponding period of 2014. The Government of India reviewed Kala-azar Control Programme in the year 2000 and recommended feasibility of its elimination from the country. The National Health Policy (2002) envisages Kala-azar Elimination by 2010 which has been revised to 2015 and further revised to 2017 or earlier during Health Sector Meeting on 14th March, 2016.

1.18 The Government of India signed a pentalateral Memorandum of Understanding with Nepal, Bangladesh, Bhutan, Thailand and India in May 2005, on the elimination of Kala-Azar from the South-East-Asia Region by 2017 or earlier.

1.19 Kala-azar elimination Programme has also provided Consultants, Kala-azar Supervisors (KTS) for strengthening monitoring & supervision in Bihar, Jharkhand, West Bengal. Further, funds have also been provisioned for training & mobility. Motor Cycles to KTS & MUV for Programme managers have also been provided for effective supervision & monitoring.

Initiatives

(1) Hon'ble Prime Minister reviewed Kala-azar under PRAGATI with Chief Secretaries of Bihar West Bengal, Jharkhand and Uttar Pradesh & with Secretary (H). GOI on 17th Feb'16. Monthly review of Kala-azar elimination programme by Prime Minister Office (PMO) and higher officers.

(2) Hon'ble Minister of Health & Family Welfare, GoI reviewed the status of the progress of Kala-azar Elimination Programme in the country on 7th April 2016.

(3) Two days review meeting to oversee progress of implementation of National Road Map on Kala-azar Elimination was held at Patna on 21st-22nd April 2016 with Kala-azar endemic states, stakeholders & partners.

(4) National Roadmap for Kala-azar Elimination (2014) has been circulated to states with clear goal objectives, strategies, timelines with activities and functions at appropriate level. This document has been developed for focused intervention at national, state, district and sub-district levels.

(5) Single day single dose treatment and combination treatment of 10 days for better Kala-azar treatment compliance.

(6) Strengthening of human resource component by involving development partners for augmenting Kala-azar elimination effort.

(7) Incentive to Kala-azar activist/health volunteer/ASHA @ ₹300/- for referring a suspected case and ensuring complete treatment and ₹ 100/- during one round of indoor residual spray i.e ₹ 200/- for both the two rounds of spray for generating awareness for acceptance of spray by the community.

(8) ₹ 500/- as incentive to Patient for loss of wages irrespective of drug regimen and ₹ 2,000/- to PKDL cases and free diet support to patient and one attendant.

(9) Govt. of Bihar has announced an incentive of ₹6,000/- to patient as loss of wages and ₹ 400/- to attendant besides ₹ 200/ for transportation. The total amount comes to Rs 6,600/- under Chief Minister Relief fund. This will improve treatment compliance. This incentive is besides GoI incentive of ₹ 500/-. Now a patient will get ₹ 7,100/-.

(10) Construction of pucca houses for poor and marginalised community (Mahadalit Community) which are worst affected in collaboration with Ministry of Rural Development.

(11) Ensuring supply of drugs & Diagnostic Kits.

(12) IEC/BCC for community awareness & social mobilization.

(13) Use of Synthetic Pyrethorid insecticide in 21 districts of endemic states during 2016.

Achievement

- Since 2012 Kala-azar cases and deaths are showing declining trend. There is a reduction of 75% of cases (8240) in 2015 in comparison with the year of 2011 (33187 cases). Similarly deaths are reduced from 80 deaths in 2011 to 5 deaths in 2015.
- Out of 625 total endemic blocks in 4 states 502 (80%) block PHCs have achieved less than one case per 10000 population at block PHC level in the year 2015.
- 5483 patients treated with single day by Liposomal Amphotericin B in 2015.

- Stakeholders are actively monitoring the programme jointly with state counterparts.
- Programme is reviewed at the highest level of Hon'ble Prime Minister.

The following actions have been taken to further strengthen the process of elimination:

- Sustenance of blocks having achieved the elimination target in 2015 through active search, ensuring treatment and supervised IEC/BCC activities.
- In Bihar, 50 blocks having critical problem on implementation activities have been identified along with six officers to keep a track on Kala-azar implementation activities through regular monitoring and supervision in the field.
- Case detection with the help of peripheral worker (ASHAs, Kala-azar Technical Supervisor and partners).
- Ensuring complete treatment of Kala-azar cases and Post-Kala-azar Dermal Leishmaniasis (PKDL).
- Screening of Kala-azar confirmed cases for HIV-VL co- infection.
- Monitoring and supportive supervision by National Vector Borne Disease Control Programme (NVBDCP), National Centre for Disease Control (NCDC), Rajendra Memorial Research Institute (RMRI) & World Health Organization (WHO) and Bill & Melinda Gates Foundation (BMGF)/ Cooperative for Assistance and Relief Everywhere (CARE) partners.
- Regular review of Kala-azar elimination programme at MoH level.
- Extensive IEC/BCC for case reporting, complete treatment and public cooperation during IRS is going on through Hoardings, Banners, Flipchart, group discussions etc.
- Kala-core through their agency is developing Audio Video for telecasting in Television Channels, Cinema Hall of Bihar, Jharkhand, West Bengal & Uttar Pradesh.

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

Recommendation/ Observation

1.20 *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. (Para 5.25 & 5.26)

1.21 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.

Action Taken

1.22 The Committee recommendations have been, duly noted.

1.23 However, a Committee under Chairpersonship of Secretary (DHR) has recommended for phased scale-up of daily regimen in the entire country.

(C) **National Leprosy Control Progamme**

Recommendation/ Observation

1.24 *The Committee observes that this is the last year of the 12th Plan and according to the main objective of National Leprosy Control Programme (NLCP), 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 & 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)

Action Taken

1.25 (1) Status as on date with regard the goal of elimination of leprosy are as follows:-

Indicator	Target	Achievement 2015-16 (provisional)	2014-15
Prevalence Rate <1/10, 000 population	100% districts	548/669	532/669
Reconstructive surgeries	2500	3107 (of these 259 in camps)	2883

(i) 209 Districts had reported ANCDR (Annual Case Detection Rate) more than 10 per lakh population and were identified as high endemic in 2010-11.

(ii) Leprosy Case Detection Campaigns (LCDC), in line with pulse polio campaign, a unique initiative of its kind under NLEP, has been taken up in high endemic districts of the country. The rationale behind these campaigns is early detection of all hidden cases in the community so that the rising trend of Grade II disability is halted and eventually reversed.

1.26 The first LCDC was carried out in 50 high endemic districts of 7 States namely, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha and Uttar Pradesh during March-April 2016.

1.27 Again 163 High endemic districts are identified for Leprosy Case Detection Campaign activities in 2016-17 which have reported Prevalence Rate (PR)>1 during any of the last three years.

(iii) Supply of Micro Cellular Rubber (MCR) footwear in adequate quantity during 2014-15, 64890 MCR footwear and 51029 Self Care Kits were provided to Leprosy Affected Persons.

(iv) Services for diagnosis and treatment (Multi drug thereapy) are provided by all primary health centers and Government dispensaries throughout the country free of cost.

2. Action Taken on the goal of strengthening of DPMR (Disability Prevention Medical Rehabilitation) of persons affected by leprosy:-

(i) Strengthening of DPMR through Regular follow up for necuritis and reaction, Self care practices, Supply of MCR footwear/self care kits/aids and appliances in adequate quantity.

(ii) Improvement in RCS performance through camp approach are planned to reduce the disease burden.

(iii) However, in the long term, due to reduction in case load in the community, transmission of disease will be reduced.

(iv) Measures have also been taken for Capacity building, ensuring adequate availability of drugs for treatment, strengthening of District nucleus, regular monitoring & supervision and review, regular follow up for neuritis and reaction, self care practices. Extensive IEC (Information, Education and communication) for creating awareness and reducing stigma.

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

(B) National Mental Health Programme

Recommendation/ Observation

1.28 *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.* (Para 6.6 & 6.7)

1.29 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.

Action Taken

1.30 The suggestion of the Committee has been noted for compliance.

F. **Burn Injuries Scheme**

Recommendation/ Observation

1.31 *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:*

(Para 6.21 & 6.22)

- As of now, 43 Burn Units (including 13 burn units in district hospitals) have been approved by Screening Committee – Trauma & Burns.
- The IEC material utilized during the pilot phase of this programme has been modified and updated for greater reach out & 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 Govt. Medical Colleges identified during the 12^ Five Year Plan is proposed from 30th November, 2015 to 5th December, 2015 at Dr. RML Hospital & 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.

1.32 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.

Action Taken

1.33 IEC Action Plan for National Programme for Prevention & Management of Burn Injuries (NPPMBI) has already been finalized and the same is expected to be implemented during the current financial year (FY 2016-17).

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

Recommendation/ Observation

1.34 *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)

Action Taken

1.35 In order to prevent and control Non-Communicable Diseases, Government of India has launched National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) which is implemented for interventions up to District level under the National Health Mission (NFIM). NPCDCS has a focus on awareness generation for behavior and life-style changes, screening and early diagnosis of persons with high level of risk factors and their treatment and referral (if required) to higher facilities for appropriate management. Under NPCDCS, diagnosis and treatment facilities are provided through different levels of healthcare by setting up of Non-Communicable Disease (NCD) Clinics at District Hospitals and Community Health Centres (CHCs). The programme includes intervention at the level of Primary Health Centres (PHCs) and Sub-Centres also.

1.36 Besides NPCDCS other NCD programme are being funded under NHM and include National Programme for Health Care of the Elderly (NPHCE), National Mental Health Programme (NMHP), National Programme for Prevention and Control of Deafness (NPPCD), National Tobacco Control Programme (NTCP), etc.

1.37 In response to the growing burden of Non-Communicable Diseases (NCDs), the Government of India has developed a draft National Multi Sectoral Action Plan (NMSAP) for prevention and control of NCDs to guide multisectoral efforts towards attaining the National NCD objectives. The said National Multi Sectoral Action Plan (NMSAP) has been shared with relevant Central Government Ministries/Departments for their suggestions/feedback.

1.38 Department of Health and Family Welfare (MoHFW) in collaboration with World Health Organisation organized an inter-ministerial consultation on National Multisectoral Action Plan (NMSAP) for prevention and control of Non-communicable Diseases (NCDs). The objective of the consultation was to sensitize the nodal officers from different sectors about the NMSAP.

1.39 India is the first country globally to adopt the NCD Global Monitoring Framework and Action Plan to its National Context. The Framework includes a set of nine voluntary targets and 25 indicators which can be applied across regional and country settings.

1.40 It has been decided to use knowledge available in AYUSH systems and Yoga for preventive aspects of Non Communicable diseases such as Hypertension and Diabetes. It is further informed that the services of AYUSH Doctors are being utilized under NPCDCS in 6 districts on pilot basis.

H. **THALASSEMIA**

Recommendation/ Observation

1.41 *The Committee finds that a genetically inherited disease called Thalassemia is also prevalent in our country and lakhs of Thalassemia 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 Thalassemia should also be included in list of various diseases and budgetary allocations should be made for this disease as well. (Para 6.29)

Action Taken

1.42 Thalassemia is common genetically inherited disease involving defective haemoglobin (Oxygen Carrying Pigment in the Blood) prevalent in India. There are few lakhs of thalassemia patients and carriers of the disease in the population. As this is a major health problem, Ministry for Health & Family Welfare has issued a Guideline to prevent and control Flaemoglobinopathies consisting of Thalassemia, Sickle Cell Disease and others in India. This guideline also includes implementation framework, required Human Resource and Budget estimates. These Guidelines have been sent to the State/UT Governments for necessary action. As per this framework, the target groups required to be screened for prevention and detection are new-borns, young children and also pregnant women during antenatal check-ups. The already existing RBSK programme under Child Health is utilized to coordinate with a view to early detection and intervention for the Children and new-born. Through this framework, it is also envisaged to create new human resources and infrastructure in the form of quality laboratory services. The programme is expected to be implemented in convergence with RBSK and Blood Banks under Blood Cell. The budgetary estimates under different Pleads have also been provided in the said Operational Guidelines. The States are required to reflect the expenditure in the PIP proposals. Such programmes are implemented through the states as Health is a state subject.

X. DEFICIENCY OF HEALTH INFRASTRUCTURE AND MANPOWER IN RURAL AREAS

Recommendation/ Observation

1.43 *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 Pediatricians. 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)

Action Taken

1.44 Public health being a State subject, the primary responsibility to ensure availability of doctors/specialists in public health facilities lies with the State Governments. However, under the National Health Mission (NHM), financial and technical support is provided to States/UTs to strengthen their healthcare systems including support for engagement of doctors/specialists on contractual basis, based on the requirements posed by the States/UTs in their Programme Implementation Plans (PIPs).

1.45 Support under NHM is also provided to States/UTs for multi-skilling of doctors, for giving hard area allowance to doctors/specialists for serving in rural and remote areas and for their residential quarters so that they find it attractive to serve in public health facilities in such areas. Also, States/UTs are advised to put in place transparent policies of posting and transfer, and ensure rational deployment of medical professionals. As the posts required for health facilities are filled up by respective State/UT Governments, they are impressed upon from time to time to fill up the vacant posts.

1.46 Further, in order to encourage doctors to work in remote and difficult areas, the Medical Council of India, with the previous approval of Central Government, has amended the Post Graduate Medical Education Regulations, 2000 to provide:

(i) 50% reservation in Post Graduate Diploma Courses for Medical Officers in the Government service, who have served for at least three years in remote and difficult areas; and

(ii) Incentive at the rate of 10% of the marks obtained for each year in service in remote or difficult areas as upto the maximum of 30% of the marks obtained in the entrance test for admissions in Post Graduate Medical Courses.

1.47 The Government has taken the following steps to further augment the supply of doctors in the country:

(i) The ratio of teachers to students has been revised from 1:1 to 1:2 for all MD/MS disciplines and 1:1 to 1:3 in subjects of Anaesthesiology, Forensic Medicine, Radiotherapy, Medical Oncology, Surgical Oncology and Psychiatry.

(ii) DNB qualification has been recognized for appointment as faculty to take care of shortage of faculty.

(iii) Enhancement of maximum intake capacity at MBBS level from 150 to 250.

(iv) Enhancement of age limit for appointment/extension/re-employment against posts of teachers/ dean/principal/ director in medical colleges from 65-70 years.

(v) Relaxation in the norms for setting up of a medical college in terms of requirement for land, faculty, staff, bed/ bed strength and other infrastructure.

(vi) Strengthening/upgradation of State Government Medical Colleges for starting new PG courses/ Increase of PG seats with fund sharing between the Central and State Government.

(vii) Establishment of New Medical Colleges by upgrading district/referral hospitals preferably in underserved districts of the country with fund sharing between the Central Government and States.

(viii) Strengthening/ upgradation of existing State Government/Central Government Medical Colleges to increase MBBS seats with fund sharing between the Central Government and States.

Recommendation/Observation

1.48 *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 requisite budget to requisite 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)

Action Taken

1.49 For Nurses it may be mentioned that under the INC framework, near to 3 lakh Nurses are completing their education each year. Since there is no National level council for Allied Health, data in respect of allied health is not maintained centrally.

Recommendation/Observation

1.50 *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)

Action Taken

1.51 The issue of compulsory rural service comes under the ambit of State Governments, which are principal employers of doctors. However, to encourage doctors working in remote and difficult areas, the MCI with the previous approval of Central Government, has amended the Post Graduate Medical Education Regulation, 2000 to provide:-

(i) 50% of the seats in Post Graduate Diploma Courses shall be reserved for Medical Officers in the Government services, who have served for at least three years in remote and difficult areas. After acquiring the PG Diploma, the Medical Officers shall serve for two more years in remote and /or difficult areas; and

(ii) Incentive at the rate of 10% of the marks obtained for each year in service in remote or difficult areas upto the maximum of 30% of the marks obtained in the entrance test for admissions in Post Graduate Medical Courses.

CHAPTER-II

RECOMMENDATIONS/OBSERVATIONS WHICH THE COMMITTEE DOES NOT DESIRE TO PURSUE IN VIEW OF THE GOVERNMENT REPLIES

II. BUDGETARY ALLOCATION

Recommendation/ Observation

2.1 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)

Action Taken

2.2 The information on the impact of State budget on the said essential sectors is not available.

2.3 However the State- wise information on health budget (Plan and Non Plan) during 2014-15 and 2015-16 is attached as Annexure-B.

2.4 Under NHM, support is provided to States based on requirements posed by them in their Programme Implementation Plans. The information regarding public health facilities functioning as per IPHS norms as per Rural Health Statistics 2015 is attached as Annexure-C.

2.5 The information on approvals given under NHM for establishing new SHCs, PHCs and CHCs in 2015-16 is attached as Annexure-D.

2.6 Information relating to approvals given for implementation of innovations listed at (i), (ii), (iii), (iv), (v) & (vi) in 2015-16 is attached as Annexure-E.

2.7 Progress achieved under Rashtriya Kishore Swasthya Karyakram (RKSK) are as follows:

- Adolescent Friendly Health Clinics (AFHCs): AFHCs are dedicated clinics within health facilities which provide clinical, counselling and referral services to adolescents. The clinics are manned by trained staff. In 2014-15, the total number of clinics established was 6619; additional 670 clinics have been established in 2015-16. Currently there are 7289 clinics across the country.

- Adolescent Health Counsellors: Availability of dedicated manpower is essential for strengthening of AFHCs. It is envisaged that counselors trained on AFHS would not only provide counselling services but also conduct outreach visits in the community. This will help to link community with services available at the facility level. 260 new counselors have been recruited in 2015-16 bringing the total number of AH Counsellors across the country to 1402.

- Peer Educator Programme: Peer Educator Programme is the community based intervention under RKSK. 213 districts across the country have been selected in the first phase for the implementation of the programme. Peer Educators are selected from the community and trained to conduct sessions with adolescents to inform and educate them on health related issues. As of now 89503 peer educators have been selected and are being trained.

2.8 Weekly Iron and Folic Acid Supplementation (WIFS) Programme: The programme was launched in 2012 with the aim to reduce the prevalence and severity of nutritional anaemia amongst adolescents. The programme was rolled out across the country gradually and it is currently being implemented in all States except Bihar. The total beneficiary coverage has increased from 23.8% in 2014-15 to 27.3% in 2015-16.

2.9 Under the Rashtriya Bal Swasthya Karyakram (RBSK), as reported by States and UTs

- Number of mobile health teams in position 10,410 (including 1095 Junior Public Health Nurses (JPHNs) in Kerala)

- Number of District Early Intervention Centres (DEICs) operational 92

- Number of children screened 18.7 crores (8.36 crores in 0-6 years and 10.3 crores in 6-18 years enrolled in Govt. and Govt. aided schools)

- Number of children identified with 4Ds - 1.37 crores

- Number of children accessed secondary tertiary services -45.6 lakhs

Recommendation/ Observation (Para 2.27 & 2.28)

2.10 *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.

2.11 *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 of 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.

Action Taken

2.12 The public expenditure on health is based *inter-alia,* on the availability of financial resources, keeping in view competing demands on the resources of the Government and absorptive capacity of the Health Sector.

2.13 The allocation to Health Sector falls within the purview of Ministry of Finance and observations of the Parliamentary Standing Committee have been communicated to Ministry of Finance under this Department O.M. No. H-l1019/02/2016-BP dated 17th May, 2016.

Recommendation/ Observation

2.14 *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)

Action Taken

2.15 (i) One of the key approaches of NHM is managerial support at various levels was to be built by setting up of Programme Management Units (PMUs) at State, district and block level. Up to 6.5 % of the

annual resource envelope of the State is available for programme management and monitoring. The key objective of setting up the PMU is to strengthen the existing management structures/functions for smooth implementation and functioning of the mission. The Programme Management Units generally consist of skilled professionals for providing support primarily related to programme management, financial management, and monitoring and evaluation.

2.16 The pace of completion of construction works sanctioned is regularly taken up at all levels during review meetings of programme. To ensure States complete their constructions works within the stipulated time-frame, under NHM, support is not provided for escalation costs beyond three years and even the quantum of escalation costs has been restricted. Support under NHM is also provided for civil engineering staff on deputation basis and also for third party monitoring.

2.17 Under NHM, support is being provided to States/UTs for provision of essential drugs free of cost in public health facilities. As a result of strong advocacy by Government of India (GOI), all States have notified policy to provide free drugs in public health facilities as on date. Under NHM, to ensure that there is no stock out, support is also provide to State for IT backed drug inventory supply chain management system besides putting in place mechanisms like prescription audit, grievance reprisal etc. The Ministry has also web-linked the drug procurement price lists of major States to facilitate comparison of rates for procurement. As a facilitation measure to States, the Government of India also prepared and circulated facility wise Essential Drug List (EDL) to States. Specs of commonly used equipment in Special Newborn Care Units ((SNCUs), ambulance, Mobile Medical Units (MMUs), labour rooms, etc. were developed and shared with the States.

2.18 To augment human resources in States, many measures have been taken. Support under NHM is provided for multi skilling of doctors, higher remuneration, financial incentives and improved accommodation arrangements to serve in rural areas so that health professionals find it attractive to join public health facilities in rural areas. The Ministry has also signed MOU with Indira Gandhi National Open University (IGNOU) for roll out of bridge course for training Ayurveda Doctors and Nurses in primary care and public health. Under NHM, support is also being provided for strengthening district Hospitals for multi-speciality care and as training sites for HR including nurses, paramedical staff, doctors & specialists through DNB courses/ accredited/certified diploma course. States are also being incentivised for putting in an IT backed HR Management and Information System. The Guidelines on engaging/obtaining services of specialists were developed and released to the States. States are encouraged to opt for recruitment of health HR based on skill competency test. Ministry has suggested engagement of qualified HR firms to facilitate recruitment. As a facilitation measure, GoI has empanelled HR agencies after following due process which is available to States for recruitment of health HR.

2.19 To ensure functional equipment in public health facilities, inventory mapping of bio-medical equipment was undertaken across States. 29 States and UTs have completed inventory mapping of equipment, machineries. NHM is also supporting rollout of the Biomedical Equipment Management and Maintenance Programme, the guidelines for which has also been issued.

2.20 Further, in order to increase the availability of doctors and to encourage doctors to work in remote

and difficult areas, the Medical Council of India, with the previous approval of Central Government, has amended the Post Graduate Medical Education Regulations, 2000 to provide:

(i) 50% reservations in Post Graduate Diploma Courses for medical Officers in the Government service, who have served for at-least three years in remote and difficult areas; and

(ii) Incentive at the rate of 10% of the marks obtained for each year in service in remote or difficult areas as upto the maximum of 30% of the marks obtained in the entrance test for admissions in Post Graduate Medical Courses.

2.21 The Government has taken the following steps to further augment the supply of doctors in the country:

(i) The ratio of teachers to students has been revised from 1:1 to 1:2 for all MD/MS disciplines and 1:1 to 1:3 in subjects of Anesthesiology, Forensic Medicine, Radiotherapy, Medical Oncology, Surgical Oncology and Psychiatry.

(ii) DNB qualification has been recognized for appointment as faculty to take care of shortage of faculty.

(iii) Enhancement of maximum intake capacity at MBBS level from 150 to 250.

(iv) Enhancement of age limit for appointment/extensions/re-employment against posts of teachers/ dean/principal/director in medical colleges from 65-70 years.

(v) Relaxation in the norms for setting up of a medical college in terms of requirement for land, faculty, staff, bed/bed strength and other infrastructure.

(vi) Strengthening/upgradation of State Government Medical Colleges for starting new PG courses/ Increase of PG seats with fund sharing between the Central Government and States.

(vii) Establishment of New Medical Colleges by upgrading district/referral hospitals preferably in underserved districts of the country with fund sharing between the Central Government and States.

(viii) Strengthening/upgradation of existing State Government/Central Government Medical Colleges to increase MBBS seats with fund sharing between the Central Government and States.

2.22 Under PMSSY, 6 All India Institute of Medical Sciences (PMSSY) have been established and 12 new AIIMS have been approved to be set up in different parts of country. 70 Medical Institutions are being upgraded to Super - speciality hospitals and 58 District hospitals are being upgraded to Medical colleges.

