P.A.C. No 588

PUBLIC ACCOUNTS COMMITTEE (1977-78)

(SIXTH LOK SABHA)

FORTY-NINTH REPORT

THREE GOVERNMENT HOSPITALS IN DELHI

MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

[Paragraph 30 of the Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil)]

Presented in Lok Sabha on 23-12-1977

Presented in Rajya Sabha on 23-12-1977

LOK SABHA SECRETARIAT
NEW DELHI

December, 1977/Agrahayana, 1899 (S)

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Shri B. K. Mukherjee—*Joint Secretary*

Shri T. R. Ghai—*Senior Financial Committee Officer.*

INTRODUCTION

I, the Chairman of the Public Accounts Committee, as authorised by the Committee, do present on their behalf this Forty-Ninth Report of the Public Accounts Committee (Sixth Lok Sabha) on paragraph 30 of the Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil) relating to the Ministry of Health and Family Welfare (Department of Health) on "Three Government Hospitals in Delhi" namely Safdarjang Hospital, Willingdon Hospital and Irwin Hospital (now re-named "Lok Nayak Jai Prakash Narain Hospital").

2. The Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil) was laid on the Table of the House on 26 March, 1976. The Public Accounts Committee (1976-77) examined the paragraph relating to Three Government Hospitals at their sittings held on 15 and 16 October, 1976 but could not finalise the Report on account of dissolution of the Lok Sabha on 18 January, 1977.

3. The Public Accounts Committee (1977-78) considered and finalised this Report at their sitting held on 7 December, 1977, based on the evidence taken and the further information furnished by the Ministry of Health and Family Welfare (Department of Health). The Minutes of the sittings of the Committee form Part II* of the Report.

4. A statement containing conclusions/recommendations of the Committee is appended to the Report (Appendix III). For facility of reference these have been printed in thick type in the body of the Report.

5. The Committee place on record their appreciation of the commendable work done by the Chairman and Members of the Public Accounts Committee (1976-77) in taking evidence and obtaining information for this Report.

6. The Committee also place on record their appreciation of the assistance rendered to them in the examination of the subject by the Comptroller and Auditor General of India.

7. The Committee would also like to express their thanks to the officers of the Ministry of Health and Family Welfare, Planning Commission and

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Delhi Administration for the cooperation extended by them in giving information to the Committee.

C. M. STEPHEN,
Chairman,
Public Accounts Committee.

NEW DELHI;
December 9, 1977
Agrahayana 18, 1899 (*S*)

REPORT

CHAPTER I

A. Introductory

1.1. In India the medical care to the masses is catered mainly through the hospitals, dispensaries and health centres, the main objective of these being to provide efficient services to the maximum number of persons. Among these the hospital services are the most important public utility services and it has been observed that the number of hospitals have increased from 8600 in 1951 to 15000 in 1971 with a number of beds from 1,25,000 to 2,98,304 respectively. With the increase in these facilities, there is an increase in the budget allocation for the provision of medical care since it requires substantial amount of money. In spite of this increase in facilities the demand for medical care services in hospitals are not being fully met because of the ever increasing demand.

1.2. Some of the more important causes for the low state of health in India as identified at tne commencement of the First Five Year Plan were—lack of hygienic environment conducive to healthful living, low resistance due to lack of adequate diet and poor nutrition, lack of proper housing, safe supply and proper removal of human wastes, and the lack of medical care, curative and preventive status. These were considered as serious impediments to rapid progress. The country's financial resources were, however, limited, trained personnel were lacking and the whole programme of health development was bound up with a broader programme of social development.

1.3. It has been stated in the Draft Fifth Five Year Plan that commendable improvements have taken place in the health indices of the country. The mortality rate has declined from 26.4 per 1000 in the year 1949-50 to 15.1 per 1000 in 1971. Life expectancy at birth has gone up from 32 years (in 1951) to 50 years (in 1971). Infant mortality rate has dropped to 140 from 183 per thousand in the last 20 years. The bed population ratio has also gone up to 0.49/1000 from 0.32/1000 during this period.

1.4. The outlays on health care programmes during the Plan periods are as under:

(Rs. crores)

First Plan	90
Second Plan	146
Third Plan	226
1966 69	140
Fourth Plan	434
Fifth Plan (envisaged	796

1.5. The position in 1950-51 and the progress achieved in some important sectors of health activity are indicated in the following statement:

	1950-51	1955-56	Beginning of Fourth Plan	End of Fourth Plan period	End of Fifth Plan (envisaged)
Hospital Beds	1,13,000	1,25,000	2,55,700	2,81,600	3,21,600
Primary Health Units	..	725	4,919	5,250	5,351
Sub-centres	..	(not available)	22,826	33,000	44,056
Rural Hospitals	..	..	..	..	1,293
Medical Education	..	..	..	..	..
Medical Colleges	30	42	93	99	99
Annual Admissions	2,500	3,500	11,500	12,500	13,000
Medical Personnel—					
Doctors in practice or in service	56,000	65,000	1,02,520	1,38,000	1,76,000
Nurses in practice or in service	15,000	18,000	61,000	88,000	1,25,000

1.6. Despite all these achievements, the position is unsatisfactory. For example, the recommended Mudaliar Committee norm of one bed per 1000 population and one doctor per 3000-3500 population is still not within reach. There are considerable regional disparities in the country in the availability of medical services. 80 per cent of our population which lives in rural areas has only 30 per cent of the hospital beds and 20 per cent of the doctors in the country. The nurse bed ratio is far below the recommended norms in certain regions of the country.

1.7. So far as Union Territory of Delhi is concerned its medical care needs are being mainly met by the three principal hospitals, *viz.* Safdarjang, Willingdon and Irwin Hospitals. With the rapid increase in the population of Delhi from 17.44 lakhs in 1951 to 40.66 lakhs in 1971, as per census, the health services have not kept pace with the needs of the growing population, particularly in the new settlement and jhuggi-jhopri colonies which have since sprung up in scores round about old and New Delhi. The rural area is also being progressively eroded by urban expansion. This has added load to the already over-strained hospitals of Delhi.

1.8. A brief set up of the three hospitals (Safdarjang, Willingdon and Irwin) is indicated below:

Safdarjang Hospital

1.9. This hospital had been put up by the American Forces in India during the Second World War and on the termination of hospitalities, was taken over by the Government of India to serve the needs of the civil population residing in Delhi South and adjoining rural sector. It functioned as an Annexe of the Irwin Hospital up to 1954 when it was taken over by the Ministry of Health, for providing indoor facilities for Government servants and their families under the Central Government Health Scheme and also to serve as the hospital for All India Institute of Medical Sciences.

1.10. The present authorised bed strength in Safdarjung Hospital is 1207 and 174 bassinets. In addition to these, there are 4 casualty beds and 8 Intensive Care Units. The staff position in the hospital is as under:

	Medical	Non-Medical	Para Medical	Non-Technical & Ministerial	Total
Group 'A'	105	..	4	1	110
Group 'B'	18	6	18	4	46
Group 'C'	282	315	612	224	1433
Group 'D'	..	4	1	1080	1085
TOTAL . . .	405	325	635	1309	2674

1.11. During the year 1975, a total number of 11,26,684 patients were attended in the Out Patient Departments and 72, 645 patients were treated as indoor. The O.P.D. of the hospital has the facilities for all specialities *viz.* Medical Surgical, Paediatrics, Eye, E.N.T., Gynae and Obst., Dental, Dermatology, Orthopaedics, Psychiatry, etc. Evening O.P.D. in Medicine, Surgery, Orthopaedic, Paediatrics, Gynaecology and Obst. are also functioning. There are a number of special clinics running regularly for the benefit of patients. Emergency Services in all the specialities are available round the clock.

1.12. This hospital has a Central Sterilised Supply Department which functions round the clock. There is also a mechanical laundry. There is the Blood Bank and the Grystaloid manufacturing unit. There are also

Biochemistry, Bateriology, Histopathology Laboratories and Indian Registry of Pathology under Indian Cuncil and Medical Researches.

Medical Examination of all the staff working in the Department of Personnel and of the Ministry of Home Affairs is carried out in this hospital. It also covers the Medical Examination of all Central Services Class I and II for which the examinations are conducted by the Union Public Service Commission and of the defence personnel for commutation of pension. The Standing Medical Board or the specially constituted medical board also take up review cases referred to this hospital by the other Ministries.

1.13. This hospital is affiliated to the Delhi University for Post-Graduation teaching.

Willingdon Hospital.

1.14. This is a Teaching-*cum*-Service Hospital and provides medical care primarily to the residents of West Delhi and old city. This was established in 193435 to meet the needs of high officials of the Government and well-to-do citizens. It had then 50 beds (Hospital 32 and Nursing Home 18). The hospital was maintained by the New Delhi Municipal Committee till January 1954 when it was taken over by the Government of India, Ministry of Health.

1.15. The present authorised bed strength in the Willingdon Hospital including Nursing Home is 730. These are 47 beds in the Nursing Home for General diseases and 14 beds for Maternity and Gynaecological cases. 90 per cent of the total beds in the Nursing Home are for entitled category *i.e.* for the Central Government servants and their dependents holding C.G.H.S. card with a basic pay of Rs. 750 p.m. The Members of Parliament and their dependents are also entitled for the admission to Nursing Home. Only 10 per cent of the total beds are made available to the members of the public.

1.16. The staff position in the hospital is as under:

	*Medical	Non-Medical	Para-medical	Non-technical and Ministerial	Total
Group 'A'	66	2	1	1	70
Group 'B'	40	7	..	2	49
Group 'C'	79	..	427	72	578
Group 'D'	..	..	..	651	651
Total	185	9	428	726	1,348

*The strength includes the medical staff of CGHS and Lady Hardinge Medical College and Hospital working in this hospitals.

1.17. During the year 1975, a total number of 7,18,562 patients were attended in the Out-patient Departments and 35,057 were treated as in-patients. In Nursing Home, 1873 patients were admitted.

1.18. The O.P.D. of the hospital has the facilities for all specialities *viz.* Medical, Surgical, Paediatrics, Gynaecology and Obst., Dental, Dematology, Orthopaedics, Psychiatry, Evening O.P.D. in Medicine, Surgery, Orthopaedic, Paediatrics, Gynaecology and Obst. are also functioning. Emergency Services in all the specialities are available round the clock.

1.19. Central Services Block in the hospital comprises of Central Sterile Room, Blood Bank, Dialysis Unit, X-ray Department and Operation Theatres. In addition to these, there are a number of special clinics running regularly for the benefit of patients.

1.20. This hospital is recognised for post-graduation in M.D. (Medicine and Radiology), M.S. (Surgery) and D.C: This hospital has specialised in coronary and head injury cases.

1,21. The Medical Examination of Group 'C' and Group 'D' Government servants in the Central Government on their first appointment is conducted in this hospital The Medical Examination of Gazetted Officers of the Central Government belonging to the Ministries other than the Ministries of Home Affairs and Defence is also conducted by the Central Standing Medical Board of this hospital.

Irwin Hospital

1.22. This hospital is under the control and management of the Delhi Administration. It had initially started functioning with a bed strength of 320 in the year 1936 which gradually increased and at present its sanctioned strength is 1175 beds. Now it is considered to be one of the biggest hospitals in the metropolis of Delhi, catering to the needs of the patients of adjoining States also. Since 1963, the hospital provides facilities of the post-graduates and the faculty staff of the Maulana Azad Medical College by way of providing clinical material, medical records and such other investigations which are needed for completion of research purposes. There are nine medical specialities in the Irwin Hospital and all the heads of the Units and senior doctors upto the level of lecturers are members of teaching staff in the Maulana Azad Medical College and on the pay roll of the College. One school for training in Nursing with diploma course is being run by the hospital besides imparting training ir the Radiography (two years diploma course).

1.23. On the administration side there is one Medical Superintendent, who heads the hospital administration and he is assisted by two Deputy Medical Superintendents and one Assistant Medical Superintendent. The Medical Superintendent is the Head of the Institution and is vested with all administrative and financial powers of the Head of the Department. He has further delegated his financial and administration powers to the Deputy Medical Superintendent (Administration), who has been declared head of the office.

1.24. The nursing service is also under the administartive control of the Medical Superintendent. The is one Nursing Superintedent who is responsible for nursing care and she is assisted by one Deputy Nursing Superintendent and nine Assistant Nursing Superintendent.

1.25. The Medical Superintendent of Irwin Hospital co-ordinates the function of all the medical specialities of Irwin Hospital. All the Medical specialities are inter related and work together for patient care in the hospital.

1.26. Since the Irwin Hospital is under the management and control of the Delhi Administration, there is no direct link between the Ministry of Health and Family Welfare and the Irwin Hospital. All the policy matters and important decisions concerned with hospital administartion and patient-care are the responsibility of the Delhi Administartion and it is the Delhi Administration which is in communication directly with the Ministry of Health and Family Welfare. However, the senior doctors in Irwin Hospital belong to the Central Health Service and their postings and transfers are controlled by the Ministry of Health and Family Welfare. The rules and regulations framed by the Parliament relating to the Ministry of Health and Family Welfare are also applicable to the Irwin Hospital and the Hospital has to work within the framework provided by the Government of India regarding medical services and facilities.

1.27. Administratively Irwin Hospital is independent and it does not have any co-ordinated administration with Safdarjang and Willingdon Hospitals. However, in the interest of medical care of patients visiting these hospitals, as a matter of practice and convention, all these hospitals work as referral hospital for one another.

1.28. During the year 1975-76 a total number of 9,04,328 patients were attended in the Out Patient Departments and 52,386 were treated as in-patients. The O.P.D. of this hospital has the facilities for all specialities *viz.*, Medical, Surgical Paediatrics, Eye, E.N.T. Gynae/Obst., Dental, Dermatology, Orthopaedics and Psychiatry. Evening O.P.D. is also functioning in all the specialities. During the period January 1976 to June 1976 a total number of 15,404 patients were treated in the evening O.P.D.

1.29. Emergency Service in all the Specialities are available round the Clock.

1.30. The hospital has an Eye Bank where eyes are donated and transplantation done. The unit has a speciality for its outstanding work in the field of Corneal grafting. It has carried out a record number of 1712 corneal grafting till date.

1.31. The Unit has also the capability of manufacturing contact lens since 1972. Soft lens are at present under experiment. It also prepares a lens of "low vision aid" for visually handicapped and crippled. Minor and Major operations are conducted by the Eye camps which are organised every year as a regular feature to provide door service to the poor masses in the villages.

1.32. Since 1971 the hospital has an unique National Ear Bank—first of its kind in Asia and Africa. Here besides other ear-treatment, the ear drums can be transplanted.

1.33. Medical Examination of Class III & IV Staff of Delhi Administration and that of the employees of the autonomous bodies is being conducted in this hospital. Medical examination of the gazetted officers of Delhi Administration and other referred cases from the courts/other States is also conducted.

1.34. The following table indicates the bed strength, attendance etc., in the three hospitals during 1974-75 and 1975-76:

	1974-75			1975-76		
	Safdar-jang	Willing-don	Irwin	Safdar-jang	Willing-don	Irwin
(i) Bed strength . .	1,207	730	1,175	1,207	730	1,175
(ii) No. of patients admitted . .	65,393	30,528	51,465	74,610	37,894	52,386
(iii) No. of Outpatients treated . .	9,92,208	616,110	7,23,623	1131,382	741,696	904,328

B. Expenditure on Hospitals

Audit Paragraph

1.35. The details of expenditure of the three hospitals during the three years ended March 1975 are given below:

(Rs. in lakhs)

		Safdarjang			Willingdon			Irwin		
		1972-73	1973-74	1974-75	1972 73	1973-74	1974-75	1972-73	1973-74	1974 75
(i)	Estibalishment Charges	101	101	151	50	56	79	71	70	11
(ii)	Medicines . .	51	48	64	19	22	36	33	33	3
(iii)	Diet . . .	8	10	12	6	6	7	8	9	10
(iv)	X-ray including cost of film and Chemicals .	6	4	8	4	3	3	9	9	10
(v)	Equipment . .	14	14	17	12	12	9	25	26	22
(vi)	Linen . . .	3	3	6	2	1	2	1	2	3
(viii)	Miscellaneous . .	19	19	22	13	15	14	16	10	20
	Total : . . .	202	207	280	106	115	150	163	159	217

1.36. The expenditure on medicines in Irwin hospital during 1972-73 to 1974-75 remained almost the same, although the cost of medicines has been rising consistently.

1.37. The treatment in all the three hospitals is free of cost except that patients whose total income exceeds Rs. 250 per month have to pay for laboratory tests, X-rays etc., if they attend as O.P.D. (outpatient department) patients in Safdarjang and Willingdon hospitals. The limit of income prescribed in Irwin hospital is Rs. 400 per month. The beneficiaries of Central Government Health Scheme (C.G.H.S.) are treated free of cost in the two Central Government hospitals and similarly the officials of the Delhi Administration are treated free of cost in Irwin hospital.

[Paragraph 30 of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil)]

1.38. The following table gives the total expenditure on each of the three hospitals *viz.*, Safdarjang, Willingdon and Irwin, during each of the four years, from 1972-73 to 1975-76:

Year	Safdarjang Hospital	Willingdon Hospital	Irwin Hospital	Total
			(Rs. in lakhs)	
1972-73	202	106	163	471
1973-74	207	115	159	481
1974-75	280	150	217	643
*1975-76	316·08	170	264	750·08
Total	1005·08	541	803	2349·08

*Not vetted in Audit.

1.39. Compared with the expenditure in 1972-73, the expenditure incurred in 1975-76 in each of the three hospitals has marked an increase of 56.5 per cent in Safdarjang, 60.4 per cent in Willingdon and 62.0 per cent in Irwin.

1.40. The break-up of expenditure in 1975-76, under various heads, hospital-wise, is given below:

	Safdarjang	Percentage of increase over 1972-73	Willingdon	Percentage of increase over 1972-73	Irwin	Percentage of increase over 1972-73
				(Rs. in lakhs)		
(i) Establishment charges . .	175·61	73·8	93	86·0	128	80·3
(ii) Medicines .	73·74	43·8	38	100·0	47	42·4
(iii) Diet . .	10·67	33·3	8	33·3	11	37·5
(iv) X-ray including cost of film and chemicals .	7·27	21·1	8	100	16	77·7
(v) Equipment & machinery .	21·24	51·7	6	100·0 (decrease)	26	4·0
(vi) Linen . .	3·57	19·0	3	50·0	2	100
(vii) Misc. (transport charges water and electricity charges etc.. . ..	24·38	28·3	14	7·7	34	112·5
	316·08		170		264	

1.41. The reason for highest increase in percentage of establishment charges in Willingdon Hospital as compared to other two hospitals during the same period as explained by the Department of Health is that in Willingdon Hospital the bed strength was increased from 679 to 730 during 1972. The full complement of staff sanctioned for this purpose was, however, in position in the subsequent years.

1.42. Asked to state the steps taken to effect economy and efficiency in the administration of each of the three hospitals, the Department of Health in a written note have stated:

> "To improve the efficiency of the administration in the Safdarjang and Willingdon Hospitals additional staff as per the recommendations of the Staff Inspection Unit has been sanctioned. While sanctioning the staff utmost care has been taken to effect the fullest economy.
>
> In order to improve efficiency in administration and to effect economies a post of Deputy Medical Superintendent (Administration) has been created for the Irwin Hospital. Similarly creation of posts of Senior Administrative Officers for the Willingdon and Safdarjang Hospitals in the Grade of Deputy Secretary to the Government of India are under consideration."

1.43. It is observed that while the expenditure on medicines in Safdarjang Hospital and Irwin Hospital had increased by 43.8 per cent and 42.4 per cent respectively during the period 1972-73 to 1975-76, the expenditure in Willingdon Hospital had increased by 100 per cent during the same period.

1.44. In a note furnished by the Ministry, the reasons for the high rise in expenditure on medicines in Willingdon Hospitals have been explained thus:

> "(i) Increase in prices of drugs.
>
> (ii) Increase in the number of beds from 679 to 730.
>
> (iii) Clinician's choice of proprietory drugs in the interest of patient care, especially in the case of Nursing Home patients and CGHS beneficiaries."

1.45. It is seen from the Audit paragraph that while the expenidture on medicine increased during the period 1972-73 to 1974-75 from Rs. 51 lakhs in to Rs. 64 lakhs at the Safdarjang Hospital and from Rs. 19 lakhs to Rs. 36 lakhs at Willingdon, it remained at Rs. 33 lakhs for 1972-73 and 1973-74 and increased only to Rs. 35 lakhs in 1974-75 in the case

of Irwin Hospital. Asked about the reasons for this more or less stationary expenditure on Irwin Hospital when the cost of medicine has been consistently going up in the market, the Medical Superintendent of Irwin Hospital has stated during evidence:

> "Although the sizes of Irwin and Safdarjang Hospitals are the same, the total budget allocated to Irwin was much less. Secondly we have got a teaching institution attached to the hospital for which we need equipment. Last year we spent Rs. 53 lakhs. This year the expenditure will be Rs. 70 lakhs."

He has further added:

> "In 1973-74 the budget was much lower....".

1.46. As regards the budgeting procedure of Irwin Hospital, the Secretary (Medical and Public Health) of Delhi Administration has explained the position as under:

> "The procedure is that the Irwin Hospital sends its demands to the Delhi Administration. After taking the overall budgetary position into account the latter suggests an amount to the Ministry; and the Ministry accepts the same amount, or makes a cut. When the budgetary figures come back, the Delhi Administration does not give separate sub-grants under the different heads. It tells the Irwin Hospital: 'You have got Rs. 250 lakhs.' The Medical Superintendent is supposed to divide it as best as he deems fit....During the last two years, the position has greatly improved."

He has further added

> "As per the Audit Report, the O.P.D. attendance and admissions in Safdarjang are about 23 per cent more than at Irwin. If Safdarjang spends Rs. 70 lakhs by that comparison, Irwin should be spending Rs. 60 lakhs. We have not been able to achieve that figure."

1.47. It is observed that the expenditure on linen in Safdarjang hospital, Willingdon hospital and Irwin hospital during 1975-76 was Rs. 3.57 lakhs, Rs. 3 lakhs and Rs. 2 lakhs respectively. During the same period the bed strength of these hospitals was 1207, 730 and 1175 respectively. In terms of actual in-patients also the number of in-patients in Irwin hospital was more than that of Willingdon hospital. Such being the position, the Committee desired to know why the expenditure on linen in the Irwin hospital was the lowest. To this, the Medical Superintendent Irwin hospital, has stated:

"The requirements would have been fully met provided we had the funds to purchase it. Now we have made the purchases to a large extent and have come up to the standard of other hospitals."

1.48. When the Committee pointed out that if Willingdon Hospital was taken as an optimum average then the cost of linen expenses for nearly twice the number of patients in Safdarjang and Irwin hospital seemed to be unduly low. Judging by the standard of linen provided in the Willingdon Hospital (Nursing Home), the Committee felt that the linen service in the other two hospitals would not be any better. On this point, the Secretary, Ministry of Health and Family Welfare has stated:

"I entirely agree that the situation in respect of linen in the Irwin hospital has been far from satisfactory and perhaps action has been taken now and I hope it will continue to provide better service so far as linen is concerned. You have remarked that in the Nursing Home of Willingdon hospital the linen is not of adequate cleanliness. The great difficulty is that previously we have been buying khadi. I do not say that we should not buy khadi but khadi does not get cleaned in the machines and it is very difficult to keep them clean also. So far its being hygienic is concerned, it is washed in machines, it is hygienic. Previously I understand that they were changing the linen once a week only. Now I nave told them that in all the hospitals the linen must be changed twice a week. I am sure the standard of cleanliness so far as the linen is concernd would definitely improve."

1.49. In reply to a question, the Medical Superintendent, Irwin Hospital, has clarified that "the linen is always changed when the patient changes. But if a patient is in bed for 7 days the linen is changed only once".

1.50. In a note subsequently furnished to the Committee, the Ministry have stated:

"This was a period of acute financial stringency and because of paucity of funds adequate linen could not be purchased during the period 1975-76."

1.151. Asked about the steps taken to improve the quality and quantity of linens supplied to the three hospitals, the Ministry have stated:

"In Irwin Hospital the existing machines have been overhauled and better quality of washing materials are being provided

to the laundry. Additional quantity of linens are being procured to meet the needs of the hospital.

For Safdarjang and Willingdon Hospitals orders have been issued for procurring mill made cloth for lines like bed sheets and pillow covers etc. Linen is purchased for the hospitals according to the needs."

1.52. It is seen that while the expenditure on diet has shown a slight increase during 1975-76 in Willingdon and Irwin Hospital (which appears to be justified due to increase in number of patients), in Safdarjang it has decreased during that year, *vis-a-vis* 1974-75 (from Rs. 12 lakhs in 1974-75 to Rs. 10.67 lakhs in 1975-76). Asked about the reasons for this decrease, the Medical Superintendent of Safdarjang Hospital has stated during evidence:

"A marginal reduction has been made in the quantum of diet given to the patients. There was a letter from the Ministry saying that there should be some economy made in the expenditure of the hospitals. This was done without the concurrence of the Ministry, at the level of the Medical Superintendent. That has caused a reduction in the expenditure. No reference was made to the Ministry."

1.53. Asked whether the decrease in the quantum of diet resulted in diminition of standards, the witness has replied:

"Not exactly in standard; but the quantum was reduced from 400 grams to 300 grams, the calories supplied through the diet to the patient remained at 2400."

He has further added:

"We feel that our diet is adequate and a good diet. By the process of re-arranging the diet and eliminating the wastage the cost has been brought down to this level. We are confining ourselves to a vegetarian diet; no meat or eggs. It consists of chapatis of a certain weight, vegetable or dal, half a cup of curd and a cup of milk."

1.54. As regards the diet in Irwin Hospital, the Medical Superintendent of Irwin Hospital has stated during evidence:

"Up till now we have been following the diet schedule that has been prescribed to us, and that has been done after consultation with the Director General, Health Services and the specialists in this regard."

He has added:

> "If I find it is satisfactory (in Safdarjang Hospital), that is to say, we can achieve economy without sacrificing efficiency, we might reduce the rate of wheat from 400 to 300 grams."

1.55. In reply to a query, the Medical Superintendent of Willingdon Hospital has stated during evidence that "the cost is slightly higher for Willingdon Hospital because it supplies meat once a day besides vegetables". Asked whether the supply of meat at public expenditure in the context of the need for economy, was essential even though the supply of vegetarian diet would have been enough, the Medical Superintendent of Willingdon Hospital has stated:

> "Purely for medical reasons I feel that non-vegetarian diet should be allowed."

1.56. In the case of expenditure on X-ray (including the cost of films and chemicals) it is seen that while in Safdarjang hospital and Willingdon Hospital the expenditure has remained almost the same from 1972-73 to 1974-75, it has risen from Rs. 10 lakhs in 1974-75 to Rs. 16 lakhs in 1975-76 in the case of Irwin Hospital and from Rs. 3 lakhs in 1974-75 to Rs. 8 lakhs in 1975-76 in the case of Willingdon Hospital. Asked about the reasons for this abrupt rise in the expenditure in Irwin Hospital, the Department of Health have stated:

> "The actual expenditure of X-ray films and chemicals was Rs. 7.66 lakhs. The cost of the new X-ray machine (approximate Rs. 7.5 lakhs) was included in the total figure of Rs. 16 lakhs."

1.57. The Committee note that the expenditure on each of the three hospitals viz. Safdarjung, Willingdon and Irwin, has progressively increased from year to year. They find that the expenditure in 1975-76 in these hospitals has increased from Rs. 202 lakhs in 1972-73 to Rs. 316 lakhs (i.e. 56.5 per cent) in 1975-76 in Safdarjung hospital, from Rs. 106 lakhs to Rs. 170 lakhs (60.4 per cent) in Willingdon hospital and from Rs. 163 lakhs to Rs. 264 lakhs (62 per cent) in Irwin hospital. The increase in expenditure over these years is more significantly marked under various heads such as Establishment Charges, Medicines, Diet, X-ray and Linen, as will be seen from the following observations made by the Committee:

(i) The expenditure on Establishment Charges in Safdarjang, Willingdon and Irwin hospitals had increased from 1972-73 to 1975-76 by 74 per cent 86 per cent and 80 per cent respectively. The reason for highest increase of expenditure in Willingdon hospital as compared to the other hospitals is

stated to be due to increase in bed strength of Willingdon from 679 to 730 during 1972.

(ii) The expenditure on medicines in Safdarjang Hospital and Irwin Hospital from 1972-73 to 1975-76 had increased 44 per cent and 42 per cent respectively whereas the expenditure during the same period in Willingdon Hospital had increased 100 per cent. The abnormal increase in Willingdon is stated to be due to increase in prices of drugs and increased expenditure on medicines in Nursing Home.

Similarly, it is observed that while the expenditure on medicines increased from Rs. 51 lakhs in 1972-73 to Rs. 64 lakhs in 1974-75 at Safdarjanug hispital and from Rs. 19 lakhs to Rs. 36 lakhs in Willingdon, it remained at Rs. 33 lakhs in 1972-73 and 1973-74 and increased only to Rs. 35 lakhs in 1974-75 in the case of Irwin, though the cost of medicines has been consistently going up in the market. The reasons for more or less stationary expenditure on medicines in Irwin hospital, as stated by the representative of the Delhi Administration, is due to default in the allocation of funds under various heads of expenditure within the budget allotments during these years.

(iii) In 1975-76 the expenditure on linen in Irwin hospital (Rs. 2 lakhs) was the lowest as compared with Safdarjang (Rs. 3.57 lakhs) and Willingdon (Rs. 3 lakhs), although the bed strength in Irwin hospital (1175) during the year was more than in Willingdon (730) and marginally less than in Safdarjang (1207). The wide gap in expenditure in Irwin hospital as compared with other two hospitals is stated to be due to paucity of funds.

(iv) Whereas the expenditure on diet has shown a slight increase during 1975-76 in Willingdon (from Rs. 7 lakhs in 1974-75 to Rs. 8 lakhs) and Irwin (from Rs. 10 lakhs in 1974-75 to Rs. 11 lakhs in 1975-76), which appears to be justified due to increase in number of inpatients, the expenditure in Safdarjang hospital has come down (from Rs. 12 lakhs in 1974-75 to Rs. 10.67 lakhs in 1975-76) though the number of inpatients there was the highest during the year as compared with Willingdon and Irwin hospitals. This decrease in expenditure is stated to be due to a marginal reduction in quantum of diet given to patients in Safdarjang hospital.

(v) While in Safdarjang and Willingdon hospitals, the expenditure on X-rays (including the cost of films and chemicals) has

remained almost the same from 1972-73 to 1974-75, it has risen from Rs. 10 lakhs in 1974-75 to Rs. 16 lakhs in 1975-76 in Irwin and from Rs. 3 lakhs in 1974-75 to Rs. 8 lakhs in 1975-76 in Willingdon Hospital. The reason for abrupt rise in expenditure in Irwin Hospital was that the cost of new X-ray machine, costing about Rs. 7.5 lakhs is included in the figure of Rs. 16 lakhs.

1.58. The Committee have dealt with the above aspects extensively in the subsequent Chapters of this Report. What they would, however, like to emphasise here is that the Ministry should go into the rationale of the expenditure incurred by the three hospitals under various heads during the last 5 years or so, to see as to how far it has been in consonance with the requirements of the hospitals, with particular reference to their bed-strength. The Ministry may also lay down norms and guidelines for bringing about uniformity in the working of these hospitals as far as possible, so as to provide a common approach for tackling the problem of these hospitals in a co-ordinated manner.

CHAPTER II

CASUALTY AND EMERGENCY

Audit Paragraph

The casualty department provides, round the clock, immediate diagnosis and urgent treatment for illness of emergent nature and injuries from accidents. The cases are attended to by the casualty medical officer and the less serious cases after giving preliminary treatment are sent back home with instructions to attend OPD the next day. Cases of serious nature are admitted in emergency wards or other wards. With a view to rendering immediate medical aid without loss of time, certain departments like gynaecology, entertain Patients direct without the intervention of casualty departments. The hospitals do not have a separate strength of doctors for manning the emergency services. For providing medicare in the wards and the O.P.Ds each discipline in the hospital has been divided into three/four compact units of doctors headed by professors, consultants or specialists. A unit comprises of several medical officers. A unit in each discipline is on duty in the O.P.D. for two days in a week. On those days some of its doctors are placed in the Emergency to look after emergent cases pertaining to its discipline. Certain information about the emergency services in the three hospitals during April 1975 to June 1975 is given below:

	Safdarjang	*Willingdon*	*Irwin*
(i) Total number of beds. . . .	62	124*	32
(ii) Average daily number of patients as per mid-night statistics.	99	135*	23
(iii) Number of days on which the number of patients exceeded the bed strength	91	84	10
(iv) Number of doctors normally available			
(a) first shift	6	5	3
(b) Second shift	6	5	7
(c) Third shift	6	6	3

*These beds are available at four floors—ground floor 20, 1st floor 35, 2nd floor 29 (excluding 11 beds of incentive coronary care unit) and 3rd floor 40 (where emergency, children and burn cases are put).

The average daily number of patients as per mid-night statistics on these floors was 29, 31, 27 and 48 respectively.

	Safdarjang	*Willingdon*	*Irwin*
(v) Doctor-patient ratio (as per mid-night statistics) .	1:16	1:23	1:10
(vi) Number of nurses normally available			
(a) first shift	4	9	8
(b) second shift	4	8	7
(c) third shift	3	7	7
(vii) Nurse-patient ratio (as per mid-night statistics)	1:33	1:19	1:4

2.2. From the details against (i) to (iii) above it would seem that the number of beds in this ward in Safdarjang hospital is inadequate; patients have to be put on floor in this hospital when beds are not available. The Ministry stated (December 1975) that "the position is, however, likely to improve when the space presently occupied by the Super Bazar within the hospital will be vacated. The matter has already been taken up with the Super Bazar authorities."

2.3. The work load on the doctors and nurses is more than that is brought out in (v) and (vii) of the above table because a large number of cases seen are kept under observation for varying periods of time and discharged or transferred to wards, if their further stay in emergency ward is not warranted, before mid-night. Very serious cases arriving at the emergency wards often require immediate attention and care of more than one doctor/nurse in order to save life. The Ministry stated (December 1975) that patient care in Safdarjang hospital would improve when the additional staff recommended by the staff inspection unit is sanctioned. It was further stated that the mid-night statistics shown against (ii), (iii), (v) and (vii) in the above table for Irwin hospital did not show the correct picture as the number of beds in the casualty and emergency wards was considerably less than that of other two hospitals and "as such in order to accommodate the patients coming to casualty, the respective medical officers have to make rounds from time to time to transfer patients from emergency wards to wards concerned."

2.4. Airconditioning facilities are regarded as necessary for management of certain conditions like heat stroke cases etc. Whereas central airconditioning covers about 50 per cent of the beds in Irwin hospital, this facility does not exist in Safdarjang and Willingdon hospitals. The Ministry stated (December 1975) that airconditioning of casualty ward in Willingdon hospital had been agreed to in principle and that detailed proposals in this regard were being worked out.

* * * * *

2.5. It was observed that important medicines including certain life saving drugs like geramycin, reverine, adrenalin, clauden, decadron, ampicillin, achromycin, chloromycetin, crystalline pencillin etc. were not available with the emergency wards in the three hospitals during certain times. Injection ampicillin, an antibiotic, was not available in the casualty and emergency wards of Safdarjang and Willingdon hospitals during 4th June, 1975 to 22nd September, 1975 and 1st November, 1974 to 1st January, 1975 respectively. Injection ampicillin was, however, available in the stores of Safdarjang Hospital. The Ministry stated (December, 1975) that medicines stated to be not available in Safdarjang hospital were normally procured "from the D.G.S&D", and in Willingdon hospital medicines not available in the casualty and emergency wards were procured from other Wards, super bazar or local market depending on the urgency of the situation and that patient care was not allowed to suffer.

2.6. For providing intensive care, special units with 8, 3 and 6 beds exist in Safdarjang, Willingdon and Irwin hospitals respectively. In Safdarjang and Willingdon hospitals coronary care units equipped with monitoring facilities for 2 and 11 patients respectively at a time also function. For Irwin hospital, this facility is provided by G.B. Pant hospital.

2.7. In resuscitation ward (intensive care unit) of Irwin hospital one hypothermea machine meant for regulating body temperatures purchased in 1964 at a cost of about Rs. 10,000 has been lying out of order since 1973. No other machine is available in the hospital for this purpose. Such a machine is stated to be in working condition in Safdarjang hospital, while Willingdon nospital has none. Another machine, earoxemeter, used for measuring oxygen tension purchased in 1964 for about Rs. 11,000 has been lying out of order in Irwin hospital since 1969. The Ministry stated (December 1975) that these machines "have outlived their normal life. However, efforts are being made to repair and use them". The other two hospitals do not have a similar machine.

2.8. In Safdarjang hospital, all the three oxygen tents meant for giving oxygen-rich environment purchased at a cost of Rs. 20,000 have been out of use since January 1973 (two) and December 1974 (one) because of non-availability of canopy which is an imported item. The Ministry stated (December 1975) that "indigenous canopy was tried but it did not work for more than two months. Recently a firm has offered to supply canopy of the required specification."

