REPORT NO.

82

PARLIAMENT OF INDIA
RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HEALTH AND FAMILY WELFARE

EIGHTY-SECOND REPORT

On

DEMANDS FOR GRANTS 2015-16 (DEMAND NO. 48) OF THE

DEPARTMENT OF HEALTH AND FAMILY WELFARE

(Ministry of Health and Family Welfare)

(*Presented to the Rajya Sabha on 24th April,* 2015)
(*Laid on the Table of Lok Sabha on 24th April,* 2015)

Rajya Sabha Secretariat, New Delhi
April, 2015/ Vaisakha, 1937 (SAKA)

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***to be appended at printing stage**

COMPOSITION OF THE COMMITTEE (2014-15)

1. Shri Satish Chandra Misra - **Chairman**

RAJYA SABHA

2. Shri Ranjib Biswal
3. Shri Rajkumar Dhoot
%4. Shri Vijay Goel
^5. Dr.Bhushan Lal Jangde
5. Shrimati B. Jayashree
6. Dr. R. Lakshmanan
7. Shrimati Kahkashan Perween
&8. Dr. Vijaylaxmi Sadho
9. Chaudhary Munvvar Saleem
10. Dr. T.N. Seema
@11. Shri Jairam Ramesh

LOK SABHA

12. Shri Thangso Baite
13. Dr. Subhash Bhamre
14. Shri Nandkumar Singh Chouhan (Nandu Bhaiya)
15. Dr. Ratna De (Nag)
16. Dr. Heena Vijaykumar Gavit
17. Dr. Sanjay Jaiswal
18. Dr. K. Kamaraj
19. Shri Arjunlal Meena
20. Shri J. J.T. Natterjee
21. Shri Chirag Paswan
22. Shri M.K. Raghavan
23. Dr. Manoj Rajoriya
24. Shri Alok Sanjar
#25. Dr. Mahesh Sharma
26. Dr. Shrikant Eknath Shinde
27. Shri Raj Kumar Singh
28. Shri Kanwar Singh Tanwar
29. Shrimati Rita Tarai
30. Shri Manohar Untwal
31. Shri Akshay Yadav
*32. Shrimati Ranjanaben Bhatt
**33. Dr. Pritam Gopinath Munde

SECRETARIAT

Shri P.P.K. Ramacharyulu	Joint Secretary
Shri R.B. Gupta	Director
Shrimati Arpana Mendiratta	Joint Director
Shri Dinesh Singh	Joint Director
Shri Pratap Shenoy	Committee Officer

% resigned from the membership of the Committee w.e.f. 2nd December, 2014
^nominated as a member of the Committee w.e.f. 19th December, 2014
&ceased to be member of the Committee w.e.f. 28th November, 2014.
@ nominated as a member of the Committee w.e.f. 28th November. 2014.
# ceased to be member of the Committee w.e.f 9th November, 2014.
*nominated as a member of the Committee w.e.f. 22nd December, 2014.
** nominated as a member of the Committee w.e.f. 22nd December, 2014.

PREFACE

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 82nd Report of the Committee on the Demands for Grants (Demand Nos. 48 & 50) of the Department of Health and Family Welfare including NACO, Ministry of Health and Family Welfare, for the year 2015-16.

2. The Committee held one sitting on 30th March, 2015 for examination of Demands for Grants (2015-16) of the Department of Health and Family Welfare and heard the Secretary (Ministry of Health and Family Welfare) and other Officers thereon.

3. The Committee considered the Draft Report and adopted the same in its meeting held on 23rd April, 2015.

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

(i) Address by the President of India to both Houses of Parliament assembled together on 23rd February, 2015;

(ii) Speech of Finance Minister on 28th February, 2015 while presenting the Union Budget 2015-2016;

(iii) Implementation of Budget Announcements 2014-2015;

(iv) Detailed Demands for Grants of the Department of Health and Family Welfare for the year 2015-2016;

(v) Annual Report of the Department for the year 2014-2015;

(vi) Outcome Budget of the Department for the year 2015-2016;

(vii) Detailed Explanatory Note on Demands for Grants of the Department of Health and Family Welfare for the year 2015-2016;

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

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

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

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

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

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

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

NEW DELHI;
April 23, 2015
Vaisakha 3*, 1937 (Saka)*

Satish Chandra Misra
Chairman,
Department-related Parliamentary
Standing Committee on Health and Family Welfare

LIST OF ACRONYMS (HEALTH SECTOR)

Ads - Additional Directors
BE-Budget Estimates
CRI - Central Research Institute
CDSCO - Central Drugs Standard Control Organization
cGMP - Good Manufacturing Practice
CGHS Central Government Health Scheme
CGEPHIS - Central Govt. Employees and Pensioners Health Insurance Scheme
CIP - Central Institute of Psychiatry
DNEA - Diploma in Nursing Education and Administration
GIA-Grants-in-aid
IFD - Integrated Finance Division.
ICU -intensive care unit
IVF - In Vitro Fertilization
INC - Indian Nursing Council
IPC - Integrated Purchase Committee
LC - Letter of Credit
LHMC - Lady Harding Medical College
LRHS - Lady Reading Health School
METI - Monitoring, Evaluation and Technical Cell of India
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
PGIMER -Post-Graduate Institute of Medical Education And Research
PII - Pasteur Institute of India
PMSSY - Pradhan Mantri Swasthaya Suraksha Yojana
PMC - Project Management Committee
RDs-Regional Directors
RIMS-Regional Institute of Medical Sciences
RML - Dr. Ram Manohar Lohia Hospital
RSBY-Rashtriya Swasthya Bima Yogana
SSB - Super Specialty Block
SOE-Statement of Expenditure
SJH & VMMC- Safdarjung Hospital & Vardhman Mahavir Medical College
UCs-Utilization Certificates
UIP - Universal Immunization Programme

OVERVIEW

1. The Ministry of Health and Family Welfare is instrumental and responsible for implementation of various programmes on the national scale in the areas of Health and Family Welfare, prevention and control of major communicable diseases. Apart from these, the Ministry also assists the States in preventing and controlling the spread of seasonal diseases' outbreaks and epidemics through technical assistance.

2. The Ministry of Health and Family Welfare comprises the following two Departments–

- Department of Health and Family Welfare including National AIDS Control Organisation (NACO); and

- Department of Health Research.

3. Expenditure is incurred by Ministry of Health & Family Welfare either directly under Central Schemes or by way of grants-in-aids to the autonomous/ statutory bodies etc. and NGOs. In addition to the centrally sponsored family welfare programmes, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria and Tuberculosis in designated areas. Besides, State Health Systems Development Projects with World Bank assistance are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health and Family Welfare only facilitates the States in availing of external assistance.

4. The National Health Policy framed from time to time provides the framework for the implementation of policies and programmes for health care. The Eleventh Five Year Plan had focused on the poor and the underprivileged. Accessible, equitable and affordable health care was a priority concern and therefore emphasis was accorded to reducing disparities in health across regions and communities by ensuring access to

affordable health. The Twelfth Plan envisages building on the achievements of the Eleventh Plan for extending outreach of public health services and for moving towards the long term objective of establishing a system of Universal Health coverage through National Health Mission.

5. The Department of Health and Family Welfare comprises Health Sector, NHM Sector and NACO. The various activities under the Health Sector to name a few include Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), Central Government managed hospitals and autonomous institutions of Medical Education under the Department, Central Government Health Scheme (CGHS), Central Drugs Standard Control Organisation (CDSCO), various National Programmes, etc. Similarly, the National Health Mission is comprised of two sub-components viz. National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). The National AIDS Control Organisation is implementing the National AIDS Control Programme as 100% Centrally Sponsored Scheme. This Report comprises three parts - A, B and C. Part A deals with Health Sector, Part B with National Health Mission (NHM) and Part C with National AIDS Control Organisation (NACO).

REPORT

PART- A (DEMAND NO. 48)

HEALTH SECTOR

I. BUDGETARY ALLOCATIONS

1.1 The Ministry of Health & Family Welfare presented its Detailed Demands for Grants (2015-16) in Lok Sabha/Rajya Sabha on 19th March, 2015. A perusal of Demand No. 48 which pertains to the Department of Health & Family Welfare, reveals that the total approved Annual Plan 2015-16 Outlay (i.e. Budget Estimates) of the Department of Health & Family Welfare is Rs. 24549.00 crore of which Rs. 18295.00 crore is for National Health Mission (NHM) and Rs. 6254.00 crore for Non-NHM (i.e. Health) Schemes.

1.2 The following table, as given in the Outcome Budget 2015-16, gives a summary of statement of Plan and Non-Plan allocation in respect of Department of Health & Family Welfare grouping it under the flagship programme-National Health Mission (NHM) and Schemes/Programmes outside (NHM):

Table No. 1

(Rs. in crore)

Name of Scheme	**Approved outlay (2015-16)**		
	Department of Health & Family Welfare		
	Plan	**Non-Plan**	**Total**
National Health Mission (NHM)	18295.00	33.46	18328.46
Non NHM(Health)	6254.00	5070.54	11324.54
Total (NHM & Non	24549.00	5104.00	29653.00

NHM)			

1.3. The total 12th Five Year Plan approved outlay, Budget Estimates (BE) and Revised Estimates (2013-14 and 2014-15) and the actual expenditure incurred in 2013-14 and 2014-15 are given in **ANNEXURE I.**

1.4 In reply to a question, the Department has informed the Committee that the projected demand of the Department of Health & Family Welfare-Health Sector for Plan funds for 2015-16 was Rs. 14,456.07 crore against which actual allocation made is Rs. 6254.00 crore resulting in the shortfall to the extent of Rs. 8202.07 crore. The shortfall in Plan allocation has been attributed to non-allocation of funds for certain State Plan Schemes in the Health Sector. It has been stated that the effect of shortfall can be offset by way of projection of additional requirement through supplementary grants and also in the Revised Estimates 2015-16.

1.5 During the course of his deposition before the Committee on 30th March, 2015 in connection with examination of Demands for Grants (2015-16), the Secretary, (Health & Family Welfare) submitted that for Health and Family Welfare, an allocation of Rs. 24549.00 crore has been made. It is less than the BE 2013-14 provision of Rs. 30,000/- crore, but it is, more or less, on the same level as the RE 2014-15 allocation of Rs. 24400/- crore. This cut has to be seen in the context of the Fourteenth Finance Commission's recommendation whereby the share of State Governments in Central Taxes has been increased from 32 per cent to 42 per cent. The cut in the share of the Central Government in Central Taxes has translated into cuts in various sectors and Health Sector has also suffered on account of that. Some of the important schemes have not got any budgetary provisions. The tertiary health care initiatives of the Department have not got any budgetary provision and the Department has been told that they should be merged into National Health Mission (NHM). But merging tertiary healthcare initiatives into NHM could be a difficult thing to do because NHM is only upto primary and secondary healthcare. The Secretary further submitted that the Government is considering a

proposal to raise the share of the Central Taxes from the share of the States in the Centrally Sponsored Schemes upto 50 per cent. If that happens, then the Department will get about Rs. 12000/- crore additional funds, out of which about Rs. 9000 crore would be spent on the Family Welfare side and remaining in NACO and other Health Sector schemes. Once additional funds of Rs. 12000 crore are received, the amount will have to be redistributed amongst the various schemes on the Health side and also on the Family Welfare side. But this can be done at the time of the first Supplementary Budget and States also would have to do accordingly because States would not have done that at this stage. So there is a bit of uncertainty till the first Supplementary Budget of the Central Government and also of State Governments are passed.

1.6 The Secretary also submitted that Rashtriya Swasthya Bima Yojana (RSBY) has been transferred from the Ministry of Labour to the Department of Health and Family Welfare from the 1st April 2015 but the Budget provision continues to be in the Ministry of Labour and they will authorise Department of Health and Family Welfare and then this Department will be able to make expenditure from that head. From the next Budget onwards, the Budgetary provision under RSBY would be coming to Ministry of Health and Family Welfare.

1.7 Responding to a query regarding the reasons for making no budgetary provisions for certain schemes like medical education, tertiary care health programmes, etc., the Secretary submitted that his Ministry has been told that they will be subsumed in the National Health Mission. Secondly, the share of the State and Central Government in the funding pattern will be changed and some of the Central requirements of funds would get subsumed by the increased amount which will be received by way of State contribution. So it was not as if it was made zero, but these health programmes have now become part of NHM. But the problem is that NHM has a very specific mandate of primary and secondary healthcare and if tertiary care is merged into that, then the money will start flowing to tertiary care and that will not be desirable. The second option for obtaining required funds is to get it from the increased share of the State

Governments. How much the States will be able to bear are larger issues and it is difficult to answer. But there will be some increase. In the National Health Mission currently, Rs. 18000 crore are there and Rs. 9000 crore is the State contribution. If the State share goes up from 25% to 50%, then the Ministry will get Rs. 9000 crore additional money. In NACO, currently the State Governments are not contributing and the entire Rs. 1400 crore is Central Government's money. If the States agree to contribute, then the Ministry will have about Rs. 1400 crore from there.

1.8 In replying to a question the Secretary submitted that the State share will also get increased in the schemes where the State Governments are contributing. As per rough estimation, about Rs. 12000 crore additional funds would be available to the Ministry. But this will not automatically come to those schemes where there is no Budget provision. The Ministry will have to marginally reduce its contribution in the NHM, NACO and other Centrally Sponsored Schemes where the State Governments would contribute. Some amount of the money which comes out as a result of the reduced Central share will be transferred to the medical education and other tertiary care schemes. These are continuing programmes and cannot be discontinued and therefore money will have to be found through some means. Once policy issues are sorted out, the Ministry will have to come to Parliament again with supplementary demands for those areas where there is no Budget provision.

1.9 On being asked about the reasons for budgeted funds remaining under-utilized, the Secretary replied that 75 per cent of the money goes to the States who have to spend that money. The States have to furnish Utilization Certificates (UCs), subsequent releases are made after UCs are received. The Secretary stated that the current expenditure of 2014-15 compares quite favourably with the Budget Estimates and the Revised Estimates of 2014-15. Explaining the reasons for under-utilization of funds allocated for Central Sector Schemes/ Projects, the Secretary stated that the bulk of the expenditure has been in new AIIMS and some of the facilities which are to be created in AIIMS, Safdarjung Hospital, Dr. RML Hospital etc. In AIIMS, between 2005 and 2010, there was very little expenditure because the Ministry did not have the experience of having that kind of

structure constructed. After 2010, the expenditure has picked up. With strong monitoring mechanism being put in place, the expenditure is certain to improve.

1.10 The Secretary also flagged two other issues, which according to him, had a bearing on the expenditure level. He submitted that from 2014-15, the money flow is through the State Governments and not through the Societies. Earlier, the money used to be released through the State Health Societies directly and money was going quickly. Now the money has to go to the State Budgets. The State Governments have to make a Budget provision. They have to draw that amount and pass it on to the Health Societies. There are about four to five months' delay in transferring money from the Central Government to the Health Societies. The second factor responsible for under-utilization is an instruction that if an agency has a Utilization Certificate pending against it even for a paisa, then no releases can be made to that agency.

1.11 On being asked about the specific steps taken to liquidate pending UCs and whether any review meeting had been taken by the Health Secretary, to tackle the problem, the Additional Secretary and Financial Advisor in the Ministry of Health and Family Welfare who was present during the evidence, submitted that the status of pending UCs was being constantly reviewed and starting from September 2014, the review is being done on a monthly basis. In April, 2014 the amount involved in pending UCs was Rs. 4481.00 crore in the Health Sector alone which has been brought down to Rs. 2200.00 crore by February, 2015 through regular follow-up and constant review. A meeting of all Financial Advisors posted in big institutions under the Ministry have been called in April, 2015 to take this issue up in a focussed manner so that pending UCs do not become reasons for non-release of funds.

1.12 On being asked about the reaction of the States after the Budget 2015-16 was passed and share of the State Governments in Central Taxes was increased from 32 per cent to 42 per cent, the Secretary submitted that the general impression of most of the States is that they are getting less money than before. The Secretary added that this

should not happen because if the Central Government is not getting Rs. 1,80,000/- crore due to hike in the State share of Central taxes, it has to go to the States.

1.13 On being asked as to which are the schemes for which nil or negligible allocations have been made but which are critical for addressing the imbalances in healthcare and thus non-negotiable and must be protected from budgetary cuts, the Ministry has furnished the following list:

Table No. 2

LIST OF SCHEMES WHERE REQUIREMENT FOR FUNDS IN 2015-16 IS NON-NEGOTIABLE: HEALTH SECTOR (TERTIARY CARE)

(Rs. in crore)

S.No.	SCHEME	BE 2014-15	BE 2015-16	PROJECTED REQUIREMENT
1	Trauma Care (Capacity Building for Developing Trauma Care facilities in Govt. Hospitals on National Highways)	70.00	Nil	472.38
2	Burn Injuries (National Programme on Prevention and Management of Burn Injury)	28.00	Nil	171.00
3	National Tobacco Control Programme	73.00	Nil	73.66
4	National Mental Health Programme	200.00	Nil	295.60
5	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke	680.00	Nil	500.00
6	Health Care for Elderly	157.00	Nil	176.20
7	National Programme for Control of Blindness	70.00	Nil	70.00
8	Human Resource for Health	1256.11	Nil	1527.00
9	Telemedicine	44.77	Nil	65.30
	TOTAL	2578.88		3350.94

1.14 In reply to a question, the Department has, in a written submission informed that the level of Government spending on health as a percentage of GDP stands at 1.1% in 2013-14 (RE). The public health expenditure between Centre and States is in the ratio of 31:69. As per 12th Five Year Plan document, total public funding by the Centre and States, plan and non-plan, on core health is envisaged to increase to 1.87 per cent of GDP by the end of the Twelfth Plan. When viewed in the perspective of the broader health

sector, the total Government expenditure as a proportion of GDP is envisaged to increase to 2.5 per cent by the end of the Twelfth Plan. To meet the targeted expenditure level, the availability of resources and absorptive capacity of the sector are crucial factors. The availability of resources is dependent on the fiscal scenario of the Government and competing claims on the resources of the Government.

1.15 The Committee views with serious concern the sharp reductions in allocations of funds for Health and NHM in the Central Plan in 2015-16 and feels that huge assumption has been made that 42 per cent transfer of Central Taxes to the States in the form of untied funds would compensate for the shortfall in Central funds for Health and if this assumption is not validated, then there will be a very severe shortfall of health expenditure in several backward States which fare poorly in terms of various health indicators and are, therefore, required to increase their health expenditure, but are unable to do so due to various reasons. The past experience shows that if the spending is left to the States, contractor-intensive sectors takes priority over non-contractor intensive sectors and Health, not being a contractor intensive sector, will take a backseat in such circumstances. The increase in education expenditure that took place from the mid 80s, in many ways, forced the States to make an increase in their expenditure commensurately and one of the objectives of the National Rural Health Mission which has now become the National Health Mission is to spur the States to spend more on health. The Committee also takes note of the fact that a a number of States have already presented their Budgets for the financial year 2015-16 and no budgetary provisions have been made therein for meeting the shortfall in expenditure on key health schemes. Also, given the precarious state of States' finances, expecting the States to allocate adequate financial resources for health for the financial year 2015-16 is unrealistic. Keeping all these factors in view, the Committee apprehends that in the financial year 2015-16, targeted health outcomes would be seriously jeopardized if the Central Government does not move quickly towards shouldering a bigger share in overall public spending on health. The Committee, therefore, recommends that instead of depending on the States for additional resources for health, in the year 2015-16, the Central Government should enumerate a fiscal

roadmap for generating and allocating more financial resources for health so that the vision of moving towards universalization of affordable healthcare is translated into reality. The Committee also recommends that the Ministry institute a regular system of review with states so that an up-to-date assessment is always available on whether states are indeed allocating resources to health as the Central government is hoping. The Committee would like to kept informed about such assessments on a regular basis.

1.16 The Committee notes that due to broad budgetary cuts imposed by the Ministry of Finance, fifteen important Health Schemes of the Ministry of Health & Family Welfare have been left without any budgetary provisions for 2015-16. The Committee also notes that Ministry has furnished a list of nine schemes of tertiary care (Table No. 2), which in the opinion of the Ministry are essential for correcting the existing imbalances in tertiary healthcare and therefore non-negotiable from the point of view of budgetary support but for which no funds have been allotted for 2015-16. The Committee is appreciative of the fiscal constraints faced by the Ministry of Finance due to moderation in economic growth and the impact of global slowdown. But given the fact that public funding is estimated to be of the order of only 19.67% of the expenses of healthcare in the country [as per National Health Accounts Estimates (2004-05)] and most of private expenditure is Out-of-Pocket (OOP) expense which has the potential of pushing even the non-poor into poverty, the Committee is of the firm view that starving the above said health schemes of budgetary support may have catastrophic implications for the expansion of tertiary care facilities and equitable distribution of tertiary care to different segments of population. Keeping in view the slightly tight fiscal space, the Government is in and seeking to strike a balance between public good and need for containing fiscal deficit, the Committee recommends that out of the nine schemes indicated by the Ministry for providing budgetary outlay, the following five schemes are of critical importance: (i) Trauma Care (Capacity Building for Developing Trauma Care facilities in Govt. Hospitals on National Highways); (ii) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke; (iii) Health Care for Elderly; (iv) National Programme for Control of

Blindness; and (v) Human Resource for Health. This recommendation of the Committee warrants utmost attention of Ministry of Finance. The Committee would like the Ministry of Health and Family Welfare to bring this recommendation to the notice of the Ministry of Finance with a sense of urgency and expediency and apprise the Committee of the follow-up action taken by them (i.e. Ministry of Finance). If adequate budgetary provisions are not made for these schemes, the Committee may call the Secretary to acquaint itself with the reasons behind non allocation of funds for the schemes.

1.17 The Committee also takes note of the Health Secretary's admission that despite the hike of the State share in the Central Taxes and the resultant freeing up of funds to the tune of Rs. 180,000.00 crore for transfer to the States, most of the States are complaining that "they are actually not getting even as much as they were getting in the last year". The Committee is not aware of the reasons behind such an impression of the States. The Committee would, therefore, like the Government to spell out its policy stance in this matter in greater detail and with more clarity and come out with a narrative explanation of how the additional resources of Rs. 1,80,000.00 crore will flow into the States' kitty.

1.18 The Committee also takes note of the Health Secretary's submission that there is a changeover from society route of funds to treasury route of funds. The Committee observes that with this changeover, UCs conditionality will no longer be an absolute bar for release of funds. The Committee hopes that this will have positive bearing on better utilization of budgeted funds as well a timely release of the funds. Though the changeover from society mode to treasury mode has been made for the purpose of better utilization of funds, the Committee would like the Ministry of Health and Family Welfare to be vigilant and ensure that this changeover does not lead to fiscal profligacy and funds so released result in corresponding benefits and assets creation on the ground. The Committee takes note of the Health Secretary's submission that this changeover has resulted in delay in transfer of funds to the Health Societies. The Committee would like the Ministry to initiate immediate remedial measures in

coordination with the States and quickly iron out the hindrances coming in the way of speedy transfer of Central funds to the State Health Societies.

1.19 The Committee observes from the information furnished that as per the Twelfth Five Year Plan document, the total public funding by the Centre and the States, both Plan and Non-Plan, on core health issues is envisaged to increase to 1.87 per cent of the GDP by the end of the Twelfth Plan, but for the BE 2014-15, this figure is 1.2 per cent of the GDP. The budget allocation for the fourth year of the Twelfth Plan, i.e. 2015-16, is also almost 1.2 per cent of GDP. Three years of the 12th Five Year Plan has already elapsed and only two years are left. This implies that the target of government spending of 1.87 per cent of GDP on core health will not be achieved. The Committee observes that the existing per capita public spending on health is low which raises serious doubts on achieving the goals of raising the total Government expenditure on the broader Health Sector to 2.5% of GDP by the end of the 12th Plan. The Committee, therefore, recommends that Government should chalk out a solid fiscal roadmap for generating and allocating additional financial resources for health so that the States are provided a much larger resource envelope for health and the urgency of raising government spending on health to 2-3 % of GDP is also not lost sight of.

1.20 The Committee takes note of the submission of the Health Secretary that the funding pattern of Centrally Sponsored Schemes is proposed to be revised and States' contribution in the Centrally Sponsored Schemes is proposed to be raised, which is likely to spare additional resources to the order of about Rs. 12000.00 crore which would be transferred to various heads of account like Medical Education, Tertiary Care Initiative etc. Once this proposal is approved and implemented the Central Government's contribution in NHM and NACO will reduce. The Committee observes that the success on this front depends on the States sparing a substantial amount of money and withdrawal of Central contribution out of NHM and NACO and redistribution of the same amongst the various health schemes which "would mean a little bit of uncertainty till the first Supplementary Budget of the Central Government and also of the State Governments are passed", as admitted by the Health Secretary

himself. The Committee has serious doubts over the efficacy of this arrangement. The Committee would, however, recommend that the policy issues concerning this arrangement may be sorted out expeditiously. The Committee would like to be apprised of the developments in this regard.

1.21 The Committee has learnt that there is a proposal in the Government to do away with the distinction between Special Category & Non-special Category States and if this proposal is finalized and implemented, the 11 Special Category States, who depend heavily on Central Sector funds for their Plan schemes, will be hit hard as they will end up paying much more than 10% and face huge shortfall in their expenditure for Health. The Committee would like to be kept updated in this regard.

Savings/Unspent Funds on Capital and Revenue Account

1.22 The approved outlay for Twelfth Five Year Plan for Health Sector is to the tune of Rs.75145.29 crore. The overall trend of Plan funds allotted and expenditure incurred thereon for the last three years of XII Five Year Plan is as under:

Table No. 3

(Rs. In crore)

XII Plan (2012-17)	Budgetary Estimates	Actual Expenditure
2012-13	6585.00	4145.40
2013-14	8166.00	4205.74
2014-15	8733.00	4580.97 (upto 19th March 2015; prov.)

1.23 In reply to a question, the Department has informed the following information regarding the quantum of savings in 2013-14 and 2014-15 under Health Sector:-

Table No. 4

(Rs. in crores)

Major Head	2013-14			2014-15		
	BE	**Amount surrendered**	**% wrt BE**	**BE**	**Amount surrendered**	**% wrt BE**
Revenue Section						
2251	8.00	-	-	10.00	-	
2210	4610.16	1485.80	32.23	3134.53	21.14	0.67
2211	0	-		665.75	1.40	0.21
2552	692.85	233.79	33.74	812.91	164.08	20.18
3601	0.06	-	-	2118.95	1178.96	55.64
3602	0			26.37	25.65	97.23
Total	***5311.07***	***1719.59***	***32.38***	***6768.51***	***1391.23***	***20.55***
Capital Section						
4210	2552.48	1261.93	49.44	1829.34	990.99	54.17
4211	0	-		0.27	-	-
4216	302.45	210.80	69.70	89.88	26.01	28.94
4552	0	-		45.00	45.00	100.00
Total	***2854.93***	***1472.73***	***51.58***	***1964.49***	***1062.00***	***54.06***
G. Total	**8166.00**	**3192.32**	**39.09**	**8733.00**	**2453.23**	**28.09**

The amount in both the years was surrendered on last day of the financial year, i.e., on 31st March.

1.24 The Committee is dismayed to note that huge savings have been registered in the Capital Account during the last two years. Such gross under-utilization of funds under Capital Section of the Demands for Grants points to the fact that development oriented activities have been seriously impaired. The Committee, therefore, observes that the occurrence of huge savings on the Capital Account warrants special attention and proactive steps by the Ministry so that this pernicious trend could be tackled in an effective manner.

1.25 The Committee notes from the Outcome Budget 2015-16 that as against the RE allocation of Rs. 6772.18 crore for 2014-15, only Rs. 3457.49 crore could be spent till December, 2014. It means that the remaining expenditure would have to be squeezed in the last quarter of 2014-15. Since as per the norms stipulated by the Ministry of Finance, there is ceiling of 33% on expenditure in the last quarter, the Committee would like the Department to explain its apparent disregard of the financial norms and lack of fiscal discipline on the part of the Ministry of Health & Family Welfare.