(ii) Approval for undertaking activities under NUHM like engagement of Human Resource, health system strengthening, community processes are conveyed to the States as per the Programme Implementation Plan received from the States. The Ministry has developed & shared with the States guidelines on module for ASHA, Mahila Arogya Samiti (MAS), Quality Assurance (QA)

Assessment guidelines for Urban Public Health Centre (UPHC) in urban areas for providing support for implementation of activities approved. Orientation and training workshops on ASHAs, Quality Assurances and Health Management Information System (HMIS) were conducted for all states and UTs. Besides approval for training of Medical Officer, Programme Urban Local Body (ULB) Officers and Para Medical Staff have been accorded for States and UTs as per Programme Implementation Plan (PIP) submitted by the States.

2.23 The State Governments have been requested to prioritise implementation of the NUHM Programme and letters from Secretary (HFW) to Chief Secretaries of all the States/UTs were sent in January, 2015 and August, 2015. In respect of States where implementation is through the ULBs, a joint letter was sent from the Secretary (MoHFW) and Secretary, Ministry of Urban Development (MoUD) on 29.04.2016 to Chief Secretaries/Principal Secretary/Secretary Health, Principal Secretary/Secretary Urban Development and Mission Director (NHM) of 7 States/UTs to improve coordination between the Urban Local Bodies (ULBs) and State Health Departments to ensure expeditious implementation of the NUHM Programme. Also, a letter dtd. 21.6.2016 from AS&MD (NHM) was sent to the Municipal Commissioners of 7 metro cities regarding undertaking activities under immunization programme. D.O. letters dtd. 27.05.2016 from Joint Secretary (UH) were also sent to the States for accelerating the pace of utilization of funds and reducing unspent balances under NUHM. Annexure-F.

TRIBAL SUB PLAN (TSP)

Recommendation/ Observation

2.24 *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."* (Para 2.33, 2.34 & 2.35)

2.25 *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%.*

2.26 *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.*

Action Taken

2.27 *There is a significant improvement in strengthening Health Infrastructure and augmenting health HR in tribal areas. Comparative data as per Rural Health Survey (RHS) 2007 and 2015 is attached as* Annexure-G. *This indicates that there is an improvement in access to healthcare.*

Recommendation/ Observation (Para 2.36)

2.28 *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.

Action Taken

2.29 Public Health being a State subject, under the National Health Mission, the Central Government provides support to the States/UTs for strengthening their healthcare systems including for health infrastructure and augmenting health human resource on contractual basis based on the requirements posed by the States/UTs in their Programme Implementation Plans.

2.30 Under NHM many measures have been taken to ensure access to quality healthcare services in tribal areas such as:

- Relaxed population norms for hilly and tribal Areas norms for infrastructure

Public Health Facility	Plain Area	Hilly/ Tribal/ Difficult Area
Sub Centre (SC)	5,000	3,000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

- A new norm for setting up a Sub Health Centre (SHC) based on 'time to care' within 30 minutes by walk from a habitation has been adopted for selected district of hilly and desert areas. This new norm was adopted keeping in mind the wide dispersal of population coupled with difficult terrain.
- While other states can utilize only up to 25% of NHM resource earmarked for infrastructure under NHM, in tribal areas, the ceiling is enhanced to 33%.
- Norms For Human resource. ASHAs, Mobile Medical Units (MMUs) etc. under NHM are relaxed for tribal and hilly areas.
- Under NHM, all tribal majority districts whose composite health index is below the State average have been identified as High Priority Districts (HPDs) and these districts are expected to receive more resources under the NHM as compared to the rest of the districts in the State. These districts also receive focused attention, supportive supervision and allowed innovative approaches.

- Many of the tribal districts are already designated as High Priority districts.
- The other tribal districts whose health indices are better than states average are also categorized as Special Focus Districts that are to receive focused attention and allowed innovative approaches to address their special healthcare needs.
- The additional funds and focused attention is ensuring that health facilities in tribal areas get strengthened on priority.
- A letter has also been sent to all concerned States to make health facilities, particularly those in tribal areas functional on priority.
- Over 16000 ambulances have been approved for effective referral transport in States with high tribal population. Further all the Sates/UTs have notified policies to provide free essential drugs free of cost in public health facilities.

Recommendation/ Observation (Para 2.37)

2.31 *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.*

Action Taken

2.32 To operationalise FRUs on priority basis States were repeatedly requested:-

1. To conduct rational deployment of HR.
2. Skill based training to MBBS doctors (LSAS & EmOC)
3. To conduct campus recruitment based on negotiable remuneration
4. Empanelment / in-sourcing of private specialist basically in area where in house resources are inadequate, difficult area allowance, performance based incentives.

UTILIZATION CERTIFICATES (UCs)

Recommendation/ Observation **(**Para 2.38, 2.39 & 2.40)

2.33 *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-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

2.34 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-8

as on 03/03/2016

Sl. No.	Schemes	No.	Amount (₹)
	NRHM-RCH Flexible Pool (2005-2010)	0	0
	NRHM-RCH Flexible Pool (2010-2015)	58	10.20
	Total	58	102.09
	RCH Flexible Pool (2005-	2	.21
	RC IT Flexible Pool (2010-	86	177.41
	TOTAL	88	17,76,37,80,981

Table-9

as on 03/03/2016

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

Sl. No.	2013-14				2014-15				Total Amt.
	Release	Exp	Amt. of UC Reed.	Amt. of UC pending	Release	Exp	Amt. of UC Reed.	Amt. of UC pending	of UC pending
TOTAL	662.23	10.13	10.13	652.10	1345.82	436.31	395.43	954.22	1606.32

2.35 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.

Action Taken

2.36 There is a significant progress in the settlement of UCs and under the NRHM - RCH Flexible Pool during the period of last 10 years. A total number of 146 UCs amounting to ₹ 2,797.28 Crore are in the process of settlement. The copy of the pending UCs is annexed at Annexure-H.

2.37 It is further submitted that there is no pending UCs related to the F.Y. - 2005.

2.38 The Department is very serious about early settlement of UCs. It is ensured that, the funds / Grant in aids are released to States/UTs only after receiving the UCs of the previous year by the Ministry keeping in view GFR provisions. Accordingly, UCs from all the State Health Societies have been received up to 2014-15. and these are in the process of settlement in the Ministry.

2.39 Under NHM, the following corrective measures have been taken to ensure proper implementation of schemes and proper utilization of funds:

(i) Release of subsequent installments is based on the extent of utilization of earlier funds released,

(ii) Settlement of UCs by organizing camps at Ministry,

(iii) Senior officer's visit to the States/UTs for monitoring and collection of pending UCs,

(iv) Audit by the Department of Comptroller and Auditor General (CAG) under NHM,

(v) Annual Statutory Audits by CAG empanelled major CA firms,

(vi) Concurrent Audits;

(vii) Institute of Public Auditors of India (IPAI) has conducted performance review audit to review financial aspects of NHM,

(viii) Implementation of Public Financial Management System (PFMS) in NHM to track flow of Funds.

III. **NRHM-RCH FLEXIBLE POOL**

Recommendation/ Observation (Para 3.8, 3.9 & 3.10)

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

11 States have achievedMDG4 (U5MR <42 per 1000 live births)	Andhra Pradesh, Delhi, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Maharashtra,
7 States have higher U5MR than national average (49)	Assam (75), Madhya Pradesh (69), Odisha (66), UttarPradesh (64), Rajasthan (57), Bihar

- 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–10

Country	U5MR in	U5MR in	MDG-4
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 expectionally high in 1990 with 556 women dying during child birth per hundred thousand live births. Approximately 1.38 lakh women were dying every 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–11

Country	MDG-5		
	MMR in 1990	MMR in 2015	MDG-5
Banaladesh	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)

2.41 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.

2.42 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.

Action Taken

Reducing Infant Mortality Rate

2.43 The Government of India is implementing the following interventions under the National Health Mission (NHM) all across the country to reduce child mortality:

(i) Strengthening of delivery points for providing comprehensive and quality Reproductive, maternal, newborn, Child and Adolescent Health (RMNCH+A) Services, ensuring essential newborn care at all delivery points, establishment of Special Newborn Care Units (SNCU), Newborn Stabilization Units (NBSU) and Kangaroo Mother Care (KMC) units for care of sick and small babies. Home Based Newborn Care (HBNC) is being provided by ASHAs to improve child rearing practices. India Newborn Action Plan (INAP) was launched in 2014 to make concerted efforts towards attainment of the goals of "Single Digit Neonatal Mortality Rate" and "Single Digit Stillbirth Rate", by 2030.

(ii) Early initiation and exclusive breastfeeding for first six months and appropriate Infant and Young Child Feeding (IYCF) practices are promoted in convergence with Ministry of Women and Child Development. Village Health and Nutrition Days (VFINDs) are observed for provision of maternal and child health services and creating awareness on maternal and child care including health and nutrition education.

(iii) Universal Immunization Programme (UIP) is being supported to provide vaccination to children against many life threatening diseases such as Tuberculosis, Diphtheria, Pertussis, Polio, Tetanus, Hepatitis B and Measles. Pentavalent vaccine has been introduced all across the country and "Mission Indradhanush" has been launched to fully immunize more than 89 lakh children who are either unvaccinated or partially vaccinated; those that have not been covered during the rounds of routine immunization for various reasons.

(iv) Name based tracking of mothers and children till two years of age (Mother and Child Tracking System) is done to ensure complete antenatal, intranatal, postnatal care and complete immunization as per schedule.

(v) Rashtriya Bal Swasthya Karyakram (RBSK) for health screening, early detection of birth defects, diseases, deficiencies, development delays including disability and early intervention services has been operationalized to provide comprehensive care to all the children in the age group of 0-18 years in the community.

(vi) Some other important interventions are Iron and folic acid (IFA) supplementation for the prevention of anaemia among the vulnerable age groups, annual deworming on National Deworming Day (NDD), home visit by ASHAs to promote exclusive breast feeding and promote use of ORS and Zinc for management of diarrhoea in children.

(vii) Government of India has adopted the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (RMNCH+A) to improve maternal and child health outcomes. The RMNCH+A strategy recognizes that child health and survival is inextricably linked to women's health across all life stages. Besides this, 184 high priority districts with relatively weaker status of maternal and child health indicators have been identified, for the intensification of RMNCH+A efforts.

Reducing Maternal Mortality Ratio

2.44 As per the UN Inter-Agency Expert Group's MMR estimates in the publication "Trends in Maternal Mortality: 1990 to 2015", MMR of Brazil, Thailand and Srilanka is placed below, which indicates that India has a high MMR compared to Brazil, Thailand and Srilanka:

Sl. No.	Country	MMR
1	Sri Lanka	30
2	India	174
3	Brazil	44
4	Thailand	20

2.45 As far as addressing fundamental issues in bringing accelerated pace of decline in MMR is concerned, these are quality ante-natal care, high home deliveries in certain pockets and operationalization of FRUs for provision of emergency obstetric care services. Most of these fundamental issues need to be addressed by the State, as Health is a state subject.

2.46 MOHFW under NHM has taken several steps to address these issues including other measures for a faster pace of decline of MMR so as to achieve India's commitment for achieving the Sustainable Development Goal of reducing MMR to 70 per 100,000 live births by 2030 *i.e.* post MDG which are as under :

- Janani Suraksha Yojana (JSY), a demand promotion and conditional cash transfer scheme for promoting institutional delivery was launched in April 2005 with the objective of reducing Maternal and Infant Mortality. It has been lauded as a successful scheme bringing about a surge in institutional deliveries since its launch. Institutional deliveries in India have risen sharply from 47% in 2007-8 to over 78.7% in 2013-14 while Safe delivery has simultaneously climbed from 52.7% to 81.1% in the same period.

- Building on the phenomenal progress of this safe motherhood scheme, another major initiative "Janani Shishu Suraksha Karyakram" (JSSK) was launched in June 2011 to eliminate out-of-pocket expenses for both pregnant women and sick neonates. Under JSSK, every pregnant woman is entitled to free delivery, including caesarean section, in public health institutions. This includes absolutely free to and fro transport between home and institution, diagnostics, medicines, other consumables, food and blood, if required. The scheme has been expanded to cover sick infants up to one year of age and cases of ante natal and post-natal complications as well.

- For ensuring fast tracking of operationalization of FRUs, a D.O letter from Secretary (H&FW) dated 28th April, 2015 has gone to the states giving key steps to be taken such as Appropriate Planning, Placing of HR, operationalization of Blood Storage/ Blood Bank, Infrastructure upgradation, equipment's and drugs and Supervision and monitoring which needs to be

implemented by the State. DO letters from JS(Policy) and AS& MD(NHM) has also gone to the states regarding operationalization of FRUs through appropriate planning and also addressing HR related issues by adopting campus recruitment, hard area and performance linked incentives to specialists, in-sourcing of specialist, empaneling not for profit institutions and hiring of private anesthetists to conduct C-sections for management of obstetric complications under JSY.

- Establishing Maternal and Child Health (MCH) Wings at high caseload facilities to improve the quality of care provided to mothers and children.
- Engagement of approximately 9.15 lakh Accredited Social Health Activists (ASHAs) to facilitate accessing of health care services by the community, particularly pregnant women.
- Maternal Death Review (MDR) is being implemented across the country both at facilities and in the community. The purpose is to take corrective action at appropriate levels and improve the quality of obstetric care.
- Comprehensive abortion care is being provided as it is an important element in the reproductive health component of the RMNCH+A strategy as 8% of maternal deaths in India are attributed to unsafe abortions.
- Care for Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) is being provided at health facilities as they constitute an important public health problem in India as studies suggest that 6% of the adult population in India is infected with one or more RTI/ STI. Syndromic case management is being provided at the appropriate level delivery points. A policy decision has been taken for universal testing of HIV and syphilis in pregnant women.
- Monthly Village Health and Nutrition Days (VHND) as an outreach activity is done at Anganwadi centers for provision of maternal and child care including nutrition in convergence with the ICDS. In 2014-15, more than 80 lakhs VHNDs were conducted in the States & UTs.
- Prevention & Control of Anemia: Under the National Iron+ Initiative, for prevention and control of anemia in pregnant and lactating women, iron and folic acid (IFA) supplementation is being given at health facilities and during outreach activities. IFA is now being given for six months during ANC and six months in the PNC period.
- States have also been directed for line listing and tracking of high risk and severely anemic pregnant women by name for their timely management at health facilities.
- A joint Mother and Child Protection Card of Ministry of Health & Family Welfare and Ministry of Women and Child Development (MOWCD) is being used by all states as a tool for monitoring and improving the quality of MCH and Nutrition interventions.
- Capacity building of MBBS doctors in Anesthesia (Life Saving Anesthesia Skills -LSAS) and Emergency Obstetric Care including C-section (EmOC) skills to overcome the shortage of

specialists in these disciplines, particularly in rural areas and Skilled Birth Attendants training of Staff Nurses/Auxiliary Nurse Midwives/Lady Health Visitors for improving quality in care during pregnancy and childbirth.

- "Prevention of PPH through Community based advance distribution of Misoprostol" by ASFIAs/ ANMs has been launched for high home delivery districts.
- Setting up of Skill Labs with earmarked skill stations for different training programs to enhance the quality of training and strengthen the quality of capacity building of different cadres of service providers in the states. Guidelines and training modules of skill labs have been disseminated to the States. National Skill labs are now operational for conducting training of traine₹
- Regular IEC/BCC is done including messages on early registration for ANC regular ANC, institutional delivery, nutrition, care during pregnancy, delay in age of marriage, counselling for sexual and reproductive health for adolescents etc.
- To further accelerate the pace of decline in MMR and improving quality of ante-natal care, new guidelines have been prepared and disseminated to the states for screening for diagnosis & management of gestational diabetes mellitus, hypothyroidism during pregnancy, training of General Surgeons for performing Caesarean Section, Calcium supplementation during pregnancy and lactation, de-worming during pregnancy, Maternal Near Miss Review, screening for syphilis during pregnancy, standardization of Labor rooms at Delivery points, training manual for facilitators and training manual for participants for the Daksh Skills Lab for RMNCH+A services and Dakshata guidelines for strengthening intra-partum care.
- Guidance note on use of uterotonics during labor, Guidance note on prevention and management of postpartum hemorrhage and Guidance note on Birth Companion have been released to the States which will further improve quality in service delivery during intrapartum and post-partum care.
- These interventions when rolled out will further accelerate the pace of decline of maternal morbidity and mortality and will also help fulfil India's commitment to the latest UN target for the Sustainable Development Goals for MMR at 70 per 100,000 live births by 2030.

Recommendation/ Observation

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

2.48 *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.*

2.49 *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 those states which have high TFR. (Para 3.11, 3.12 & 3.13)

Action Taken

2.50 India's TFR as per SRS 2013 is 2.3. 24 States/UT have already achieved replacement TFR. The momentum for population growth has declined sharply as evident from the Census figures. NFHS III (2005-06) figures also shows that the wanted fertility is 1.9. Declining growth rates and averting unwanted fertility may accelerate the process of population stabilization in the country.

STRATEGIES ADOPTED TO ACHIEVE POPULATION STABILIZATION

On-going Interventions under Family Planning Programme

- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees in all state and districts.
- Increasing male participation and promotion of 'Non Scalpel Vasectomy".
- 'National Family Planning Indemnity Scheme' (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.
- Compensation scheme for sterilization acceptors -under the scheme MoHFW provides compensation for loss of wages to the beneficiary on account of undergoing sterilisation. The scheme has been recently enhanced for 11 high focus states (8 EAG+ Assam+ Gujarat+ Haryana)
- Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.
- Improving contraceptives supply management up to peripheral facilities
- A rational human resource development plan is in place for provision of IUCD, Mini lap and NSV to empower the facilities (DH, CFIC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Emphasis on Minilap Tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/ surgeons.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.

2.51 **New interventions under Family Planning**

(1) The packaging for Condoms, OCPs and ECPs has now been improved and redesigned so as to influence the demand for these commodities.

(2) The current basket of choice has been expanded to include the new contraceptives *viz.* Injectable contraceptive DMPA, Centchroman and Progrsterone Only Pills (POP).

(3) To increase the demand for family planning, new Family Planning media campaign (with Shri Amitabh Bachchan as a brand ambassador) has also been launched.

(4) Promotion of IUCDs as a short & long term spacing method - Introduction of Cu IUCD-375 (5 years effectivity) under the Family Planning Programme.

(5) Emphasis on Postpartum Family Planning (PPFP) services with introduction of PPIUCD and promotion of minilap as the main mode of providing sterilization in the form of post-partum sterilization to capitalize on the huge cases coming in for institutional delivery under JSY.

(6) Appointment of dedicated RMNCH+A counsellors at high case load facilities.

(7) Assured delivery of family planning services - In last four years states have shown their commitment to strengthen fixed day family planning services for both IUCD and sterilization.

(8) Scheme for Home delivery of contraceptives by ASHAs at doorstep of beneficiaries has been expanded to the entire country *w.e.f.* 17th Dec, 2012.

(9) Scheme for ASHAs to ensure spacing in births:

(a) Under the scheme, services of ASHAs are being utilised for counselling newly married couples to ensure delay of 2 years in birth after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child.

(b) The scheme is being implemented in 18 states of the country (8 EAG, 8 North East, Gujarat and Haryana). Additionally the spacing component has been approved in West Bengal, Karnataka, Andhra Pradesh, Telangana, Maharashtra, Daman Diu and Dadra and Nagar Haveli

10. Celebration of World Population Day & fortnight (July 11 - July 24):

(a) The World Population Day celebration is a step to boost Family Planning efforts all over the country.

(b) The event is observed over a month long period, split into an initial fortnight of mobilization/ sensitization followed by a fortnight of assured family planning service delivery.

1. June 27 to July 10: "Dampati Sampark Pakhwada" or "Mobilisation Fortnight"

2. July 11 to July 24 "Jansankhya Sthirtha Pakhwada" or "Population Stabilisation Fortnight"

2.52 **Following strategies have been adopted by Jansankhya Sthirata Kosh/National Population Stabilization fund as population control measures:**

- **Prerna Strategy:-** JSK has launched this strategy for helping to push up the age of marriage of girls and delay in birth of first child and spacing in birth of second child in the interest of

health of young mothers and infants. The couple who adopt this strategy are awarded suitably. This helps to change the mindsets of the community.

- **Santushti Strategy:-** Under this strategy, Jansankhya Sthirata Kosh, invites private sector gynaecologists and vasectomy surgeons to conduct sterilization operations in Public Private Partnership mode. The private hospitals/nursing home who achieved target of 10/per month or more are suitably awarded as per strategy.

- **National Helpline:-** JSK is also running a call centers for providing free advice on reproductive health, family planning, maternal health and child health etc. Toll free no. is 1800116555.

2.53 Government of India is already promoting various family planning services through the ongoing schemes like enhanced compensation scheme for sterilization, Prerna Scheme as discussed above.

B. UNIVERSAL IMMUNISATION PROGRAMME (UIP)

Recommendation/ Observation

2.54 *National Technical Advisory Group on Immunization (NTAGI) has recommended introduction of four new vaccines in routine immunization i.e. Rubella vaccine, Inactivated*

2.55 *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 3.16 & 3.17)

Action Taken

2.56 As per the recommendation of National Technical Advisory Group on Immunization (NTAGI) and the approval of Mission Steering Group (MSG), the following new vaccines were planned for introduction:

(1) **Inactivated Polio Vaccine (IPV):** By May 2016, IPV has been expanded to all States/UTs.

- In 8 states (Andhra Pradesh, Telangana, Puducherry, Tamil Nadu, Kerala, Karnataka, Odisha, Maharashtra) two fractional doses are given at 6th & 14th weeks from birth and in remaining 28 States/UTs single full dose is given at 14th weeks.
- Till May 2016, more than 46 lakh children have been vaccinated with IPV

(2) **Rota Virus vaccine:** Vaccine Introduced in 4 states (Andhra Pradesh, Haryana, Himachal Pradesh, Odisha). Till May 2016, 2,74,294 doses of RVV have been administered to children.

(3) **Adult Japanese Encephalitis (JE) vaccine:** NVBDCP had identified 21 districts in (5 districts in Assam, 7 in Uttar Pradesh and 9 in West Bengal) with high disease burden in adult population for JE vaccination. The adult JE campaign has been completed in all 21 districts. More than 2.6 crore adults have been vaccinated with JE vaccine.

(4) **Rubella vaccine:** The vaccine is planned to be introduced in the year 2017-18 as Measles-Rubella (MR) campaign targeting children in 9 months to 15 years of age group in a phased manner.

2.57 All the vaccines which have been introduced are licensed products in India. However, ICMR has been requested for evaluation of Rotavirus vaccine and WHO has been requested to evaluate IPV.

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

Recommendation/ Observation

2.58 *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)

Action Taken

2.59 NUHM was launched as a sub-mission of National Health Mission in 2013 and the details of allocation, releases, expenditure and unspent balance are given as under:-

(₹ in crores)

Year	Allocation	Release	Expt.	Unspent Balance
2013-14	1000	662.23	10.13	652.10
2014-15	1924.43	1345.82	436.43	882.39
2015-16	1386	725.00	947.37	-222.37
2016-17	950			
TOTAL	5260.43	2733.05	1393.93	1312.12

2.60 NUHM is new programme which was launched in the year 2013-14. It may be seen from the details given in the table above that so far an amount of ₹ 2733.05 crores has been released, however, as per the absorption capacity of the States with regard to the release of funds, expenditure is to the tune of ₹ 1393.93 crore. It may be stated that utilization of funds by the States under NUHM is low due to the various reasons like recruitment and positioning of HR, Operationalization of health facilities etc. Recently, D.O. letter dt. 27th May, 2016 from Joint Secretary (UH) have been sent to the Principal Secretaries of all the States/ UTs requesting to focus on major components and the accelerate the pace of utilization of funds. A video

conference with the Mission Directors of the States was also held on 14th June, 2016 by JS (UH) in this regard. Copy of the minutes are attached at **Annexure-I**. Allocation of resources would be made available under NHM as the pace of utilization improves by the States/UTs.