[Para 30 of the Report of the C&AG for the year 1974-75—Union Government (Civil)].

2.9. The Ministry of Health and Social Welfare at the instance of the Committee have furnished the following details regarding the bed capacity of the casualty and emergency wards of the three hospitals, the arrangement existing when the in-patients exceed the bed strength and the total number of patients who were admitted in the above wards of the three hospitals during each of the months from May to July 1976:

Sajdarjang Hospital.

The bed capacity of the casualty and Emergency Wards in this Hospital is as under:

(i) Casualty.	4	(No patient is kept on the floor in the casualty).
(ii) Emergency A (Medical)	30	(including 5 skin)
(iii) Emergency B (Surgical)	35	(including 6 for skin)

When the In-patients exceed bed strength there is no alternative but to accommodate them on the floor. The number of Patients who were admitted in these wards during the months of May, June and July, 1976 is as under:—

Month	*Emergency-A*	*Emergency-B*
May, 1976	1703	814
June, 1976	1723	735
July, 1976	1733	74

The number of patients who were not provided with beds during the months of May, June and July, 1976 in Emergency Ward A&B is as under:

Month	*Emergency Ward-A*	*Emergency Ward-B Surgical*
May, 1976	928	90
June, 1976	973	57
July, 1976	958	50

In emergency wards patients are kept for a day (maximum 24 hours). Thereafter either they are discharged or transferred to the respective wards.

Willingdon Hospital

(a) Bed capacity of Ground Floor—	36	Total 163 (including Extra-39).	
Emergency Block 1st Floor—	39		
2nd Floor—	42		
3rd Floor—	46		

When patients exceed bed strength, Stretchers are provided as we do not put patients on Floor. The minimum stay is one day in the Emergency, but no fixed period can be made as it depends upon the nature of illness of individual patient.

(b) Total No. of patients admitted in the Emergency Wards	May, 1976—	2754
	June, 1976—	2576
	July, 1976—	2412

Irwin Hospital

The bed capacity of Casualty and Emergency Ward is 48 at present. The minimum and maximum duration of stay of a patient in Casualty and Emergency Ward varies from 2 to 24 hours respectively. To relieve presure on Casualty and Emergency Wards the medical officers on emergency duty ensure that less serious patients are transferred to the general wards at the earliest and only serious patients are kept in the Emergency Wards. Consequently there has been no occasion when the number of patients in the Emergency exceeded the available bed strength. The total number of patients admitted in the Casualty and Emergency Wards from May to July, 1976 is as under:

May, 1976	1714
June, 1976	1648
July, 1976	1733

2.10. It is seen that against 1933 patients admitted in July 1976 in Emergency-A Ward of Safdarjang Hospital the number of patients, who were not provided with beds during the same period was 958 (about 55 per cent) whereas in Irwin Hospital all the 1733 patients admitted during July 1976 were provided with beds. Asked to elucidate this varying feature in both the hospitals, the Ministry in a note furnished to this Committee on 31st December, 1976, have stated:

> "As has already been indicated, the less serious patients in Irwin Hospital are transferred to the General Wards at the earliest

to relieve pressure on Casualty and Emergency Department. In Safdarjang Hospital 958 patients could not be provided with beds in Emergency-A Ward because of inadequate number of beds. To improve the situation sanction for construction of additional accommodation in Casualty Block of Safdarjang hospital has been issued."

2.11. The Committee desired to know whether due to over-crowding and pressure on space, the hospital authorities are constrained to release some patients before time. To this, the Medical Superintendent, Safdarjang Hospital, has stated:

"To a certain extent, you are right that we may have to discharge a patient who perhaps could have stayed on for a couple of days or more. But if he requires any observation to see whether he develops some complications, he is kept there."

2.12. When further asked, if it was the practice that the patient is asked to give a bond that he is going out on his own responsibility, the Medical Superintendent, Safdarjang Hospital, has clarified:

"No. It is more than often on the request of a patient or his relatives that he is allowed to leave hospital. If the physician feels that a patient should not leave the hospital and in spite of that if his relatives want to take him home, they have to sign a bond that they are taking the patient home on their own risk."

2.13. The Committee desired to know the total bed strength and percentage of bed occupancy during the last three years in these hospitals. The Ministry of Health and Social Welfare in a written note have stated as under:

"*Safdarjang Hospital*

Year	Bed strength	Percentage of bed-occupancy
1973-74	1207	94·2
1974-75	1207	77·9
1975-76	1207	94 3

Willingdon Hospital

Year	Bed strength	Percentage of bed occupancy.
1973-74	730	85
1974-75	730	88
1975-76	730	96·5

Irwin Hospital

Year	Bed Strength	Percentage of bed occupancy
1973-74	1173	106
1974-75	1173	94
1975-76	1175	102

2.14. One of the reasons advanced during evidence for the low bed occupancy in Safdarjung Hospital in 1974-75 was the strike by doctors. The Ministry have, however, informed the Committee in a written note that during the strike of the doctors, the essential services were maintained in the hospitals by posting regular doctors drawn from the Central Government Health Scheme.

2.15. Asked to state when the bed strength of each of these hospital was last fixed and to what extent it has increased from year to year, the Ministry have furnished the following information:

Safdarjang Hospital

Year	*Bed Strength*
1962	945
1963	994
1964	1107
1965	1142
1969	1207

Willingdon Hospital

Year	*Bed strength*
1963-64	330
1965-66	600
1968-69	679
1971-72	730

Irwin Hospital

Year	*Bed strength*
1962	1068
1968	1103
1970	1107
1972	1173
1973	1175

2.16. As stated in the Audit paragraph, the hospitals do not have separate strength of doctors for manning the emergency services. For providing medicare in the wards and the O.P. Ds each discipline in the hospital has been divided into three/four compact units of doctors headed by professors, consultants or specialists. Doctor-patient ratio in the Emergency Wards of Safdarjang, Willingdon and Irwin Hospitals as per midnight statics during April 1975 to June 1975 was 1:16, 1:23, 1:10 respectively. The Committee enquired about this wide variation in the ratio from hospital to hospital. The Secretary, Ministry of Health and Family Welfare, has stated during evidence:

> "Actually, there cannot be any uniform system. The Irwin Hospital is a teaching hospital and it is a training hospital, in the sense you have got a large number of house surgeons, interns and registrars. That is not the case with Willingdon and Safdarjang. We have got a medical college attached to the Irwin Hospital. So, the doctors will be there. They are qualified doctors, but they are in the process of being trained. Therefore, you cannot compare a teaching hospital with a non-teaching hospital."

2.17. In the same context, the Medical Superintendent, Irwin Hospital, has stated:

> "The doctor-patient ratio varies from discipline to discipline. In medical there is one doctor and 38 patients. In Emergency it is 1.25 because the number of patients is less...."

2.18. In a note subsequently furnished to the Committtee the Ministry have also stated that the average daily number of patients as per mid-night statistics in Safdarjung Hospital (99) and Willingdon Hospital (135) far exceeded the number of patients in Irwin Hospital (29). Hence there was a variation in the Doctor-patient and Nurse-patient ratio.

2.19. In reply to a question, the Ministry of Health have further informed the Committee that the reasonable number of patients that can be left to the care of doctors in the emergency ward of a hospital should be 1:10. This, however, depends upon the seriousness of the emergency cases.

2.20. According to the Audit Paragraph, the Nurse-patient ratio (as per mid-night statistics during April 1975 to June 1975) in the Safdarjung, Willingdon and Irwin hospitals was 1:33, 1:19 and 1:4, respectively. It has been stated that the work load on the nurses is more than that is brought out in the ratios. Very serious cases arriving at the Emergency Wards often require immediate attention and care of more than one nurse in order to save life. Asked if the number of nurses in the three hospitals was sufficient to meet the present requirement, the Secretary of the Ministry has stated during evidence:

> "We have actually got guidelines in this regard, indicating the staff required for hospitals with different bed-strength *e.g.* the ideal number of staff that you need for hospitals with 100, 250 or 500 beds. By and large those norms are kept."

2.21. Explaining the position in each of these three hospitals, the respective Medical Superintendents have stated as under:

Medical Supdt.—Safdarjung Hospital

> "The nurse-patient ratio in Safdarjung hospital works out to about 1:5 beds. But this also includes nurses who are working in specialised departments like OPD, X-ray and Operation Theatres. This again does not take into account the extra number of beds that are always present in the various wards of the hospital, with the result that the nursing efficiency is stretched to its limit and often it falls short of the required care which they would like to give to a patient. If you want to take away specialised departments the ratio is 1:33."

Medical Supdt.—Willingdon Hospital

> "We have mentioned that the ratio in Willingdon Hospital is 1:19 i.e. 19 patients have to be attended by one nurse. There are certain intensive care areas where the proportion is much

less i.e. 1:5 or 1:3. In the intensive care units, accident and emergency cases are kept, e.g. cases requiring coronary care, heart attack cases etc. Similarly, in the casualty department where the patients are received first the ratio is higher. In nursing Home, we have definitely a very high ratio."

Medical Supdt.—Irwin Hospital

"The figure is more or less the same in my hospital. It is 1:5 but but it does not take into account nurses working in the Operation Theatre, Emergency and Intensive care units. Nurses are now provided at the family planning units also."

2.22. In the same context, the Director General, Health Services, has stated:

"Traditionally, norms have been laid down for the provision of nurses in the hospitals by the Nursing Council, which were accepted by the Government."

2.23. Asked as to how the ratio of 1:19 in the Willingdon Hospital had worked, the Director General, Health Services. has stated:

"That ratio did not work. A study had been made by the Staff Inspection Unit and on the basis of actual requirements, additional staff have been approved recently. So we have given additional 55 nurses to the Safdarjung hospital and some more to Willingdon hospital."

2.24. In a note subsequently furnished to the Committee it has been stated that in Safdarjung hospital three additional nursing staff have been posted in Casualty and Emergency Department and two more are being posted. In reply to a question it is stated that the reasonable number of patients that can be left to the care of staff nurse should be 1:5.

2.25. A study of general hospitals in Delhi carried out by the National Institute of Health Administration and Education (1972) revealed that the nurses spend 43.3 per cent of the available time in various other activities of non-nursing nature. Commenting on this the Medical Superintendent of the Willingdon Hospital has stated during evidence:

"We have introduced the system of master clerks whose job is to maintain record of linen, medicines, furniture, etc. and the nurses are spared to do more of nursing duty. I do realise that lot of time of the nurses is wasted in getting the stock of medicines, linen, etc. but with the appointment of master clerks, now nurses are doing more of nursing duties than of

non-nursing duties. Still the nursing sisters are incharge of stores but they are doing more of nursing duties."

2.26. Pointing out that there was a serious agitation by the nurses in the Delhi hospitals some years back the Committee enquired whether any improvement has been made in their service conditions. In reply, the Secretary of the Ministry has stated:

"I do not have the full information, but I would say that two things have been done. One is that their pay-scales have been revised i.e. in accordance with the recommendations of the Third Pay Commission, they are getting much more than what they used to get. The other was that the residential accommodation in various hospitals was not adequate. There is considerable improvement now in that regard also."

2.27. Clarifying the position regarding accommodation, the Director General, Health Services has stated:

"The question of accommodation is receiving the attention of the Government. According to the traditional practice un-married girls were not permitted to live outside the nurses hostel. Now they are demanding the right to live outside. This aspect is receiving consideration. Because some of them are in favour of living outside and want house rent allowance. Some are against it. So they are divided on this issue."

2.28. Questioned whether the nurses are provided transport facilities when they attend the night shift; the Director General, Health Services has explained:

"The female component of the staff in every hospital is quite large; there are not only nurses but ayahs and lady doctors. There was a time when the nurses were expected to come on duty even after they have done eight hours' of duty. Now they have only regular hours of shift duty. So, no transport is provided to them."

2.29. With regard to the position as obtaining in Willingdon hospital, the Medical Superintendent has stated:

"All single nurses, whether training nurses, staff nurses, sisters, assistant matrons or matrons, they are supposed to stay in the nurses hostel. Only very rarely a request comes from a single nurse to stay outside. We do not like it and we hardly give such permission. When they get married and want to stay

outside, they are doing it at their own risk and responsibility. We do not provide any transport."

2.30. Enquired whether there was a regular drain of nurses from the country to foreign countries, because they are providing better facilities, the Secretary of the Ministry has explained:

> "The hon. Member is right. Some of the nurses have gone and they are still going. We have banned the export of nurses and yet somehow or other they slip out. They are getting a lot of money in the Arab countries. So, in spite of our best efforts they some-how go out. I really do not know how to solve this problem."

2.31. The Committee desired to know the number of nurses who had left the three hospitals during the last five years for joining new assignments in foreign countries and how many of them were granted study leave and whether all of them have come back on expiry of the leave. The Ministry in a note have furnished the following information in respect of each of the three hospitals:

"Irwin Hospital

2.32. No particulars of the nurses who resigned from Irwin Hospital and then went abroad were maintained because foreign assignment was not mentioned as the reason for their resignations. However, during the last five years 306 nurses resigned from service. No study leave was granted during the last five years to any member of the nursing staff for studies abroad.

Safdarjung Hospital

Year	Total number of resignations	U.S.A.	Canada	U.K.	Personal reasons
1972	59	20	1	..	38
1973	80	21	..	..	59
1974	66	13	..	1	52
1975	70	8	1	..	61
1976	54	2	..	..	52
	329	64£	2£	1£	262

£The above figures has been arrived at on the basis of letters received from foreign countries about their references. In their resignations the nurses mentioned that they are esigning on personal grounds.

Study Leave—Only one case Shri Gobind Singh, Ward Master

From 27-10-73 to 7-11-74 under WHO Fellowship.

Willingdon Hospital

2.33. During 1972-76, 158 nursing staff resigned. Presumably they have gone abroad. No information to which country each one of them has gone is available.

2.34. During this period 14 of the nursing staff did courses but none was given study leave. They availed of their own leave and all of them have come back for duty after completion of their courses.

2.35. Asked about the steps taken to contain drain of nurses out of the country, the Ministry have stated:

> "To stop the drain of nurses out of the country, the Ministry of External Affairs and the Department of Personnel and Administrative Reforms have been requested that all recruitments of nurses and para-medical staff done by foreign agencies in India or by various agencies in India for foreign employers should be done in consultation with the Ministry of Health and Family Planning."

2.36. According to the Audit Para, the Ministry had informed the Audit in December 1975 that patient care in Safdarjung Hospital would improve when the additional staff recommended by the Staff Inspection Unit was sanctioned. Asked whether the additional staff recommended by the Staff Inspection Unit has been sanctioned and posted, the Ministry of Health and Family Welfare in a written note have stated:

> "*Safdarjung Hospital*—The Staff Inspection Unit submitted its report on 27th August, 1973 and a corrigendum in March, 1974. As against 272 posts recommended for creation and 95 posts recommended for abolition, 221 posts have been created and 82 posts have been abolished in February and May, 1976. 108 posts have been filled and the rest are expected to be filled soon."

2.37. Explaining as to why the remaining posts have not been filled, the Medical Superintendent of Safdarjung hospital has stated during evidence:

> "We have 221 posts sanctioned and 82 posts have been abolished. We have filled up 108 posts and the remaining posts for various reasons are yet to be filled. The main reason is that these

are new posts and recruitment rules for these are under consideration. Unless and until recruitment rules are finalised, we cannot fill up these posts. Secondly, there are certain medical officers posts. These posts are to be filled up by the Ministry with the help of the UPSC. I understand that a requisition has already gone to the UPSC in this regard."

2.38. The witness has further added that the sanction of the Ministry was communicated to them on 6 May 1976. The Committee enquired why it took the Ministry nearly three years to sanction even these posts when the staff Inspection Unit had submitted its report as far back as 27 August 1973. In reply, the Secretary, Ministry of Health has stated:

"The SIU has made a study of this hospital. They gave a half report. We put it up to the Ministry of Finance but they wanted full report. Then a corrigendum was issued in March, 1974 and then it was submitted to the Ministry of Finance. At that time there was a ban on the creation of posts. All these difficulties arose and then we prepared a note for the Cabinet. With very great difficulty we are able to create these posts, because of financial stringency and ban on creation of posts."

2.39. As regards the desirability of the extra appointments recommended 3 years ago, the Medical Superintendent of Safdarjung Hospital stated during evidence "We certainly want them". The witness has further added:

"We could certainly not do without them. We were waiting for SIU's concurrence. We were waiting for them to be filled up."

2.40. As the Staff Inspection Unit had also recommended for abolition of 95 posts in Safdarjung Hospital and only 82 posts were subsequently abolished, the Committee asked why the Finance Ministry dissented from the recommendations of the Staff Inspection Unit, the representative of Ministry of Finance deposed:

"No doubt, the Staff Inspection Unit is a part of the Ministry of Finance. This examines the problem after studying the work load in each Ministry. But its recommendations are not automatically binding either on the Ministry of Finance or the administrative Ministry. Actually, there is always a discussion thereafter. Sometimes, the abolition of the post is not accepted as also creation of the post. The administrative Ministry does not want all the posts which are there, to be abolished. And the Ministry of Finance is arguing that the posts suggested are such that the work can be carried on without them. That

is why there is a difference between the recommendations and the actual position."

2.41. In a note, subsequently furnished to the Committee, the Ministry have clarified its stand for not abolishing the remaining 13 posts as under:

"Against the total of 95 posts recommended for abolition, by the Staff Inspection Unit, 83 have already been abolished and one (Sr. Physiotherapist) has since been agreed to by S.I.U. for continuance. The remaining 11 posts are of General Duty Officers (5), Registrars (3) and House Surgeons (3). Against these the Staff Inspection Unit had also recommended the creation of 9 posts of General Duty Officers, 13 posts of Registrars and 15 posts of House Surgeons for the various departments. These posts have not been created nor the posts recommended for abolition as stated above, have been abolished because after the Staff Inspection Unit had made recommendations, a Committee was appointed by the Government to assess the strength of the Registrars, House Surgeons, etc. in the Delhi Hospitals. The Committee fixed the number of Registrars and House Surgeons under the now known as Residency Scheme after taking into account the number of beds and senior doctors available and other factors."

2.42. As stated in Audit para, air-conditioning facilities are regarded as necessary for management of certain conditions like heat stroke cases etc. Whereas central air-conditioning covers about 50 per cent of the beds of Irwin Hospital, this facility does not exist in Safdarjung and Willingdon Hospitals. The Ministry had informed the Audit in December, 1975 that air-conditioning of casualty ward in Willingdon Hospital had been agreed to in principle and that detailed proposals in this regard were being worked out. The Committee desired to know the latest position regarding air-conditioning facilities in casualty wards of Willingdon and Safdarjung Hospitals. The Ministry of Health in a written note have stated:

"The formal sanction for air-conditioning of Casualty Ward of Willingdon Hospital has not yet been issued as estimates are awaited from the CPWD. A budget provision of Rs. 5.00 lakhs exists in the budget for the year 1976-77.

The Casualty Ward in Safdarjung Hospital continues to be in the barracks. There is no proposal for airconditioning this."

2.43. It has been pointed out in the Audit paragraph that important medicines including certain life saving drugs like geramycine, reverine, adrenalin, clauden decadron, amicillin, achromycin, chloromycitin, crystalline pencillin etc. were not available in the Emergency wards of the

three hospitals during certain times. Injection ampicillin, an antibiotic, was not available in the Casualty and Emergency Wards of Safdarjung and Willingdon Hospitals during 4 June 1975 to 22 September 1975 and 1 November 1974 to 1 January 1975 respectively. Injection ampicillin was, however, available in the stores of Safdarjung Hospital. Asked to state the reasons for non-availability of these medicines and the position in respect of them during January to June 1976, the Ministry have stated in a written note:

"The period of January, 1974 to early 1975 was one of acute drug shortages due to oil crises. This reflected itself even in the availability of drugs in the hospitals. From January to June 1976 the position has been satisfactory.

Safdarjung Hospital

In Safdarjung Hospital except the Ampicillin, Clauden and Adrenalin Injections all other life saving drugs were available in the Medical Stores, Casualty and Emergency Wards during the period from 4-6-75 to 22-9-75. Injection Chloromycetin was in short supply in second week of August 1975, however it was never out of stock.

The reasons for non-availability of some of the Injections stated above was on account of the following factors:

(1) *Injection Ampicillin*: The DGS&D had concluded a contract with M/s. Indian Drugs and Pharmaceutical Ltd. The firm did not supply the injections.

(2) *Injection Clauden*: This item was deleted from the hospital formulary.

(3) *Injection Adrenalin*: This item was not available at Medical Stores Depot, Karnal. On account of acute shortage of raw material it could not be procured from the local market also.

(4) *Injection Chloromycitin*: Although it was in short supply the requirements of the Casualty and Emergency Wards were fully met.

During the period January 1976 to June 1976 except for injection clauden which was deleted from the hospital formulary rest were available in the hospital stores.

The non-availability of certain drugs in the Willingdon Hospital was due to their not being available with the manufacturers. However, substitutes were usually

provided to the Casualty and Emergency Wards after procuring from the open market, so that treatment did not suffer.

There was no shortage of life saving drugs/injections for emergency cases in Irwin Hospital. During the period January to June 1976 all the necessary life saving drugs were available in the medical store."

2.44. The Committee desired to know the procedure in the three hospitals regarding procurement of medicines/drugs and the alternate arrangement available when a particular medicine was not available from the normal source of supply. The Ministry of Health in a written note have stated:

"*Safdarjung and Willingdon Hospitals*

(a) All the Vocabulary of Medical Stores items are normally procured by placing formal indents from the Medical Stores Depot, Karnal.

(b) Indents are placed with DGS&D for items which cost more than Rs. 50,000/-.

(c) Proprietary items are purchased directly from the manufacturers with the approval of the Joint Purchase Committee of the Safdarjung Hospital and Willingdon Hospital.

(d) Such of the items which are not procured either from the Medical Stores Depot, Karnal or through DGS&D are purchased from the open market on competitive rates with the approval of the Joint Purchase Committee.

(e) Urgent requirements costing not more than Rs. 250/- are made from the local market with the approval of the Medical Superintendent.

Items which are not available from the normal sources are procured by calling tenders from registered firms/known suppliers. Non-availability certificate is obtained from medical stores depot Karnal etc. before making purchases. In case of non-availability of proprietary items substitutes are procured in consultation with the concerned departments. Where the suppliers with whom the DGS&D have concluded contracts fail to supply the goods or where supplies are delayed against supply orders by the rate of the contract holders, tenders are invited and the items procured with the approval of the Joint Purchase Committee."

2.45. The Ministry have further stated that the normal source of supply of drugs in case of Irwin Hospital is Medical Stores Depot, Karnal and DGS&D rate contract firms. In the event of non-supply of these drugs by the above sources the procurement is made from the manufacturers/ distributors and Government Undertakings etc. in the open market.

2.46. Enquired whether any list is prepared of such medicines/drugs as are in short supply so that advance action may be taken for stocking them, the Ministry in a note have stated:

> "The Drugs Controller (India) keeps a watch on the supply position of drugs particularly 'life saving drugs' in the market. He gets reports from State Drugs Controllers from time to time. Drugs Controller also takes up the question of import of essential drugs through Ministries concerned when considered necessary. No particular drug can be said to be in short supply for a very long time. Generally what happens is that scarcities are created for short periods and as soon as supplies are available of the concerned drug the scarcity disappears.
>
> Medical Stores Depots maintain a list of vital items and the depots have been asked to ensure stocks of such items are available for emergencies. Monthly stock reports of these drugs are received by the Directorate."

2.47. It has been stated in Audit para that in Safdarjung and Willingdon Hosiptals there are coronary care units equipped with monitoring facilities for 2 and 11 patients respectively. Asked about the steps being taken to sanction necessary staff for the Intensive Coronary Care Unit of Safdarjung Hospital, the Ministry have stated:

> "For the Intensive Care Unit, the sanctioned strength of the staff is:
> Jr. Resident.....3
> G.D.Os.....1
>
> A consultant in Medicine is the overall incharge of this Unit. At present there is no proposal for the increase in the staff strength in the Intensive Coronary Care Unit as it is not considered necessary."

2.48. According to the Audit paragraph, one hypothermea machine meant for regulating body temperatures purchased in 1964 at a cost of Rs. 10,000/- and another machine earoxemeter, used for measuring oxygen tension purchased in 1964 for about Rs. 11,000, have been lying out of order in Irwin Hospital since 1973 and 1969 respectively. When

asked as to how the work has been carried on in the absence of these machines, the Ministry of Health have stated:

> "The hypothermea machine was put into commission in May 1976. During the period when this machine was out of order body temperature was regulated by 'Surface Cooling' process. The eroxemeter was also repaired and put to use in May 1976. This machine has again gone out of order and has outlived its life. It has been replaced by Micro Astrup apparatus."

2.49. According to the Audit para, in Safdarjung Hospital, all the three oxygen tents meant for giving oxygen-rich environment purchased at a cost of Rs. 20,000 have been out of use since January 1973 (two) and December 1974 (one) because of non-availability of canopy. In reply to a question whether it has been possible to obtain canopy for these tents, the Ministry of Health have stated:

> "It has not been possible to obtain the canopy for the oxygen tents as no Indian firm is in a position to make it. Patients care has not been allowed to suffer on that account as other means of oxygenation have been used."

2.50. A study of Emergency and Casualty Department in Irwin Hospital was conducted by a Study Team of the National Institute of Health Administration and Education, New Delhi in April, 1971. The Study Team investigated the functioning of the Emergency Services Department in terms of the existing policies and procedures, lay-out, work load, staffing pattern and physical facilities, identified the areas needing improvement or better utilisation and suggested changes to solve these problems without involving any substantial additional expenditure. The Study Team had *inter alia* suggested:

> "(i) In order to help improve the functioning of the various categories of employees in the Department, there is absolute need for their training just before they are posted to the Casualty and Emergency department. This training should primarily revolve around:
>
> (a) their functions,
>
> (b) improvement of their role in the total spectrum of their departmental efficiency,
>
> (c) policies and the procedures of the department, and
>
> (d) need for team work for efficient job performance and job satisfaction.

(ii) All the casualty and emergency services operating in the hospital except those of maternity should be brought under one roof. The composite casualty and emergency department with the O.P.D. should form a single department under the charge of a full time administrator preferably the Deputy Medical Superintendent of the hospital. He will be in entire charge of this department in terms of planning, guiding, directing, controlling and supervising the work concerned with this department.

(iii) There shall be a coordination Committee with the Medical Superintendent of the hospital as the Chairman and Heads of the Departments of Anasthesiology, Medicine, Surgery, Orthopaedics, Paediatrics, Ophtholmology, ENT, Radiology etc., Nursing Superintendent of the hospital, officer I/c of the Stores, Officer incharge of Central Transport Unit of the hopsital as members and the administrator of this department as the Member-Secretary. This Committee would periodically meet (at least once a month) and discuss the policies, problems, the perspectives as presented by the Member-Secretary and help solve the same."

2.51. The National Institute of Health Administration and Education also made a study of existing facilities and working pattern of Emergency and Casualty Departments of Safdarjung and Willingdon Hospitals in June 1976.

The following were some of the main observations of the Study Team of the Institute:

1. Facilities in waiting space are quite inadequate in both the hospitals for the patients and attendants. Toilet facilities for relatives of patients are absent in Safdarjung whereas in Willingdon there are inadequate facilities.

2. The number of trolleys and wheel chairs in both the hospitals is inadequate. Many were not in the working condition resulting in delay in the reception and transportation of the patients.

3. The number of ancillary workers like sweepers, nursing orderlies and stretcher bearers allotted to the casualty and emergency departments is inadequate and this is further reduced by using them for duties like calling specialists etc. Staffing position in respect of nurses is generally inadequate in both the hospitals. Medical staffing is also insufficient while availability of consultant services needs much to be desired.

4. A systematic emergency tray system of drugs is not maintained properly. Linen supply is inadequate in both hospitals with the result that the bed sheets and other linen appears to be dirty. No reserves of linen supply are maintained.

2.52. Emergency service of a hospital is assuming increasing importance on account of the stresses of modern living in urban conditions where the people are subject to different types of accidents which require immediate attendance and medical care. With ever-increasing tensions leading to cardiovascular and cerebral diseases in the community, there is a growing pressure in the casualty and emergency wings of the Delhi Hospitals. In order that the emergencies are attended to quickly and effectvely, it is necessary to have an efficient set up, well-knit with other departments of the hospitals with well laid-out procedures and work distribution. While reporting on the Casualty and the Emergency services in the three Delhi Hospitals, viz. Safdarjung, Willingdon and Irwin, Audit have observed that 'the hopsitals do not have a separate strength of doctors for manning the emergency services'.

2.53. For providing medicare in the wards and the O.P.Ds., each discipline in the hospital has been divided into three/four compact units of doctors headed by Professors, Consultants or Specialists. According to the Government's own calculations, the reasonable number of patients that can be left to the care of a doctor and a nurse in the Emergency Wards of a hospital should be 1:20 and 1:5 respectively. Whereas the strength of doctors and nurses in Irwin Hospital appears to be somewhat satisfactory, the doctor-patient ratio and nurse-patient ratio in the Emergency Wards of Safdarjung and Willingdon Hospitals during April 1975 to June 1975 were 1:16, 1:23, 1:33 and 1:19 respectively which are in no way near the norm of doctor-patient ratio of 1:10 and nurse-patient ratio of 1:5.

2.54. The significant difference in the strength of doctors in Irwin Hospital as compared with the other two hospitals has been explained by the Ministry of Health by the fact that the Irwin Hospital, being a teaching Hospital, has got a large number of House Surgeons, Interns and Registrars which is not the case with Willingdon and Safdarjung Hospitals. The Committee are of the opinion that as the average daily number of patients in Emergency Wards in Safdarjung Hospital (99) and Willingdon Hospital (135) far exceeds the number of patients in Irwin Hospital (29); the strength of doctors in the Emergency Wards of Safdarjung and Willingdon Hospitals needs to be reviewed and refixed on the basis of well determined norms so as to enable them to render satisfactory service to patients admitted in these important wards. The Committee are of the view that the Casualty and Emergency Wings should provide the best possible service in

a hospital as it is here that a patient and his relatives first come into contact with the doctors under emotional strain and anxiety. It is, therefore, imperative that the Casualty and Emergency Wards are manned by experienced and competent doctors who may render effective and timely medical aid and win the confidence of the anxious patients and their relatives.

2.55. The Committee have been informed that norms have been laid down for the provision of nurses in the hospitals by the Nursing Council which were accepted by the Government. In view of the fact that the nurse-patient ratio excluding the specialised departments, is 1:33 in the Safdarjung Hospital and 1:19 in the Willingdon Hospital as against the ideal ratio 1:5, the Committee feel that there is considerable shortage of nurses for manning the Emergency and Casualty Services in the three hospitals. It is necessary to work out the revised strength of nurses in all the three hospitals on the basis of norms laid down for the purpose so that the patient-care does not suffer in any way.

2.56. The Committee find that the National Institute of Health Administration and Education, in its study of the working of various hospitals in 1972 had revealed that 43.3 per cent of the available time of the duties of the nursing staff is utilised in non-nursing activities. The Medical Superintendent of Willingdon Hospital also conceded during evidence that "a lot of the time of nurses is wasted in getting the stock of medicines, linen, etc."

2.57. The Committee understand that some additional nursing staff has been sanctioned in the Casualty and Emergency Wards of Safdarjung and Willingdon Hospitals. The Committee desire that there should be no further delay in rationalising the duties and responsibilities of the nursing staff so as to see that they devote practically their whole time attention to nursing duties proper in the Casualty and Emergency Wards and not allow peripheral administrative duties to take away their precious time.

2.58. The Committee are perturbed over the alarming number of nurses who had resigned during the 5 years from 1972 to 1976, presumably for availing of opportunities offered to them for service abroad. It is observed that in Safdarjung Hospital alone the number of nurses who had resigned during the above period was 329. While no particulars of nurses who had gone on foreign assignments was maintained in Irwin Hospital (as foreign assignment was not mentioned in resignations) the number of resignations during the above period was 306. Similarly, in the case of Willingdon Hospital 158 nurses had resigned during 1972—76, presumably for going abroad. The Secretary, Ministry of Health, conceded during evidence that "somehow or other they slip out".

2.59. The Committee are not able to understand how such a large number of nurses have been allowed to leave the hospitals without the problem having been analysed in depth and remedial measures taken. Apart from the preventive measures to discourage nursing staff to migrate abroad, it is essential that the working conditions, housing and environment for them should be improved so that service of efficient and devoted nursing staff which is essential for the satisfactory running of hospital services, is maintained. The Committee also desire that the question of augmenting the facilities for training of nurses may be gone into on an urgent basis so that nurses in adequate numbers are turned out not only for meeting the country's requirements but also to avail of the employment opportunities which may be available outside the country.

2.60. A study of Emergency and Casualty Department in Irwin Hospital was conducted by a Study Team of the National Institute of Health Administration and Education, New Delhi in April 1971. The Study Team investigated the functioning of the Emergency Services Department in terms of the existing policies and procedures, layout, work-load, staffing pattern and physical facilities, identified the areas needing improvement or better utilisation, and suggested changes to solve these problems without involving any substantial additional expenditure. The Study Team suggested that all the casualty and emergency services operating in the hospital except those of maternity should be brought under one roof. The composite casualty and emergency department with the O.P.D. should form a single department under the charge of a full time administrator preferably the Deputy Medical Superintendent of the hospital. He will be entire charge of this department in terms of planning, guiding, directing, controlling and supervising the work concerned with this department. The Study Team also suggested that there should be a Coordination Committee with the Medical Superintendent of the Hospital as the Chairman and Heads of the Departments of Anaesthesiology, Medicine, Surgery, Orthopaedics, Paediatrics, Ophtholmology, ENT, Radiology, etc., Nursing Superintendent of the hospital, Officer incharge of the Stores, Officer incharge of Central Transport Unit of the hospital as members and the administrator of this Department as the Member-Secretary. In order to help improve the functioning of the various categories of employees in the department, the Study Team stressed the need for their training before they are posted to the Casualty and Emergency department. The training should primarily revolve around their functions, improvement of their role in the total spectrum of their departmental efficiency, policies and procedures of the department and need for team work for efficient job performance and job satisfaction.

2.61. The National Institute of Health Administration and Education made a similar study of the existing facilities and working pattern of

Casualty and Emergency department of Safdarjang and Willingdon Hospitals in June, 1976.

2.62. The Study Team of the Institute had inter alia **observed that facilities in waiting space were quite inadequate in both the hospitals for the patients and attendaats; toilet facilities for relatives of patients were absent in Safdarjang Hospital whereas in Willingdon Hospital they were inadequate, the number of trolleys and wheel chairs was inadequate; the number of ancillary workers, like sweepers, nursing orderlies and stretcher bearers was inadequate; staffing position in respect of nurses was inadequate in both the hospitals; medical staffing was also insufficient while availability of consultant services needed much to be desired; a systematic emergency tray system of drugs was not maintained properly; linen supply was inadequate in both the hospitals etc.**

2.63. The Committee are greatly concerned that in spite of the recommendations of the Study Team of the National Institute of Health Administration and Education which gave their Report on the Emergency and Casualty Departments in Irwin Hospital in April, 1971 and Safdarjang and Willingdon Hospitals in June, 1976, conclusive action has not been taken to rationalise and reinforce the services in the Emergency and Casualty Wards so as to ensure proper and adequate service being rendered to those who repair to these wards in emergency. The Committee would like Government and other authorities concerned to take conclusive action in the light of these recommendations so as to ensure that improvements in the Casualty and Emergency Services in the three hospitals, which have to cater to a very large number of casualties and emergency admissions, are effected without further delay. The Committee would like to be informed of the concrete action taken and improvements effected within three months of the presentation of the Report.

2.64. From the material made available to them, the Committee note that the cases in Casualty Department are attended to by the Casualty Medical Officer round the clock. The less serious cases are, after preliminary treatment, sent back home with instructions to attend O.P.D. the next day and the cases of serious nature are admitted in the Emergency Ward where they are usually kept for a maximum of 24 hours. Thereafter, either they are discharged or transferred to the respective wards.

2.65. During April 1975 to June 1975, the average daily number of patients as per midnight statistics in Emergency Ward of Safdarjang and Willingdon Hospitals were 99 and 135 as against bed strength of 62 and 124 in the respective hospitals. As a consequence, many patients had to be accommodated on the floors whenever the number of patients exceeded the bed strength.

..

2.66. In Irwin Hospital, there had been no occasion when the average number of patients (29) in the Emergency exceeded the available bed strength (32) because the Medical Officer on emergency duty ensured that less serious patients were transferred to the general wards at the earliest and only serious patients were kept in Emergency Wards.