1.26 Another disquieting matter which has engaged the Committee's attention is that certain schemes for which substantial allocations had been made at the BE or RE stage, suffered at the take-off stage itself. As is evident from a scrutiny of Annexure 1 , despite substantial budgetary provisions made in the years 2013-14 and 2014-15 for the schemes like "Integrated Vaccine Complex, Chengalpattu & Medi Park", "Strengthening of Existing Branches and Establishment of 27 Existing Branches of NCDC", "Health Insurance (CGEIPS)", "Procurement of Supplies & Materials", "National Mental Health Programme", "Health Care for the Elderly", " Strengthening/Creation of Paramedical Institutions(NIPS/RIPS)", " Strengthening of Government Medical Colleges-UG seats", " Establishing New Medical Colleges", "Strengthening of State Drug Regulatory System", nothing could be spent. The Committee deprecates the Ministry for earmarking such huge amounts for the aforesaid schemes which could not be taken up during 2013-14 and 2014-15. The Committee notes that the three years of the 12th Five Year Plan have already elapsed and wonders as to how the Ministry would be able to achieve the envisaged objectives of these schemes in the remaining two years. The Committee would expect an explanation from the Ministry in this regard. The Committee would also recommend even at the cost of repetition, that the Ministry should at least now, take urgent and tangible action to ensure that the 12th Plan approved outlays for the above said schemes do not remain idly parked. The Committee would like to be apprised of the measures taken in this direction.

1.27 A perusal of Annexure 1 reveals that in the Plan provision of the Health Sector for 2013-14, the actual expenditure was Rs. 4205.74 crore as against the BE of Rs. 8166.00 crore which was reduced to Rs. 5065.00 crore at RE stage. In 2014-15 also, the actual expenditure has been Rs. 3457.49 crore as against the BE of Rs. 8733.00 crore which was reduced to Rs. 6772.18 crore at the RE stage. The Committee is dismayed to observe that the slippages in utilization of the budgeted funds must have had an adverse bearing on moving towards the avowed objective of universal health coverage for the populace of the country. The Committee in its 67th Report on Demands for Grants 2013-14 had expressed concern at occurrence of huge savings and recommended that the Department should take concrete steps to ensure proper utilization of funds by means of prudent assessment of the fund requirements and design effective mechanism to make a balance between spending and savings. The Committee again expresses its displeasure at substantial and recurrent underutilization of the allocated funds and observes that such a state of affairs is indicative of serious shortcomings in budgetary planning and monitoring of utilization of the budgeted funds. The Committee, therefore, recommends that realistic projection of fund requirements should be given utmost priority at the highest level of the Ministry and periodic meetings should be held to review and constantly monitor the progress of expenditure so that large variations in the BE,RE and AE could be avoided.

1.28 From a perusal of Table No. 4, the Committee notes with serious concern that a significant proportion, i.e. 39.09% and 28.09 % of allocated funds amounting to Rs. 3192.32 crore and Rs. 2453.23 crore has been surrendered in the years 2013-14 and 2014-15, respectively. The Committee also notes that these unspent budgetary provisions were kept till the close of the respective financial years despite reduction in the budgetary provisions at RE stage and surrendered on 31st March in both the years. The Committee observes that had the Department exercised rigorous monitoring of the progress of expenditure on a periodic basis it would have been able to foresee the quantum of unspent budgetary provisions timely and surrendered the same much before without waiting for the fiscal end. The Committee further observes that a resource constrained country like India cannot afford to keep a vast chunk of its

financial resources locked up and surrendered towards the end of financial year and recommends that the provisions of General Financial Rules be adhered to scrupulously and unspent budgetary provisions may be surrendered timely for their gainful utilization for other fund-starved projects/schemes.

1.29 In response to a query regarding any exercise undertaken by the Ministry to analyse fund requirements for various projects/ initiatives, the Ministry has informed that a detailed exercise/analysis in this regard is undertaken at Programme Division level dealing with various projects/initiatives keeping in view the current status of their implementation, new interventions coming up, the capacity for spending at central level and at the state level. Accordingly, based on this exercise done by various programme divisions for requirement of funds for the year 2015-16, the projection was submitted for consideration of the Competent Authority. In reply to another question, it has been stated that with a view to streamline the formulation of budgetary requirements in a realistic manner an exercise was undertaken to review/evaluate all the ongoing schemes and consequently, a number of schemes/programmes were merged in certain pools for optimum utilization of the budgetary assumption.

1.30 The Committee takes note of the submission that 'a number of schemes/programmes were merged in certain pools for optimum utilization of budgetary assumptions' and feels that there is a need to carry out an appraisal of the efficacy of the new measures initiated and formulate remedial measures based on the findings for better financial performance. The Committee would like to be kept apprised of the efficacy of the new measures initiated for better utilization of budgetary provisions.

<u>Utilization Certificates (UCs)</u>

1.31 As regards the progress made in settling pending Utilization Certificates, it has been submitted that a special drive was initiated by field PAOs with concerned

Programme Divisions and Health Society of States concerned during the period 9th February to 13th February 2015 and UCs amounting to Rs 160.59 crore were liquidated. As a whole, UCs amounting to Rs.2257.51 crore have been settled for May 2014 to February, 2015. On being asked about the total number of pending utilization certificates, amount involved therein and the time since when the UCs have been pending, the Ministry in a written reply submitted the following: "the main reason for underutilisation of funds under this sector has been non-settlement of Utilisation Certificates (UCs). The funds could not be released under some schemes after issue of economy instructions of the Ministry of Finance dated 14.11.2012 which necessitated submission of UCs under the particular scheme as well as under all schemes of the Ministry/ Department". It has also been informed that the UCs have been pending since the year 1993.

1.32 Subsequently, the Department furnished the status of pending UCs scheme –wise as under:-

Table No. 5

Scheme-wise pending UCs (as on 31.3.15)

Sl. No.	Scheme	Number of UCs	Amount (Rs. in crores)
1	NATIONAL PROGRAMME FOR PREVENTION OF DIABETES, CVD & STROKE / NATIONAL PROGRAMME FOR HEALTH CARE FOR ELDERLY / NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS	791	680.52
2	CANCER RESEARCH	210	175.95
3	TRAUMA CENTRE	182	281.30
4	MOTHER & CHILD HEALTH (MCH)	41	32.71
5	TELE MEDICINE	17	8.91

6	MENTAL HEALTH	326	313.96
7	NURSING	193	212.05
8	OTHER SCHEMES /INSTITUTES / HOSPITALS	322	491.55
	TOTAL	**2082**	**2,196.95**

1.33 The Committee takes note of the submission of the Ministry that the main reason for under-utilization of funds under Health Sector has been non-settlement of Utilization Certificates (UCs). Though some measures have been taken to liquidate pending UCs, given the fact that a substantial amount to the tune of Rs 2,196.95 crore is still involved in pending UCs and the pending UCs date as far back as year 1993, it is obvious that a lot still remains to be done. The Committee, therefore, recommends that the Ministry should put in place a dedicated mechanism in this regard to ensure that all pending UCs are liquidated within a period of six months. The Committee desires to be kept apprised of the action taken and the outcomes thereof within a period of three months from the date of presentation of this Report.

II. SAFDARJUNG HOSPITAL & VARDHMAN MAHAVIR MEDICAL COLLEGE (SJH & VMMC), NEW DELHI

2.1 Safdarjung Hospital is a Central Government Hospital providing services in various specialties and super specialties in almost all major disciplines along with Homoeopathic and Ayurvedic dispensaries running in its premises. Vardhaman Mahavir Medical College is associated with this Hospital. In the year 2014, OPD attendance of patients was 27,02,264.

2.2 As per the information given in the Background Material, the approved outlay for SJH & VMMC for the 12th Plan is Rs. 2468.00 crore. The status of Plan funds for the year 2014-15 allotted and utilized (as on 5th March 2015) is as under:

Table No. 8

(Rs. in crore)

Head	BE	RE	AE
SJH	330.00	580.90	310.22
VMMC	9.50	9.50	9.22
SJH & VMMC	339.50	590.40	319.44

2.3 The Committee observes that in the year 2014-15, the BE of Rs. 330.00 crore for the Safdarjung Hospital was increased to Rs. 580.90 crore at RE stage but the actual expenditure is Rs. 310.22 crore as on 5th March, 2015 and is likely to be around the BE, given the trend of expenditure witnessed so far. The Committee would, therefore, like to be apprised of all the factors warranting increase in budgetary provisions at RE stage and the reasons for not utilizing the enhanced allocations.

2.4 On a query regarding the progress made towards re-development plan of the hospital and the steps taken to ensure that time-lines fixed are adhered to, the Department has informed that the Cabinet in its meeting held on 4th June, 2014 approved the Redevelopment Plan of Safdarjung Hospital with estimated cost of Rs. 1333 crore inclusive of Rs. 165 crore towards expenses on operations for the first year. The proposal comprises the establishment of two separate building blocks having a 807 bed Super Specialty cum Paid Ward block and a 500 bed Emergency block, with both blocks having an intensive care unit (ICU) beds & the estimated completion of time of the project is 47 months, inclusive of 12 months of medical care commissioning and stabilization phase. As far as the progress of Super Specialty Block (SSB) is concerned, the work of construction has started on 12.12.2013 at an estimated cost of Rs. 444.70 crore and the timeline set for the project to get completed is 24 months. The structural work is completed upto 6th level and the expenditure to the tune of Rs. 125 crore (approximately) has been incurred till Jan 2015. With respect to the Emergency block, the work of construction has been started on 26.01.2014 at an estimated cost of Rs. 196.73 crore and the set timeline of 24 months. The present status of the RCC Structural work has been substantially completed. The engineering equipment (lift, HVAC, fire-fighting systems and other electrical equipment) procurements have been deferred on account of non-

availability of funds and expenditure to the tune of Rs. 65.00 crore (approximately) has been incurred till Jan 2015. Further, it is also submitted that for both the blocks, the process for procurement of medical equipment has been initiated with formation of technical sub-committees to freeze the technical specifications. The committees are in the process of finalization of specifications.

2.5 The Committee would like to be informed of (i) the total expenditure incurred on the Re-development of the Hospital vis-à-vis the total approved outlay for the project in the Twelfth Plan; (ii) the total surrenders of the budgeted plan funds under this head; (iii) whether all the required approvals for the Project had been obtained; (iv) the original cost of the Project and the revised cost, if any, and (v) the original time-line for completion of the project.

2.6 The Committee is unable to comprehend as to why there was non-availability of funds when the RE of Rs. 580.90 crore was steeply higher than the actuals of Rs. 310.22 crore. The Committee would like the Ministry to clarify the position in unambiguous terms.

2.7 Keeping in view the slow pace of Redevelopment work of Safdarjang Hospital, the Committee strongly recommends to the Department to streamline its monitoring mechanism and ensure that set targets are accomplished within the designated timeline and there are no cost overruns.

2.8 With respect to the setting up of IVF lab at Safdarjung Hospital, the Committee has been informed that most of the key equipments could not be procured due to single quotation and the Department concerned then decided to implement the project on "turnkey" basis. Further, Central Design Bureau was asked to create conceptual layout plans for the addition/alteration of ART clinic. CPWD granted AA & ES for addition alteration of ART clinic for Rs. 20,27,500 vide sanction letter no. 3-46/2013-14/EST-13 on

31/12/2013. On the request of the Hospital, designs were revised which were approved by the Department. The Department in a meeting on 13.05.2014 informed CPWD that the site plan needs to be modified specially the corridor for transfer of patient to be completed first. They also submitted electricity and other related requirements. Electricity department has also issued sanction of Rs. 75,04,875 for providing air conditioning work in the proposed IVF lab vide sanction letter no. 3-62/2014-15/Est-14 dated 30.10.14. The site was handed over by the department to the CPWD in 2014 and the construction work is about to be completed.

2.9 The Ministry prepared Memorandum for Standing Finance Committee, which has been processed and approval of competent authority has been obtained. It is now being forwarded to Ministry of Finance for seeking their approval as it requires creation of posts.

2.10 It may be worthwhile to mention that the delay in setting up of In Vitro Fertilization (IVF) clinic had found mention in the Committee's 39th and 54th Reports presented to Parliament on 28th April, 2010 and 26th April, 2012 respectively. Considerable time has passed since then but this project is still hanging fire. The Committee expresses its unhappiness at the continuing delay in implementation of this Project and impresses upon the Department to proactively pursue the matter of setting up of IVF Lab at Safdarjung Hospital and obtain all necessary clearances expeditiously so that this project is implemented in the year 2015-16 and is not delayed any further.

2.11 The status of sanctioned strength, in-position and vacant posts of doctors and other staff in Safdarjung Hospital as furnished by the Department is as under:-

Table No. 9

	Sanctioned	**In –position**	**Vacant/lapsed**
Doctors(group A)	390	328	62
Non-doctors	54	8	46
Group B(gazetted)	66	27	23/16

Group B (Non-gazetted)	1470	1269	181/20
Group C	932	826	100/6
Group D	1246	967	279

2.12 As regards Group A (Doctors) category, out of 390 sanctioned posts, 62 are vacant posts. The Department has informed that in order to fill up the vacant posts UPSC is being closely followed on regular basis; contractual appointments are being made to meet immediate requirement of patient care; monitoring of status of incumbency being done fortnightly and the recruitment rules have been modified and notified in April, 2014.

2.13 **The Committee takes note of the measures taken/ being taken by the Department to fill up the vacant posts. Taking into account the fact that there is huge mismatch between requirement and availability of doctors, the Committee recommends that it would require more measures than merely modifying Recruitment Rules to attract more doctors to Safdarjung Hospital. The Committee, therefore, directs the Department to pay adequate attention for making the pay packages being offered and service conditions to doctors more attractive.**

2.14 The Committee is astonished to note that out of sanctioned strength of 54 in Group A (Non-Doctors) only 8 are in position and as many as 46 posts are vacant. Similarly, there exists huge number of vacant posts in group B, C & D in various categories. The Committee feels that the efficiency of any hospital does not only depend on the doctors but also the supporting staff of the hospital who have a vital role to play. The Committee can well appreciate the shortage of doctors in the Hospital, but the vacancies in non-medical category are beyond its comprehension. The Committee therefore, recommends that efforts be made for early filling up of the vacancies.

III. Dr. RAM MANOHAR LOHIA HOSPITAL (RML),NEW DELHI

3.1 Dr. Ram Manohar Lohia Hospital(RML),New Delhi is Center of Excellence in Health care under Government Sector Hospitals. In the year 2014, the Hospital catered to

approximatly 17.46 lakh OPD, 66279 IPD and 2.73 lakh patients in Emergency & casualty departments.

3.2 The Plan funds allocated to Dr RML Hospital in 2014-15 was Rs. 176.00 crore and the actual expenditure as on 19th March, 2015 was Rs. 143.78 crore. The Department has also informed that the unspent amount owing to non-finalization of tenders of Pediatric Cath Lab & other equipments and non-starting of construction work of ladies hostel was surrendered.

3.3 In reply to a query regarding the progress made in respect to the on-going projects i.e. construction of six storeyed New Emergency Care Building (NECB) and Dharmashala Project at the Hospital, the Department has informed that the construction of NECB has been completed and it has started functioning on trial basis w.e.f. 17th February, 2015. As regards Dharmashala project, the construction work has been completed and the clearance from various statutory agencies would be obtained shortly. The Department has also informed that Dr. RML Hospital has asked the CPWD of Dr. RML Hospital Division to submit the estimate for construction of new building for College of Nursing and dismantling of the existing College of Nursing.

3.4 Enumerating the constraints faced in executing the above projects, the Department has indicated the following:-

1. Involvement of multiple agencies in getting various clearances.
2. Lack of technical resource person at the initial stage for such an innovative iron structure building to interact with various Government agencies specialized to assess strength and quality of material used for construction.

3.5 The Committee notes that the New Emergency Care Building (NECB) and Dharmshala have been completed but are yet to be operationalized fully. In its earlier Reports, the Committee had commented upon the slow pace of the progress in executing the above projects. The Committee is, therefore, pleased that the construction of the NECB and Dharmashala has been completed. The Committee would

like the Department to proactively pursue the pending clearances with the authorities concerned enabling full operationlization of the above projects. The Committee would like to be kept informed of full operationalization of both the projects.

3.6 As regards the construction of new building for College of Nursing, the Committee would like to be apprised of the estimated cost of the Project and the time-frame set for its execution.

3.7 In response to a query regarding the sanctioned strength vis-à-vis the in-position posts at the Hospital, the Department has furnished the following status:-

Table No. 10

s. no.		Classification of post	Total sanctioned strength	In position	Vacancies
MINISTERIAL					
1	DOCTORS	Group A	304	226	62
2	Joint doctors	Group A	1	0	1
	Deputy Director		3	1	2
		Group B Gazetted	12	6	6
		Group B	36	26	10
		Non-gazetted			
		Group C Ministerial posts	159	134	25
Total			211	167	44
3.	Nursing staff	Group A,B	1203	987	216

		'B' Non-gazetted			
4.	Technical	Group A,B& C	589	370	219
5.	Group C	HMTS The Erstwhile Group D	986	627	359
6.	Dietician	Group A	05	02	03

3.8 The Committee is perturbed to note the persistent existence of vacancies in various categories. Keeping in mind the patient load at RML Hospital, the Committee feels that the vacancies to such extent will certainly result in undue strain on the existing manpower and impair delivery of quality healthcare services.

3.9 Shedding light on the efforts made for filling up the vacant posts, the Department has stated as under:-

i. UPSC is being closely followed to fill up vacant posts on regular basis.
ii. Contractual appointments are also made by respective Hospitals to meet the immediate requirement of patient care.
iii. The status of incumbency is being monitored fortnightly.
iv. The RRs have been modified and notified in April, 2014. The requirements for filling up the posts under all sub-cadres are being placed with UPSC on time bound manner.

3.10 The Committee in its earlier Reports had been impressing upon the Department to take necessary steps to fill the gaps in manpower shortage. The Committee regrets to observe that no tangible progress has been made towards addressing the shortage of manpower in Dr. RML Hospital. The Committee, therefore, recommends even at the cost of repetition, that the Department should explore the possibility of offering better financial incentives so that the manpower shortage in Dr. RML Hospital could be overcome.

3.11 Asked about the status of the construction of super-specialty Block and Paid Ward at G Point, the Department has informed the following:-

1. Keeping in view the increased patient load and the inadequate infrastructure in the existing building of the Dr. RML Hospital, Government has 'in-principle' approved the Re-development plan of the hospital. The re-development would be completed in the 12th & 13th Five Year Plan in two phases. In the first phase, it has been planned that a Super Specialty Block & Paid Ward Block in the vacant land at G-point would be developed.

2. It may be pointed out that the plan drawn earlier envisaged construction of Super Specialty Block at an area of land measuring 3.99 acres at G-point. However, on re-survey of the land, which was conducted by DDA, L&DO and CPWD, it came to notice that out of 3.99 acres of land at G-point, 1.74 acres of land belongs to the President's Estate. Therefore, revised plan for construction of the Super Specialty Block in the remaining 2.2 acres in G-point has been drawn. The plan is still at conceptual stage and may require some time to firm up. In the meanwhile the clearance from the Airport Authority has been obtained.

3. In view of the above, it is submitted that no expenditure has incurred so far on construction activities.

3.12 During examination of Demands for Grants 2013-14, the Committee had been apprised by the Department that keeping in view the increased patient load and outdated infrastructure in the existing building of the Dr. RML Hospital, Government had prepared an EFC proposal regarding redevelopment of plan for construction of Super Speciality and Paid Ward at Dr. RML Hospital. In the first phase, it had been planned in consultation with M/s. HSCC (the Project Consultant) that a Super Speciality Block and Paid Ward in the vacant land at G Point would be developed at the estimated cost of more than Rs.700 crore. This new block would add the bed strength of 447. The draft EFC of the proposal was circulated to all the Departments/Ministry concerned for seeking their comments. The comments received so far have been under compilation. The Committee is surprised to note that in 2013, an EFC proposal had been prepared for redevelopment of Dr. RML Hospital and construction of Super-Speciality and Paid Ward in the vacant land at G point at an estimated cost of Rs. 700.00 crore and the

draft EFC had also been circulated to all the Ministries/ Departments concerned. Now, after almost two years, Department has informed that out of 3.99 acres of land at G-point 1.79 acres belong to the President's Estate. The Committee is constrained to observe that the Department has been lackadaisical in its approach in the matter and not done due diligence, resulting in delay in conceptualization and finalization of this Project. Now that the Government has accorded its "in-principle" approval to the Re-development Plan of Dr. RML Hospital, the Committee would expect the Department to quickly complete all approval-related formalities and take concrete steps towards translating the vision of Redevelopment into reality. The Committee desires to be kept apprised of the developments in this regard.

IV. LADY HARDING MEDICAL COLLEGE (LHMC) & SMT. S.K.HOSPITAL, NEW DELHI

4.1 The Hospitals statistics for a period of 2014-15 (till date) shows OPD and IPD attendance of 438200 and 23565 patients respectively. A comprehensive Re-development Plan was prepared by Ministry of Health and Family Welfare under the supervision of HSCC (I) (Project Consultant).

4.2 In reply to a question regarding Redevelopment Plan of LHMC and its associated Hospitals, the Committee has been submitted the following information:-

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

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

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

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

(ii) Procurement of the machines and equipment

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

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

ii. However the construction work by M/S Unity Infraprojects Ltd is at standstill.

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

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

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

(e) Status of Funds released to HSCC for civil work

Table No. 11

(Rs. in crore)

Funds released to HSCC	284.00
Funds released to the builders (M/S Unity Infraprojects Ltd) by HSCC	161.19
Funds released to the builders (M/S Sam Built Well Pvt. Ltd.) by HSCC	34.71
Balance available with HSCC	88.04

4.3 The Committee is dismayed to note that despite the fact that the construction work by M/s Unity Infraprojects has been "at a standstill" for more than a year, the desired priority was not accorded to implementation of the Redevelopment Plan of LHMC and Associated Hospitals and monitoring mechanism is slack. The Committee,

therefore, recommends that the Ministry should gear up its monitoring mechanism and periodically review the progress of construction work at the highest level.

4.4 **The Committee notes that the whole project was targeted to be completed by May/ June 2014. Almost a year has elapsed since then but its completion is still a far cry. The Committee would like to be apprised of the new target date for completion of the Project. The Committee would also like to know as to what decision has been taken on M/s Unity Infraprojects Ltd's request to withdraw the show-cause notice and extend the project completion period.**

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

4.6 The status of existing staff strength *vis-a vis* sanctioned posts and vacancies at Lady Hardinge Medical College and Smt.Sucheta Kriplani Hospital are as under:

Table No. 12

	Sanctioned	In-position	Vacant
Doctors 'A'	307	228	79
Non-Doctors	3	2	1
Senior Resident	301	234	67
Junior Resident	64	55	8
Group B	15	7	8
Group C	192	86	106
Technical Staff	257	102	155
Group D	739	541	198

4.7 The steps taken by the Department to fill up the vacant posts are as follows:

I. DOCTORS

The steps taken by the Ministry in order to fill up the vacant post of doctors:

i. UPSC is being closely followed to fill up vacant posts on regular basis.
ii. Contractual appointments are also made by respective Hospitals to meet the immediate requirement of patient care.
iii. The status of incumbency is being monitored fortnightly.
iv. The RRs have been modified and notified in April, 2014. The requirements for filling up the posts under all sub-cadres are being placed with UPSC on time bound manner.

II. STAFF NURSES

AIIMS, Delhi has been authorized by DGHS to initiate the process for filling up these vacant posts on the proposed RRs. AIIMS has already invited the applications. After scrutiny of application, written examination would be conducted.

III. TECHNICAL POSTS

Some of the posts falling in this category are lying vacant for a period of more than 3 years and are deemed to be abolished as per extant instructions. A proposal for revival of these posts is under consideration.

- The recruitment processes have already been initiated for filling up the posts of Sr. ECG Technicians (14), Jr. ECG Technicians (18). The written examination bas been conducted and short listing is underway for interview. Similarly, the recruitment process for filling up posts of OT Technician has been completed.
- For Physiotherapist (7), Occupational Therapists and OT Assistants (16), the applications are under scrutiny.
- Amendment to Recruitment Rules is under process.

IV. ERSTWHILE GROUP – 'D' STAFF:

- The offer of appointment for 57 posts of MTS sponsored by Staff Selection Commission (SSC) is underway.

4.8 **The Committee takes note of the steps taken by the Department to fill up the vacancies in various categories. The Committee desires that the steps be taken on**

overcoming manpower shortage in Lady Hardinge Medical College and its associated hospital.

V. ALL INDIA INSTITUTE OF MEDICAL SCIENCES (AIIMS), NEW DELHI

5.1 The Committee has been informed that the Institute was allocated Rs. 700.00 crore under the Plan head for the year 2014-015. The expenditure status of Plan funds is as under:

Table No. 13

(Rs. in crore)

S. No.	Head of Accounts	Allocation 2014-15 (RE)	Funds released from the Ministry	Expenditure upto Feb., 2015
1.	Grants-in-aid (GIA) Salaries	187.00	187.00	178.43
2.	Grants-in-aid (GIA)General	170.00	170.00	111.83
3.	Creation of Capital Assets	343.00	148.33	108.70
	Total	**700.00**	**505.33**	**398.96**

5.2 It has further been informed that the entire amount of Rs.170.00 crore under GIA General (Plan) will be utilized during the current financial year as payment of AMC/CMC and the purchase of books/ journals is under process. Computerisation of various projects is going on and the payments are work linked. The pace of expenditure under Creation of Capital Assets is gearing up as the tender process for procurement of various Machinery & Equipments is in the final stages. The entire grant of Rs. 343.00 crore is likely to be utilized by the end of the current financial year 2014-15**.**

5.3 The Committee notes the assertion of the Department that the entire grant of Rs. 343.00 crore was likely to be spent by the end of the financial year 2014-15, as against the allocation of Rs. 343.00 crore in RE 2014-15 for creation of capital assets,

the expenditure incurred till February was only Rs. 108.70 crore (31.6%) and Rs. 243.30 crore (i.e. 68.4%) was left unspent. Given the fact that as per the norms stipulated by the Ministry of Finance, not more than 15% can be spent in the last month of the financial year, the Committee wonders as to how the Department would be able to achieve the feat of spending Rs. 243.30 crore (68.4%) in the last month without violating the provisions of General Financial Rules. The Committee would like the Department to explain the dichotomy in this regard.

5.4 On perusal of the physical targets and achievements in various projects as furnished by the Department, it is revealed that 15 projects are either at the award stage or are underway at various stages of completion.

5.5 The status of BE, RE & AE for the last three years is as below:

Table No. 14

(Rs. in crore)

	BE	**RE**	**AE**
2012-13	**474.00**	**496.00**	**470.00**
2013-14	**550.00**	**550.00**	**485.00**
2014-15	**550.00**	**700.00**	**433.33 (upto 5/3/15**

As per the information furnished to the Committee, the Institute has been allocated funds of Rs. 550.00 crore under Plan head for the next financial year 2015-16 against the Institute's projection of Rs. 2325.50 crore. The projection included Rs.300.00 Crore for National Cancer Institute, Jhajjar, Rs.120.00 Crore for OPD Block at Masjid Moth, Rs.50.00 crore for Paid Ward and Rs.60.00 crore for acquisition of land. The provision of Rs.1000 crore was made by AIIMS for transfer of funds to the Ministry of Urban Development on demand at appropriate stage for transfer of Houses to AIIMS from

Central Government Accommodation pool for the East Kidwai Nagar Housing Project and because large number of Civil Engineering projects are coming on time.

5.6 The Committee observes that there is huge mismatch between the AIIMS's projected demand of Rs. 2325.00 crore and allocation of Rs. 550.00 crore. The Committee observes that the funds allocated for 2015-16 is the same as it was in RE 2013-14. The Committee notes from the information made available to it that a large number of developmental activities are currently underway at AIIMS and inadequacy of Plan funds may prove to be big factor in limiting the progress in executing important initiatives like National Cancer Institute, Jhajjar new OPD Block at Masjid Moth etc. The Committee, therefore, lends its full support for enhanced budgetary support to AIIMS at RE stage.

5.7 The following information has been given on the status of vacancies in faculty positions at AIIMS:-

Table No. 15

Sr. no	Name of Post	Vacant
1.	Director	-
2	Medical Superintendent	-
3	Professor	61
4	Additional Professor	10
5	Associate Professor	17
6	Assistant Professor	144
7	Principal & Lecturer in Nursing	-
8	Lecturer in Nursing	2
	Total	234

5.8 The Department has informed that 234 vacant posts in different categories have arisen due to creation of new faculty posts/ retirements/ resignations. The Department has further informed that out of 115 advertised posts in 2011-12, 99 were filled up; out of 148 advertised posts in 2012-13, 116 were filled in 2014-15, 96 posts are advertised and filling up process is in action.