Recommendation/ Observation

2.61 *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)

Action Taken

2.62 With regard to the low positioning of HR under NUHM, it may be stated that the States are in the process of recruiting the new HR and all the HR sanctioned will be put in place by the States in due course. Currently, the progress is ascertained through the Quarterly Progress Report from the States which gives activity-wise progress of the activities approved under the program.

2.63 It may also be mentioned that Technical support for implementation of the programme is made available through National Health Systems Resource Centre (NHSRC). Field visits are being undertaken by officials to monitor the implementation of the program. A letter will be sent to States/ UTs to explore requirement for creation of monitoring committee at the State/District level for regular interface and ensue filling up of the vacant posts and expedite pace of the fund utilization under NUHM as it is a new programme.

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

Recommendation/ Observation

2.64 *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.*

2.65 *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 5.16 & 5.17)

Action Taken

2.66 Standard treatment guidelines for AES cases has been prepared after detailed deliberation and the same has been circulated to all the endemic states for effective management of AES cases which envisages

early diagnosis and referral of all AES cases to higher centres so that motility and disability could be minimized.

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

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

Recommendation/ Observation

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

Action Taken

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

2.69 NHM Component: This is for the support of Health Facilities [District level and below] of the states with the following components of a Dental Unit:

- Manpower support [Dentist, Dental Hygienist, Dental Assistant]
- Equipments including dental Chair
- Consumables for dental procedures

2.70 Progress in FY 2015-16 (NHM): Proposals from 29 states/UTs were received through main and supplementary PIPs demanding grants to the tune of ₹ 80.9 Crore to strengthen oral health care delivery at public health facilities. A total approval of ₹ 25.13 Crore for 26 states/UTs has been given to support proposed activities of NOHP. Grants have been released to the states/UTs under Health System Strengthening (HSS) of Mission flexipool under NHM.

Progress in FY 2015-16 (Pilot Scheme under Central component):

- Two review meeting-cum-workshop for state nodal officers have been conducted on 13th & 14th July 2015, at AIIMS, New Delhi and from 15th February to 17th February 2016 at NIHFW, New Delhi for better program implementation.
- IEC materials in the form of posters, leaflets have been developed and final approval has been obtained. 3,21,000 posters have been disseminated to 10 states e.g Rajasthan, Haryana, Madhya Pradesh, Himachal Pradesh, Gujarat, Maharashtra, Odisha, Sikkim, Nagaland & Delhi in 1st phase for wide spread awareness generation and publicity of the program.
- On the occasion of World Oral Health Day on 20th March 2016, a SMS campaign was organised for creating awareness on oral health and 5,37,00,000 SMS messages were pushed to mobile users across 22 states of the country.

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

Recommendation/ Observation

2.71 *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 inrease 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.*

2.72 *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.*

2.73 *The Committee welcomes the proposal of the Department for addition of 82 district hospitals to the Scheme (i.e. Establishment of New Medical Colleges Attached with Existing District / Referral Hospitals) 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 7.1, 7.2 & 7.3)

Action Taken

2.74 The Ministry administers a Centrally Sponsored Scheme for "Establishment of new Medical Colleges attached with existing district/referral hospital". Under this Scheme, 20 States/UTs were identified with consultation of State Governments/UT Administration to establish 58 new Medical Colleges attached with district/referral hospital. As on date, 47 districts have been approved under the scheme to establish new medical colleges and funds to the tune of ₹ 1104.73 crore have been released to the State Governments/UT Admin. Till 30.06.2016. Under this Scheme, four Medical Colleges *i.e.* at Port Blair (A&N Islands); Rajnandgaon (Chhattisgarh); Saruja (Chhattisgarh); Gondia (Maharashtra); and Nahan (Himanchal Prades) are already functional.

2.75 Draft EFC Memorandum for Expenditure Finance Committee containing proposal for Establishment of 82 New Medical College attached with Existing District Hospitals/Referral Hospitals - Phase-II during the 13 Plan Period (2017-18 to 2021-22) has been prepared and a copy has been circulated to NITI Aayog and Ministry of Finance (Deptt. of Expenditure) for their comments.

VIII. **RASHTRIYA SWASTHYA BIMA YOJANA**

Recommendation/ Observation (Para 8.9)

2.76 *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)

Action Taken

2.77 Health being a state subject, RSBY is being implemented by the State Governments through the selected Insurance companies. The responsibility of administration and effective implementation remains with the State Governments. Contractual agreement is signed between the State Nodal Agency and the selected Insurance Company. Central Government provides policy guidelines and directions. Central share on premium is released to the States as per their claim. The provisions of the GFR are adhered to while releasing central share to the State Nodal Agency.

2.78 RSBY has been transferred to Ministry of Health & Family Welfare w.e.f. 01.04.2015 from Ministry of Labour & Employment. Since then the restructuring of the scheme is under consideration of the Government of India (Gol). Gol has also made budget announcement that a NHPS would be launched during 2017-18 which would replace RSBY.

Under these circumstances, MoHFW has not made any evaluation as to ascertain to what extent the scheme has been able to promote access to healthcare and provide financial protection to the targeted families. However the number of beneficiary families enrolled category-wise against targeted families as on date is at **Annexure-J.**

IX. STERLIZATION DEATHS IN CHHATTISGARH

Recommendation/ Observation

2.79 *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.*

2.80 *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 9.1 & 9.2)

2.81 **Action Taken**

- Ensuring quality family planning services is a key strategy under National Family Planning Program. Post Chhattisgarh incident there has been re-emphasis on quality and standards for sterilization.

- Immediately after the incidence an **advisory** covering the directives to ensure hygienic conditions, adherence to regulations and safety of people undergoing the operations etc. was issued to all the states.
- Further on directions of the Hon'ble Supreme court two meetings of the state health secretaries was conducted under the chairmanship of Union Health Secretary to review the action taken by the states on the various quality parameters.
- State level orientation workshops on updated standards and guidelines for programme officers and service providers was conducted in all the states of India.
- Based on the responses and queries received from the participants a separate document on 'Frequently Asked Questions' was prepared and disseminated to all the states.
- There is a restriction on number of cases to be conducted by a surgeon in the camps and emphasis is laid on the timings of the camp for quality services.
- Each year supportive supervision visits are being carried out at National level, State Level and District level. The monitoring teams have representation from government as well as non government organizations.
- Consent forms are an integral part of any sterilization procedure and availability of the same is ensured at all levels of service delivery.
- Simultaneously the providers are being sensitized through workshops and SSVs on importance of informed consent.

CHAPTER-III

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE

II. BUDGETARY ALLOCATION

Pending Utilization Certificates

Recommendation/Observation

3.1 *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.*

3.2 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.

Action Taken

3.3 Matter of record

Further Recommendations

3.4 **The Committee, while making its recommendations in paras 2.22 and 2.23 of its 93rd Report had highlighted the fact that even the Twelfth Plan approved outlays for the Health Sector had not been allocated which impinged upon the effective delivery of health care services to the people and expected the Government to outline a roadmap for reversing this undesirable trend. Instead of addressing the concern of the Committee on the need for greater allocation of resources for the Health Sector, the Department has merely chosen to state that it is a "matter of record". The Committee therefore cannot but deprecate the cavalier manner in which the Department has formulated its reply. The Committee therefore desires that the spirit of the Committee's recommendation may be captured by way of formulating a roadmap for putting a strong case for getting the approved outlays from the Finance Ministry.**

Recommendation/Observation

3.5 *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.* (Para 2.25)

Action Taken

3.6 A Statement showing state wise increase in Health Budget in 2016-17 over last year is placed at Annexure-A.

3.7 On the basis of information made available by the States, it is observed that out of 36 States/UTs, 22 States/UTs have increased their State Health Budget by 10% or more in comparison to last financial year 2015-16.

3.8 It may further be noted that in light of revised fund sharing formula, release of subsequent instalments is contingent on State providing its share as per revised fund sharing formula against released amount. This is expected to ensure that all the States (except North East + Hill States whose state share is unchanged) provide enhanced allocation for Health.

Further Recommendations

3.9 **From the information submitted by the Ministry, it is indicated that States/ UTs like Chandigarh, Daman & Diu, Karnataka, Maharashtra, Manipur and Sikkim in the year 2016-17 have not shown any increase in their Health Budget. On the contrary, the percentage increase is showing a negative trend. No information has been provided for States/ UTs like Nagaland & Pondicherry.**

3.10 **The Committee recommends the Department to keep a close watch on the States and ask them to increase their share in Health commensurate with their increase in Revenues from time to time.**

3.11 **The Committee also observes that it is an imminent necessity in the interest of full achievement of health goals that the allocated funds indeed get spent also. It is therefore necessary on the part of the Department to undertake an effective exercise for ensuring optimal utilization of the allotted sums by States.**

III. **NRHM-RCH FLEXIBLE POOL**

Pulse Polio Immunisation

Recommendation/Observation

3.12 *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.*

3.13 *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.*

(Paras 3.21 & 3.22)

Action Taken

3.14

1. As part of commitment to Polio endgame strategy, country has introduced IPV with Gavi support.

2. In second year, the vaccine will be procured with domestic funds for which order has been given to the domestic manufacturer.

3. There is global shortage of vaccine and as bulk is produced outside India, therefore, India is also facing the problem. The domestic manufacturers have not been able to fulfill the country's requirement.

Further Recommendation

3.15 **The Committee cautions the Department to maintain strict surveillance with respect to domestic production of IPV, as shortage of IPV while switching to IPV mode would jeopardize the hard earned success in elimination of Polio. Attention should also be given to the domestic manufacturers in the form of incentives so that the country's requirement of these vaccines is fulfilled by them and the import of these vaccines is reduced gradually and stopped eventually.**

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

Integrated Disease Surveillance Project (IDSP)

Recommendation/Observation

3.16 *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.*

3.17 *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 12th Five Year Plan. The Committee desires that in the last year efforts should be made to open maximum number of labs.* (Paras 5.33 & 5.34)

Action Taken

3.18 A total of 300 district public health labs are envisaged to be developed during the 12th Plan to improve the quality of lab based surveillance data outbreak investigations. Though 222 labs. have been approved for strengthening till 2015-16, of which 111 district labs are currently functional (2015-16).

3.19 The States of Tamil Nadu, Gujarat, Punjab, Rajasthan, Kerala, Assam, Andhra Pradesh and Odisha have taken strong initiative in this activity. However in the States of J&K, Bihar, Chhattisgarh, West Bengal, Telangana, North Eastern States (except Assam), Himachal Pradesh and Uttar Pradesh, the pace of strengthening of labs has been slow due to, among others, delayed procurement and slow recruitment process. However, efforts are being made to make functional maximum number of labs in the last year of the plan period (2012-17).

Further Recommendation

3.20 **The Committee is dismayed to note the pace of work in strengthening of the District Public Health Labs. Out of the 300 such Labs envisaged only 111 district labs are functional (2015-16) of the 222 approved labs. This scheme being of vital importance has been marred by procedural glitches entailing delayed procurement and slow recruitment process. The Committee is of the firm view that this being the final year of the 12th Five Year Plan, the Ministry should make all out efforts to make functional the remaining labs by overcoming the challenges faced. Concerted efforts should be made to motivate and encourage the States like J&K, Bihar, Chhatisgarh, West Bengal, Telagana, North-East States, Himachal Pradesh and Uttar Pradesh so that they strive towards successful implementation of the project of strengthening of District Public Health Labs.**

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

National Programme for Control of Blindness

Recommendation/Observation

3.21 *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 ₹ 169.41Crore, expenditure of ₹99.67 has been reported by States/UTs till 31.12.2015.*

3.22 *The Committee observes that the fund utilisation as reported by States/UTs under the National Programme for Control of Blindness (NPCB)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.* (Paras 6.2 & 6.3)

Action Taken

3.23 NPCB is being monitored regularly at the Central and State levels to ensure maximum utilization of the allotted funds under the programme as per NPCB guidelines. State Health authorities are being regularly stressed upon to utilize the allotted budget so as to develop eye care infrastructure and also ensure regular flow of quality eye care services. Apart from periodic reports from States, the programme is also being monitored through Management Information System (MIS). During the financial year 2015-16, under the NPCB, against the approval of ₹ 169.41 crore, expenditure of ₹ 99.67 crore has been reported by the States/ UTs.

Further Recommendation

3.24 **The Committee would like the Department to realize that a more optimal utilization of funds alongwith achievement of goals projected is the need of the hour as the present utilization of**

funds is far from satisfactory which is bound to have a definite impact on the services being provided.

NATIONAL PROGRAMME FOR THE HEALTH CARE OF ELDERLY (NPHCE)

Recommendation/Observation

3.25 *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 ₹ 377.80crore 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 31.122015.*

3.26 *The Committee finds that during the financial year 2015-16 under National Programme for the Health Care of Elderly (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.* (Paras 6.10 & 6.11)

Action Taken

3.27 NPHCE is being funded under the overarching umbrella of National Health Mission within the NCD flexible pool and the approval of amount & the activities in the draft ROPs is submitted to the NHM- Division rather to States/UTs directly. A total of 227 districts of 32 States/UTs had been approved for the implementation under the Programme in the draft ROPs during financial year 2015-16. Also, the fund is being released by NHM-Division to States/UTs for the programme under the NCD flexible and Division is taking up the matter with the States/UTs for healthy utilization of the funds. However, the States/UTs have been reminded time and again through the review meetings at Central and State level to ensure the optimum utilization of funds released by the Government of India.

Further Recommendation

3.28 **The Committee is of the view that the number of aged people has increased in the past one decade due to higher life expectancy. However from the reply given by the Department only 32 of the total 227 districts had been approved in the draft ROPs during the financial year 2015-16 and further more the utilization is very slow inspite of repeated reminders to the States. The Committee recommends that 'strict instructions' instead of just 'reminders' should be issued to States to ensure proper utilization of funds.**

NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)

Recommendation/Observation

3.29 *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)".*

3.30 *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.*

3.31 *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.* (Paras 6.13, 6.14 & 6.15)

Action Taken

3.32 It may please be noted that the Legislation pertaining to amendment of COTPA -2003 was placed in the Public domain as part of the pre-legislation consultation to elicit comments of all the stakeholders including the general public.

3.33 The above said amendment proposal evoked a large number of comments from the various stakeholders and public estimated to be more than 2 lakh that too in other regional languages. Therefore, The scrutiny of these comments and examination would take considerable time, which is under process.

Further Recommendation

3.34 **As per media reports roughly one million people die in India every year due to tobacco use which is an alarming situation. The Committee is of the view that the Ministry should expedite the process of scrutiny of the comments of the stakeholders received as part of the pre-legislation consultation to the amendment of COPTA-2003 and conclude the same within specified time-frame keeping in mind the importance of the amendment which has a direct impact on the health of the population. The scrutiny and review of the consultation undertaken should be prioritized and the amended bill be brought in the Parliament as inordinate delay in completion of the consultation process is certainly not desirable.**

CHAPTER-IV

RECOMMENDATIONS/ OBSERVATIONS IN RESPECT OF WHICH FINAL REPLIES OF THE GOVERNMENT ARE STILL AWAITED

II. BUDGETARY ALLOCATION

Recommendation/Observation

4.1 *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.* (Para 2.24)

Action Taken

4.2 The recommendation of the Committee has been brought to the notice of the Ministry of Finance and their response is awaited.

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

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

Recommendation/Observation

4.3 *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 lor 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).*

4.4 *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 6.24 & 6.25)

Action Taken

4.5 Action have been taken to prepare the protocol and survey documents, seeking funds from WHO for the component relating to piloting the protocol and other formalities before launching the full survey. The results/outcomes of the study will be apprised to the Hon'ble Committee on completion of the Study.

REPORT

PART B - HEALTH SECTOR

The Report of the Committee deals with the Action taken by the Government on the recommendations contained in the Ninety-third Report of the Committee on Demands for Grants (Demand No. 42) of the Department of Health and Family Welfare for the year 2016-17.

2. Action Taken Notes (ATNs) have been received from the Government in respect of the recommendations contained in the 93rd Report. They have been categorized as follows:

(i) Recommendations/Observations in respect of which replies of the Government have been accepted by the Committee: 1.24, 1.25, 1.27, 3.5, 3.9, 3.10, 5.11, 7.3, 7.5. 8.6, 8.7, 8.8, 9.2,9.3,9.4,9.8, 10.5, 11.3, 12.25, 12.27, 12.28, 13.11, 13.12, 13.16, 13.17, 14.6, 15.5

TOTAL – 27 (Chapter-I)

(ii) Recommendations/Observations which the Committee does not desire to pursue in view of the Government's replies: 1.23, 1.26, 1.28, 1.29, 2.10, 5.12, 5.16, 10.6, 12.22, 12.24, 13.9, 13.10, 14.8, 14.11

TOTAL – 14 (Chapter-II)

(iii) Recommendations/Observations in respect of which replies of the Government have not been accepted by the Committee: 1.30, 1.31, 2.11, 2.12, 2.13, 3.8, 4.6, 5.13, 5.14, 5.15, 6.5, 6.6, 12.21, 12.23, 12.26, 14.7

TOTAL – 16 (Chapter-III)

(iv) Recommendations/observations in respect of which final replies of the Government are still awaited: Nil

TOTAL – 0 (Chapter-IV)

3. The details of the ATNs are discussed in various Chapters in the succeeding pages.

CHAPTER-I

PART-B (HEALTH SECTOR)

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE BEEN ACCEPTED BY THE COMMITTEE

I. BUDGETARY PROVISIONS

Recommendation/ Observation

1.1 *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 Yojana; 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-a-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)

Action Taken

1.2 The additional requirement for implementation of tertiary level activities under the National Mental Health Programme would be projected at the RE Stage.

1.3 One of the Schemes being administered is "Establishment of new Medical Colleges attached with district/referral hospitals". For the current financial year 2016-17, an amount of ₹445.00 crore has been allocated in B.E. 2016-17 for the above mentioned Central Sponsored Scheme and the same has been released to concerned Sates/UT. To meet the objective of the "Establishment of new Medical Colleges attached with district/referral hospitals" Scheme, the allocation of an additional amount of ₹1355 crore has been requested to Ministry of Finance during the current financial year 2016-17.

1.4 Ministry of Finance has been approached to get additional funds to the extent of ₹ 3477.00 crores in the First Batch of Supplementary Demands for Grants for 2016-17 to meet the urgent requirement of the following programmes/ schemes:-

(₹ in Crore)

FP for CD - RNTCP	360.00
CGHS*	30.00
State Drug Labs.	200.00
NRHM - RCH Flexible Pool Immunisation Prog.	500.00
ANM/GNM	100.00
FP for NCD (Dialysis & NCD Screening)	544.00
HRH - New Medical Colleges	1355.00
PGIMER, Chandigarh	72.00
Para-medical Education Instts. In States	50.00
Free Supply of Contraceptives	110.00
NACO	156.00
TOTAL	3477.00

* In addition to above, an additionality to the extent of ₹ 1964.25 Cr. has been projected towards Externally Aided Projects (EAP).

Recommendation/ Observation

1.5 *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)

Action Taken

1.6 The suggestion of the Committee has been noted for compliance.

1.7 The projection for 2016-17 has been made on the basis of agreed terms of MOU signed with concerned State/UT Governments for establishment of new medical colleges by upgrading existing District/referral hospitals under the Centrally Sponsored Scheme for "Establishment of new Medical Colleges attached with district/referral hospitals"

Recommendation/ Observation

1.8 *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)

Action Taken

1.9 Under the Scheme of Upgradation/strengthening of Nursing Services & Establishment of ANM/ GNM. 128 ANM and 137 GNM Schools have been sanctioned in those districts of 23 high focus states of the country where there is no such school. ₹ 775.241 crore has been released to states for establishment of ANM/GNM Schools as on date. The reason for less expenditure against the BE allocation is non-receipt of Utilisation Certificate from State Governments.

1.10 In the year, 2014-15, an amount of ₹ 112.5849 crore was released against BE allocation of ₹ 200.00 crore for construction of 24 ANM and 28 GNM Schools as per details at **Annexure-A.**

1.11 For the year, 2015-16 no fund were allocated under the above Scheme. However, ₹ 46.8945 crore was released from the allocated funds from NHM-HRH for construction of 17ANM and 7 GNM Schools as per details at Annexure - B.

1.12 During the financial year 2014-15, in F.E. the allocation was reduced to ₹10 crore only. Out of this allocation, the ₹10 crore were released in 2014-15 *i.e.* 100% expenditure was made against the allocated budget under the Centrally Sponsored Scheme for Strengthening and Up-gradation of State Government Medical Colleges for starting new Post raduate (PG) disciplines and increasing PG seats. For the financial year 2015-16, there was nil allocation of funds for the above Scheme.

1.13 In the financial year 2014-15 no releases were made against the approved Scheme of Setting up of State Allied Health Colleges. During financial year 2015-16 no budgetary allocation was made for the scheme.

1.14 The recommendation has been noted for guidance. The major reason for non-utilization of funds allocated to CDSCO was the delay in the recruitment of officers through the UPSC and SSC and inability to release the funds for civil works.

III. DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

Recommendation/ Observation

1.15 *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)

Action Taken

1.16 It is submitted that the matter was taken up with DUSIB, Govt. of NCT of Delhi, which has informed that the policy for rehabilitation of Jhuggi Dwellers is under preparation. Since policy framing is a long process, it may take some more time. The observations of the Committee have been noted and the matter would be pursued with the Government of NCT of Delhi.

Recommendation/ Observation

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

Table–13

Statement 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	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

Sl. No.	Head Code 2210 (PLAN)	Object Head	B.E	R.E	Expe. Upto 14-03-2016
7	400011	TA	.030	.020	.013
8	400028	Professional Service	.020	.020	0
9	400020	Other Admn. Expenses	.015	.01	0
10	400021	Supply & Materials	.075	.075	.040
11		Total	2.90	2.90	2.51
12		4210 (Plan)			
13		Machinary & Equipment	.10	.10	.001

Action Taken (Para 3.9)

1.18 Matter of record

Recommendation/ Observation

1.19 *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)

Action Taken

1.20 It is submitted that the facts given do not represent the true picture of expenditure, as under the Heads - other Charges and Medical Treatment ₹ 13 Lakh and ₹ 7.45 lakh expenditure was made. Similarly under the Head Professionals Service and other Admin. Expenses, expenditure of ₹ 17.04 Lakh and ₹ 13.60 Lakh were incurred respectively. The allocation of ₹ 1.00 Crore was not utilized because there was no capital project. However more funds will be required when approval for Hostel project is obtained from competent authority.

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

Recommendation/Observation

1.21 *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)

Action Taken

1.22 The Institute has been allocated funds of ₹700.00 crore under Plan for the Financial Year 2015-16, the head-wise allocation *vis-a-vis* provisional expenditure (upto March, 2016) are given below:

(₹ in crore)

Sl. No.	Head of Accounts	Allocation 2015-16 (RE)	Funds Released from the Ministry	Expenditure upto March, 2016
1.	Grant-in-aid Salaries	200.00	200.00	200.49
2.	Grant-in-aid General	190.00	190.00	190.00
3.	Creation of Capital Assets	310.00	310.00	330.36*

*₹ 16.04 crore from previous year.

1.23 The Institute has been allocated funds of ₹ 1000.00 crore under Plan for the current Financial Year 2016-17. All efforts will be made to ensure pace of expenditures as per quarterly targets.

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

Recommendation/ Observation

1.24 *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)

Action Taken

1.25 Approval of the Standing Finance Committee has been obtained. All procedural issues such as preparation of DPR, approval of the DPR, approval of the estimate, appointment of in-house consultant, selection of contractor/agent by in-house consultant etc. have been addressed.

1.26 These infrastructure projects are being closely monitored by the 'Project Review Committee' consisting of senior officials of the Institute and executing agency and 'Project Monitoring Committee' of the institute headed by Medical Superintendent. These projects may no witness time overruns and concurrent cost overruns.