2.67. The Committee are concerned to note that whereas the bed strength in the Casualty and Emergency Wards has increased from 124 in June 1975 to 163 in May 1976 in case of Willingdon Hospital, 32 to 48 in case of Irwin Hospital, the increase in the case of Safdarjang Hospital has been only from 62 to 69 beds during the same period. The Committee find that there appears to be no discernible norm in the provision of bed strength in the Casualty and Emergency Wards as compared to the total bed strength in the hospital. For example, while in the Willingdon Hospital as against the total strength of 730 beds, the number of beds in the Casualty and Emergency Wards is 163 representing 22.3 per cent in Safdarjang Hospital and Irwin Hospital such percentage is 5.7 and 4.1 respectively. The result of this unbalanced strength of beds in Casualty and Emergency Wards, particularly in Safdarjang Hospital, has been that a large number of patients in Casualty and Emergency Wards were not provided with beds at all.

2.68. The Committee find that in Safdarjang Hospital during July, 1976 alone against 2475 patients admitted in Casualty and Emergency Wards as many as 1008 (40.7 per cent) were not provided with beds. The Committee stress that having regard to the area served by each of the hospitals, the type of cases which have been gaining admission to the Casualty and Emergency Wards, the total strength of the beds in the hospital, etc., norms may be laid down and concerted efforts made to bring up the position to the expected norms. In particular, the Committee would like to point out the need for taking urgent measures to bring up the strength of the beds in the Casualty and Emergency Wards of the Irwin Hospital which serves a very large area of the old city and is gravely short of the requisite number of beds.

2.69. Another significant feature which the Committee have noted is that in Safdarjang Hospital though the number of beds in Emergency-A (Medical) (30) was less than those in Emergency-B (Surgical) (35), the number of patients admitted (1733) in July 1976 in the former was more than twice the number of patients admitted (742) in the later during the same month. The Committee would like the authorities to keep the detailed requirements in view while allocating beds for medical and surgical cases. This may be specially taken into account when the additional accommodation for Casualty and Emergency Wings becomes available on completion of the new construction which has been sanctioned.

2.70. The Committee note that as against 272 posts recommended for creation and 95 posts recommended for abolition by the Staff Inspection Unit in August 1973 in Safdarjung Hospital, 221 posts were created and 82 posts abolished in February and May 1976 respectively. It is further noted that out of the additional sanctioned posts, 108 posts only have been filled so far and in the case of abolition one more post has since been abolished and one has been agreed to by the Staff Inspection Unit for continuance. The remaining 11 posts of Registrars, House Surgeons, etc. have not been abolished because against these, 37 posts of House Surgeons etc. which were to be created have still not been created. The Committee are unhappy to record that a majority of the posts recommended in 1973 for creation have still not been filled up. Even more regrettable is the fact that it took nearly three years to sanction even 108 posts which have been filled up so far. The Committee are not convinced by the plea that the recruitment rules and UPSC stood in the way of filling up the remaining posts as they feel that these administrative details should have been resolved with a sense of urgency instead of allowing the matter to drag on for years. The Committee would like Government to review the matter and take urgent and effective follow-up measures to fill up the remaining posts without further loss of time. The Committee stress that the procedure regarding recruitment of staff etc. in the hospitals may be streamlined in consultation with the concerned authorities so as to obviate such heavy delays in future.

2.71. Though the air-conditioning facilities in the hospitals are considered necessary for management of certain conditions like heat-stroke cases etc., the Committee understand that there is no immediate prospect of air-conditioning of the Casualty Ward of Safdarjung Hospital as it continues to be located in barracks. As the construction of new building for Casualty Ward may take sometime, the Committee would suggest making of some alternate arrangement, like provision of coolers etc., so that the ward is kept cool at least during the hot months of the year.

2.72. The Committee regret to note that in the case of Willingdon Hospital though the air-conditioning of the casualty ward was agreed to in principle in 1975 the details are still being worked out by the CPWD. The Committee would like the authorities concerned to draw up a time-bound programme for providing this essential facility and inform the Committee of it.

2.73. The Committee regret to note from the observations in the Audit paragraph that important medicines including certain life saving drugs were not available with the Emergency Wards in the three hospitals at certain times. In Safdarjung Hospital, Ampicillin, Clauden and Adernalin Injections were not available in the Casualty and Emergency Wards during the

period from 4 June 1975 to 22 September 1975. The Committee understand that injection Ampicillin was available in the stores of Safdarjung Hospital. The Committee have been informed that injections Ampicillin and Adrenalin were not available because in the former case the firm with which DGS&D had concluded a contract did not supply the injections and in the latter case the item was not available with the Medical Stores Depot, Karnal. Though the position in this regard is stated to have been satisfactory during the first half of 1976, the Committee would still like to stress the need for better coordination between the hospitals and two main suppliers of medicines, viz., DGS&D and Medical Stores Depot, Karnal, so as to ensure that the patient care is not allowed to suffer in any way because of the non-availability of certain medicines.

2.74. The Committee would also urge that the formularies of the hospitals may be reviewed from time to time so that the latest medicines/ drugs of proven effectiveness are included therein. The Committee have made detailed observations on the subject elsewhere in the Report.

2.75. The Committee note that one Hypothermea machine meant for regulating body temperature purchased in 1964 and another machine Earoxemeter also purchased in 1964 used for measuring oxygen tension have been lying out of order in Irwin Hospital since 1973 and 1969 respectively and no steps were taken all these years to get them repaired. It appears that it was only on receipt of the Audit paragraph that the authorities realised the need of taking action in the matter. These two machines were repaired and recommissioned in May 1976, the Earoxemeter has, however, again gone out of order and has outlived its life.

2.76. The Committee would like the hospital authorities/Ministry to go into not only the question of maintenance and use of these two machines but also other life-saving equipment and machines which have been purchased from time to time in the hospital so as to make sure that there are adequate arrangements for their maintenance and that these machines which have been purchased at considerable public cost are put to the best use in the interest of the patients. It may be worthwhile to maintain a history of each of these machines and review the position from time to time to see that the objective underlying their purchase is being subserved and to take remedial measures as necessary.

2.77. The Committee note that in Safdarjung Hospital all the three oxygen tents meant for giving oxygen-rich environment, purchased at a cost of Rs. 20,000/- have been out of use since January 1973 (two) and December 1974 (one) because of the non-availability of canopy which is an imported item.

2.78. The Committee are unable to accept this plea and desire that if the canopy is essential for the working of the oxygen tents which were purchased in the interests of saving the lives of patients, it should have been possible to arrange most expeditiously for the canopies whether from indigenous sources or from abroad. Canopies may be arranged without further delay and the Committee informed of the dates when these three oxygen tents have again been pressed into service.

CHAPTER III

OUT-PATIENT SERVICE

Audit paragraph

3.1. The outpatient department is one of the most important departments of a hospital where nearly all patients (old and new) suffering from diseases of minor, serious, acute and chronic nature have to report first. All the three hospitals run several O.P.Ds. and clinics (for specific diseases) to cater to the needs of a large number of patients who come to the hospitals for treatment. The outpatient departments function both in the morning and in the evening. The evening outpatient departments in Irwin Hospital started functioning in December 1973, whereas these departments in Safdarjang and Willingdon Hospitals were started in July 1975. No additional staff to man these departments has been sanctioned so far (December 1975) in Safdarjang and Willingdon Hospitals. The Ministry stated (December 1975) that proposal for additional staff for the evening O.P.D. in the two hospitals was under active consideration of Government. While the outpatient departments in the morning have all the specialities of the hospital, the outpatient departments in the evening, except in Willingdon Hospital, have a limited number of specialities. The clinics are held only in the afternoons.

3.2. Safdarjang Hospital has 16, Willingdon Hospital 10 and Irwin Hospital 14 outpatient departments in the morning and 6, 10 and 4 in the evening respectively. The number of clinics are 32, 21 and 30 in the respective hospitals. The following table gives certain information about the three main disciplines of medical, surgery and paediatric in the morning O.P.Ds. of the three hospitals during April 1975 to June 1975 (76 working days).

	Safdarjang	*Willingdon*	*Irwin*
(i) *Medical*			
(a) Total number of paitents . . .	27,770	16,727	38,622
(b) Number of patients seen per day . . .	365	220	508
(c) Number of doctor hours available per day	28	20	48
(d) Number of patients seen per doctor per hour. .	15	11	11

	Safdarjang	*Willingdon*	*Irwin*
(ii) *Surgery*			
(a) Total number of patients	14,478	13,411	21,438
(b) Number of patients seen per day . . .	191	176	282
(c) Number of doctor hours available . . .	24	16	64
(d) Number of patients seen per doctor per hour .	8	11	4
(iii) *Paediatric*			
(a) Total number of patients	18,803	12,134	15,704
(b) Number of patients seen per day . . .	247	160	207
(c) Number of doctor hours available per day . .	24	20	28
(d) Number of patients seen per doctor per hour .	10	8	7

3.3. The number of patients seen per hour by a doctor in the O.P.Ds. as worked out above is based on the total strength of the unit present in O.P.D. In actual practice the number of doctors available for initial examination of the patients in the O.P.D. is lower. The senior doctors see only referred cases and those old cases which were previously seen by them. The time that can be devoted to a patient by a junior doctor is only 3-4 minutes.

3.4. A study by the Department of Administrative Reforms in Safdarjang Hospital in 1972 showed that a new and an old patient normally spent 105 and 58 minutes respectively for registration; and 50 and 115 minutes more in waiting for consultation. The patients advised X-ray and/or laboratory tests often have to come the next day since those departments close their registration at 11.30 A.M. (Saturday 10.30 A.M.)

A similar study conducted in Willingdon Hospital in that year showed that on an average the total waiting time of a patient at the points of registration and doctor's cubicle was about 150 minutes. The position in both the hospitals on date remain the same. Further, a patient has to spend normally 30-50 minutes for receiving the prescribed medicines. The average waiting time for a patient in O.P.D. in Irwin Hospital is about the same. The Ministry stated (December 1975) that "time taken for examining patients and waiting time for the patient is related to the number of medical officers available for examination and advice. The position might improve slightly when the additional staff is sanctioned."

3.5. The medicines stocked by a hospital for issue to outpatients and inpatients are detailed in the hospital formulatory/pharmacopoea. Since

February 1975 the two Central Government hospitals have got a common formulatory in which 576 medicines are listed. Of these 229 are injections, 220 tablets and the remaining 127 are mixtures, syrups, ointments, lotions and powders. While all medicines are issuable to inpatients, the number of medicines approved for issue to outpatients is 130 (16 injections, 67 tablets and 47 mixtures, ointments etc.) in Safdarjang hospital and 81 in Willingdon hospital (8 injections, 28 tablets and 45 mixtures, ointments etc.). On the other hand, in Irwin hospital which had, till September 1975, 344 medicines (86 injections, 121 tablets and 137 mixtures, ointments etc.) in its pharmacopoea, 217 items (15 injections, 73 tablets and 129 mixtures, ointments etc.) were authorised for issue to outpatients.

[Paragraph 30 of the Report of C&AG for the year 1974-75, Union Government (Civil)]

3.6. Following are the total number of out-patients treated in the three hospitals during 1974-75 and 1975-76:

	Safdarjang	*Willingdon*	*Irwin*
1974-75	9,92,208	6,16,110	7,23,633
1975-76	11,31,382	7,41,696	9,04,328

3.7. Since the number of out-patients treated in Irwin Hospital during 1974-75 and 1975-76 was less than those treated in the Safdarjang during the same period, though the former is situated in the heart of the city and is close to most thickly populated parts of Delhi, the Committee desired to know the reasons for this varying feature. In reply, the Secretary, Ministry of Health has explained the position thus:

> "There are two reasons. One is that the Safdarjang Hospital draws all the Central Government employees and their dependents which is not the case with the Irwin Hospital. The Irwin Hospital is not meant for the CGHS beneficiaries. As far as the Willingdon and the Safdarjang Hospitals are concerned, they are only meant for the families of the Central Government Servants. The other reason is that on this side where the Safdarjang Hospital is situated, there are no other worthwhile hospitals and other facilities. In the Safdarjang Hospital we are attracting a very large number of people from the rural areas, which is not the case with the Irwin Hospital."

3.8. The Committee have been informed during evidence that a large number of patients are attracted to Delhi from the areas in Rajasthan, Haryana and U.P. as also from some other States. This results in over-

crowding in both in the in-patient and out-patient wings of the Delhi hospitals. In a note furnished to the Committee, the Ministry have indicated the following main reasons for over-crowding in the hospital:

1. Increase in the number of patients due to population growth in Delhi;
2. Inadequate hospital facilities in peripheral areas in the adjoining States;
3. Shortage of space and staff which is not keeping pace with the growing requirements;
4. Better quality of patient care in the Delhi hospitals as compared to the facilities available in the neighbouring States and in the hospitals and dispensaries run by the local bodies.

3.9. As a result of this over-crowding the out-patients have to wait for a considerable time for their turn. The Committee have been informed during their visit to Willingdon Hospital that on an average a patient had to wait for two hours for his turn. On an average about 300 patients were being daily admitted and discharged. There was, of late, a marked increase in the number of patients coming to Willingdon hospital on account of the nearness of the bus terminus at the Central Secretariat. According to a study by the Department of Administrative Reforms in Safdarjang Hospital in 1972 the OPD gets the largest number of out-patients. The majority of the patients are rural folk who are mostly illiterate. The ratio of new and old is 56:44. Though different timings are displayed for registration of the new and old patients (New from 8.30 to 10.30 A.M. and old from 10.00 to 11.00 A.M.) these timings are not being followed. Registration for both, new and old, starts at 0900 hrs. Patients, however, start arriving from 0600 hrs. onwards and nearly 63 per cent of the new patients and 49 per cent of the old patients are in the queue before the commencement of registration. The average waiting time for a patient in O.P.D. in Irwin hospital is about the same.

3.10. As it is only after waiting for long hours, first for registration and then for consultation with the doctor, that a patient is able to consult the doctor for 3 or 4 minutes, the Committee wanted to know whether in this period the patient gets the correct medical advice. To his, the Director General, Health Services has stated:

> "We were wanting to make a study as to whether there has been a decrease in the time taken for waiting at the registration and at various places. This has not been done. We are wanting to do it. We have increased the number of counters at the registration and taken various steps to reduce the time of waiting.

The impression that I get from the Medical Superintendent is that there has been definitely a decrease in the waiting time.

There are three kinds of patients, the patients suffering from common ailments, the patients who have been seen earlier, that is, the old patients and the patients suffering from serious ailments. An OPD usually consists of two doctors, two specialists, one general duty medical officer, two senior resident doctors and four or more junior resident doctors. All patients suffering from common ailments are seen by a doctor and the old cases are always referred. If the diagnosis of a patient depends upon the clinical evaluation of the symptoms that are complained of by the patient, if the diagnosis can be made on the basis of the examination of his past history, then medicines are prescribed. But if the diagnosis cannot be made on that basis, then investigations are prescribed and if the patient requires admission, the patient is admitted."

3.11. According to the Audit Report, the number of patients seen per doctor per hour in the three main disciplines of medical, surgery and paediatric in the O.P.Ds of the three hospital during April 1975 to June 1975 varied as under:

	Medical	*Surgery*	*Paediatric*
Safdarjang	15	8	10
Willingdon	11	11	8
Irwin	11	4	7

3.12. Asked to state the reasons for the varying standards, the Ministry of Health in a note furnished to the Committee have stated:

"Doctor patient ratio varies because of various factors like the number of doctors in the O.P.D. their popularity, availability of para-medical staff, nature of illness etc. The Irwin Hospital being an associate hospital of Maulana Azad Medical College more doctors are provided in the Out-patient Department and the doctors take somewhat more time in examining the patients as they have also to explain the nature of illness etc. to the medical students who are placed under them."

3.13. In reply to a query, the Committee have been informed that the ideal doctor-patient ratio in O.P.Ds. in the various branches should be 1:40 per three hours. However, no norms have been fixed by any expert body so far.

3.14. In this connection the Committee desired to know whether the National Institute of Health Administration and Education, an autonomous body fully financed by the Ministry of Health has made any practical suggestions which could be implemented straightway by the hospital administrations. The representative of the National Institute of Health Administration and Education has stated during evidence:

> "Actually, we started studying these hospitals in the last ten years. As far back as 1967, we took up the study of the Safdarjang Hospital only in the Orthopaedic Department we found that there was a waiting time of about 120 minutes. We suggested some improvements which were immediately adopted.

3.15. In reply to a query as to whether suggested improvements brought better results, the witness has stated:

> "To a certain extent, yes".

Asked to quantify the improvement, the witness added:

> "We have not made a study in the same area. Subsequently, we have made a study in some other areas. There, we find that the waiting time is about 100 minutes."

3.16. The National Institute of Health Administration and Education in their study made in 1976 of OPDs of Safdarjang and Willingdon hospitals had observed that the problem of excessive waiting time for out-patients in the OPD of both the hospitals was to some extent due to lapse of administrative procedures at each step.

3.17. At the instance of the Committee, the Ministry of Health have stated that the following steps have been taken in the three hospitals to reduce average waiting time of out-patient both old and new, at different stages like registration, examination by doctors, delivery of medicines etc.:

(i) The actual registration starts 30 minutes before the doctors start examination the patients.

(ii) The number of windows for distribution of medicines have been increased.

(iii) To epedite distribution for medicine the system of distribution is being modified so that a patient is not required to stand in different queues for different types of medicines.

(iv) It is proposed to start the "screening clinics" in the out-patient departments. The staff in the screening clinics of the hospital

will consist of general duty medical officers who will be able to screen and provide treatment for minor ailments, etc., and those needing specialist services will then be sent to the concerned Consultants in the O.P.Ds. It is hoped that this will considerably reduce the waiting time of the patients for examination by doctors.

3.18. As regards the provision of screening clinics the National Institute of Health Administration and Education in their study in 1976 had observed as under:

"Provision of screening clinics within the OPD may not be the answer to reduce overcrowding in both the Hospitals. Nearly 3000 to 3500 patients on an average visit daily the OPD in Safdarjang Hospital. The corresponding figures for Willingdon Hospital is between 2000 to 2500 patients. As has already been pointed out there is excessive waiting time before the patients are seen by the Doctors in the respective OPDs. There is no assurance that the waiting time will be reduced with the introduction of the screening clinics. Our fear is that probably the waiting time will increase, since the patient has to be screened first in the screening clinics and then is to be referred to respective OPD where against the patients will have to wait for their turn. The better alternative as suggested earlier would be to fix up certain norms for each doctor as to the number of patients he has to see per hour and accordingly the strength of doctors can be determined."

3.19. The Department of Administrative Reforms while studying the OPDs in Willingdon and Safdarjang Hospitals in 1972 had noticed that usually the majority of patients came in different OPDs for treatment even before starting the registration, and thus resulting in overcrowding particularly in first two hours. They recommended that to reduce the waiting time of the patients two more doctors should be made available during first two hours at each OPD. It was further observed that as the ratio of new and old patients was 3:2 respectively the distribution of doctors should be in the same ratio.

3.20. The National Institute of Health Administration and Education in their study had also observed:

"The registration timings of the laboratory services coincide with those of the registration of OPD. The result is that by the time the patients are seen by the respective clinicians the registration for getting laboratory test done are closed, and the patients, have to come next day which causes a lot of irritation and wastage of their time."

3.21. In this context, the Department of Administrative Reforms in their study in 1972 had observed that 31 per cent of the patients referred to laboratory and X-ray unit had to make second trip on the next day.

3.22. The clinical laboratories in the three hospitals work from 9 A.M. to 4 P.M. with lunch break of an hour from 1 to 2 P.M. The specimens for the investigations in the laboratories and the patients in X-ray units are received up to 11.30 A.M. though OPD works up to 1 P.M. daily.

3.23. During evidence the Committee pointed out that many times people have to go and stand in one long queue for registration, then another long queue for prescription and then yet another long queue for investigation and directions. Then they are asked to come next day for investigations to be made and then investigations are made in a rather shabby and disorderly fashion. In many cases people from the villages and also from the urban centres, who have not received the present-day education, come and they do not know what to do and are driven from pillar to post. Not only their time is wasted but the doctors' psychology is also disturbed. In such circumstances the Committee desired to know whether any efforts had been made to rationalise the procedure so as to minimise the number of queues for investigations, etc. In this connection, the respective Medical Superintendents of the three hospitals have explained the position as under:

Medical Superintendent, Safdarjang Hospital

"The patients who attend the OPD are more often than not given some investigations to be done in the clinical laboratory. Now, as regards urine test, they can easily pass urine and give it for investigation rightaway."

The witness has added:

"If the investigations are urgent the urine test is done rightaway and he has to be provided with the vessel."

He has further added:

"Regarding blood test the patient has to come with empty stomach, naturally if he has not come on empty stomach, he cannot have it done. This is the reason and not because the laboratory closes at 11.30.

Similarly you have to bring the stool. That means he will have to come the next day. Then, Sir, doing investigations takes time also. That is why the specimens are received up to 11.30 only. The laboratory people want sometime to do the tests before

the results can be given. If they are busy in taking the specimens all the time, they cannot do the test. The rest of the time is to do these tests.

The laboratories are functioning right up to 4 O'clock and some work round the clock also. But out-door specimens are there, the laboratory is functioning round the clock."

The Medical Superintendent of Willingdon Hospital

"So far as Willingdon Hospital is concerned, 'kabaries' are sitting near the hospital who charge 12 paise per bottle. When any patient is asked to bring urine, he goes to the 'kabari' brings the bottle from him on payment to pass urine and gives the same to the laboratory. There are 500 specimens per day in every OPD. They can hardly finish by 4 O'clock. Urgent cases are attended to round the clock. Most of the X-rays are done in the same trip because it is not necessary in those cases that the patient should be on empty stomach. But in certain cases purgative on the previous night is necessary and the patient is supposed to get X-rayed on empty stomach. We try to reduce the trips of the patients to the best possible extent.

The Medical Superintendent of Irwin Hospital

Only the time has been fixed for handing over the samples up to 11.30 A.M. Laboratory works round the clock. Otherwise, the normal working hours of the laboratory are upto 4.30 p.m. The results are provided the next day. X-ray in certain cases has to be taken on empty stomach. In cases where they need not be in emtpy stomach, they are attended to the same day. In urgent cases in Irwin Hospital the work is done the same day. X-rays are done up to 1 O'clock. Reports are ready the same day. We have got drying mechanism which can dry the wet X-ray in 1½ minutes."

3.24. Further clarifying the position, the Director General of Health Services has stated:

"I only wanted to confirm that the laboratories do not close at 11.30 A.M. X-rays for chest, fracture or any other part of the body where preparation is not required are done the same day. X-rays which happen to be not of good quality are done the following day. Specimen of stool, etc. cannot be attended the same day."

3.25. As certain delays could be overcome by better organisation and better management, the Committee desired to know if some ways and means could be evolved to reduce these delays. The Secretary, Ministry of Health has stated:

> "I can assure you and the Members of the Committee that I shall personally look into the question of delays in the laboratories and if it is found that it is because of shortage of staff or because of shortage of equipment we will take adequate steps. I can assure you that we will try to close laboratory as and when hospital closes. We will keep it open for receiving samples up to 1 O'clock if it can be arranged by adding equipment and man-power."

3.26. During evidence when the Director General of Health Services informed the Committee that the National Institute of Health Administration and Education has been asked recently to undertake a study regarding increasing the timings for registration from 11.30 to 13.00 hours, the Committee enquired as to why it did not strike the Ministry or the Directorate earlier as the Institute had been working for the last 10 years.

3.27. To this, the Secretary, Ministry of Health has stated during evidence:

> "Sir, the figure of OPD and indoor patients shows how the pressure on the hospitals is increasing. From 7 lakh it has gone up to 11 lakh and these services are overstrained. But I would personally go into this and see whether this problem can be sorted out by more staff, more equipments, building etc."

3.28. It may be relevant to mention here that a study of the laboratories of Willingdon hospital was conducted by the National Institute of Health Administration and Education in 1975 and had made a number of suggestions for improving the laboratory services. Some important suggestions are enumerated below:

1. "At present working hours for specimen collection centre are from 9.00 to 10.30 or 11.00 A.M. for outpatients. These timing should be from 9.00 A.M. to 1.00 P.M. in order to minimise the number of refused cases and avoid inconvenience caused to patients. The working hours of the laboratories should be changed to 10.10 A.M. to 5.15 P.M. instead of present working hours from 9.00 A.M. to 4.00 P.M. This will help in better utilisation of the time of technicians and other staff, because they will start their work after specimens have already been collected between 9.00 A.M. to 10.15 A.M.

2. All the laboratories should be brought closer to one another so that the patients movement may be minimised.

3. The collection of the specimen for all the laboratories should be centralised by locating the different counters for different purposes all at one place.

4. The results of the tests performed by technicians/laboratory assistants should be verified by senior technicians or junior doctors attached to the laboratories at least on a sample basis. This will help in improving the quality of work.

5. It is important to assess periodically (say, once in 5 years) the adequacy of staff, keeping in view the increase in work load. Recruitment of technicians should be done on the basis of their training and qualifications. There should be more technicians and fewer laboratory attendants. There should be provision for their in service training also and promotion on the basis of their performance, so that they feel motivated to do good and more work.

3.29. Following are some of the main observations of National Institute of Health Administration and Education when they carried out a study of OPD and Diagnostic Service in Safdarjang and Willingdon Hospitals in August, 1976 :

Out-Patient Departments

1. In Safdarjang Hospital the space for OPD is very inadequate for waiting as well as for consultation rooms. Sharing of one table by more than one doctor is a common feature.

2. OPD attendance in Safdarjang Hospital now touched the million mark from just 2 lakhs in 1958 without a corresponding increase in facilities and equipment etc. This has caused an undue strain on the meagre hospital resources. Overcrowding cause instanitary conditions and dilution in patient care.

3. Another significant observation in both the hospitals is the lack of polite and courteous behaviour of the staff towards the patients. The solution for this lies in giving orientation and inservice about a change in their attitude and behaviour and improving the supervision.

4. Overcrowding which is one of the main problems can be greatly reduced by adopting "referral system" under which only patients referred by other doctors and dispensaries are seen treated.

5. Guidance to outpatients is not at all satisfactory. Hospital staff appear to be busy and sometimes indifferent.

Laboratory Services

Patients are not properly informed or guided by any guides or by doctors regarding the procedure to be followed to get their blood, urine, stool, etc. samples to be examined. This causes unnecessary and avoidable hardship to the patients. It is recommended that such guidance should originate from the doctor who prescribes these various tests.

On observation, it is seen in both the hospitals especially so in Safdarjang Hospital that they have out-dated equipment and the general maintenance is very poor. Out of the three microscopes in Safdarjang hospital two are out of order, so there is delay in work done by the laboratory due to the equipment being out of order. It is suggested that the laboratory should be modernised and preventive maintenance should be instituted in order to improve the accuracy of the test results.

3. It is seen that there is no inservice training programme for the technicians. It is recommended that they should be sent for or given training in the hospital to keep their knowledge upto date on the latest techniques.

4. There is no quality control procedure in the laboratory tests so the realiability of the reports is doubtful. A junior pathologist should be appointed to help the senior in charge to do this responsibility.

5. It is observed in both the hospitals that one laboratory is catering to the indoor tests, outpatients and emergency patients resulting in over work for the staff and inaccuracy of the results. It is strongly suggested that OPD in the hospital should have a separate laboratory with adequate staff.

6. Staff in Safdarjang is less than what is needed and it is suggested that two more technicians for blood collection and two more for urine collection and three more for analysis may be provided.

Radiological Services

1. The registration time at the X-ray department in the two hospitals in the same as that of the OPD. So sometimes when the patients come after getting the slip from the doctor, the counter is closed and they have to come again next day.

It is, therefore, very essential to extend the timings for registration so that at least the routine X-rays can be done on the same day.

2. Instructions and guidance to patients as regards procedures to be observed for some specific type of X-rays should be communicated to the patients by the doctors themselves at the time of making the requisition or they should be printed on the back of the requisition slip.

3. For special type of X-ray investigations presently it is observed that the patients first stand in the registration line and then they are told to go to the radiologist concerned to get the appointment so a lot of inconvenience is faced by patients and also their time is wasted. It is, therefore, recommended that patients who need special type of X-ray examination requiring prior preparation should be given a firm appointment by the registration clerk himself.

3.30. As the main reasons for excessive waiting time was the overcrowding in the hospitals, the Committee desired to know the steps which could be taken in this respect. The Secretary, Ministry of Health has stated during evidence:

"The ultimate answer is to disperse the patients and decentralise the services. Everybody has to come for clinical tests and radiological services to the hospitals. The ultimate solution lies in decentralising these services."

He has added:

"Taking these things into consideration, we have already opened, three months ago, a hospital with 30 beds in R. K. Puram. It was not there previously. Another 30 beds are going to be provided in the hospital. All the facilities will be available. The people living in that area will not be required to come to these hospitals for the child services and female services."

3.31. In a note subsequently furnished to the Committee the Ministry of Health have stated that the following measures have been/are being taken to reduce overcrowding in the OPD of the three hospitals in Delhi.

"*Short Term*

1. Evening OPDs have been started in the three hospitals. Unfortunately this has not been very much of a success because

a large number of patients who come for treatment in the three hospitals are from outside Delhi and like to come in the morning.

2. Additional staff has been sanctioned for the Safdarjang and Willingdon Hospitals with a view to improving the Services.

3. Construction of two additional floors over the OPD in Willingdon Hospital has been sanctioned.

4. Administrative measures like the extension of registration time at laboratory, X-ray, OPD etc. have been taken to reduce overcrowding by providing quicker services.

Long Term

1. In order to coordinate the functioning of various hospitals in Delhi, a Delhi Hospital Board with the Lt. Governor as the Chairman, has been set up. The idea is to cover the areas where hospital facilities are not adequate.

2. Delhi Administration plan to open six 100-bedded hospital in the rural areas of Delhi to correct geographical imbalance and to avoid rush of people from the rural areas and neighbouring States to the main hospitals. In addition, two 500 bedded hospitals are proposed to be opened, one at Shahdara and the other at Hari Nagar."

3.32. According to the Audit Paragraph the evening out-patient department in Irwin Hospital started functioning in December 1973 whereas these departments in Safdarjang and Willingdon hospitals were started in July 1975.

3.33. Referring to the opening of the out-patient Departments in the evening, the Secretary, Ministry of Health has stated during evidence:

"We are of the view that the hospital rush is largely between 9 A.M. to 12.30 P.M. Thereafter, the huge investment on buildings, equipment, furniture, etc. remains unutilised in the afternoons. Therefore, taking a cue from the second shift in the schools, we thought that it would give some relief to the people if we open OPDs in the evening also. Unfortunately, this has not been much of a success. One of the things that worries me is X-ray facilities, blood test facilities and other radiological tests in the evening because of shortage of staff and equipment. We are having a second look at it. I do hope that it will be possible for us to increase the facilities in the evening OPDs with the result that the people will be

able to utilise the services and there will be no over-crowding in the morning."

3.34. The Ministry have informed the Committee in a note that the total number of patients who were attended to in the three main disciplines of medical, surgery and paediatrics in the evening OPDs of the three hospital during each of the months from January 1976 to June 1976 was as under:

	Safdarjang Hospital		Paedia-trics	*Willingdon Hospital*		Peadia-trics
	Medical	Surgical		Medical	Surgical	
January, 76 . .	849	Evening OPD started functioning with effect from 16-8-76	226	760	534	129
February, 76 . .	839		311	827	579	160
March, 76 . .	970		306	1071	614	171
April, 76 . . .	925		247	934	457	181
May, 76 . . .	948		307	895	488	128
June, 76 . . .	1204		307	899	661	152
	5735		1704	5386	3333	921

Irwin Hospital

	Medical	*Surgical*	*Paedia-trics*
January, 76	1179	1261	174
February, 76	1175	1453	194
March, 76	1476	1309	150
April, 76	1593	1155	177
May, 76	1579	2202	149
Juae, 76	735	495	49
	7737	6774	893

3.35. The Ministry had informed the Audit in December, 1975 that proposal for additional staff for the evening OPD in Safdarjang and Willingdon Hospitals was under active consideration of Government. The

Committee desired to know whether the necessary staff had been provided in both these Hospitals. In this connection the Secretary, Ministry of Health has explained:

> "Actually, the evening OPD was started as an experimental measure; and we were finding out whether it would prove popular or not. Unfortunately it has not proved very popular. We are now trying to find out how to make it popular. So far as the Irwin Hospital is concerned, the staff is likely to be sanctioned in the near future. So far as these other two hospitals are concerned, I am not sure what staff would be required. Unless and until we know that such-and-such is the work load to be catered to, it is difficult for us to adopt a norm. These doctors have to attend in the evening OPD, to about 20 or 30 persons. Frankly speaking, some re-thinking will have to be done whether to continue this, and if it is to be continued, with what additions and amendments. It appears to me that the evening OPD should be strengthened not only by giving additional staff, but also by providing specialist services. Otherwise the hospital buildings are lying unutilized for a number of hours per day. This was an experimental measure which we tried on our own last year."

In the same context the Ministry of Health, in a written note, have stated as under:

"*Safdarjang Hospital and Willingdon Hospital*

> The scheme was launched in 1975 as an experimental measure. The figures of attendance indicate that it has not been much of a success and the position is being reviewed. If it is kept on a permanent basis, additional staff will be sanctioned.

Irwin Hospital

> Attendance in the evening OPD at the Irwin Hospital is more than in other hospitals. At present the evening OPD is being run with the existing physicians/surgeons. The questions of sanctioning additional staff for manning the evening OPD in the Irwin Hospital is being considered."

3.36. The Audit para has pointed out that while the out-patient department in the morning have all the specialities of the hospital, the out-patient departments in the evening except in Willingdon Hospital have limited number of specialities.

3.37. Clarifying the position the Medicial Superintendent of Safdarjang Hospital has stated:

> "The doctors who are posted in the evening OPD are relieved from their place of duty at 12 noon; and they come at 4.30 P.M. to run the evening OPD. The OPD is run between 4.30 and 6.30 P.M. These doctors are in the grade of Junior Medical Officers or GIMO Gr. I, and Registrars. No specialist services are provided; and the departments which run this OPD are, as my Secretary said, Surgery, Medicine, Obstetrics, Gynaecology and Paediatrics".

3.38. In reply to a question as to what steps are being taken to make the evening OPD popular, the Secretary, Ministry of Health has stated:

> "Last time, when it was introduced, there was a full coverage for about a fortnight on the television. And there were insertions in the newspapers. There were Press reports also. In the beginning, the workload was fairly heavy; but then slowly it dwindled off. I do not think that people do not know that there is an evening OPD. What happens is that, simultaneously, round the clock, we have the facility of Emergency as well. Sometimes people like to go to the Emergency rather than to the OPD. The greatest difficulty with the OPD is that the people that go there cannot get their urine collected and tested. So, in any case they have to come the next day. That means, the laboratory facility has to be strengthened. That is where the bottleneck lies. Another problem is that the specialist service is not available in the evening. We consulted our doctors and advisers whether it would be appropriate straightway to open the staff at the specialist level. The concensus was: let us wait and see what is the number of patients that come in the evening. It is functioning for the last one year. Some staff has been provided. But I am not sure whether it is possible to appoint special staff for the evening."

3.39. As one of the reasons for poor response in the evening OPDs of the three hospitals is stated to be the non-existence of X-ray facilities, blood test facilities etc. because of shortage of staff and equipment, the Committee desired to know the steps that are proposed to be taken in this regard. The Ministry of Health in a written note have stated as under:

> "The creation of Laboratory facilities for the OPDs in the evening has limited utility because patients are not in a position to give blood on empty stomach, stools, etc. However, limited facilities are available at the present moment. The question

of expansion of these facilities is under examination. It is also intimately connected with the number of patients visiting the OPDs in the evening."

3.40. The Committee desired to know whether the morning services can be extended to reduce the evening service, which is not popular. To this Secretary, Ministry of Health has stated during evidence:

"Our difficulty is that in the morning the peak has already been reached. I really do not know whether by appointing some staff we will be able to meet the situation. That is why we wanted to have an evening OPD also. Unfortunately it has not proved very useful. In the Irwin Hospital it is quite popular. It depends upon the circumstances of each case and the location of the hospital. The Safdarjang Hospital caters to the rural population coming from Haryana, Rajasthan and UP. They prefer the morning OPD. They do not like to come in the evening, in which case they have to spend the night in Delhi."

3.41. According to the Audit para the two Central Government hospitals, i.e. Willingdon and Safdarjang have got a common formulary in which 576 medicines including injections, tablets, mixtures, etc. are listed. While all medicines are issuable to inpatients, the number of medicines approved for issue of outpatients is 130 in Safdarjang Hospital and 81 in Willingdon Hospital. On the other hand, the Irwin hospital which had, till September, 1975, 344 medicines in its pharmacopoeia 217 items were authorised for issue of outpatients. The Committee, desired to know how the Irwin Hospital managed to issue more number of drugs to OPD patients as compared to the other two hospitals although it spent much less on purchase of medicines in 1974-75. The Ministry of Health in a note furnished to the Committee, have stated:

"Drugs are issued to the patients in the three hospitals in accordance with the formulary (pharmacopoeia) drawn up for each hospital. In respect of Irwin Hospital some costly and brand drugs are not given to the out-patients. It may be further mentioned that the large number in formularly of Irwin Hospital is because of the variety and not with reference to the cost and/or quantity of medicines."