5.9 The Committee notes that a large number of faculty posts are still vacant. Even the advertised posts could not be filled up completely since 2011. The Committee is disappointed to note the persistent shortage of manpower especially in the faculty positions. The Committee, in its earlier Reports, had urged the Department to accord due priority to filling up of the vacant faculty posts but satisfactory progress has not been achieved in this direction. The Committee once again recommends with all the power at its command that the Department should play its role of facilitator in filling up the vacancies in faculty position in a more effective way and help fill up the vacant faculty and other category posts.

5.10 The Committee would also like to be apprised whether Recruitment Rules for faculty posts and doctors have been codified and if not, the reasons therefor.

5.11 As regards the vacancy positions of resident doctors which include Academic as well as NON- Academic Senior Residents and Junior residents, the following status has been furnished:

Table No. 16

Sr. No	Posts	Sanctioned	Vacant
1	Senior Residents Academics	191	8
2	Junior Residents Academics	702	50
3.	Senior Residents Non-Academics	758	86
4.	Junior Residents Non-Academics	79	20

5.12 The Department has further informed that for vacant seats, the selection has already been held in the month of January, 2015 and joining is in process. For Academic Section, selections for Academic Residents (Junior Residents as well Senior Residents) are done every 6 months and number of vacancies in academic positions are generally in basic and para clinical discipline i.e. Anatomy, Physiology etc. and there is no impact of such vacancies on patients care services. For Non-Academic Residents, positions are of Senior Residents and Junior Residents and there are comparatively more vacancies in these positions because those who are employed in these positions leave these positions mid-way, whenever they get any permanent employment, admission to some academic course or to start their own practice. There is minimal impact on patient care because their work is looked after by academic residents for these departments. Moreover, the various measures which are taken to fill these vacancies and minimize adverse impact on patient care are as follows:-

i) Maintaining waiting list and offering positions to wait listed candidates wherever it is feasible; (ii) holding walk-in-interviews and special recruitment drives to fill such vacancies; (iii) holding regular selection every six months.

5.13 The Committee takes note of the fact that the selection of Resident Doctors had already been done and joining is in progress. The Committee desires that instead of keeping vacancies, they should be filled from the waitlist when feasible.

5.14 The Committee has been informed that out of 22 projects started to be completed in XIth Plan, 12 are completed, 02 are in progress, 03 are in tendering stage, 2 have been shelved and 3 have been held up on account of low priority and non-clearances from statutory bodies.

5.15 The Committee notes from the information made available that a major development work in the form of expansion of OPD Block at AIIMS had been planned with the estimated cost of Rs. 573.00 crore out of which Rs. 4.02 crore had been spent.

The Committee would like to be apprised of the time-frame within which this Project is targeted to be completed.

5.16 The Committee would also like to know whether any of the 12 completed projects of AIIMS witnessed time overrun and cost escalation. The Committee further wishes to be apprised of the Projects which have been shelved and also the reasons therefor.

5.17 On a query regarding progress made towards starting a Burns Unit at JPNATC, the Department has informed that the matter was placed before the Standing Finance Committee's meeting held on 05.03.2015 for their consideration and approval. Minutes of the said meeting are awaited.

5.18 The Committee desires that after its approval by SFC, early action be taken to start the Burns Unit.

VI. POST-GRADUATE INSTITUTE OF MEDICAL EDUCATION AND RESEARCH (PGIMER), CHANDIGARH

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

6.2 On being asked about the reasons for reduction of the allocation at RE 2014-15 stage, the Ministry has informed that the Institute reduced the demand from Rs. 200.00 crore to Rs. 160.00 crore at RE stage during the financial year 2014-15, as this amount was sufficient for ongoing works. The actual expenditure during 2014-15 as on 19.03.2015 (prov.) is Rs. 112.50 crore.

6.3 Giving information on the status of sanctioned posts, vis-à-vis actual strength and vacancies existing in the Institute and steps taken to fill up the vacancies, the Department has informed that out of total 8840 sanctioned posts in various categories at the Institute, 2275 are vacant. The detailed status of sanctioned strength, in position and vacant position with steps taken to fill up the posts is as under:-

Table No.17

Sl. No.	Name of Category	Sanctioned Strength	In-position	Vacancy	Remarks (action initiated by the Institute to fill up the vacant posts)
1.	Faculty	554	346	208	• Out of 208, 117 faculty posts of different specialties have already been advertised and the meeting of the Standing Selection Committee is likely to be fixed shortly.
2.	Residents	1290	1219	71	• The posts of Residents have been filled up twice in a year i.e. (in December Session and in June Session). The vacant posts will be filled up in June Session.
3.	Teaching posts (Non Faculty)	111	68	43	• The direct recruitment posts have been advertised and likely to be filled up shortly.
4.	Nursing Staff	2569	1938	631	• 468 posts were advertised for which written tests conducted on 1.2.2015. Results declared interview are being conducted

					shortly.
5.	Administrative Staff	622	392	230	• 91 posts of LDCs have been notified and is being filled up shortly. • 19 posts of Store Keeper have been notified and likely to be filled up shortly. • 26 posts of Stenographer have been notified and the process to advertise the posts is being initiated. • 13 posts of Office Superintendent are being filled up shortly by Limited Departmental Competitive Examination and by promotion. • 81 Post of Assistants/ Personal Assistant and Junior Accounts Officer/Legal Assistant/Asstt./ Sr Accounts officer/ Jr. Auditor/ Asstt. Purchase Officer, Asstt. Admn.Officer/Asstt. Accounts officer, Admn.Officer/Pvt. Secretary are being filled up on promotion basis.
6.	Engineering Staff	803	504	299	• The process for filling up the 117 posts on direct recruitment basis is under process and likely to be filled up shortly. • Process for filling up 182 posts on promotion basis is under process and likely to be filled up shortly.
7.	Paramedical /technical	1046	776	270	• 183 posts under direct recruitment basis have been notified and are under process of filling. • Remaining 87 promotional posts are under process.

8.	Supporting Staff	1845	1322	523	• The posts i.e. Lab. Attendant, Hospital Attendant, Sanitary Attendant, Security Guards, Dark Room Attendant, Animal Attendant, Masalchi Bearer, Laundry Staff have been outsourced for the time being.
	Total	**8840**	**6565**	**2275**	

6.4 The Committee notes that the action has been initiated to fill up the vacant posts at PGIMER, Chandigarh. The Committee also notes that out of 208 vacancies in faculty posts, only 117 have been advertised for selection. The Committee would like to know the reasons for not advertising the remaining faculty posts.

6.5 The Committee notes from the Outcome Budget 2014-15 that a number of Projects are currently under implementation and a number of new schemes have also been approved but work is yet to be started. Some of these important schemes/ Projects are (i) Advanced Eye Centre Phase II, (ii) Advanced Cardiac Centre Phase II (iii) Modernisation of Research A & B Block (iv) Modernisation of Nehru Hospital (v) Construction of Satellite Centre at Sangrur (vi) Remodelling of Emergency Medical OPD Hall, Nehru Hospital (vii) SITC of HVAC system in the new OPD block etc. The Committee would like to be informed whether any timeline has been set for execution of the above projects and whether any of the above projects have witnessed time and cost overruns. The Committee would also like to be informed of the total approved outlay for each of the above projects and the expenditure incurred thereon.

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

7.1 The Committee has been informed that National Institute of Mental Health and Neuro Sciences, makes available comprehensive patient care services in Psychiatry, Neurology, Neurosurgery and other related fields. The institute renders yeoman services to patients from all over the country as well as other developing Asian, Arabic and African nations, particularly to the needy and underprivileged. Apart from outpatient and inpatient services in all the specialties of mental health and neurological disorders, a comprehensive Psychological and neurorehabilitation is provided to facilitate integration of patients into their families and society at large.

7.2 NIMHANS continued to provide comprehensive quality patient care services, guided by knowledge and enabled by skill, in the fields of mental health and neurosciences. During the period (1 April 2014 to 31 December 2014), about 3.8 lakh patients from various parts of the country and across the globe received medical care.

7.3 The status of Plan funds allocated vis-a vis expenditure for 2012-13, 2013-14& 2014-15 is as under:

Table No. 18

(Rs. In Crore)

	BE	RE	AE
2012-13	109	109	109
2013-14	132.80	132.80	132.80
2014-15	132.80	158.46	143.22(upto 19/3/15

7.4 **The Committee is glad to note that there has been optimal utilization of funds during last three years which indicates target oriented approach of the Institute in carrying out the activities as planned.**

7.5 The Committee has also been informed that against the projected requirement of Rs. 235.70 crore, an allocation of Rs. 140.00 crore has been made during 2015-16 due to less plan outlays given by the Ministry of Finance, which will have the following repercussions:

i) As reported by the Institute, the deficit will have to be met by reduction in expenditure towards grants for creation of capital assets.

ii) Impact on the planned procurement of the Gamma Knife Perfection System, Dedicated State of the art Scanner, Animal PET MRI and other equipment.

iii) Restricted fund availability for the planned establishment of a Sub Specialty Block in Neuro Science (125 Beds, 2 Operation Theatres and 25 Beds for ICU).

As there is a reduction in Plan Capital Expenditure, the Institute may have to take these projects forward until there is substantial increase in Budget under Plan. However, the Department will strive to make additional provision at the Revised Estimates stage.

7.6 The Committee notes with concern that the budgetary support provided to NIMHANS in 2015-16 is not adequate and may delay the developmental activities. Though the Committee lends its support for making higher provisions for NIMHANS in RE 2015-16, it simultaneously impresses upon the Institute to economise on expenditure and deploy the available resources in a more efficient manner.

7.7 The Committee further notes that 185 posts of Faculty Senior Residents and Junior Residents have been created and the process of filling up of the posts is underway. Early action should be taken for filling up posts without any delay.

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

8.1 The Committee has been informed that North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences has been established in Shillong on the lines of AIIMS, New Delhi and PGIMER, Chandigarh, with the objective of providing advanced specialized health care to the people of North-eastern region.

8.2 During the course of examination of Demands for Grants 2013-14, the Committee had been informed of the two projects, i.e. (i) Establishment of Undergraduate College and (ii) Establishment of Regional Cancer Institute, stating that "the project of Establishment of Undergraduate College and Regional Cancer Centre at an estimated cost of Rs. 196.92 crore was circulated in January, 2012. However, the appraising agencies raised certain queries/ clarification which remain to be clarified. It is expected that the revised projects would again be circulated to the appraising agencies in the first quarter of financial year 2013-14".

8.3 The Committee is constrained to note that the projects (i) Establishment of Undergraduate College and (ii) Establishment of Regional Cancer Institute are still hanging fire. An early decision should be taken in this regard. The Committee would also like to be informed of the on-going projects of North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences and whether implementation of the projects is on schedule or they have witnessed any time and cost overruns.

8.4 The Committee notes that under the broad head-strengthening of Institutions for Medical Education, Training and Research, which *inter-alia* covers NEIGRIHMS, an allocation of Rs. 490.00 crore has been made in BE 2015-16 on the Plan side. The Committee desires that there should not be any shortfall in expenditure and physical and financial targets should be achieved.

IX. DEVELOPMENT OF NURSING SERVICES

9.1 Nursing Personnel are the largest workforce in Hospital setup and play important role in healthcare delivery system. As per information furnished, the activities under the programme include in-service training of nurses to update their knowledge and skills; strengthening of Nursing schools and colleges to improve quality of education being imparted to students and National Florence Nightingale Award for nursing personnel.

9.2 In order to improve the quality of nursing services, the government has taken steps for the strengthening & upgradation of Nursing education & services through the following Centrally Sponsored/Centre Sector schemes:- (i) Upgradation/ Strengthening of Nursing Services & Establishment of ANM/ GND; (ii) Development of Nursing Services. The plan for the year 2015-16 under development of nursing services is: (i) establishment of 15 Centres of Nursing Excellence across the country, (ii) setting up of Indian Institute of Advanced Nursing (IIAN) in order to provide high quality of nursing education in the country.

9.3 In reply to a question, the Department has informed the Committee that under Development of Nursing Services Rs. 10.00 crore has been allocated under BE for the year 2014-15. The expenditure as on date is Rs.52.00 lakh (Rs. 44.00 lakh for conducting National Nightangle Florence Award and Rs. 8,26,500/- on Training). Funds could not be released to the States because of pending Utilisation Certificates. Proposal for releasing of fund to the tune of Rs. 8.36 crore is being taken up with IFD of Ministry of Health & Family Welfare.

9.4 The Committee observes that with the changeover from Society route of funds to Treasury route of funds in 2014-15, release of funds should no longer be hamstrung by pending UCs. However, the Committee would impress upon the Department not to slacken its efforts for liquidation of old UCs which are still pending.

9.5 As per information made available to the Committee, the following ongoing activities under the Development of Nursing Services are to be continued during 12th Plan Period:

(i) Training of nurses, (ii) Strengthening of nursing institutions, (iii) Up-gradation of School of Nursing into College of Nursing; (iv) Assistance to three Central Government institutions to up-grade their infrastructure; and (v) Annual Florence Nightingale Award Ceremony.

9.6 The new activities which are to be carried out during the 12th Plan Period under the scheme are:

(i) Up-gradation of Lady Reading Health School (LRHS), New Delhi to enable the institute to conduct P.B.B.Sc. Indian Nursing Council (INC) has decided to discontinue Diploma in Nursing Education and Administration (DNEA) and all such institutions can conduct P.B.B.Sc. after up-gradation. In order to implement the decision of INC, it is necessary to up-grade the Lady Reading School of Nursing into College of Nursing to enable the Institute to conduct P.B.B.Sc. (Nursing) course. The total financial implication for the above proposal at (i) is Rs. 12.45 crore.

(ii) Formation of Monitoring, Evaluation and Technical Cell of India (METI).

The monitoring, evaluation & technical cell of India, in short, known as METI will be established at the Ministry of Health and Family Welfare for monitoring and evaluating the implementation of various nursing development programmes across the country. The main objectives of METI are as under:-

1. To develop appropriate programmes for the development of nursing in the country.
2. To monitor and evaluate the implementation of various nursing development programmes and facilitates recourses to achieve the preset goals and desirable outcomes.
3. To provide feedback to Ministry of Health and Family Welfare for release of funds

to various nursing projects.

The total financial implication for activities at (ii) will be Rs. 4.75 crore.

9.7 The Committee observes that very important initiatives are proposed under Development of Nursing Services during the 12th Plan Period. Keeping in view the fact that there are imbalances in ratio of doctors to nurses, the Committee welcomes the above initiatives and desires them to be taken forward.

9.8 The Ministry has informed that the proposed requirement for implementing various sub components of the Scheme for the year 2015-16 was Rs. 56.00 crore. Against this an allocation of Rs. 13.00 crore has been made available. On being asked whether the allocation of Plan funds of Rs. 13.00 crore is sufficient to meet the requirements of various activities under the project, the Department submitted that the amount is quite inadequate & with the existing fund allocation, the old components which were continued from 11th Plan Period could only be executed.

9.9 The Committee views with serious concern the inadequacy of the allocated funds and is apprehensive that this would certainly lead to undermining the national health objective because effective delivery of healthcare services is not possible without addressing the imbalances in the ratio of doctors to nurses and ensuring availability of adequate manpower mix. The Committee, therefore, lends its support for enhancing the allocations at RE stage. The Committee, however, desires that the shortfall in expenditure should be avoided.

<u>Upgradation of Rajkumari Amrit Kaur College of Nursing</u>

9.10 In reply to a question regarding the progress made with respect of upgradation of RAK college of Nursing to Centre of Excellence, the Department has informed the

Committee that Revised Memorandum of Understanding has been signed between Principal, RAKCON and HSCC. The process of obtaining permission from Civic Bodies like MCD, Fire Department is under process. Construction process will be started very soon, subject to availability of funds.

9.11 The Committee is dismayed to observe the persistent slow pace of the upgradation of Rajkumari Amrit Kaur College of Nursing despite Committee's repeated recommendations in this regard. If this is the state of affairs at the preparatory stage, it is hard to imagine the time by when this Centre of Excellence would see the light of day. The Committee would like the Department to proactively pursue the formality for obtaining permissions from civic bodies. The Committee is satisfied with the allocation of adequate funds for the Project, but is pained to observe that this project has been languishing since long with the budgeted allocations surrendered year after year. The Committee wishes to be updated on the progress made towards starting the Project.

Residential Accommodation for Nurses

9.12 In reply to a query regarding the residential accommodation for nurses vis-à-vis the demand and steps taken with respect to providing accommodation along with transportation facilities to the nursing personnel considering their night shifts, the Department has informed that there are four Central Government hospitals in Delhi, namely, Safdarjung Hospital, Dr RML Hospital, LHMC Hospital and Kalawati Saran Children's Hospital. Government of India has constructed a Nurses Residential Complex at Srinivaspuri comprising 413 flats, for providing residential accommodation to the Nurses working in these four hospitals. Besides, Directorate of Estates has allowed for allotment of flats to nurses from General Pool. As regards demand and availability of residential accommodation for nurses and to provide transportation facilities, the hospitals concerned are being advised to make an assessment and to take further actions.

9.13 The Committee expresses its displeasure at the tenor of the reply furnished by the Department. The reply is of generic nature and contains no substantive information like availability of residential accommodation vis-à-vis demand and transportation facilities for nurses. The Committee notes that this issue had figured in its 39th Report and 54th Report presented to Parliament on 28th April, 2010 and 26th April, 2012, respectively. The Department in its Action Taken Note on the 39th Report had given the same reply as it has given now. This shows that nothing concrete has been done in this regard so far despite Committee's repeated recommendations. The Committee deprecates such a casual and desultory approach of the Department. The Committee feels that Nursing Personnel is a very vital workforce in the healthcare delivery system and provision of accommodation and transportation is certain to act as multiplier to the professional competence and moral boosting of nurses. The Committee, therefore, recommends that Department accord utmost priority to providing accommodation and Transportation facilities to all nurses within a specified timeframe. The Committee wishes to be kept apprised of the action taken by the Department in this regard.

9.14 On being asked about the status of availability vis-à-vis the sanctioned strength of nurses in various Hospitals/ Institutes and the efforts made to fill up the vacancies, the Department has submitted that DGHS/Hospitals concerned have been asked to initiate actions towards filling up of all the vacant posts of nurses, after following due procedures.

9.15 The Committee takes serious note of the fact that instead of formulating a substantive reply delineating the number of vacancies and the efforts made to fill them up, the Department has furnished a casual reply which does not address the query posed. The Committee deprecates the casual approach of the Department in this regard. The Committee also desires to be apprised of the sanctioned, in-position and vacant posts of nurses in Central Government Hospitals and the steps taken to clear the vacancies and success achieved therein.

9.16 The Committee's attention has been drawn towards a news item titled "Reform Medical Education, Transform Healthcare" by Dr. Devi Shetty published in the Times of India dated 23rd March, 2015 wherein it has *inter-alia* been stated that *"the Nursing Profession in India is on the verge of extinction because career progression is limited in the field. Admissions to nursing colleges have come down by nearly 50%. Soon we may have to import nurses at exorbitant salaries from countries like the Philippiness or Thailand."*

9.17 The Committee is extremely distressed to note the grim picture emerging from the article of Dr. Devi Shetty. The Committee observes that lack of career progression of nurses and the resultant dwindling population of nurses have very grave implications for the healthcare delivery system and therefore, requires urgent attention. The Committee, accordingly, impresses upon the Department to take prompt cognizance of the dwindling population of nurses and its causative factors and formulate a fair career progression policy for nurses so that this trend of decreasing workforce of nurses can be checked, existing workforce is kept motivated and more and more people are attracted towards this stream of health profession. The Committee would like to be apprised of the action taken by the Department in this regard within a period of three month from the date of presentation of this Report.

X. CENTRAL DRUGS STANDARD CONTROL ORGANIZATION (CDSCO)

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

10.2 The Committee has been informed that allocation of Rs. 121.50 crore in BE 2015-16 comprises budgetary provisions for the following Institutes/Schemes:-

Table No.19

(Rs. in crore)

Sl. No.	Name of the Institute/Scheme	B.E. 2015-16
1.	Central Drugs Standards Control Organisation.	98.50
2.	Indian Pharmacopiea Commission	17.00
3.	National Pharmacovigilance	6.00
	Total	**121.50**

10.3 The utilization status of the funds for the years 2012-13, 2013-14 & 2014-15 are as follows:

Table No. 20

(Rs. In crore)

	BE	RE	AE
2012-13	72.60	62.38	27.82
2013-14	251.00	110.36	58.61
2014-15	100.00	67.00	39.33(upto 5/3/15)

10.4 With respect to the steps taken to optimise utilisation of funds earmarked for the CDSCO, the Department has informed that the funds allocated to Central Drugs Standard Control Organization are being utilised to strengthen the regulatory structures. These include systemic improvements such as e-Governance project, accreditation of Ethics Committees Investigator and Clinical Trial sites; putting in place a Track & Trace Mechanism to ensure the quality/genuineness of drugs; and creating a separate vertical in the CDSCO for medical devices. Besides, the Drugs & Cosmetics Act, 1940 is also being amended to give a distinct treatment to medical devices sector.

10.5 The Committee observes that the actual utilization of funds has been persistently and significantly less than the allotted funds over the last three years. This trend of underutilization of funds is indicative of inadequate budgetary planning and projection of funds in a ritualistic manner without any correlation with their deployment. Since CDSCO is mandated to play a critical role in ensuring that the drugs being supplied to the public are safe, efficacious and conform to prescribed quality standards, such financial under performance year after years is deplorable. The Department owes an explanation to the Committee on the reasons for persistent and significant suboptimal utilization of allotted funds year after year and that too when the Committee has been repeatedly recommending for strengthening of the CDSCO. The Committee recommends that to improve financial performance of CDSCO, quarterly expenditure targets may be fixed and expenditure monitored on a regular basis.

10.6 In reply to a question regarding the updated status of appointments of Drug Inspectors, vacant posts vis-à-vis sanctioned strength and the Department's effort to fill up the vacant posts, the Ministry has furnished the following information:-

Table No. 21

A. Details of sanctioned posts:

i)	Permanent Sanctioned Posts	32
ii)	Temporary Posts	
	created w.e.f. 15.07.2008	62
	created w.e.f. 18.08.2009	75
iii)	Newly created w.e.f. 03.07.2013	110
	Total posts	279

B. Details of vacant posts:

i)	Total Sanctioned Post	279
ii)	Total Posts filled as on date	(-) 143
iii)	Vacant Posts	136

A requisition for 147 vacancies has since been sent to the UPSC on 23.01.2015. The UPSC has advertised the posts on 28.02.2015.

10.7 The Committee is deeply concerned to note that CDSCO is reeling under shortage of manpower. The Committee is of the firm view that without the required manpower, the strengthening of CDSCO will be seriously jeopardized and its functioning will get crippled. The Committee, therefore, recommends that the Department proactively pursue filling up of the vacant posts with UPSC and simultaneously explore innovative ways of filling up the vacancies so that the objective of uniform and effective implementation of the Drugs and Cosmetics Act 1940 and Rules framed thereunder is not compromised.

10.8 In reply to a question, the Committee has been informed that steps to strengthen the States Drug Regulatory System have been discussed with the State authorities. The Scheme relating to strengthening of the States Drug Regulatory System under 12th Five Year Plan is yet to be considered and approved by the competent authority.

10.9 In reply to another question, the Ministry has informed that Centrally Sponsored Scheme for Strengthening of Drugs Testing Labs has been approved by the Expenditure Finance Committee with an outlay of Rs. 850 crore. However, the scheme is yet to be approved by the CCEA and hence no financial assistance has been provided till date under the scheme.

10.10 The Committee in its 59th Report had made a detailed study of the functioning of CDSCO and *inter-alia* made the following recommendations regarding strengthening of State drug regulatory mechanism.

"4.1…….the Committee concludes that shortcomings witnessed in respect of coordination with and between the States as also in implementation of applicable legislations in the States are primarily an offshoot of inadequacies in manpower and infrastructure in the States. Strengthening the regulatory mechanism in the States will remain a far cry unless these infirmities are taken care of."

"4.2 Given the lack of adequate resources in the States it would be unrealistic to expect them to improve the infrastructure and increase manpower without Central Assistance for strengthening drug control system. The Committee, therefore, recommends that the Ministry of Health and Family Welfare should work out a fully centrally sponsored scheme for the purpose so that the State Drug Regulatory Authorities do not continue to suffer from lack of infrastructure and manpower anymore. The Committee desires to be kept apprised of the initiatives taken by the Ministry in this regard."

The Ministry in its Action Taken Note had made the following submission:-

"4.3 The Ministry agrees with the observations of the Hon'ble Committee and envisages strengthening of the States' drug regulatory system during the Twelfth Five Year Plan through a suitable scheme."

10.11 The Committee notes that the Ministry had accepted above Recommendations of the Committee on strengthening of the States' drug regulatory system. More than two years have elapsed since then but finalization, leave alone implementation, of the Scheme is still a far cry. The provisions of the Drugs and Cosmetics Act are implemented by both the Centre and States. The quality control of drugs falls largely in the domain of the State Drug Licensing Authorities who are mandated to draw samples of drugs for analysis, prosecution etc. Given the grossly inadequate infrastructure and manpower of States and lack of resources with them, it was imperative on the Central Government to quickly move towards addressing the pending issues pertaining to approval of the Centrally Sponsored Scheme for the State Drug Testing Laboratories. The Committee, therefore, deprecates the Department for lagging behind in addressing the inadequacies of the State Drug Regulatory System. 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 tardy pace of progress in the matter is, therefore, of serious concern and has serious implications for the healthcare system as well as economy as a whole. The Committee, therefore, recommends the Department

to vigorously pursue the approval and finalization of Centrally Sponsored Scheme for Strengthening of Drug Testing Labs with the Cabinet Committee on Economic Affairs and ensure that the same is launched in the financial year 2015-16 without fail. The Committee would also like to be apprised of the exact contours of the proposed Scheme as soon as the necessary permissions/approvals in this regard, are obtained by the Department.

XI. MANUFACTURE OF SERA AND VACCINE AND PUBLIC HEALTH LABORATORIES (BCG VACCINE LABORATORY, GUINDY, PASTEUR INSTITUTE OF INDIA, CONOOR AND CENTRAL RESEARCH INSTITUTE, KASAULI)

11.1 The Committee had made an extensive study on the various issues connected with the three vaccine manufacturing producing PSUs, namely, the Central Research Institute (CRI), Kasauli, the Pasteur Institute of India (PII), Conoor and the BCG Vaccine Laboratories, Guindy, Chennai and presented to the Parliament four Reports i.e., 34th Report on 18th February, 2009, 38th Report on 18th December, 2009, 43rd Report on 4th August, 2010 and 52nd Report on 4th March, 2011 dealing with issues like the problems ailing them; their revival; effect of the closure of the three PSUs on the Universal Immunization Programme, resultant spiralling vaccine prices in the country, status of making them current Good Manufacturing Practice (cGMP) compliant etc. The Committee has since been calling for progress reports on bi-monthly basis on the status of progress made towards making them cGMP compliant.

11.2 On being asked about the updated status of progress made towards making the three vaccine producing PSUs cGMP complaint, the Ministry in its latest reply has furnished the following information:-

Central Research Institute, Kasauli

11.3 The new DPT facility has been completed and made cGMP compliant in January, 2014. The installation qualification and operational qualifications of DPT blocks have been successfully completed. The staff engaged in the production units is trained to operate the newly installed machinery and equipment. The bulk for Consistency/ Commercial batches of TT has been successfully produced. The Consistency/ Commercial batches of Diphtheria and Pertussis batches are under process.

BCG Vaccine Laboratory, Guindy

11.4 The work of upgradation of BCG Vaccine Manufacturing facility has been completed by 90%. The installation qualification and operational qualifications of the installed equipment is under process and likely to be finished by June, 2015. The staff engaged in the production units is being trained in batches to operate the newly installed machinery and equipment. The R&D batches of BCG vaccine would be initiated in June, 2015. The Consistency/ Commercial batches of BCG vaccine would be initiated batches by December, 2015.