Recommendation/ Observation

1.27 *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)

Action Taken

1.28 JIPMER is working in close coordination with the Govt, of Puducherry. The Government of Puducherry has transferred approximately 80 acres of land to the Institute for establishment of JIPMER-II at Karaikal. The land is without litigation and encroachment. The Government of Puducherry has also handed over GNM building for classroom-cum-laboratory facilities; and authorised Puducherry Housing Board to grant lease/rent for 5 years the 24 LIG and 33 MIG flats to JIPMER. Urban Health Centre is being built on JIPMER land after demolition of old building.

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

Recommendation/ Observation

1.29 *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)

Action Taken

1.30 The capital works and the equipments indicated for completion/procurement during the year 2016-17 were approved as part of the proposal of the Institute for the 12 Five Year Plan period. An allocation of ₹ 63 crore has been made under the 'Grants for creation of Capital Assets' component during the financial year 2016-17. As desired by the Committee, the procedural/administrative constraints in the implementation of the project would be addressed in time and additional budgetary requirements will be projected at the RE stage to ensure the projects are not delayed due to insufficient funds.

Recommendation/ Observation

1.31 *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.* (Para 8.7)

Action Taken

1.32 Matter of record

Recommendation/Observation

1.33 **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 N1MHANS. 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)

Action Taken

1.34 Necessary steps are being taken to fill the vacant posts.

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

Recommendation/Observation

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

Table–19

GIA	Allocation	Expenditure (As on)
Grant in Aid(Capital)	₹47.00 Cr.	₹ 16.77 Cr.
Grant in Aid (Salary)	₹88.00 Cr.	₹67.77 Cr.
Grant in Aid(General)	₹65.00Cr.	₹35.04 Cr.
TOTAL:	₹200.00 Cr.	₹l 19.58 Cr.

Action Taken (Para 9.2)

1.36 Matter of record

Recommendation/Observation

1.37 *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.* (Para 9.3)

Action Taken

1.38 Matter of record

Recommendation/Observation

1.39 *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)

Action Taken

1.40 The amount spent on account of Grant-in-Aid Creation of Capital Assets and reason for not able to spend the entire amount is as follows:

Approved Budget estimate 2015-16 (₹ in crores)	Amount spent as on 31.01.2016 (₹ in crores)	Amount spent as on 31.03.2016 2015-16 (₹ in crores)
47.00	16.77	28.91

1.41 Substantial amount was projected for the new projects both in the Budget Estimates & Revised Budget Estimates along with the procurement of Gas Manifold, but since the Tendering formalities took time for completion, the same could not be spent. However, now all the tendering processes have been completed and the same shall be placed before the next Standing Finance Committee (SFC) for obtaining approval.

Recommendation/Observation

1.42 *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)

Action Taken

1.43 Tenders were invited for the projects and Price Bids have been opened. Negotiations were held with the lowest bidder and the recommendations of the Negotiating Committee are to be placed before the SFC for approvals.

1.44 The time of completion of the MBBS College & Hostel and RCC is 30 calendar months from the date of Commencement Order for the Nursing College & Hostel is 24 Calendar Months from the date of placement of Commencement order.

1.45 In order to have an effective monitoring mechanism to obviate any possibility of time overruns and cost escalation of these projects, a Monitoring Committee will be constituted.

X. CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI

Recommendation/Observation

1.46 *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)

Action Taken

1.47 A proposal for re-development of the Institute is under consideration in this Ministry. Appropriate measures would be taken for addressing deficiencies in project formulation and implementation to avoid cost and time overruns. The Committee would be apprised of the progress of implementation of the re-development plan of CIP.

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

Recommendation/Observation

1.48 *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)

Action Taken

1.49 The progress of upgradation of RIMS has suffered due to non performance of Agency M/s RDB Realty and Infrastructure Ltd. The aforementioned Agency has been expelled by HSCC and retendering is in

process. Despite the temporary delay, the Internee Hostel has been completed and handed over to RIMS which is in use.

1.50 The total approved cost of the project related to upgradation of RIMS is 111.55 crores. The Expenditure incurred by HSCC is Rs 57.18 crores. The expected timeline for completion of Package I and Package II of Phase II Project has been re-fixed and it is estimated that the work of two packages will be completed by January 2018 and October 2017 respectively.

1.51 The cost of the proposal for creation of additional infrastructure for increasing the number of MBBS seats from 100 to 154 per annum is Rs 176.17 crores. A sum of Rs 40 crores has been released to HSCC. The stipulated time for completion of two packages of the project is January 2018.

XII. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

Recommendation/Observation

1.52 *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)

Action Taken

1.53 Government of UP has been conveyed in-principle approval for the establishment of new AIIMS at Village Khuttan, Tehsil Sadar Distt. Gorakhpur subject to examination of representation of one Sh. Raman Das wherein the representationist has highlighted certain interim orders of Hon'ble High Court, Allahabad restricting the parties in the case from creating any third party right and confirmation of encumbrance-free status of land and subject to providing the required 4-lane connectivity/approach road by the State Government.

Recommendation/Observation

1.54 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)

Action Taken

1.55 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 problem some.

1.56 The Ministry has considered the above and put in place following system to ensure adequate accountability of the local AIIMS, both in financial terms and by way of performance:

- The ERC at local AIIMS level, chaired by Director of respective AIIMS have been empowered to sanction EOT, variation, deviation etc.
- Payment activities like Running Account Bills (RA Bills) and Project Funds have been transferred to the respective AIIMS in order to ensure timely payment to the Agencies/Contractors involved in the construction work of the AIIMS for fast and smooth execution of work.
- 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.
- With a view to strengthening the hands of SEs at the local level, 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. 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.
- 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.
- 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.

1.57 The progress is also reviewed periodically.

Recommendation/Observation

1.58 *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)

Action Taken

1.59 A plan allocation of ₹ 2450 crore has been made for execution of PMSSY project under B.E. 2016-17 against the demand of ₹ 4344.76 crore. However, six new AIIMS are being mobilized to take necessary action to generate resources to meet the expenditure to be incurred to run the AIIMS to lessen the dependency on the Central Government.

XIII. CENTRAL DRUGS STANDARD CONTROL ORGANISATION (CDSCO)

Recommendation/Observation

1.60 *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)

Action Taken

1.61 The Cabinet Committee on Economic Affairs (CCEA) 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, ₹850 crore is the Central Government's share for upgrading and strengthening the Drug Regulatory system in the States. Proposals for strengthening have been requested for from all the States and 16 States have since forwarded their proposals which are being examined in the Ministry (as per Annexure-J). The Department of Expenditure has been requested to provide necessary funds for the State component at the level of Secretary, HFW. The components of the proposal relating to Central drug regulatory structures are at different stages of approval/implementation.

Recommendation/Observation

1.62 *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)

Action Taken

1.63 Action has already been taken to fill up all these vacancies (as per Annexure-K). Currently, 13 Assistant Drug Inspectors (ADI) are yet to join and their joining formalities are at different stages. With this all posts of ADIs will have been filled up. As regards Drugs Inspectors (DI), the result of written part has been declared by Union Public Service Commission (UPSC) and it would take some more time for UPSC to fill up the posts. The requisition to fill up the posts of Deputy Drugs Controller (DDC) has been sent to UPSC for convening the Departmental Promotion Committee (DPC). Similarly, offer letter had been issued to 08 DR ADCs, out of which three have since joined. The DPC proposal in respect of remaining ADCs has been sent to UPSC.

Upgradation of Sera and Vaccine Manufacturing Units

Recommendation/Observation

1.64 *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)

Action Taken

1.65 The observations of the committee are noted for compliance. The updated status of progress made with respect to upgradation work at BCGVL, Guindy, and PII, Coonoor is as follows:

1. **BCG Vaccine Laboratory, Guindy:**

    - The physical construction and validation of the facility is completed.
    - National Regulator Authority (CDSCO) team completed inspection of the facility on 30th March, 2016.
    - The rectification works on the observations made by NRA team are in progress.
    - After rectification work the initiation of Trial batch of BCG Vaccine will commence by June, 2016.

2. **Pasteur Institute of India, Coonoor:**

    - Civil work for the new GMP project was initiated in the month of June, 2013.

- All Major works of DP, Animal Experimental, Utility, Formulation, Tetanus and Microbiology Block has been completed.
- The physical construction including installation of equipments of the facility will be completed by September, 2016.

1.66 Validation activities of the equipments to be completed in March, 2017.

Recommendation/Observation

1.67 *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)

Action Taken

1.68 The observations of the committee are noted and complied by reviewing the performance of the vaccine producing Units weekly basis at the highest level in the Department of Health and Family Welfare.

XIV. **CENTRAL GOVERNMENT HEALTH SCHEME**

Recommendation/Observation

1.69 *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)

Action Taken

1.70 The updated actual expenditure as on 31.03.2016 of the funds earmarked for CGHS in 2015-16 is submitted below:

(₹ in Crore)

Head Account	B.E.	R.E.	Autual as on 31.03.2016
Non-Plan	815.00	815.00	798.11
Plan	111.00	139.00	119.77
PORB	965.00	1065.00	1058.71
TOTAL	1891	2019	1948.03

1.71 The recommendation of Hon'ble Committee is accepted. Director, CGHS has been taking periodic meetings with the Addl. Directors to ensure better utilization of funds under Plan Head during 2016-17.

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

Recommendation/Observation

1.72 *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)

Action Taken

1.73 The decision taken by NITI Aayog for providing financial assistance in the ratio 60:40 among Central and State Govt. (90:10 for North-east and hilly States and 100% Central funding for UTs) is applicable to all Programmes/ Schemes of the Government of India including the Capacity Building for developing Trauma Care facilities in Govt. Hospitals on National Highways being implemented under the aegis of this Ministry. The new sharing ratio has also been shared with all the concerned State Governments by this Ministry. The progress of the scheme is being reviewed from time to time and the Ministry is quite optimistic about the successful implementation of the scheme with the active participation of the State Governments.

CHAPTER-II

RECOMMENDATIONS/ OBSERVATIONS WHICH THE COMMITTEE DOES NOT DESIRE TO PURSUE IN VIEW OF THE GOVERNMENT'S REPLIES

I. BUDGETARY PROVISIONS

Recommendation/Observation

2.1 *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-a-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)

Action Taken

2.2 The Central allocation of funds for health sector is based inter-alia on the availability of resources and competing claims on these resources. An increase growth rate of the economy generates increased resources for funding the health sector.

2.3 As regards to gap between the total 12th Plan approved outlays for Health Sector and the sanctioned Budget in the five years of the 12th Plan period (2012-13 to 2016-17), it may be stated that the allocation made by the Planning Commission in the beginning of the Five Year Plan is indicative only. The actual plan allocation on year to year basis is made on the basis of total plan outlays as may be decided by the Ministry of Finance in consultation with the Planning Commission. Further, Annual Plan Outlays for an year are dependent on actual expenditure *vis-a-vis* physical achievement made during previous year.

Recommendation/Observation

2.4 *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)

Action Taken

2.5 Centrally Sponsored Scheme for "Establishment of new Medical Colleges attached with district/ referral hospitals" was approved in January, 2014.

2.6 During the year 2014-15, in F.E. an amount of ₹149.53 crore was allocated for Centrally Sponsored

Scheme for "Establishment of new Medical Colleges attached with district/referral hospitals" and out of this an amount of ₹ 128.53 crore was released to States based on total availability of funds.

2.7 During the year 2015-16, the budget allocation was made in the Supplementary Demands and additional amount of ₹ 199.20 crore was allocated in F.E only three days before the year closing. However, this Division succeeded in releasing the 100% of allocated.

Recommendation/Observation

2.8 *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-fmalization 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)

Action Taken

2.9 The suggestion of the Committee has been noted for compliance.

2.10 The grant-in-aid in the central sponsored schemes "Establishment of new Medical Colleges attached with district/referral hospitals" is related to Capital Assets only. During the year 2014-15, in F.E. an amount of ₹149.53.00 crore was allocated and out of this an amount of ₹ 128.53 crore was released to States.

2.11 During the year 2015-16, the budget allocation was made in the Supplementary Demands and additional amount of ₹ 199.20 crore was allocated in F.E only three days before the year closing. However, this Division succeeded in releasing the 100% of allocated amount under the Centrally Sponsored Scheme of "Establishment of new Medical Colleges attached with district/referral hospitals".

2.12 The Ministry of Finance as a proactive step has decided to review the progress on Capital Expenditure in the last month of every quarter, *i.e.* June, September, December and March accordingly.

Recommendation/Observation

2.13 *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)

Action Taken

2.14 The allocation under Health Sector for National Mental Health Programme amounting to ₹35.00 crores was fully utilized. The suggestion of the Committee has been noted for compliance in the future.

2.15 For the financial year 2015-16, no allocation of funds were made in B.E 2015-16. However, later on in the Supplementary Grants, an amount of ₹531.20 crore was allocated in 2015-16. Out of this ₹ 199.20 crore was provided in the F.E. 2015-16 itself from savings reported from other Divisions of the Ministry. The 100% expenditure was made during the financial year 2015-16.

2.16 The suggestion of the Committee has been noted for compliance.

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

Recommendation/Observation

2.17 *The Committee notes the submission of the Department that the re-development 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 re-development 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)

Action Taken

2.18 The approval of the Ministry of Finance for creation of posts has been received and sanction order for creation 408 posts has been issued vide this Ministry's letter No. A. 11013/4/2015-MH-I (Pt.) dated 2.6.216.

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

Recommendation/Observation

2.19 *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)

Action Taken

2.20 As the work of New OPD at Masjid Moth has been awarded on 10th June, 2015, physical progress achieved upto end of April. 2016 is 29% and in terms of financial progress expenditure incurred upto April, 2016 is to the tune of ₹80.30 crore. Scheduled date of completion is June, 2017. Project will be executed within the approved cost and designated time-line.

Recommendation/Observation

2.21 *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)

Action Taken

2.22 Every effort has been/is being made to fill up vacant faculty positions in phased manner. In the year 2014, 116 appointments and in the year 2015, 76 appointments were made against the vacant faculty positions. Apart from this, the Institute has advertised 91 vacant posts of Assistant Professor/Lecturer in Nursing on 2nd February, 2016. The procedure for screening of application has been started. In addition, 27 posts of Assistant Professor have also been advertised on 18th June, 2016. The advertised vacant positions include backlog vacancies as well. The selection process to fill up these vacancies will be initiated soon.

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

Recommendation/Observation

2.23 *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)

Action Taken

2.24 The suggestions of the Committee have been noted for compliance.

XII. **PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)**

Recommendation/Observation

2.25 *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)

Action Taken

2.26 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 six (06) 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 face of various complications such as non-responsive 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.

(v) 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.

(vi) The progress is also being reviewed periodically.

Recommendation/Observation

2.27 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)

Action Taken

2.28 Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) has been launched with the objective of correcting the imbalances in the availability of tertiary care Hospitals/Medical Colleges providing Super Speciality services and improving the quality of medical education in India.

2.29 Upgradation of 13 existing Govt. Medical Colleges in the first phases of PMSSY was taken up in 10 states where the States/institution(s) were unable to find adequate resources for improving the facilities for the quality medical education. In the Phase-I Upgradation programme of PMSSY, the following broad criteria were adopted for upgradation of medical college institutions:

(i) State in which new AIIMS is not being set up;

(ii) State not being served by existing Super-Speciality institutes like AIIMS, New Delhi/ PGIMER, Chandigarh/ NEIGRIHMS, Shillong.

2.30 Procurement of medical equipment for PMSSY Phase-I upgradation projects is expected to completed by September-2016.

XIII. **CENTRAL DRUGS STANDARD CONTROL ORGANISATION (CDSCO)**

Recommendation/Observation

2.31 *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)

Recommendation/Observation

2.32 *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)

Action Taken

2.33 ₹31.50 crore allocated under Capital Outlay ('Major works' and 'Machinery & Equipment') during the financial year 2015-16 could not be utilized fully as the Scheme for strengthening of Drug Regulatory System in the country was approved by Cabinet Committee on Economic Affairs (CCEA) only in the month of August, 2015. Identifying Government land for construction of CDSCO offices and labs at different locations and working out the requirement of specialised equipment, with technical specifications, identifying Procurement Support Agency, and completion of tendering processes, seeking approval of the competent authority for procurement of high end equipment. However, the processes could not be completed in time.

XIV. **CENTRAL GOVERNMENT HEALTH SCHEME**

Recommendation/Observation

2.34 *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.* (Para 14.8)

Action Taken

2.35 There is no sanctioned post of PRO under CGHS. Addl. Director, CGHS(HQ) has been appointed as nodal officer for Medical Centre at Parliament House Annexe. In addition the CMO posted at Medical Centre would provide information assistance about CGHS and medical facilities.

Recommendation/Observation

2.36 *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)

Action Taken

2.37 Government is considering a proposal for opening CGHS Wellness Centres in more locations. The proposal for opening CGHS in another city in Kerala is also included in the cities under consideration

CHAPTER-III

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE

I. BUDGETARY PROVISIONS

Recommendation/ Observation

3.1 *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)

Action taken

3.2 All the State Government have been requested to furnish the Utilisation Certificates of the released Grant-in-Aid from time to time. A Central Team was also visited to the States for monitoring the Schemes to ensure effective implementation.

3.3 Efforts are constantly made for settlement of Utilization Certificates in respect of funds released under the National Mental Health Programme in the previous years. Any subsequent release to any grantee Institution under the programme is made only after settlement of Utilization Certificates of the previous years.

3.4 Under the Central Sponsored Scheme administered in ME-II Section, an amount of ₹128.53 crore was released during the year 2014-15. For clearing the UCs, letters have been sent to all concerned authorities. In addition, this issue is being taken up regularly with State Health Secretaries during various meetings with States/UTs.

3.5 As per records of this office the position of Pending UCs as on 27.07.2016 as under:

Sl. No.	Year	No. of UCs	Amount (₹ in crore)
1	2005-2015	2,423	3186.88

Further Recommendation

3.6 **The Committee has been given to understand that 2423 UCs worth the amount ₹ 3186.88 crore are pending from 2005-2015 and the Ministry is trying its best to liquidate pending UCs and requesting State Governments to furnish UCs. The matter is also being taken up regularly with State Health Secretaries. Further, a Central Team also visited to the States for monitoring the schemes to ensure effective implementation. The Committee is of the view that the Central Team visiting the States would be in a better position to understand the problems faced by State**

Governments in furnishing UCs. The Central Team can identify the problem areas and find solution in consultation with the State Governments. Monitoring of schemes for its better implementation is essential but it should bring out the desired results in liquidation of UCs too so that further release of funds is not obstructed. Utilisation Certificate gets delayed in many states due to limited time available for work like North-Eastern States. A special provision can be made for North-Eastern States.

Recommendation/Observation

3.7 *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)

Action Taken

3.8 The requisite information in respect of RIMS, Imphal and RIPANS, Aizawl is in Annexure C.

3.9 Ministry of Health and Family Welfare is pursing the progress of implementation of these projects, on regular basis.

Further Recommendation

3.10 **The Committee notes the snail pace of the projects as more than 4 years have elapsed and the projects are at tendering stage only. The Committee feels that such long delay in providing basic facilities like hostel accommodation would indirectly have an adverse impact on the healthcare services being provided at RIMS, Imphal. The Committee, accordingly, recommends that the Department should put in dedicated timelines for completion of the projects and also a stringent monitoring mechanism to check the progress of project underway. The Department should also frame a roadmap for execution of the project and judicious utilization of the available physical and financial resources.**

Recommendation/Observation

3.11 *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. (Para 2.11)

Action Taken

3.12 CPWD has assigned the work of project of additional infrastructure of VMMC to Arinem Consultants for constructions of Lecture Halls, auditorium and Hostel at West Kidwai Nagar. CPWD has obtained the permission of DUAC, DFS and other agencies. Forest Department has rejected the application of cutting of trees, citing one reason or the other. CPWD has re-applied for permission. The matter is being pursued by Safdarjung Hospital with CPWD.

Further Recommendation

3.13 **The Committee is of the firm view that delays due to lack of requisite permission/clearance in completion of projects is not justifiable. Therefore, the Committee would like to impress upon the Department to act without further delay to ensure mobilization of the projects.**

Recommendation/Observation

3.14 *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 operationalization of the IVF lab at Safdarjung Hospital.* (Para 2.12)

Action Taken

3.15 *Infrastructure is at the end of its completion and handing over from CPWD is awaited. Supply order has been issued for procurement of general instruments such as OT tables, OT light, etc. Technical bid for Turnkey basis operation of IVF-ET Centre was opened in April, 2016. Bid evaluation meeting with external experts has been fixed.*

Further recommendation

3.16 **Operationalization of IVF lab at Safdarjung hospital is pending over last six years. The Committee recommends that since the procedural aspects are taking a considerable time in getting the project operationlised, all out efforts should be made to cut down further time loss on these accounts.**

Recommendation/Observation

3.17 *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)

Action Taken

3.18 The Safdarjung Hospital has been asked to constitute a Committee under the Chairmanship of Medical Superintendent, Safdarjung Hospital to devise an action plan for filling up of vacant posts immediately and send quarterly reports to this Directorate about the vacant and filling up of such posts.

The Committee should assess the functional requirement of the posts which is not required any more and be deleted from the total vacancy position.

The posts, which could not be filled up immediately owing to any reason, should not be kept vacant. Hospital should fill up such posts on contractual basis till regular appointments are made and a proposal may be sent to this Directorate on priority.

The posts are likely to fall vacant in the near future; i.e. about 6 months, procedure for filling up of such posts should be initiated in advance.

Further Recommendation

3.19 **The Committee is dismayed to note that uptill now, no concrete action has been taken to fill up the large number of vacant post in Group A & B of the Safdarjung Hospital. The hospital has only been asked to constitute a Committee under the Chairmanship of Medical Superintendent to devise an action plan for filling up of vacant posts. Further information about whether this Committee has been constituted or not and whether it has taken any action to accomplish its derived objective has not been shared with the Committee. The Committee is of the view that Safdarjung Hospital is an important hospital catering to patients from all over the country. Such a lackadaisical attitude towards filling up of vacant posts will seriously affect the functioning of the Hospital. The Committee is of the firm view that concerted efforts need to be made to take up the matter of filling up of vacant posts in Safdurjang Hospital on a priority basis.**

III. **DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI**

Recommendation/Observation (Para 3.8)

3.20 *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.*

Action Taken

3.21 As per Annexure D.

Further Recommendation

3.22 **On reviewing the Department's reply, the Committee feels that despite measures taken to**

fill the various posts, the situation is still not satisfactory. The Committee feels that for a hospital set up, technical staff plays crucial role in rendering healthcare services. Shortage of medical as well as non medical staff would cripple the day to day functioning of hospital and would tend to overload the existing staff. Since, Dr. Ram Manohar Lohia Hospital caters to the health care needs of a large number of people, the Committee recommends that the Department should make all out efforts to fill all the existing vacancies in stipulated time frame.

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

Recommendation/Observation

3.23 *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)

Action Taken

3.24 Subsequent to the cancellation of agreement with the contractor, after the contractor absconded the site, a proposal of revised cost estimates of the remaining work project has been prepared and under process for seeking approval of competent authority. Every effort will be made to complete the project at the earliest. In order to complete the project in time, various guarantees as mentioned in the reports of the Hon'ble Committees were taken. However, the delay of the project is mainly attributed to the financial crunch faced by the contractor, which is depended on the market and beyond control of the client. As a client, all the guarantees deposited by the Contractor have already been deposited in the public account.

Further Recommendation

3.25 **The Committee recommends that infrastructure companies which have executed large hospital projects be shortlisted for execution of projects in time.**

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

Recommendation/Observation

3.26 *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)

Action Taken

3.27 (i) The time overrun and cost overrun of 12 completed projects is given in Annexure-E.

(ii) Out of 22 projects, as on date, there are 06 projects in progress. The cost and time line of these 06 projects is given in Annexure-F.