3.42. The Out-patient Department is the most important and an accepted constituent unit for the hospital where nearly all patients suffering from diseases of minor, serious, acute and chronic nature report first. There is a shift from the traditional inpatient care to the ambulatory care. It is here that a patient forms his first impression of the type of service, that he

should expect to get the hospital. The value of an efficient out-patient department in treating minor illnesses and avoiding unnecessary admissions to hospital is enormous. It is, therefore, of utmost importance that adequate diagnostic and a full spectrum of services be provided at a place that is reasonably accessible with a minmum waiting time, with courteous behaviour apart from good medical care.

3.43. A study of the National Institute of Health Administration and Education (NIHAE) in 1976 reveals that OPD attendance in Safdarjang Hospital has now touched the million mark from just two lakhs in 1958 without a corresponding increase in facilities and equipments etc. Earlier, a similar study by the Department of Administration Reforms in Safdarjang and Willingdon Hospitals in 1972 had shown that on an average the total waiting time of a patient at the point of registration and doctor's cubicle was about 150 minutes. It was also observed that 31 per cent of the patients referred to laboratory and X-ray unit had to make second trip on the next day mainly due to the reason that the registration for clinical tests used to close before the closing hours of OPD. The Committee, during their visit to Willingdon Hospital on 23rd August, 1976, were also informed that on an average a patient has to wait for two hours for his turn.

3.44. From Audit para and from what has been tendered before the Committee during evidence, the Committee have every reason to believe that even now in all the three hospitals under examination the patients advised for X-ray and/or Laboratory tests often have to re-visit the next day since these departments close their registration at 11.30 A.M. whereas the OPDs work up to 1 P.M. The Committee have been informed that in order to reduce over-crowding the scheme of evening OPDs was started. While in Irwin Hospital the evening OPD started in December, 1973, such departments in Safdarjang and Willingdon Hospitals were started in July, 1975. This scheme, however, has not proved a success due to some inherent shortcomings. Notwithstandingly all the short-term steps taken by the hospital authorities over-crowding in the OPDs thus continue to pose a problem. The Committee feel that this problem has to be tackled boldly and effectively so as to minimise the inconvenience and irritation caused to patients and also to restrict undue strain on meagre hospital resources, insanitary conditions and dilution in patient care which arise as a result of overcrowding.

3.45. The Committee are surprised to note that the number of patients treated in Irwin Hospital is less as compared to Safdarjang Hospital although the former is located in the heart of the city and is close to most thickly populated area of Delhi. They find that the number of out-patients treated in Irwin Hospital during 1974-75 and 1975-76 was 7,23,633 and 9,04,328 as compared to 9,92,208 and 11,31,382 in Safdarjang Hospital during the

same period. The reasons for this varying feature, as advanced by the Ministry of Health that the Safdarjang Hospital draws all the Central Government employees and their dependents which is not the case with the Irwin Hospital and in the Safdarjang Hospital a very large number of people are attracted from the rural areas does not sound convincing as the Willingdon Hospital where patients treated in OPD are less as compared to Irwin Hospital also caters to the needs of the CGHS beneficiaries and a large number of rural patients also visit the Irwin Hospital. It has been stated before the Committee during evidence that some costly and brand drugs are not given to the outpatients in the Irwin Hospital. The Committee would like the Ministry to investigate whether the smaller number of out-patients treated in Irwin Hospital as compared to Safdarjang Hospital is due to the inadequate medical facilities provided to the patients.

3.46. The Committee note that as a result of over-crowding in the hospitals, the patients in the out-patient departments have to wait for a considerable time for their turn. In this regard, a study carried out by the National Institute of Health Administration and Education as far back as in 1967 in the Orthopaedic Department of Safdarjang Hospital revealed that there was a waiting time of about 120 minutes and several improvements were suggested to tackle the problem of excessive waiting time. The Committee feel concerned that in spite of recommendations made by NIHAE in 1967 and some measures suggested by the Department of Administrative Reforms in 1972 to minimise the excessive waiting time, no marked improvement in the average waiting time of the patient has been achieved. What has caused more concern to the Committee is the further finding of NIHAE in their study of OPDs of Safdarjang and Willingdon Hospitals in 1976 that the problem of excessive waiting time of out-patient departments of both the hospitals is to some extent due to lapses of administrative procedures at each step. The Committee are of the view that although certain delays are inherent in the situation and thus are inevitable, yet to a certain exetnt these can be overcome by rationalising the existing procedures and strengthening the organisations where necessary. The Committee need hardly stress that a senior faculty member may be assigned the charge of OPD services in each hospital who with the help of the Public Relation Officer may look into the difficulties of the patients and the staff with a view to reviewing the overall functioning of the OPD from time to time and suggest measures for effecting improvements. A board showing the name, designation and telephone of such an officer may be displayed at a prominent place near the Out-patient Department of each hospital so that the patients may contact him for guidance and redressal of their difficulties. The Committee also suggest that accredited social workers should also be associated with the hospital authorities to provide necessary guidance and help to the needy patients.

3.47. The Committee have been informed that in order to reduce the excessive waiting time of the patients the actual registration now starts 30 minutes before the doctors start examining the patients and the system of distribution of medicines is being modified so that a patient is not required to stand in different queues for different types of medicines. In this connection, the Committee desire that all possible efforts should be made to issue all types of medicines from the same counter. In case there is a long queue of patients, the number of such counters may be increased to two or three, but these may be side by side so that the rush is equally balanced on all the counters.

3.48. The Committee also note that it is also proposed to start 'screening clinics' in the OPDs. Under this scheme, the general duty medical officers will be able to screen and provide treatment for minor ailments etc. and those needing specialist services will then be sent to the concerned consultants in the OPDs. In this connection, the Committee agree with the views expressed by NIHAE in their study in 1976 that provision of screening clinics within the OPD may not be the answer to reduce over-crowding in both the hospitals as they fear that probably the waiting time will increase since the patient has to be screened first in the screening clinics and then to be referred to respective OPDs where again the patient will have to wait for his turn. The Committee desire that this matter should be looked into in depth.

3.49. In a study by Department of Administrative Reforms of the Outpatient Departments of Safdarjang Hospital in 1972, it was revealed that "patients start arriving from 6 A.M. onwards and nearly 63 per cent of the new patients and 49 per cent of the old patients are in the queue before the commencement of the registration." The Committee find that more or less the same situation continues in the OPDs of the three hospitals, thus resulting in over-crowding particularly during the first two hours of the usual OPD timings of four hours. Therefore, the Committee feel that additional doctors may be made available during the first two hours at each OPD of the hospitals, and the process of examination of old and new patients so rationalised that the waiting time is considerably minimised. The Committee also observe from the Audit para that a new and an old patient normally spent about 105 and 58 minutes respectively for registration and 50 and 115 minutes more in waiting for consultation. The ratio of new and old patients coming to OPD for treatment was 56:44. The Committee feel that it would be more appropriate if the strength of the doctors is also fixed taking into account the ratio of new and old patients. In fact, the Committee consider that there should be an in-built organisational arrangement to deploy more doctors if and when there is unusual rush. Norms should be laid down on the number of patients a doctor can conveniently examine per hour and

accordingly the strength of the doctors may be suitably fixed so as to bring down the maximum waiting time of out-patients to half an hour at the most. The Committee would like to emphasise that Ministry should not sit on the fence when human sufferings continue to mount. If need be the strength of doctors should be suitably augmented without any loss of time so that the social benefits of the hospitals percolate to the lower strata of the population in and around Delhi.

3.50. The Committee note that the clinical laboratories in the three hospitals work from 9 A.M. to 4 P.M. With an hour lunch break from 1 to 2 P.M. The specimens for investigation in the laboratory and the patients in the X-ray unit are received upto 11.30 A.M. only although patients are seen in OPDs upto 1 P.M. As a result of this, sometimes the patients coming after getting the slip from the doctors find that the counters for registration in laboratories and X-ray units are already closed, with the result that they have to come the next day which causes a lot of irritation and wastage of their time. The Committee agree that certain investigations such as blood test in which case the patient has to come with empty stomach, stool test, etc. cannot be conducted the same day but at the same time they feel that it may be possible to minimise the percentage of the patient's making re-visits the next day to a greater extent if the working hours of the laboratories are changed from 10 A.M. to 5 P.M. instead of present working hours from 9 A.M. to 4 P.M. with specimens collection time staggered from 11.30 A.M. to 1 P.M. In fact, the Secretary of the Ministry has assured the Committee during evidence that "we will try to close laboratory as and when hospital closes. We will keep it open for receiving samples upto 1 O'Clock if it can be arranged by adding equipment and manpower." The Committee would like the matter to be gone into in depth and the Committee informed of the improvements effected including change of time.

2.51. The Committee would like to point out that NIHAE in their study of 1976 have already made a number of concrete suggestions which can be implemented without much hesitation, to improve the working of OPDs in the hospitals. The Committee agree with their views and would like to reiterate that—

(i) to encourage polite and courteous behaviour of the staff towards the patient, orientation and in-service training opportunities should be provided to the staff.

(ii) Out-patients should be properly guided by the doctors issuing prescriptions regarding the procedure to be followed to get their blood, urine, stool, etc. samples tested.

(iii) Laboratories may be modernised and out-dated equipment replaced as early as possible to improve the accuracy of the test

results because these tests form the basis of the medical treatment which the patients are to be imparted.

(iv) OPDs in the three hospitals should have separate laboratories with adequate staff for their exclusive use.

3.52. The Committee note that in order to cope with the increasing rush in the OPDs of the respective hospitals, the evening OPD was started in the three hospitals. This scheme, however, has not proved a success as is evident from the fact that the average daily number of patients who were attended to by the three main disciplines of medical, surgery and paediatrics in the evening OPDs of the Safdarjang and Willingdon Hospitals during the six months from January 1976 to June 1976 comes to 41 in Safdarjang and 54 in Willingdon as against daily average of 2500 to 3500 out-patients visiting the OPDs of these hospitals respectively. It was stated during evidence that the workload was fairly heavy in the beginning but slowly it dwindled off. The Committee would like the Ministry of Health to investigate the specific reasons for this decline in workload in spite of initial good start and take suitable remedial measures.

3.53. The Committee are unhappy to note that although the proposal for additional staff for the evening OPD in the respective hospitals was under active consideration in December, 1975 it has not yet been sanctioned as it is being contended that the evening OPDs are on experimental basis and the necessary measures in this direction will be taken if it is to be kept on a permanent basis. The Committee feel that the reasons for poor response in the evening OPDs are non-existence of essential facilities like X-ray units and laboratories facilities because of shortage of staff and equipment. Further, the specialist services are also not available in the evening. The Committee are not convinced by the reply of the Ministry that creation of laboratory facilities in the evening has limited utility as patients are not in a position to give blood on empty stomach stool, etc. because these difficulties are experienced in the morning OPDs also. The Committee feel that more and more patients can be attracted to avail of the evening OPD facilities by strengthening the laboratory and radiological services and extending specialist services. Further, to make it more popular adequate publicity of the availability of these services also needs consideration. These steps may be taken as the saturation point has already been reached in the morning and an effective decentralisation of the services being the long term solution, is the need of the hour.

3.54. The Committee feel that one of the reasons for over-crowding in all the three hospitals is the fact that a large number of patients are attracted from the peripheral areas in the adjoining States to these main hospitals in Delhi because of inadequate hospital facilities and poor quality patient-care

existing in those areas. The Committee find that as short term measures the evening OPDs have been started, though without much success, in the three hospitals; additional staff has been sanctioned for the Safdarjang and Willingdon Hospitals; construction of two additional floors over the OPD in Willingdon Hospital has been sanctioned and administrative measures like the extension of registration time at laboratory, X-ray unit etc. have been taken to reduce over-crowding by providing quicker services. The Committee further note that a hospital with 30 beds has been opened in R. K. Puram, New Delhi and another 30 beds are going to be provided in this hospital. The Committee would like the Government to take a stock of the improvements which have been effected or are likely to be effected as a result of these measures so that an over-all view of the situation may be taken to take further remedial steps in the matter.

3.55. The Committee have been informed that some long-term measures have been taken or are proposed to be taken to reduce the over-crowding in the Delhi hospitals. These measures are (i) setting up of a Delhi Hospital Board with the Lt. Governor as the Chairman to coordinate the functioning of various hospitals in Delhi, particularly in the areas where hospital facilities are not adequate; (ii) proposals to open six 100 bedded hospitals in the rural areas of Delhi to correct the imbalances and to avoid rush from the rural areas and neighbouring States to the main hospitals. In addition, two 500-bedded hospitals are proposed to be opened, one at Shahdara and the other at Hari Nagar; (iii) Provision of 30-beded Nursing Home in Irwin Hospital; (iv) Addition of 70 beds in General Ward and 96 beds in the Nursing Home of Willingdon Hospital; and (v) Establishment of Eye Centre as an adjunct to the Irwin Hospital. The Committee welcome these measures and would like the Government to take urgent and concerted steps to expedite the implementation of these proposals, within a time-bound programme. The Committee, however, need hardly stress that greater emphasis should be laid on the provision of hospital facilities in the rural areas in general and re-settlement and jhuggi-jhonpri colonies in and around Delhi in particular. The hospitals so set up should be self-contained so that the flow of patients from these areas to the main hospitals in Delhi is contained satisfactorily. For this purpose, the Committee would like the Government to set up a team of experts with members drawn from the Ministry of Health, Ministry of Finance, Delhi Administration and Public representatives so as to go into the question of adequacy of existing medical facilities in and around Delhi and recommend remedial measures in this respect on which follow up action may be taken without delay.

3.56. The efficiency of Yoga in promoting health and building up resistance to disease has been widely demonstrated and recognised. The Committee need hardly point out that when patients flock to OPD's of hos-

pitals for treatment, they are anxious not only to get well but also to take recourse to such treatment and measures which would help them to build up resistance against recurrence of the disease. This receptivity of mind could well be taken advantage of by the authorities to provide knowledge of cheap easily available health building diets and Yoga exercises. Practical demonstration in Yoga exercises could be given by persons who are well-versed in this ancient science in close coordination with the medical authorities. The Committee suggest that the matter may be gone into carefully and the scheme sincerely tried out on pilot basis in Irwin Hospital; care being taken to publicise the facility amongst the outdoor patients so as to rouse and sustain their interest. The Committee would like to be informed of the action taken in pursuance of the recommendations and the result of the experiment.

CHAPTER IV

INPATIENT SERVICE

A. Diet

Audit Paragraph

4.1. Each of the three hospitals has qualified dieticians on their staff who are consulted for the therapeutic diets. In addition, it is their duty to supervise preparation of food and service to the patients. The diet is supplied to patients in the general wards free of costs, which on an average worked out to Rs. 2.81, Rs. 2.95 and Rs. 2.30 in Safdarjung, Willingdon and Irwin hospitals respectively during 1974-75. Indents for diets are sent by the sisters-in-charge of the wards to the dieticians a day in advance. The total number of diets issued as compared to the number of patients accounted for during mid-night census in 1974-75 is shown below:—

		Safdar-jung	*Willing-don*	*Irwin*
(i)	Number of patients as per mid-night census. .	405247	192317	413892
(ii)	Number of diets issued	445501	225060	438748
(iii)	Number of excess diets issued . . .	40254	32743	24856
(iv)	Percentage of excess diets to census figures .	9 9	17 0	6 0

4.2. There was wide variation in the percentage of excess diets issued in the three hospitals.

4.3. A recent survey (July 1975) at Willingdon hospital by the Nutrition Cell of the Director General of Health Services (D.G.H.S.) disclosed that the diet served in the general wards did not come up to the prescribed standards in the matter of calories and proteins. It also found the washing facility inadequate for keeping cooking utensils hygienically clean, cloak rooms and sanitary conveniences dirty and poor. For conveyance of food to the wards, the available thermostatic trolleys were not being used on the ground that they were too heavy to be pushed by a single person from kitchen to the ward. Health check-up of the staff in the kitchen and other staff handling food required to be done once in six months had not been done during the last one year. The Ministry stated (December 1975)

that "the kitchen in Willingdon hospital was constructed to meet the requirements of 250 patients. The present bed strength is 730. The proposal to build a new kitchen has been postponed for the present due to financial constraints. The medical check-up of the kitchen staff is being done."

4.4. In Irwin hospital, the last medical check-up of the staff working in the kitchen was conducted in 1971.

4.5. In Safdarjung hospital medical check-up of the kitchen staff is done once a year. The Ministry stated (December 1975) that last check-up was done in October 1975, and "such staff members who were not found healthy/suitable have been sent on leave or transferred to other Departments."

[Paragraph 30 of the Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil)]

B. Nursing Home

Audit Paragraph

4.6. Willingdon hospital has a 63-bedded nursing home for use by the C.G.H.S. beneficiaries drawing pay Rs. 750 or above per month and members of the public on payment.

A comparative picture of the facilities available to the patients in the nursing home vis-a-vis the general wards during the year 1974-75 is given below:—

	Nursing home including 10 beds in special wards (73 beds)	General Wards (522 beds)
(i) Carpet area		
(a) Old Nursing home	24·40 sq. metres per room	34·02 sq. metres for room with 6 beds.
(b) New nursing home	15·00 sq. metres per room (containing one bed for the patient and one bed for the attendant)	
(c) Maternity nursing home	16·00 sq. metres per room.	
(d) Floor area of special wards	19·00 sq. metres per room with four beds.	

	Nursing home including 10 beds in special wards (73 beds)	General wards (522 beds)	
(ii) Furniture	6-9 items	3 items	
(iii) *Para-Medical staff*			
(a) Number of staff nurses	31	67	
(b) Nurses-bed radio	1:2·35	1:7·79	
(c) Number of nursing sisters	4	19	
(d) Nursing orderlies	23	45	
(e) Nursing orderlies-bed ratio	1:3·2	1:11·6	
(f) Sweepers	27	70	
(iv) *Kitchen staff*			
(a) Number of bearers	6	7	Nursing homes kitchen provides for 69 beds and general wards kitchen provides for 667 beds—beds including emergency etc.
(b) Number of masalchis	4	4	
(c) Number of cooks	4	7	
(d) Number of Khidmatgars	6	8	
(e) Number of cookmates	3	6	
(f) Number of sweepers	1	2	
(v) Expenditure on diet cost per patient per day.	Rs. 13·59	Rs. 2·95	

Rupees 7 per day (fixed in 1954) are recoverable as diet charegs both from the C.G.H.S. beneficiaries and the members of public making use of the nursing home. The Ministry stated (December 1975) that the "case for revision of diet charges is under consideration." In the nursing home 24 rooms are fitted with airconditioners and four rooms with air-coolers. A heater is supplied to every room during winter. The patients admitted to the air-conditioned rooms have to pay Rs. 8 per day as air-conditioning charges. In the general wards cooling and heating facilities are provided in surgical and children wards as and when it is considered necessary.

Patients from the general public can also make use of 10 per cent of the rooms in the nursing home on payment of room rent, operation fee, clinical charges, attendance charges etc., at various rates depending on their monthly income. The following table shows the number of patients

(category-wise) making use of the nursing home during the three years ending March 1975:—

	C.G.H.S beneficiaries	General public	Total	Percentage of patients from general public to the total No. of patients
1972-73	1539	515	2054	25
1973-74	1479	606	2085	29
1974-75	1470	543	2013	27

4.7. The hospital has blood bank to cater to the needs of the patients both of the nursing home and the genral wards. A test check of indents for blood from the bank during the period January to July 1975 disclosed varying response to the needs of the patients of the nursing home *vis-a-vis* the general wards as indicated below:—

	Nursing Home		General Wards	
	Emergent most urgent cases	Routine cases	Emergent most urgent cases	Routine cases
(i) Number of patients	6	4	10	4
(ii) Number of blood units recommended by the doctor	18	11	40	8
(iii) Number of blood units actually supplied	19	11	14	4
(iv) Number of units replaced by relative donor.	2	..	3	4

4.8. The Ministry stated (December 1975) that "blood is provided on 100 per cent replacement basis. However, when no donor is available and the condition of the patient warrants immediate transfusion, blood is issued from the Bank as a life saving measure. The required Units are supplied to save patients' lives even when no replacement is forthcoming."

[Para 30 of the report of the C&AG for the year 1974-75, Union Government (Civil)]

Cost of Diet

4.9. According to the Audit para the cost of the diet supplied in the General Wards, though supplied free of cost, worked out to Rs. 2.81, Rs. 2.95 and Rs. 2.80 in Safdarjung, Willingdon and Irwin Hospitals respectively during 1974-75. The Committee desired to know the reasons for this

variation in cost of diet from hospital to hospital. In a note furnished to the Committee, the Ministry of Health have stated as under:—

> "Safdarjung and Irwin Hospitals provide only vegetarian diet whereas in the Willingdon Hospital non-vegetarian diet is also provided. Expenditure on non-vegetarian diet is definitely higher.
>
> There would always be some difference between the cost incurred on particular service in one Hospital as compared to the other because of various factors like location, nearness to market, contracts offered, facilities provided, etc. It may also be pointed that the Safdarjung Hospital buys its dietary articles from the Super Bazar which ensures better quality even though at a marginally higher price. A common scale of diet has been prescribed for all the three hospitals.

4.10. During evidence the Medical Superintendent of Safdarjung Hospital has stated that as a measure of economy the quantum of diet in Safdarjung Hospital was reduced from 400 gms to 300 gms without diminishing the standard of diet and the calories supplied through the diet remained at 2400. When the Committee pointed out that if the decision of reducing the quantum of diet has been made after a careful study then it should be adopted in other hospitals as well in order to achieve economy. In reply, the Secretary Ministry of Health has stated:—

> "I must frankly admit that except taking interest in the stopping of leakage of diet in the hospitals, I have not been able to devote myself to this aspect of the matter. I have made some efforts to ensure that the diet does not leak out. It was in the 60s that the standard diet was fixed. When I was having a meeting for preparing myself for this evidence, it come to my knowledge that in some hospitals they are debiting the pay of the cooks, bearers and everything to the diet expenses while in some other hospitals they are not doing so, and that accounts for some sort of variation. I must frankly admit that there is need for going into it in greater detail and having a systematic study of it so that it can be uniformly applied to all the hospitals. Only then we will be able to have a meaningful comparison."

4.11. As mentioned earlier, only vegetarian diet is supplied in Safdarjung Hospital and Irwin Hospitals whereas in Willingdon non-vegetarian diet is also supplied. The Medical Superintendent of Willingdon Hospital is of the view that purely for medical reasons the non-vegetarian diet should be allowed.

4.12. During their visit to Irwin Hospital, the Committee were informed that non-vegetarian diet had been discontinued there because the quality of meat supplied had been very poor. It was also stated that the price of meat was quoted at 90 paise per kilo. In this connection, the Medical Superintendent, Irwin Hospital, has explained the position during evidence as under:—

> "We invited quotations (1972-73) and in that the contractor had quoted 90 paise. That was unbelievable. That was one of the reasons why we discontinued it and the quality was very very poor."

4.13. Asked whether the matter was pursued with the supplier whose bona fides was obviously suspect regarding supply of good quality of meat, the Medical Superintendent, Irwin Hospital, has stated:—

> "I am sorry, we did not take any step. but we will find out and report the matter to the appropriate authority'

4.14. As regards bringing about uniformity in diet in all the three hospitals, the Committee pointed out that greater importance should be attached to the views of the scientists. Explaining the position in this regard the Secretary of the Ministry of Health has stated:—

> "We have in the Ministry and Adviser who is known as 'Adviser (Nut)' meaning nutrition. The Director-General of Health Services, the Adviser (Nutrition) and the three Medical Superintendents should sit together and work out a formula so that the whole thing could be systematised, and that could be followed uniformly in all the hospitals of Delhi, and we could circulate it to the States also."

Excess Diets Issued

4.15. According to the Audit para, the number of excess diets issued in Safdarjung, Willingdon and Irwin Hospitals as compared to the number of patients accounted for during mid-night census in 1974-75 was 40,254 (9.9 per cent), 32,743 (17.0 per cent) and 24,856 (6.0 per cent) respectively.

4.16. It is learnt from the Audit that in regard to Irwin Hospital the Ministry had informed them in December, 1975 that "the reasons for excess diets issued to wards are that the large number of patients on the floor are not shown in the mid-night census." In this context the Medical Superintendent of Willingdon Hospital has elucidated during evidence:—

> "As most of the patients come from CGHS usually the Surgeon takes a round in the morning and discharges patients, but we

find that the patients are removed after office hours. So, they were taking extra lunch. But what was supplied to the kitchen that is the census is taken in the morning. So, there is a discrepancy in the extra diet."

The witness has added:—

"In big hospitals, there are so many changes in the patients. For example, in the emergency ward, we do not allow any diet. Whatever is left is either supplied to the Casualty Department or the Emergency Ward. So, it happens that some patients leave earlier and some patients leave late but we see to it that everybody is fed."

4.17. Clarifying the position further, the Secretary, Ministry of Health has stated:—

"Your impression that the extra diet goes waste is not correct. The extra diets are served to the Casualty because the mid-night census is there. Then the patients in the Casualty and the Emergency continue to come and go. The extra diets are used. Whatever is left may be stored. I think that nothing is going to be wasted. The characteristics of the in door patients in the Willingdon Hospital are slightly different fror. the Safdarjung and the Irwin Hospitals. In the Safdarjun, Hospitals, we have quite a large number of patients coming from outside and when they are discharged in the morning, they go away; they leave the hospital. But, as the Medical Superintendent of the Willingdon Hospital has pointed out, in the case of the Willingdon Hospital, even though the Medical Officer concerned issues the discharge slip in the morning, the patient is removed only in the evening when the attendant returns from the office with the result that he claims diet during lunch time. We have decided that the discharge slip should be corrected and that he may be discharged in the evening. For all practical purposes, this discrepancy will go away, but it will not mean that there will be saying on the diet."

4.18. In a note subsequently furnished to the Committee, the Ministry have explained the position hospital-wise thus:—

"Safdarjang Hospital

The Audit has pointed out certain amount of excess diets issued in the Safdarjung Hospital. It appears that the Audit has based their figures entirely on the midnight census of the

Medical Record Section where the figures with regard to the children in the nurseries are not included. The average number of children in the nurseries on any day is 50. The hospital issue milk diet to these nursery children also. Milk diet is also counted as a complete diet. The midnight census will not give the correct figures of the number of diets to be issued as there are subsequent admissions which necessitate issue of supplementary diets.

Willingdon Hospital

Issue of excess diets was examined the following are the reasons that can be adduced for the excess drawal of diets in the wards/departments.

(1) Patients in the observation area of the Accident and Emergencies Department are not reflected in the mid-night census report who are issued diets as and when needed.

(2) Audit has taken mid-night census as the basis for working out the number of patients whereas in actual practice the diets are supplied according to diet requisitions received from verious wards.

(3) A large number of patients admitted in the Willingdon Hospital are CGHS beneficiaries. Although they are discharged in the morning they actually leave the hospital in the evening when their attendants visit the hospital after office hours. In the process they are given lunch.

Irwin Hospital

The main reason for this excess issue of diets is that the census of the patient in the Irwin Hospital is taken at midnight but some patients who are admitted in the emergency after midnight and transferred to the various wards in the next morning are included in the diet sheets for the patients and consequently there is differenc between the census and the actual diet issued to the patients. As matter of fact no excess died is issued over and above the requirements indicated in the diet sheets.

The question of fixing new norms for preparation of diets in the hospitals is being looked into."

Diet issued in Nursing Home vis-a-vis *General Wards*

4.19. As stated in the Audit report cost on diet per patient per day in Nursing Home and General Ward of Willingdon Hospital is Rs. 13.59 and Rs. 2.95 respectively. Rupees 7 per day (fixed in 1954) are recoverable as diet charges both from the C.G.H.S. beneficiaries and the members of

public making use of the Nursing Home. It is learnt from the Audit that the question of effecting economy in expenditure on drugs, diet, articles, etc. in hospitals in Delhi was discussed in a meeting held in the Ministry in July 1974 which noted that "at present the cost of the diet charges in the nursing home of the Willingdon Hospital is Rs. 7/- per day and that it is very low considering the high increase in the cost of the dietary articles." The Ministry had informed the Audit in December, 1975 that the case for revision of diet charges was under consideration. The Committee desired to know as to when the question of enhancement of diet charges for the Nursing Home was taken up and whether the rates had since been revised. The Ministry of Health in a note have stated as under:

> "The question of revision of the diet charges in respect of the Nursing Home of Willingdon Hospital was taken up in early 1974. After a series of meetings with the Medical Supdt. of the Hospital, DGHS and the Ministry of Health and Family Planning wherein various aspects of the issue were considered in detail orders for revision of rates were issued in April, 1976, taking into account the scale of diet prescribed and the then market rate of various items comprising that diet and a percentage of cost of salary of dieticians, stewards, store-keeper, kitchen staff, other staff employed on procurement of articles, supervision of food from kitchen to room, kitchen rent, electricity and water charges, depreciation of utensils."

4.20. In a subsequent note furnished to the Committee it has been stated that revised diet charges in the Nursing Home are Rs. 10/- per day for vegetarian diet and Rs. 12/- per day for non-vegetarian diet.

4.21. The Medical Superintendent of Willingdon Hospital has stated ing evidence that:—

> "The expenditure on the Nursing Home food does not reflect on the General Ward diet. That is quite separate."

4.22. Explaining the reasons for different type of food supplied in Nursing Home and General Ward, the witness has stated:—

> "The Nursing Home people are charged. The General Ward patients are not charged. So, their food is slightly better than that of the General Ward."

4.23. When the Committee pointed out that except for medical reasons, there should not be any distinction in food supplied to Nursing Home and General Ward of a hospital, the Secretary, Ministry of Health has stated:—

> "Conceptually, I would agree with you, Sir, that so long as a patient is in the hospital, he should be given the diet which

is therapeutically necessary. But the background of the patient is equally important."

4.24. Further justifying the wide gap between the Nursing Home and General Ward diet costs, the Ministry in a note subsequently furnished to the Committee have stated:—

"Diet in the hospital is provided keeping in view the ailments of the patients. In the Nursing Home the patients are required to pay not only for the treatment and accommodation but also for the diet. The food provided in the Nursing Home is therefore more expansive as it has to cater to patients coming from different socio-economic status."

4.25. The Ministry of Health in a note have furnished the following information regarding the caloric value of the diets served in the Nursing Home and General Wards of Willingdon Hospital:

Nursing Home	*General Ward*
Caloric values	
Vegetarian diet	3950 2450
Non-vegetarian diet	4400 to 4500 2650

4.26. A survey conducted in July 1975 at Willingdon Hospital by the Nutrition Cell of the Directorate General of Health Services, as mentioned in the Audit Para, disclosed that the washing facility was inadequate for keeping cooking utensils hygienically clean; cloak rooms and sanitary conveniences dirty and poor; for conveyance of food to the wards the available thermostatic trolleys were not being used on the ground that they were too heavy to be pushed by a single person from kitchen to the ward. The Committee during their visit to the Hospital on 23 August, 1976 also found that the lights in the kitchen were inadequate and the kitchen needed white-washing. Some utensils in the kitchen also needed nickel plating from inside. The Committee desired to know the position in other two hospitals and the steps taken to rectify the situation. In a note furnished to the Committee the Ministry have stated:—

"The diet issued to the patients in Safdarjung and Irwin Hospitals is in accordance with the standards laid down by the Government. A survey in Willingdon Hospital was conducted in July, 1975 which showed a cut had been imposed for economy reasons. The cut was restored immediately thereafter."

4.27. In this connection, the Ministry is stated to have informed the Audit in December 1975 that the kitchen in Willingdon Hospital was constructed to meet the requirements of 250 patients while the present bed strength was 730. The proposal to build a new kitchen has been postponed for the present due to financial constraints. The Committee desired to know when the proposal to build new kitchen was considered and postponed. The Ministry in a note have stated:—

> "The proposal for building a new kitchen was made in March, 1972. For lack of funds in the Fifth Plan this proposal did not materialise. However, plans are now being prepared. The work will be taken up when the funds are available."

4.28. As stated in the Audit para, in Willingdon Hospital, the health check-up of the staff in the kitchen and other staff handling food required to be done in six months had not been done during the last one year. The Committee have been informed by the Ministry that the medical check up of kitchen staff in the Willingdon Hospital was last conducted in June 1976. In Irwin Hospital the last medical check up of the staff working in the kitchen was conducted in 1971. In Safdarjung Hospital medical check-up of the kitchen staff is done once a year and the last check-up was done in October, 1975. When the Committee asked about the system of annual check up of the kitchen staff in the three hospitals, the Medical Superintendent of Safdarjung Hospital has statetd:—

> "In the Safdarjung Hospital the kitchen staff were checked every year and the checking consists of a complete physical examination and X-ray of the chest, the examination of the excreta, *i.e.* urine and stools and any further examination that may be needed as desired by the physician. We have a record in the kitchen of all the staff who have undergone this examination and if anybody is found deficient in some way or the other, he is treated and till such time as he is cured of his condition, he is not allowed to go back to the kitchen."

4.29. In regard to the position in Irwin Hospital the Medical Superintendent of the Hospital has stated:—

> "The procedure in the Irwin Hospital is absolutely the same as in Safdarjung Hospital. But it is regretted that since 1971-for four years there was no medical check up done. But instructions have been issued and the check up has been now completed and three persons have been removed as a result of this check from the kitchen to other places. Till they recover from their ailment they will not be allowed to go back to the kitchen."

4.30. To a question as to why the check up has not been done for the last four years, the witness has added:—

> "Because the official concerned *viz.* the staff Surgeon was changed quite often. Now it has been made the responsibility of the Administrative Officer to see to it that it is carried out. It was left to the discretion of the Staff Surgeon at that time. Meantime, unfortunately there were three changes and I regret that it has not been done."

4.31. As Medical check-up of staff in Willingdon Hospital is done once in 6 months and in Safdarjang Hospital once in a year, the Committee enquired why there are no uniform instructions in this regard. The Ministry in a note have stated:—

> "Medical check-up of the kitchen staff once a year is considered adequate. The Willingdon Hospital has been doing it every six months as a precautionary measure. It will now be done once a year in Willingdon Hospital as well."

Nursing Home Facility

4.32. According to the Audit Paragraph Willingdon Hospital has a 63-bedded Nursing Home for use by the CGHS beneficiaries drawing pay of Rs. 750 or above per month and members of public on payment. Patients from the general public can make use of 10 per cent of the rooms in the Nursing Home on payment of room rent, clinical charges etc. on various rates depending on their monthly income. The income limit for admitting non-CGHS beneficiaries in the Nursing Home of Willingdon Hospital is also Rs. 750/- per month.

4.33. The number of patients (category-wise) who made use of the Nursing Home during each of the years from 1972-73 to 1975-76 is as follows:—

	CGHS beneficiaries	General Public	Total	Percentage of patients from general public to the total No. of patients.
1972-73	1539	515	2054	25
1973-74	1479	606	2085	29
1974-75	1470	543	2013	27
1975-76	1533	416	1949	21

4.34. The Ministry have informed the Committee in a note dated 23 August, 1977 that two rooms are usually kept vacant in the Nursing Home with a view to meeting urgent requirements. The admission of patients to the Nursing Home is authorised jointly by the Medical Supdt. and Physician-in-charge of the Nursing Home.

4.35. At the instance of the Committee, the Ministry have furnished the following break-up of the CGHS beneficiaries falling in the various income range who availed of the facilities of the Nursing Home during 1975-76:—

Income Group	No. of beneficiaries who availed of the facility.
Rs. 750—1100	599
Rs. 1100—1500	404
Above Rs. 1500/-	390

4.36. The Ministry have further informed the Committee that the pensioners are also eligible to seek admission in the Nursing Home under CGHS quota if they are contributing at last pay drawn and their basic pay at the time of superannuation was above Rs. 750/- per month.

4.37. As stated in the Audit para, the Willingdon Hospital has a blood Bank to cater to the needs of the patients both of the Nursing Home and the general wards. A test check of indents for blood from the bank during the period from January to July 1975 disclosed that against 18 units to blood recommended by the doctors in Nursing Home, 19 units of blood was actually supplied while dealing with most urgent cases whereas in general wards of the hospital only 14 units of blood were supplied against 40 units recommended by the doctor in such cases. Similarly, in routine cases while all the 11 recommended units of blood were supplied in Nursing Home, in general wards only 4 units of blood were supplied against a demand of 8 units. It is also observed that out of 30 units of blood supplied in Nursing Home, only 2 units were replaced by the relatives of patients whereas in general wards as many as 7 units were replaced by the relative donors out of 18 units supplied to the patients in all. The Committee desired to know how it was that the requirements of blood were met in full both in routine and emergent cases in the Nursing Home whereas supplies for general ward patients were met less than the recommended units. In a note furnished to the Committee, the Ministry of Health have explained:—

> "As regards emergent cases the policy is to supply blood immediately to both Nursing Home and General Ward patients whether donors are available or not. No life is allowed to be lost for want of blood or medicine. An attempt is made after the

emergency is over for replacement of blood, as far as possible both from Nursing Home and General Ward patients. In routine cases, however, blood is supplied free for General Ward patients as far as possible if no donors are available. In the case of Nursing Home patients, however, attempt is made for replacement of blood from donors as far as possible because there is no provision to supply free blood to Nursing Home patients.