Pasteur Institute of India, Coonoor

11.5 HLL, which is the Project Manager, has initiated civil construction work on the project in June, 2013. The basic infrastructure of the Diphtheria and Petussis blocks has been completed. Work ranging from 30 to 90% of the various other blocks such as formulation block, Sterility and Microbiology block and animal experiment has been completed. The new DPT facility is to be completed and made GMP compliant in April, 2016. The trail batches of DPT vaccine would be initiated in December, 2016. The Consistency/ Commercial batches of DPT vaccine would be initiated by June, 2017.

11.6 The Committee observes that considerable time has passed since the project of making the three vaccine producing PSUs cGMP complaint was undertaken but completion of cGMP complaint structures at two of the above PSUs, namely, BCG Vaccine Laboratory, Guindy, Chennai and Pasteur Institute of India is yet to be accomplished. It escapes the Committee's comprehension as to why the completion of cGMP complaint structure has been delayed inordinately despite adequate funds being made available for the project. This explains total negligence and apathy of the Department towards this. The Committee, therefore, recommends with all the power at its command to expedite completion of work regarding cGMP compliance and enable the vaccine manufacturing PSUs to contribute their mite to the Universal Immunization Programme (UIP). The Committee also suggests to the Department to insulate the UIP from price and supply uncertainty. The Committee would like to be updated on the progress made towards completion of the works concerning cGMP compliance and full operationalization of the three PSUs on a quarterly basis.

11.7 The Department has furnished the following information on financial performance under the head-Manufacture of Sera and Vaccine.

Table no. 22

(Rs in crore)

Year	BE	RE	Actual
2012-13	218.00	195.67	184.55
2013-14	187.86	61.00	71.93
2014-15	144.02	92.64	33.50(upto 5/3/15)

11.8 The Committee is concerned to note that there is huge financial underperformance in the years 2013-14 and 2014-15 which is not acceptable and

expects the Department to explain the reasons behind the conspicuous mismatch in BE and AE of 2013-14 and 2014-15.

11.9 On being asked whether the vaccine for UIP are being procured from private players and the reasons thereof, the Committee has been informed that the PSUs viz. Pasteur Institute of India, Coonoor; Central Research Institute, Kasauli and BCG Vaccine Laboratory, Guindy produce mainly DPT, TT & BCG Vaccines. The requirement of DPT, TT & BCG Vaccines under the UIP is much more than the production of these PSUs. In order to run the Immunization Programme effectively, the Vaccines are also procured from private companies after inviting Global tender. The cost of vaccine procured from private players vis-à-vis those supplied by vaccine manufacturing PSUs during the year 2014-15 is given in following table:-

Table No. 23

2014-15 (Current Year)						
Vaccine purchased from manufacturers under Universal Immunization Programme 2014-15						
S. No	Vaccine	Quantity ordered (in lakh doses	Name of the Company	PSU/ Private	Rate per vial (in Rs.)	Total Value (Rs. in Lakh)
1.	BCG	761.208	M/s Serum Institute of India, Pune	Private	27.10+CST/VAT@5%=28.455	2166.02
2.	DPT	1250	M/s Indian Immunological Limited, Hyderabad	PSU	43.47 (All inclusive)	5433.75
		106.7	M/s Pasteur Institute of India, Coonoor	PSU	41.40 (All inclusive)	441.74

3.	TT	250	M/s Shantha Biotechnics Ltd., Hyderabad	Private	21.60+CST / VAT@ 5%=22.68	567.00
		1197.87	M/s Indian Immunological Limited, Hyderabad	PSU	23.75+CSGT/VAT@ 5%=24.9375	2987.19

11.10 The Committee takes note of the submission that "the requirement of DPT, TT and BCG Vaccines under the UIP is much more than the production of these in PSUs." The Committee would like to draw the attention of the Department to the following observation made by the Javid Chowdhury Committee on the three PSUs:-

"*Para 5.1. To insulate the UIP from the price and supply shocks a cardinal principle of public health requires the sourcing of vaccines from public sector manufacturing units to a substantial extent*."

11.11 The purpose of quoting from the Javid Chowdhury Committee Report is only to impress upon the Department the imperative need for streamlining the monitoring of the on-going work of cGMP compliant structures and expediting the completion thereof.

11.12 The Committee gathers from the information made available to it that the quantity of BCG Vaccine produced by BCGVL was nil in 2014-15. The Committee would like to be apprised of the reasons therefor and its impact on the prices of BCG Vaccine as also on exchequer.

XII. ASSISTANCE FOR CAPACITY BUILDING FOR TRAUMA CARE FACILITIES IN GOVERNMENT HOSPITALS ON NATIONAL HIGHWAY

12.1 As per information in the Annual Report 2014-15, road traffic injuries are one of the leading causes of deaths and disabilities. According to WHO "Global Status Report on Road Safety 2013", more than 1.2 million people die in road accidents every year and as many as 50 million are injured. Deaths due to road accidents are in the eight leading causes of death globally which is expected soon to be the fifth common cause of death by the year 2030 unless the problem is addressed urgently. As far as India is concerned, death and disabilities due to accidents are gradually rising. During the year 2011, there were around 4.98 lakh road accidents which killed 1.42 lakh people and more than 5 lakh were injured. During 11th Five Year Plan the Govt. of India initiated a scheme on trauma care with an outlay of Rs.732.75 crore with 100 % central funding provision to develop a network of 140 trauma care facilities in the Govt. Hospitals along the Golden-Quadrilateral highway corridor. Out of the identified 140 hospitals, the trauma centres in 118 hospitals were funded under the trauma scheme, 20 hospitals were funded under PMSSY scheme and 2 trauma centres in Delhi's Dr. RML Hospital & AIIMS were developed with their own funds. The trauma care network was so designed that no trauma victim has to be transported for more than 50 kms to a designated hospital having trauma care facilities. For this purpose an equipped basic life support ambulance was to be deployed by National Highway Authority of India (NHAI) (Ministry of Road Transport and Highways) at a distance of 50 kms on the designated National Highways. MoRTH has supplied these ambulances on National Highways. An amount of Rs**.** 352.69 crore was released during the 11th plan.

12.2 The scheme has been extended to the 12th plan period and has already been approved by CCEA with total budget outlay of Rs. 899.29 crore. The proposal was approved for development of another 85 new Trauma care centres on the same pattern with following minor variations:

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

1. Connecting two capital cities;
2. Connecting major cities other than capital city;
3. Connecting ports to capital city;
4. Connecting industrial townships with capital city and
5. Accidental black spot data.

b) The identification of the hospitals for development of 85 trauma centres will be done in consultation with all the stake holders. Preference will be given to states which are not covered during 11th plan and Hilly & North Eastern States.

c) Unlike the 11th plan, the scheme is not 100% centrally sponsored. Now the amount of assistance will be shared between Central and State Governments in a ratio of 70:30. The ratio of sharing for North Eastern states and hill States of Himachal Pradesh, Uttarakhand and Jammu & Kashmir will be 90:10.

d) The scheme has been merged within the ambit of "Human Resource in Health and Medical Education Scheme". Hence, 12th plan component of the scheme will be governed according to the norms set under this umbrella scheme. However, the components of 11th plan will be as per the original plan of 11th plan.

12.3 The Ministry has furnished the following information regarding fund utilization under this head during the last three years:-

Table No. 24

(Rs in crore)

	2012-13	2013-14	2014-15
BE	100	66.49	70
RE	50	28	40
AE	23.90	23.67	19.38 (upto 5th

			March, 2015)

12.4 It is revealed from the above table that allotted funds were substantially reduced at RE stage and actual expenditure figures were even less than the funds allotted at RE stage. The Department has further informed about the reasons for under-utilization of funds during financial year 2014-15 as under:-

(i) The extension of 11th Five year plan of Trauma scheme for the remaining period of the 12th Five Year Plan was approved by Cabinet Committee on Economic Affairs only in February, 2014. This was followed by implementation of code of conduct by Election Commission leading to further delay in implementation.

(ii) Funds could not be released further to Trauma Care facilities to which part of funds were released during the 11th Five Year Plan due to pendency of audited Utilisation Certificates (UC) and Statement of Expenditure (SOE) by these centres. Letters and reminders at various levels have been sent to the States for submitting the audited UCs & SOEs. The Regional Directors (RDs) have also been requested to follow up with State Government to expedite the submission of audited UCs & SOEs.

(iii) A meeting of the State Nodal Officers was held in September, 2014 in which they were informed regarding the components of the Programme and the activities to be carried out by them.

12.5 The Committee has been informed that no budgetary provisions have been made for the scheme- 'Assistance for Capacity Building for Trauma Care' for financial year 2015-16.

12.6 The Committee is constrained to observe that there was underutilization of more than Rs. 20.62 crore (as compared to RE 2014-15) as per the trend of utilization of outlay as on 5th March, 2015 and conveys its disapproval of such suboptimal utilization of budgeted funds. What is equally disturbing for the Committee is that no funds have been earmarked for the Scheme for 2015-16. The Committee observes that accidental trauma is one of the leading causes of mortality and morbidity in India and lack of budgetary provisions will seriously jeopardize the envisaged objective of this vital

scheme. The Committee, therefore, recommends that the Department should raise demand for adequate funds for this Scheme in the Supplementary Grants 2015-16.

XII. CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI

13.1 Central Institute of Psychiatry (CIP), Ranchi is a leading organization in the country providing diagnostic and treatment facilities in mental health apart from conducting post graduate courses in psychiatry. During 2014-15, till Sept, 2014, a total number of 38415 patients have utilized the services of OPD, 2149 patients were hospitalized for indoor treatment.

13.2 The trend of utilization vis-a-vis allotted funds for the last 3 years is as follows:

Table No. 25

(Rs.in crore)

	BE	RE	AE
2012-13	45.74	43.80	25.29
2013-14	50.00	41.31	28.53
2014-15	40.00	49.78	18.41(upto 5/3/15)

13.3 During 2014-15, the targets set & achieved by the Institute are as follows:

- The major equipments such as Robotized Coil Positioning System, 32 Channel EEG Machine, 3D Neuro Navigational System, 256 Channel ERP Systems, 16 blade server, Ultra Brief Pulse ECT Machine, CCTV Surveillance etc. have been procured at the Institute during the current financial year.
- The Master Plan for the development of the Institute and Architectural drawing for the construction of Family Ward , OT Block, Diagnostic Centre, Pharmacy Block, OPD Block and Neurology Block & CSSD Block have already been submitted by the Institute. These construction activities were approved

by the EFC in the year 2008, A proposal for construction of 90 nos. residential quarter has been approved and the same is underway.

- The 119 posts in various categories at the Institute have been created in 2014.
- Budget allocation for Capital Works includes Rs. 16.00 crore for purchase of a MRI equipment at the Institute which has already been approved by the Integrated Purchase Committee (IPC) under the Chairmanship of Director General of Health Services. Letter of Credit (LC) for the purchase of the said equipment is yet to be opened.

13.4 The Committee observes that there is persistent under utilization of funds by the Central Institute of Psychiatry, Ranchi during the last three years consecutively. While there were a number of ongoing activities at the Institute viz. Construction work, procurement of equipments, and recruitment process for 2014-15, the expenditure incurred is approximately 37% of the allotted funds. The Committee fails to understand the reasons for this mismanagement of funds and feels that in the present scenario of resource crunch, it would expect the Department to deploy the available resources in a more efficient manner and ensure proper correlation between their availability and utilization.

13.5 The Committee has been informed that the Plan allocation for the Institute in BE 2015-16 is Rs. 50.00 crore. The Ministry has informed that the allocated funds would be utilized for strengthening of existing services as per the redevelopment plan, training of manpower, addition of new infrastructural facilities and purchase of new machinery and equipments. The ongoing capital works at the Institute will be continued during the next financial year in addition to the proposed four lane connectivity from CIP Campus to the main road. The Institute has envisaged procurement of major machines and equipments like Ultra Brief Pulse ECT Machine, 40 Channel Wireless Digital Video EEG System, 40 Channel Video Polysomnography System, Premium-End Colour Doppler Ultrasound System, DNA Sequencer and DNA Lab, Mineral Water Plants, mechanized laundry etc. during the financial year 2015-16.

13.6 The Committee would expect the Ministry to formulate an action plan and streamline the monitoring mechanism for expeditious execution of the on-going activities of the Institute within the approved cost and specified timeframe. There should not be any shortfall in achieving physical and financial targets.

XIV. PRADHAN MANTRI SWASTHAYA SURAKSHA YOJANA (PMSSY)

14.1 As per information furnished by the Department, allocation for PMSSY for the Twelfth Five Year Plan is Rs.12,000.00 crore. Year-wise allocation and amount spent during the last three years is as under:-

Table No. 26

Year	BE	RE	Amount spent
2012-13	1376.21	850.00	858.89
2013-14	1475.00	925.00	811.94
2014-15	1956.00	891.00	772.81 (upto 05.03.2015)

14.2 Although Medical College, OPD and IPD have started functioning at all the six new AIIMS under PMSSY Phase-I, full functionalization of the Institutes has been delayed due to certain specific issues which emerged during construction. It is expected that the work will be completed in the financial year 2015-16.

14.3 As regards the upgradation of medical colleges, it was stated that out of 13 medical colleges in the first phase of PMSSY, civil work involved at 10 institutes and work has completed at 8 institutes. At Srinagar Medical College, civil work has got delayed due to internal disturbances and bad weather conditions. At Kolkata Medical College, civil work has been scheduled in two stages and work of OPD and Academic Block in the first stage has already been undertaken and completed. For Super Speciality Block scheduled for second stage, civil work was awarded in 2011 but due to non-provisioning of clear

site by State Government, the contractor had opted out as per tender conditions. Thereafter, tenders were invited many times. Tender is now at finalization stage.

14.4 Out of 6 medical colleges under PMSSY Phase-II Upgradation programme, civil work involved at 5 and work at 1 at Tanda Medical College has already been completed in Feb., 2014 and at Aligarh Medical College is likely to be completed by end of the financial year. The work at PGIMS, Rohtak has got delayed initially due to modification of plan and the construction work is expected to be completed by next year. Work at Madurai Medical College has also got delayed due to change of location by the State Government and work could start only in February, 2014 which is likely to be completed in the financial year 2015-16. Work at Amritsar Medical College will also be completed in the financial year 2015-16.

14.5 In respect of upgradation of 39 medical colleges in the third phase of PMSSY, it has been informed that Cabinet approval was obtained on 7.11.2013. Gap analysis was conducted in 38 medical colleges and Detailed Project Reports received from respective Statements are under examination/review by Technical Committee.

14.6 Further, as per announcement made in Budget Speech 2014-15 by the Finance Minister, the Government also proposes to establish four new AIIMS, one each at Andhra Pradesh, Vidarbha in Maharashtra, West Bengal and Poorvanchal in UP and upgrade 12 more existing Government medical colleges.

There will be some cost escalation in AIIMS project due to addition of certain facilities like construction of School of Public Health etc.

14.7 The Committee has also been given to understand that construction of the 6 new AIIMS like institutions are not complete even after 9 years when they were announced and they are nowhere close to their model, i.e. AIIMS, New Delhi. The construction work of the 6 AIIMS started in 2009-10 and only 60% has been completed so far, resulting in

cost-overruns. In Bhopal AIIMS, the cost of construction has doubled from its estimate of Rs. 682.00 crore in 2009. In addition to this the equipment of worth Rs. 70.00 crore are lying unutilized because of incomplete infrastructure. The delay in construction of AIIMS, Patna has led to severe shortage of floor space. As regards the human resources, despite offering same salary structure as AIIMS Delhi, only quarter of the sanctioned faculty posts have been filled in these institutes. In context of nursing and technical staff, most institutes are using contract labour or have outsourced nursing to external agencies. Against the sanctioned strength of 305, AIIMS, Raipur has only 64 faculty members for 24 non-clinical and clinical departments; only 200 nurses are working on contract against the sanctioned strength of 1800 nursing posts. Similarly, at AIIMS Bhubneshwar, 68 faculty members have been hired out of which 6 left within a year of joining due to non-utilization of their services. It has also been pointed out that most of these institutes lack super-speciality departments, such as cardiology, nephrology, endocrinology, neurosurgery, burns and plastic or even intensive care units (ICUs). AIIMS, Patna does not have a labour room, blood bank emergency services, CT and MRI facilities. AIIMS, Raipur has no ICU, life support and obstetric care facilities. With such deficiencies, these institutes started MBBS course with admission of 50 students in 2012 with enhanced take of 100 students next year and by August, 2014, third batch has also joined. The hostel facilities are incomplete with severe faculty shortage and poor in-patient facilities for the purpose of clinical training. On an average approx. Rs. 800.00 crore has been set aside in Financial Year since 2009 for the "PMSSY". With this allocation being shared by 6 AIIMS and a dozen State hospital for their up gradation, it does not amount to much. In the year 2015-16, an allocation of Rs. 2156.00 crore would be shared by 16 AIIMS like institutions plus upgradation of existing Government hospitals.

14.8 In reply to a question, the Ministry has informed that the actual expenditure incurred during 2014-15 (upto 19.3.2015) is Rs. 775.98 crore vis-à-vis allocation of Rs. 1956.00 crore.

14.9 It has also been informed that there will be some cost escalation in AIIMS project due to addition of certain facilities.

14.10 The Department has informed the Committee that the amount of Plan funds of Rs. 2156.00 crore allocated in BE 2015-16 will be utilized by way of Grants-in-aid to six new AIIMS; undertaking construction activities at new AIIMS and upgradation projects; procurement of medical equipment for new AIIMS as well as upgradation projects; and consultancy fee for various agencies like DPR Consultants/Project Consultants etc. for new AIIMS/Upgradation projects. In addition, establishment of 9 more new AIIMS and upgradation of 12 more existing Government Medical Colleges are also proposed to be taken up as per Finance Minister's Budget Speech 2014-15 and 2015-16.

14.11 On being asked about the steps taken by Department for establishing a monitoring mechanism for the upgradation work under PMSSY, the Department has informed that the Project Management Committee (PMC) has been constituted in the Ministry of Health and Family Welfare under the Chairmanship of Secretary (Health) and comprising of Director General of Health Services, Director (AIIMS), Director (PGIMER), Additional Secretary (Health), Special Secretary & FA / Additional Secretary & FA, Director General (CPWD), Advisor (Health –Planning Commission), Joint Secretary (PMSSY), MoHFW, a representative each from Ministry of Statistics & Programme Implementation, Ministry of Railways, Ministry of Defence, Airport Authority of India. The PMC National Highway Authority of India is the Apex Steering and Monitoring Body for all the PMSSY projects including upgradation projects.

14.12 **The Committee notes that PMSSY was launched in March 2006 with the primary objective of correcting the imbalances in availability of affordable tertiary healthcare facilities in the country as also to augment facilities for quality medical education in the under-served areas of the country. But inordinate delay in full operationalization of six AIIMS-like Institutions announced in 2006, has not only resulted in massive cost-escalation but also blunted the objective of correcting the mismatch between demand for and supply of equitable, accessible and good quality tertiary healthcare infrastructure and services. As per the feedback received by the Committee, all the six AIIMS like Institutes are facing shortage of infrastructure,**

accommodation and qualified/ trained manpower. The Committee also takes note of the Health Secretary's submission that the Department did not have the requisite experience of having that kind of structure constructed and procurements made, but after 2010, the expenditure has picked up, civil constructions have happened and equipments have been procured and a strong mechanism has been put in place and in the coming years things will witness better performance. The Committee sincerely hopes and trusts that the full operationalization of AIIMS like institutions will gather momentum. The Committee would like to be kept apprised of the progress made towards full operationalization of six AIIMS-like Institutions on a bi-monthly basis.

14.13 The Committee also notes that upgradation of several existing medical institutions are envisaged under PMSSY and in Phase I, 13 Medical Colleges are targeted to be upgraded. The Committee would like to know the original estimated cost of upgradation per Medical College in Phase I, escalation therein, if any, and designated timeline for completion of the upgradation.

14.14 The Committee would also like to be apprised whether normative requirements in respect of upgradation of all 39 medical colleges included in Phase III have been fulfilled.

14.15 The Committee observes that total 70 medical colleges have been selected for upgradation while the updated number of AIIMS like institution is 16. The Committee would like to be informed whether total estimated cost of all these projects have been worked out.

14.16 Given the fact that Government spending on health is nowhere close to the targeted level of 2.5 per cent of GDP during the 12th Plan Period and health budget for the financial 2015-16 is grossly inadequate, the Committee would like to know whether the Government has the fiscal strength to make huge investments on PMSSY and how the financial resources will be mobilized to implement this ambitious project.

14.17 The Committee also desires that Project Management Committee meet frequently to review the progress of implementation of PMSSY.

XV. CENTRAL GOVERNMENT HEALTH SCHEME (CGHS)

15.1 Central Government Health Scheme (CGHS) is a health scheme mainly for serving/retired central government employees and their families. This scheme was started in 1954 in Delhi. Overtime it has spread to 25 cities and 12 more cities are to be covered soon. CGHS has beneficiary base of 36,67,795 with more than 40% in Delhi & NCR. There are 273 allopathic dispensaries, 19 polyclinics, 73 labs and 85 AYUSH dispensaries under CGHS. The CGHS has empanelled 748 hospitals, 215 eye clinics, 74 dental clinics and 148 diagnostic labs so far.

15.2 Status of allocation of Plan funds and utilization thereof for the years 2012-13, 2013-14 and 2014-15 is as under:-

Table No. 27

(Rs. in crore)

Year	BE	RE	AE
2012-13	92.01	94.46	74.56
2013-14	101.20	110.00	86.60
2014-15	101.20	156.93	66.45 (upto 5th March,2015 (prov.)

15.3 In reply to a question, the Department has informed that the reasons for enhancement of funds in RE of 2014-15 were to enable payment towards contractual doctors and other contractual staff and construction of Administration Office of CGHS, Delhi and renovation of CGHS Wellness Centers.

15.4 **The Committee notes that during the last three years, i.e. 2012-13, 2013-14 and 2014-15, the allocations made for CGHS at BE stage was revised upwards at RE stage but the actuals were less than the BEs and REs in all the three years. The**

Committee observes that this is yet another case of inefficient utilization of funds on the part of the Department. The Department has miserably failed in expansion of facilities under CGHS and the precious funds allocated for the purpose were surrendered.

15.5 The Committee also observes that despite raised allocation of funds at RE 2014-15 stage for capital work and payment towards contractual doctors and staff, the actual utilization of funds is less as compared to funds allotted at BE stage, implying deficiencies in projection of funds at RE stage. The Committee would like the Department to exercise greater fiscal discipline while making fund projection in future.

15.6 The projected and approved outlay for CGHS for the year 2015-16 is as under:

Table No. 28

Projection Submitted		Allocation thereof	
NON PLAN	PLAN*	NON PLAN	PLAN*
1036.14	186.74	815.00	111.00

*Including projection/allocation in NER under Plan budget

15.7 The Department has informed that the reduced allocation of funds under Plan & Non Plan funds is likely to impact on the procurement of medicines in CGHS cities and other related expenses.

15.8 The Committee would like to observe that given the resource constraints due to the moderation in the growth of the economy it may not be possible to mobilise the required funds for CGHS. In such a scenario, it is imperative on the part of the Department to economise on expenditure and deploy the available resources in a more efficient manner. The Committee would, therefore, like the Department to prioritize the activities to be undertaken by the Department under CGHS and ask for enhanced funds at RE stage on the basis of qualitative improvement in expenditure.

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

16.1 Regional Institute of Medical Sciences (RIMS) is an institute of regional importance catering to the needs of the north eastern region in the field of medical education by providing undergraduate and post graduate courses. RIMS is a 1074 bedded teaching hospital having intake capacity of 100 MBBS, 150 PG, 50 BDS,50 BSc. Nursing among other courses including MCh. & MPhil. seats. The OPD attendance for the year 2014-15 was 3,22,4777 and in-patients admissions were 42,425 (as on 30/11/14).

16.2 The approved outlay for the 12th Plan for the Institute is Rs. 1088.00 crore. This amount will be used for procurement of medical equipments, expansion and development of infrastructure of the Institute and for enhancement of annual intake of the students in various courses.

16.3 The Committee has been informed that the Status of funds allocated and utilized in last three years at the Institute is as under:

Table No. 29

(Rs. in Crore)

	BE	RE	AE
2012-13	178.25	178.25	173.45
2013-14	196.00	211.00	227.40
2014-15	230.00	280.00	280.00 (upto 27/3/15)

As per information given in the Annual Report 2014-15 against the requirement of Rs.430.00 crore for 2014-15, the Department had provided a sum of Rs. 230.00 crore only in BE 2014-15.

16.4 The Committee also takes note of the fact that for the year 2015-16, Rs. 250.00 crore has been allocated for the RIMS, Imphal and the major projects of the Institute are as follows:

(i) The Project for up-gradation of RIMS to bring it at par with AIIMS, New Delhi (Phase-II) at an estimated cost of Rs. 129.00 crore is under implementation, which is also monitored by the PM Office on monthly basis.

(ii) Increasing the number of undergraduate seats from 100 to 150 for which EFC proposal at a cost of Rs. 202.00 crore has already been approved.

16.5 During the evidence of the Health Secretary on 30th March, 2015, the Members of the Committee raised an apprehension regarding adequacy of the funds made available to the Institute. In response thereto, the Health Secretary submitted that the quantum of Grants-in-aids to RIMS would be increase further in the years to come depending upon the requirement of the Institute under various projects.

16.6 The Committee notes with concern that despite good track record of fund utilization by the RIMS, Imphal during the years 2012-13, 20130-14 and 2014-15, the grants-in-aid of Rs.250.00 crore earmarked for the Institute for 2015-16 is even less than the RE 2014-15 figure of Rs. 280.00 crore. The Committee observes that RIMS caters to the healthcare needs of North EASTERN Region including providing medical education. Given the fact that North Eastern Region have weak public health indicators and weak health infrastructure, strengthening and capacity building of RIMS assumes added significance. The Committee, therefore, lends its full support to any higher fund projection for RIMS and recommends that enhanced grants-in-aid may be provided to the Institute.

16.7 The Committee notes that a project for upgradation of the Institute for bringing it at par with AIIMS, New Delhi is under estimation. The Committee desires that early action and final decision be taken in this regard at the earliest.

XVII. NATIONAL CENTER FOR DISEASE CONTROL, NEW DELHI

17.1 National Centre of Disease Control was earlier known as National Institute of Communicable Diseases. The Institute is under administrative control of the Director General of Health Services, Ministry of Health & Family Welfare. The Institute has its headquarters in Delhi and has 8 branches located at Alwar (Rajasthan), Bengaluru (Karnataka),Kozhikode (Kerala), Coonoor (TamilNadu), Jagdalpur (Chhattisgarh), Patna (Bihar), Rajahmundry (Andhra Pradesh) and Varanasi (Uttar Pradesh). The activities/projects being run by NCDC, New Delhi are: Integrated Disease Surveillance Project (IDSP), Upgradation of National Centre for Disease Control; Strengthening of Existing Branches and Establishment of 27 New Branches of NCDC; Division of Parasitic Diseases among many others.

17.2 The actual expenditure status vis- a-vis allocated funds (Plan) in last three years is as follows:

Table No. 30

(Rs. in Crore)

	BE	RE	AE
2012-13	17.50	16.17	10.64
2013-14	18.00	12.88	11.36
2014-15	13.00	12.95	8.70 (upto 19/3/15)

17.3 The Committee has been informed that the Status of physical targets set and achieved during 2014-15 is as under:-

Table No. 31

Name of the Scheme	Objective	Status/activities
National Centre for Diseases Control	Disease Surveillance and outbreak investigation, Training Programme, Operational Research, MPH courses	Out of 103 newly created scientific and technical posts, 14 posts have been filled up.
NCDC (upgradation) (Capital)	To upgrade the National Centre for Disease Control(NCDC) Cabinet Committee on Economic Affairs (CCEA) approved in December, 2010, the proposal for upgradation o NCDC at a total cost estimates of Rs. 382.41 crore.	The project has been registered with ADARSH for GRIHA RATING. During the year the consultancy fee of Rs. 87,60,558/- to HSCC. The construction has started in February, 2013 after receipt of Final approval on building plans from NDMC on 28.01.2013 and the civil & services work is in process..

17.4 As regards the ongoing initiatives/activities undertaken by the Institute, the Department informed that the activities viz. implementation of Yaws Eradication Programme, Guinea-worm Eradication Programme, Disease Survillance Programme, etc. are being undertaken by National Center for Disease Control (NCDC).