(iii) There are 04 projects which have been abandoned/ shelved. The details are given in Annexure-G

Further Recommendation

3.28 **The Committee takes note of the on-going/ in-progress projects of AIIMS. Out of the twelve completed projects, six projects faced cost and time overruns due to reasons like increase in scope of work, retendering the work, increase in area as per the site requirement, shifting of different services etc. Keeping in view the stipulated completion dates of the ongoing projects that varies from September, 2016 to June 2020; the Committee suggest that Department should prioritize the projects on basis of the urgent needs and follow prudent approach while allocating funds for the selected projects. Also, stringent monitoring mechanisms should be kept in place and authorities be made accountable for timely completion of the projects. All the requisite approvals should be taken before putting funds into the projects to avoid unnecessary blockage of funds and subsequent time and cost overruns.**

Recommendation/Observation

3.29 *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)

Action Taken

3.30 Status of all pending/ongoing development projects at AIIMS are enclosed as Annexure-H.

Further Recommendation

3.31 **The Committee takes note of the projects under Oversight Committee head and Plan Head of AIIMS. The Surgical Block project, awarded at cost of ₹ 50.18 crore, ₹ 49.54 crore have already been spent and only 70% of the work is completed till date indicating cost escalation and delay in completion. Similarly, with trauma expansion and night shelter at trauma centre, timelines have already been passed. For all other projects expected to get completed in the year 2017-18, the Committee would like to suggest the Department to keep a check on the activities being undertaken under these projects to ensure timely completion of the projects without any cost escalations.**

Recommendation/Observation

3.32 *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)

Action Taken

3.33 The proposal of setting up of Bum Unit at AIIMS has been got approved in 211th Standing Finance Committee for award of work to the L1 bidder. Work has been awarded in May 2016.

Further Recommendation

3.34 **The matter of setting up of Burns ward at AIIMS has been pursued since long and the project has been awarded in May, 2016. The Committee now recommends the Department to be aggressive in getting the administrative and bureaucratic approvals, completing requisites formalities so as to complete the project in a time bound manner.**

VI. **POST GRADUATE INSTITUTE OF MEDICAL EDUCATION AND RESEARCH, CHANDIGARH**

Recommendation/Observation

3.35 *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 11 Five Year Plan but are nowhere close to execution even after the lapse of four years of the 121 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)

Action Taken

3.36 Updated status on the three projects are as under:-

(a) Advanced Cardiac Centre (Phase-II)

The Civil, Electrical and HVAC components pertaining to this work has already been completed and put to use.

(b) Modernization of Research A and B Block

After the approval of SFC in its meeting held on 19.08.2015, the scheme submitted by NBCC for Up-gradation of External Engineering Services of Research Block A & B has been finalised in meeting of the Monitoring Committee held on 24.2.2016. The tender document and estimate prepared by NBCC have been vetted by the department and the same are expected to be finalized shortly.

(c) Modernization of Nehru Hospital

After the approval of SFC in its meeting held on 3.12.2015, NBCC has prepared revised scheme which is being vetted by the Department.

Further Recommendations

3.37 **The Committee observes that the three projects are still lagging behind. The Committee reiterates its previous recommendation in 93rd report and suggest that Department should speed the procedural aspects like getting the estimates approved and vetted in time-bound manner so that these activities do not eat with the execution of the construction work. A strict vigil is needed to check any time and cost overruns.**

Recommendation/Observation

3.38 *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 Flouses 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)

Action Taken

3.39 Progress on various projects are as per Annexure-I

Further Recommendation

3.40 *The Committee notes that all the 9 projects are underway and no timelines have been set for 8 projects except "setting up of Satellite Centre of PGIMER at Sangrur (Punjab)". Also, the projects (iv), (v), (vi), (vii) and (viii), are at different stages of approvals. The Committee while expressing its dismay at the slow pace of progress in eight out of the nine projects recommends the department to ensure that projects at point no (ii) should be examined within a period of three months; (iii) should be scrutinized at the earliest; (iv), (vi), (vii) and (viii) should be fast tracked for approval of competent authority; (v) should be put up for*

approval of EFC within one month; and (vi) letter of acceptance may be issued without further delay. The Committee would like to be apprised of quarterly progress in each of the above referred projects.

XII. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

Recommendation/Observation

3.41 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)

Action Taken

3.42 The savings are reflected on account of strict financial discipline being enforced on construction and procurement of equipments for all the AIIMS. While construction of respective AIIMS could not achieve targeted goals during the financial years due to local site specific issues the milestone linked payment scheme being implemented in each AIIMS suffered due to above cause resulting in greater savings reflected in financial statements. However with greater emphasis on accomplishment of work and disbursal of milestone linked payments, it is expected that the data from financial year 2015-16 may show a reversal in trend.

3.43 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.

Further Recommendation

3.44 **The Committee feels that Department should not be contented with the existing structure. A constant monitoring of the agencies being engaged should be done to ensure achievement of the targets as envisaged. PMSSY being a flagship programme of the Government needs to be monitored at the highest both at the central and State Government levels. Professional agency with a proven track record may be engaged to complete the civil work in time.**

Recommendation/Observation

3.45 *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 11 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)

Action Taken

3.46 The Ministry is making all out efforts to recruit more personnel in faculty and non-faculty posts. The procedural issues are being quickened to fasten the process. Efforts are being taken to organize Institute Body and Governing Body of the AIIMS respectively. However these are conducted based on their requirements and requests. The AIIMS are not yet fully functional. As and when the functionality increases automatically these meetings will increase as per the envisaged standard.

Further Recommendation

3.47 **The Committee would like to reiterate its previous recommendation in its 93rd report and feels that shortage of staff (faculty and non-faculty) would defeat the purpose of the available infrastructure as it will remain unutilized. The delay in recruiting the workforce would eventually defer the purpose of the well constructed buildings. Therefore, the Committee suggests that the Department must complete the recruitment process as early as possible.**

Recommendation/Observation

3.48 *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)

Action Taken

3.49 Cabinet Committee on Economic Affairs (CCEA) has approved the proposal for up-gradation of the 39 medical colleges/institutions in the third phase of PMSSY (list attached) on 7th November, 2013 at an approved cost of ₹ 150 crore each (Central Contribution-₹ 120 crore and State Share-₹ 30 crore).

3.50 CPWD, HSCC(I) and HITES Ltd. have been appointed as PMSC/Executing Agencies for civil work at 39 medical colleges. HITES Ltd., a subsidiary of HLL Lifecare Ltd. has been assigned up-gradation work of 12 GMCs, HSCC (I) of 19 GMCs and CPWD in r/o 8 GMCs for civil work.

3.51 DPRs in r/o 37 GMCs out of 39 GMCs have been approved. The revised DPR in respect of Agartala GMC, Tripura received and submitted for approval of Technical Committee. Gap Analysis for Goa Medical College, Panaji approved by competent authority. However, DPR is yet to be submitted by Govt. of Goa.

3.52 Advance Project Funds @ of 3% in respect of 18 GMCs to Executing Agency HSCC (I) and in respect of 12 GMCs to Executing Agency HITES as per approved DPR for civil work and initial deposits @ 10% of approved DPRs has also been placed at the disposal of concerned Executive Engineers in CPWD. Further Advance Project Funds @ of 7% in respect of 9 GMCs to Executing Agency HSCC (I) and in respect of 9 GMCs to Executing Agency HITES as per approved contract value/cost as per moU for civil work.

3.53 MoU between Executing Agencies i.e. HSCC (I) and HITES and MoHFW has been signed on 04.12.2015. MoU between CPWD and MoHFW has also been signed on 17.03.2016.

3.54 Tenders for 34 GMCs have since been floated by concerned Executing Agencies (12 by HITES Ltd., 18 by HSCC (I) Ltd. & 4 by CPWD). Further, MoU with concerned State Government has been finalized and forwarded to concerned State Govt, for signing of the same.

3.55 Foundation stone has been laid by Hon'ble HFM in r/o (i) Assam Medical Colleges, Dibrugarh, Assam on 12.o2.2016 (ii) Guwahati Medical College, Guwahati, Assam on 21.02.2016 and (iii) Govt. TD Medical College, Alappuzha, Kerala on 20.02.2016 (iv) Gajira Raja Medical College, Gwalior, Madhya Pradesh on 28.06.2016.

3.56 Work Committee to review the progress of execution of up-gradation work under Phase III has been constituted.

3.57 Tenders for construction work have been awarded in respect of 24 GMCs (HSCC (I)-12 and HITES-10 and CPWD-2).

Further Recommendation

3.58 **Upgradation of medical colleges under PMSSY is a critical component of taking tertiary healthcare to rural masses. Innovative approach by engaging proven professional agencies which has prior experience of execution will prevent delays. The Committee recommends for speedier upgradation of medical colleges under PMSSY.**

XIV. **CENTRAL GOVERNMENT HEALTH SCHEME**

Recommendation/Observation

3.59 *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)

Action Taken

3.60 The following initiatives have been taken by the Ministry to attract GDMO's and Non-Teaching Specialist to join CGHS :

- In order to encourage more doctors to join CGHS, the posting of doctors is normally being made after due consideration of their residence/domicile.
- Promotion up to SAG level has been made time bound under the Dynamic Assured Career Scheme vide this Ministry's OM no. A.45012/2/2008-CHS.V dated 29/10/2008 (Annexure-L).
- In non-teaching sub-cadre, in order to ensure that the candidates recommended by UPSC, join at places outside Delhi, the Ministry has started sending separate requisitions to UPSC exclusively for stations outside Delhi.

3.61 In addition, Government has issued notification for enhancement of retirement age of CHS doctors up to 65 yrs w.e.f. 31.05.2016 **(Annexure-M).** At present, there are 376 GDMOs and 91 Specialists are vacant under CGHS.

Further Recommendation

3.62 **The Committee notes that there are 376 GDMOs and 91 specialists posts still lying vacant under CGHS. It appears that the Department has not made the efforts to ascertain reasons for doctors not joining CGHS post their selection as recommended by the Committee. The Department should make all out efforts to fill up all the vacancies urgently.**

CHAPTER-IV

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH FINAL REPLIES OF THE GOVERNMENT ARE STILL AWAITED

-Nil-

REPORT

PART C-NACO

The Report of the Committee deals with the Action taken by the Government on the recommendations contained in the Ninety-third Report of the Committee on Demands for Grants (Demand No.42) of the Department of Health and Family Welfare for the year 2016-17.

2. Action Taken Notes (ATNs) have been received from the Government in respect of the recommendations contained in the 93rd Report. They have been categorized as follows:

(i) Recommendations/Observations in respect of which replies of the Government have been accepted by the Committee: 1.14, 2.2

TOTAL – 2 (Chapter-I)

(ii) Recommendations/Observations which the Committee does not desire to pursue in view of the Government's replies: 1.15, 1.16, 1.17, 3.4

TOTAL – 4 (Chapter-II)

(iii) Recommendations/Observations in respect of which replies of the Government have not been accepted by the Committee: 3.5

TOTAL – 3 (Chapter-III)

(iv) Recommendations/observations in respect of which final replies of the Government are still awaited: Nil

TOTAL – Nil (Chapter-IV)

3. The details of the ATNs are discussed in various Chapters in the succeeding pages.

CHAPTER-I

PART-C (NACO)

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE BEEN ACCEPTED BY THE COMMITTEE

II. BUDGETARY ALLOCATION

Recommendation/Observation

1.1 *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 2016-17stage.* (Para 1.14)

Action Taken

1.2 National AIDS Control Organization acknowledges the support of the Committee for additional allocation of funds for effective implementation of its programmed activities to maintain the steady decline in National adult HIV prevalence in India. The actual expenditure during 2015-16 is incurred to the extent of ₹ 1601.25 crore. Requirement of appropriate additional funds will be requested at RE 2016-17 from the Ministry of Finance.

II METRO BLOOD BANKS

Recommendation/Observation

1.3 *The Committee observes that the budgetary provisions to the tunc 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)

Action Taken

1.4 Department has noted the observation of Parliamentary Standing Committee on Health & Family Welfare reiterating that there will be no further delay in implementation of the project.

1.5 It is informed that MoU have been approved by respective State Govts. Further MOU has been signed by Government of Tamil Nadu on 14.06.16 for Metro Blood Bank Project and project has since been flagged off.

CHAPTER-II

RECOMMENDATIONS/OBSERVATIONS WHICH THE COMMITTEE DOES NOT DESIRE TO PURSUE IN VIEW OF THE GOVERNMENT'S REPLIES

II. BUDGETARY ALLOCATION

Recommendation/Observation

2.1 *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)

Action Taken

2.2 Steps for settlement of the pending UCs are taken invariably, besides recommending release of the Grants in aid to SACS only after furnishing of all due UCs by them. Concern of the Committee is noted for compliance.

Recommendation/Observation

2.3 *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)

Action Taken

2.4 The concern of the Committee is noted. Efforts are afoot to liquidate the same. The amount has been brought down from ₹ 352.00 lakh to ₹ 73.33 Lakhs (Para 5.3 of 89th Report) and effort to recover the balance amount too from these NGO's with the involvement of Local Administration, are being taken. With the span of time this amount will also come down.

Recommendation/Observation

2.5 *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)

Action Taken

2.6 Concern of Committee is noted and it is submitted that all releases to SACS are made through e - payment only with direct credit of money to their bank accounts. As a result of e-transfer, funds release to SACS by NACO are credited into account of SACS immediately, thereby enabling the SACS to carry out the various plan activities smoothly.

Achievements under National AIDS Control Programme- Phase IV

Sl. No	Indicator	2016-17	
		Annual Target (2016-17)	Achievement (till July 2016)
1.	STI/RTI patients managed as per national protocol	90 lakh	25.09 lakh
2.	Blood collection in NACO supported blood bank	55 lakh	20.73 lakh
3.	Proportion of blood units collected by Voluntary blood donation in NACO Supported Blood Banks	80%	75%
4.	Clients tested for HIV (General clients)	140 lakh	57.7 lakh
5.	Pregnant Women tested for HIV	140 lakh	49.1 lakh
6.	Percentage of mothers initiated on lifelong ART and babies initiated on ARV prophylaxis (MB Pair)	90%	85%
7.	HIV-TB Cross Referrals	17 lakh	7.6 lakh
8.	New ART Centers established	5	3
9.	PLHIV on ART (Cumulative)	10.5 Lakh	9.76 lakh
10.	Opportunistic Infections treated	3 lakh	1.72 lakh
11.	Campaigns released on Mass Media - TV/Radio	3	3
12.	New Red Ribbon Clubs formed in Colleges	100	0#
13.	Persons trained under Mainstreaming training programmes	3 lakh	0.52 lakh
14.	Free Distribution of Condoms	36.6 crore Pieces	5.26 crore Pieces

Note: # achievement of RRC is zero till July 2016, as the academic session in colleges starts from July-August.

III **HIV PREVALENCE**

Recommendation/Observation

2.7 *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)

Action Taken

2.8 As the Committee themselves has noted, the NACO has taken steps to contain rising trend of HIV prevalence.

2.9 As per India HIV Estimation 2015 report, at national level adult HIV prevalence has declined from 0.34% in 2007 to 0.26% in 2015. Declining trends in adult HIV prevalence are sustained in all the high prevalence States (Andhra Pradesh & Telangana (0.94% to 0.66%), Karnataka (0.68% to 0.45%), Maharashtra (0.60% to 0.37%), Manipur (1.94% to 1.15%), Nagaland (0.98% to 0.78%) and Tamil Nadu (0.37% to 0.28%)) during 2007 to 2015.

2.10 NACO provides all the technical and financial support to all State AIDS Control Socities (SACS) including high prevalence states for better implementation of various schemes/interventions. Regular review and monitoring of the programme intervention are done for better implementation of the programme interventions.

2.11 There are 9.40 lakh People living with HIV who are being provided free ART treatment in India till March 2016.

2.12 The schemes/programs being implemented through SACS by NACO for prevention, care and treatment of HIV/AIDS patients are ensured that the benefits of the specific reaches to intended beneficiaries.

CHAPTER-III

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE

III HIV PREVALENCE

Recommendation/Observation

3.1 *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)

Action Taken

3.2 There are currently over 25000 reporting units which include around 2500 PPP model -Integrated Counselling and Testing Centres and 19 Private organization supported ART centres in the country which provide counselling and testing services and Treatment services respectively in the country. Apart from these, there are 1684 Targeted Intervention Programme implemented through Non-Governmental Organization(NGOs)/ Community Based Organization (CBOs), which provide prevention services to High Risk Groups and Bridge Population (Long Distance Trucker/ High Risk Migrants).

3.3 All the services including HIV/AIDS cases are reported from these PPP/Private/NGOs service facilities

3.4 As noted by the Parliamentary Committee 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 and a lot of data from private clinics and private hospitals is not being captured.

3.5 It might be true, however currently there is no system to collect information from all the private clinics. However, NACO as part of mainstreaming and Employer led model intervention is actively engaging private sector in prevention and treatment services of HIV/AIDS through MOUs. This may optimally reduce under-reporting of HIV/AIDS cases.

Further recommendation

The Committee observes that reliable and credible data is essential for policy planning purposes and absence of authenic statistics regarding the number of AIDS patients being treated at private health facilities would seriously hamper prevention and treatment services of NACO. The Committee, therefore, recommends that the Department should endeavour to improve data quality concerning AIDS/HIV patients being treated at private health clinics and ensure that the data received from private clinics is duly validated. (para 3.6)

CHAPTER-IV

RECOMMENDATIONS/OBSERVATION IN RESPECT OF WHICH FINAL REPLIES OF THE GOVERNMENT ARE STILL AWAITED

-NIL-

RECOMMENDATIONS/OBSERVATIONS — AT A GLANCE

Part A (NHM)

II. BUDGETARY ALLOCATION

Pending Utilization Certificates

The Committee, while making its recommendations in paras 2.22 and 2.23 of its 93rd Report had highlighted the fact that even the Twelfth Plan approved outlays for the Health Sector had not been allocated which impinged upon the effective delivery of health care services to the people and expected the Government to outline a roadmap for reversing this undesirable trend. Instead of addressing the concern of the Committee on the need for greater allocation of resources for the Health Sector, the Department has merely chosen to state that it is a "matter of record". The Committee therefore cannot but deprecate the cavalier manner in which the Department has formulated its reply. The Committee therefore desires that the spirit of the Committee's recommendation may be captured by way of formulating a roadmap for putting a strong case for getting the approved outlays from the Finance Ministry. (Para 3.4)

From the information submitted by the Ministry, it is indicated that States/ UTs like Chandigarh, Daman & Diu, Karnataka, Maharashtra, Manipur and Sikkim in the year 2016-17 have not shown any increase in their Health Budget. On the contrary, the percentage increase is showing a negative trend. No information has been provided for States/ UTs like Nagaland & Pondicherry. (Para 3.9)

The Committee recommends the Department to keep a close watch on the States and ask them to increase their share in Health commensurate with their increase in Revenues from time to time. (Para 3.10)

The Committee also observes that it is an imminent necessity in the interest of full achievement of health goals that the allocated funds indeed get spent also. It is therefore necessary on the part of the Department to undertake an effective exercise for ensuring optimal utilization of the allotted sums by States. (Para 3.11)

III. NRHM-RCH FLEXIBLE POOL

Pulse Polio Immunisation

The Committee cautions the Department to maintain strict surveillance with respect to domestic production of IPV, as shortage of IPV while switching to IPV mode would jeopardize the hard earned success in elimination of Polio. Attention should also be given to the domestic manufacturers in the form of incentives so that the country's requirement of these vaccines is fulfilled by them and the import of these vaccines is reduced gradually and stopped eventually. (Para 3.15)

V. FLEXIBLE POOL FOR COMMUNICABLE DISEASES

Integrated Disease Surveillance Project (IDSP)

The Committee is dismayed to note the pace of work in strengthening of the District Public

Health Labs. Out of the 300 such Labs envisaged only 111 district labs are functional (2015-16) of the 222 approved labs. This scheme being of vital importance has been marred by procedural glitches entailing delayed procurement and slow recruitment process. The Committee is of the firm view that this being the final year of the 12th Five Year Plan, the Ministry should make all out efforts to make functional the remaining labs by overcoming the challenges faced. Concerted efforts should be made to motivate and encourage the States like J&K, Bihar, Chhatisgarh, West Bengal, Telagana, North-East States, Himachal Pradesh and Uttar Pradesh so that they strive towards successful implementation of the project of strengthening of District Public Health Labs. (Para 3.20)

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

National Programme for Control of Blindness

The Committee would like the Department to realize that a more optimal utilization of funds alongwith achievement of goals projected is the need of the hour as the present utilization of funds is far from satisfactory which is bound to have a definite impact on the services being provided. (Para 3.24)

NATIONAL PROGRAMME FOR THE HEALTH CARE OF ELDERLY (NPHCE)

The Committee is of the view that the number of aged people has increased in the past one decade due to higher life expectancy. However from the reply given by the Department only 32 of the total 227 districts had been approved in the draft ROPs during the financial year 2015-16 and further more the utilization is very slow inspite of repeated reminders to the States. The Committee recommends that 'strict instructions' instead of just 'reminders' should be issued to States to ensure proper utilization of funds. (Para 3.28)

RECOMMENDATIONS/OBSERVATIONS — AT A GLANCE

PART B (HEALTH)

I. BUDGETARY PROVISION

The Committee has been given to understand that 2423 UCs worth the amount ₹ 3186.88 crore are pending from 2005-2015 and the Ministry is trying its best to liquidate pending UCs and requesting State Governments to furnish UCs. The matter is also being taken up regularly with State Health Secretaries. Further, a Central Team also visited to the States for monitoring the schemes to ensure effective implementation. The Committee is of the view that the Central Team visiting the States would be in a better position to understand the problems faced by State Governments in furnishing UCs. The Central Team can identify the problem areas and find solution in consultation with the State Governments. Monitoring of schemes for its better implementation is essential but it should bring out the desired results in liquidation of UCs too so that further release of funds is not obstructed. Utilisation Certificate gets delayed in many states due to limited time available for work like North-Eastern States. A special provision can be made for North-Eastern States. (Para 3.6)

The Committee notes the snail pace of the projects as more than 4 years have elapsed and the projects are at tendering stage only. The Committee feels that such long delay in providing basic facilities like hostel accommodation would indirectly have an adverse impact on the healthcare services being provided at RIMS, Imphal. The Committee, accordingly, recommends that the Department should put in dedicated timelines for completion of the projects and also a stringent monitoring mechanism to check the progress of project underway. The Department should also frame a roadmap for execution of the project and judicious utilization of the available physical and financial resources. (Para 3.10)

The Committee is of the firm view that delays due to lack of requisite permission/clearance in completion of projects is not justifiable. Therefore, the Committee would like to impress upon the Department to act without further delay to ensure mobilization of the projects. (Para 3.13)

Operationalization of IVF lab at Safdarjung hospital is pending over last six years. The Committee recommends that since the procedural aspects are taking a considerable time in getting the project operationlised, all out efforts should be made to cut down further time loss on these accounts. (Para 3.16)

The Committee is dismayed to note that uptill now, no concrete action has been taken to fill up the large number of vacant post in Group A & B of the Safdarjung Hospital. The hospital has only been asked to constitute a Committee under the Chairmanship of Medical Superintendent to devise an action plan for filling up of vacant posts. Further information about whether this Committee has been constituted or not and whether it has taken any action to accomplish its derived objective has not been shared with the Committee. The Committee is of the view that Safdarjung Hospital is an

important hospital catering to patients from all over the country. Such a lackadaisical attitude towards filling up of vacant posts will seriously affect the functioning of the Hospital. The Committee is of the firm view that concerted efforts need to be made to take up the matter of filling up of vacant posts in Safdurjang Hospital on a priority basis. (Para 3.19)

III. DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

On reviewing the Department's reply, the Committee feels that despite measures taken to fill the various posts, the situation is still not satisfactory. The Committee feels that for a hospital set up, technical staff plays crucial role in rendering healthcare services. Shortage of medical as well as non medical staff would cripple the day to day functioning of hospital and would tend to overload the existing staff. Since, Dr. Ram Manohar Lohia Hospital caters to the health care needs of a large number of people, the Committee recommends that the Department should make all out efforts to fill all the existing vacancies in stipulated time frame. (Para 3.22)

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

The Committee recommends that infrastructure companies which have executed large hospital projects be shortlisted for execution of projects in time. (Para 3.25)

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES. NEW DELHI

The Committee takes note of the on-going/ in-progress projects of AIIMS. Out of the twelve completed projects, six projects faced cost and time overruns due to reasons like increase in scope of work, retendering the work, increase in area as per the site requirement, shifting of different services etc. Keeping in view the stipulated completion dates of the ongoing projects that varies from September, 2016 to June 2020; the Committee suggest that Department should prioritize the projects on basis of the urgent needs and follow prudent approach while allocating funds for the selected projects. Also, stringent monitoring mechanisms should be kept in place and authorities be made accountable for timely completion of the projects. All the requisite approvals should be taken before putting funds into the projects to avoid unnecessary blockage of funds and subsequent time and cost overruns. (Para 3.28)

The Committee takes note of the projects under Oversight Committee head and Plan Head of AIIMS. The Surgical Block project, awarded at cost of ₹ 50.18 crore, ₹ 49.54 crore have already been spent and only 70% of the work is completed till date indicating cost escalation and delay in completion. Similarly, with trauma expansion and night shelter at trauma centre, timelines have already been passed. For all other projects expected to get completed in the year 2017-18, the Committee would like to suggest the Department to keep a check on the activities being undertaken under these projects to ensure timely completion of the projects without any cost escalations.