Willingdon Hospital caters to a large number of important patients in its Nursing Home. They have therefore to be given all medical care as quickly and efficiently as possible."

C. Disinfection of Matresses and Washing Linen

Audit Paragraph

An imported disinfector plant for mattresses, pillows and blankets costing Rs. 0.75 lakh was acquired by Safdarjang Hospital in 1960. The plant worked erratically up to March 1974 and thereafter it has been out of order. The Ministry stated (December 1975) that the plant "is not working as spare parts are not available indigenously. Non-availability of furnace oil is also a reason for non-functioning of the plant. The Indian Oil Corporation do not supply furnace oil less than 10,000 litres. The hospital has no facility to store such a huge quantity of oil. It is contemplated to build a storage tank and with the appointment of operating staff the plant will start working. In the meantime mattresses, blankets etc. are passed through high pressure steam for their disinfection and to avoid cross infection." The other two hospitals have not acquired any disinfector plant.

The three hospitals are equipped with mechanical laundries for washing linen. The minimum requirement of linen articles per impatient at a time is five (2 articles to wear and 3 for bed). The Ministry stated (December 1975) that in the coronary care unit, burn unit, intensive care ward, casualty ward, recovery room and nursing home of Willingdon Hospital sterilized linen is supplied daily and in the remaining wards twice a week. In Safdarjang and Irwin Hospitals linen is required to be changed twice a week. To afford twice a week change in the general wards 6.34 lakhs pieces of washed linen in Safdarjang, 3.24 lakhs in Willingdon and 6.11 lakhs in Irwin were required during 1974-75. The actual number of linen pieces washed during the year, however, was 5.15 lakhs, 1.38 lakhs and 2.92 lakhs respectively which were insufficient for even one change in a week in Willingdon and Irwin hospitals. Administrative approval for construction of a modern laundry in Willingdon Hospital was stated to have been issued on 18th December, 1975.

[Para 30 of the Report of the C&AG for the year 1974-75, Union Govt. (Civil]

4.38. The Ministry had informed the Audit in December 1975 that the imported disinfector plant was not working as spare parts were not available indigenously. Non-availability of furnace oil was stated to be another reason for non-functioning of the plant. The Committee have been informed in a note that the furnace oil storage tank of capacity 9,000 litres for disinfector plant was acquired in August 1976. Immediately thereafter the plant was put into operation.

4.39. The Committee desired to know the facilities available for disinfecting mattresses pillows and blankets in Irwin and Willingdon Hospitals. The Ministry of Health in a note have stated that in Willingdon Hospital mattresses, pillows and blankets are disinfected by exposing them to sun. There is a mechanical laundry in the Irwin Hospital and all the linen used for the patients, doctors and nursing staff are disinfected in the mechanised laundry by using high pressure steam. The mattresses and pillow covers are changed frequently and disinfected by high pressure steam to stop cross infection. The Committee desired to know why the Irwin and Willingdon Hospitals have not acquired any disinfector plant and whether the existing arrangements there for disinfecting the mattresses, pillows etc. were considered adequate and effective to prevent cross infection. In a note, the Ministry have intimated:—

> "The present arrangement of disinfecting with steam by the Mechanical laundry is considered satisfactory. It is, therefore, not proposed to purchase further disinfecting plants and moreover, these plants are not available indigenously."

4.40. The Delhi Hospital Review Committee (1968) had recommended that to reduce cross infection in Wards in each hospital "mattress sterilizers must be provided. Blankets should be chemically sterilized."

4.41. As regards the steps taken to prevent cross infection in the three hospitals, the Ministry in a note furnished to the Committee have stated:—

> "The Government are concerned about the high rate of cross infections in the hospitals. Recently a Group has been constituted by the Government of India, Ministry of Health and Family Welfare with the following terms of reference:—
>
> 1. To investigate the appearance of Salmonella Newport in Delhi Hospitals, its origin, the effect it has had in terms of motrality and morbidity and the measures that have been taken so far by the hospital authorities to check the spread of this infection;
>
> 2. To assess the effectiveness of the machinery that exists in the hospitals to monitor and control the hospitals cross infections; and

3. To suggest measures for the detection and control of such infections.

The Committee is expected to submit its report shortly. Further measures will be taken on receipt of the recommendations of this Committee.

Normal measures taken to prevent cross infection in the hospitals are the following:

1. C.S.S. Department ensures sterilization of all hospital equipment and Operation Theatre gowns and linen.
2. Periodical bacteriological tests of equipments and articles of Operation Theatre and wards.
3. Timely disposal of waste materials of wards and units by the sanitation Department.
4. Maintenance of strict sanitation of the wards and units.
5. Frequent changes of bed-sheets and other lines (twice a week).
6. Periodical medical check up of kitchen staff.
7. Periodical white washing of the entire hospital.
8. Construction of chutes."

4.42. The Committee enquired when the Group was constituted by the Government of India to suggest measures for detection and control of such infection and whether its report had been received. To this the Secretary, Ministry of Health has stated during evidence:—

"The problem of cross infection in hospitals is a very important and sensitive subject. Unfortunately, the biggest cause is the over-crowding. We appointed a Committee of experts to go into the whole problem of cross infection on 9 August, 1976. The Working Group has met several times. They are going to finalise their report. That does not mean that effective measures are not being taken in the hospitals now to check cross infection."

4.43. During their visit to Safdarjang Hospital on 11 October, 1976, the Committee were informed that one of the reasons for cross infection was non-observance of visiting hours by friends and relatives of the patients.

4.44. In this connection it would be relevant to mention that the Delhi Hospital Review Committee (1968) had recommended that each hospital should have a standing Committee for the prevention of hospital infection with the Chief of Surgery, the Chief of Medicine, the Chief of Microbiology Department and the Anaesthsiologist to meet regularly once a month and

review the position regarding hospitals infection and effectiveness of sterilization and recommend measures to comat infection.

4.45. According to the Audit para, the three hospitals are equipped with mechanical laundries for washing linen. In Safdarjang and Irwin Hospitals linen is required to be changed twice a week. To afford twice a week change in the general wards 6.34 lakhs pieces of washed linen in Safdarjang, 3.24 lakhs in Willingdon and 6.11 lakhs in Irwin were required during 1974-75. The actual number of linen pieces washed during the year, however, was 5.15 lakhs, 1.38 lakhs and 2.92 lakhs respectively which were insufficient for even one chance in a week in Willingdon and Irwin Hospitals.

4.46. When the Committee drew attention to the above state of affairs, the Secretary of the Ministry has stated:

> "You are right. We have made certain improvments. There were no driers. Therefore, it could not be washed. The figures for 1975-76 show that the position is very much better."

4.47. The Committee desired to know whether the mechanical laundries were fully utilised in the three hospitals and what was their capacity per day and the actual number of linen pieces washed during 1975-76 in each of them. In a note furnished to the Committee the Ministry have stated:

"*Safdarjang Hospital*

> The mechanical laundry in the Safdarjang Hospital is fully utilised. The capacity of the laundry is 4000 pieces per day. The actual number of linen pieces washed during the year 1975-76 in the Safdarjang Hospital laundry is 10,19,822. The present capacity of cleaning dirty linen in the laundry is sufficient and at present no difficulty is felt in supply of adequate number of clean linen to wards etc.

Willingdon Hospital

The following equipment is available in the laundry department of this hospital:

1.	Washing Machine	150 lbs	1
2.	Washing Machine	100 lbs	1
3.	Sluicing Machine	12 lbs	1
4.	Hydro-extractor	25 lbs	1
5.	Hydro-extractor	50 lbs	1
6.	Calendering Machine		1
7.	Drying Chamber		1
8.	Charcoal fired hand press		2

The machines can wash 1600 to 2000 linen pieces per day and are fully used.

The number of linen pieces washed during 1975-76 is 4,31,749.

Irwin Hospital

The mechanical laundry is fully utilised in Irwin Hospital. Each of the three machines installed in Irwin Hospital has 100 lbs load capacity per hour. All the three machines can wash 2500 to 3000 pieces of clothes per day.

The actual number of linen pieces washed during the year 1975-76 was 7,14,143. The supply of clean linen to the wards etc. is adequate."

4.48. The Committee on their visit to Willingdon Hospital were informed that though the working capacity of the laundry in Willingdon Hospital was 1800-2000 pieces of linen daily yet that was too inadequate to meet the present needs of the hospital. It was stated that a new building for expansion of the laundry had been sanctioned and was likely to be completed in a year. In a note furnished to the Committee, the Ministry have stated that the tenders for the construction of modern laundry in Willingdon Hospital have been called for by the CPWD recently.

4.49. The Committee note that the cost of diet in the General Ward though supplied free of cost varies from hospital to hospital. During 1974-75 the average cost of diet in General Wards in Safdarjung, Willingdon and Irwin Hospitals was Rs. 2.81, Rs. 2.95 and Rs. 2.30 respectively. The Ministry have stated that the difference in cost on diet in one hospital as compared with other is sometimes due to such factors as location, nearness to market, contracts offered, facilities provided, etc. Another reason contributing to this variation in costs which has been put forward by the Ministry is that in Willingdon Hospital, non-vegetarian diet is also provided along with vegetarian diet whereas Safdarjung and Irwin Hospitals provide only vegetarian diet. It has also come to the notice of the Committee that as a measure of economy in Safdarjung Hospital the prescribed quantum of diet has been reduced from 400 gms to 300 gms whereas no such reduction has been carried out in the other two hospitals. The Committee cannot but conclude that no uniform system in the quantum and type of diet is being followed in the three hospitals. From the facts disclosed the Committee are led to the conclusion that there is no rational approach in regard to the dietary in the three hospitals. For the health and well-being of the patients the hospital authorities should have settled in consultation with expert dieticians the contents and quantities of diet keeping in view its calorific and therapetic value.

4.50. The Committee are concerned to note that on the plea of economy, the quantum of diet in Safdarjung Hospital was reduced from 400 gms. to

300 gms. Any reduction in diet for the sick and the needy should have been preceded by an expert examination of the issue from the nutritional point of view. The Committee, however, note in this connection that the Secretary Ministry of Health has assured during evidence that the Director General, Health Services, the Adviser (Nutrition) and the three Medical Superintendents would jointly work out a formula so that the procedure regarding diet could be systematised and followed uniformly in all the hospitals of Delhi. The Committee would like to be informed of the outcome of the joint discussions.

4.51. The Committee further note that the number of excess diets issued as compared to the number of patients accounted for during mid-night Census in Safdarjung, Willingdon and Irwin Hospitals in 1974-75 was 40,254, 32,473 and 24,856 respectively which represented 9.9, 17.0 and 6.0 per cent. The reason for excess diets in Irwin Hospital is stated to be on account of large number of patients on the floor having been not shown in the mid-night census. In the case of Willingdon Hospital it has been stated that though Medical Officer concerned issues the discharge slip in the morning the patient is removed only in the evening with the result that he takes extra lunch. The Committee are not convinced by the plea advanced by the Ministry as in Safdarjung Hospital, where the percentage of excess diet is 9.9 as compared to 17.0 in Willingdon Hospital, large number of patients come to the hospital, from the outside and when they are discharged in the morning they leave the hospital. The Committee emphasise that the matter should be gone into in depth and the problem resolved. One method to achieve the purpose is to fix norms which should be strictly adhered to. The Committee are constrained to note that whereas economy in expenditure on diet is being thought of by reducing quantum of diet, other measures to effect economy without diminishing the quality and quantity of diet such as plugging leakages of diet, have not been given the attention they deserved. In the opinion of the Committee the leakage of diet may possibly be one of the reasons for issue of excess diets over the census figures. Therefore, it is necessary that institutional arrangements are made to watch that leakages of diet and dietary materials do not take place. The Committee would like to be informed about the measures taken and proposed to be taken in this regard.

4.52. The Committee note that cost of diet per patient per day in Nursing Home and General Wards is Rs. 13.59 and Rs. 2.95 respectively. The Committee further note that the calories supplied through the diet in General Wards and Nursing Home are 2450 and 3950 in case of vegetarian diet and 2650 and 4400-4500 in case of non-vegetarian diet respectively. Though to some extent it may be desirable that the patients coming to the Nursing Home, where charges are levied for diet, be served better food the Committee feel that large gaps in the calorific values of diets served to the

patients in the Nursing Home and General Wards may be avoided. It should be ensured that so long as a patient is in Hospital he should get diet which is therapeutically necessary. The Committee would like the Government to review the position and apprise them of the decision taken in the matter.

4.53. The Committee are concerned to note that although the expenditure on diet cost per patient per day in Nursing Home came to Rs. 13.59, only Rs. 7 (fixed in 1954) were being recovered as diet charges both from CGHS beneficiaries and the members of the public making use of the Nursing Home. What is more distressing is the fact that the question of revision of the rate of Rs. 7/- has been under consideration since July, 1974 and it was only in April 1976 that orders for revision of the rates that is Rs. 10/- per day for vegetarian and Rs. 12/- for non-vegetarian diet, were issued. The Committee find no justification whatsoever for giving gratuitous benefits to the affluent sections of the society who could afford to pay for a higher food bill, by recovering a paltry sum of Rs. 7/- as diet charges from patients admitted to the Nursing Home. It is inexplicable how a rate fixed in 1954 should have continued without a change till 1976. The special consideration shown to a special class of patients is indefensible.

4.54. The Committee note that patients from the general public can make use of 10 per cent of the rooms in the Nursing Home on payment of room rent and clinical charges. With the augmentation of accommodation in the Nursing Home, as mentioned in the previous Chapter, the Committee hope that it would be possible to admit a larger number of patients from the general public. The criteria of admission should be not the social status of the patients but the gravity of the illness. The Committee desire that a set of guidelines governing the admission to the Nursing Home should be worked out for general application.

4.55. The Committee note that in case of Blood Bank in Willingdon Hospital, a test check of indents for blood from the Bank during the period from January to July, 1975 had revealed that against 18 units of blood recommended by the doctors in the Nursing Home 19 units of blood were actually supplied while dealing with most urgent cases whereas in General Wards only 14 units of blood were supplied against 40 units recommended by the doctors. Similarly, the routine cases also all the recommended units of blood were supplied in Nursing Home whereas in General Wards only units of blood were supplied against a demand of 8 units.

4.56. As the life of a patient whether in General Ward or in Nursing Home, is equally precious, the Committee feel that no discrimination may be made while supplying the recommended units of blood. To overcome the problem of deficiency of blood in the Blood Banks, the Ministry should in cooperation with voluntary organisations and with the Red Cross mobilise public opinion for donation of blood to the blood banks.

4.57. The Committee regret to note that an imported disinfector plant for mattresses, pillows and blankets, acquired by the Safdarjung Hospital in 1960 at a cost of Rs. 0.75 lakh worked erratically up to March 1974 and thereafter it went out of order for want of spare parts and non-availability of furnace oil. It has been stated that after acquiring the furnace oil storage tank of the capacity of 9000 litres in August, 1976 the plant has been again put into operation. The Committee need hardly point out that timely action should have been taken to put back into operation the disinfector plant. As matters stood, it is only after the Audit Report that the Ministry took corrective action.

4.58. The Committee have been informed that in Willingdon Hospital, mattresses, pillows and blankets are disinfected by exposing them to Sun. In Irwin Hospital disinfection is done with steam by the mechanical laundaries. In this connection, the Committee would like to point out that the Delhi Hospital Review Committee had recommended in 1968 that in order to reduce cross-infection in wards in each hospital mattress sterilizers must be provided and that blankets should be chemically sterilised. The Committee regret that although a decade has elapsed since the recommendations of that Committee were made, no provision of mattress sterilizers has been made in the hospitals. The Committee would like that the question of sterilization of hospital beds etc. should be given a high priority and conclusive action taken to remedy the existing deficiencies in this regard.

4.59. The Committee have been given to understand that a Group was constituted on 9 August, 1976 by the Ministry of Health to investigate the appearance of Salmonella Newport in Delhi hospitals, its origin, the effect it had had in terms of mortality and morbidity and the measures that have been taken so far by the hopsital authorities to check the spread of this infection. This Group is stated to have also been asked to assess the effectiveness of the machinery that exists in the hospitals to monitor and control the hospital cross-infection and to suggest measures for detection and control of such infections. The Committee would like to be informed of the findings of the Group and the conclusive action taken in pursuance of its recommendations.

4.60. The Committee regret to observe that the medical check up of the staff in the kitchen and other staff handling food, required to be done once in six months, had not been done for 6 years in the Irwin Hospital. The plea of the Ministry that such check-up could not be done because the Staff surgeon was changed quite often is not at all convincing. If anything, it speaks poorly of the hospital

administration. The Committee would like that medical check-up of the kitchen staff should invariably be done once a year and that responsibility for medical check up of the staff working in the hospitals should be fixed on the Administrative Officer in each hospital. The staff working in the hospital Kitchen should be provided with the requisite uniform.

4.61. The Committee are constrained to note that a survey conducted in July, 1975 by Nutrition Cell of Director General, Health Services, in Willingdon Hospital had found the washing facility inadequate for keeping utensils hygienically clean, cloak room and sanitary conveniences dirty and poor. The Committee also noted on their visit to the Willingdon Hospital in August, 1976 that the kitchen needed adequate light and white washing. To the surprise of the Committee even the cooking utensils were not adequately nickel plated from inside. The Committee deplore the casualness on the part of the hospital authorities for not taking sufficient care to observe the basic precautions against infection and cross-infection due to unhygienic conditions in the kitchens.

4.62. The Committee note that the kitchen in Willingdon Hospital which was constructed to meet the requirements of 250 patients, has to cater to the needs of the present bed-strength of 730. As a result of this, the unsatisfactory and congested conditions are bound to grow up in the kitchen itself. The Committee find that the proposal for building a new kitchen made in March, 1972, could not materialise for lack of funds in the Fifth Plan. The Committee need hardly stress that the construction of new kitchen in the hospital equipped with appropriate cooking facilities should be taken up on a priority basis.

4.63. The Committee find that the present capacity of laundry to wash linen is 4000 pieces per day in Safdarjang Hospital, 1600-2000 in Willingdon Hospital and 2500-3000 in Irwin Hospital. The number of linen pieces washed during 1975-76 was 10.20 lakh in Safdarjang Hospital whereas 4.32 lakh and 7.14 lakh pieces of linen were washed in Willingdon and Irwin Hospitals respectively during the same year. Though the position has improved in 1975-76, still much remains to be done. The Committee have been informed that a modern laundry is proposed to be set up in the Willingdon Hospital. The Committee would like the construction of the laundry to be expedited. It should also be ensured that the existing capacities in the other two hospitals for washing are fully utilised.

CHAPTER V

(A) Rehabilitation Centre of Safdarjang Hospital

Audit Paragraph

5.1. The rehabilitation department in Safdarjang hospital helps handicapped patients to go back to their normal lives. It has five sections, viz. physiotherapy, occupational therapy, psychology, vocational centre and workshop. The physiotherapy section treats patients by electrotherapy and exercises and the occupational therapy by therapeutic arts and crafts. The vocational section imparts job-oriented training and helps in getting employment for the handicapped. The psychology section renders treatment to mentally sick patients and workshop helps by manufacturing essential equipments. The department attended to 71,430,77,355 and 75,157 cases in the O.P.D. during the three years ending December 1974 respectively.

5.2. The workshop attached to the department prepares on order artificial limbs, calipers, corsets and shoes prescribed for the patients. Due to heavy work-load in the workshop the patients have to wait for a long time for getting these appliances. The number of pending orders is large in leather and shoe sections due to shortage of staff. Out of the three posts of shoe-makers, one has been lying vacant since June 1971. Out of the three hospitals, only Safdarjang hospital has the centre for supply of artificial appliances.

[Paragraph 30 of the Report of C&AG for the year 1974-75— Union Government (Civil)]

5.3. The following number of patients were attended to by the Rehabilitation Department of Safdarjang Hospital during the period from 1972 to 1975:

Year	Number of patients
1972	71,430
1973	77,355
1974	75,157
1975	87,568

5.4. There is no Rehabilitation Department in Willingdon and Irwin Hospitals. However, the number of patients attended to by the Physiotherapy Department of the two hospitals during 1975 was as under:

Willingdon Hospital	..	55,132
Irwin Hospital	..	79,200

5.5. It is seen from the Audit paragraph that due to heavy workload in the workshop attached to the Rehabilitation Department of Safdarjung Hospital, the patients have to wait for a long time for getting their appliances. The Committee desired to know the number of orders pending in Leather and Shoe Section as on 31 December, 1975 and the date of the oldest order. In a note furnished to the Committee, the Ministry of Health have stated:

> "68 shoes and 56 jobs were pending in the Shoe Section and the Leather Section respectively on 31 December 1975. The oldest order in the Shoe Section dated back to 29-9-1975 which was delivered on 1-1-1976. The oldest order pending in the Leather Section was 4-1-1975, 23-4-1975, 9-4-1975, 12-7-1975 but all these orders have since been delivered."

5.6. The Ministry have further stated that most of these jobs were pending as the patients were not reporting to take the delivery. In reply to a question as to whether the costs of the articles are not charged in advance at the time of placing orders, the Ministry have stated:

> "Patients are usually asked to deposit 50 per cent of the estimated cost of the appliances. The advance money is adjusted against the total cost when the appliances are delivered to the patients. In cases, where they do not have the full amount of 50 per cent, they are asked to deposit whatever amount they can deposit. But these are only applicable to the exceptional and deserving cases. Since the patients haev deposited the money in advance repeated reminders are sent to the patients to pay the balance and collect the appliances."

5.7. As regards the steps taken to expedite the work, the Ministry have stated:

> "We had appointed one Shoe-maker on daily wages from 26-2-1976 to 29-4-1976. In the meantime, we got sanction for creation of two additional posts of Shoe-makers and 3 posts of Leather workers. These posts have been filled up. All the jobs pending on December 31, 1975, have been delivered to the patients. Previously, on an average 3-4 months was the waiting time which has now been reduced to 4 weeks to 6 weeks."

5.8. During their visit to Safdarjung hospital on 11 October 1976, the Committee found the Rehabilitation Department, which was located in barracks, over-crowded. The rooms though well-equipped, were dark and dingy. The patients had to wait for long period before they could get proper attention. The Committee were informed that the patients were charged for supply of artificial appliances.

5.9. In this connection, the Committee desired to know whether the supply of artificial appliances formed part of treatment and if so, why cost were charged from the patients, particularly from those who could not afford them. In reply, the Ministry in a note have explained:

> "Provision of artificial limbs and other appliances is not a part of treatment and as such they are not given free to any patient. Government of India however try their best to help poor patients by supplying these appliances at as low a cost as possible and as such charge for the cost of material only."

5.10. The Committee note that the Rehabilitation Department in Safdarjung Hospital helps handicapped patients to go back to their normal lives through its 5 Sections, viz. Physiotherapy, Occupational therapy, Psychology, Vocational Centre and Work-shop. The utility of the Department can be judged from the fact that the number of patients attended to by it has risen from 71,430 in 1972 to 87,568 in 1975. The Committee are, however, surprised to find that no Department rendering such varied services to handicapped patients exists in Irwin hospital which caters to thickly populated areas of Delhi. With this consideration in view as also to reduce the overcrowding at the Rehabilitation Department of Safdarjung hospital, the Committee need hardly emphasize that the feasibility of extending the existing physiotherapy Department in Irwin Hospital on the lines of Safdarjung Hospital may be examined so as to afford greater facilities to handicapped patients of Delhi city. The Committee are not happy about the accommodation provided to the Rehabilitation Department in Safdarjung Hospital. The rooms are crowded and congested and physiotherapy patients have to wait for a long time for getting proper attendance. The Ministry should see that the Rehabilitation Department functions under more congenial environment and that over-crowding is avoided by quicker attendance and service to patients.

5.11. The Committee regret to note that due to heavy workload in the workshop attached to the Rehabilitation Department of Safdarjung the patients had to wait for long time for getting their appliances. It is observed that 68 shoes and 56 jobs were pending in the Shoe and Leather Sections respectively as on 31 December, 1975. What is more regrettable is the fact that in spite of large number of pending orders in these Sections due

to shortage of staff, out of 3 posts of Shoemakers one had been lying vacant since June 1971. It appears that it was only, on the receipt of Audit comments that the need of filling up the vacancies was realised and one Shoemaker on daily wages was appointed on 26 February 1976. The Committee have been given to understand that two additional posts of Shoemakers and 3 posts of leather workers have been filled up subsequently. As a result of these appointments it has been possible to reduce the average waiting time of patients seeking artificial appliances from 3-4 months of 4-6 weeks. The Committee desire that in view of the urgency to rehabilitate the handicapped patients within the shortest possible time efforts may be made to further improve upon this average waiting time.

5.12. It has come to the notice of the Committee that supply of artificial limbs and other appliances does not form a part of the treatment and as such they are not given free to any patients. It has, however, been stated by the Ministry of Health that they try their best to help poor patients by supplying these appliances at as low a cost as possible. The Committee desire that the patients seeking artificial appliances should be categoriesd in different groups on the basis of their monthly income. For extremely poor patients the supply of these appliances may be treated as part of the medical treatment and such appliances supplied free of cost.

(B) Eye Bank

Audit Paragraph

5.13. One of the two eye banks in Delhi is located in Irwin hospital, the other being located at All India Institute of Medical Sciences. The bank registers donors, collects eyes on their death and performs corneal transplantations. During 1972-73 to 1974-75 the bank collected 644 eyes for keratoplasty and carried out 543 transplantation operations. The eye department of this hospital has also facilities for fitting patients with contact lenses on payment.

[Paragraph 30 of the Report of the C&AG for the year 1974-75, Union Government (Civil)]

5.14. Following are the number of eyes collected and transplantation operations done in Irwin hospital during the period from 1972 to September, 1976:—

	1972-	1973	1974	1975	1976	(upto 25 Sept. 76)
Donor eyes collected	317	305	172	105	107	
Keratoplastry	300	289	156	97	93	

5.15. The declining trend of the number of eyes collected and transplantation operations done from 1972 to 1975 has been explained by the Ministry of Health thus:

> "In 1972 and 1973 the unit had a Professor and one Assistant Professor. Therefore the output was high. In 1974 the Professor was on leave from May onwards and resigned later in the year. Therefore for all practical purposes the unit had only one Assistant Professor. In 1975 the lone incumbent, one Associate Professor (promotee Assistant Professor) was on training abroad for 4 months and therefore the figures declined. In 1976, the trend has reversed in the opposite direction. Figures show a perceptible rise even though the department still continues to function with one Associate Professor."

5.16. In view of the fact that from 1974 onwards the eye bank in Irwin Hospital worked with only one Professor as against two in 1972 and 1973, the Committee desired to know as to why the vacancy was not filled up during these years. To this, the Ministry have stated:

> "No post of Professor in the Eye Department in Irwin Hospital was lying vacant from 1974 onwards. Only for a short period the post of Professor and Head of the Department was vacant because of resignation by the Head of the Department. One Associate Professor was abroad for training for 4 months and for such terms vacancies for posts are not filled as it is not possible to recruit highly qualified and trained staff for short period."

5.17. According to the Audit Paragraph there are two eye banks, one in the Irwin hospital and other in All India Institute of Medical Sciences. The Committee enquired whether these two banks are adequate to meet the present needs of eye transplantation. The Medical Superintendent of Irwin hospital has stated during evidence:

> "In Irwin hospital we have got an eye bank and the officer incharge is of the rank of Associate Professor. He is collecting eyes and he is also transplanting the eyes i.e. attending to the replacement of cornea. So far as Irwin Hospital and its neighbouring areas are concerned, it is adequate."

The witness has added:

> "We have started the construction of Guru Nanak Eye Centre which will have 300 beds. At the moment we have 74 beds for eye patients."

5.18. During their visit to Irwin hospital the Committee were given to understand that there were more doners of eyes than the capacity of the unit to handle. There was also the paucity of the staff. In this connection, the Secretary, Ministry of Health has stated during evidence:

> "Some trining is being to the people and this facility will be available all over the country in various medical colleges and in course of time things will improve."

Blindness

5.19. The problem of curable and incurable blindness in this country is posing serious public health, social and economic problems. The main diseases recognised as responsible for visual impairment and blindness in India are cataract (55 per cent), trachoma (5 per cent), infections of the eye (15 per cent), small pox (3 per cent), malnutrition (2 per cent), injuries (1.25 per cent), squint (0.25), glaucoma (0.5 per cent) and others (18 per cent).

5.20. There are about 45 million people suffering from visual impairment and over 9 million blind which include about 5 million who can be cured by proper surgical interference (i.e. 10 million operations or a backlog). It has been estimated that about 1.2 million intra-ocular surgical operations are required every year while there are only facilities for about 5 lakhs operations including those through eye camps and existing hospital facilities.

5.21. There are about 2,50,000 blind children in the country who have lost sight mostly due to nutritional deficiencies, injuries and squints. In a report of the working party of Indian Council of Medical Research on pre-school children, it is stated that 14,000 pre-school children suffer from vitamin 'A' deficiency eye problems at any one point. Most of the visual impairment and blindness are preventable or curable but there is woeful inadequancy of opthalmic services in the country, especially in rural, semi-urban and small urban areas. The total trained personnel available is about 3,500 eye specialists while the need is for 60,000 eye doctors calculating on a basis of one eye doctor for 15,000 population.

5.22. It is stated that in order to reduce the incidence of blindness for children due to nutritional deficiency, distribution of vitamin 'A' as a part of family welfare and nutrition programme has already been launched. It will prevent 2 per cent of the blind population from going blind particularly amongst the children. The Government of India has also launched a National Trachoma Control Programme since 1963 which is centrally sponsored. The programme has almost eliminated 5 per cent of blindness in the population covered because in these years blinding complications of Trachoma have been eliminated. This programme now will be integrated

with the National Programme on Prevention and Control of Visual impairment and Blindness as the two will overlap to a certain extent. The Government have already controlled small pox and this has taken care of 3 per cent of blind. In the course of intraocular surgery including cataract about 5 to 6 lakhs operations are being done by 100 and odd medical colleges, district hospitals, eye hospitals and eye camps. This leaves about the same number of unoperated (total annual requirement 10 lakhs operations).

5.23. As regards the cataract operations to be carried out, the Secretary, Ministry of Health has stated during evidence:

> "First of all, we are launching 85 per cent mobile teams in various divisions of the States. We will finance them, the Government of India will finance them and they will go from place to place and perform operations so that the people who need to be operated, are operated."

5.24. The Committee desired to know whether there were any plans to disseminate in different parts of the country the advantages of the new knowledge acquired through eye surgery of various descriptions. The Secretary, Ministry of Health, has stated during evidence:

> "In the Fifth Plan we have a scheme for prevention of blindness in the country. The number of blind persons is fairly large in our country. Our capacity for performing operations is only 6 lakhs while the backlog is about 1.5 million. Therefore, in consultation with the Planning Commission we have evolved a scheme which is known as the Scheme for Prevention of Blindness. It has various contents. It is also a part of the plan that there would be regional institutions, super-specialist service would be made available. Training programme is already on in the Rajendra Prasad Eye Hospital attached to All India Institute of Medical Sciences. Similarly there is an institute in Bangalore where this sort of treatment and training is going on. It is also going on in Sitapur hospital. These will be the focal point from where the people will radiate with training.
>
> It has also been decided that the Government of India will give support, financial or otherwise, to the setting up of such centres in all medical colleges in the country. We have 107 medical colleges at present in the country and we do hope that in course of time this expertise will be sufficiently disseminated and dispersed to be available to the people in various parts of the country."

5.25. In a note submitted to the Committee the Ministry of Health have stated that the Scheme for prevention of blindness in the country, has since been cleared and taken up for implementation. The details of the scheme are given in Appendix.... It will be seen from the Appendix that under the scheme there is provision for providing diagnostic and treatment facilities in the rural and Taluka and even district hospitals. Mobile ophthalmic units are to be established in order to provide medical and surgical treatment, educate people in the methods of prevention of eye diseases and take care of ocular health of school children. There is also a proposal for setting up regional institutions with a view to operating eye-banks, having ophthalmic specialists and providing medicals for research in banks, having ophthalmic specialists and providing medicines for research in ophthalmology. Some international agencies to WHO, SIDA, DANIDA etc. have evinced keen interest in the programme and have extended financial help in a big way.

5.26. The Committee are concerned to note a steep decline in the number of eyes collected and transplantation operations carried out in Irwin Hospital as they find that against 305 eyes collected in 1973, the number had fallen to 172 in 1974 and 105 in 1975. Similarly, against 289 eye transplantation operations conducted in 1973, the figures for the years 1974-75 were only 156 and 97. Though the position has improved in 1976 (as 107 eyes have been collected and 93 operations carried out upto September 1976), it is still far from satisfactory considering the gigantic magnitude of the problem. The Committee have been informed that the reasons for substantial decline in the number of eyes collected and transplantation operations carried in 1974 was that against the strength of 2 Professors (one Professor and one Assistant Professor) in the Eye Bank Unit, one Professor went on leave from May 1974 and resigned later in the year. The Committee are surprised that instead of filling up the vacancy, the lone Associate Professor was sent on training abroad for 4 months in 1975 without making alternate arrangement and this further handicapped the Eye Bank in its work. During their visit to the Irwin Hospital on 14 October 1976 the Committee were given to understand that there were more donors of eyes than the capacity of the Unit to handle which was limited due to the paucity of the staff. The Committee feel that the delay in filling up the vacancy created in 1974 cannot be the only reason for the declining trend in collection of eyes and carrying out operations during 1974 and 1975 as it can be seen from the fact that the position in this respect has improved in 1976 even though the Department still continues to function with one Associate Professor. The Committee would like the Ministry of Health to investigate the specific reasons for this decline and take suitable remedial measures in this behalf. In order that the Eye Bank and Keratoplastry Unit are able to serve a larger number of patients, the Committee desire that the Ministry of Health should examine as to how the existing facilities can be augmented for the betterment of the community in general and the poorer sections of the population in particular.

5.27. It is a matter of great concern that there are over 45 million people suffering from visual impairment and over 9 million blind which include 5 million who can be cured by proper surgical interference. About 1.2 million intra-ocular surgical operations are required every year while there are facilities for about 5 lakhs operations only. The problem of curable and incurable blindness in this country is posing serious public health, social and economic problems.

5.28. The Committee note that in order to prevent blindness in the country a national scheme for Prevention of blindness included in the current five-year Plan has been cleared and taken up. Under this scheme there is provision for providing diagnostic and treatment facilities in the rural and taluka and even district hospitals. Mobile ophthalmic units are to be established in order to provide medical and surgical treatment, educate people in the methods of prevention of eye diseases and to take care of ocular health of school children. There is also a proposal for setting up regional institutions with a view to operating eye-banks, training opthalmic specialists and providing facilities for research in ophthalmology. The Committee desire that the scheme for prevention of blindness should be energetically implemented so that there is a positive improvement within the shortest possible time in the ocular health of children both pre-school and school-going, and vulnerable groups given top priority within a time-bound schedule. The Committee would like to be apprised of the progress made in this regard and results achieved thereof.

CHAPTER VI

MACHINERY AND EQUIPMENT

A—X-rays

Audit Paragraph

For diagnostic purposes the hospitals provide for special X-ray tests included barium meal for tracking ulcers in the abdomen and I.V.P. for determining the condition of the kidneys. The number of special X-ray tests conducted during 1974-75 and the period for which the patients had to wait before X-rays could be taken in these hospitals is given in the table below:

	Safdarjung	Willingdon	Irwin
(i) Number of barium meal tests done	3,300	1,126	2,943
(ii) Number of I.V.P. tests done	1,500	1,401	1,543
(iii) Waiting time for barium meal and I.V.P. tests :			
a) for inpatients	1 to 10 days	7 to 15 days	1 to 5 days
b) for outpatients	8 to 12 weeks	6 to 12 weeks	10 to 15 days
(iv) Total number of machines available	4	2	4
(v) Total number of machines utilised	1	1	4

6.2. For manning 23 X-ray machines (inclusive of four meant for special investigations) 17 posts of radiographers have been sanctioned in Safdarjung hospital. Of these, the radiology department could spare one to two radiographers only on each day to undertake the special tests. According to the Ministry (December 1975) this staff was not able to cope with the work. Willingdon hospital has 14 sanctioned posts of radiographers for operating 13 X-ray machines (inclusive of two intended for special tests). Only one senior radiographer, who has other supervisory duties also, could be spared for carrying out special investigations in 1974-75. For handling dry as well as wet films at a time in three dark rooms the sanctioned strength of dark room assistants is only 2 in Willingdon hospital as against 9 in Safdarjang hospital for its three

dark rooms. Consequently, in Willingdon hospital the work is generally entrusted to non-technical persons like nursing orderlies to cope with heavy rush. The Ministry stated (December 1975) that in Willingdon hospital "the time lag will be reduced when new X-ray Department is opened. The delay is also due to non-availability at times of contrast dyes, many of which are imported. Attempt is, however, made that emergent cases are not delayed."