17.5 **The Committee notes that out of 103 newly created scientific and technical posts, only 14 posts could be filled by the NCDC, New Delhi. The Committee recommends that the steps may be expedited to fill up the remaining posts .**

17.6 The Committee would also like to be apprised of the timeline fixed for completion of upgradation of the Centre.

XVIII. HEALTH SECTOR DISASTER PREPAREDNESS

18.1 On being asked about the actual expenditure incurred vis-à-vis allocations made in 2014-15 and physical targets set and achievements made during 2014-15 under the head- "Heath Sector Disaster Preparedness", the Department has furnished the following information:

"The actual expenditure incurred vis-à-vis allocations made in 2014-15 under Plan upto 19.3.2015 is Rs. 1.11 crores. Under the Programme, action on prevention, mitigation and preparedness measures in health sector for man-made and natural disasters is initiated."

18.2 In response to a query regarding the drastic reduction of Plan allocation of Rs. 27.00 crore at BE stage to Rs. 11.50 crore (Plan) at the RE stage in 2014-15 and enhancement to Rs. 27.00 crore in BE 2015-16 along with the manner in which the enhanced allocation is proposed to be utilized, the Department provided the information as follows:

"The allocation of Rs. 27.00 crore is meant for Health Sector Disaster Preparedness & Management including Emergency Medical Relief."

18.3 With respect to the initiatives/activities proposed under the programme during 2015-16, the Committee has been informed that "the allocation is meant for strengthening of Disaster Preparedness & Management System in health sector for man-made and natural disasters and emergency medical relief."

18.4 The Committee takes serious view of the cursory replies given by the Department, which lack totality and are not precise. The Committee would like the Department to indicate concrete reasons for drastic reduction of funds at RE 2014-15, under-utilization of funds during 2014-15 and proposals/ activities which are planned to be implemented for strengthening of the Disaster Preparedness and emergency medical relief for man-made and natural disasters in the country. The Committee strongly recommends that the financial indiscipline should be avoided. Projections

should be made after all formalities are completed instead of making projection and allocations and then start out on clearances etc.

PART – B (Demand No. 48)

National Health Mission (NHM)

I. INTRODUCTION

NATIONAL HEALTH MISSION (NHM)

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

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

1.3 Specific goals for the States will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

NATIONAL RURAL HEALTH MISSION

1.4 National Rural Health Mission (NRHM) was launched in 2005 to provide effective health care particularly to the rural population throughout the country with special focus on 18 states having weak public health indicators and/or weak health infrastructure. It was launched with the objective of improving the access to quality healthcare especially for the rural women and children and in strengthening of health infrastructure, capacity building, and decentralised planning. The Mission aims at effective integration of health with social determinants of health like sanitation and hygiene, nutrition, safe drinking water, girls education etc. The Mission was conceived as an umbrella programme subsuming all the then existing programmes of Health and Family Welfare including RCH-II, National Disease Control Programmes for Malaria, TB, Kala-azar, Filaria, Blindness and Iodine Deficiency. The Mission targets to provide universal access to rural people to effective, equitable, affordable and accountable primary health care. Some of the strategies employed by the Mission to achieve its goals were -: promoting access to improved healthcare at household level through ASHAs, strengthening sub-centres, PHCs and CHCs, preparing and implementing of inter-sectoral district health plans and integrating vertical health programmes at all levels, envisaging convergent health plans for each village through the Village Health Sanitation and Nutrition Committee, etc.

1.5 Over the last nine years, large numbers of contractual manpower including Doctors, Specialists, Paramedics, Staff Nurses and ANMs, etc. have been added to augment the human resources in health facilities at different levels. Better infrastructure, availability of man power, drugs and equipments and other factors has led to improvement in health care delivery service and increase in OPD and IPD services. Similarly, contractual people have been engaged to man the Programme Management Units at the State and District levels. The community based functionaries, named as Accredited Social Health Activist (ASHA) have been envisaged under the NRHM as a first port of call for any health related demands of deprived sections of the population, especially women and children, who were finding it difficult to access health services. The role of ASHA in creating awareness on health and its social determinants and mobilising the community towards local health planning and increased utilization and accountability

of the existing health services and in providing basic package of curative health care has been well acknowledged.

NATIONAL URBAN HEALTH MISSION (NUHM)

1.6 National Urban Health Mission (NUHM) was approved by the Union cabinet on 1st May, 2013 as a sub-mission under an overarching National Health Mission (NHM) for providing equitable and quality primary health care services to the urban population with special focus on slum and vulnerable sections of the Society. NUHM aims to improve the health status of the urban population, particularly the poor and other disadvantaged sections by facilitating equitable access to quality health care through a revamped primary health care systems, targeted outreach services and involvement of the community and the urban local bodies. NUHM covers all cities and towns with more than 50,000 populations as well as district headquarters and State headquarters, while smaller cities/ towns will be covered under National Rural Health Mission (NRHM). The Centre-State funding pattern is 75:25 for all the States except North-Eastern States including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the Centre-State funding pattern is 90:10.

II. BUDGETARY PROVISIONS

2.1 The Committee has been informed that against the projected outlay of Rs. 43,795.00 crore under National Health Mission (Plan), only Rs. 18,295.00 crore has been allocated for the Financial Year (FY) 2015-16. The budgetary allocation of Rs. 18,295.00 crore is marginally higher than the Revised Estimates of Rs. 17,627.82 crore and steeply lower than BE of Rs. 21912.00 crore for the FY 2014-15. The Ministry has informed the Committee that the budgetary cuts will certainly impact the up-scaling of existing interventions and implementation of new interventions in light of goal of Universal Health Care. Major impact will be in the following Sectors:-

1. Strengthening of Health facilities to IPHS standards,

2. Establishing new SHCs, PHCs and CHCs as per the norms,
3. Up-scaling of existing initiatives like Rashtriya Kishore Swasthya Karyakram (RKSK) and Rashtriya Bal Swasthya Karyakram (RBSK),
4. Implementation of new interventions, such as those mentioned below, will be adversely affected:-
   (i) Expansion of coverage of Non Communicable Diseases programmes,
   (ii) Strengthening of District Hospitals,
   (iii) Universal Health Coverage (UHC) Pilots,
   (iv) Implementation of free drugs and free diagnostics scheme,
   (v) Expanding scope of primary health care to make it comprehensive and develop SHCs as first port of call,
   (vi) Increasing availability for SHCs in tribal & hilly areas based on 'time to care' concept.

2.2 During evidence before the Committee, on 30th March, 2015, the Additional Secretary, Ministry of Health and Family Welfare while making a power-point presentation reiterated the inadequacy of budgetary provisions for 2015-16 and its implications for various schemes under NHM. Explaining further the adverse impact of inadequate allocations on the various specific activities/ schemes and making a plea for enhanced allocations, the Additional Secretary submitted that "Non-communicable diseases screening requires a lot of intensive resource which we are not able to find". There is a lot of load on tertiary care institutions like AIIMS, New Delhi and AIIMS-like Institutions. Unless the district hospitals are strengthened and specialties are created there, this will not stop. The Ministry has not been able to roll out the scheme of free drugs and diagnostics across the country. "Many States have done free diagnostics but not all have been able to do it because they have a resource crunch". ".....In the North-Eastern States, there is a specific problem that it is not just a population norm that we are following; we have a time-to-care approach where we are saying that if within an hour, a person cannot reach a facility, he will find it difficult." So, additional facilities are required there, but resource constraint is a problem in the North Eastern States. Another problem is that except for some of the advanced States like Tamil Nadu and Andhra

Pradesh who are themselves making huge investments, the State investments in health are not very high.

2.3 On being asked about the existing shortfall in Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) against the norms of Indian Public Health Standards, the Additional Secretary submitted that there is a 20 percent shortfall in the Sub-centres, 23 percent in the PHCs and 32 percent in the CHCs and additional resources are required to correct the shortfall.

2.4 On being asked as to which of the programmes under NHM are essential to be protected from the budgetary cuts and which of the programmes are desirable to be protected and how much increase in the allocation for NHM for 2015-16 is essential, the Ministry in a written reply has furnished the following information:-

"Based on their impact and value for money, support for following activities is essential besides on-going programmes and interventions:-

Essential activities:

- Free drugs and diagnostics,
- Strengthening of District Hospitals particularly in High Priority Districts ,
- Strengthening of Sub Health Centres as 'first port of call' to provide comprehensive primary care

Desirable activities:

- Up-scaling of existing initiatives like RKSK,
- Strengthening of Health facilities to IPHS standards
- Implementation of interventions related to Non Communicable Diseases(NCDs),
- Universal Health Coverage (UHC) Pilots,
- Increasing availability for SHCs in tribal & hilly areas based on 'time to care' concept.

2.5 The Ministry has also stated that in order to undertake the essential activities as mentioned above, besides the on-going activities, the desirable increase in allocation is Rs.10,500.00 crore i.e. total BE should be Rs.10,500/- + Rs.18,295= Rs.28,795 crore."

2.6 In reply to another query about the impact of budget cuts on allocation on Tribal Sub-Plan, the Ministry has submitted the following written information:-

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

2.7 The Committee notes that as compared to Rs. 21912.00 crore provided in BE 2014-15, the allocation of Rs. 18,295.00 crore in BE 2015-16 is steeply lower and is only marginally higher than the RE 2014-15 allocation of Rs. 17627.82 crore. This small increase of Rs. 667.18 crore in BE 2015-16 over RE of 2014-15 is grossly inadequate as it will be eaten up by inflation. The country has a huge burden of communicable and non-communicable diseases and studies have shown that a long and expensive illness can drive not only the non-poor into poverty but creates immense stress even among those who are financially secure. As is evident from the information furnished by the Ministry, there is 20 percent shortfall in Sub-Centers, 23 per cent in PHCs and 32 percent in CHCs against the norms set by Indian Public Health Standards (IPHS) and additional resources are required to meet this shortfall in health facilities. The Committee also takes note of the submissions that except for some of the advanced States, most of the States including the North East States are not able to augment their spending on health. Keeping in view all the above facts, the Committee

is extremely disappointed with the low level of budgetary allocation for NHM for the financial year 2015-16. At the behest of the Committee, the Ministry has furnished two lists of activities i.e. (i) Essential activities which must be protected from budgetary cuts and (ii) Desirable activities where the increase in funds can be made if resources are available. The Ministry has also indicated that in order to undertake the essential activities, the minimum increase in allocation would be Rs. 10,500.00 crore and thus the total BE for 2015-16 should be Rs. 28,295.00 crore. Keeping in view the fact that the Central Government has a dominance in the domain of public resource mobilization by way of collection of tax revenue and several States including North Eastern States will be in severe handicap because of the manner in which these budgetary cuts have taken place, the Committee lends its full support to the demand for additional funds to the tune of Rs. 10,500. 00 crore for undertaking the "essential activities" viz. (i) Free Drugs and Diagnostics (ii) Strengthening of District Hospitals particularly in High Priority Districts and (iii) Strengthening of Sub Health Centres as "first port of call" to provide primary care and recommends that above essential activities must be protected from the budgetary cuts. The Committee would like the Department of Health and Family Welfare to immediately bring the above recommendation to the notice of Ministry of Finance and also intimate it of their response.

2.8 The Committee is aware that the stipulations of the Fiscal Responsibility and Budget Management Act 2004, (FRBM Act) warrant the Government to bring down the levels of fiscal deficit. Keeping in view the need to maintain the sanctity of the FRBM Act, the Committee recommends that as regards the "Desirable activities", the Ministry should work with the States to put in more money and persuade them to supplement the Central expenditure on the activities like strengthening of Health facilities to IPHS standards, implementation of interventions related to Non-Communicable Diseases (NCDs), Universal Health Coverage (UHC) Pilots, etc. The Committee also recommends that when the growth momentum of the economy is revived and the additional resources become available as a result of revenue buoyancy, the Central allocation for the "Desirable activities" should be increased accordingly.

2.9 The Committee is extremely concerned to note the submission of the Ministry that due to the overall reduction in NHM budget for 2015-16, there will be proportional reduction in allocation for tribal sub plan, which will adversely impact the proposed interventions in tribal areas. The Committee observes that the whole idea of NHM is to focus on the areas which are challenged from the point of view of infrastructure and health indicators. The tribal areas in the country have the worst health indicators. The Committee also takes note of the written submission of the Ministry that "all tribal districts whose composite health index is below the States' average are classified as High Priority Districts and these are supposed to get 1.3 times higher allocation per capita in comparison to non-High Priority Districts of the States". Given the stark inequities in the health system in tribal areas, the Committee recommends with all the power at its command that the Department must work out a formula to ensure that the tribal sub-plan is protected from budgetary cuts.

2.10 The Committee has learnt that a new disease-sickle cell anaemia, a serious type of anaemia, is spreading very fast amongst the Tribals of Maharashtra and Gujarat and experts fear that it may also spread to other Tribal areas of the country which require immediate attention so that this dreaded disease is contained.

2.11 The Committee is not comfortable with the huge structure of the National Health Mission in which 75 percent activities of Ministry has been converted into a Mission. The Committee is of the opinion that the basic idea of a Mission is to achieve something focused with a specific performance target, specific time target and specific cost target. But converting almost entire healthcare delivery system into a Mission by adding more and more schemes into the National Health Mission is making it unwieldy as well as putting a question mark on its operational efficiency. The Committee feels that there is a need to seriously review the scope of the National Health Mission and to make the Mission precise, more focused and manageable. The Committee, therefore,

recommends that the structure of National Health Mission may be reviewed in order to make it more focused and precise. The Committee also recommends that a matrix may be provided on the uses of funds released and success made in achieving the health goals under NHM so that the NHM framework facilitates in judging the extent of the health outcomes obtained due to NHM (and not due to any other health programmes).

2.12 Other issue that was brought to the attention of the Committee was the change in the route of transfer of funds to the States under the Centrally Sponsored Schemes, the Department has submitted as follows:

(i) Till 2013-14, Central Assistance to States under NHM was being transferred to the State Health Societies (SHS). This seamless procedure for disbursement of funds ensured that funds for various health programmes reached the implementing agencies without delay and bottlenecks. As part of the Government restructuring of Centrally Sponsored Schemes in Twelfth Five Year Plan, a decision was taken that all funds to States under central assistance scheme (including NHM) are to be routed through the consolidated fund of the States i.e. State Treasury.

(ii) Accordingly, from F.Y. 2014-15, the funds are being transferred through the consolidated fund of the States. However, this system has caused considerable delays in transfer of funds to the State Health Societies. The delay in release of funds from State treasury to SHS account has ranged from 30 days to more than 170 days. These delays have seriously impacted the implementation of NHM Programmes. Uncertainty and lack of timely availability of funds are affecting smooth implementation and timely payments of salaries etc. Further, a lot of time and effort of senior health officials was wasted in chasing the releases from the State Finance Department and leaves less time for monitoring and supervision by them. The Department is continuously reviewing the fund transfer position and following up with States. Almost all the States (Health Departments) have requested the Ministry to follow the earlier mode of fund transfer.

2.13 The Committee notes that there have been significant delays in transfer of funds from Treasury of the State Governments to the State Health Societies which is not condonable. However, keeping in view the fact that different States cannot be judged by the same yardstick, the Committee recommends that the Department should make continuous, vigorous and dedicated efforts to sensitise the State Governments especially those who have contributed to significant delays on the need to transfer funds to the State Health Societies as soon as possible to ensure proper and timely utilization of funds. The Committee desires that the request of the States to follow earlier mode of fund transfer may also be considered.

2.14 The Committee finds from the information furnished by the Department that for the previous years there have been 282 UCs pending amounting to Rs. 5984.31 crores. The Committee finds this trend disturbing and recommends that the Department ought to ensure liquidation of all pending UCs within a period of six months from the date of presentation of this Report.

2.15 On specific efforts made by the Department to convince the Ministry of Finance to provide adequate funds, the Department has informed that the Ministry of Finance had been requested repeatedly at different fora to increase the budgetary provision so as to strengthen public health systems, improve healthcare delivery and reduce out of pocket expenditure on healthcare. The EFC memo on National Health Assurance Mission had also been submitted to Department of Expenditure.

2.16 The Committee is of the view that adequate financial resources for health should be made available so that the efforts made by the State Governments are supplemented and complemented. Given the precarious state of finances in the States, it would be a wishful thinking to expect the States to allocate a major chunk of their budget for health. It is too obvious to labour a statement that provision of affordable "Health For All" will remain a far cry if adequate budgetary provisions are not made in

a timely manner as health is a vital parameter on which the success and progress of the society and the country depends. The Government, therefore, needs to take expeditious decision on the enhanced fund allocations for health sector.

III. NRHM-RCH Flexible Pool

A. RCH Flexible Pool

3.1 The financial performance of RCH during the 2013-14 and 2014-15 is given below:

Rs.in crore

Year	BE	RE	Expenditure
RCH			
2013-14	5347.01	4391.00	4652.17
2014-15	5700.00	4462.03	4159.08*
*19.02.2015 PAO			

3.2 The Committee notes that in the year 2013-14 the actual expenditure for RCH was Rs. 4652.17 crore against the plan outlay of Rs. 5347.01 crore. Similarly in the year 2014-15 the actual expenditure for RCH is Rs. 4159.08 crore (as on 19.02.2015) against the plan outlay of R. 5700.00 crore. The Committee notes that the actual expenditure incurred in 2013-14 and 2014-15 was way behind the approved outlay. The Committee recommends that the Department needs to strengthen its fiscal discipline so that the funds provided are utilized in a time bound and judicious manner to ensure that in the coming year the funds allocated are not reduced at RE due to under utilization in the previous year. The Committee would like to be apprised of the measures taken or proposed to be taken to arrest this trend.

3.3 On the efforts made so far to reduce MMR, IMR and TFR and whether the same would be able to meet the targets set for the Millenium Development Goals, the Department has provided the following status:

(i) **MMR** : Under the Millennium Development Goal 5 (MDG 5) the target is to reduce Maternal Mortality Ratio (MMR) by three- quarters between 1990 and 2015. Based on the UN Inter–Agency Expert Group's MMR estimates in the publication "Trends in Maternal Mortality: 1990 to 2013", the target for MMR is estimated to be 140 per 1,00,000 live births by the year 2015 taking a baseline of 560 per 100,000 live births in 1990. If the MMR declines at the same pace, India will achieve an MMR of 140 per 100,000 live births by 2015 and India will achieve the MDG target.

As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), Maternal Mortality Ratio (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.

3.4 Under National Health Mission (NHM), the key steps taken by Government of India to address the above concerns and to accelerate the pace of reduction for Maternal Mortality Ratio (MMR) are:

- Promotion of institutional deliveries through Janani Suraksha Yojana.
- Capacity building of health care providers in basic and comprehensive obstetric care.
- Operationalization of sub-centres, Primary Health Centres, Community Health Centres and District Hospitals for providing 24x7 basic and comprehensive obstetric care services.
- Name Based Web enabled Tracking of Pregnant Women under Mother &Child Tracking System (MCTS) to ensure antenatal, intranatal and postnatal care.
- Mother and Child Protection Card in collaboration with the Ministry of Women and Child Development to monitor service delivery for mothers and children.
- Antenatal, Intranatal and Postnatal care including Iron and Folic Acid supplementation to pregnant & lactating women for prevention and treatment of anaemia.
- Engagement of more than 8.9 lakhs Accredited Social Health Activists (ASHAs) to generate demand and facilitate accessing of health care services by the community.
- Village Health and Nutrition Days in rural areas as an outreach activity, for provision of maternal and child health services.

- Health and nutrition education to promote dietary diversification, inclusion of iron and folate rich food as well as food items that promote iron absorption.
- Janani Shishu Suraksha Karyakaram (JSSK) has been launched on 1st June, 2011, which entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick infants accessing public health institutions for treatment.
- To sharpen the focus on the low performing districts, 184 High Priority Districts (HPDs) have been prioritized for Reproductive Maternal Newborn Child Health+ Adolescent (RMNCH+A) interventions for achieving improved maternal and child health outcomes.
- Provision of call centre based ambulance system to minimise delays in reaching appropriate healthcare facility for delivery services and also avoid costs on travel to access institutional care. Nearly 20,000 patient transport vehicles (Dial 108, Dial 102/104 and empanelled vehicles) have been supported under the NHM .

(ii) **IMR-** Infant Mortality Rate currently stands at 40 /1000 live births (SRS 2013), against the MDG target of 29 /1000 live births by 2015. **15 States/Uts** have already achieved MDG 4 (<29 per 1000 live births) namely Kerala, Tamil Nadu, Goa, Andaman & Nicobar Islands, Chandigarh, Daman & Diu, Delhi, Lakshadweep, Puducherry, Manipur, Maharashtra, Nagaland, Tripura, Sikkim and Punjab. Further, **13 States/Uts** are near to achieving MDG4 namely West Bengal, Gujarat, Karnataka, Jharkhand, Uttarakhand, Himachal Pradesh, Jammu & Kashmir, Dadar & Nagar Haveli, Arunachal Pradesh, Mizoram, Bihar, Haryana and Andhra Pradesh.

3.5 Under National Health Mission, the following interventions are being implemented to reduce infant and maternal mortality rates.

- Operationalization of sub-centres, Primary Health Centres, Community Health Centres and District Hospitals for providing 24x7 basic and comprehensive obstetric care services.

- Capacity building of health care providers: Various trainings are being conducted under NHM to train doctors, nurses and ANMs for early diagnosis and case management of common ailments of children and care of mother during pregnancy and delivery. These trainings are on Integrated Management of Neonatal and Childhood Illnesses (IMNCI), Navjaat Shishu Suraksha Karyakram (NSSK), Skilled Birth Attendance (SBA), Life Saving Anaesthesia Skills (LSAS), Comprehensive Emergency Obstetric Care (CemOC), Basic Emergency Obstetric Care (BemOC), etc.

- Under National Iron Plus Initiative (NIPI), through life cycle approach, age and dose specific IFA supplementation programme is being implemented for the prevention of anaemia among the vulnerable age groups like under-5 children, children of 6 – 10 years of age group, adolescents, pregnant & lactating women and women in reproductive age along with treatment of anaemic children and pregnant mothers at health facilities.

- Promotion of Institutional Delivery through Janani Suraksha Yojana (JSY): Promoting Institutional delivery by skilled birth attendant is key to reducing both maternal and neonatal mortality.

- Janani Shishu Suraksha Karyakaram (JSSK): entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick infants accessing public health institutions for treatment till one year of age.

- Emphasis on facility based newborn care at different levels to reduce Child Mortality: Setting up of facilities for care of sick newborns such as Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Care Corners (NBCCs) at different levels is a thrust area under NHM.

- Management of Malnutrition: Nutritional Rehabilitation Centres (NRCs) have been established for management of severe acute malnutrition.

- Appropriate Infant and Young Child Feeding (IYCF) practices are being promoted in convergence with Ministry of Woman and Child Development. Village Health and Nutrition Days (VHNDs) are organized to improve child care practices.

- Mother and Child Tracking System (MCTS): A name based Mother and Child Tracking System has been put in place which is web based to ensure registration and tracking of all pregnant women and new born babies so that provision of regular and complete services to them can be ensured.

- Engagement of more than 8.9 lakh Accredited Social Health Activists (ASHAs) to generate demand and facilitate accessing of health care services by the community.Home Based Newborn Care (HBNC) through ASHA has been initiated to improve new born practices at the community level and early detection and referral of sick new born babies.

- India Newborn Action Plan (INAP) has been launched to reduce neonatal mortality and stillbirths.

- Newer interventions to reduce newborn mortality- Vitamin K injection at birth, Antenatal corticosteroids for preterm labour, kangaroo mother care and injection gentamicin for possible serious bacillary infection.

- Intensified Diarrhoea Control Fortnight was observed in August 2014 focusing on ORS and Zinc distribution for management of diarrhoea and feeding practices to improve child survival.

- Integrated Action Plan for Pneumonia and Diarrhoea (IAPPD) launched in four states with highest infant mortality (UP, MP, Bihar and Rajasthan) to focus on pneumonia and mortality-biggest childhood killers following neonatal causes.

- Universal Immunization Programme (UIP): Vaccination protects children against many life threatening diseases such as Tuberculosis, Diphtheria, Pertussis, Polio, Tetanus, Hepatitis B and Measles. Infants are thus immunized against seven vaccine preventable

diseases every year. The Government of India supports the vaccine programme by supply of vaccines and syringes, Cold chain equipment and provision of operational costs.

- To sharpen the focus on vulnerable and marginalized populations in underserved areas, 184 High Priority Districts have been identified for implementation of Reproductive Maternal Newborn Child Health+ Adolescent (RMNCH+A) interventions for achieving improved maternal and child health outcomes.

- Mission Indradhanush was launched on 25th December, 2014 with aim to cover all those children who are partially vaccinated or unvaccinated. It will be a nation-wide programme with special focus on 201 high focus districts.

3.6 With regard to ASHA scheme, the Committee notes that there is a need to bring a change in the scheme of incentivisation given to ASHAs in respect of immunization. The Committee observes that presently they have a fixed remuneration irrespective of the number of children brought for immunization, i.e., the incentive remains the same whether they bring two children or three hundred. The Committee recommends that incentives should be given according to the number of children an ASHA brings for immunization. The effect of such a scheme of incentivisation at the actual ground level would boost the immunization drive to a great extent.

3.7 With regard to the Mission Indradhanush, which is touted as the Health Ministry's ambitious programme to immunize children against various diseases, it has come to the knowledge of the Committee through media reports that it faces a major challenge with regard to availability of Haemophilus Influenza Type b(Hib) vaccine which safeguards the infants from deadly infections like meningitis, pneumonia and severe throat infections and which was added to the bouquet of vaccines to be administrated under the Mission. The Committee also finds that even outside the scope of this Mission few children have been covered by this vaccine whose penetration in the rural areas is as low as four percent inspite of the fact that the vaccine has been available in the country since 1997. The Committee finds that even the existing public and private DPT coverage levels are low at less than 60% in the States such as Bihar, Madhya Pradesh, Rajasthan, Uttar

Pradesh (BIMARU) and Assam, where more than 50% of children live, which leads to the conclusion that the coverage levels of New Hib vaccine may be similar to the present weak coverage of DPT in these States. It may be noted here that India has the highest Hib disease burden in the world with around 2.4 million cases and 72, 000 Hib- related deaths annually accounting for four percent of total child deaths in the country.

3.8 **The Committee finds that these figures alone tell the story on the difficulties which would be faced in the actual implementation of the Indradhanush Mission on the ground as the current penetration of DPT vaccination outside this Mission is less than 60 % in BIMARU States and Assam where more than 50% of the children reside. The Committee fails to understand that with this low penetration of DPT vaccine, how objectives of the Mission would be achieved. The Committee, therefore, recommends that the Department needs to scale up its operations in the vaccine producing Public Sector Units at Guindy, Coonoor and Kasauli so that the Mission objectives are integrated in a seamless chain with these Public Sector Units to ensure regular and continuous production of these vaccines.**

3.9 On a query on not seeking additional budget for Mission Indradhanush under Immunization programme, the Department has given the following clarification / justification:

- The Government of India has launched Mission Indradhanush as a special drive to vaccinate all unvaccinated and partially vaccinated children under the Universal Immunization Programme.
- *Supply of Vaccine & Syringes*: Vaccines and AD Syringes are provided for 100% target in the beginning of the programme. However, the quantity is allocated on actual consumption by the States/UTs on yearly basis and supplied to States/UTs on bimonthly basis.
- *Operational Cost*: Funds for Strengthening of Routine Immunization are allocated under part 'C' of the Programme Implementation Plan [PIP] annually. Since, same activities are conducted under Mission Indradhanush, the States/UTs have been given the flexibility to use funds allocated under Part 'C' of the PIP as Mission Indradhanush is an extension of Routine Immunization.

- *Monitoring*: Besides the monitoring done by Central and State Government, Mission Indradhanush programme is also being monitored through the strategic partners viz.United Nations International Children's Emergency Fund (UNICEF), World Health Organization (WHO), Bill & Melinda Gates Foundation (BMGF), United States Agency for International Development (USAID), Department for International Development (DFID), United Nations Fund for Population Activities (UNFPA), Norway India Partnership Initiative (NIPI), Rotary International etc. The expenditure of monitoring is borne by them only.
- *IEC Activities*: The IEC activities are strengthened by the funds already allocated by Central and State governments. In addition, GAVI HSS funds are also being utilized for IEC activities.