(Para 3.31)

The matter of setting up of Burns ward at AIIMS has been pursued since long and the project has been awarded in May, 2016. The Committee now recommends the Department to be aggressive in getting the administrative and bureaucratic approvals, completing requisites formalities so as to complete the project in a time bound manner. (Para 3.34)

VI. POST GRADUATE INSTITUTE OF MEDICAL EDUCATION AND RESEARCH, CHANDIGARH

The Committee observes that the three projects are still lagging behind. The Committee reiterates its previous recommendation in 93rd report and suggest that Department should speed the procedural aspects like getting the estimates approved and vetted in time-bound manner so that these activities do not eat with the execution of the construction work. A strict vigil is needed to check any time and cost overruns. (Para 3.37)

The Committee notes that all the 9 projects are underway and no timelines have been set for 8 projects except "setting up of Satellite Centre of PGIMER at Sangrur (Punjab)". Also, the projects (iv), (v), (vi), (vii) and (viii), are at different stages of approvals. The Committee while expressing its dismay at the slow pace of progress in eight out of the nine projects recommends the department to ensure that projects at point no (ii) should be examined within a period of three months; (iii) should be scrutinized at the earliest; (iv), (vi), (vii) and (viii) should be fast tracked for approval of competent authority; (v) should be put up for approval of EFC within one month; and (vi) letter of acceptance may be issued without further delay. The Committee would like to be apprised of quarterly progress in each of the above referred projects. (Para 3.40)

XII. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

The Committee feels that Department should not be contented with the existing structure. A constant monitoring of the agencies being engaged should be done to ensure achievement of the targets as envisaged. PMSSY being a flagship programme of the Government needs to be monitored at the highest both at the central and State Government levels. Professional agency with a proven track record may be engaged to complete the civil work in time. (Para 3.44)

The Committee would like to reiterate its previous recommendation in its 93rd report and feels that shortage of staff (faculty and non-faculty) would defeat the purpose of the available infrastructure as it will remain unutilized. The delay in recruiting the workforce would eventually defer the purpose of the well constructed buildings. Therefore, the Committee suggests that the Department must complete the recruitment process as early as possible. (Para 3.47)

Upgradation of medical colleges under PMSSY is a critical component of taking tertiary healthcare to rural masses. Innovative approach by engaging proven professional agencies which has prior experience of execution will prevent delays. The Committee recommends for speedier upgradation of medical colleges under PMSSY. (Para 3.58)

XIV. CENTRAL GOVERNMENT HEALTH SCHEME

The Committee notes that there are 376 GDMOs and 91 specialists posts still lying vacant under CGHS. It appears that the Department has not made the efforts to ascertain reasons for doctors not joining CGHS post their selection as recommended by the Committee. The Department should make all out efforts to fill up all the vacancies urgently. (Para 3.62)

RECOMMENDATION/OBSERVATION — AT A GLANCE

PART-C (NACO)

III. HIV PREVALENCE

The Committee observes that reliable and credible data is essential for policy planning purposes and absence of authentic statistics regarding the number of AIDS patients being treated at private health facilities would seriously hamper prevention and treatment services of NACO. The Committee, therefore, recommends that the Department should endeavour to improve data quality concerning AIDS/ HIV patients being treated at private health clinics and ensure that the data received from private clinics is duly validated. (Para 3.6)

MINUTES

*III

THIRD MEETING

(2016-17)

The Committee met at 3.00 P.M. on Wednesday, the 14th December, 2016 in Room No '139', First Floor, Parliament House Annexe, New Delhi.

MEMBERS PRESENT

1. Prof. Ram Gopal Yadav — *Chairman*

RAJYA SABHA

2. Shrimati Renuka Chowdhury
3. Dr. Vikas Mahatme
4. Shri Ashok Siddharth
5. Shri Gopal Narayan Singh
6. Shri K. Somaprasad
7. Dr. C.P. Thakur

LOK SABHA

8. Shri Thangso Baite
9. Dr. Ratna De (Nag)
10. Dr. Sanjay Jaiswal
11. Shri Arjunlal Meena
12. Shri Chirag Paswan
13. Shri C. R. Patil
14. Shri M.K. Raghavan
15. Dr. Manoj Rajoria
16. Shri R.K. Singh (Arrah)
17. Shri Bharat Singh
18. Shri Kanwar Singh Tanwar
19. Shrimati Rita Tarai

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* First and Second meetings of the Committee relate to other matters.

SECRETARIAT

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

Shrimati Arpana Mendiratta, *Director*

Shri Rakesh Naithani, *Joint Director*

Shri Dinesh Singh, *Joint Director*

Shrimati Harshita Shankar, *Assistant Director*

Shri Pratap Shenoy, *Committee Officer*

1. **Opening Remarks**

2. The Chairman, at the outset, welcomed the Members of the Committee and apprised them of the agenda of the meeting, *i.e.*, to consider and adopt draft 96th Report, *** and *** on the Action Taken by the Government on the recommendations/observations contained in the 93rd, *** and *** Report of the Committee on Demands for Grants (2016-17) of the Department of Health and Family Welfare, ***and ***, respectively.

II. **Consideration and adoption of draft 96th, *** and *** Reports of the Committee.**

3. The Committee then took up the consideration and adoption the draft 96th, *** and *** Reports. After some discussion Reports were adopted with some minor changes. The Committee authorized the Chairman and in his absence, Dr. Vikas Mahatme, Member, Rajya Sabha and in his absence, Shri Gopal Narayan Singh, Member, Rajya Sabha to present the 96th, *** and *** Reports in Rajya Sabha on the 15th December, 2016 and Dr. Manoj Rajoria, Member, Lok Sabha and in his absence, Shrimati Rita Tarai, Member, Lok Sabha to lay the above-said Report*** in Lok Sabha on 15th December, 2016.

III. * * *

4. * * *

5. * * *

6. The Committee then adjourned at 4.20 P.M.

*** Relate to other matters.

ANNEXURES

ANNEXURES – PART A - NHM

ANNEXURE-A

State Health Budget

(₹ in Crores)

Sl. No.	States	2015-16				2016-17				
		Plan	Non-Plan	Total	% of Increase	Plan	Non-Plan	Total	% of Increase	12th Plan Avg.
1	2	3	4	5	6	7	8	9	10	11
1.	Andaman and Nicobar Islands	287.63	73.44	361.07	92%	210.44	80.91	291.35	19%	42%
2.	Andhra Pradesh	1,986.81	3741.42	5,728.23	31%	3,170.93	2,933.73	6,103.73	7%	6%
3.	Arunachal Pradesh	302.52	337.59	640.11	69%	465.87	426.10	891.97	39%	33%
4.	.....	2,656.52	1,374.33	4,030.85	38%	not finalised				
5.	Bihar	2,363.00	2,608.67	4,971.67	-6%	5.337.18	2,897.52	8,234.70	66%	30%
6.	Chandigarh	167.07	193.07	360.14	34%	135.77	215.12	350.89	-3%	11%
7.	Chhattisgarh	2,54.01	697.40	3,239.41	21%	3,163.05	810.43	3,973.48	23%	27%
8.	Dadra and Nagar Haveli	67.35	9.89	77.24	-2%	89.82	–	89.82	16%	36%
9.	Daman and Diu	52.60	10.09	62.69	33%	42.43	11.15	53.58	-15%	13%
10.	Delhi	3,138.00	1,649.00	4,787.00	27%	3,200.00	2,059.00	5,259.00	10%	16%
11.	Goa	186.41	205.56	391.97	39%	429.45	316.06	745.51	90%	34%
12.	Gujarat	2,812 30	446,77	3,259.07	-55%	3,269 58	494.43	3.764.01	15%	9%
13.	Haryana	1,845.88	1,182.73	3,028.61	-1%	2,595.43	1,321.51	3,916.94	29%	21%
14.	Himachal Pradesh	309.01	1,099,48	1,408.49	-3%			1,944.19	38%	18%
15.	Jammu and Kashmir	144.26	1,822 10	1.966.36	4%	264.00	2,004.31	2,268.31	15%	9%
16.	Jharkhand	1,875.43	838,14	2,713.57	82%	2.129.18	920.49	3,049.67	12%	22%
17.	Karnataka	4,026.90	2,421.10	6,448.00	-3%	4,237.82	2,065.23	6,303.05	-2%	14%

1	2	3	4	5	6	7	8	9	10	11
18.	Kerala	1,457.31	3,707.48	5,164.79	14%	1,524.06	4,171.72	5,695.78	10%	16%
19.	Lakshadweep	36.50	19.97	56.47	10%	40.00	24.16	64.16	14%	5%
20.	Madhya Pradesh	2,418.69	2,289.37	4,708.06	2%	2,985.89	2,623.61	5,609.50	19%	22%
21.	Maharashtra	4,625.37	3.594.18	8,219.55	46%	3,095.34	3,817.05	6,912.39	-16%	15%
22.	Manipur	263.06	202.80	465.86	4%	389.59	–	389.59	-16%	3%
23.	Meghalaya	380.74	202.12	582.86	25%	470.00	258.88	728.88	25%	35%
24.	Mizoram	211.25	166.81	378.06	73%	226.25	188.03	414.28	10%	21%
25.	Nagaland	2.00	330.29	332.29	10%					
26.	Odisha	2,238.82	1,774.90	4,013.72	6%	2,830.30	1,941.57	4,771.87	19%	28%
27.	Pondicherry	304.95	206.28	511.23	26%		not finalised due to election			
28.	Punjab	990.82	2,143.89	3,134.71	12%	1.168.68	2,136.74	3,305.42	5%	11%
29.	Rajasthan	4,975.88	3,265.27	8,241.15	49%	6,046.14	3,491.25	9,537.39	16%	24%
30.	Sikkim	199.23	108.60	307.83	18%	169.96	115.02	284.98	-7%	5%
31.	Tamil Nadu	3,915.88	4,694.91	8,610.79	20%	3,837.37	5,233.48	9,070.85	5%	15%
32.	Telangam	2,459.01	2,472.54	4,931.55	21%	2,462.83	3,504.05	5,966.88	21%	#DIV/01
33.	Tripura	497.20	410.89	908.09	21%	464.84	252.58	717.42	21%	17%
34.	Uttar Pradesh	9,073.84	6,854.27	15,928.11	32%	11,667 92	7,877.66	19,545.58	23%	23%
35.	Uttarakhand	600.79	677.70	1,278.49	-15%	723.21	68450	1,407.71	10%	20%
36.	West Bengal	2,588.90	3,536.03	6,124.93	9%	2,999.22	3,936.73	6,935.95	13%	11%
	TOTAL	62,003.94	55,369.08	1,17,373.02	15%	69,841.65	56,813.02	1,28,598.86	10%	17%

ANNEXURE-B

State-wise information on Health Budget (Plan and Non Plan)

Sl. No.	States	2014-15				2015-16			
		Plan	Non-Plan	Total	% of Increase	Plan	Non-Plan	Total	% of Increase
1	2	3	4	5	6	7	8	9	10
1.	Andaman and Nicobar Islands	124.40	63.87	188.27	6%	168.92	70.11	239.03	27%
2.	Andhra Pradesh	1.040.70	3.322.22	4.362.92	-32%	1.986.81	3,741.42	5,728.23	31%
3.	Arunachal Pradesh	78.90	299.33	378.23	26%			384.00	2%
4.	Assam	1,717.04	1.203.03	2.920.08	46%	2.656.52	1,374.33	4,030.85	38%
5.	Bihar	2,837.48	2.425.95	5.263.43	69%	2.363.00	2,608.67	4,971.67	-6%
6.	Chandigarh	111.90	157.31	269.21	9%	176.42	191.07	367.49	37%
7.	Chhattisgarh	2,086.59	601.15	2,687.74	54%	2.435.04	707.03	3,142.07	17%
8.	Dadra and Nagar Haveli	69.88	9.24	79.12	40%	67.35	9.89	77.24	-2%
9.	Daman and Diu	38.01	9.20	47.21	37%	52.60	10.09	62.69	33%
10.	Delhi	2227.00	1546.05	3.773.05	32%	3,138.00	1,649.00	4,787.00	27%
11.	Goa	121.37	160.99	282.36	9%	186.41	205.56	391.97	39%
12.	Gujarat	5.666.90	1.563.59	7.230.49	30%	6.193.85	1,627.78	7,821.63	8%
13.	Haryana	2,006.60	1.041.48	3.048.08	36%	1,845.88	1,182.73	3,028.61	-1%
14.	Himachal Pradesh	1,451.76		1.451.76	22%	309.01	1.099.48	1,408.49	-3%
15.	Jammu and Kashmir	253.71	1.638.99	1.892.70	10%	127.44	2,429.41	2,556.85	35%
16.	Jharkhand	672.47	815.70	1,488 16	14%	1.130.00	829.78	1,959.78	32%
17.	Karnataka	4,384.28	2,260.72	6,645.00	12%	3,888.98	2,269.16	6,158.14	-7%

1	2	3	4	5	6	7	8	9	10
18.	Kerala	1,118.94	3,411.34	4,530.28	18%	1,581.64	4,018.81	5,600.45	24%
19.	Lakshadweep	33.5	18.97	52.47	4%			36.50	-30%
20.	Madhya Pradesh			4,626.83	46%			5,133.30	11%
21.	Maharashtra	2,478.57	3,147.91	5,626.48	11%	4.308.04	3,554.81	7,862.85	40%
22.	Manipur	251.82	194.42	446.24	11%	263.06	202.80	465.86	4%
23.	Meghalaya	282.06	183.82	465.88	53%	380.74	202.12	582.86	25%
24.	Mizoram	83.01	135.07	218.08	-6%	171.46	166.81	338.27	55%
25.	Nagaland	18.25	284.28	302.53	13%	2.00	330.29	332.29	10%
26.	Orissa	2.217.70	1,556.30	3,774.00	63%	2,238.82	1.774.90	4,013.72	6%
27.	Pondicherry	237.00	169.53	406.53	21%	304.95	206.28	511.23	26%
28.	Punjab	1,021.77	1,768.42	2,790.19	37%	990.82	2,143.89	3,134.71	12%
29.	Rajasthan	2,513.75	3,027.28	5,541.03	15%	6,063.72	3,352.55	9,416.27	70%
30.	Sikkim	255.33	98.68	354.01	35%	234.81	108.60	343.41	-3%
31.	Tamil Nadu	3,033.53	4,142.75	7,176.28	10%	3,729.19	4,516.22	8,245.41	15%
32.	Telangana	2,283.00	1,780.00	4,063.00	-	2,459.01	2,472.54	4,931.55	21%
33.	Tripura	435.21	317.70	752.91	35%	497.20	410.89	908.09	21%
34.	Uttar Pradesh	5,894.16	6,169.18	12,063.34	16%	9.073.84	6,854.27	15,928.11	32%
35.	Uttarakhand	600.00	900.00	1,500.00	91%	600.79	677.70	1,278.49	-15%
36.	West Bengal	2,211.06	3.430.28	5,641.34	15%	2.588.90	3,536.03	6,124.93	9%
	TOTAL	49,857.65	47,854.74	1,02,339.23	26%	62,215.22	54,535.02	1,22,304.04	20%

ANNEXURE-C

Facilities functioning as per IPHS norms (As on 31st March, 2015 - RHS Bulletin 2015)

Sl. No.	State/UT	No. of Sub Centres Functioning as per IPHS norms	No. of PHCs Functioning as per IPHS norms	No. of CHCs Functioning as per IPHS norms
1	2	3	4	5
1.	Andhra Pradesh	7659	1069	179
2.	Arunachal Pradesh	0	0	0
3.	Assam	NA	NA	NA
4.	Bihar	NA	NA	NA
5 .	Chhattisgarh	0	0	0
6.	Goa	209	21	4
7.	Gujarat#	7274	358	100
8.	Haryana	77	8	8
9.	Himachal Pradesh	0	0	0
10.	Jammu and Kashmir	NA	NA	0
11.	Jharkhand	0	0	0
12.	Karnataka	0	0	0
13.	Kerala	0	1	7
14.	Madhya Pradesh	0	0	6
15.	Maharashtra	1755	693	127
16.	Manipur^	0	0	0
17.	Meghalaya	0	0	0
18.	Mizoram	0	0	0
19.	Nagaland	0	0	0
20.	Odisha	0	NA	NA
21.	Punjab	NA	NA	NA
22.	Rajasthan	3022	555	194
23.	Sikkim	75	23	0
24.	Tamil Nadu	2854	1271	317
25.	Telangana	4863	668	114

1	2	3	4	5
26.	Tripura	208	51	14
27.	Uttarakhand	295	71	46
28.	Uttar Pradesh	0	170	134
29.	West Bengal	3230	223	155
30.	Andaman and Nicobar Islands	122	21	4
31.	Chandigarh	4	0	2
32.	Dadra and Nagar Haveli	0	7	1
33.	Daman and Diu	26	2	2
34.	Delhi	1	5	0
35.	Lakshadweep	14	4	3
36.	Puducherry	54	24	3
	ALL INDIA	31742	5245	1420

Notes:

NA: Not Available

Data for 2013 repeated

^ Data for 2013-14 repeated

* The % figure given here is based on Sub Centres with ANM Quarters

ANNEXURE -D

Facility	Number of New Construction works sanctioned in 2015-16 under NHM
Sub Health Centre (SC)	1971
Primary Health Centre (PMC)	310
Community Health Centre (CMC)	33

ANNEXURE -E

Sl. No.	Subject	Comments
(i)	Expansion of coverage of Non-Communicable Diseases programmes, the screening for which requires intensive resources at district hospitals.	(i) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was under implementation in 369 Districts as on 31.3.2015 which had been expanded to cover 468 Districts till 31.3.2016. (ii) Government of India has also approved for expansion of NPCDCS from 468 Districts to 616 Districts during 2016-17. (iii) GoI launched population based screening for Diabetes, Hypertension and Common Cancer (viz. Oral, Breast and Cervical Cancer among the population of the age of 30 years and above. Guidelines for the same have been released on 22.6.2016 to States/UTs. (iv) All the States and UTs have been requested to implement the population based screening programme and make provisions for financial assistance in their States specific PIPs. The States should ensure referral of suspected cases for confirmatory diagnosis and treatment of eligible subjects.
(ii)	Strengthening of district hospitals especially in High Priority Districts(HPDs)	In 2015-16, 24 District Hospitals approved for Strengthening in HPDs
(iii)	UHC Pilots	Rs 3.30 crore approved for UHC pilots in 7 States
(iv)	Implementation of Free Drugs and free diagnostics scheme	Operational Guidelines for the NHM Free Drugs Services Initiative were developed in consultation with States, experts and stakeholders and disseminated among States/ UTs on 2nd July, 2015. As on date, all States have notified policy to provide free essential drugs in public health facilities. 25 States have operationalised an IT enabled inventory management system to track drug availability and

Sl. No.	Subject	Comments
		minimise stock outs and wastages. In 2015-16, an amount of ₹ 3217 Crore has been approved (including kind grants). As for implementation of NHM Free Diagnostics Services Initiative, operational Guidelines for the NHM Free Diagnostics Services Initiative also issued on 2nd July, 2015. The Operational Guidelines provide an illustrative list of essential packages diagnostics tests specific to various levels of care that include 7 tests at Sub Centre level, 19 tests at PHC level, 39 tests at CHC level and 57 1tests at SDH/ DH level. Under the Janani Shishu Suraksha Karvakram (JSSK), funds were being provided to States/ UTs for providing free essential diagnostic tests for pregnant mothers and sick infants and for this an amount of ₹ 187.66 crore was provided to States in 2015-16. Further, an approval of Rs 265.01 Crore was provided to 14 States which started implementing the initiative in FY 2015-16.
(v)	Expanding the scope of primary care to make it comprehensive and develop sub-centres as first port of call.	In 2015-16, approval was given for 562 Sub-Centres for functioning as first port of call.
(vi)	Increasing availability for sub-centre in tribal & hilly areas based on time to care concept.	In 2015-16. approval given form 1000 Sub Centres based on time to care concept.

ANNEXURE -F

C.K. Mishra, IAS
Additional Secretary &
Mission Director, NHM
Telefax : 23061066, 23063809
E-mail : asmd-mohfw@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली-110011

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110011

D.O. No. L-19017/51/2016-UH
Dated the 21th June, 2016

Dear Dr. Mohan,

You are aware that immunization is one of the key interventions for protection of children from life threatening conditions, which are preventable. The Government is committed to ensuring that every child is immunized and protected. The Immunization trend has shown a decline in urban areas particularly with respect to some cf the big States as Tamil Nadu, Maharashtra etc. which have large urbanised population.

This Ministry has launched special initiatives, such as Mission indradhanush, to cover children who are either unvaccinated or partially vaccinated and those that have not been covered during the rounds of routine immunization for various reasons.

As you would appreciate that urban population under the jurisdiction of metropolitan areas may require focussed attention so as to ensure full coverage. I would request that necessary directions may be issued to officials in urban areas for extending support to officials engaged in Immunisation programme. It is essential for municipal authorities to target, particularly, the underserved population in urban areas. Your active participation in the programme will help in achieving national goals in this direction and also ensure a healthy population.

With regards,

Yours sincerely,

Sd/-
(C.K. Mishra)

Dr. B. Chandra Mohan,
Commissioner, Chennai Municipal Corporation,
Rippon Buildings,
Chennai-600003

Dr. K. Rajeswara Rao, IAS
Joint Secretary
Telefax: 23061723
e-mail: Kr.rao62@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
कमरा नं. 145-ए, निर्माण भवन,
नई दिल्ली-110011

Government of India
Ministry of Health and Family Welfare
Room No. 145-A, Nirman Bhawan,
New Delhi-110 011

D.O. No. G21011/3/2016-UH

19th May, 2016

Dear Shri Mahapatra

As you are aware National Urban Health Mission was launched during 2013-14 and funds have been released to the States/UTs during last three FY namely 2013-14, 2014-15 and 2015-16. The Ministry is in constant touch with the States/UTs for expediting activities approved under NUHM and expenditure incurred.

2. As you are aware, that as per the Financial Management Report (FMR) submitted by your State/UT for the last F.Y. 2015-16, an amount of Rs. 36.72 Crore has been utilized under NUHM. The unspent balance of Rs. 29.10 crore reflects slow pace of utilization of funds under the NUHM. You would appreciate that, in view of high unspent balance with the State/UT, it would not be possible to release further funds in the current financial year unless the pace of utilization under the programme is improved.

3. In view of this, you may like to review the reasons for the high unspent balances under the NUHM and focus on major components and pending amounts of 2013-14 and 2014-15 as a priority and to accelerate the pace of utilization of funds and reducing the unspent balances.