[Paragraph 30 of the Report of the Comptroller & Auditor General of India for the year 1974-75, Union Government (Civil)]

6.3. In a note from the Ministry of Health the Committee have been informed that the total number of X-ray diagnostic machines in Safdarjung Hospital was 22 and out of which 17 machines were in working order. The number of X-ray therapy machines was 7. In Willingdon Hospital, the total number of X-ray machines was 14 including 8 installed machines and 6 portable machines. Out of these 14 machines, 13 machines were in working order. The total number of X-ray diagnostic machines in Irwin Hospital was 14. All the 14 machines were in working order. The total number of X-ray therapy machines was 3.

6.4. The Committee desired to know since when the 5 X-ray diagnostic machines were not in working order in the Safdarjung Hospital and what steps have been taken to put them to commission them. In reply, the Ministry have stated:

"The details are as under:—

1. 1000 MA G.D.R. X-Ray Unit went out of order in August 1976 and was repaired in October 1976.

2. 200 MA Redon House X-ray Unit went out of order in July 1976 and was repaired in October 1976.

3. *Watsons Mass Miniature Camera*:—It went out of order five years ago in 1971. M/s. Escorts were asked to undertake repairs. They replied that the Camera had become obsolete and spare parts were not available here and it should be condemned. It has now been condemned.

4. 30 *MA Mobile X-ray Unit (Escorts Make)*:—It went out of order in May 1975. M/s. Escorts were asked to examine and do the repairs. They have given a very prohibitive estimate of about Rs. 14,000|-. It was considered to be uneconomical to spend Rs. 14,000|- on an old X-ray unit, so it has been considered advisable to condemn this unit. It is 13 years old.

5. 60. *MA Ward Mobile X-ray Unit (Philip make)*:—It is out of order since January, 1976. M/s. Phillip were asked to examine and do the repairs. They have reported that spare parts were not available as the Unit is an absolete one. It was purchased twenty years ago. Therefore, it is being condemned."

6.5. The Committee enquired the reasons for not getting the machines repaired in time. The Additional Secretary, Ministry of Health and Family Welfare has stated during evidence:—

"These machines from East Germany and Russia etc. were obtained on concessional terms and perhaps we did not find out about spare parts availability within the country. Lack of servicing facility near Delhi is one of the major headaches which the Medical Superindendents are facing."

6.6. The Committee pointed out that certain machines were lent to Vellore Hospital and were returned in 1971 in damaged condition. When enquired of the reasons for not taking timely action to set them right, the Director General of Health Services has state:

"In emergent circumstances at that time because the machine in Vellore hospitals had gone out of order this machie was loaned to Vellore hospital. There was some fear of damage during transit but all precautions were taken so as to see that no damage is done. Even then on receipt it was found that it has got damaged. Immediate steps were taken to get in touch with the producer and they were claiming that board will be replaced. The cost of the machine is Rs. 1 lakh whereas the cost of the board would have been 25,000. We waited till ultimately they said that they have contemplated not to manufacture the boards but will replace the whole machine. Similarly, in regard to GDR machine the GDR said that they will send their representative to see the machine. Then they came to the conclusion that this had become an old model and they are prepared to give the new model at a cost which was considered not wise. Sir, this is a new sophisticated speciality in which numerous developments have taken place. In order to use this machine—as has been pointed out—blood has to be used. In view of all these circumstances this decision has been taken to condemn the machine."

6.7. The Ministry of Health and Family Welfare have informed the Committee that during 1975-76, the total number of special X-ray tests

conducted in Safdarjang Hospital, Willingdon Hospital and Irwin Hospital was 4985, 4035 and 6492 respectively. The Committee pointed out that while the number of X-ray machines available in the three hospitals differed, the special X-rays done on them were not in the proportion to these X-ray machines. The total number of special X-rays done in Safdarjang Hospital on 17 machines was 4985, in Willingdon Hospital and Irwin Hospital the total number of special X-rays done on 13 machines in each was 4035 and 6492 respectively. The Committee enquired the reasons for these variations. The Secretary of the Ministry has replied:

> 'This figure is in respect of special X-rays. The number of ordinary X-rays has not been mentioned. These machines are being utilised for ordinary as well as special X-rays. If you take into consideration the total number of X-rays done then you will see these machines have been fully utilised there also."

6.8. With regard to long waiting time taken for the special tests, the Committee have been informed that the Deputy Director General (Medical) Health Services in his Inspection Report on his visit to X-ray Department of Safdarjang Hospital on 5.9.1973 had observed *inter alia* the following:

> "Waiting period for these investigations is one week for the ward patients and two to three months for the O.P.D. patients. In view of the long waiting time for the ward patients resulting in unnecessary pressure on the hospital beds and for the O.P.D. patients causing inconvenience to them, the question of reducing this period was discussed with Dr....., Chief Radiologist in the presence of Medical Superintendent, Dr.....pointed out that they have sufficient X-ray machines...Out of 7 rooms where X-ray Units rae installed only 4 are being utilised due to shortage of staff. He pointed out that if he could be given two more Radiologists and four more Radiographers it would be possible for him to commission all the 7 rooms and thereby reduce the waiting period considerably, i.e. 2 to 3 days for the indoor and 1 to 2 weeks for the O.P.D. I feel the demand is quite justified."

6.9. The Committee pointed out that in Safdarjung Hospital a patient had to wait for quite a long time and patients with barium meal X-ray had to wait for two three months, and enquired the steps proposed to be taken to reduce the waiting time The Medical Superintendent, Safdarjung Hospital has said during evidence:

"In urgent cases the X-ray is done within 24 hours whereas in the case of these who can wait future date is given. No urgent case which requires X-ray is refused or asked to come after four to six weeks."

6.10. In reply to a question, the witness has stated:

"If there is a patient of appendicitis and you want to take barium meal X-ray and then follow it up, then the patient can wait and have it done during one to three months time."

In reply to another question, the witness has assured the Committee that every case which required immediate X-ray was attended to.

6.12. The Committee pointed out that the National Institute of Health Administration and Education which had undertaken a study of X-ray Department of Willingdon Hospital in 1972 had observed that daily on an average 8 or 9 patients were turned back during morning hours due to inability of the Department to serve them and the Institute had suggested that the afternoon timings of the main X-ray Unit which was mainly used for in-patients should also be used for out patients. The Medical Superintendent, Safdarjang Hospital, has stated:

"Those cases are not urgent. We cannot fill up an X-ray form without examining a patient and it is only after examining by the clinician that he writes whether an X-ray investigation is urgent or it could wait. In urgent cases registration is done even after 11.30. urgent cases are never refused."

6.13. As regards the staff attached to X-ray Units in the three hospitals, the Committee have been informed that in Safdarjang Hospital, 19 Radiographers, 3 X-ray Assistants and 9 Dark Room Assistants were posted. In Willingdon Hospital, there were 14 Radiographers and 2 Dark Room Assistants and in Irwin Hospital out of the sanctioned strength of 22 Radiographers, 21 Radiographers were posted.

6.14. The Committee pointed out that the National Institute of Health Administration and Education had in 1972 recommended that with the optimum utilisation of staff it was possible to reduce the number of X-ray films missing. Explaining the position the Director General of Health Services has stated:

"I can say only that two things happen. Just as in photography, similarly in X-ray also, because of the light, etc. exposure may not be corect and information wanted of the X-ray may not be adequate for the treatment of the patient and therefore x-ray has to be repeated; this often happens in urgent cases.

Secondly, there is this point. There has been a persistent demand in Safdarjang hospital that the staff in the X-ray department was inadequate. I must confuess that we had a long session in the staff inspection unit but they in their wisdom did not come to the conclusion that additional staff was necessary. Besides X-rays like barium meals, etc. can only be done by the medical officer, not by the radiographer. About mixing up, as far as I remember, no case came to my notice while I was there and I do not know whether any such case has come to the notice of Dr. Pramanick."

6.15. The Medical Superintendent, Safdarjang Hospital, has stated:

"I do not think that there is any justification for missing of films. But there is a possibility that it may be missing because we have to take about 400 X-rays every day. The possibility of it being misplaced cannot be ruled out. So far, nothing has come to my notice that such and such X-ray has been found missing."

6.16. The Medical Superintendent, Willingdon Hospital, has explained:

"Sometimes it happens that because of illegible writing, X-rays are diverted to some other Department. For example, for Surgical Department, they might have been sent to O.P.D. or some other Department. But with a little effort, X-rays are usually found. It is very rare that X-rays are not found. The workload is very heavy, about 400 X-rays are taken every day and we have to distribute them at 40 points. Sometimes it may happen that a few of them might have been mis-despatched."

6.17. The Audit paragraph points out that in Willingdon Hospital non-technical persons like nursing, orderlies were entrusted work in X-ray dark rooms to cope with heavy rush of work. Enquired whether the non-technical persons were able to properly perform the duties in the dark rooms, the Ministry in a note furnished to the Committee have stated:

"All the dark room assistance are generally drawn from Group D Staff only (previously Class IV). Experinenced non-technical persons 'Group D Staff' are able to perform the routine duties in the dark room satisfactorily."

6.18. The Committee find that out of 5 X-ray machines having gone out of order in Safdarjang Hospital, two machines were repaired after a

period of 3 to 4 months. One which went out of order in 1971 has been condemned now as its spare parts are not available and the remaining two which went out of order in 1975 and 1976 have also been condemned as these have become obsolete. The failure of the hospital authorities to take timely action to get these machines repaired or to take concurrent action to obtain supplies of maintenance spares when the machines were purchased is regrettable. The Committee note that it was only after the Audit Report that action was initiated for getting the machines repaired. The Committee urge that a half-yearly review of the working of the X-ray machines in the three hospitals should be made so as to take timely action to rectify the defective ones. Urgent action may also be taken to dispose of the obsolete machines and to indent for the new ones in accordance with the procedure laid down for this purpose.

6.19. The Committee are concerned to note that patients have to spend a long time for getting themselves X-rayed in the three hospitals. According to the audit para the waiting time for barium meal and I.V.P. tests for out-patients in Safdarjang, Willingdon and Irwin Hospitals is 2 to 12 weeks, 8 to 12 weeks and 10 to 15 days respectively. The Committee need hardly emphasise that the hospital authorities should find ways and means to reduce the present waiting time so that early treatment of patients may be started. The Committee also desire that patients needing special tests should be given perior appointment so that they need not wait unnecessarily. The patient with prior appointment need not be registered again on the appointed date of visit so that his time is saved.

6.20. Since a number of patients are turned back during morning hours due to incapacity to serve them, the Committee recommend that afternoon timings of the main X-ray Unit which is generally used for in-patients only may be used since during this time the men and machines are idle for most of the time.

6.21. The Committee are distressed to note that in spite of the recommendations made by the Deputy Director General Health Services in his Inspection Report on his visit to Safdarjang Hospital on 5 September 1973 that to reduce long waiting time for the ward patients as well as O.P.D. patients, more staff should be attached with the X-ray units, no positive and conclusive action appears to have been taken so far to review and augment strength of the staff of X-ray units of the hospitals. The Committee need hardly emphasise that the matter should be gone into urgently so as to effect qualitative improvement in the working of the X-ray units in the three hospitals. The usefulness of the available machines for diagnostic purposes and the manpower required to handle them should be critically gone into.

B. Artificial Kidney Machines

Audit Paragraph

6.22. For dealing with acute and chronic cases of renal failure, artificial kidney machines are used for conducting haemodialysis. For this purpose Safdarjang hospital had acquired four imported machines (costing about Rs. 45,000 each) during 1963—70. All these machines stopped working by April 1973. The Ministry stated (December 1975) that one of these machines "is working since 27th October 1975. The other machines are not working on account of difficulty in the procurement of spare parts." In Irwin and Willingdon hospitals one machine each was procured in 1970 and 1960 respectively; they have not functioned satisfactorily since then. The Ministry stated (December 1975) that the machine in Irwin hospital "did not function properly due to defective membrane but during the last 3 months it has been used successfully 6 times." In Willingdon hospital the machine was stated (December 1975) to be in working order but was not being used for want of trained medical officer in the speciality. The Ministry stated (December 1975) that Willingdon hospital has "deputed a medical officer to A.I.I.M.S. for training. The unit will start working when he returns after training."

[Paragraph 30 of the Report of the Comptroller & Auditor General of India for the year 1974-75, Union Government (Civil)]

6.23. The Committee desired to know the steps taken by Government for proper functioning of the costly artificial kidney machines in the three hospitals. The Ministry in a note furnished to the Committee, have stated:

"There have been technical advances in the field of Artificial Kidney Machines and the models purchased in early years are out of date and difficult to operate.

The procedure for haemo-dialysis has undergone improvement in recent years. Whereas the older machines require priming with donor's blood (with consequent likelihood of infection and cross infection) and take about 10 hours for one dialysis, the newer machines do not require any priming and take only about 5 hours.

The machines in the hospitals went out of order due to various reasons like lack of local servicing arrangement and non-availability of spare parts etc.

For ensuring smooth working of costly imported machines, these are generally purchased from manufacturers (or their authorised agents) who have adequate arrangements for servicing

and repairing of equipment supplied. The hospital authorities on their part ensure that only trained personnel who are available are allowed to handle them.

The present position of the artificial kidney machines in the three hospitals is as under:—

Safdarjang Hospital

Out of 4 machines the following three are out of order:—

(i) *GDR Machine*: This was purchased in 1966 and went out of order in June 1969. The matter was taken up with the representatives of GDR but they could not repair the machine. In May 1971, engineers from GDR visited the hospital and informed that spare parts required for repair were not available as manufacture of this unit had been stopped. It is proposed to condemn this machine.

(ii) *Kill Machine (American)*: This machine was purchased in 1966 and was in use till 1970, when some parts of this machine like board with clamps which hold the machine, were loaned to the Christian Medical College, Vellore. These were received back in 1971 in a damaged condition. Action for procurement of board from abroad is being taken.

(iii) *Russian Machine*: This was bought in 1972. It was in working condition for about 1 year. In May 1973, the gasket of this machine got burnt. The membranes required for dialysis are not available. It is now proposed to condemn the machine.

Willingdon Hospital

The GDR (Kedons) Machine purchased in 1959 is out of order. It is now considered uneconomical to work the old model which requires an input of six units of blood.

Irwin Hospital

The existing East German model has been functioning erratically, due to defective membrane and dialyser, which could not be repaired by the East German Engineers who were summoned by the local representatives of Madras of the East German Firm. However, this mechine can be put into action with alternative accessories (dialyser and membrane) which have already been sanctioned by the Delhi Administration."

6.24. The Committee enquired whether the Directorate General of Health Services had assessed in advance the replacement of sophisticated machines like artificial kidney machines in the hospitals and had initiated and coordinated action in anticipation of the requirements. The Director General, Health Services, has stated during evidence:

> "The machinery for coordination between the various hospitals has so far not been fruitful and in the field of artificial kidney or sophisticated equipment, we could not do anything. Now, we shall certainly evolve a machinery for maintaining coordination and also an evaluation will be done as to what equipment is out of order and whether any of them require replacement or are to be condemned."

6.25. Supplementing the information the Secretary, Ministry of Health and Family Welfare, has deposed:

> "For major hospitals, we have Hospital Control Board and I am the Chairman of that Board. The D.G. is a Member and if I am not able to go and attend the Board meeting, then the Additional Secretary goes. We hold the meetings in the hospital concerned. These meetings are meant to be held every three months, but they have always been held at least thrice a year. At that time we review the stock position. We take into consideration the state of these mechines, which machines can be replaced or condemned, what can be done to reduce the workload, what can be done to improve the discipline, what can be done to improve the drug supply, what is the position regarding the Emergency and Casualty Wards, whether there is any problem which the Ministry could solve and such other matters. You are right that there is no coordination at the D.G.H.S. level. I may submit that these things are applicable in all hospitals of the Government of India. It does not apply to the Irwin hospital as such because this comes under the Delhi Administration."

6.26. The Committee asked what were the machines that required replacement. The Secretary of the Ministry has replied during evidence:

> "These dialyser machines have become very much out of date, in the sense that they are not workable now. The replacement cost is about Rs. 50,000. The machines which we have already got are not to be repaired. We are not thinking of replacing them but we are trying to buy new machines and condemn old ones for ever."

6.27. In reply to a question, the Secretary of the Ministry has stated that in future they would maintain inventory of sophisticated machines.

6.28. The Committee are distressed to note that three out of four artificial kidney machines which were imported for conducting haemodialysis at a cost of about Rs. 45 thousand each by Safdarjang Hospital are out of order. The GDR Machine purchased in 1966 went out of order in 1969; the Kill Machine (American) purchased in 1966 got damaged in 1971 and the Russian Machine bought in 1972 went out of order in 1973. The fourth machine which became unserviceable, in April, 1973 could be repaired in October, 1975 only. Similarly, the GDR (Kedons) Machine purchased in 1959 for use in Willingdon Hospital is also out of order and is uneconomical to work. The Committee note that some of these machines have been declared irreparable due to non-availability of spare parts and are now being condemned. Since these costly and sophisticated machines had become unserviceable within a period ranging from one to five years from the date of their purchase, the Committee have a suspicion that no attention was being paid to their maintenance. As these machines have been lying out of order for a number of years, the Committee would like to know whether this matter was brought to the notice of the Ministry of Health for advice. In any case the Ministry may conduct a probe into the working of these machines since their purchase. The Committee may be informed about the findings.

6.29. Since the procedure for haemo-dialysis has undergone improvement in recent years and sophisticated and easy to operate machines have come in the market, the Ministry should examine if newer machines could be acquired in place of those which have become obsolete. Alongside the acquisition of modern and sophisticated machines, the Ministry should take early action to build up a cadre of suitably trained persons to operate these machines. The D.G.H.S. should draw up a coordinated programme for the repair/replacement of sick/obsolete machines well in time so that the working efficiency of the various services/specialities of the hospitals does not suffer for want of equipment, machinery and necessary qualified staff to handle them.

6.30. The Committee also recommend that each hospital should maintain an inventory, which unfortunately was not being done, of sophisticated and costly machines including artificial kidney machines and the respective Hospital authorities should submit a half-yearly return to the Ministry regarding the working condition of each such machine.

C. Ambulance

Audit Paragraph

6.31. For bringing accident cases and patients suffering from serious ailments the hospitals are provided with ambulances. Out of the six

ambulances available in Safdarjang hospital, three are being mainly used as load carriers. The other three are used only partially as ambulances. A stretcher bearer accompanies the ambulance to bring the patients. The Ministry stated (December 1975) that "There has never been a case when the ambulance service of the hospital failed to bring a patient whatever the number of ambulances available with the hospital. However, the required number of vehicles, including ambulances are being obtained."

6.32. Out of four ambulances available with Irwin hospital, two have been out of order and off the road since January 1975 and May 1975 respectively. Out of 231 trips covering 3,107 kilometres undertaken by these vehicles during April 1975 to June 1975, only 84 trips covering 1,129 kilometres were for transportation of patients. A nursing orderly is sent, if available. The Ministry stated (December 1975) that action was being taken to get the vehicles repaired and put on the road.

6.33. In Willingdon hospital, four ambulances in working condition are available. It was, however, intimated (December 1975) that action had been initiated to obtain the required number of vehicles, including ambulances.

[Paragraph 30 of the Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil)]

6.34. In a note furnished at the instance of the Committee, the Ministry have explained the latest position regarding maintenance of ambulances in the three hospitals as under:

"*Irwin Hospital*: Out of the 2 ambulances which went out of order, one was repaired and recommissioned in November, 1975. This ambulance was purchased on 29-3-1968. The other ambulance is still out of order. It met with an accident in May, 1975 and this vehicle was once sent to Government workshop but the vehicle could not be repaired. Action has already been taken to get the ambulance repaired by inviting quotations from private workshops. This ambulance was purchased on 1-8-1966.

Safdarjang Hospital: There are six ambulances in the Safdarjang Hospital. Five are in good working condition. One is off road at present and is under repairs. It is expected to be in working order in the first week of October, 1976.

Willingdon Hospital: Out of 6 ambulances in the Willingdon Hospital, three are in working condition, 2 are under repair and one has been condemned."

6.35. The Committee enquired the reasons for not getting the ambulance belonging to Irwin Hospital, which met with an accident in May, 1975, repaired at the Central Health Transport Organisation. The Medical Superintendent, Irwin Hospital, has stated during evidence:—

> "We have four ambulances and three of them are on the road. One of them is still out of order and since the Government Organisation concerned with the repairs has failed to do it, we have now called for quotations and we have finalised and within a month this ambulance will be put on the road."

6.36. In response to a query, the Medical Superintendent, Safdarjang Hospital has stated:

> "These ambulances are sent to the Central Health Transport Organisation and they tried to repair as much as possible. We keep a check but our thinking is that this organisation is not doing very well."

6.37. In reply to a question, the Medical Superintendent, Willingdon Hospital, has stated:

> "We have very constant liaison with the Central Health Transport Organisation. They have some difficulties of their own also. They say that they do not have any revolving fund to buy spare parts. Every time they inspect the vehicle, prepare the estimate and ask us to buy spare parts. We have to run ourselves to buy the spare parts at a competitive rate. We buy the spare parts. At times the spare part has to be changed because the spare part purchased is not of the right type. At times this causes delay. They do not have sophisticated workshop and do not have sufficient spare parts."

6.38. Elaborating the position, the Director General of Health Services has stated:

> "This has been engaging our attention for a long time. We have all along been feeling that there should be an organised central ambulance service. In the beginning for this purpose phone '102' service was established. The centre was located in Safdarjang Hospital. The intention was anybody anywhere in Delhi wanting this service should ring 102 and 102 would inform the person concerned of the nearest hospital from where ambulance could be made available. At time 102 was not functioning and there were other difficulties felt.

This scheme was prepared in the year 1972—'Centralised Ambulance Service.' For this purpose a number of ambulances were given.

There were a number fleet of vehicles available with the Family Planning Department. It was decided that Delhi may be converted into six zones and a number of vehicles were allotted to each zone. This was in the year 1975. Some vehicles had been lying for some time. Therefore, it was uneconomical."

6.39. When enquired about the authority which looked after ambulances available with the Family Planning Department, the Director General of Health Services has stated during evidence:

"There were surplus vehicles with the Family Planning Department.

Five ambulances had been in operation for cases of road accidents. Police authority is the first to reach the place of accident. They have wireless. That service is working satisfactorily.

The vehicles which are more than 10 years old and which have been off the road should be taken for condemnation and replaced by vehicles of standard pattern. Study is being made as to how the Services of the Central Service of Civil Defence, Red Cross or fire Brigade might be utilised for the purpose."

6.40. The Committee asked whether the procedure regarding maintenance of ambulances could be streamlined and made more effective. The Secretary of the Ministry stated:

"We are greatly concerned about the inefficiency of this service. This is largely due to the old fleet not having been replaced and not having been maintained. We have taken the following steps.

We have persuaded the Department of Police as police is readily available and they have a wireless system. They have flying squad in each zone. We have told them to keep an ambulance also. Since they go to the place of accident or if somebody happens to ring them, they will send their own ambulance and transport the casualty to the nearest hospital. This is working satisfactorily. Five vehicles are working with them. This was done last year."

6.41. In reply to another question, with Secretary of the Ministry has stated:

"At the present moment the system is that the hospitals are asked to supply ambulance. This is obviously not working satisfactorily. Therefore, we propose to have a fleet of vehicles placed at the disposal of the fire brigade so that anybody can give a ring to them and they would be able to send the vehicle. Fire Brigade offices are in various zones. The nearest office of the Fire Brigade will pick up the patient to the hospital.

We have issued orders for the replacement of the old vehicles which were in those hospitals and which needed condemnation."

6.42. In reply to a further question, the Secretary, Ministry of Health and Family Welfare, has stated:—

"Hospital ambulances will be maintained. In addition there will be other services. Anybody ringing up for ambulance service will get the same on asking."

6.43. The Committee referred to the findings of the National Institute of Health Administration and Education which had studied the ambulance service in Safdarjang and Willingdon Hospitals and had observed that availability of ambulances in these two Hospitals was grossly inadequate. In both the hospitals, the ambulance was also used by staff members to get the doctors on call duty or leave the staff at their residence. As a result the ambulance services were not really available for the patients in need. Maintenance of the ambulances was a major problem and there was need for a simple system of ambulance maintenance. There was no internal communication system between the Casualty Medical Officer and the ambulance driver, with the result that a messanger had to be sent every time for the driver. When the Committee asked to elucidate the position, the Medical Superintendent, Willingdon Hospital, has stated:

"For want of ambulance no patient suffers because to call the doctor we have made this provision that if the staff car is not available, they are allowed to use taxi and we pay for it.

As regards patients, we see that at least two ambulances are always on the road. I may say that these ambulances are 10 years old and as they were used very roughly by the drivers not like our cars, you can imagine the condition of the ambulances. Now the Government has sanctioned four more ambulances of the diesel type where the maintenance will also be easy and cheap."

6.44. Clarifying the position regarding the use of the ambulances for purposes other than for carrying the patients, the Secretary of the Ministry has stated:

> "Sometimes utilisation of an ambulance for bringing a set of medicines from the depot is not resisted by the Medical Superintendent. It is curbed to the best possible extent. But there may not be much of an objection because this is a valid hospital use provided other services do not suffer.
>
> Similarly, the same thing applies to the utilisation of an ambulance for bringing a doctor. Suppose a doctor is away at a distance and night taxi service is not available. Ambulance is available. I hope you would not object to the doctor being brought in the ambulance."

6.45. The Committee asked whether any arrangement existed for treatment in the ambulance to serious patients. In reply, the Ministry have in a note explained the position thus:

> "Of the three hospitals, only Irwin Hospital has one ambulance with medical equipments and life saving drugs to provide medical care to the serious patients during their removal to the Hospital. Recently Police is providing ambulance service through 5 ambulances for accident cases. These ambulances are all equipped to provide necessary first aid treatment."

6.46. The Committee are unhappy to note that ambulances meant for bringing accident cases and patients suffering from serious ailments were not being maintained properly by the three hospitals. They also note that the number of ambulances maintained by the hospitals was not only inadequate but many of them were out of order for long periods. It is regrettable that in the face of shortage of ambulances sometimes, these vehicles were being used as load carriers for bringing machines etc. from the depot or for bringing doctors to hospitals from their residences. It is patent that hospital authorities had not taken sufficient care to ensure that the ambulances under their charge were being well maintained and were put to proper use.

6.47. The Committee have been informed during evidence that the Central Health Transport Organisation, which is responsible for carrying out repairs to ambulances, is "not doing very well" as it is not equipped fully, with the result that ambulances are not repaired in time. This Organisation has also not revolving fund to buy spare parts and as such the hospital authorities are asked every time to buy spare parts for their vehicles. This procedure takes a long time in carrying out the required repairs. The Committee need hardly emphasise that the working of the Central Transport

Organisation may be reviewed urgently with a view to bring out deficiencies and short-coming, for remedial action. The Committee would like to be assured that this organisation has been provided with the requisite facilities for carrying out repairs to hospital vehicles promptly and efficiently.

6.48. The Committee also recommend that Government should urgently and seriously consider the feasibility of establishing an organised central ambulances service to meet the needs of people of the city. Such an organisation should have functional coordination with other bodies like Red Cross, Police, Fire Brigade etc. so that ambulances may be available from a number of sources and patients may not suffer on this account. The Committee would like to be informed of the Government's decision in this regard. Incidently the Committee would like to stress that the ambulances should be road worthy at all times and their maintenance should be looked after by a senior functionary of the hospitals. This officer should maintain a proper log book and register for all the ambulances and also keep a record of distances covered and P.O.L. used.

6.49. The Committee note that of the three hospitals, only Irwin Hospital has one ambulance with medical equipments and life saving drugs to provide medical care to the serious patients during their removal to the hospital. The Committee desire that more such ambulances should be provided in other hospitals as well.

CHAPTER VII

DRUGS AND MEDICAL SUPPLIES

Audit Paragraph

Purchase of medicines

The requirement of medicines, including surgical dressings, is worked out before commencement of the financial year on the basis of actual consumption during the previous year. The three main sources of procurement are the Medical Stores, Depot, Karnal, firms on the D.G.S.&D. rate contracts and the open market. The expenditure on purchases made from the open market was 63.93 per cent of the total expenditure on purchases made by the three hospitals during the year 1974-75 as indicated below:

	M.S.D. Karnal	Purchases through D.G.S.&D. rate contract	Purchases through Open market	Total purchases	Percentage of expenditure on open market purchase to the total expenditure
		(Lakhs of Rupees)			
(i) Safdarjang	7·95	19·59	36·10	63·64	67
(ii) Willingdon	8·58	6·56	21·38	36·52	59
(iii) Irwin	2·65	3·39	28·87	34·91	83

(The above figures of expenditure include adjustment of debits for supplies in previous years).

7.2. The Medical Stores Depot, Karnal, had either not met or met only partially the requirements of the hospitals during the year leading to purchase of medicines from the open market. The Ministry stated (Janu-

ary 1976) that the position of items indented and those supplied by the M.S.D., Karnal, during 1974-75 was as follows:

	Safdarjang		Willingdon		Irwin		Total Number of items	Value*
	Number of items	Value*	Number of items	Value*	Number of items	Value*		
Items indented	201	10·03	406	13·86	230	17·64	837	41·53
Items supplied in full	97	5·10	162	3·53	82	1·82	341	10·45
Items supplied 50 per cent and above	15	0·41	41	0·61	13	0·27	69	1·29
Items supplied less than 50 percent	23	0·40	58	1·12	59	1·66	140	3·12
Items not supplied	66	3·52	145	7·09	76	5·63	287	18·54

* Value in lakhs of rupees. For items indented estimated value has been given. For items supplied actual value has been given.

7.3. The main reasons for non-supply or part supply by the Depot were stated to be (i) inadequacy of funds, (ii) dependence on the D.G.S.&D. for bulk purchases and (iii) policy of the Depot to achieve widest distribution of its available stocks giving preference to smaller units located in rural and semi-urban areas which constituted its vast clientele.

7.4. The Medical Stores Depot, Karnal, set up in 1947 is responsible for making supplies to hospitals, dispensaries and some other medical institutions located in Punjab, Haryana, Himachal Pradesh and Delhi. The depot is run on commercial basis and the recipient institutions have to pay for the stores, their packing and departmental charges at the rate of 10 per cent of the value of stores supplied. Provisioning of stores for a particular financial year is based on the demand in terms of quantities for the previous three years or twelve previous months whichever is less. The provisioning statements of all the depots are consolidated in the office of the D.G.H.S. For items costing more than Rs. 50,000 each, the D.G.H.S. places indents with the D.G.S.&D. who enters into contracts through acceptance of tender; the consignees being the various depots. Individual items costing less than Rs. 50,000 each are procured either on rate contracts approved by the D.G.S.&D. or by open market purchase by the Karnal Depot. The following table shows purchases made through the various sources and

the turnover, *i.e.*, the supplies by the Depot, for the three years ending March 1975:

	1972-73	1973-74	1974-75
		(Lakhs of rupees)	
(i) Open market purchase	45·79	42·87	42.67
(ii) Purchases through DGS&D . . .	169·81	94·03	109·64
(iii) Received from other Depots . . .	29·01	28.60	18·15
(iv) Total	244·61	165·50	170·36
(v) Turnover	280·66	200·28	Figures not available pending finalisation of proforma accounts.

7.5. From a test check of 44 items (of heavy consumption) indented by the three Delhi hospitals during 1974-75, it was noticed that the Depot could not supply 19 items as it had either no or had only inadequate stock of those medicines. Twenty two items could be supplied by the Depot only upto 50 per cent and three items were supplied more than 50 per cent of the quantities indented. The main reasons for non-supply/short supply of those stores were understood to be as follows:

(i) Omission of certain items not supplied during the year by the Depot from the next year's requirements.

7.6. The Ministry stated (January 1976) that "there is no guarantee that the demand for a particular item will necessarily repeat itself to the same extent in the next year as in the previous year." It was further stated that "the medicines constitute a rapidly changing field of merchandise and any large scale acquisition of stocks can lead to losses to the State if the drugs concerned become obsolete and are no longer prescribed to the same extent."

(ii) The provisioning statements for 1974-75 were sent to the D.G.H.S. in February 1974. Authorisations to make local purchases of provisioned items valuing less than Rs. 50,000 were received by the Depot only in July 1974 and August 1974. For items valuing above Rs. 50,000 the D.G.H.S. placed indents on the D.G.S.&D. as late as June 1974 to March 1975.

7.7. The Ministry stated (January 1976) that "it is not the time which is taken to return the items for local purchase to Depots but the paucity of

funds which is the real limiting factor." It was further stated that "the indents on the D.G.S.&D. could not be placed earlier than June-July 1974 as placement of such indents involves a very long drawn exercise in the Directorate."

(iii) Non-supply of stores by the firms on D.G.S.&D. rate contracts in anticipation of revision of the rates.

7.8. In certain cases the medicines were purchased by the three hospitals from the open market even though they were on D.G.S.&D. rate contracts the rates of which were lower than the market rates. Extra expenditure incurred on purchase of such medicines was Rs. 2.30 lakhs in 1974-75. The details of medicines in which extra expenditure of Rs. 5,000 or more was incurred due to their purchase from the open market are given below:

	Open market rate	D.G.S.&D. rate	Quantity purchased	Extra amount paid	Remarks
1	2	3	4	5	6
	Rs.	Rs.		Rs.	
Safdarjang Hospital					
(i) Aspirin (1,000 tablets)	16·50 + sales tax	6·60 + sales tax	10,00,000	10,530	Orders on rate contract firms placed but supplies not received in time.
(ii) Mysoline (1,000 tablets)	243·90 + sales tax	137·00 + sales tax	50,000	5,345	
(iii) Cottonwool absorbant (per packet of 400 gms.)	6·65 + sales tax	4·20 + sales tax	2,200	5,390	
(iv) Do.	5·95 + sales tax	4·20 + sales tax	6,000	10,500	
(v) Normal saline (per bottle of 540 ml.)	5·40 + sales tax	4·50 + sales tax	25,600	24,192	
Willingdon Hospital					
(vi) B. Complex (1,000 tablets)	55·64 + sales tax	26·00	2,00,000	5,928	No supply order was placed with firms on rate contract.
Irwin Hospital					
(vii) Analgin (1,000 tablets)	129·50 + sales tax	79·90 sales tax	1,25,000	6,510	Indian Drugs & Pharmaceuticals Ltd. withheld supply pending revision of rates

1	2	3	4	5	6
(viii) Plaster adhesive zinc oxide 7·5 Cm x5 metres (per dozen)	107·27+ sales tax	56·40	2,400	10,683	Not supplied due to shortage of raw material.
(ix) Do.	105·00+ sales tax	56·40	4,800	20,412	Firm withheld supply pending revision of rates.
(x) Predonisolone (1,000 tablets)	112·06+ sales tax	80·00	3,00,000	10,300	Firm withheld supply even after grant of extension of time for delivery.
(xi) Di-iodohydroxy quinoline (1,000 tablets)	53·90+ sales tax	29·70	4,50,000	11,435	Firm withheld supply pending revision of rates.
(xii) Acetyl salicylic acid (1,000 tablets)	14·60+ sales tax	6·65	33,16,000	27,750	Supply order for six months' quirement was placed with one of thpl two firms on D.G.Se.&D rate contract bus no supply wa received.

7.9. The Ministry stated (December 1975) that Safdarjang and Willingdon hospitals "have to take resort to purchase emergent requirements from local market in the interest of patient care when supplies from usual sources i.e. M.S.D., Karnal, or through the D.G.S.&D. rate contract firms are not forthcoming or are being inordinately delayed. The supply of medicines to patients is the elementary and primary responsibility of any public hospital and if for want of medicines any patients lives are lost, the criticism to which the institution will be exposed can well be imagined. The plea of non-supply by approved sources will be treated as untenable. Utmost efforts are, however, made to keep the purchase of medicines from the local market to the minimum. Only if more rigid conditions are put on the D.G.S.&D. rate contract firms, they could be expected to comply with the contracts on agreed conditions, otherwise they would continue to back out from agreements thus necessitating local purchase by hospitals at higher prices."

Sub-standard Medicines

7.10. Certain medicines were found to be sub-standard, on chemical analysis by the testing laboratory. Bulk of these medicines had already been consumed by the time the test results were received as shown below:—

	Quantity received	When received	Value Rs.	Date of taking samples for testing	Date of receipt of test report	Quantity consumed before receipt of report
Willingdon Hospital :						
(i) Dextrose 5 percent of 540 mml.	10,000 bottles	February and April 1974	42,500	16-7-74	28-10-74	9,761 bottles
(ii) Normal saline 5 per cent 540 mml.	15,000 bottles	January and March 1974	75,000	May & June 1974	August 1974 to Jan. 1975	4,294 bottles
(iii) Ringer Lactate	10,000 bottles	April 1973	Recived as gift	23-5-74 4-6-74	Sept. 1974 to Feb. 1975	5,984 bottles
(iv) Hydrocortisone Acetate Ointment 0·5 per cent	600 tubes	June 1973	576	3-8-73	5-11-73	402 tubes
(v) Aspirin tablets I.P. 30 mg.	4,00,000	14-12-70	2,730	March 1973	10-5-73	3,41,000 tablets
Irwin Hospital :						
(vi) Tetracycline oral supsension 40 ml.	1,250 bottles	25-7-72	3,875	19-8-72	19-7-73	1,250 bottles
(vii) Prednisoione 5 mg. tablets	3,00,000	16-5-73	24,720	4-6-73	16-12-74	3,00,000 tablets
(viii) Injection Levarternol bitartrate.	4,200 ampules	20-7-73	14,70	12-12-73	19-8-74	4,200 amp.
(ix) Injection Heparin 5 ml.	190 vials	13-10-73	4,797	9-8-74	24-12-74	190 vials
(x) Injection Atarax	2,250 ampules	12-6-72	2,739	19-8-72	21-8-73	2,450 amp.