3.10 The Committee hopes that the States/UTs will be able to manage the operationalization of the Mission with funds allocated under Part 'C' of the Programme Implementation Plans (PIP). The Committee recommends that the Department should closely monitor the implementation of the Mission and ensure that funds are made available whenever needed by the States for smooth implementation of the Mission.

(iii) **TFR:** The TFR has declined by 25% from 3.2 in 2000 to 2.4 in 2012.

3.11 24 States/UTs (48% of population) have already achieved replacement level fertility (i.e. 2.1 or less). Another 3 States (10% of the population are on the verge of achieving the replacement TFR. The country should be able to meet the XIIth plan goal of achieving replacement TFR by 2017.Improving access to quality FP services, related to both spacing and terminal methods and IEC for enhancing age of marriage, spacing between children and small family –happy family has been taken up.

3.12 The Committee appreciates the steps being taken to reduce IMR, MMR and TFR. The Committee, however, finds that the family planning methods being taken up by the Department of Health and Family Welfare have not been able to bring any noticeable

difference in controlling population growth nor have been able to reduce the skewed growth which is in favour of male population. The Committee recommends that the Department needs to have 'best practices approach' in which States having a healthy male-female ratio and share their experiences either by way of a quarterly seminar or by use of information technology interface on the methods or steps taken by them which had helped to ensure a healthy male-female population ratio. The Committee recommends that innovative approaches on the lines mentioned above can go a long way in ensuring that the targets for health set by way of Millennium Development Goals are not only achieved but are achieved equitably.

3.13 With regard to Population Control Methods being adopted by the States, the Committee is of the view that the present budgetary allocations primarily focus on female sterilization and there is no emphasis on the budgets for Information, Education and Communication (IEC) or spacing methods or training providers to do counselling, instead, spending is only on terminal methods of family planning. As per figures from Budget estimates of 2011-12, the amount spent on female sterilization was Rs. 317.80 crore and Rs. 17.70 crore on male sterilization, which has a clear indicator that focus is on female sterilization only. The Committee also notes that there are no budgetary allocations for quality assurance and monitoring. The Committee, therefore, recommends that the Department should focus on providing budget for quality services, family planning clinics and quality monitoring.

B. <u>Mission Flexible Pool</u>

3.14 The Financial performance of Mission Flexible Pool during 2013-14 and 2014-15 is given below:

(Rs.in crore)

Year	BE	RE	Expenditure
2013-14	5764.00	5092.33	5006.66
2014-15	5892.11	4464.00	4409.78*
*5.03.2015			

3.15 The Committee notes with concern that the Department was not able to fully utilise the funds provided at RE stage. The expenditure pattern in 2014-15 is way below the expenditure pattern in 2013-14. The Committee also takes note of the fact that even though approved outlay at BE stage has been increased in 2014-15, it was significantly reduced at RE stage. The Committee hopes that the cuts have been made at RE stage due to uniform budgetary cuts across the Board and not due to under utilization of allocated funds.

3.16 The Committee notes that some members of Parliament have given Mobile Medical Units (MMUs) from their MPLADS Scheme. However, it has come to the notice that most of these units are lying unutilised. The Committee feels that in view of shortage of budgetary funds available with the Department, integration of these with the NRHM, would help the Department to tide over the shortage of funds though to a small extent. The Committee, therefore, recommends that the Department should take immediate steps to integrate these MMUs within the NRHM.

C. Routine Immunization Programme

3.17 As per information furnished by the Department, the Physical and Financial performance under Routine Immunization during the years 2013-14 & 2014-15 are as under:

Physical performance

Survey	Year	Full Imm (%)	BCG (%)	DPT-3 (%)	OPV-3 (%)	Measles-1st dose (%)
HMIS	2013-14	86.7	91.3	86.8	88.22	87.0

HMIS (Till Dec 2014)	2014-15	85.6	91.1	68.5	83.59	86.5

Financial performance

(in crores)

Year	Total budget			Total expenditure
	Budget Estimates	Revised Estimates	Final Estimates	
2013-14	800.00	800.00	519.04	519.04
2014-15 (till 2nd March 2015)	818.10	490.00	*	426.06

*Not Yet finalized

3.18 The Committee on a bare perusal of the data given above, finds that the amount of funds provided at the RE stage has been halved from those at BE stage in 2014-15. The Committee is of the opinion that the Department either lacks the proper machinery to implement the scheme as is reflected from the expenditure figures enumerated above or there are other constraints which are coming into its way in achieving the desired objectives. The Committee finds that this trend of expenditure does not strengthen the Department's demand for more funds from the Ministry of Finance. The Committee impresses upon the Department that it should ensure that the funds available are spent judiciously and in a time bound manner to derive the desired outcomes and for that all necessary processes should be put in place.

3.19 As per information provided by the Department, Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which

are preventable. Expanded programme for Immunization (EPI) was introduced in 1978 through a World Assembly Resolution. The Universal Immunization Programme (UIP) was launched by the Govt of India during 1985. It became the part of Child Survival & Safe motherhood Programme (CSSM) in 1992 and currently one of the Key areas under National Health Mission since 2005. Under the Universal Immunization Programme, Government of India is providing vaccination to protect against nine vaccine preventable diseases i.e. Tuberculosis; Diphtheria; Pertussis; Tetanus, Polio; Measles; Hepatitis B across the country and Japanese Encephalitis in selected districts and Meningitis/Pneumonia due to Haemophilus Influenza type B in selected States. Haemophilus Influenza type B(Hib) containing Pentavalent vaccine is introduced in 8 States viz. Kerala, Tamil Nadu, Goa, Gujarat, Haryana, Jammu & Kashmir, Karnataka and Puducherry and 12 more States are planned for expansion in 2014-15. The programme is also being reviewed by NTAGI from time to time. National Technical Advisory Group on Immunization (NTAGI) has recommended an introduction of four new vaccines in routine immunization i.e. Rubella vaccine, Inactivated Polio vaccine (IPV), Rota vaccine and Adult JE vaccine. Necessary process for the approval from Mission Steering Group has been initiated. Maternal and Neonatal Tetanus Elimination has been validated in 32 States/UTs.

3.20 The Committee observes the fact that the Department is taking steps to bring new vaccines in the Routine Immunization Programme. The Committee feels that even though new interventions in the Routine Immunization Programme are laudable but as the Committee has observed above the final utilization figures in the existing immunization programme leaves much to be desired. The Committee, therefore, reiterates its recommendation that a birds eye view on maintenance of fiscal discipline is a sine-qua-non and the Department while launching new vaccination programmes should ensure that the funds allocated are utilized efficiently.

D. <u>Pulse Polio Immunisation</u>

3.21 The Polio Vaccine was initially introduced in 1978 to prevent Polio among children aged 0-5 years. However with the Global resolution in 1988 with aim to eradicate the Polio from the country, Pulse Polio Immunization Programme was launched in India in

1995. Under Pulse Polio Immunization Programme two National Immunization Days (NID) rounds are held in the entire country. During each NID nearly 172 million children are immunized. Nearly 2.3 million vaccinators under the direction of 15500 Supervisors visit 200 million houses to administer Oral Polio vaccine to children up to 5 years. Besides, Sub National Immunization Day (SNID) and Mop up rounds are also held in the country to cover Polio endemic States and other areas at risk of importation of Polio virus. The Mobile and transit teams are also deployed at Railway stations, inside running trains and Bus stand, market areas brick kiln, construction sites, etc. In addition, Boarder areas are also being covered under Polio campaign. Last Polio case was reported on 13th January 2011 from Howrah, West Bengal and since then no Polio case has been reported so far.

3.22 The WHO on 24th February 2012 removed India from the list of countries with active endemic wild Poliovirus transmission. India along with South East Asia region of WHO consisting of 10 countries is certified polio free by Regional Certification Commission (RCC) on 27th March 2014. The programme is also being reviewed by the India Expert Advisory Group (IEAG) twice a year and its recommendations are being followed. The Pulse Polio Immunization Programme is currently one of the key areas under National Health Mission (NHM) since 2005.

3.23 The Committee would like to be apprised of the outcome of review being done by the India Expert Advisory Group (IEAG) twice a year and also the status of implementation of its recommendations being carried out to ensure that the country remains polio-free. The Committee also recommends that the success of the polio immunization should be replicated in other health programmes also.

E. <u>National Iodine Deficiency Disorders Control Programme(NIDDCP)</u>

3.24 The financial achievement under the programme during 2014-15 (upto 05th March 2013) is as under:

(Rs. in crores)

Name of the Scheme	B. E. 2014-15	R. E. 2014-15	Utilization 2014-15 (till 05.03.2015)
National Iodine Deficiency Disorders Control Programme	49.00	35.25	27.49

3.25 Iodine is an essential micronutrient required daily at 100-150 micrograms for the entire population for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf, mutism, squint, loss of IQ, compromised school performance & various types of goiter etc. As per surveys conducted in the country by the Directorate General of Health Services, Indian Council of Medical Research, the State Health Directorates and Health Institutes it has been found that out of 386 districts surveyed in all the 28 States and 7 Union Territories, 335 districts are endemic i.e. where the prevalence of Iodine Deficiency Disorders is more than 5%. No State/UT is free from Iodine Deficiency Disorders. The goals of NIDDCP are to bring the prevalence of IDD to below 5 % in the country by 2017 and to ensure 100% consumption of adequately iodated salt (15ppm) at the household level. The main objectives of the programme are:

(i) Surveys to assess the magnitude of the Iodine Deficiency Disorders in districts.

(ii) Supply of iodized salt in place of common salt.

(iii) Resurveys to assess iodine deficiency disorders and the impact of iodized salt after every 5 years in districts.

(iv) Laboratory monitoring of iodized salt and urinary iodine excretion.

(v) Health Education and Publicity / Information, Education & Communication (IEC).

3.26 The Committee notes that the goals of NIDDCP are to bring the prevalence of IDD to below 5 % in the country by 2017 and to ensure 100% consumption of adequately iodated salt (15ppm) at the household level. However, the Committee finds that the Department's allocation had been reduced at RE stage to Rs. 35.25 crore from Rs. 49.00 crore at BE Stage and the actual amount spent was Rs. 27.49 crore. The Committee is of the view that the Department on the one hand has planned to bring

the prevalence of IDD to below 5 % in the country by 2017 and ensure 100% consumption of adequately iodated salt (15ppm) at the household level and on the other hand is not able to utilize even the allocated funds properly. The Committee, therefore, recommends that in order to meet its targets, the Department needs to ensure that the machinery to implement the plan funds is robust and is able to optimally utilize the allocated funds so that its objectives are met in letter and spirit.

F. Strengthening of District Hospitals for providing advanced secondary care

3.27 As per information furnished by the Department, for the 12th Five Year Plan an allocation of Rs. 11714.09 crore was made under this head. However the Committee finds that in 2012-13, no allocation was made; in the year 2013-14, an allocation of mere 1.00 crore was made and in 2014-15 and in 2015-16 no allocations have been made.

3.28 **The Committee is dismayed to find that even after three years of the initiation of the 12th Plan, allocation of a mere Rs. 1.00 crore has been made for this scheme but the status of its utilization has not been reflected. The Committee takes serious exception to the lackadaisical approach of the Department and recommends that the Department should take corrective steps to ensure that the scheme takes off during remaining years of the 12th Plan.**

G. Providing free generic medicines in all PH institutions in the country

3.29 As per information furnished by the Department, for the 12th Five Year Plan an allocation of Rs. 16000.00 crore was made . However, the Committee finds that in 2012-13, no allocation was made; in the year 2013-14, an allocation of mere 1.00 crore was made and in 2014-15 also, an allocation of mere 1.00 crore was made and no allocation has been made in 2015-16.

3.30 The Committee fails to understand that a scheme of such immense importance is being consistently allocated notional funds over the last three years of 12th Plan. This trend of allocation indicates that scheme is yet to take off with intended pace, and also puts a question mark on the ability of the Department to objectively project its

requirements. The Committee is unable to understand as to why a huge sum of Rs. 16000 crore was earmarked for the scheme when the Department was not prepared to implement the Scheme. The Committee impresses upon the Department to act now with vigor and energy and see that the schemes take off at least this year.

IV. National Urban Health Mission(NUHM)-Flexible Pool

4.1 The Department has informed that the National Urban Health Mission (NUHM) was approved as a sub-mission of the National Health Mission (NHM) by the Cabinet on 1st May, 2013. NUHM envisages to strengthen the existing primary health care facilities & establish new primary health centres based on detailed mapping of the slum & vulnerable population to improve access of the urban poor to quality & equitable primary health care services.

FINANCIAL PROGRESS

4.2 The Committee was informed that in the 12th Plan an allocation of Rs. 15,143 crores has been made for NUHM. Rs. 1000 crore was provided in the Revised Estimate of 2013 – 14 for NUHM out of which Rs. 662.23 crore was released to 29 States/UTs on the basis of PIPs received from the States/UTs. An outlay of Rs.1924.93 crore was allocated for the financial year 2014-15 and an amount of Rs. 1345.82 crore has been released to 34 States and UTs.

PHYSICAL PROGRESS(as on 30th November, 2014)

4.3 The Physical progress regarding implementation of various activities under NUHM was obtained from the States/Uts. For the period ending November 2014 the program implementation progress reported is as follows-

- Planning and Mapping completed in 269 out of 906 cities/towns approved.
- Recruitment has been done for Medical officers, ANM/Paramedical staff for U-PHCs-
    - 807 MO against 2353 sanctioned
    - 1213 Staff Nurse against 7209 sanctioned
    - 856 Pharmacist against 2978 sanctioned
    - 841 Lab Technician against 3231 sanctioned
    - 6056ANM against 17584 sanctioned
- Steps have been taken by State/Uts to operationalize new U-PHCs sanctioned.

- 29012 MAS has been formed out of 92173 sanctioned
- 30155 ASHAs have been engaged out of 56002 sanctioned.

4.4 The Committee has been given to understand that under NUHM recruitment has been made for 807 Medical Officers, 1203 Staff Nurses, 856 Pharmacists, 841 Lab Technicians, 6056 ANM against sanctioned strength of 2353, 7209, 2978, 3231 and 17584 posts, respectively. The Committee finds that there is a wide gap between the sanctioned and the recruited manpower. The Committee hopes that the persons recruited would actually join their respective postings. Steps may be taken to increase allocations to the scheme and fill up all posts.

V. Flexible Pool for Communicable Diseases

A. National Vector Borne Disease Control Programme(NVBDCP)

5.1 On being asked about the target set and achievement made under NVBDCP after the commencement of 12th Five year plan till date, the Department has furnished the following information:

VBDs	Target	Achievement
Malaria	• To maintain ABER of at least 10% • To Reduce API to 1 or less than 1	ABER – 9.3 %(sustained around 10%) API has been reduced to – 0.72%
Lymphatic Filariasis	• To cover all eligible population living in all (presently 250) Lymphatic Filariasis endemic districts during MDA. • To line list the cases of lymph edema in all the districts and augment home based morbidity management and hydrocele operations in identified district hospitals/CHCs.	• 250 LF endemic districts (now 255 due to bifurcation of districts) are being covered under MDA. During 2014, out of 255 districts, 163 districts in 17 states/UTs are being covered under MDA because phasing out with validation through transmission Assessment Survey (TAS) has started. • Till 2013, 23 districts have cleared TAS and 69 districts are preparing for pre-TAS activities and expected to complete TAS by March, 2015 for which the test kits (ICT) are being supplied by WHO. • Line listing of clinically manifested cases (elephantiasis and hydrocele) of Lymphatic Filariasis was initiated in 2004-05 and till

		date 877594 lymphoedema and 407307 hydrocele cases have been line listed. • 1.11 lakh out of 4 lakh hydrocele cases have been operated so far as per reports received from states. • State have been advised to train all lymphoedema cases for "Home based care" with provision of morbidity management kit.
Kala-azar	• Elimination of Kala-azar by 2015 by <1 case per 10,000 population as block/PHC level • R3eduction in annual incidence & mortality due to Kala-azar.	• 67% block/PHC have shown less than one case per 10,000 population in 2013 • Treatment of Kala-azar patient with single dose liposomal Amphotericin B in the country. • National Road map for Kala-azar elimination with time line prepared & shared with states. • Development partners involved in training, treatment & in service delivery. • Two round indoor residual spray with DDT in allocated villages. • NACO and NLEP will work closely with the programme on treatment of HIV-VL co-infection and diagnosis of PKDL cases resembling with Leprosy skin symptoms.
Dengue & **Chikungunya**	• Dengue case facility rate to below 1%. • Functional Sentinel Surveillance Hospital in all endemic districts/towns/cities. • Functional Rapid Response Team (RRT) in all endemic districts/towns/cities.	• CFR brought down 85% from 2006 to 2013 (1.3 to 0.3) against the target of Mid Term Plan &12th FYP (Sustaining CFR<1.0%). • Expanding diagnostic facilities from 110 in 2007 to 438 SSHs in 2014. • Ensuring RRT in all districts in collaboration with IDSP.
JE/AES	• Improve the JE/AES surveillance by establishing sentinel laboratories. • JE vaccinajtion	• Numbers of Sentinel Surveillance sites have been increased from 51 in 2010 to 104 in 2014. • Out of 181 endemic districts, 155 districts have been covered under JE vaccination including all 60 high priority districts of five states. • 23 new districts have been identified for JE Vaccination for campaign in 1-15 yrs age group.

		• a catch up round was conducted in 10 districts of Uttar Pradesh and 8 districts of Bihar during 22nd -23rd June, 2014 to cover the left out children. • 20 new districts have been identified for Adult JE vaccination . • Out of 60 identified districts funds have been released for 27 districts of five states. As so far 23 districts have made ICU functional.
	• Establishment of Pediatric ICU at district level in 60 high burdened districts and capacity building in critical case management of the medical and paramedical staff.	• Training of Master Trainers from 5 states on Critical Care Management of AES/JE cases was conducted at SGPGI Lucknow during 2013-14 following which training of Medical and Para medical staff in the state of West Bengal and Tamil Nadu has already been initiated. In remaining 3 states the similar action is contemplated shortly.
	• Establishment of Physical Medicine and Rehabilitation Department in 10 identified medical college of five states.	• Out of 10 proposed PMR in five states funds have been released for establishment of 5 Physical Medicine & Rehabilitation (PMR) departments in 5 states during 2013-14 @ Rs. 5.0 Crore each. • Rs. 20.00 Crore has been allocated during 2014-15 for 4 PMR (1each for Assam, Bihar, Uttar Pradesh and West Bengal) • Out of 10 Medical Colleges, PMR are functional in 8 Medical colleges and in remaining 2 up gradation from Physiotherapy Department to PMR department is under process.

5.2 On a perusal of the progress made in respect of the National Vector Borne Disease Control Programme (NVBDCP), the Committee finds that for combating JE/AES, out of 181 endemic districts, 155 districts have been covered under JE vaccination including all 60 high priority districts of five States. The Committee is, however, of the opinion that the Department by leaving out the remaining districts is making the fight

against the diseases difficult as it is susceptible to spread to other areas of the country. The Committee recommends that the Department should put in place a multipronged strategy to target all identified districts at the same time to ensure complete elimination of the disease. The Committee also recommends that the Department should ensure vigorous efforts by means of Information, Education and Communication (IEC) to educate the public about the precautions e.g. to have clean drinking water, etc. in order to prevent themselves from being affected by AES.

5.3 It has been brought to the notice of the Committee that dengue is claiming quite a number of lives in the country and now the victims are losing their eye sight also due to dengue. What is more worrisome is that dengue causing virus is mutating which is a very dangerous signal. The Committee views this with serious concern and recommends that the matter should be looked into seriously and urgent measures should be initiated to arrest the spread and incidence of dengue and also to overcome the problem of mutation of dengue virus.

B. National Tuberculosis (T.B) Control Programme

5.4 As per information furnished by the Department, India is the highest TB burdened country in the world, accounting for about 24% of the global prevalence. As per Tuberculosis Report by WHO, out of the estimated global annual incidence of 9.0 million TB cases; 2.0 -2.3 million were estimated to have occurred in India with a best case estimate of 2.1 million cases. An infectious case, if not treated, on an average infects 10-15 persons in a year. About one person dies from TB in India every two minutes; 760 people every day and almost 2.8 lakh every year.

5.5 The Revised National TB Control Programme (RNTCP) based on internationally recommended strategy of Directly Observed Treatment Short Course (DOTS) had the objective to reduce the incidence and mortality due to TB by March 2006. Entire population of the country in all 632 districts had been covered under the Programme. Since its inception, the programme had diagnosed more than 18 million TB cases and

saved more than 3.2 million lives. TB mortality in the country had reduced from over 38 per lakh population in 1990 to 19 per lakh population in 2013 as per the WHO Global Report, 2014. The prevalence of TB in the country has reduced from 465 per lakh population in 1990 to 211 per lakh population in 2013. Nationwide coverage of services for programmatic management of drug resistant TB has been achieved in March, 2013. Further a drug resistant survey for 13 TB drugs has been launched which is the biggest ever survey in the world and results are expected in a years' time.

5.6 On being asked on the action taken so far on the States to ensure timely liquidation of pending UC's under Revised National TB Control Programme(RNTCP) and the updated status of pending UCs and the amount involved therein, the Department has informed that necessary steps are being taken in this regard for receiving UCs in time. The Quarterly Statement of Expenditure (SOEs) and UCs scanned copies are being received through emails. The States are also being contacted for timely submission of UCs by using information technology. In addition, regular communications are being sent to States/UTs in this regard. This has resulted in better coordination with States and timely receipt of UCs. Further, all UCs have been received for the year 2012-13 and for 2013-14, UCs from 32 States/Uts have been received. In the remaining 3 States, UCs pendency is for an amount of Rs. 36.19 crore only. **The Committee recommends that a mechanism may be devised by which no State falters in submitting UCs.**

5.7 On being asked about the updated figures regarding quantum of unspent balance lying with the States and whether any innovative measures have been taken to tackle the problem of unspent balances, the Department has informed that the unspent balance amounting to Rs. 74.97 crore only is lying with the States/UTs as on 01.01.2015. Regular monitoring is being done to ensure that grants-in-aid released to State Health Societies/NGOs is utilized judiciously and scrupulously. In addition, regular review of activities with the States/UTs at national and regional level is being held. **The Committee finds that the amount of unspent balances amounting to Rs.74.97 crore as on 01.01.2015 does not bode well for implementation of a programme of huge scale**

keeping in view the vulnerability of the population affected by this disease which has a draining effect on not only the physical well being of the individual but also on his financial well being. The Committee, therefore, recommends that the Department should ensure that the Centre should encourage the States to ensure optimum utilisation of funds by means of sharing of best practices among States.

5.8 The financial achievement under the programme during 2014-15 (upto 05th March 2013) is as under:

(**Rs. in crores)**

Name of the Scheme	**B. E. 2014-15**	**R. E. 2014-15**	**Utilization 2014-15 (till 05.03.2015)**
National T.B. Control Programme	710.15	640.00	554.36

5.9 The Committee notes that there has been a sizeable reduction in funds allocated at RE stage and the expenditure figures as on 5th March, 2015 leave much to be desired. The Committee finds this extremely palpable in view of the fact that underutilization of funds can have a vital bearing on the elimination of pathogen causing the disease. The Committee, therefore, recommends that the Department should keep a tight control on effective utilization of funds to ensure that the targeted goals are not derailed by underutilization of funds.

5.10 The Committee also notes that the Department is likely to drop the DOTs programme for treatment of TB envisaging to introduce a new therapy, i.e., Daily Therapy. The Committee is of the view that in case the same is affirmative, the Department needs to have a serious introspection on the reasons behind failure of DOTs and whether the new system of Daily Therapy would be practicably applicable in a country of the size of India. The Committee recommends that the Department needs to take a serious review of the DOTs programme and also the parameters on which the

Daily Therapy Programme would run keeping in view that a change in programme would also require huge Information, Education and Communication (IEC) efforts on the part of the Department.

C. National Leprosy Control Programme

5.11 As per information furnished in the Outcome budget(2015-16), the Department has informed that the National Leprosy Control Programme was launched by the Government of India in 1955. Multi Drug Therapy (MDT) came into wide use from 1982 and the National Leprosy Eradication Programme was introduced in 1983. Since then, remarkable progress has been achieved in reducing the disease burden. India achieved the goal set by the National Health Policy, 2002 of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population at the National level in December 2005.

5.12 The main objective of NLEP is elimination of leprosy less than 1 case per 10,000 population in all the districts of the country by end of 12th Plan and strengthen Disability Prevention & Medical Rehabilitation of persons affected by leprosy. The components of the programme are:

(i) Case Detection and Management

(ii) Disability Prevention and Medical Rehabilitation

(iii) Information, Education and Communication (IEC) including Behaviour Change Communication (BCC)

(iv) Human Resource and Capacity building

(v) Programme Management

5.13 The financial achievement under the programme during 2014-15 (upto 05th March 2013) is as under:

(Rs. in crores)

Name of the Scheme	B. E. 2014-15	R. E. 2014-15	Utilization 2014-15

			(till 05.03.2015)
National Leprosy Control Programme	51.00	46.00	33.87

5.14 The Committee finds that there has been substantial reductions in fund allocation at RE stage and what is more worrisome is that the Department is not even able to utilize the reduced amount at RE stage optimally as can be seen from the utilization figures. The Committee notes that approval has been accorded to carry out the activities in 1453 blocks in 214 districts of 19 States/UTs. The Committee while appreciating the expansion of activities would simultaneously suggests to the Department that the expansion of the programme should not be made to suffer due to any under-funding. Also a close monitoring of the expenditure being incurred on the scheme is must to ensure desired results.

5.15 In response to a query regarding the findings of the National Sample Survey conducted by National JALMA Institute for Leprosy and other Myeobacterial Diseases, Agra, it was informed that as per the report of National Sample Survey-

- The trends of the disease are same as being reported in the NLEP data yearly. The differences in the disease in the present survey are more or less as expected. This being an active house to house case finding survey, the projected new cases which may occur is between 250,000 to 350,000 / year.
- Varied incidence of disease as well as the deformities associated with Leprosy in different State/UTs, calling for State specific attention.
- Migrant worker population is a common factor in states like Tamilnadu, Chandigarh and other cities, which resulted in more cases.
- More efforts for IEC, POD and DPMR activities to reduce the deformities and to prevent progression of deformities from grade I to grade II.

5.16 The Committee takes note of the findings of the National Sample Survey wherein it has been concluded that projected new cases may occur between 250,000 to 350,000 / year. The survey has further stated that more efforts are needed for IEC,

POD and DPMR activities to reduce the deformities and to prevent progression of deformities from grade I to grade II. The Committee is of the view that the volume of the projected new cases is a cause of serious concern and constrained to note that inspite of adequate funds being provided at BE stage, the Department was not able to utilize the funds for its present activities. This puts a question mark on the smooth implementation of programme. The Committee recommends that the Department needs to act on the findings of the Survey which reveals that more efforts are needed on the ground for IEC, POD and DPMR activities to reduce the deformities; to prevent progression of deformities from grade I to grade II and also keep the Committee posted of the action taken/being taken in this regard. If required, more funds may be provided to ensure timely treatment and prevention.

5.17 On the Status of Leprosy Rehabilitation Centers, the Department has informed that the elimination of leprosy is defined as achievement of prevalence rate of less than 1 case per ten thousand in a given population unit. The leprosy elimination was achieved in December 2005 by taking country as one unit. The Department has further informed that it has also achieved elimination of leprosy in all States /UTs except Chhattisgarh and Dadra& Nagar Haveli. The Committee was apprised that under the programme there is no provision of rehabilitation centre. Leprosy can be treated just like any other disease in any Government Health Care facility. There is however, a provision of corrective surgery of the patients who develop deformity due to leprosy. Such corrective surgeries are being encouraged and incentivized under National Leprosy Eradication Programme. Microcellular Rubber footwear is also being provided to leprosy affected persons who suffer from loss of sensation of feet.

5.18 The Committee would like the Government to set the target of 100% Leprosy eradication and prepare action plan in this regard.