With warm regards

Yours sincerely,

Sd/-

(Dr. K. Rajeswara Rao)

Shri P.K. Mahapatra
Adll. Chief Secretary (H & FW),
Department of Health & Family Welfare,
Government of Haryana,
R. No. 45, 6th floor, Haryana Civil Secretariat,
Sec-1, Chandigarh - 160001

ANNEXURE-G

Health Infrastructure status in tribal areas:

Facilities	All India			Tribal Areas		
	2007	2015	% Increase	2007	2015	% Increase
CHCs	4045	5396	33.40%	754	998	32.36%
PHCs	22370	25308	13.13%	3199	3957	23.69%
SCs	145272	153655	5.77%	20682	27958	35.18%
Total	171687	184359	7.38%	24635	32913	33.60%

Health Infrastructure status in tribal areas:

	Tribal Areas	All India
Doctors in PHCs	17.8	11.9
Specialists in CHCs	84.6	81.2
Nursing Staff in PHCs & CHCs	32.22	20.5
ANMs in SCs	7.1	2.6

(Source RHS 2015)

ANNEXURE-H

Dept. of NRHM

as on 03/03/2016

Sl. No.	Schemes	No. of UCs	Amount (₹)
1	NRHM-RCH Flexible Pool (2005-2010)	0	0
	NRHM-RCH Flexible Pool (2010-2015)	58	10,20,90,65,000
	TOTAL	58	10,20,90,65,000
	RCH Flexible Pool (2005-2010)	2	2,18,50,000
	RCH Flexible Pool (2010-2015)	86	17,74,19,30,981
	TOTAL	88	17,76,37,80,981
	GRAND TOTAL	146	27,97,28,45,981

ANNEXURE-I

1. **Maharashtra:** Out of the total upspent balance of ₹ 390 crore, the State has ongoing activities of ₹ 77 crore which are under progress for construction activities. The State has committed that the expenditure of atleast ₹72 crore will be booked by the end of 2nd October.

2. **Gujarat**: The State is having the expenditure level of 61% against the available funds. The State has submitted that the total unspent balance with them is ₹ 92 crore, out of which 25 crore is for ongoing activities and the same will be booked by the end of 2nd Quarter.

3. **Karnataka:** The State is having problems in recruitment of HR and in executing the civil works in urban areas due to unavailability of land. The State has commited to expedite the procurement of drugs and the expenditure to the tune of ₹ 15 crore will be booked by the end of 1st quarter. The State is under process of exploring the ESI model for NUHM implementation.

4. **Madhya Pradesh:** The State is having utilization of 53% against the approved budget which needs to be improved.

5. **Tamil Nadu:** The State has committed that the expenditure to the tune of ₹ 15 crore will be booked by the end of lst quarter.

6. **Himachal Pradesh:** Out of the total Rs 75 lakhs unspent balance tor ongoing activities. ₹ 65 lakhs is given as advances to peripheries and the same will be booked as expenditure by the end of this quarter.

7. **Rajasthan:** The State has committed that the expenditure to the tune of ₹ 56 crore will be booked by the end of 2nd quarter. The booking is done as per norms. The HR positions will be in place within 2 months and the state has kept eight months salary provision in 61 identified cities. The pace of utilization will peimproved in coming months.

8. **Punjab:** The State is having approx. 40 crore as unspent balance, out of which ₹ 30 crore is kept for ongoing activities. The State has committed that the expendiure to the tune of approx. ₹ 32 erore will be booked by the end of October, 2016. The state had explained that the slow pace of utilization of funds is due to delay in transfer of funds from State Treasury to State Health Society by approx. three months. The state has also raised a point regarding the claim of interest on the delayed release of funds from State Treasury to State Health Society. The State was clarified that the same can be raised on Treasury as per the directions of Ministry of Finance.

9. **Uttar Pradesh:** The State has committed that the expenditure to the tune of approx ₹ 70 crore will be booked by the end of 2nd Quarter. The slow pace of utilization of funds is attributed to delay in recruitment of HR which is now completed by 80%. The selection of ASHA will also be completed shortly.

10. **Bihar:** The State has replied that all doctors and paramedical staff are recruited and the MMUs have also started functioning which will improve the utilization of funds under the programme. The State

has confirmed that the shortfall in the Slate share will be cleared within two weeks (*i.e.* by the end of June, 2016).

11. **Haryana:** The activities such as special Outreach camps etc. under NUHM could not be carried out by the State as the NUHM funds were given as loan to the NRHM RCH Flexible Pool.

    The state was advised to recoup the amount of loan from NRHM RCH Flexible Pool as the facility for diversion of funds between pools is allowed on a temporary basis by the Ministry. The State was requested to ensure that temporary loan should be given from NUHM funds ensuring that programme activities are not hampered.

12. **Goa:** The State has incurred 62% expenditure so far. They were facing problems in recruitment of HR. However, now most of the M.Os. Nurses and other paramedical staff have been recruited the expenditure from the unspent balance will improve in the next quarter as the recurring expenditure on salary, training, outreach activities etc. will progress.

13. **Chhattisgarh:** The State has not done the Planning and Mapping activity. Expenditure has been incurred by the health facilities but the booking and report of expenditure is pending due to non-submission of UCs by the concerned entities. The construction of one UPHC is under completion and the constitution of MAS is under progress which will improve the expenditure in coming months. The State raised issue regarding constitution of RKS in urban areas. The State informed that one draft has been made which they were requested to share with GoI.

14. **West Bengal:** Planning and Mapping has been completed with the Department of Science and technology. The State will complete the major HR recruitment by August. The State has also planned to have a meeting with the ULB officials every Friday of the week to increase the pace of utilisation of funds.

15. **Kerala:** The State is having 62% utilization against available funds. The State responded that there is no unspent balance with the State except for salary of staff, the State has not fulfilled DoE conditionalities for release of funds.

16. **Andhra Pradesh:** The State has not fulfilled DoE conditionalities for release of funds in 2016-17 whereas the State had stated that there is no shortfall in state share as per their records. The State may reconcile the same with FMG so that fund can be released in 2016-17. The State was also asked to improve the pace of utilization of funds under NUHM.

17. **Telangana:** The State has committed that the expenditure to the tune of approx. ₹50 crore will be booked by the end of 2nd October.

18. **Tripura:** The funds of NUHM has been mainly stuck in the infrastructure and the HR Funds can be released to the state once the DoE conditionalities for release of funds has been cleared. State committed that State share shortfall will cleared by next month.

19. **Uttarakhand:** The State having 75% utilization against available funds.

20. **Assam:** The State informed that DoE conditionalities for release of funds will be cleared. The State is having committed liabilities of approx ₹ 5 crore which will be booked by the end of 2nd Quarter.

21. **Jammu and Kashmir :** The HR recruitment is in process. The salary of NUHM staff has been withheld for two months due to non-availability of funds under NRHM-RCH Flexible Pool for payment of salary of NHM staff. It was suggested to the State that the salary of the staff should not be withheld as long as there is availability of funds under any pool.

22. **Jharkhand:** Low utilization of funds under the programme is due to the delay in recruitment of HR and the execution of infrastructure works. The State has suggested that the HR recruitment may be done through NHSRC to expedite the process.

ANNEXURE-J

RSBY Scheme: State-wise Category-wise Enrolment Status

Sl. No.	State/ Category	Targetted Families	Enrolled Families	Enrollmant Conversion Ratio
1	2	3	4	5
1	Assam	2371950	1421104	59.91
	BPL	2371950	1416325	59.71
	MNREGA		4779	
2	Bihar	13822582	6888208	49.83
	Beedi Workers	48302	0	0.00
	BPL	13774280	6888208	50.01
3	Chhattisgarh	3724030	3442749	92.45
	Beedi Workers	8428	1238	14.69
	BOCW	18250	18241	99.95
	BPL	2416841	2142759	88.66
	Domestic Workers	17995	17995	100.00
	MNREGA	1247910	1247910	100.00
	Street Vendors	14606	14606	100.00
4	Gujarat	4396654	1876628	42.68
	BOCW	41971	681	1.62
	BPL	3936371	1743635	44.30
	MNREGA	417897	131991	31.58
	Railway Porters	415	321	77.35
5	Haryana	1229850	437850	35.60
	BOCW	27936	3167	11.34
	BPL	1199447	434206	36.20
	Domestic Workers	136	45	33.09
	Street Vendors	2331	432	18.53
6	Himachal Pradesh	877763	480588	54.75
	Auto Rickshaw Pullerskshaw Drivers & Taxi Drivers	84045	2698	3.21

1	2	3	4	5
	BOCW	45078	1597	3.54
	BPL	300146	211796	70.56
	MNREGA	446515	264169	59.16
	Rag Pickers	106	0	0.00
	Sanitation Workers	406	206	50.74
	Street Vendors	1467	122	8.32
7	Jharkhand	3607743	1682894	46.65
	Auto Rickshaw Pullerskshaw Drivers & Taxi Drivers	1054	759	72.01
	Beedi Workers	24878	369	1.48
	BOCW	146997	20874	14.20
	BPL	2708922	1427827	52.71
	Domestic Workers	6935	1931	27.84
	MNRIGA	709674	226506	31.92
	Rag Pickers	739	418	56.56
	Rickshaw Pullers	1121	419	37.38
	Sanitation Workers	1106	385	34.81
	Street Vendors	6315	3406	53.94
8	Karnataka	11346934	6731881	59.33
	Beedi Workers	109924	16800	15.28
	BPL	10249114	6311503.7	61.58
	Domestic Workers	15417	6286	40.77
	MNREGA	966663	394479.3	40.81
	Rag Pickers	5454	2535	46.48
	Railway Porters	362	277	76.52
9	Kerala	2221283	2021572	91.01
	Auto Rickshaw Pullerskshaw Drivers & Taxi Drivers	3328	2808	84.38
	Beedi Workers	9246	8650	93.55
	BPL	1180014	1048504	88.86

1	2	3	4	5
	Domestic Workers	19877	16772	84.38
	Mine Workers	373	284	76.14
	MNREGA	1001598	938823	93.73
	Rag Pickers	78	41	52.56
	Rickshaw Pullers	57	50	87.72
	Sanitation Workers	540	361	66.85
	Street Vendors	6172	5279	85.53
10	Manipur	120237	70925	58.99
	BPL	120237	70925	58.99
11	Meghalaya	479743	179185	37.35
	BOCW	1175	129	10.98
	BPL	74909	21856	29.18
	MNREGA	403659	157200	38.94
12	Mizoram	212572	152983	71.97
	BPL	120565	90309	74.90
	MNREGA	89812	61275	68.23
	Street Vendors	2195	1399	63.74
13	Orissa	6158498	4462959	72.47
	BOCW	16904	2653	15.69
	BPL	4940668	3636801	73.61
	MNREGA	1200926	823505	68.57
14	Punjab	452979	232352	51.29
	BPL	452979	232352	51.29
15	Rajasthan	3829760	1769097	72.30
	Beedi Workers	21110	8419	39.88
	BOCW	149566	28873	19.30
	MNREGA	3659084	2731805	74.66
16	Tripura	771225	492022	63.80
	BOCW	1021	366	35.85
	BPL	174064	96432	55.40

1	2	3	4	5
	Domestic Workers	350	115	32.86
	MNREGA	594295	394674	66.41
	Street Vendors	1495	435	29.10
17	Uttar Pradesh	5301377	1464242	27.62
	BPL	5301377	1464242	27.62
18	Uttarakhand	728216	285229	39.17
	BPL	718965	282482	39.29
	Domestic Workers	23	17	73.91
	MNREGA	9228	2730	29.58
19	West Bengal	11100347	6150716	55.41
	BPL	7863656	6150716	78.22
	MNREGA	3236691	0	0.00
	GRAND TOTAL	72753741	41243184	56.69

ANNEXURES – PART B – HEALTH

ANNEXURE-A

Upgradation/strengthening of Nursing Services (ANM/GNM)

2014-15

Sl. No.	State	ANM	GNM	Fund released
l.	Andhra Pradesh		3	10,13,62,500/-
2.	Arunachal Pradesh		2	6,75,75,000/-
3.	Arunachal Pradesh (2nd Instalment)	3		2,54,70,000/-
			1	1,75,75,000/-
4.	Assam	3		5,02,35,000/-
			1	3,37,87,500/-
5.	Bihar		3	10,13,62,500/-
5.	Chhattisgarh	2		3,34,90,000/-
7.	Haryana	2		3,34,90,000/-
8.	Gujarat	1		1,67,45,000/-
9.	J&K	2		3,34,90,000/-
			3	10,13,62,500/-
10.	J&K (2nd installment)	4		3,39,60,000/-
			5	8,78,75,000/-
11.	Madhya Pradesh	3		3,67,20,000/-
12.	Maharashtra		1	3,37,87,500/-
13.	Rajasthan	1		1,67,45,000/-
14.	Telangana		1	3,37,87,500/-
15.	Odisha	3		5,02,35,000/-
16.	Punjab (2nd Instalment)		5	11,78,75,000/-
17.	Rajasthan		3	9,89,19,000/-
	TOTAL	24	28	112,58,49,000/-

ANNEXURE-B

Upgradation/strengthening of Nursing Services (ANM/GNM)

2015-16

State	ANM Schools	Fund released	GNM Schools	Fund released
Jharkhand	Carhwa	1,67,45,000/-	Ranchi	3,37,87,500/-
J&K	Billawar	1,67,45,000/-	Rajouri	3,37,87,500/-
	Thanamandi	1,67,45,000/-		
	Surankote	1,67,45,000/-		
	Kokernag	1,67,45,000/-		
Bihar	Araria	1,67,45,000/-		
	Arwal	1,67,45,000/-		
Tripura	West Tripura	1,67,45,000/-		
Uttarakhand			Roorkhe	3,37,87,500/-
Andhra Pradesh	Narsapuram	1,67,45,000/-		
	Vijayawada	1,67,45,000/-		
	Kakinada	1,67,45,000/-		
Rajasthan	Pratapgarh	1,97,55,000/-	Bikaner	3,37,875,00/-
			Baran	4,50,75,000/-
Manipur			Chandel	1,75,25,000/-
			Thoubal	1,75,25,000/-
Gujarat	Patan	1,34,90,000/-		
Tamilnadu	Namakkal	82,90,000/-		
	Theni	82,90,000/-		
	Shivganga	82,90,000/-		
Chhattisgarh	Bijapur	1,13,60,000/-		
	(17 ANM)		(7 GNM)	
TOTAL		25,36,70,000/-		21,52,75,000/-
GRAND TOTAL		46,89,45,000/-		

The updated status of Para No. 1.31 in respect of:-

(i) Regional Institute of Medical Sciences (RIMS), Imphal

(ii) Regional Institute of Paramedical and Medical Sciences (RIPANS), Aizawl:

Institution	Project Name	Initial Cost of the Project	Initial targeted date of completion	Revised Targets		Remarks
				Cost Over-run	Time Over-run	
RIMS	Package-I					
	Construction of PG Gents & Ladies Hostel, UG Ladies Hostel, Nursing Hostel and Internee Hostel	₹ 75.96 Cr.	October, 2013	Expected 5%-10% more of initial cost	Retendering is under process	Agency M/s RDB Realty & Infrastructure Ltd. was expelled due to non performance, Retendering is under process
	Package - II Construction of OPD block	₹ 35.58 Cr.	August, 2013			
RIPANS	Construction of additional facilities Boys' Hostel, Library, Academic Block & Girls' Hostel etc.	₹68.69 Cr.	July, 2015	Nil	15 Months	Work slowed down due to difficult terrain, landslides and rains. Contractor is behind the schedule and being pursued for early completion. Two Blocks - Library & Boys' Hostel substantially completed and to be handed over shortly.

ANNEXURE-D

Vacancy Position HA-I Section (Ministerial Seat)

As on 01.04.2012

Sl. No.	Name of the Post	Pay Scale with Grade Pay	Sanction Strength	Filled	Vacant	SC Sanctioned	SC filled	ST Sanctioned	ST Filled
		Group 'A' (Non-CHS Posts)							
1.	Joint Director (Admn.) (₹ 12000-16500)	PB-3, 15600-39100+7600	1	0	1				
2.	Deputy Director (Admn.) (₹10000-15200)	PB-3, 15600-39100+6600	3	1	2				
3.	DLWC (C) (₹ 10000-15200)	PB-3, 15600-39100+6600	1	1	0				
		Total	5	2	3				
		GROUP- 'B' - Gazetted							
l.	Admn. Officer (₹7500-250-12000)	PB-2, 9300-34800+4800	2	2	0				
2.	Accounts Officer (₹7450-225-11500)	PB-2, 9300-34800+4800	1	1	0				
3.	Hindi Officer (₹6500-200-10500)	PB-3, 15600-39100+5400	1	1	0				
4.	Store Officer (₹6500-200-10500)	PB-2, 9300-34800+4600	1	0	1				
5.	Private Secretary (₹6500-200-10500)	PB-2, 9300-34800+4600	3	3	0				
6.	Dietician (₹6500-200-10500)	PB-2, 9300-34800+4600	5	1+1*	3	(* Contract Basis)			
7.	Scientific Assistant (₹6500-200-10500)	PB-2, 9300-34800+4600	2	0	2				
		Total	13	9	4				
		Group- 'B' Non-Gazetted							
1.	Astt.Admin/Acctts Officer (₹6500-200-10500)	PB-2, 9300-34800+4600	6(2+4)	1	5				
2.	Office Superintdt. (₹5500-175-9000)	PB-2, 9300-34800+4200	7	7	0				
3.	Steno. Grade I (Rs,5500-175-9000)	PB-2, 9300-34800+4200	3	2	1				
4.	Head Clerk (₹ 5000-8000)	PB-2, 9300-34800+4200	14	14	0				
5.	Sr. Stenographer (₹5000-150-8000)	PB-2, 9300-34800+4200	4	1	3				

6.	Junior Hindi Translator (₹5000-8000)	PB-2, 9300-34800+4200	2	1	1
		Total	30	25	5
		Group - 'C' (Clerical)			
1.	Accountant (₹ 4500-125-7000)	PB-1, 5200-20200+2800	4	0	4
2.	U.D.C. (₹4000-100-6000)	PB-1, 5200-20200+2400	43	38	5
3.	UDC (Cashier) (₹4000-100-6000)	PB-1, 5200-20200+2400	1	0	l
4.	Jr. Accountant (₹4000-100-6000)	PB-1, 5200-20200+2400	1	l	0
5.	Store Keeper (₹4000-100-6000)	PB-1, 5200-20200+2400	10	10	0
6.	LDC (Cashier)(₹3050-75-3950-80-4590)	PB-1, 5200-20200+1900	1	0	1
7.	Asstt. Superintendent (Store) (₹5000-150-8000)	PB-2, 9300-34800+4200	1	0	1
8.	Jr. Stenographer (₹4000-100-6000)	PB-1, 5200-20200+2400	4	1	3
9.	LD.C (₹3050-75-3950-80-4590)	PB-1, 5200-20200+1900	95	51	44
10.	Duplicating Machine Optr. (₹3050-75-3950-80-4590)	PB-1, 5200-20200+1900	1	0	1
11.	Cyclostyling Machine Optr. (₹3050-75-3950-80-4590)	PB-1, 5200-20200+1900	1	0	1
		TOTAL	113	62	51
Vacancy position of staff working on contract basis					
1.	LDC (₹ 7730/- per month consolidate) against the vacant posts of LDC at Sl. No.9 above.	On contract		25	
2.	Perfusionist (₹25000/- per month consolidate)			3	
3.	Cook for General Kitchen (₹6500/-per month consolidate)			6	
4.	Cook for Departmental Canteen (₹6480/- per month consolidate)			3	
		Total	176	115	61

Live vacancies in different Categories (Group-wise) as on 13.04.2012

Sl. No.	Name of the post	Sanction Strength	No. of Vacant Posts (Regular)	To be filled by Promotion/ DR	Whether DR vacancies cleared by Screening Committee	Action taken to fill up vacancies cleared by Screening Committee	Action taken on remaining vacancies	Remarks	Decision taken	Action taken
1.	Scientific Assistant Group 'B' Non-Gazetted PB-2, 9300-34800 GP.4600	2	2	DR	Newly created	Proposal sent to DGHS for filling up the post through UPSC	Not applicable	Proposal for filling up of this post has been sent to DGHS on 04.11.03 followed by reminders dated 13.05.2005, 01.07.2005, 01.09.2005, 07.12.2005, 24.01.2006, 23.02.2007, 04.03.2008, 08.05.2008 & 04.08.2008. In reference to our letter dated 04.08.08, the DGHS has informed to this office vide their letter dated 25.08.08 with the remarks that the matter was referred to UPSC. A letter was also sent to UPSC by M/o H&FW on 24.07.08 for seeking one time relaxation for filling up of these posts in absence of notified RRs. In this reference the file has been submitted on 06.10.09 for taking comments of RR Cell reg. position for framing of RRs. But this file is not returned in section till date.		
2.	Hindi Officer Group 'B' Gazetted PB-3 15600-39100 GP 5400	1	1	By Promotion/ Deputation/ DR	Not applicable	NA		DPC withheld on the advise of DGHS		The post of Hindi Officer has been filled in terms of F.R. 9(19) on officiating capacity *w.e.f.* 29.04.10 with the approval of the MS.
3.	Steno. Grade-I	3	1	Promotion failing which	Not applicable	Due to repatriation of Shri V.K. Soota, one	–	Last time this vacancy has been re-circulated on 05.06.2008 to	The file is being submitted to fill	

	Group 'B' Non-Gazetted PB-2.9300-34800 GP 4200			by deputation		vacancy is available *w.e.f.* 26.6.2006.		all Government Departments/ Organization & no one eligible application have been received.	up these posts on contract basis till regular recruitment is done.
4.	Stenographer Grade-II Group 'B' Non-gazetted PB-2 9300-34800 GP.4200	4	3	Promotion	Not applicable	Official is not available in the feeder grade.	Not applicable	A proposal for amendment in RRs has already been sent to DGHS. Reminder sent by RR Cell of this hospital.	
5.	L.D.C. (Group 'C') PB-1, 5200-20200 GP 1900	95	49	DR	No	2 Dossiers awaited from SSC		27 filled on contract basis. A letter followed by 2 reminders have been sent to SSC for filling of 49 posts.	
6	Accountant (Group 'C') PB-1, 5200-20200 GP 2800	4	4	Deputation	NA	NA	NA	Vacancy has been advertised, DPC will be convene soon	
7.	Junior Stenographer PB-2, 5200-20200 GP 2400	4	3	DR	NA	Letter has been sent to SSC for filling up of the Part	NA	Candidates awaited from SSC	
8.	UDC (Group 'C') PB-1, 5200-20200 GP 1900	43	5	Promotion	NA	File is under process,		CR's of eligible candidates are not available, letters have been sent to concerned candidates to provide the CR's	
9.	Dietician PB-2, 9300-34800+4600	4	2	DR	NA	File is under process			

Sanctioned Strength

CTVS Department

Name of the Post	Sanctioned strength	Existing	Vacant	
CHS Officers/Doctors/ Assistant Professor	3 Nos	03 Nos	00	
Sr. Tech. Officer CTVS	1	0	1	
Sr. Perfusionist (CTVS)	1	1	0	
Gastroentrology Department				
CHS Officers/Doctors/ Assistant Professor	03	00	03	
Pediatric Surgery				
CHS Officers/Doctors/ Assistant Professor	03	1 Regular + 1 Contract	1	
Cardiology Department	07 Nos	05*	02	*Dr. Ajay Sharma &
CHS Officers/Doctors/ Assistant Professor				Dr. Harshwardhan has been posted in Deptt. of Cardiology (Dr. Harshwardhan is retiring in the Month of Feb'2013 (VRS)
Technical Officer (Emergency Cardiac)	1	0	1	
Technical Supervisor (cardio)	1	1	0	
Technical Supervisor (Cath Lab)	1	0	1	
Technical Supervisor (Pediatric Cardiology)	1	0	1	
STA (CCU)	07	02	05	
Sr. Technical Asstt. (E.P. Lab)	2	0	2	
Pacing Lab Technician	01	0	01	
Sr. ECG Technician	19	08	11	
Jr.ECG Technician	18	02	16	

ANNEXURE-E

Status of Cost and Time overrun for the 12 completed Proiects

(Figures in crores)

Sl. No.	Name of Project	Project Cost	Completion Cost	Time Line	Cost overrun/Time overrun
1	Covering of Nallah PH.- II	20.00	26.95	Stipulated Date of Completion: May 2012. Actual Date of Completion: Sept 2013	Cost overrun: ₹6.95 Cr. Time overrun: 1 Year 4 Months. Reason: The H.T. line running above the nallah was to be shifted by the BSES. Delay was also on account of rainy reason during which the peak flow of water abstained the execution of work. Shifting of Trunk sewer line also caused considerable delay which was to be done by MCD. Earlier the proposal of reconstruction of boundary wall along the Gautam Nagar was not the part of contract. Later on it was planned which had been taken up along with main work. Hence the delay occurred.
2	Renovation of OPD and developing OPD in Old laundry block	15.84	17.00	Stipulated Date of Completion: March 2010 Actual Date of Completion: November, 2011	Cost overrun: ₹1.16 crore. Time overrun: 1 Year 8 Months. Reason: Increase in the cost was due to increase in the cope of work. Work completed in November, 2011.
3	Connecting Ansari Nagar Campus E & W and with Trauma Centre with Motorable subway.	31.15	39.00	Stipulated Date of Completion: October, 2012 Actual Date of Completion: June 2015	Cost overrun: ₹7.85 crore Time overrun: 2 Years 8 Months Reason: Permission for cutting tree took reasonable time. Further as per plan, the route of the tunnel to access Trauma Centre was through Safdarjung Hospital land. However, due to some project of Safdarjung Hospital at the same piece of land, an alternate surface access along the setback area to exit on Factory Road between Safdarjung and Trauma Centre was approved.