[Paragraph 30 of the Report of the Comptroller and Auditor General of India for the year 1974-75, Union Government (Civil)]

7.11. At the instance of the Committee, the Ministry of Health and Family Welfare have furnished the following statement regarding medicines

purchased from various sources as reported by the three hospitals during 1975-76:

Safdarjang Hospital	M.S.D., Karnal	Rs.	12·37 lacs
	D.G.S. & D.	Rs.	21·16 lacs
	Local	Rs.	39·81 lacs
	Total	Rs.	73·34 lacs
Willingdon Hospital :	M.S.D., Karnal	Rs.	10·00 lacs
	D.G.S.& D.	Rs.	11·00 lacs
	Other Sources;	Rs.	17·00 lacs
	Total	Rs.	38·00 lacs
Irwin Hospital :	M.S.D., Karnal	Rs.	7·00 lacs
	D.G.S. & D.	Rs.	12·00 lacs
	Open market/manufacturers/ distributors and Govt. undertakings	Rs.	28·00 lacs
	Total	Rs.	47·00 lacs

7.12. The Ministry have also indicated the following sources from where the Medical Stores Depot, Karnal, purchased medicines during 1975-76:—

D.G.S. & D.	Rs.	2,11,74,633
Local purhase	Rs.	67,51,063
Other sources	Rs.	18,96,293

7.13. The Committee have been informed that the extra expenditure incurred in certain cases where the modicines were purchased by the three hospitals from the open market even though such items were on D.G.S.&D rate contract during 1975-76 was as follows:—

Safdarjang Hospital	Rs.	6388·00
Willingdon Hospital	Rs.	21312·60
Irwin Hospital	Rs.	7934·00

7.14. According to the Audit Paragraph the percentage of expenditure on open market purchase to the total expenditure on medicines during 1974-75 in Safdarjang Hospital, Willingdon Hospital and Irwin Hopital was 57 per cent, 59 per cent and 83 per cent respectively. Enquired whether Government could devise a central source of procurement and purchase mechanism to cater the needs of the three hospitals and make medicines cheaper for the hospital and thus save money, the Director General, Health Services, has stated during evidence:—

"The sources of supply are MSD Karnal and D.G.S.&D. rate contract. In the case of non-availability and on having non-availability certificate from the MSD Karnal or D.G.S.&D. Rate Contract, in order that the patients do not suffer, the Medical Superintendents have to take recourse to the purchase of medicines from other sources. When we make local purchases we make two kinds of enquiries—either through open tender or through limited tender. If the medicines are of the value of more than 10,000 rupees, then we have open tender, otherwise limited tender. This has come to the notice that every hospital was doing its own purchase as MSD Karnal was not able to meet all the supplies. Quite often DGS&D were not able to meet the requirements. Medical Superintendent had to look after the requirements of the patients and, therefore, had to take recourse to other sources of supply. There was no centralised agency. Therefore, this question of difference in costs did arise. Because it has come to our notice, therefore, a decision was taken to establish a Joint Purchase Committee for the Central Hospitals—Safdarjang and Willingdon. Because we have had no experience, in order to make a uniform uninterrupted purchase of quality drugs at competitive costs, this was introduced. With the Joint Committee process there has been delay. Therefore, there has been a thinking again. We have a Medical Stores Organisation which serves various purposes. But the difficulty is when we store the drugs, space is required and there are overhead charges. It cannot supply the drugs at a competitive price. They charge 10 per cent overhead charges. This question has been engaging our attention in the past and we in the process are evolving some other scheme—'Group Supply Scheme'. The staff of the hospitals and MSD will work together so that the open tender and limited tender could be centralised.

The Government of India has made a Board for the Central Stores Organisation so that this problem of unequal price and sometimes shortage of drugs is solved."

7.15. The Secretary of the Ministry of Health and Family Welfare (Department of Health) has added:—

"The Medical Stores Depot which we have got suffers from certain disabilities.. It is not a corporation and the funds do not revolve. Drug prices have increased enormously. Medical requirements have gone up and various hospitals have come up. I would respectfully say that the budgeting system is also somewhat defective. We get Rs. 10 crores. These Rs. 10 crores are for purpose of medicines and the supplies are made over the first 3 months. Whatever is received is credited to the exchequer with the result that for 6 months in the year we have hardly any medicines except that we sometimes stagger it over the 9 months or 12 months to keep the staff busy. It is an unfortunate thing. We wanted to convert it into a corporation on no-profit and no-loss basis. The Minister held several meetings. I held several meetings at my own level. Finance Secretary also participated. It was decided that the allocation would be Rs. 15 crores. I think the situation is bound to improve. We should have a corporation or a set up where money could be revolved. They could buy, they could sell, they could replenish. In this way they can supply the large amount of medicines which dispensaries need. Unfortunately we have not still been able to take a view. We have created a Board. Mr. Premnath is there. He is our Financial Adviser. The Deputy Minister is the Chairman. The D. G. is there. We hope that this will result in improvement all-round."

7.16. In a note furnished to the Committee, the Ministry have explained the reasons for purchasing medicines from open market thus:

"Medicines are purchased from open market on competitive rates in the following cases:—

1. When they are not stocked or available with M.S.D., Karnal;

2. When the medicine is not on the DGS&D rate contract and its cost does not exceed Rs. 50,000 or the firm on the DGS&D rate contract fails to supply it;

3. Proprietory items are purchased directly from the manufacturers; and

4. Urgent requirements costing not more than Rs. 250/- at a time."

7.17. The Committee desired to know the extent to which the Medical Stores Depot, Karnal had been able to meet the requirements of the three Government hospitals. In reply, the Ministry have stated:

> "The Medical Stores Depot is not responsible for supplying all items required by a hospital. It has got a vocabulary of medical stores and undertakes to supply only those items.
>
> Details of total expenditure on purchase made by 3 hospitals during 1974-75 are given in the Audit Review. Particulars of the VMS items demanded by three hospitals and supplied by the Medical Store Depot, Karnal during the year 1974-75 are given below:—

Hospital	No. of items demanded	Value of items demanded	No. of items supplied	Value of items supplied (Rs. in lakhs)	percentage of supply
Safdarjang .	201	10·03	135	5·91	67
Willingdon . .	406	13·86	261	5·26	64
Irwin . .	230	17·64	154	3·69	67
Total .	837	41·53	550	14·86	67

The main reasons for inability of Karnal Depot to meet the demands of hospitals are:

(a) Paucity of funds and budgetary restrictions.

(b) Medical Store Depot even though a trading organisation, cannot revolve funds allocated to them for purchase and supply of items, with the result that budgetary allocations get exhausted within a short time and thereafter they have no funds to purchase and supply to various indentors. Steps are now being taken to enhance these allocations.

(c) Even though a trading organisation, it has to purchase its requirements through involved procedures of DGS&D. This results in delays in procurement and often inability of Medical Store Depot to supply indentors in time.

(d) Medical Store Depot, Karnal has a responsibility to supply not only the Delhi hospitals but also a large number of small indentors like P.H.C. taluk level hospitals etc. spread over

States of Northern India. Preference is given to small indentors because they have no facilities for purchasing drugs locally.

Action is being taken to improve the working of Medical Stores Depots. A high level committee is being appointed to supervise the working thereof."

7.18. It has been stated that the Medical Stores Depot, Karnal sueffred from certain disabilities as it was not a corporation. Though there was a proposal to convert it into a Corporation on no-loss and no-profit basis, the Ministry of Finance had not agreed to it. Giving the reasons in a chronological order, as to why the proposed conversion of the Medical Stores, Karnal into a Corporation could not be got through, the Ministry have stated:

"Medical Store Depot, Karnal is a subordinate office of the Directorate General of Health Services and along with five other similar Depots, forms part of the Medical Stores Organisation. Although the organisation has to function on commercial lines, being a Government office, it has per force to function within the framework of the rules and regulations applicable to all Government Departments funds are provided to the organisation annually like other Government departments depending upon the ways and means position rather than on the basis of actual requirements for purchasing adequate stocks to meet the growing demands of the indentors. The sale proceeds are credited to Government and not allowed to be rotated for proceurement of stores. Like other Departments, purchases have to be made through the D.G.S.&D., the works got executed through the CPWD and forms, registers, typing paper, labels etc. procured through the Chief Controller, Printing & Stationery. All these constraints cause inordinate delays and uncertainties of procurement etc. leading to frequent stock-outs in the depots.

The question of streamlining the functioning of the Depots has been under consideration for a long time. In 1971, the Administrative Staff College, Hyderabad were engaged as consultants to study the organisation's working. This report received in May, 1973, *inter alia* recommended the conversion of the Medical Store Depot into a company under Section 25 of the Indian Companies Act. A Task Force was constituted in May 1974 with representatives of other Ministries including Finance, to consider this matter. The Task Force also recommended conversion of the Medical Stores Organisation into a company. It was felt that the proposed

company would provide operational flexibility and it would also be possible to raise funds for development activities through Financial institutions besides Government loans.

During consideration of this proposal, the Ministry of Finance pointed out that instead of discarding the present system and creating a company, which may have problems of its own, a few reforms in the functioning of the organisation could be carried out to achieve the desired objectives. Some of the reforms suggested were the introduction of double entry book keeping, modern inventory control systems, computerisation and provision of non-lapsing funds.

The suggestions of the Ministry of Finance were considered and it was decided that the alternative suggestions given by them may be tried. The suggestions are now under consideration. For the present, a High Powered Board has been set up on 27-9-1976 under the Chairmanship of the Deputy Minister of Health and Family Welfare with full administrative and financial powers to take all decisions concerning the organisation. The Board, *inter alia,* includes Additional Secretary, Department of Health and the Integrated Financial Adviser."

7.19. The Committee enquired of the methodology adopted by the Medical Stores, Karnal, in regard to stocking of medicines. The Secretary of the Ministry has stated:—

"There are three important functions of the medical stores depot. They stock all the equipment that comes to the Government of India as gift from abroad. They take care of it and then distribute it to various hospitals to which it is allotted by the Government of India. This is done by all the medical stores including Karnal. Then some of the general medicines like tablets, bandages, cotton, etc. are manufactured in two medical stores depots. One is Bombay and another is Madras. It is not done in Karnal. They make bulk purchase of medicines like phenyl, boric acid powder etc. and then they bottle them and then supply to the various hospitals after testing the quality of it. In times of emergencies when we require 300 or 400 tonnes of medicines, it is this organisation which handles vast supplies and makes available to the States, of course, on payment. Then they purchase drugs and these drugs are meant to be supplied according to a formula. They have got a book which is known as formulary. They buy those drugs which are in common demand. These drugs are

packed according to the demand of the indentors. The requirement of Delhi alone is more than three crores and they have to supply to various other hospitals also. Some of the State Governments do not have supply organisation for drugs in their own States and they have to depend upon this agency. One or two States had tried to set up their own agency but they reverted back to this medical stores depot because they found that they were functioning better than their own agencies. The main constraint has been the shortage of funds and that is why, I was making a submission to you and through you to the Auditor General and other hon. Members of the Committee to make a recommendation that there should be a revolving fund so that they can buy and supply the requirements without any difficulty. The amount should be such that it would be enough to rotate six times in a year."

7.20. According to Audit Paragraph in certain cases the medicines were purchased by the three hospitals from the open market even though they were on D.G.S.&D. rate contracts, the rates of which were lower than the market rates. Extra expenditure incurred on such medicines was Rs. 2.30 lakhs in 1974-75. Asked to furnish the details of such medicines showing the prices fixed by Government, DGS&D rates and the prices paid by the three Government hospitals, the Ministry in a note have furnished the following information:—

Safdarjang Hospital

Sl. No.	Name of the item	D.G.S.&D. Rate	Rate at which purchased	Rate fixed by the Govt.
1.	Aspirin	Rs. 6·60 for 1000	Rs. 16·50 for 1000	Rs. 21·10 for 1500 July, 74 Rs. 25·10 for 1500 Nov., 74
2.	Mysolin	Rs. 137·00 for 1000	Rs. 243·90 for 1000	Rs. 309·00 for 1000
3.	Normal Saline	Rs. 4·50 each	Rs. 5·40 each	Rs. 8·13 each 540 ml.
4.	Cotton Wool Absorbent Rs. 6 60 (per pkt. of 400 gms.)	Rs. 4·20	Rs. 6·65	Not covered by Drugs Act.

Willingdon Hospital

Sl. No.	Name of the item	DGS&D rate for 1974-75	Rate at which purchased during 1974-75	Rate fixed by the Government
1.	Tab. B. Complex	Rs. 26·00 per 1000	Rs. 55·64 for 1000	Rs. 66·330 for 1000

Irwin Hospital

Sl. No.	Name of the item	DGS&D rate for 194-75	Rate at which purchased during 1974-75	Rate fixed by the Government
		Rs.	Rs	Rs.
1.	Analgin (1000 tablets)	79·90	129·50 plus Sales tax	85 per 500 tabs. plus Sales Tax.
2.	Plastor Adhesive Zinc Oxide 7·5x5 mts. (per dozen)	50·40	107·27 plus Sales Tax	107·27 plus S.T.
3.	Do.	56·40	105·00 plus Sales Tax.	107·27 plus S. T.
4.	Prednosolone (1000 tablets)	80·00	112·06 plus Sales Tax	67·05 per 500 tabs. plus S.T
5.	Di-iodohydroxy Quinoline (1000 tablets)	29·70	53·00 plus Salex Tax.	60 per 1000 tabs. plus Sales Tax.
6.	Acetyl Salizylic (1000 tablets)	6·63	14·60 plus Sales Tax	15 per for 1000 Tabs. plus S. T.'

7.21. The Audit Paragraph has pointed out that 1000 B. Camplex tablets were purchased by Willingdon Hospital in 1974-75 from the open market after paying 114% excess price over the DGS&D rate contract and no supply order was placed with firms on rate contract. Enquired of the circumstances under which these tablets were purchased from the open market instead of placing the order on firms on rate contract, the Ministry have explained the position thus:

> 'Because of oil price hike, price of drugs went up very high in the year 1974-75 and secondly there was shortage of some drugs. This was a world-wide phenomenon. Secondly manufacturers in India were also trying to get their prices revised upwards under the Prices Control Order and were perhaps withholding supplies to hospitals pending such a revision. Whether the reasons may have been, the fact is that in this

particular case an indent had been placed with IDPL which was on DGS&D rate contract for the period ending 30-9-75 for B. Complex tablets and IDPL *vide* their letter No. 811 dated 27-4-74 expressed inability to supply medicines on the rate contract till the price was revised. Vit. B. Complex tablets are administered along with antibiotics and no hospital can function without these tablets being available. As this is an essential drug, hospital administrators had to make arrangements for purchase of these drugs from the open market."

7.22. On being pointed out that the pharmaceutical industry derives a double benefit by refusing to supply medicines to Government hospitals and dispensaries at DGS&D rates even though in exceptional cases there might be some little justification for a little increase in prices, the representative of the Directorate General of Supplies and Disposal has stated during evidence:

"We have been buying drugs on the basis of rate contracts. Although the rate contract is a very convenient mode of contract for operational purposes, it is not legally a very binding contract. There are two types of contracts: one for supply by a firm and fixed quantity and at a fixed price. But this is only a standing offer, in terms of the law. And in case the supplier or the rate contract-holder so thinks, he can refuse to accept the rate contract or the supply order. This is the legal position. But once he accepts the order, it becomes a binding one and he has got to supply the material.

The witness has added:

"There is a lacuna in the very mode or form of this contract. If the firm does not accept the supply order, we are not in a position to enforce our contract."

7.23. Elaborating the point further, the Secretary of the Ministry has stated during evidence:—

"There are two points involved. I think since 1962 there is an order under which the prices of drugs are controlled, *i.e.* Drug Prices Control Order. The prices are again going up and the manufacturers have been submitting their expenditure and costs to the Ministry of Petroleum and Chemicals. They have been getting them examined and scrutinized; and that Ministry have been fixing prices from time to time. They have fixed prices for different packs and we have been buying them. Actually it is an offence for anyone to sell a drug at a price higher than

the one fixed by the Ministry of Petroleum and Chemicals. This price is stamped on the pack.

But you (Chairman) are very right in saying that the industry should supply to the hospitals in special packs, medicines at very much lower and concessional rates than what they claim from the ordinary consumer. By and large this has been the practice; but when prices go up and that Ministry revises the prices of drugs upwards—and the DGS&D is not able to enforce the rate contract—a very strange and difficult situation arrises. I agree that under these circumstances, it was in the nature of a windfall to the manufacturers and that they have made a lot of money this way."

7.24. Explaining the reasons for their failure to supply the medicines on rate contract, the representative of the Directorate General of Supplies and Disposals has stated during evidence:—

"The figure which are given in the audit report relate to that particular part of the years 1973 and 1974 when it has been a very unusual period of price fluctuations in the case of drugs. During this period the prices of raw-materials shot-up and there are a number of rate contracts for which the suppliers had difficulty in arranging the supplies. We are seized of this problem and discussed it with the Health Department. We have reorganised our working as well as the working of the Ministry of Health in the matter of placing orders. The major changes that we have made are in the matter of provisioning and in the matter of procurement. In the matter of provisioning what has been done is that instead of operating the rate contracts on a periodic basis they are now formulating their requirements for six months and placing firm indents on us against which we place *ad hoc* orders for firm quantities. This has ensured to a large extent timely deliveries of the stores which has resulted in the drop of direct purchases made by various hospitals. On our part what we have done is that we have given up the rate contract which had been used for the supply of drugs."

7.25. In reply to another question, the representative of the Directorate General of Supplies and Disposals has added:

"There is a Drugs and Cosmetics Act according to which prices of drugs are fixed by the Ministry of Petroleum and Chemicals. Even now all the prices of drugs are fixed by the Ministry of

Petroleum and Chemicals after the same are examined by the Bureau of Industrial Costs and Prices. So far as DGS&D are concerned we are purchasing these drugs at prices lower than those fixed by the Ministry of Fertilisers and Chemicals. We achieve this by competitive bidding."

7.26. In the same context, the Secretary of the Ministry has state:

"I know the rate contract was valid for one year. Meanwhile the prices shot up and the Ministry of Petroleum and Chemicals which were then responsible for fixation of prices had revised the prices upward. Even though the statutory prices were higher, the rate contract continued to be operated at the old rate. That created a situation which was awkward."

7.27. It is stated that indents are placed with DGS&D for items of medicines which cost more than Rs. 50,000 each. Asked to state the value of indents, for items of medicines which cost more than Rs. 50,000, placed on DGS&D during each of the last three years by each of the three hospitals. The Ministry have furnished the information as under:—

Year	Safdarjang Hospital	Willingdon Hospital	Irwin Hospital
	Rs.	Rs.	Rs.
1973-74 . .	5,64,100	13,59,050	3,32,575
1974-75 . .	13,39,800	73,362	16,77,852
1975-76 . .	21,18,300	6,55,470	4,38,460

There is no backlog in so far as Safdarjang and Willingdon Hospitals are concerned. In respect of Irwin Hospital, in October, 1974 an indent for the supply of surgical dressing costing Rs. 12,00,000 (Approx.) was placed with the DGS&D and complete supplies against the same were yet to be received as on 3-12-1976.

All the three Hospitals individually place indents directly on DGS&D."

7.28. The Committee further desired to know the number of times the firms failed to fulfil the contractual obligations during the last three years and the action taken against such contract holders. In reply, the Ministry of Health and Family Welfare (Deptt. of Health) in a note on 16 August, 1977 have stated:—

"The rate contract holders failed eleven times to fulfil the contractual obligations during the last three years. The failure on the part of the rate contract holders to comply with the supply order was brought to the notice of the DGS&D who have intimated that they are examining the possibility of recovering damages from the firms concerned in consultation with the Ministry of Law and will take further action in the light of the advice of that Ministry. The value of the eleven supply orders referred to above amounts to Rs. 2,89,731.70 paise."

7.29. The Committee desired to know whether any list of medicines/drugs, which were generally in short supply, had been prepared and if so, whether any advance action is taken to stock them. In reply, the Ministry have stated:

"The Drugs Controller (India) keeps a watch on the supply position of drugs particularly 'life saving drugs' in the market. He gets reports from State Drugs Controllers from time to time. Drugs Collector also takes up the question of import of essential drugs through Ministries concerned when considered necessary. No particular drug can be said to be in short supply for a very long time. Generally what happens is that scarcities are created for short periods and as soon as supplies are available of the concerned drug the scarcity disappears. Medical Stores Depot maintains a list of vital items and the depots have been asked to ensure stocks of such item are available for emergencies. Monthly stock reports of these drugs are received by the Directorate."

7.30. Further asked if the list of medicines to be supplied by the Medical Stores Depot is drawn up/revised, keeping in view the requirements of hospitals, the Ministry have stated:

"Vocabulary of Medical Stores containing lists of drugs, surgical instruments, chemicals and veterinary drugs etc. which are required to be stocked in the Medical Stores Depots for supply to the registered indentors is being maintained and kept up-to-date by making additions/deletions."

7.31. Asked why was it necessary for the Medical Stores Depot to depend on the DGS&D for bulk purchase of medicines, the Ministry, in a note furnished to the Committee, have stated:

"According to allocation of business rule DGS&D is required to purchase stores on behalf of all Ministries of the Government

of India and their attached and subordinate offices. The question of making direct purchase by the Medical Stores Organisations instead of through DGS&D was taken up with the Department of Supply. That Department has not agreed to the proposal."

7.32. In reply to a question about a decision taken in September, 1975 for the establishment of a Medical Stores Depots in Delhi to cater to the requirements of the CGHS and Delhi hospitals, the Committee were informed by the Ministry that instead of setting up a Medical Stores Depot in Delhi, an alternative proposal entitled 'Group Supply Scheme' which aimed at consolidation of demands from Willingdon and Safdarjang Hospitals and C.G.H.S. had been drawing up and was under consideration. When asked about the salient features of the Group Supply Scheme, the Ministry have furnished the following information:—

"The objectives and merits of the Group Supply Scheme are given below:

Objectives

1. Standardisation of a list of common items of Medical Stores required for use in the participating units and laying down or prescribing specifications for ensuring quality procurement.

2. To arrange supplies of quality pre-tested stores at most economical prices through bulking of demands of the Units.

3. To arrange receipt of stores at appropriate intervals so as to ensure minimum stock holding and thus avoiding unnecessary capital blockage, pressure on accommodation and deterioration of perishable items.

4. To achieve optimum stock levelling and provide inter-feeding between the various units and arranging common disposals.

Merits:

(a) Common purchases by the three units on a consolidated basis would yield better bargaining power than each until making its purchases on its own:

(b) The inherent assurance that all the units will get supplies at uniform prices from the same vendors at any given point of time;

(c) Through a regular system of monitoring the surplus stores at any unit could be diverted to another instead of the units working in isolation from one another the stock losses due

to obsolescence or changing pattern is the usage of drugs could be minimised;

(b) The units being service institutions would not be paying for Departmental charges to a formation like M. S. Organisation working on commercial lines; and

(e) Through a selective list of vendors and pre-inspection of bulk supplies by a nominee of the D.G. there would be an assurance that no sub-standard medicines or other commonly used items find their way to the participating units."

7.33. The Committee referred to the observations of the audit that certain medicines were found to be sub-standard on chemical analysis by the testing laboratory and that bulk of these medicines had already been used by the hospitals by the time the test results were known and asked the representative of the Ministry to explain the position. The Director General, Health Services, has stated:

"From the Medical Store Depots, as a matter of general rule, no drug is issued unless it has been pre-tested in a laboratory."

7.34. In this context, the Medical Superintendent, Irwin Hospital, has stated:—

"The drugs are probably tested before they are issued from Karnal, but in the records of the Irwin Hospital there was one case of Acromycin by Lederle which was found to be sub-standard subsequently on investigation. The defect was found due to transport and faulty storage which has been corrected."

7.35. The Medical Superintendent, Safdarjang Hospital has stated:

"At Safdarjung there is no record of any sub-standard drug. We have a methodology in which a drug is taken at random for sampling by the Drug Controller and tested at the laboratory. Secondly, if the physician finds that a particular drug is not having the expected effect on the patient and it is suspected to be sub-standard or adulterated, its use is immediately stopped and it is sent for testing to the laboratory."

7.36. The Medical Superintendent, Willingdon Hospital, has said:—

"From my records, I find that the glucose solution contained more particles. It was tested. Because there were particles in it, that was rejected. It belonged to a Madras firm, I think action was taken on that. Then, Analgin or Aspirin had a smaller content. Similarly, hydrocortigone in ointment was smaller in quantity."

7.37. The Committee desired to know the measures taken to ensure that only standard quality drugs/medicines were supplied to the hospitals. The Ministry of Health have furnished the following note:—

> "Each item is subjected to inspection including laboratory test etc. before it is taken to the Depot stock except in case of emergency purchases which are only from standard firms."

7.38. The Committee asked whether any methodology had been evolved so that Central Government and State Governments could put a step to the circulation of spurious drugs. The Secretary of the Ministry has replied:—

> "We have written to the States several times. There is a lacuna in the law also because, unfortunately, even a spurious drug is defined as an adulterated drug. There may be a drug where the content of a particular drug may be one per cent less it is also defined as an adulterated drug. There may be a drug where the content of a particular drug may be one percent less it is also defined as adulterated. There may be a drug, which is not drug at all, but entirely spurious, which has not been defined. We are going to introduce wholesome amendments in the law, and we have finalised the legislation. I myself had several meetings with the Ministry of Law. Actually, they had a lot of difficulties in defining what a spurious drug should be. We have been able to get over those difficulties and we propose to bring in this legislation soon. The punishment under this Act is very severe. Just as in the case of the Prevention of Food Adulteration Act, in this case also life imprisonment has been prescribed for the manufacturers of spurious drugs. The enforcement of this Act is very important. It is in the hands of the State Governments. We have been constantly goading them that the enforcement part should receive their attention.
>
> "Another important aspect of the matter is the facility for testing of drugs. Unfortunately, they were not there. Now we have given a sizeable amount of money to the various State to equip their laboratories so that they can test their drugs as soon as a specimen is received. I hope that if we are able to take these measures in the near future, the situation should vastly improve."

7.39. As regards the testing of new drugs that were being marketed by developed countries, the representative of the Indian Council of Medical Research, has stated during evidence:—

> "Recently, Government has formed a committee where each new drug introduced will be carefully examined. Its Chairman

is the Director General of the Indian Council of Medical Research. Secondly, we have also appointed ethical committees in various institutions where we want to try new drugs, and these committees are headed not by doctors alone, but by people who are retired High Court Judges or even Chief Justices of High Courts, some well-known or senior social workers and some doctors in private practice, so that we take into consideration the ethical aspects also."

7.40. The Committee pointed out that some drugs could not be manufactured in India as Government had stopped import of the ingredients which were required for the manufacture of drugs. The Committee asked whether the Health Ministry maintained a list of such scarce drugs which were not manufactured in India or were not available in India and ensured continuous supply of such drugs to hospitals and needy patients. The Secretary of the Ministry has replied:

"There are occasions when even popular drugs go out of the market because of constraints of supply or other reasons. When instances of this type come to our notice, we immediately report it to the Ministry of Petroleum and Chemicals as also the Ministry of Commerce to import and that has been done in a number of cases. We will take notice of the suggestion made by the hon. Member and will explore the possibility of allowing them to import the ingredients so that the drug is freely available in our country. I may also add that new drugs are coming out fast in foreign countries and they are sometimes not available in India and therefore the system of import of drugs for actual users had been liberalised and needy persons can import drugs to the extent of Rs. 200/- if a drug is prescribed by a doctor and it is not available in the country."

7.41. The Committee note that the three Government Hospitals namely, Safdarjang, Willingdon and Irwin Hospitals procured medicines including surgical dressings to meet their requirements through the Medical Stores Depot, Karnal, firms on the DGS&D rate contracts and the open market They are unhappy to find that due to the incapacity of the Medical Stores Depot, Karnal, firms on the DGS&D rate contracts and the open market, these hospitals has to resort to open market purchases. It is observed that during 1974-75, the percentage of expenditure on purchases made on medicines from the open market as compared to the total expenditure incurred by Safdarjang, Willingdon and Irwin Hospitals was 57 per cent, 59 per cent and 83 per cent respectively. The extra expenditure incurred on purchase of medicines from open market was the tune of Rs. 2.30 lakhs in 1974-75. During the same year, the three hospitals had indented 837 items of the value of Rs. 41.53 lakhs to the Medical Stores Depot, Karnal.

and the Depot had been able to supply in full only 341 items of the value of Rs. 16.45 lakhs; 209 items worth of Rs. 4.41 lakhs were supplied in part and the remaining 287 items (about 33 per cent) of the value of Rs. 18.54 lakhs had not been supplied at all. The reasons attributed for the non-supply or part supply by the Medical Stores Depot were stated to be (i) inadequacy of funds, (ii) dependence on the DGS&D for bulk purchases and (iii) policy of the Depot to achieve widest distribution of its available stocks giving preference to small units located in rural and semi-urban areas which constituted its vast clientele. The Committee have been informed that the Medical Stores Depot suffered from certain disabilities inasmuch as it has no revolving fund. The yearly allocation was exhausted during the first three months of the year on the purchase of medicines and whatever was received by way of sale of medicines was credited to the exchequer, with the result that for 6 months in a year there was hardly any medicines. To meet the situation it has now been decided to increase the allocation of funds from Rs. 10 crores to Rs. 15 crores

7.42. The Committee are distressed to note that the Medical Stores Depot with its inherent shortcomings had not been able to fulfil its obligations to meet the demands of the three hospitals, with the result that Government had to incur heavy expenditure on the purchase of medicines from open market.... They are surprisied to find that although the shortcomings noticed in the working of the Depot were in the knowledge of the Ministry for a long time nothing was done to improve the situation. What is more disconcerting is that though the Administrative Staff College, Hyderabad who were asked in 1971 to study the working of the Stores Depots had recommended in May 1973 the conversion of the Organisation into a company, it was only in 1976 that Government could take a decision against conversion. Even the suggestions made then by the Ministry of Finance to effect improvements in the functioning of the Medical Stores Depot are still under consideration. The Committee take a serious view of the casual manner in which the vital question of streamlining the functioning of the Stores Depot has been kept in abeyance all these years...They, therefore, like that the reasons for the delay in taking an early decision in the matter should be identified and responsibility fixed for the delay. They would also like to know what specific improvements have been made in the functioning of the Stores Depot so as to ensure that the hospitals receive their supply of medicines without any interruption.

7.43. The Committee have considered the plea advanced in favour of conversion of the Medical Stores Depot into a company and are of the view that in order to give greater flexibility and autonomy to the Organisation in its day-to-day dealings, financing as well as management matters, the question of conversion of the Stores Depot into a company set up under the Indian Companies Act, with a revolving fund at its credit, may be

examined thoroughly in consultation with the Ministry of Finance and Planning Commission. The Committee would like to be apprised of the decision taken in this regard.

7.44. The Committee have been informed that a proposal entitled 'Group Supply Scheme' which aims at consolidation of demands from Delhi hospitals/CGHS dispensaries has been drawn up and is under consideration of the Ministry of Health and Family Welfare. The Committee feel that the Scheme by ensuring common purchases of medicines at uniform prices by the three hospitals on a consolidated basis would yield better bargaining power than each unit making its purchases on its own and would be in a better position to purchase quality medicines at competitive rates. The Committee need hardly emphasise that the Scheme should be finalised and given a fair trial at the earliest. The Committee would like to be informed of the results which flow from its implementation

7.45. From the statement furnished by the Ministry of Health and Family Welfare, the Committee find that Safdarjang, Willingdon and Irwin Hospitals purchased a number of medicines/drugs from the open market by paying higher rates than DGS&D rate contract during 1974-75 and 1975-76. During evidence, the Committee have been informed that the Directorate General, Supplies and Disposals was not able to meet the requirements of the three hospitals as they were not able to force the firms to supply the medicines on rate contract as it was not legally binding contract. It has been stated that as a result of reorganisation of the working of DGS&D as well as of the Ministry of Health and Family Welfare in the matter of placing orders, instead of operating the rate contracts on a periodic basis, the latter are now formulating their requirements for six months and placing firm indents on the former who place ad hoc orders for firm quantities. This has ensured, as is claimed, to a large extent timely deliveries of the stores thereby resulting in the drop of direct purchases by various hospitals. The Committee hope that with the adoption of the new method of provisioning and procurement of medicines, the DGS&D would be able to supply medicines regularly at competitive rates to the hospitals where indents for supply are placed through them. The Committee would, however, like the Ministry to keep a constant watch over the situation and study the impact of the new procedure adopted by the DGS&D for taking further remedial measures if necessary.

7.46. The Committee have been informed in August 1977 that during the last three years the rate contract holders failed eleven times to fulfil the contractual obligations in regard to supply of medicines etc. The value of these eleven supply orders amounted to Rs. 2.89 lakhs. It has been stated by the Ministry that the matter has been reported to the DGS&D who are examining in consultation with the Ministry of Law the possibility

of recovering damages from the firms concerned. The Committee would like to know within 6 months the decision arrived at in the matter and the conclusive action taken against the defaulting suppliers including the recovery of the damages from them.

7.47. The Committee are distressed to note that certain medicines consumed by patients in the Hospitals were sub-standard. From the particulars furnished by Audit they observe that in Willingdon and Irwin Hospitals, samples of certain medicines were drawn for testing after their receipt in the hospitals and before the receipt of the test reports, a bulk of them had already been consumed. The Committee would like to have a full explanation as to why these medicines were issued to the hospitals without proper testing and secondly why their consumption in the hospitals was not held in abeyance till the result of the samples drawn were known. They would like this matter to be fully investigated and responsibility fixed for the lapses. The Committee would also like to know what conclusive measures have been taken to ensure that only genuine and fully tested medicines drugs are issued to patients in the hospitals.

7.48. The Committee have been informed during eviden e that there is a lacuna in the law as even an entirely spurious drug is defined as an adulterated drug. It has been stated that Government have now been successful in defining a spurious drug and propose to bring a legislation whereby manufacturers of spurious drugs would be awarded life imprisonment. The Committee trust that the Government would bring the necessary legislation without loss of further time and take stringent measures to see that medicines are available to the common man in adequate quantities and at reasonable prices. The Committee also feel that machinery in the States for ensuring production and marketing of quality drugs is rather weak and ineffective and needs to be strengthened.

7.49. The Committee further note that there have been periodical reports of shortage of certain medicines and it appears that no effective machinery exists to take notice of such shortage in time for remedial action in a coordinated manner. Though it was primarily the responsibility of the manufacturers to ensure that shortage did not occur and that requirements of people were met adequately, the Committee would like to emphasise that necessary guidelines may be laid down in this regard and responsibility of the State Drug Controllers fixed so as to alert the Government if shortages of any medicines did occur in any part of the country.

CHAPTER VIII

MEDICAL RESEARCH

Research on medicine in India is undertaken mainly by the Indian Council of Medical Research, Central Council of Research in Indian Medicine and Homoeopathy, the All India Institute of Medical Sciences, and various other research institutions, the medical colleges etc. The objectives of the Indian Council of Medical Research are to prosecute, coordinate and assist research projects, to exchange information with other institutions similarly engaged and interested to prepare and publish reports of research works, papers and periodicals and to grant fellowship. The Council also extends research enquiries to the various colleges in hospitals. The teaching as well as service hospitals in the country also undertake research projects in addition to attending to the Indian Council of Medical research enquiries.

8.2. Research is an integral part of any hospital where teaching and service is being given. When preventive services are also being emphasised, it is very necessary that it should take part in the epidemiological study of the disease that occurs in the region, area, etc. Hospitals, with their special facilities, could act as centres for medical research, stimulating, encouraging and assisting all those working within the area.