D. <u>Intregrated Disease Surveillance Project</u>

5.19 As per Outcome Budget (2015-16), Integrated Disease Surveillance Project (IDSP), a World Bank assisted project, aims to strengthen disease surveillance for infectious

diseases to detect and respond to outbreaks quickly. Under the project, Surveillance units have been established in all states/districts (SSU/DSU). A country wide Information Communication Technology (ICT) network connecting all District H.Qrs, State H.Qrs, major medical colleges and central surveillance unit at National Centre for Disease Control (NCDC) has been established with support from National Informatics Centre (NIC) and Indian Space Research Organisation (ISRO).World Bank provided funds for Central Surveillance Unit (CSU) and 9 States (Andhra Pradesh, Gujarat, Karnataka, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Uttarakhand and West Bengal). Domestic funding was made available for other States. The project continues in the 12th Five Year Plan with domestic budget as Integrated Disease Surveillance Programme under NRHM for all States. A Central Surveillance Unit (CSU) at Delhi, State Surveillance Units (SSU) at all State/UT head quarters and District Surveillance Units (DSU) at all Districts in the country have been established.

5.20 Under IDSP data is collected on epidemic prone diseases on weekly basis (Monday–Sunday) which provides information on the disease trends and seasonality of diseases. Whenever there is a rising trend of illnesses in any area, it is investigated by the Rapid Response Teams (RRT) to diagnose and control the outbreak. Data analysis and actions are being undertaken by respective State/District Surveillance Units. During March 2014, about 90% districts have reported weekly disease surveillance data from districts.

5.21 CSU, IDSP receives disease outbreak reports from the States/UTs on weekly basis. Even NIL weekly reporting is mandated and compilation of disease outbreaks/alerts is done on weekly basis. On an average 30- 35 outbreaks are reported to CSU weekly. During 2014 (till 28th Sept, 2014), a total of 134 outbreaks were reported and responded to by the States/UTs; majority of them were ADD (29%), Food Poisoning (22%), Dengue (17%), Viral Fever (10%) and Measles (10%).

5.22 The Committee notes that World Bank provided funds for Central Surveillance Unit (CSU) in 9 States (Andhra Pradesh, Gujarat, Karnataka, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Uttarakhand and West Bengal) and domestic funding was made

available for other States. An allocation of Rs. 63.00 crore made in BE-2014-15 was increased to Rs.64.35 crore at RE stage. However the expenditure figures as on 5th March, 2015 was only Rs. 48.59 crore. The Committee is surprised that even after the allocation had been increased at RE Stage, the actual expenditure is woefully short of even the funds allocated at BE stage. The Committee is of the opinion that even in schemes/ programmes where the funds allocation has been increased at RE stage, the Department had miserably failed in utilizing the allocated funds and there is no justification for increased allocation in next financial year with the trend of underutilization in the previous years. The Committee observes that with all the where-withal of technology available at its disposal, the Department should have made optimum utilization of funds and resources. The Committee, therefore, recommends that the Department should prioritize activities under the Scheme which are strictly non-negotiable and for which funds must be disbursed on priority basis in order to ensure that the scarce budgetary resources are utilized efficiently.

VI. Flexible Pool for Non-Communicable Diseases, Injury & Trauma

A. National Trachoma and Blindness Control Programme

6.1 National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% Centrally Sponsored Scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. Rapid Survey on Avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence of blindness from 1.1% (2001-02) to 1% (2006-07). Main causes of blindness are: Cataract, Refractive Error, Corneal Blindness, Glaucoma, Surgical Complications, Posterior Capsular Opacification, Posterior Segment Disorder and Others, Estimated National Prevalence of Childhood Blindness /Low Vision is 0.80 per thousand. The programme to continues focus on development of comprehensive eye care services targeting common blinding disorders including Cataract, Refractive Errors, Glaucoma, Diabetic Retinopathy, Childhood Blindness, Corneal Blindness etc. during the 12th Five Year Plan to combat blindness. During the 12th Plan, inter-alia, the programme would aim:

(i) To continue three ongoing signature activities under NPCB:

(ii) Performance of 66 lakh Cataract surgeries per year

(iii) School Eye Screening and distribution of 9 lakh free spectacles per year to school children suffering from refractive errors,

(iv) Collection of 50,000 donated eyes per year for keratoplasty;

(v) To reduce the backlog of avoidable blindness through identification and treatment of curable blind at primary, secondary and tertiary levels based on assessment of the overall burden of visual impairment in the country.

(vi) Develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment through provision of comprehensive universal eye-care services and quality service delivery.

(vii) Strengthening and upgradation of Regional Institutes of Ophthalmology (RIOs) to become centre of excellence in various sub-specialities of ophthalmology and also other partners like Medical College, District Hospitals, Sub-district Hospitals, Vision Centres, NGO Eye Hospital.

The physical and financial performance of National Programme for Control of Blindness during 2013-14 and 2014-15 is as under:

Physical Performance

Component	2013-14 (in lakh)		2014-15 (as on 3.3.2015) (in lakh)	
	Target	achievement	Target	achievement
Cataract Operations (Catops)	66.00	62.63	66.00	39.89
Treatment/management of other eye diseases (diabetic retinopathy, glaucoma etc.)	0.72	2.13	0.72	1.31
Distribution of free spectacles to school children under School Eye Screening Programme.	9.00	6.25	9.00	3.15
No. of donated eyes collected	0.50	0.51	0.50	0.41

Financial Performance

(Rs. in crore)

Year	BE	RE	Expenditure (As on 20.3.2015)
2013-14	230	120	88.56
2014-15	177	161	159.64

New Initiatives introduced during the 12th Five Year Plan:

6.2 The following new initiatives have been introduced under the programme during the current plan period:

(i) Provision for setting up 400 Multipurpose District Mobile Ophthalmic Units @ Rs.30 lakh per unit in the District Hospitals of States/UTs.

(ii) Provision to distribute 10 lakh spectacles @ Rs.100/- per spectacles to old persons suffering from presbyopia.

6.3 The Committee notes that utilization status of funds in the year 2014-15 is quite satisfactory as compared to that of the year 2013-14. The Committee is of the view that effective fund utilization is an exercise in continuum and near utilization in one year and unsatisfactory utilization in the previous year would not do justice to the programme and the Ministry should ensure effective fund utilization every year, so as to preclude the Ministry of Finance from cutting funds for the next year on the basis of the previous performance. The Committee hopes that the Department would be able to implement the new initiatives introduced during the 12th Plan considering that this is the fourth year of the 12th Plan. The Committee also noticed that in both 2013-14 and 2014-15 allocations were reduced. In fact in 2013-14, it was made almost 50% of the BE. Such drastic reductions derail the programmes and should be avoided.

6.4 The Committee would like to be apprised of the action being initiated by it to check the instance of loss of sight due to cataract surgeries in camps organized by

NGO's and other organizations. Also, the Committee through media reports came to know that only a small percentage of eyes donated could be used for restoration of vision. The Committee, accordingly, recommends to the Department to take adequate measures to ensure that eyes donated could be used for the benefit of large number of blind persons and not go waste.

B. <u>NATIONAL MENTAL HEALTH PROGRAMME:</u>

6.5 The objectives of National Mental Health Programme are:

(i) To ensure availability of minimum mental health care for all in the foreseeable future particularly the most vulnerable and under privileged section of the population

(ii) To encourage application of mental health knowledge in general care and social development

(iii) To promote community participation in developing mental health services and to stimulate efforts towards self-help in the country

12th plan Initiatives: The 12th FYP envisages strengthening of the Mental Health plan with expansion and few modifications in existing components including Public Private Partnership programme, Long term community treatment / Rehabilitation Services, Integration of NMHP Components with NRHM, Mental Health Services, Help-Line and Public Information Services, Mental Health Emergency Services and Integration of other Neuro-sciences facilities to Central Mental Health Institutes. The programme has been expanded to 241 districts during the 12th Five Year Plan and the National Mental Health Policy was launched in 2014 on the occasion of World Mental Health Day.

6.6 The Committee notes that an amount of Rs. 68.28 crore was allocated for BE 2014-15 for the National Mental Health Programme which was reduced to Rs.

62.00 crore at RE stage and the expenditure of Rs. 58.24 crore has been incurred. The Committee, though appreciative of the utilisation figures, is of the view that the utilisation figures vis-à-vis the funds allocated at BE stage leave much to be desired. The Committee is of the view that Mental Health is an area of critical importance as with the change in lifestyles and increase in stress the incidences of depression are on the rise. The Committee, therefore, recommends that the Department should ensure optimum utilization of funds to prevent cuts at RE stage so that the actual implementation does not suffer due to paucity of funds.

C. NATIONAL PROGRAMME FOR THE HEALTH CARE OF ELDERLY

6.7 The Ministry has launched the National Programme for the Health Care of Elderly in 2010 to provide separate, specialized and comprehensive health care to the senior citizens at various levels of state health care delivery system including outreach services. Preventive & promotive care, management of illness, health manpower development for geriatric services, medical rehabilitation & therapeutic intervention and IEC are some of the strategies envisaged in the NPHCE.

6.8 The major components/ objectives of the NPHCE are establishment of Department of Geriatric in 8 Medical Institutions identified as Regional Geriatric Centres in different regions of the country and to provide dedicated health care facilities in District Hospitals, CHCs, PHCs and Sub Centres levels in 104 identified districts of 24 States. The Regional Geriatric Centres are providing technical support to the geriatric units at district hospitals whereas district hospitals will supervise and coordinate the activities down below at CHC, PHC and Sub-Centres. The following facilities are being provided under the Programme:

(i) Geriatric OPD, 30 bedded Geriatric ward for in-patient care, etc at Regional Geriatric Centres. The Regional Geriatric Centres will also undertake PG Course in Geriatric for developing Human Resource.

(ii) Geriatric OPD and 10 bed Geriatric Ward at District Hospitals.

(iii) Bi-weekly Geriatric Clinic at Community Health Centres (CHCs).

(iv) Weekly Geriatric Clinic at Primary Health Centre (PHCs).

(v) Provision of Aids and Appliances at Sub-centres.

6.9 The Committee is of the view that with the continuous increase in life expectancy, the country is going to have a large Geriatric population in the near future. The Committee finds that out of Rs. 50.83 crore allocated in BE 2014-15, the amount has been drastically reduced to Rs. 25.50 crore at RE stage. However, what compounds the misery, is the utilization figure which amounts to Rs.21.47 crore. The Committee finds that the Department has been too slow in ensuring optimum utilization of funds which would adversely affect the actual implementation of the activities not to mention the cost overruns. The Committee, therefore, recommends that the Department needs to ensure that justice is done to the funds allocated by Finance Ministry so that in future the Department should not face any cuts in allocation due to tardy utilization record.

D. NATIONAL TOBACCO CONTROL PROGRAMME

6.10 As per the Annual Report (2014-15) of the Department of Health and Family Welfare, India is the second largest consumer of tobacco in the world. The tobacco epidemic in India is notable for the variety of smoked and smokeless tobacco products that are used and for their production by entities ranging from the loosely organized manufacture of *Bidi* and smokeless products to multinational corporations. An estimated one million Indians die annually from tobacco-related diseases. Globally, tobacco consumption kills nearly 6 million people in a year. The Global Adult Tobacco Survey India- GATS 2010 - found that 35% of Indian adults in the age group, 15 years and above use tobacco in one form or the other. The extent of use of Smokeless Tobacco Products (SLT) is particularly alarming about 33% adult males and 18% adult females in the country consume SLT. The mean age at initiation of daily tobacco use in India for those aged 20–34 years is as low as 17.8 years. According to the Global Youth Tobacco Survey - GYTS 2006, 14.6% of students aged 13-15 years in India use some form of tobacco - 4.4% smoke cigarettes and 12.5% use other forms of tobacco.

6.11 The Committee notes that the Department was allocated Rs. 40.00 crore in BE-2014-15 which has been reduced to Rs. 20.00 crore at RE stage. However the Department has been able to spend only Rs.1.40 crore. The Committee is surprised at this state of affairs. On the one hand, as per information of the Department, an estimated one million Indians die annually from tobacco-related diseases, and on the other hand the Department has only been able to spend a meagre amount of funds. The Committee, therefore, recommends that such a lackadaisical attitude cannot be condoned and such meager utilization of funds reflects on the inefficiency of the officials manning the programme and the Department should fix the accountability to ensure that such a situation is not allowed to recur in future.

E. <u>National Oral Health Programme(NOHP)</u>

6.12 As per information supplied by the Department,the Main objectives of the Programme are:

- Improvement in the determinants of Oral Health, Reduce morbidity or oral diseases upto primary and secondary level and Strengthening of existing healthcare delivery system at primary and secondary level.
- Integrate oral health promotion and preventive services with general healthcare system and other sectors that influence oral health; namely School Health Programme, Tobacco Control Programme, NPCDCS, Fluorosis, etc.
- Upgradation of 50 District Hospitals by strengthening of Dental Clinces Contractual Appointments of health professionals and imparting training for management of Oro-Dental Disease at a cost of Rs.10.20 crore.
- Generating public awareness about Oro-Dental Diseases through various IEC activities.
- Organizing training of trainers etc at central level proposed at a cost of Rs.2.39 crore.

6.13 The Department has further informed that in the 11th Five Year Plan, NOHP could not be launched. In the 12th Five Year Plan, coverage of 200 districts under NOHP is proposed with a total outlay of Rs.100 crore.

6.14 The Committee finds that in the year 2012-13, no allocation was made; in 2013-14, an allocation of Rs. 10 crore was made at BE stage which was reduced to nil at RE stage and in 2014-15 an allocation of Rs. 2.66 crore was made at BE stage which was reduced to Rs 2.00 crore at RE stage and the actual expenditure was to the tune of Rs 1.68 crore. Further a mere allocation of Rs. 2.00 crore has been made in 2015-16. The Committee is dismayed to find that even after three years of the inception of the programme the allocation and utilization figures leave much to be desired keeping in view that a plan outlay of Rs. 100 crore was made for the entire Plan period. The Committee feels that keeping in view that only 2 more years of 12th Plan are left, it would be a herculean task to ensure achieving the target set for the 12th Plan. The Committee points out that the Department had not been able to initiate the programme in the 11th Plan and the progress in the 12th Plan is not satisfactory at all. The Committee, therefore, recommends that the Department should prioritise the schemes on which it can ensure deliverables instead of stretching itself thin on introducing schemes and then being not able to deliver the same, of which this programme is a classic case.

F. ASSISTANCE TO STATES FOR CAPACITY BUILDING

6.15 Burn Injuries Scheme: As informed in the 12th Five Year plan, under the Scheme, burns unit shall be established in 67 Medical Colleges. The programme will be the part of "Human resource in Health and medical Education scheme". Apart from this the development of burn units in 19 district Hospitals though NHM umbrella shall also be taken up and assistance to be provided to the states will be governed by the norms set under this parent scheme. One of the important criteria under the scheme is that the assistance proposed under the programme for various components will be shared between the Centre and State Governments in the ratio of 75:25 (for North-Eastern and Hill States the ratio will be 90:10). The programme strategies to reduce incidence, mortality, morbidity and disability due to burn injuries are:

(i) To establish adequate infrastructural facility and network behaviour change communication, burn management and rehabilitation.

(ii) To Carry out research for assessing and determining behavioural, social and other determinant of burn so that there is an effective need based monitoring of burn injuries with subsequent evaluation.

6.16 The Committee finds that an amount of Rs.4.17 crore was allocated in the 2014-15 at BE stage, but the same was reduced to nil allocation at RE stage. The Committee fails to understand how the Department is proposing to implement the scheme when no allocations has been made at RE stage. What is more appalling is the non-receipt of the utilization figures by the Department. The Committee hopes that the Department would be able to complete the targets set for the 12th Plan period and also recommends the Department to be more circumspect in ensuring utilization of funds more so in view of the fact that an allocation of Rs. 20.00 crore has been made in 2015-16.

G. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE

6.17 Government of India launched the "National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)" during the 11th Five Year Plan in 21 States covering 100 Districts for reducing the burden of Non-Communicable Diseases (NCDs) such as cancer, diabetes, cardiovascular diseases and stroke which are major factors reducing potentially productive years of human life, resulting in huge economic loss. Total initial outlay of the programme for 2 years was Rs. 1230.90crore on cost sharing basis with the participating States in the ratio of 80:20. The main objectives of the programme is promoting healthy life style through massive health education and mass media efforts at country level, opportunistic screening of persons above the age of 30 years, establishment of Non-Communicable Disease (NCD) Clinic at Community Health Centre (CHC) and District level, development of trained manpower, strengthening of Tertiary level health care facilities and up-gradation of Medical Colleges.

6.18 During the 12th Five Year Plan the programme is being expanded to all the districts across the country with focus on strengthening of infrastructure, human resource development, health promotion, early diagnosis, treatment and referral for

prevention and control of cancer, diabetes, cardiovascular diseases and stroke. The following are the changes in the 12th plan strategy *vis-a-vis* in 11th Five year Plan: During 2013-14, Rs.75.67 Crore have been released under NCD Flexipool to 13 New States & 9 old States so far.

(i) The programme at district level and below covered under NRHM/NHM

(ii) The programme cost are shared between GOI and States (75% : 25%) and for NE and Hilly State is 90:10 Share.

(iii) PHCs have been covered.

(iv) Screening of Diabetes and hypertension in urban slums of large Cities and Metros.

(v) Screening for common cancers (Oral, Cervical and Breast Cancer)

(vi) Cardiac Care Units and Chemotherapy Centres at district hospitals are to be established / strengthened at 25% districts.

(vii) Separate Scheme for Tertiary Cancer Care to support 20 State Cancer Institutes and 50 Tertiary Cancer Centres.

(viii) Cancer Registry programme to be expanded.

(ix) Periodic NCD risk factor survey

(x) Hub and spoke model is to be provided for providing comprehensive care, where hub would be the tertiary care hospital/ Medical College and spokes would be the districts.

(xi) Establishment of State Cancer Institute & strengthening of Tertiary Cancer Centres across the country.

(xii) To link the Medical college & Districts which are in the vicinity initiatives have been taken up under NPCDCS programme to provide support, maintenance, and capacity building & referral Tertiary cancer facilities.

(xiii) NPCDCS Programme has been subsumed under NRHM for District & below level activities.

(xiv) Funds are being released through PIP mode to the State.

(xv) All districts across the country to be covered by the end of 12th Plan.

6.19 **The Committee notes that an amount of Rs. 292.55 crore was allocated in 2014-15 at BE stage which was reduced to Rs. 235.00 crore at RE stage and the actual expenditure is Rs.190.34 crore. The Committee observes that the country has been witnessing a rapid increase in the cases of cancer, diabetes, cardiovascular diseases and stroke which are affecting people from all strata of the society. The Committee would, therefore, like the Department to take more intensive and dispersed initiatives to ensure preventing the incidence of these cases. The Committee also notes that the utilisation figures, when compared to the BE and RE allocations, do not do justice to the Programme and recommends that the Department should ensure that the scheme is prioritised as 'essential' on which no compromise can be allowed and the Committee feels that nil allocation to the Programme in 2015-16 is not digestable and the Department should approach the Ministry of Finance for allocation of funds at RE stage.**

VII. MISCELLANEOUS ISSUES

PROVISION OF HEARING AIDS, SPECTACLES ,DENTURES, ETC. TO THE SENIOR CITIZENS IN RURAL AREAS UNDER NRHM

7.1 It has been brought to the notice of the Committee that the National Rural Health Mission in the country which is mandated to provide health care in rural India focuses mainly on treatment of diseases. There is no provision to provide spectacles, dentures and hearing aids etc. particularly to senior citizens in the rural areas. The Committee, therefore, recommends that the Department should look at the feasibility of the proposal for providing the aids and appliances mentioned above to the senior citizens in the rural areas under NRHM and, accordingly allocate adequate the funds for the purpose.

PART C

(Demand No. 50)

National AIDS Control Organisation

I. INTRODUCTION

1.1 India has the largest number of people living with HIV/AIDS in the world after South Africa (61 lakh) and Nigeria (34 lakh). As per information furnished by NACO, the total number of people living with HIV/AIDS in India was estimated at around 20.9 lakh in 2011, 86% of whom were in 15-49 years age-group. Children less than 15 years of age accounted for 7% (1.45 lakh) of all infections in 2011. Of all HIV infections, 39% (8.16 lakh) were among women. The estimated number of PLHIV in India has maintained a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011.

1.2 According to HIV Estimations 2012, the adult (15-49 years) HIV prevalence at national level continued its steady decline from the estimated level of 0.41% in 2001 to 0.27% in 2011. Declining trends in adult HIV prevalence were sustained in all the erstwhile high prevalence States. However, some States like Assam, Delhi, Chandigarh, Chhattisgarh, Jharkhand, Odisha, Punjab and Uttarakhand showed rising trends in adult HIV prevalence. At national level HIV prevalence among the young (15-24 years) population also declined from around 0.30% in 2001 to 0.11% in 2011.

1.3 According to HIV Sentinel Surveillance (HSS) 2012-2013, the overall HIV prevalence among ANC clinic attendees, considered a proxy for prevalence among the general population, continues to be low at 0.35% in the country, with an overall declining trend at the national level. More than 99% people are HIV negative.

1.4 The Committee notes that there is a declining trend of people living with HIV/AIDS in the country according to HIV Sentinel Surveillance (HSS). The Committee though appreciates the efforts made by NACO for bringing a steady decline in HIV prevalence in the country but would also like to know whether the mechanism put in a place to count the people living with HIV/AIDS is robust and reflects the exact count.

II. National AIDS Control Programme-IV

2.1 As per information given in the Outcome Budget 2015-16, in order to control the spread of HIV/AIDS, the Government of India is implementing the National AIDS Control Programme (NACP), as a 100% centrally sponsored scheme. The first National AIDS Control was launched in 1992, followed by NACP-II in 1999. Phase III of NACP, launched in July 2007, had the goal to halt and reverse the epidemic in the country over the five-year period (2007-2012) by scaling up prevention efforts among High Risk Groups (HRG) and general population, and integrating them with Care, Support & Treatment services.

2.2 The National AIDS Control Programme Phase-IV (2012-2017) aims to consolidate the gains made during NACP-III, and accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process during NACP-IV period. The key strategies under NACP-IV is to intensifying and consolidating prevention services with a focus on HRG and vulnerable population, increasing access and promoting comprehensive care, support and treatment, expanding IEC services for general population and high risk groups with a focus on behavior change and demand generation, building capacities at national, state and district levels and strengthening the Strategic Information Management System.

2.3 As per information in the Annual Report – 2014-15 of the Ministry of Health and Family Welfare, the package of services provided under NACP-IV includes:

Prevention Services:

- Targeted Interventions (TI) for High Risk Groups and Bridge Population (Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders/Hijras, Injecting Drug Users (IDU), Truckers & Migrants;
- Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs;
- Prevention Interventions for Migrant population at source, transit and destinations;
- Link Worker Scheme (LWS) for High Risk Groups and vulnerable population in rural areas;
- Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI);
- Blood Transfusion Services;
- HIV Counselling & Testing Services;
- Prevention of Parent to Child Transmission;
- Condom promotion;
- Information, Education & Communication (IEC) and Behaviour Change Communication (BCC) – Mass Media Campaigns through Radio & TV, Mid-media campaigns through Folk Media, display panels, banners, wall writings etc., Special campaigns through music and sports, Flagship programmes, such as Red Ribbon Express;
- Social Mobilization, Youth Interventions and Adolescence Education Programme;
- Mainstreaming HIV/AIDS response and
- Work Place Interventions.

Care, Support & Treatment Services:

- Laboratory services for CD4 Testing, Viral Load testing, Early Infant Diagnosis of HIV in infants and children up to 18 months age and confirmatory diagnosis of HIV-2;
- Free First line & second line Anti-Retroviral Treatment (ART) through ART centres and Link ART Centres, Centres of Excellence & ART plus centres;

- Pediatric ART for children;
- Early Infant Diagnosis for HIV exposed infants and children below 18 months;
- Nutritional and Psycho-social support through Community and Support Centres;
- HIV-TB Coordination (Cross-referral, detection and treatment of co-infections) and
- Treatment of Opportunistic Infections.

III. Budgetary Allocation

3.1 As per information furnished by the Department of Health and Family Welfare BE, RE and AE during the years 2012-13, 2013-14 and 2014-15 are as under:

(Rs. in Crore)

Year	Budget Estimates	Revised Estimates	Expenditure Incurred	% Budget Utilization (against RE)
2012-13	1700	1759.56	1316.07	75%
2013-14	1785.00	1500.00	1473.16	98%
2014-15	1785.00	1300.00	1253.53*	99%

* as on 27/3/15.

3.2 The NACO has informed that under NACP-IV, Rs. 11,394 crore was approved for 2012-17 but only Rs.4560 crore provided in first three years and therefore the allocation in RE stages over the years have been decreased.

3.3 On the reasons for downward revision of the allocation at RE stage, it has been informed that savings were due to mandatory cuts imposed by Ministry of Finance at RE stage, whereas the unspent balance is less than 1% of expenditure permissible within the

RE ceiling. The same was due to non materialization of some media campaigns and procurement proposals etc.

3.4 In reply to a question, it has been informed that against the Annual Plan of Rs.2633.00 crore sought by National AIDS Control Organisation (NACO) for the year 2015-16, Rs.1397.00 crore has been allocated. The NACO has also informed that various activities undertaken by NACO both at Central level and State level for prevention of AIDS patients/people living with HIV(PLHIV) are likely to be affected with the shortfall and therefore, NACO would consider to offset the effect of shortfall by two means (i) by approaching the Finance Ministry for further allocation; and (ii) respective States can fund a proportion of the requirement from their State Health budget. The proportion to be supported under State Health Budget could be variable across States. It was also stated that in 2015-16, NACO will be undertaking prioritized activities oriented mainly towards prevention, care, support and treatment of AIDS patients/ people living with HIV (PLHIV) subject to availability of funds.

3.5 The Committee notes that as compared to the funds allotted in REs 2012-13, 2013-14 and 2014-15, the level of utilization of funds by NACO has been satisfactory, though it is less than the allocations made in BEs of the respective years. A perusal of the information made available to the Committee, revealed that according to HIV Sentinel Surveillance 2012-13, which is mandated to assess the burden and trends of HIV in different States of the country, the overall HIV prevalence among the general population continues to be low at 0.35% in the country, with an overall declining trend at the national level. The estimated number of People Living with HIV/AIDS has also maintained a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011. The Committee feels that this is due to the impact of the various interventions of NACP and scaled up prevention strategies. But what is worrisome is that some low prevalence States like Assam, Chandigarh, Delhi, Jharkhand etc. have shown increase in the number of new infections. In this context the Committee is concerned about the reduced allocation for NACO for 2015-16. The Committee feels that the allocation of Rs.1397.00 crore in RE 2015-16 which is only marginally higher than the RE 2014-15 allocation of Rs.1300.00 crore may have and adverse impact on the key priorities of

National AIDS Control Programme IV and hinder scale-up of interventions in hitherto untouched areas. The Committee sincerely hopes that subsequent to the increase of State share in the Central Taxes from 32 per cent to 42 per cent, the State Governments, who are currently not contributing any money to National AIDS Control Programme (NACP), would be able to fund a proportion of the fund requirement from their State Health Budgets. The Committee, simultaneously, observes that India is a resource-constrained country and in order to obtain the best possible health outcomes, it is imperative that allocation of resources is prioritized across competing ends and the available funds are deployed in a more efficient manner. The Committee, therefore, recommends that concrete steps should be initiated to economize on expenditure and improve its efficiency so that the intended objectives of NACP IV are not adversely impacted.

IV. Unspent Cash Balances with State AIDS Control Society (SACS)

4.1 As per information received by the NACO, cash balance with State AIDS Control Societies as on 01.03.15 is Rs 194.84 crore. An updated statement indicating States with substantial amount of unspent cash balances is given below:-

(Rs. in crore)

SACS	Unspent cash balances as on 1.3.15
Assam SACS	7.43
Chattisgarh SACS	7.25
Delhi SACS	5.49
Jharkhand SACS	10.22
Karnataka SACS	37.99
Maharashtra SACS	30.17
Orissa SACS	10.02
Tamil Nadu SACS	17.84

4.2 In reply to a query about the steps/action taken by NACO towards utilization of unspent balances available with State AIDS Control Society (SACS), the NACO has

informed that close monitoring of cash balances with SACS is undertaken and position is reviewed to direct the SACS to liquidate the cash balances with them. Review meeting with SACS officials /personal intervention of SACS Project Directors inter alia for liquidating the cash balances has improved the position. In 2014-15, due to delay in release of funds by the Treasury route at States, the utilization picture would be clearer by March 2015 end. Constant watch is being kept to further reduce the balance of advances. All the releases made to SACS from NACO are after adjusting the cash balance/advances pending with them.