Sl. No.	Name of Project	Project Cost	Completion Cost	Time Line	Cost overrun/Time overrun
4	Additional lift in Hospital	5.75	6.50	Stipulated Date of Completion: March 2007 Actual date of Completion: March 2010	Cost overrun: ₹0.75 crore Time overrun: 3 Years Reason: It was a deposit work entrusted to CPWD. Work abandoned by the firm. Thereafter, the work executed through different agency after retendering the work.
5	Air conditioning in Main Hospital (SH: Replacing AHU's.	3.81	2.79	Stipulated Date of Completion: Nov 2011 Actual Date of Completion: March 2014.	Cost overrun: NIL Time overrun: 2 years 4 months Reason: Site was made available in piece meal without affecting the day to day working of the Hospital. Scope of work has also been reduced.
6	Construction of Underground parking at AIIMS -435 cars extra	50.94	58.89	Stipulated Date of Completion: Oct 2012 Actual Date of Completion 31.10.2012	Cost overrun: ₹7.95 crore No Time overrun Reason: Cost increased due to scope and items execute as per actual requirement at site.
7	Construction of boundary wall and providing street light at 300 acres Campus at Jhajjar.	4.80	5.20	Boundary wall work completed. Streetlight work deferred. Date of start: 04.02.2011 Date of Completion: 03.8.2011	Cost overrun: ₹ 0.40 crore No Time overrun
8	Minor works: Renovation, Addition alteration works in hospital, hostels, and residential areas in all campus of AIIMS.	126.42	127.37	As per schedule Date of start: 1.4.2007 Date of Completion: 31.03.2012	Cost overrun : ₹0.95 crore No Time overrun.
9	Jhajjar outreach OPD	12.00	14.57	Stipulated Date of Completion: Oct 2012 Actual Date of Completion: 24.11.2012	Cost overrun: ₹2.57 crore Time overrun - One month Reason: Cost overrun is due to change in scope of work and increase in area as per site requirement.

10	Development of campus at Badsha (Irrigation Deptt.	5.00	5.00	Paid to Haryana Govt. in FY 2011-13	No cost overrun and no time overrun (Deposit work)
11	RPC Lift	1.08	1.08	Date of start: April 2010 Date of Completion: April 2011	No cost overrun and no time overrun Completed on time
12	Covering of Nallah Ph-I.	20.73	22.50	Stipulated Date of Completion: June 2007 Actual date of completion: Aug 2008.	Cost overrun- ₹1.77 Crore Time overrun -1 Year 2 months Reason: Because of shifting of different services etc.

ANNEXURE-F

Status of 'on going/in progress' Projects

(Figures in crores)

Sl. No.	Name of Project	Project Cost	Time Line
1	New OPD Block (At Masjid Moth)	293.75	Stipulated Date of Completion: June 2017
2	New Emergency Ward cum Diagnostic Block at Masjid Moth	565	Stipulated Date of Completion: November 2019
3	Expansion of Existing Cafeteria in Eastern Campus	10.49	Stipulated Date of Completion: September 2016
4	New Multi storied animal house in East Campus	70.00	Under planning. Likely date of completion is June 2019
5	Master Plan & Site development Ansari Nagar campus.	20.00	Stipulated Date of Completion: June 2020 [Master Plan approved with some proviso by NDMC. Site development work shall be taken up once the building work completes substantially]
6	Paid Wards (Revised location)	82.70	Stipulated Date of Completion: July 2018

ANNEXURE - G

(Refer Para 5.13)

Abandoned Projects

Sl. No.	Name of Project	Cost in Crore	Remarks
1	Air conditioning in Main Hospital (SH:O.T's Additional Plant).	3.00	Abandoned. Alternate augmentation measures taken.
2	Construction of Community Centre/ housing at A.V. Nagar, AIIMS	360.00	Abandoned. Proposal has been deferred as it is being taken up now under redevelopment plan by NBCC.
3	Construction of facilitation block	11.00	Abandoned. Work not needed as of now.
4	Consultancy of Jhajjar Campus	125	A Committee under the chairmanship of Secretary (H) has finalized the blocks/facilities to be built in the said land. Global tenders invited, in response 13 firms submitted the tender out of which 4 qualified as per terms and conditions for presentation. After presentation, 2 firms were shortlisted for opening of financial bid. Financial bids opened & due to ambiguous bid of the L-1 firm, same was rejected. Further proposal has been shelved as separate tender are being invited amongst the PSU's for individual Projects/Centres at Jhajjar.

ANNEXURE - H

Status of Pending/Ongoing Development Projects of AIIMS

Oversight Committee Head

(Figure in crore)

Sl. No.	Name of Projects	Status	Awarded Cost	Expected date of Completion	Expenditure till date	Physical progress of work
1	Hostel Block	Awarded	₹ 72.84	One Block completed in February 2016. Balance by October 2016.	₹54.04 (including consultancy)	75% work completed.
2	Surgical Block	Awarded	₹50.18	September 2016	₹49.54 (including consultancy)	70% work completed.
3	Mother & Child Block	Awarded	₹204.44	May 2017	₹37.48 (including consultancy)	17% work completed.
1	Tunnel Link between AIIMS & JPNTC	Awarded	₹38.89	July 2016	₹38.89 (including consultancy) Almost completed.	Only connection of road from Safdarjung Hospital to Trauma Centre is to be done on surface connecting factory road.
2	Private Ward (Revised proposal)	All approvals received.	₹92.04	January 2018	₹10.17 (including consultancy)	Contract terminated, under retender stage. Likely to be awarded in July, 2016.
3	OPD at Masjid Moth	Awarded	₹293.57	June 2017	₹80.30 (including consultancy)	29% work completed.
4	Trauma Expansion	Awarded	₹28.48	October 2016	₹16.68 (including consultancy)	80% work completed.

5	Dharamshala/Night Shelter at Trauma Centre	Awarded	₹23.46	October 2016	₹20.98 (including consultancy)	80% work completed.
6	Cafeteria	Awarded	₹10.49	September 2016	₹2.54	80% structure completed.
7	National Cancer institute at Jhajjar Haryana (AIIMS-II)	All approvals received. Package-I awarded.	₹505.58 (Package-I)	March 2018	₹60.00	10% work completed.
8	Residential Package	Awarded	₹312.99	June 2018	Nil	Work awarded in July 2016.

ANNEXURE-I

Reference Para 6.6 of 93rd Report of Department-related Parliamentary Standing Committee on Health & Family Welfare

Sl. No.	Name of the Projects	Updated Status
1.	Setting up of Satellite Centre of PGIMER at Sangrur (Punjab)	The work of Temporary OPD, Guest House and Boundary wail is almost completed.
2.	Expansion of Nehru Hospital (250 bedded) at PGIMER, Chandigarh (under OBC)	The Reinforced Cement (RCC) structure work of Building including linear accelerator has been completed. At all the floors, work of outer envelope wall with Aerated Cement Concrete Blocks has been completed. The internal plastering work is in progress. Works for installation of Elevators, HT connectivity and 11 KV sub-station have been awarded. The tenders of remaining services are under preparation with CPWD. The Revised Cost Estimate Memorandum amounting to ₹ 182.05 crores has been received from PGIMER, Chandigarh. The same is under examination.
3.	SITC of HVAC system in New OPD works.	The detailed estimate and DNIT has been approved by the competent authority. Tenders were floated on 02.04.2016. The eligibility bids have been opened on 26.04.2016 and are under scrutiny.
4.	Up-gradation and Special Repair of Residential houses of PGIMER, Sector 12, Chandigarh.	The Detailed Estimate and DNIT for up-gradation were placed before Engineering Sub-Committee meeting held on 12.04.2016. Recommendations/ observations of the Committee are under consideration for approval of Competent Authority.
5.	Revised Estimate for Construction of Residential Complex & Hostels at PGIMER Campus, Sector-12, Chandigarh under OBC Implementation Scheme	Revised Cost Estimate to be put up for EFC approval as per revised powers.
6.	Re-construction/ raising of Boundary Wall, Replacement of Entry Gate & Reconstruction of Driveway etc. in Type-VI & VII houses, Sector-24, Chandigarh.	Estimate & DNIT has been submitted for approval of the Competent Authority.

Sl. No.	Name of the Projects	Updated Status
7.	Expansion of existing Multi-level Parking, Construction of new Multilevel parking and connecting passage from Multi Level Parking to New OPD, PGIMER, Sector-12 Chandigarh	RFP for appointment of consultant is being submitted for approval.
8.	Up-gradation and Special Repair of Residential houses of PGIMER, Sector 24, Chandigarh (Module-I, II & III)	The Detailed Estimates and DNITs for up-gradation of module I, II and III were placed before Engineering Sub-Committee meeting held on 12.04.2016. The Recommendations/observations of the Committee are under consideration for approval of Competent Authority.
9.	Up-gradation of HVAC System of Operation Theater Complex, Nehru Hospital, PGIMER, Chandigarh	The Standing Finance Committee in its meeting held on 17.05.2016 has approved the award of work to the lowest quote. The letter of acceptance is being issued.

ANNEXURE-J

Comprehensive List of Major Equipments Finalised for Procurement by Laboratories of CDSCO

Sl. No.	Name of Instrument	Requirements of the Laboratories							Total No. of Equipments	Cost per unit (₹ in Crore)	Approx. Total Cost (₹ in Crore)
		CDL Kol kata	CDL Kasauli	CDTL Hyderabad	CDTL Mumbai	CDTL Chennai	RDTL Guwahati	RDTL Chandigarh			
1	UV/VIS Spectrophotometer	2	1	-	-	2	2	-	7	0.1	0.7
2	FT-IR Spectrophotometer with accessories	1	-	-	-	1	-	-	2	0.12	0.24
3	HFLC (Gradient) with PDA, fluorescent & RI detector. Auto sampler & essential Columns	1	1	-	-	0	0	-	2	0.25	0.5
4	HPLC (Gradient) with PDA, & ELSD, Auto sampler & essential Columns	1	0	1	1	1	1	1	6	0.5	3
5	HPLC (Gradient) with UV detector, auto sampler & essential Columns	5	-	9	8	6	5	8	41	0.25	10.25
6	Fast HPLC (Gradient) with UV detector, auto sampler & essential Columns	1	0	1	l	1	1	1	6	0.3	1.8
7	CLC with FID detector with head space	1	-	-	-	1	1	-	3	0.3	0.9
8	Atomic absorption spectrometer (AAS) with hybrid & graphite furnace	Nil	-	-	1	0	0	-	1	0.3	0.3
9	HPTLC	Nil	-	-	l	1	-	-	2	0.7	1.4
10	Poteniometric Titiator with necessary electrodes	2	-	1	2	2	1	1	9	0.1	0.9
11	KF titrator	1	1	1	1	1	1	1	7	0.1	0.7
12	Dissolution apparatus with auto sampler	2	1	1	1	1	1	1	8	0.12	0.96
13	Dissolution Media Preparation System	1	1	1	1	1	1	1	7	0.15	1.05

14	Polari meter digital with multi wavelength	1	-	-	-	0	1	-	2	0.12	0.24
15	Refractrometer digital	1	-	1	1	1	1	1	6	0.07	1.42
16	Analytical balance (5 digit) with printer along with Anti Vibration table	2	1	1	1	1	1	1	8	0.06	0.48
17	Pharma Refrigerator (2-8 degrees Centigrade) 1000 L	1	2	1	1	1	1	1	8	0.09	0.72
18	Pharma Refrigerator (2-8 degrees Centigrade) 500 L	2	2	1	1	1	1	1	9	0.06	0.54
19	Water purification system	4	1	1	1	1	1	1	10	0.08	0.8
20	Bacterial Endotoxins Appaiatous (KTA/KCA)	1	1	1	1	1	1	1	7	0.12	0.84
21	Tensil Strength Tester	1	-	-	1	-	-	-	2	0.14	0.28
22	Amino Acid Analyzer	1	-	-	1	-	-	-	2	0.5	1
23	Liquid Nitrogen Storage System	-	1	-	-	-	-	-	1	0.1	0.1

ANNEXURE-K

The present status of vacancies at CDSCO (as on 12.05.2016) and action taken to till up the above posts is as under:

Sl. No.	Name of the post/ Mode of Recruitment	No. of Sanctioned Posts	In Position	Vacant Posts	Present Status
i	DDC(I) (i) 50% by promotion failing which by direct recruit (ii) 50% by direct recruitment	23	15	08	Requisition for 04 posts under direct recruitment quota has been sent to the UPSC by the Ministry. As regards 04 vacancies under Promotion Quota the proposal for convening a DPC is under consideration with the Ministry of Health and Family Welfare and UPSC.
2	ADC(I) 100% by promotion failing which by deputation (including short-term contract) failing both by direct recruitment	41	29	12	The UPSC sponsored 07 candidates (Court case is pending against one candidate) under direct recruitment. Regarding remaining 05 posts under promotion quota the proposal for convening a DPC is being sent to the Ministry shortly.
3	Drugs Inspector Direct Recruitment	279	133	146	UPSC has conducted the examination and shortlisted the candidates. Interviews are expected to be conducted shortly by UPSC.
4	Assistant Drug Inspector 100% by direct recruit	81	65	16	Offer of appointment has been sent to 05 candidates who are expected to join shortly. 03 candidates have been referred for medical examination at Dr. RML Hospital. 02 candidates have been found medically unfit. Police Verification is pending for 06 candidates and the concerned district authorities have been reminded to expedite.

ANNEXURE-L

F.No. A.45012/2/2008-CHS.V
Government of India
Ministry of Health & Family Welfare
CHS Division

Nirman Bhavan, New Delhi
Dated: 29th October, 2008

Office Memorandum

Subject: Extension of Dynamic Assured Career Progression (DACP) Scheme upto Senior Administrative Grade (SAG) level in respect of officers of Central Health Service (CHS) and Dental Doctors under the Ministry of Health and Family Welfare.

Vide this Department's OM of even number dated 29.10.2008, orders have been issued to extend the scheme of DACP upto SAG level (Grade Pay of Rs,10,000 in Pay Band-4, Rs. 37400-67000) to all Medical/ Dental Doctor in the Central Government, whether belonging to Organised service or holding Isolated Posts.

2. In so far as various sub-cadres of Central Health Service and Wental Doctors under this Ministry are concerned, the promotions under DACP scheme will be as under:-

A. GDMO Sub-Cadre

Promotions Under DACP Scheme		No. of years of regular service required for promotion
From	To	
Medical Officers (Grade Pay ₹5400 in PB-3)	SMO (Grade Pay ₹6600 in PB-3)	4 years in Grade Pay of ₹5400 in PB 3 including service rendered in the pre-revised scale of ₹8000-13500.
SMO (Grade Pay ₹6600 in PB-3)	CMO (Grade Pay ₹7600 in PB-3)	5 years in Grade Pay of ₹ 6600 in PB-3 including service rendered in the pre-revised scale of ₹ 10000-15200.
CMO (Grade Pay ₹7600 in PB-3)	CMO (NFSG) (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹ 12000-16500
CMO (NFSG) (Grade Pay ₹8700 in PB-4)	SAG Grade (Grade Pay Rs 10000 in PB-4)	7 yrs in Grade Pay of ₹ 8700 in PB-4 including service rendered in the pre-revised scale of ₹ 14300-18300 or 20 years of regular service.

B. Teaching Sub Cadre

Promotions Under DACP Scheme		No. of years of regular service required for promotion
From	To	
Assistant Professor (Grade Pay ₹6600 in PB-3)	Associate Professor (Grade Pay ₹7600 in PB-3)	2 years in Grade Pay of ₹ 6600 in PB-3 including service rendered in the pre-revised scale of ₹10000-15200
Associate Professor (Grade Pay ₹7600 in PB-3)	Professor (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹12000-16500
Professor (Grade Pay ₹8700 in PB-4)	Director Professor (Grade Pay ₹10000 in PB-4)	7 years in Grade Pay of ₹ 8700 in PB-4 including service rendered in the pre-revised scale of ₹14300-18300
C. Non Teaching and Public Health Sub Cadre		
Specialist Grade-II (Junion Scale) (Grade Pay ₹6600 in PB-3)	Specialist Grade- II (Sr. Scale) (Grade Pay ₹7600 in PB-3)	2 years in Grade Pay of ₹ 6600 in PB-3 including service rendered in the pre-revised scale of ₹10000-15600.
Specialist Grade-II (Sr. Scale) (Grade Pay ₹7600 in PB-3)	Specialist Grade-1 (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹12000-16500
Specialist-Grade-I (Grader Pay ₹ 8700 in PB-4)	Consultant/ SAG Grade (Grade Pay ₹ 10000 in PB-4)	7 years in Grade Pay of ₹ 8700 in PB-4 including service rendered in the pre-revised scale of ₹14300-18300.
D. Dental Doctors		
Dental Surgeon (Grade Pay ₹5400 in PB-3)	Jr. Staff Surgeon (Grade Pay ₹ 6600 in PB-3)	4 years in Grade Pay of ₹ 5400 in PB-3 including service rendered in the pre-revised scale of ₹8000-13500.
Jr. Staff Surgeon (Grade Pay ₹6600 in PB-3)	Staff Surgeon (Grade Pay ₹7600 in PB-3)	5 years in Grade Pay of ₹ 6600 in PB-3. including service rendered in the pre-revised scale of ₹ 10000-15200.
Staff Surgeon (Grade Pay ₹7600 in PB-3)	Staff Surgeon (NFSG) (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹12000-16500.

Promotions Under DACP Scheme		No. of years of regular service required for promotion
From	To	
Staff Surgeon (NFSG) (Grade Pay ₹ 8700 in PB-4)	Consultant/ SAG Grade (Grade Pay Rs 10,000 in PB-4)	7 yrs in Grade Pay of ₹ 8700 in PB-4 including service rendered in the pre-revised scale of ₹ 14300-18300 or 20 years of regular service.
E Dental Doctors (Teaching)		
Assistant Professor (Grade Pay ₹6600 in PB-3)	Associate Professor (Grade Pay ₹7600 in PB-3)	2 years in Grade Pay of ₹ 6600 in PB-3 including service rendered in the pre-revised scale of ₹ 10000-15200
Associate Professor (Grade Pay ₹7600 in PB-3)	Professor (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹ 12000-16500
Professor (Grade Pay ₹ 8700 in PB-4)	Professor (SAG) (Grade Pay ₹ 10000 in PB-4)	7 years in Grade Pay of ₹ 8700 in PB-4 including service rendered in the pre-revrsed scale of ₹ 14300-18300
F. Dental Doctors (Specialists)		
Maxillofacial Surgeon (Grade Pay ₹6600 in PB-3)	Maxillofacial Surgeon (Sr.Scale) (Grade Pay ₹7600 in PB-3)	2 years in Grade Pay of ₹ 6600 in PB-3 including service rendered in the pre-revised scale of ₹ 10000-15200
Maxillofacial Surgeon (Sr. Scale) (Grade Pay ₹7600 in PB-3)	Maxillofacial Surgeon (NFSG) (Grade Pay ₹8700 in PB-4)	4 years in Grade Pay of ₹ 7600 in PB-3 including service rendered in the pre-revised scale of ₹12000-16500
Maxillofacial Surgeon (NFSG) Grade Pay ₹8700 in PB-4)	Maxillofacial Surgeon (SAG) (Grade Pay ₹ 10000 in PB-4)	7 years in Grade Pay of ₹8700 in PB-4 including service rendered in the pre-revised scale of ₹14300-18300.

3. The above mentioned promotions under DACP Scheme will be made by this Ministry without linkage to vacancies. Other conditions for effacting promotions will be governed by the respective Recruitment Rules as amended from time to time and Department of Personnel & Training's instructions in this regard.

4. These orders wiil take effect from the date of their issue.

5. This issues with the concurrence of Ministry of Finance, Department of Expenditure, IC U.O. No. 4.2/21/2008-IC dated 30.9.2008

6. The amendments to the respective Recruitment Rules wherever necessary, consequent upon the above decisions, shall be made in due course.

Sd/-
(Pawan Kumar)
Under Secretary to the Government of India

1. All Participating Units of CHS
2. The Pay & Accounts Officer, Ministry of Health & F.W., Nirman Bhawan, New Delhi
3. DoPT (Estt.D), North Block, New Delhi.
4. Deptt. of Expenditure (IC Section), Ministry of Finance, North Block, New Delhi
5. Secy., UPSC, Dholpur House, New Delhi
6. Department of Ayush, Red Cross Building, New Delhi
7. Ministry of Railway, Railway Board, Rail Bhawan, New Delhi
8. Ministry of Defence (D-Med Section), Sena Bhawan, New Delhi
9. Ministry of Home Affairs, (PF.I Section), North Block, New Delhi
10. The Commissioner, Municipal Corporation of Delhi, Town Hall, Delhi
11. Director Central, ESIC, Basaidarapur, New Delhi
12. Administrator, NDMC, Connaught Place, New Delhi
13. PS to HFM/PS to MOS
14. PPS to Secy (HFW)/Secy (AYUSH)/Addl. Secretaries
15. All Joint Secretaries
16. DS(CHS)/US(CHS.I-II)/US (CHS.III-IV)
17. CHS.I/II/III/IV/CHS.VI/Finance Desk-II

ANNEXURE-M

The Gazette of India : Extraordinary [Part II—Sec. 3(i)]

MINISTRY OF PERSONNEL, PUBLIC GRIEVANCES AND PENSIONS
(DEPARTMENT OF PERSONNEL AND TRAINING)

NOTIFICATION

New Delhi, the 31st May, 2016

G.S.R. 567(E).— In exercise of the powers conferred by the proviso to the article 309 of the Constitution, the President hereby makes the following roles further to amend the Fundamental Rules, 1922, namely:—

1. (1) These rules may be called the Fundamental (Amendment) Rules, 2016,

(2) They shall come into force on the date of their publication in the Official Gazette.

2. In the Fundamental Rules, 1922, in the rule 56, for clause (bb), the following shall be substituted, namely:—

(bb) The age of superannuation in respect of General Duty Medical Officers and Specialists included in Teaching, Non-Teaching and Public Health Sub-cadres of Central Health Service shall be sixty-five years.

[F. No. 25012/3/2013-Estt. (A-IV)]

ARCHANA VARMA, Jt. Secy.

Note: *The Fundamental rules were published in the Gazette of India on 1st January, 1922 and were last amended vide notification under G.S.R. 27(E), dated the 17th January, 2014*