4.3 The Committee notes that inspite of interventions of NACO, availability of unspent balances with some SACS are still quite high. The Committee, therefore, recommends the NACO to introduce stricter monitoring mechanism and plan viable strategy to clear the unspent balances so that funds do not get accumulated and locked but are utilized in a more productive manner. The Committee also reiterates its earlier recommendation made in its 70th Report on Demands for Grants 2013-14 of the erstwhile Department of AIDS Control that in order to ensure timely and effective utilization of unspent balances, NACO should insist on quarterly feedback from all the SACS. The Committee also desires to be apprised of the number and dates of review meetings taken in 2014-15 to expedite liquidation of the unspent cash balances with SACS.

V. Role of NGOs

5.1 As per information given in the Outcome Budget 2015-16, Targeted Interventions (TIs) is one of the important prevention strategies under the National AIDS Control Programme. Targeted Interventions (TIs) comprise preventive interventions by working with focused client populations in a defined geographic area where there is a concentration of one or more High Risk Groups (HRGs). TIs are implemented by NGOs/CBOs contracted by State AIDS Control Societies. In response to a query regarding steps taken to recover the unspent balances from defaulting NGOs, the NACO has informed that a number of mechanisms have been initiated to see that the outstanding balances are recovered and appropriate actions are taken against the defaulting NGOs

due to which outstanding amount to be recovered has declined from Rs.352.17 lakh to Rs.79.69 lakh.

5.2 The Department has initiated actions like seeking statement for the last three years, monitoring of monthly expenditures through the Computerized Financial Management Systems (CPFMS), placing of a technical programme officer for every 10-15 Targeted Interventions to monitor programme performance and financial statements, six monthly performance analysis by States AIDS Control Society, etc. The NGOs are visited every 2 years by an independent evaluation team to assess governance system, staffing and HR policy, experience in implementing projects, financial management systems, procurement system, planning, monitoring and financial activities regularly. NACO has also suggested to State AIDS Control Societies (SACS) to speed up legal action against the defaulting NGOs by sending letters from DDG (TI & JS) and several SACS have initiated legal action against defaulting NGOs. As per information received in respect of 11 States, out of Rs. 100.86 lakh, an amount of Rs.25.88 lakh has been recovered and Rs.74.98 lakh will be recovered as on March, 2015.

5.3 The Committee welcomes the action initiated by NACO to deal with the issues - like recovery of unspent balances with discontinued NGOs and steps taken for monitoring and control of programmatic and financial activities etc. The Committee, would, however, like the Department to make an assessment of the impact of actions initiated for a recovery of unspent balances with defaulting NGO's.

VI. Metro Blood Banks

6.1 In reply to a query regarding the progress made towards establishment of the four Metro Blood Banks, the NACO has informed that the Metro Blood bank project is conceived to create Regional Centres of Excellence in Transfusion Medicine so as to complement the entire Blood Transfusion Service efforts and is focused on the four metro cities of Delhi, Mumbai, Kolkata and Chennai. The proposal for Setting up of Metro Blood Banks is one of the approved activities under NACP-III and has been continued in NACP-IV. The Cabinet Committee on Economic Affairs (CCEA) had approved the scheme in August 2008 at an estimated cost of Rs.468.00 crore and the date of commencement of project was 1.1.2009. The project went into time and cost overrun

mainly due to delay in obtaining land free of cost from the States. The revised cost is Rs.1024.00 crore which was submitted to EFC for approval in December, 2012. However, EFC did not concur and Department took steps to submit a revised proposal for the same which was concurred with some suggestions. Budget was estimated for two centres at Rs.403.93 crore.

6.2 A budgetary provision of Rs.83.00 crore was made in BE 2014-15 , but due to pending approval of EFC, the same was reduced to nil at RE stage in financial year 2014-15. The Committee has been informed that it is expected that the project would take off in first quarter of the financial year 2015-16 i.e. 1st July, 2015, after which it could take around 18 months for completion of construction. Cost overrun of Rs. 85.00 crore per centre is estimated when compared to initial approval of the project.

6.3 The Committee notes that the proposal for setting up of Metro Blood Banks is one of the approved activities under NACP-III and has been continued in NACP-IV. But its implementation is still a far cry. Budgetary allocations to the tune of Rs. 83.00 crore was made in BE 2014-15 but was surrendered in toto due to pending approval of Expenditure Finance Committee. The Committee disapproves of providing as much as Rs. 83.00 crore in BE 2014-15 although necessary approval of EFC remained to be obtained for implementing the project and exhorts that maximum possible care be taken while formulating Budget Estimates under this head in future so that realistic projection of funds requirements is ensured. Now that the project has been approved, the Committee recommends the Department to ensure that this important project is taken up for implementation without further delay. The Committee would like to be updated on the progress made towards implementation of this project and targeted time line for its completion.

VII. Setting up of new District level Blood Banks

7.1 In a reply to a query regarding status of setting up of new District Level Blood banks (DLBB), the following information has been furnished:-

Sr.No.	Name of the State	Target for	Targets	Target to be

		NACP-III	Achieved (DLBB)	achieved
1	Bihar	1	0	1
2.	Chhatisgarh	2	2	
3.	Jharkhand	11	7	4
4.	Karnataka	4	4	
5.	Kerala	1	1	
6.	Mizoram	2	2	
7.	Uttar Pradesh	15	15	
8.	Uttrakhand	3	0	3
	Total	39	31	8

7.2 The NACO has also informed that equipments for all these centres were procured and supplied during NACP-II, however, since wherever States had not made necessary infrastructure and manpower available to fulfill licensing requirements, the concerned licensing authority did not grant licenses.

7.3 The Committee notes that the NACP-III was to be implemented during 2007-2012. The Committee finds that out of the 39 new District Level Blood Banks to be set up during NACP-III, 8 DLLB are still to be implemented even though three years have elapsed since NACP-III concluded. The Committee notes that most of the reasons cited for the delay are non-availability of necessary infrastructure, manpower and delay in issuance of license. The Committee, therefore, recommends the Department to play a pro-active role by taking up the matter with the concerned State Governments as well as its agencies at an appropriate level to iron out the procedural hindrances and help achieve the targets set. The Committee also gathers that equipment for the Centres were procured and supplied during NACP-II. The Committee is perturbed to find such a national waste in resource country like ours.

7.4 On enquiring about the position of special care of the underserved areas including districts of Uttar Pradesh, Jharkhand and Uttarakhand in respect of blood banks, the NACO has informed that communications have been sent to all States to make blood storage centres functional with support from NHM to improve access to safe blood for underserved areas. The Committee would like to be apprised about the progress made in this regard.

VIII. Antiretoviral Therapy (ART) Centre

8.1 The Department in a written submission has informed that it is estimated that the scale up of free Anti-Retroviral Treatment (ART) since 2004 has averted over 1.5 lakh deaths due to AIDS related causes till 2011. Wider access to ART has led to 29 % reduction in estimated annual AIDS related deaths from 2.07 lakh in 2007 to 1.48 lakh in 2011, highlighting the impact of scale of the ART services in the country.

8.2 In a reply to a query, under NACP-IV, 600 Anti Retroviral Therapy (ART) centres are proposed to be set up in the country by March, 2017 to make available quality treatment to eligible People Living with HIV/AIDS (PLHIV). 466 ART Centres were made functional till 31st January, 2015 and remaining 134 ART centres will be made functional by March, 2017.

8.3 **The Committee would like to be apprised of the progress made in respect of setting up of 134 ART centres which are proposed to be made functional by March, 2017, within a period of six months from the date of presentation of this Report.**

IX. Setting up of Plasma Fractionation Centre (PFC)

9.1 The NACO has informed that EFC for Plasma Fractionation Centre (PFC) was concurred in NACP-III. However, the Expression of Interest (EOI) failed for Project Management Consultant (PMC) selection. Accordingly, EOI for identification of Plasma Fractionation Centres was floated in August 2014 which was also not successful. Thereafter, setting up of Plasma Fractionation Centre (PFC) and policy matters pertaining to Plasma have been deliberated in several expert group consultations and a Plasma Policy has been formulated as an addendum to the National Blood Policy 2002 and launched in June 2014.

9.2 The NACO has also informed that Public Private Partnership as the modality has been approved for PFC and the NACO is exploring the same to set up the Plasma Fractionation Centre accordingly. Availability of raw material, i.e, blood plasma, to make such plasma fractionation centre is still being explored. It is evidently a resource intensive

and technologically difficult area with limited expertise available within the government sector, but efforts are underway to make the project function.

9.3 The Committee desires that the project should take off at the earliest. All necessary steps may be taken in this direction.

X. Setting up of District AIDS Prevention and Control Units (DAPCUs)

10.1 The NACO has informed that District AIDS Prevention and Control Units (DAPCUs) have been established in 189 districts spread over 22 States under NACP-III. Under NACP IV, training for DAPCU staff on revised programme guidelines was initiated in September, 2014 and is currently in progress. Till March, 2015, a total of 686 staff from 158 DAPCUs have been trained in 22 batches. The remaining 209 DAPCU staff in Andhra Pradesh, Telangana, and Rajasthan will be trained by June, 2015.

10.2 The Committee appreciates the efforts of NACO to set up 189 DAPCUs in the country. The Committee notes that further expansion of DAPCUs would be undertaken , if required, after finalization of district re-categorization which is still in process. The Committee recommends that the district re-categorization should be completed at the earliest.

HEALTH SECTOR

ANNEXURE - I

Year-wise Approved plan outlay & Expenditure for 2013-14 & 2014-15 (Health)

(Rs. in crore)

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
A (I)	CENTRAL SECTOR SCHEMES	42757.78	5942.11	4691.49	4037.67	5334.09	4698.77	2644.27
1	Oversight Committee	1827.00	350.00	244.00	150.38	183.13	205.93	34.44
2	Strengthening of the Institutes for Control of Communicable Diseases	1162.00	250.46	117.70	126.42	202.09	165.09	67.05
	(a) National Institute of Communicable Diseases, New Delhi	107.00	18.00	12.88	11.36	13.00	12.95	7.19
	(b) National Tuberculosis Institute, Bengaluru	15.00	2.65	2.49	1.97	2.65	2.36	1.69
	(c) B.C.G. Vaccine Laboratory, Guindy, Chennai	183.00	12.86	15.00	31.93	12.02	12.64	0.59
	(d) Pasteur Institute of India, Coonoor	232.00	40.00	46.00	40.00	40.00	40.00	18.00
	(e) Integrated Vaccine Complex, Chengalpattu &Medi Park	285.00	135.00	0.00		92.00	40.00	0.00
	(f) Lala Ram Swarup Institute of T.B. and Allied Diseases, Mehrauli, Delhi	300.00	35.00	34.38	34.38	35.00	42.28	35.00
	(g) Central Leprosy Training & Research Institute Chengalpattu (Tamil Nadu)	13.00	2.25	2.25	2.25	2.25	3.11	1.17
	(h) Regional Institute of Training, Research & Treatment under Leprosy Control Programme:	27.00	4.70	4.70	4.53	5.17	11.75	3.41
	(i) R.L.T.R.I., Aska (Orissa)	...	0.30	0.30	0.27	0.30	5.74	0.03
	(ii) R.L.T.R.I., Raipur (M.P.)	...	0.70	0.70	0.70	0.70	0.79	0.44
	(iii) R.L.T.R.I., Gauripur (W.B.)	...	3.70	3.70	3.56	4.17	5.22	2.94
3	Strengthening of Hospitals & Dispensaries	3221.06	518.90	457.22	336.57	428.35	465.21	279.89
	Central Government Health Scheme	562.01	101.20	110.00	86.60	101.20	156.93	71.71
	Central Institute of Psychiatry, Ranchi	279.00	50.00	41.31	28.53	40.00	49.78	18.99
	All India Institute of Physical Medicine & Rehabilitation, Mumbai	110.00	16.00	9.37	5.28	6.00	6.90	3.83
	Dr. R.M.L. Hospital & Research Institute , New Delhi	1956.00	270.55	212.80	174.65	200.00	201.60	144.60
	Others	314.05	81.15	83.74	41.51	81.15	50.00	40.76
	Institute for Human Behaviour& Allied Sciences, Shahdara, Delhi	0.05	0.01	0.00	0.00	0.01	0.00	0.00
	All India Institute of Speech & Hearing, Mysore	314.00	81.14	83.74	41.51	81.14	50.00	40.76

Annexure-I (Health Sector)

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
4	Strengthening of Institutions for Medical Education, Training & Research	2979.00	475.90	409.56	356.71	423.90	488.55	271.14
	(a) Medical Education:	2480.00	400.55	357.03	313.44	370.56	432.01	247.18
	North Eastern Indira Gandhi Institute of Health & Medical Sciences, Shillong	916.00	160.00	140.00	106.25	160.00	177.00	87.66
	N.I.M.H.A.N.S., Bengaluru	900.00	132.80	132.80	132.80	132.80	158.46	117.60
	Kasturba Health Society, Wardha	305.00	50.00	50.00	50.00	50.00	55.55	31.92
	National Medical Library, New Delhi	159.00	27.75	34.22	24.39	27.75	41.00	10.00
	National Board of Examinations, New Delhi	200.00	30.00	0.01	0.00	0.01	0.00	0.00
	(b) Training:	256.00	31.05	7.41	6.29	12.85	13.44	1.76
	Development of Nursing Services	153.00	20.00	5.00	4.68	10.00	10.00	0.55
	Nursing Colleges	103.00	11.05	2.41	1.61	2.85	3.44	1.21
	(i) R.A.K. College of Nursing, New Delhi	97.00	10.00	1.55	1.08	1.80	2.33	0.77
	(ii) Lady Reading Health School	6.00	1.05	0.86	0.53	1.05	1.11	0.44
	(c) Research:	30.00	6.00	12.19	12.48	7.19	11.19	0.00
	Membership for International Organisation	30.00	6.00	12.19	12.48	7.19	11.19	0.00
	(d) Public Health	105.00	18.80	13.64	9.62	13.80	13.96	8.69
	Institute of Public Health (PHFI)	2.00	0.30	0.30	0.00	0.30	0.30	0.00
	All India Institute of Hygiene & Public Health, Kolkata (AIIH&PH) and Serologist and Chemical Examiner, Kolkata	103.00	18.50	13.34	9.62	13.50	13.66	8.69
	i. AIIH&PH, Kolkata	98.00	17.60	13.00	9.50	13.00	13.20	8.40
	ii. Serologist & Chemical Examiner, Kolkata	5.00	0.90	0.34	0.12	0.50	0.46	0.29
	(e) Others	108.00	19.50	19.29	14.88	19.50	17.95	13.51
	Indian Nursing Council	2.00	0.40	0.40	0.00	0.40	0.20	0.00
	Vallabh Bhai Patel Chest Institute, Delhi	94.00	16.90	16.94	13.75	16.90	16.90	12.70
	National Academy of Medical Sciences, New Delhi	6.00	1.10	0.85	0.63	1.10	0.35	0.31
	Medical Council of India, New Delhi	6.00	1.10	1.10	0.50	1.10	0.50	0.50
5	System Strengthening including Emergency Medical Relief/Disaster Management	3851.70	384.15	215.06	161.15	257.62	206.02	94.55
	(a) Health Education, Research & Accounts	20.00	2.70	2.03	0.93	1.95	2.25	0.69

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
	Health Education	6.00	1.00	0.23	0.11	0.25	0.55	0.05
	Health Intelligence and Health Accounts	14.00	1.70	1.80	0.82	1.70	1.70	0.64
	i. Intelligence	10.00	1.70	1.80	0.82	0.01		
	ii. Accounts	4.00				1.70	1.70	0.64
	(b) System Strengthening :	3127.70	268.00	171.67	126.20	187.67	155.00	68.70
	(i) Strengthening of Deptts under the Ministry	40.00	8.00	8.42	6.30	10.00	5.00	3.28
	(ii) Strengthening of DGHS	20.00	3.00	2.90	1.55	4.75	3.00	1.34
	(iii) Central Drugs Standard & Control Organization (CDSCO)	1800.00	125.00	73.36	42.65	85.00	50.00	26.28
	(iv) Food Safety & Standards Authority of India(Prevention of Food Adulteration)	850.00	85.00	66.86	58.57	62.92	62.92	26.43
	(v) Indian Pharmacopeia Commission	92.00	16.00	13.00	12.63	10.00	12.00	6.66
	(vi) National Pharmacovigilance Programme	100.00	10.00	4.00	3.33	5.00	5.00	3.16
	(vii) Port Health Authority	225.70	21.00	3.13	1.17	10.00	17.08	1.55
	(c) Emergency Medical Relief	510.00	68.50	6.65	1.75	27.00	11.50	0.99
	Health Sector Disaster Preparedness and Management	500.00	66.50	4.65	0.00	25.00	10.00	0.00
	Emergency Medical Relief (including Avian Flu)	10.00	2.00	2.00	1.75	2.00	1.50	0.99
	(d) Others	194.00	44.95	34.71	32.27	41.00	37.27	24.17
	Central Research Institute, Kasauli	94.00	19.95	9.71	7.53	10.00	6.27	2.67
	National Institute of Biological Standardisation& Quality Control, Noida(U.P.)	100.00	25.00	25.00	24.74	31.00	31.00	21.50
6	Pradhan MantriSwasthya Suraksha Yojana(PMSSY)	12000.00	1975.00	1377.00	1273.23	1956.00	891.00	667.26
7	National Centre for Disease Control	350.00	100.00	77.20	75.30	75.00	54.40	30.07
8	National Advisory Board for Standards	14.00	2.50	1.85	0.24	2.00	1.00	0.20
9	Redevelopment of Hospitals / Institutions	14507.00	1783.00	1787.93	1557.67	1739.00	2211.17	1199.50
	All India Institute of Medical Sciences & its Allied Departments,	6900.00	550.00	550.00	485.00	550.00	700.00	395.83
	New Delhi							
	P.G.I.M.E.R., Chandigarh	1200.00	200.00	200.00	150.00	200.00	160.00	112.50
	J.I.P.M.E.R., Puducherry	1000.00	160.00	210.00	151.83	160.00	220.00	120.00
	Lady Hardinge Medical College & Smt. S.K. Hospital, New Delhi	1100.00	195.00	88.40	83.00	95.00	93.20	68.32

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2014-15			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
	Kalawati Saran Children's Hospital, New Delhi	194.00	38.50	34.73	30.04	38.50	38.57	23.92
	Regional Institute of Medical Sciences, Imphal, Manipur	1088.00	196.00	211.00	227.40	230.00	280.00	146.51
	LokpriyaGopinathBordoloi Regional Institute of Mental Health, Tejpur, Assam	332.00	64.00	64.00	64.00	66.00	66.00	49.75
	Regional Institute of Paramedical and Nursing Sciences, Aizwal, Mizoram	225.00	40.00	48.00	41.09	60.00	63.00	36.17
	Safdarjung Hospital &VardhmanMahaveer Medical College, New Delhi	2468.00	339.50	381.80	325.31	339.50	590.40	246.50
10	Strengthening of existing branches & establishment of 27 branches of NCDC	400.00	32.00	1.00	0.00	2.00	0.00	0.00
11	Strengthening intersectoral coordination of prevention & control of Zoonotic Diseases	25.00	2.00	1.37	0.00	1.00	0.00	0.00
12	Viral Hepatitis	30.00	2.00	0.80	0.00	2.00	0.10	0.07
13	Anti-Micro Resistance	30.00	2.00	0.80	0.00	2.00	0.20	0.10
14	Health Insurance(CGEIPS)	2061.00	50.00	0.00	0.00	50.00	10.00	0.00
15	Emergency Medical Services	300.00	14.20	0.00	0.00	10.00	0.10	0.00
16	Medical Stores Organisation	0.02	0.00	0.00	0.00	0.00	0.00	0.00
A(II)	** CENTRAL SECTOR SCHEMES -FAMILY WELFARE	...	...	...	...	**715.03**	**872.18**	**446.27**
1	Social Marketing Area Projects	...	...	...	...	0.04	0.00	0.00
2	Social Marketing of Contraceptives	...	...	...	...	75.00	101.00	38.98
3	Funding to Institutions	...	...	...	...	43.58	41.13	22.53
	(i) Population Research Centres	...	...	...	...	15.00	16.50	9.34
	(ii) CDRI, Lucknow	...	...	...	...	0.00	0.00	0.00
	(iii) NIHFW, New Delhi	...	...	...	...	15.00	14.90	9.75
	(iv) IIPS, Mumbai	...	...	...	...	10.00	5.57	3.00
	(v) NPSF/National Commission on Population	...	...	...	...	2.00	2.59	0.27
	(vi) Funding to Training Institutions	...	...	...	...	1.58	1.57	0.17
	(a) F.W. Training and Res. Centre, Mumbai	...	...	...	...	0.57	0.57	0.14
	(b) Rural Health Training Centre, Najafgarh	...	...	...	...	0.01	0.00	0.00
	(c) Travel of Experts/Conf./Meetings etc.	...	...	...	...	1.00	1.00	0.03

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
4	Central Procurement Agency	...	...	...	...	0.01	0.00	0.00
5	International Cooperation	...	...	...	...	4.98	9.70	3.57
6	FW Linked Health Insurance Plan	...	...	...	...	1.00	3.00	0.00
7	Free distribution of contraceptives	...	...	...	...	75.00	153.30	71.71
8	Procurement of Supplies & Materials	...	...	...	...	50.00	20.00	0.00
9	IEC (Inf., Edu. and Communication)	...	...	...	...	252.00	281.38	197.51
	(a) Non-RCH	...	...	...	...	...	...	...
	(b) RCH	...	...	...	...	...	...	...
	(c) Adolescent Health	...	...	...	...	...	...	...
10	Area Projects	...	...	...	...	...	...	...
	(a) USAID assisted Projects	...	...	...	...	...	...	...
	(b) EC assisted SIP Project	...	...	...	...	...	...	...
	(c) IPP Project	...	...	...	...	...	...	...
11	***Forward Linkages to NRHM	...	...	...	...	...	...	...
12	Strengthening of National Programme Management of NRHM	...	...	...	...	40.00	94.19	19.35
13	National Drug De-addiction Control Programme	...	...	...	...	35.00	37.27	20.67
14	Other CSS Activities	...	...	...	...	138.42	131.21	71.95
	(a) Other Family Welfare Activities	...	...	...	...	3.10	3.65	0.71
	(i) Role of Men in Planned Parenthood	...	...	...	...	1.00	1.00	0.42
	(ii) Training in Recanalisation	...	...	...	...	0.05	0.05	0.04
	(iii) FW Programmes in Other Ministries	...	...	...	...	0.55	1.10	0.25
	(iv) Technology in Family Welfare- IUD & Fallopian	...	...	...	...	1.50	1.50	0.00
	(b) Gandhigram Institute	...	...	...	...	2.70	2.72	1.75
	(c) Assistance to IMA	...	...	...	...	0.01	0.01	0.00
	(d) Expenditure at HQs (RCH)	...	...	...	...	0.01	0.00	0.00
	(e) Research & Study	...	...	...	...	0.10	0.00	0.00
	(f) Regional Offices	...	...	...	...	27.65	29.48	15.16
	(g) RCH Training	...	...	...	...	11.50	12.00	7.92

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
	(h) Information Technology	...	...	...	...	2.50	2.50	1.30
	(i) NGOs (Public-Private Partnership - PPP)	...	...	...	...	0.85	0.85	0.00
	(j) Management Information System(MIS)	...	...	...	...	90.00	80.00	45.11
B	CENTRALLY SPONSORED PROGRAMMES	32387.51	2223.89	373.51	168.07	2683.88	1201.23	366.95
1	Cancer Control	871.00	100.00	70.51	52.81	173.00	76.00	54.87
	National Cancer Control Programme (CNCI Kolkata)	600.00	50.00	39.21	27.93	100.00	36.00	30.00
	National Tobacco Control Programme	271.00	50.00	31.30	24.88	73.00	40.00	24.87
2	National Mental Health Programme	1222.54	150.00	30.00	6.39	200.00	15.00	0.00
3	Assistance to State for Capacity Building(Trauma Care)	1350.00	86.50	29.00	23.72	98.00	50.00	24.46
	(i) Injury & Trauma Care	900.00	...	...	...	70.00	40.00	18.86
	(ii) Prevention of Burn Injury	450.00	...	...	...	28.00	10.00	5.60
4	E-Health including Telemedicine	122.00	5.00	3.00	0.15	44.77	11.00	0.73
5	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke	3200.00	365.00	50.00	3.90	680.00	360.00	147.53
6	$National Programme for Deafness	...	5.00	1.00	0.00	...	...	...
7	Health Care for the Elderly	562.57	100.00	3.00	0.00	157.00	5.00	0.00
8	National Programme for Control of Blindness	293.10	60.00	14.80	12.45	70.00	70.00	48.37
9	Human Resources for Health	21518.30	1151.66	100.00	42.67	1255.11	612.00	90.91
	(i) Upgradation/Strengthening of Nursing Services	2000.00	200.00	45.23	11.75	200.00	91.00	90.91
	(ii) Strengthening/Upgradation of Pharmacy Schools/ Colleges	65.00	5.01	0.00	0.00	5.00	5.00	0.00
	(iii) Strengthening/Creation of Paramedical Institutions(NIPS/RIPS)	1200.00	200.00	22.46	0.00	200.00	200.00	0.00
	(iv) Strengthening of Govt. Medical Colleges-UG Seats	7500.00	300.00	0.00	0.00	327.00	296.00	0.00
	(v) Establishing New Medical Colleges	8500.00	140.00	7.31	0.00	147.00	10.00	0.00
	(vi) Setting up of State Institutions of Paramedical Sciences in States and setting up of College of Paramedical Education	600.00	20.00	0.00	0.00	20.00	0.00	0.00
	(vii) Setting up of College of Pharmacy in Govt. Medical Colleges	824.30	26.65	0.00	0.00	26.00	0.00	0.00
	(viii) District Hospitals- Upgradation of State Government Medical Colleges-PG Seats	829.00	260.00	25.00	30.92	299.00	10.00	0.00
	(ix) *Strengthening of District Hospitals for providing Advanced Secondary Care	...	...	...	...	31.11	0.00	0.00

Sl. No.	Name of the Schemes / Institutions	12th Plan (2012-17) Approved Outlay	2013-14			2014-15		
			Approved Outlay	Revised Estimate	Expenditure	Approved Outlay	Revised Estimate	Expenditure (Upto Dec.14)
10	Pilot Projects@	509.48	45.73	27.20	16.82			
	National Programme for Sports Injury(Sports Medicine)	59.00	10.00	13.20	13.03	...	...	...
	Leptospirosis Control Programme	4.00	0.50	0.50	0.00	...	...	...
	Control of Human Rabies	50.00	2.00	1.00	0.70	...	...	...
	Medical Rehabilitation	100.00	5.00	1.00	0.49	...	...	...
	^^National Organ Transplant Programme	150.00	12.50	8.50	0.77	5.00	2.23	0.08
	Oral Health	11.48	5.73	1.00	0.00	...	...	...
	National Programme for Fluorosis	135.00	10.00	2.00	1.83	...	...	...
11	Strengthening of State Drug Regulatory System	1200.00	100.00	20.00	0.00	...	...	...
12	Strengthening of State Food Regulatory System	1500.00	55.00	25.00	9.16	...	...	...
13	Innovation based Schemes	38.52	0.00	0.00	0.00	1.00	0.00	0.00
	TOTAL (A+B)	**75145.29**	**8166.00**	**5065.00**	**4205.74**	**8733.00**	**6772.18**	**3457.49**
14	**National AIDS Control Organization***	...	...	...	...	**1785.00**	**1300.00**	**1088.00**
Shifted from NHM-*Strengthening of District Hospitals for providing Advanced Secondary Care and **family welfare -central sector schemes except ***forward linkage to NHM during 2014-15								
Shifted to NHM-#Strengthening of State Food &Drug Regulatory System, $National Programmefor Deafness and ^pilot projects except ^^National Organ Transplant Programme during 2014-15								
GRAND TOTAL (NHM+HEALTH)		**268551.0**	**29165.00**	**23165.00**	**22472.66**	**30645.00**	**24400.00**	**18544.02**

* National AIDS Control Organization has been merged in the Department of Health & Family Welfare during 2014-15. BE, RE &Expenditure for 2014-15 has not been included in the grand total.