8.3. As regards the medical research that is being promoted by Indian Council of Medical Research, the representative of ICMR has stated during evidence:—

> "The research is promoted in two ways. One is through permanent institutions. We have 9 permanent institutions under the Indian Council of Medical Research. We also promote research through the various medical institutions and other organisations which have the capacity to do the research. In research there are two aspects. One is that the person should be capable of conducting the research and the other is that we must have the necessary equipment to do the research. Wherever these facilities are available, the ICMR has been trying to promote research. In this context, I would like to submit to you that recently we have changed our policy and 90 per cent of our budget is earmarked for research which is in conformity with the needs of the community. 60 per cent

of our budget goes on research of communicable diseases, another 30 per cent of our budget goes on fertility control and only 7 to 8 per cent is earmarked for basic research. This is the trend of research programmes that are being undertaken. The ICMR also undertakes research programmes of their own. For example, we have the National Nutrition Monitoring Bureau where we are monitoring nutrition programmes that are going on all over the world. As you know the subsidised milk scheme was there. Then there are other subsidised or subsidiary feeding programmes that are going on. We are monitoring these programmes. These are going in 9 States. Similarly, every now and then we call Expert panels to go into the subjects of national importance, like blindness, diabetes, cancer etc. We have research panels which go into these subjects. They demarcate areas of research in these fields. We also on our own promote research in these various fields."

The witness has added:

"I might bring to your kind attention that the ICMR was also concerned with the hospitals infection and we had a workshop in collaboration with the WHO. This was successively completed and as a followup action we have been able to bring out certain publications which give the details about the common hospital infection and how to prevent these infections.

8.4. The Committee desired to know as to how research work was being conducted on the three hospitals *viz.* Safdarjung, Willingdon and Irwin Hospitals. To this, the Secretary, Ministry of Health, has stated during evidence:—

"There are two factors to be taken into consideration where talking about research. One is, there are teaching hospitals and there are service hospitals. In teaching hospitals, the Professors, Associate Professors, the Lecturer and others have to get themselves updated and they have to do research and inculcate a feeling of research in the persons whom they teach. Therefore, it is only fair and proper that there should be more of research in the Pant and Irwin Hospitals because they are attached to the Medical College. So far as, Willingdon Hospital is concerned some services are also manned by the Lady Harding Medical College. In certain fields of activity, the Professors and Associate Professors carry out certain research. That was not so in the Safdarjung Hospital. Now there is a college there also. Perhaps the things would change These are some of the constraints."

The witness has added:

> "There are two types of research. One is that post-graduates write thesis because they have to carry out research and results flow as a result of the research being made by them as a part of their studies. The other is that the Indian Council of Medical Research gives them projects and as a result of the studies made by them they are taken note of by the Indian Council of Medical Research. These are assessed by a Technical Committee and Experts. It is a different type of research."

8.5. Further explaining the position in this regard, the representative of the Indian Council of Medical Research has stated:

> "As far as research is concerned in these three hospitals, as the Secretary has already pointed out the Willingdon Hospital is a service hospital with the result that we have not been in a position to support research. As far as the other two hospitals are concerned, they have their teaching institutions and we have been able to support 18 research programmes ,that is 7 in Safdarjung and 11 in Irwin. Here, again, we are supporting programmes which will be of national importance. For example, there is a programme which we have undertaken, which is for a period of 4 years and that has been going on from 1975. This is about the longitudinal study of a prospective studies of birth cohort of 6,000 babies through the pre-school years. This is of great importance, because under family planning programme we are suggesting that the number of children should be limited. We have to see how far, what we are saying that children do live afterwards, is true and what are the constraints that are coming in the way. Like this we have several programmes which are of really national importance particularly leprosy, the use of antibiotics etc."

8.6. Asked how an institution like Willingdon Hospital could be described as only a Service Hospital where research was not to be either encourged or nurtured, the Medical Superintendent of Willingdon Hospital has stated:

> "Previous all the Specialists of Willingdon Hospital were teaching at Lady Harding Medical College. However, last year some teachers of Lady Harding Medical College went to the Court and now the position is that only staff of the Lady Harding teachers is there and the other 2/3rd of the Willingdon Hospital staff is not teaching. That is the legal problem, but otherwise we are quite academic minded and used to bring out a

journal every year, which contains the research work of our staff. In spite of the handicaps, we are doing as much research as possible. We have some Indian Council Medical Research Schemes. We are doing clinical research in the various departments. I can assure you that if we are given chance to teach and to undertake research in association with Lady Harding Medical College, we will definitely be able to do better."

8.7. The Committee desired to know the facilities which have been made available to the Doctors in the three hospitals for undertaking research work. In a note furnished to the Committee, the Ministry have stated:

"The basic responsibility of Doctors of the three hospitals is service to the patients, both indoor and outdoor, and accident and emergency. The teaching and the research responsibility of the three hospitals is only secondary and is as usual carried out by the staff in these hospitals which have teaching designations. All the three hospitals have the facilities for clinical research.

Research activities are undertaken in various departments of the Safdarjung and Willingdon Hospitals with a view to promoting knowledge in the field of medicine. No regular provision for research is allocated for these hospitals.

At Irwin Hospital, which is under the administrative control of Delhi Administration, no research as such is carried out. Since both Irwin and G. B. Pant Hospitals are part of Maulana Azad Group of Hospitals, Dean, Maulana Azad Medical College, coordinates research activities in the entire complex. The research activities undertaken by various departments, students and staff are on individual basis for their academic needs. Research enquiries are also received at these hospitals from various agencies, such as ICMR, University Grant Commission, the Bombay Hospital Trust, etc."

8.8. Statements showing information regarding the fields in which the Doctors in Safdarjung, Willngdon and Maulana Azad Medical Colleges and associated Irwin and G. B. Pant Hospitals have undertaken research during 1976-77, are at Appendix I.

8.9. It is seen from the statement (i) (*vide* Appendix I) that the research projects undertaken in Safdarjung Hospital during 1976-77 concern departments of Burns, Plastic and Maxillofacial Surgery, Obstetrics and Bynaecology, Haematology and Nuclear Medicine, Radiology; Orthopaedics, Paediatric and S.T.D. and in Willingdon Hospital Departments of

Medicine Surgery and Radio Diagnosis are the fields where research is to be conducted.

8.10. It is also seen from statement (ii) of Appendix I that I.C.M.R. has sanctioned research enquiries to the 11 doctors of the Maulana Azad Medical College and Associate Irwin and G.B. Pant Hospital, New Delhi and for this purpose Rs. 3,18,811 has been sanctioned. Out of this amount Rs. 98,385 are earmarked for 3 research inquiries to be attended to by the Head of Department of Obstetrics and Gynaecology and Paediatrics of the Irwin Hospital. Out of these 11 enquiries, 8 pertain to the year 1975-76 and the remaining 3 to the year 1976-77.

8.11. In view of the fact that use of atomic energy for medical purposes is very important, the Committee desired to know if any special assistance was given to the nuclear medicine section for research in the Hospitals. The Head of the Department of Nuclear Medicine in the Safdarjung Hospital, has stated in reply:

> "This is one of the most modern and latest addition to the disciplines of medicine. The speciality was really started in the international sphere soon after the Second World War. At the end part of forties it was started. In India we made a beginning of a nuclear medicine with the use of radio active medicines for diagnosis, treatment and medical research in 1957-58, soon after our atomic energy station went into production. Since that time this has been started in several Hospitals more or less in the elementary way. Today in our country we have got three major centres of nuclear medicine. One of them is the radiation medicine centre of the atomic energy, the institute of nuclear medicines in the Ministry of Defence and in our Ministry of Health we have got the centre in the Safdarjung Hospital. At Safdarjung Centre, we attend to nearly 50,000 -20,000 patients every year. The scope of nuclear medicine is all the time expanding particularly in the fields of diagnosis and medical research. Today practically one cannot think of advanced medical research without using nuclear medicine as a technique. So, there is need to enter into this particular sphere in a very large way."

8.12. In reply to a query as to whether we have any kind of recognition in the world countries as a country which makes some contribution in the field of nuclear medicines the witness has stated:

> "The three Centres I have referred to are internationally recognised of which Safdarjung Hospital is the largest hospital centre."

8.13. Asked if the Centre was getting the requisite facilities for its development and better recognition, the witness has stated:

> "This is fast-expanding discipline and it demands more facilities and more space. I think, the Ministry is fully aware of all the requirements what we have been submitting from time to time. This is one of the disciplines which needs more encouragement and expansion of the existing facilities basically from the points of modernisation of medical care and medical research."

8.14. Clarifying the stand of the Ministry in this regard, the Secretary, Ministry of Health has stated:

> "It is receiving the attention of the Ministry and we are trying to strengthen. We are trying to open more centres in other places, in the All India Institute of Medical Sciences as also in the Post Graduate Medical College and Hospital in Chandigarh."

8.15. During evidence the Committee desired to know whether the Government have any idea of the number of medicinal herbs in the country from which drugs could be produced for the use of the country as well as for export. To this, the representative of the ICMR has stated:

> "Recently the ICMR has brought out a monograph of all the herbs that are useful for medicinal purposes. The first volume has been released. Recently we have started collaborative research with one of the Ayurvedic centres in Coimbatore on particular aspects of diseases, where we feel that their treatment is much better than the Allopathic treatment. Particularly we have taken into consideration the treatment of reheumatoid arthritis. The WHD is also collaborating in this. Up till now the difficulty has been that there has been no scientific observation as far as the results are concerned. So, we are trying first to establish the diagonosis through modern scientific methods, and then hand over the cases to the Ayurvedic people and periodically assess the improvement in the patient, and when the patient is finally cured, we want to further assess and find out what changes have occurred. When an Ayurvedic drug is effective, we would further analyse the drug and find out which part of the drug is useful in the treatment of a particular disease."

8.16. The Committee pointed out that though India produces a large percentage of the World's herbs, these are not utilised to the maximum possible extent. India can produce drugs of its own and export them also. The Committee felt that if the Health Ministry and other related Ministries take keen interest, something might emerge which would be concrete and helpful to the country. Reacting to the idea, the Secretary, Ministry of Health has stated:

> "This is a very valuable suggestion, and I am grateful to you. It has been received from the Deputy Chairman of the Planning Commission also. We are working out the details."

8.17. In a note subsequently furnished to the Committee on the exploitation of indigenously available medicinal herbs for domestic use and for export, the Ministry of Health have, *inter alia* stated as under;

"*Drug Research*:

> The programme connected with various aspects of drug has been taken up by the Central Council for Research in Indian Medicine and Homoeopathy, through survey of Medicinal Plants Units and multi-disciplinary research schemes which envisages Pharmacognostical, chemico-pharmacological and clinical studies. Units dealing with evolving standards for raw drugs, method of manufacture and finished products on the lines indicated in Ayurveda adopting the available modern technique that are suitable to elucidate the principles described. Efforts are also made to cultivate drugs under known conditions with accent on making suitable experiments in the cultivation to increase the yield without the drugs loosing their inherent/innate potentialities Indian medicine advocates use of crude drugs and natural products and by this the patient is not subjected to vagaries of the unanticipated or unforeseen effect of isolated material which is later synthesised. Study of this must be exhaustive from all angles and aspects before applied at clinical level. The Council has taken up the investigation certain therapeutic potentialities claimed for some drugs by providing them to certain units under code numbers. This coded drug trial can provide an unbiased study of drug effects whenever any potentiality is reported. In view of the heavy demand and shortage of supply of drugs like saffron, musk and gandhamarjara veerys, efforts have been made to obtain these drugs in pure form.

Family Welfare .

The Council has taken up to a large scale trial of drugs showing promising contraceptive potentiality. Vidangadiyoga and japakusum are considered to be suitable for this as per the results obtained and further work is in progress to establish the same.

The Council is thus primarily concerned with research in India Systems of Medicine. The approach of Council has thrown light and that these systems can thrive and develop only through a systematic research. The Central Research Institutes and Regional Research Institutes as well as the Clinical Research Units established by the Council are making efforts to evolve cheap and effective medicines for the treatment of various clinical conditions. The usefulness of Mandookparni (Centella agiatics) in cases of mentally retarded subjects, (Kanthocarpum) in cases of respiratory diseases, Ashwagandha (With aniacomnifera in cases of joint troubles and also as Rasayana, Karaveera (Nerium Indicum), in certain types of Hridroga (Cardiac-disorders), Haridra (Curcuma Longa) in cases of eosinophilic lung diseases are a few of the many drugs that have shown promising leads for inclusion in the therapeutic armamentarium.

Different type of Institutions started to undertake the above programmes ahead with the work allotted to them. The Research is a continuous process and the data collected during the past 4-5 years is inadequate to come to any definite conclusions. The Scientific Advisory Boards for Ayurveda, Unani, Siddha are guiding and supervising the research activities of these centres under the respective systems from time to time. The scope and functions of each centre are decided and formulated by the respective technical bodies. The work of each unit is also evaluated by them periodically. It also evolves methods to streamline the work of different institutions based on the experience and necessities from time to time, which are being implemented in accordance with the guidelines laid down by the Scientific Advisory Boards.

The following are some of the achievements of the Council in brief.

The following is the list of a few drugs whose therapeutic potentiality is established and steps are in progress to explore and identify new areas of usefulness and utility.

Ayurveda:

Guggulu (*Commiphora mukul*) in *Medorooga. Mandookaparni Centella asatica* in mentally retarded subjects.

Karaveera (*Nerum Indicum*) in *Hridroge.. Kantakari* (*solamun*) *Zanthogarpum*) *in Swasa. Haridra* (*Curcuma Longa*) *in Savasa* and *Amavata* and as antihisteminic agent. *Purarnava* (*Boehaa, via Diffusa*) *in*

Prasarini (*Poederia foetida*) in *Gridrasi* and *Sandhigataveta.*

Yashtimadhu (*Glyeprrhiza glabra*) in *Idarasoola. Changeri* (*Oxalis Corniculata*) in *Amlapitta. Aragwadha* (*Classia fistula*) in *skin diseases.. Sirisha* (*Albizzia lebbeck*) as anti histaminic effect and Swasa.

Shigru (*Moringapterygosperma*) *in Udarakrimi. Katukarobini Picrorhiza Kurgoa* in *Pakritroga, Mammajjak* (*Enicestemma Littorale*) in *Madhumeha.. Varuna* (*Cretnaeva nurvala*) in *ashmari* and *Udarshoola.*

2. Further steps have been taken to use simple compound preparations described in ayurveda with a few alterations in the ingredients is given trial to extend the base of the drug usefulness.

3. The Council has evolved pharmacopoeial standards for about 475 medicinal preparations.

4. Standards helpful for identification of about 200 single drugs are evolved.

5. Chemico pharmacological information on about 70 drugs is worked out.

6. Pharmacognostic study of drugs alongwith common adulterants/ substitutes as well as allied species.

7. The Council has conducted medico-botenical survey of about 200 forest Zones to assess the quantitative drug wealth and also need of the drug requirements of research institutions of the country and collected 13,500 herbarium sheets.

8. The Council was able to discover the following taxa new to science.

   (a) Impatiens raziana sp. Nov.

   (b) Marsedenia raziana sp. Nov.

   (c) Impatiens acaulis Arn. Var. G ramulata Var. Nov.

   (d) Sonnerila peduncueloga Thw.

9. Experimental and large scale cultivation of those drugs which are either rare to this country or which are being imported for the present or which are utilised on large scale. So far 1,24,000 medicinal plants have been brought under cultivation consisting of about 70 different species.

10. A programme of cultivation of saffron in the areas away from where they are normally cultivated was launched.

11. The Council was able to find out areas/belts where Shilajith, Sulphur, borax, arsenic, Jaharmohra, Ambergis, Corals, Cinnamomum, Camphor are available.

12. Medico-botanical survey of the leh Laddak, Arunachal Pradesh, Andaman Nicobar and certain tribal pockets of Nilgiris have been undertaken to explore its medicinal wealth.

13. The Council conducted survey and surveillence programme in various renderly selected areas to obtain information on diet habits, disease proninence, resource, wealth and folklore, in addition to providing incidential medical aid which is also made available by various Institutes/Centres/Unit etc. of the Council all over India.

14. About one thousand folklore claims-drugs having traditional usage-background have been collected.

15. A centre for breeding of musk deer and civet cat set on experimental basis with a view to study the possibility of obtaining genuine musk and Gandha majrara veerya which is used fairly and frequently in most of the preparations.

16. The Council found out cheap effective remedy for (1) Epilepy (2) Leucoderma (3) Mental retardation (4) Psychogenic headache and (5) Mental disorders.

Family Planning:

17. The Council has taken up an extensive drug trial programme drugs like vidangadi Yoga, Japakusum and Ayush AC which showed promising effects at experimental and pilot levels in regard to their anti fertility potentiality.

18. The Council is able to find out three cheap and effective drugs for family planning purposes.

19. The Council is publishing two journals *viz.* Journal of Research in Indian Medicine and Bulletin of Indian Institute of History of Medicine quarterly with information on research activities that will help medical teams all over the country.

20. The Council has brought 22 monographs to help medical men as well as research workers within this short spell.

21. The Council has applied for 13 patents for the new procedures items which are finding of extensive research within this short period.

22. The Council has organised a scientific seminar of research workers in 1972 for exchanging the views and to discuss the achievements done by the Council.

23. Seminar on Yoga, Science and Man was arranged in 1974 which had the world wide applause.

24. The Council was able to present an Ayurvedic Kit to the nation which contains simple effective remedies for common ailments.

Future Programme:

Having regard to the progress and achievements made by the Council during the last 4-5 years, now it is also proposed to consolidate the working pattern of the various research projects of the Council in a phased manner to obtain the optimum result with the available resources, keeping in view of the principles indicated in the classifical treatises. Further it is also proposed to bring the various scientists and discipline under one roof to have the better co-ordination. The extensive study of cheap remedies are initiated keeping in view the nations need. Special survey parties will be sent to Sikkim, Lakshwadeep etc. to explore the medico-botanical wealth of the country besides collection of folklore claims,

which are for the present unexplored. Intensive collection of the materials related to 350 India medicinal plants including other alleged species approved by the Ayurvedic Pharmacopoeia Committee of Health Ministry will be carried out.

8.18. As regards the export of Indian Medicinal Plants, a list of such plants that were exported during 1974-75 and the quantity of each exported during that year are shown in Appendix II.

8.19. It will be seen from the above statement that 112 medicinal plants were exported during 1974-75. Regarding export promotion of Indian herbs, the Ministry of Health have further stated in a note:

"So far no systematic efforts appear to have been made for promotion of export of Indian herbs or for determining export potential of Indian Herbs. Foreign countries importing Indian drugs do not utilise them exclusively for clinical purposes. Some of herbs find their way to chemical industry. There is also an instance of Isabgol being used in France for manufacture of Ice cream. Therefore, for determining export potential of the Indian herbs, a special study has to be arranged by Indian trade diplomatic representatives abroad or by some other specialised agency. There is no machinery under Ministry of Health and Family Planning for undertaking such a task."

8.20. Stressing the need for production of indigenous drugs from medicinal plants, the Estimate Committee (1975-76) in their 102nd Report (5th Lok Sabha) had commented as under:-

'The Committee are glad to note that the All India Institute of Medical Sciences have done considerable work in the study of indigenous drugs and are presently engaged in carrying out clinical examination and trial of some of the indigenous drugs like development of peruvoside for treatment of heart diseases, calophyllolide (which prevents blood clotting) and extract of Guggulu (which has been found effective in joint diseases and hear diseases). The Committee urge that clinical trials of these drugs should be expedited and if found successful the drugs adopted for universal use.

The Committee suggest that lists of the indigenous drugs standardised and tested may be prepared and furnished to all Government and local hospitals/dispensaries.

The Committee also note that the Institute is working on an Ayurvedic herb preparation called "Rudrawanti" for treatment of cancer. The Committee desire that the tempo of such studies should be accelerated and that the Institute should play pioneering role and give a lead in developing and assimilating the knowledge available in the Indian system of medicine so as to serve the health needs of the vast majority of our people."

8.21. The Committee note that the Indian Council of Medical Research which supports the medical research in the country serves as an apex body in this field. Besides, carrying out research through its 9 permanent institutions, the ICMR also helps to promote the research through various medical institutions and other organisations which have the capacity to do the research. The Committee have been informed that 60 per cent of the budget of the Council is spent on research on communicable disease, another 30 per cent on fertility control and only 7 to 8 per cent is earmarked for basic research. Though research on communicable and other diseases which take a heavy toll, is welcome, the Committee feel that there should not be any kind of rigid artificial compartmentalisation as between basic research and other kinds of research. The divisions should be more appropriately done on the basis of scientific evaluation and the health needs of the vast majority of the people.

8.22. The Committee have a feeling that research in the three hospitals is a secondary responsibility of the doctors and the service to the patients is one of prime importance. The research activities are undertaken in Safdarjang and Willingdon Hospitals by the staff who have teaching designations with a view to promoting knowledge in the field of medicine. No regular provision for research is allocated for these hospitals. In Irwin hospital no research as such is carried out there. Since both Irwin Hospital and G. B. Pant Hospitals are part of the Maulana Azad Group of Hospitals, Dean, Maulana Azad Medical College coordinates research activities in the entire complex. The research activities undertaken by various Departments, students and the staff are on individual basis for their academic needs. These hospitals also attend to various agencies, such as Indian Council of Medical Research and University Grants Commissions etc.

8.23. The Committee are unhappy that the Indian Council of Medical Research has not been able to support much of the research projects in Willingdon Hospital whereas it has supported 18 research projects in other two hospitals that is 7 in Safdarjung and 11 in Irwin. The reason that has been given is that the Willingdon Hospital is only a servicing hospital while the other two are both teaching and servicing hospitals. The Com-

mittee further find that in the case of Willingdon Hospital there is only a partial association with Lady Hardinge Medical College. The Committee are unable to understand how a large and effective medical institution like the Willingdon Hospital should be deprived of all opportunities of research work and should have no association with an academic institution and particularly when medical science, teaching, research and practice have all to go together. In fact, during evidence before the Committee, the Medical Superintendent, Willingdon Hospital has assured the Committee that "if we are given chance to teach and to undertake research in association with Lady Hardinge Medical College, we will definitely be able to do better." The Committee need hardly urge upon the Ministry to ensure that as far as possible, the hospitals should be linked with some academic institutions so that the doctors and other who are research minded are not inhibited from pursuing research of their own.

8.24. The Committee find that during 1976-77 the research projects undertaken by doctors in Safdarjung hospital include 7 Departments whereas in Willingdon hospital there are only 3 Departments. The Committee also find that during 1975-76 and 1976-77, the Indian Council of Medical Research has sanctioned 11 research enquiries to the various doctors of the Maulana Azad Medical College and associate Irwin and G. B. Pant Hospitals and for that a budget of Rs. 3,18,811 was sanctioned. Out of these 11 research enquiries only 3 are to be attended to by the Heads of the Departments of Obstetrics and Gynaecology and Paediatrics of the Irwin Hospital. The Committee desire that more and more time-bound and result-oriented research enquiries should be sanctioned to the various Departments of the Hospitals by the ICMR and other agencies. Great care should be taken in the matter of selection of the projects so that priority is given to research on diseases which are widely prevalent and for the prevention of specially the weaker sections of the society.

8.25. In the opinion of the Committee the tempo of medical research and practical applications of results achieved in this field could be considerably intensified by the application of nuclear methods. As the medical research by nuclear methods is a fast expanding discipline and demands more facilities and more space, the Committee would like to urge upon the Government to enter into this particular sphere in an effective way by starting more centres in the hospitals for conducting research. This is a field which could be pursued not only intrinsically for itself but also for the results which could follow.

8.26. The Committee find that the programme of exploiting medicinal herbs in the country has been taken up by the Central Council of Research in Indian Medicine and Homeopathy, through survey of medicinal plants units and multi-disciplinary research schemes which envisages pharmaco-

nostical, chemicopharmacological and clinical studies. The trials of certain drugs like Vidan-gandiyoge and Japakusum have shown promising contraceptive potentiality and the usefulness of some other medicinal herbs in cases of mental retardation, respiratory diseases, joint troubles etc., has also been established. As the data collected by the different institutions working under the Council during the last 4-5 years is inadequate to come to any definite conclusion, the Committee urge that clinical trials of these drugs should be expedited. The Committee agree with the views expressed by the Ministry in this respect that the working pattern of the various research projects should be consolidated in a phased manner so as to obtain the optimum results with the available resources. Efforts should also be made to send special survey parties to the Medico-Botanical fields of the country to explore more and more medicinal plants. Extensive studies should be intiated on these plants with a view to evolving cheap remedies to the various diseases in the country. This can be achieved by bringing the scientists and disciplines under one roof to have co-ordination for better results.

8.27. The Committee learn that the All India Institute of Medical Sciences has done considerable work in the study of indigenous drugs and are presently engaged in carrying out chemical examination and trial of some of the indigenous drugs for treatment of heart diseases, joint diseases and hear diseases. The Estimates Committee (1975-76) in their 102nd Report (5th Lok Sabha) have suggested that lists of indigenous drugs standardised and tested should be prepared and furnished to all Government and local hospitals/dispensaries. The Committee hope that in the matter of research work in indigenous drugs, there would be complete co-ordination between Central Council of Research and Homeopathy and the All India Institute of Medical Sciences so as to avoid duplication of effort in their research a great scope for intensifying the export efforts.

8.28. The Committee find that no systematic efforts have been made for promotion of export of Indian herbs or for determining export potential of the Indian herbs. As the foreign countries importing Indian drugs do not utilise them exclusively for clinical purposes but also for chemical industries, the Committee desire that a special study to determine export potential of the medicinal herbs may be undertaken by Indian trade agencies abroad for the benefit of the overseas buyers. Considering the fact that 112 medicinal plants were exported during 1974-75, the Committee feel that there is a great scope for intensifying the export efforts.

CHAPTER IX

MEDICAL AUDIT

Audit paragraph

The Health Survey and Planning Committee (1959-61) in its report had suggested that medical audit should be encouraged in every hospital/ institution. The Delhi Hospital Review Committee headed by Dr. K. N. Rao, in its report submitted in April 1968, had recommended that each hospital should appoint immediately a Medical Audit Committee, with a Pathologist, a Surgeon, a Physician and a Medical Record Officer. The Medical Audit Committee was to function as a patient care evaluation cell and look into wide ranging issues which impinge on patient care. This recommendation was accepted by the Government of India and instructions were issued for its implementation (February 1970). No such Committee has been constituted in any of the three hospitals so far (September 1975).

9.2. The Rao Committee had also recommended that in each hospital mortality review should be carried out periodically. This recommendation was also accepted by Government (February 1970) and, in pursuance thereof mortality review committees are functioning in Safdarjung and Irwin Hospitals. No such committee is functioning in Willingdon Hospital. These committees in their deliberations review the course of treatment given essentially from the professional angle, with a view to draw legislation for future guidance. The Ministry stated (December 1975) that action was being taken to introduce medical audit and mortality review immediately wherever it was not being done.

9.3. In Safdarjung Hospital, 4 committees constituted to review the mortality cases held 20 meetings during 1974-75 and reviewed 2 to 68 (average 26) cases in each sitting. The principal findings were:

(i) Recording of a case history poor,

(ii) case notes were incomplete and not in order,

(iii) Operation notes were not recorded,

(iv) details of the resuscitation measures carried out were not mentioned.

9.4. In Irwin Hospital there is one committee to review the mortality cases. During 1974-75 it held 10 meetings during which it reviewed 4 to 10 cases in each sitting. The main findings were:

(i) Documentation was sketchy.

(ii) Due regard was not given to the calorific intake of the patient when he was put on high doses of geramycine.

(iii) As there were a number of deaths as a result of tetanus it was decided that in future ATS may be invariably used instead of tetanus toxide.

(iv) In the case of a patient, who developed tetanus after operation it is observed that tetanus toxide injection was given instead of ATS.

(v) Patients in the resuscitation ward might be seen by the senior members of the faculty instead of senior residents.

[Paragraph 30 of the Report of the C&AG for the year 1974-75, Union Government (Civil)].

9.5. It is seen from the Audit paragraph that the mortality review committees were set up in Safdarjung Hospital and Irwin Hospital in pursuance of the recommendations made by the Review Committee on Delhi Hospitals (1968). As regards the Willingdon Hospital, the Ministry of Health have informed the Committee that the mortality review committee in Willingdon Hospital has been functioning since May 1976.

9.6. As stated in Audit para, 4 committees constituted in Safdarjung Hospital to review the mortality cases held 20 meetings during 1974-75 and reviewed 2 to 68 (average 26) cases in each sitting. The Committee desired to know why there was so much variation in the number of cases reviewed in each sitting of the review committee in Safdarjung Hospital. In a note furnished to the Committee, the Ministry have stated:

"In all hospitals, the respective departments are supposed to review the cases of death occurring in that Department. Cases where deaths could have been prevented or where cause of death are not certain or which are of interest from the medical stand point are referred to mortality review committee. This helps in improving the knowledge of the doctors and their capability of handling such cases in future. Such a system exists in all the hospitals. Under the circumstances explained above, there are bound to be variations in the number of such cases."

9.7. As regards the steps taken to remedy the deficiencies in documentation pointed out by the Review Committee in Safdarjung Hospital, the Min-

istry have stated that the deficiencies are immediately brought to the notice of the concerned Medical Officers for their future guidance.

9.8. The Committee further desired to know the action that has been taken on the findings of the Review Committee set up in Irwin Hospital on mortality cases. The Ministry, in a note have stated:

> "Instructions have been issued to improve documentation and other points made by the Review Committee have been noted.
>
> The resuscitation ward attached to the emergency department has been improved and has been provided with necessary life saving equipments. A proposal from Irwin Hospital for setting up an accident centre has been sent to Planning Commission."

9.9. The Committee are constrained to note that despite the recommendations made by the Health Survey and Planning Committee (1959—61) and the Delhi Hospital Review Committee (April 1968) to appoint a medical audit committee in every hospital with a pathologist, a surgeon, a physician and a medical record officer to function as a patient care evaluation cell, no such committee has been constituted in any of the three hospitals so far. The Committee also note that the Ministry had informed the Audit in December 1975 that action was being taken to introduce medical audit committees wherever it was not done. As the appointment of such committees will ensure specific checks on the standard of the work performed in the hospitals, the Committee would like to be informed whether such committees have since been constituted in each of the three hospitals.

9.10. The Committee regret to note that although the recommendation of the Review Committee for carrying out hospital mortality review periodically was accepted by the Government in February 1970, it was only after a lapse of six years (May 1976) that the mortality review committee started functioning in Willingdon Hospital. The Committee hope that the deficiencies in documentation pointed out by the Review Committee would receive the careful attention of the concerned medical officers.

9.11. While the Committee appreciate that resuscitation wards attached to the Emergency have been provided with necessary life saving equipments, they would suggest that patients in these wards should be examined by senior members of the faculty instead of senior resident doctors.

NEW DELHI;
December 9, 1977.
Agrahayana 18, 1899 (*Saka*).

C. M. STEPHEN,
Chairman,
Public Accounts Committee.

APPENDIX—I

(*Vide* para 8.8 of the Report)

(i) STATEMENT SHOWING INFORMATION REGARDING RESEARCH PROJECTS UNDERTAKEN IN SAFDARJANG AND WILLINGDON HOSPITALS DURING THE YEAR 1976-77.

SAFDARJANG HOSPITAL

Name of Research Project :	
Deptt. of Burns, Plastic and Maxillo-facial Surgery.	1. Serial Tangential Excision & Skin Grafting. 2. Burn Injuries. 3. Clinical Trial of Furacin. 4. An investigation in the Haemolytic state in Post Burn Anaemia. 5. Clinical Trial of Medecassol in local treatment of Burns & Keloids.
Deptt. of Obstetrics & Gynaecology	1. Post dated pregnancy. 2. Complication of labour 3. Anaemia in pregnancy; and 4. Mid Trimester, abortion with prosta glandins.
Deptt. of Haematology & Nuclear Medicine	1. Research on New Theory of Diabetes and Heart Disease. 2. Research on Poisonous Snakebite. 3. Development of new diagnostic procedure by Nuclear Medicine.
Deptt. of Radiology . . .	1. Post radiation changes in the intestines as seen in X-ray study by Barium Meal. 2. Role of Ex Cretomy Miography in Carcinoma of the Cervix. 3. Roentgen findings in hands in systemic diseases of the children.
Deptt. of Orthopaedics . . .	1. Studies on Osteoporosis. 2. Studies on Bone formation rates in normal Indian Population. 3. Studies on Bone formation rates in healing fractuers 4. Restoration of hand function following tendon transfer in peripheral nerve injuries. 5. Restoration of function in spastic hands. 6. Management of fracture neck or femur. 7. Histochemical studies of Bone tumour. 8. Fracture of elbow in children. 9. Low back ache. 10. Scoliesis.
Deptt. of Paediatric . . .	1. A longitudinal study of a prospectively studied birth cohord. 2. Ante-body assay after DPT immunization. 3. A study of the relationship of Etiological factors, growth and development pattern to birth and gestational age in babies with birth weight of 2000 gms. of below.

Deptt. of S. T. D. . . .	1. Response of "Myron" in the treatment of T. V. Gaginitis moniliasis and non-specific Leucorrhoea in women. 2. "Fortegs" another indigenous drug in the treatment of sexual problems in male. 3. Oral Pencillin in the treatment of Gonorrhoea. 4. Teramycin injections in the treatment of Gonorrhoea.

WILLINGDON HOSPITAL

Deptt. of Medicine . . .	1. A study of latent iron deficiency. 2. Electro cardiographic changes following Electro-convulsive therapy in non-cardiac cases.
Deptt. of Surgery . . .	1. A study of correlation between clinical picture and biochemical changes following head injuries. 2. Role of magnesium derangements in Actiology of Paediatric Urolithiasis.
Deptt. of Radio Diagnosis . .	1. Roentgen and Isotopec evaluation of Biliary disorders.

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ii) STATEMENT SHOWING I.C.M.R. RESEARCH ENQUIRIES SANCTIONED TO MAULANA AZAD MEDICAL COLLEGE AND ASSOCIATED IWRIN AND G.B. PANT HOSPITALS

S. No.	Name of the Officer-in-charge	Title of the Research Enquiry	Total Budget sanctioned
			Rs.
1.	Dr. (MISS) S. Padmavati, Director & Consultant, Department of Cardiology, G. B. Pant Hospital, New Delhi-2.	"Study on prophylaxis of rheumatic fever and rheumatic heart disease" .	85,640·00
2.	Dr. Kunal Saha, Associate Prof. of Microbiology, G. B. Pant Hospital, N. Delhi-2.	"Chemical, immunological and biological Characteristics of immunoglobulins in sera and urine from leprosy patients"	7,800·00
3.	Dr. P. S. Narayanan, Associate Prof. of Cardiothorasic Surgery, G. B. Pant Hospital, New Delhi-110002.	"A study of the feasibility of maintaining artificial ventilation in a new method of jet ventilation through percutaneously introduced tracheal catheter"	10,200·00
4.	Dr. (Mrs.) Sobha Janah, Lecturer in Biochemistry, G. B. Pant Hospital, New Delhi-2.	"Influence of iron deficiency anaemia on cell mediated immunity and antibody forming immune mechanisms in guinea pigs.."	7,800.00
5.	Dr. P. C. Beohar, Associate Prof. of Pathology, G.B. Pant Hospital, New Delhi-2.	"Chick embryo model alongwith its several organelles for experimental testing of unvironmental substances etc."	30,900.00
6.	Dr. S. N. Mukherjee, Prof. & Head of Obstt. & Cynae., Irwin Hospital, New Delhi-2.	"Collaborative study on short term sequelae after abortions.." . .	55,645·00
7.	Do.	"Collaborative study on sequelae of Tubal sterilization"	30,540·00

Sl. No.	Name of the Officer-in-charge	Title of the Research Enquiry	Total Budget sanctioned
			Rs.
8.	Dr. (MISS) Satya Gupta, Prof. & Head of Paediatrics, Irwin Hospital, New Delhi-2.	"A study of nutritional anaemias in pre school children with special reference to folic acid deficiency" . . .	12,000·00
9.	Dr. D. S. Agarwal, Prof. & Head of Microbiology, M.A.M.C., New Delhi-2.	"Staphylococcal Phage Typing Centre"	43,386·00
10.	Dr. R. Nigam, Spl. Prof. & Student Consullor, M.A.M.C., New Delhi-2.	"Clinical epidemiological study of occulusive peripheral vascular disease" ·	17,700·00
11.	Dr. M. Bhaskar Rao, Asstt. Prof. of Medicine, M.A.M.C., New Delhi-2.	"Collaborative studies on diabetes & endocrinology (i) Serum lipid studies etc. (ii) Isocaloric diets of varying composition in the management of Indian diabetics".	17,000·00

Note :—S. No. 1, 2, 3, 5, 6, 8, 9 and 10 pertains to 1975-76 and 1976-77.
S. No. 4, 7 and 11 to 1976-77.

APPENDIX II

(*Vide* para 8.18 of the Report)

EXPORT OF INDIAN MEDICAL PLANTS (1974-75)

Sl. No.	Latin Name	Ayurvedic Drug	Export Items (As per list)	Quantity in Kg.
1	2	3	4	5
1	*Acorus Calamus* Linn. . . .	vaca	Calamus Root	40,000
2	*Adhatoda Vasica* Nees. . . .	Vasa		21,320
3	*Aegle Marmelos* Corr. . . .	bilva	(Beela)	840
4	*Agaricus campestris*	—	Mushroom (Golden)	11,318
5	*Alpina galangal*	—	Kulinjan	89,050
6	*Anacyclus Pyrethrum* DC . . .	akarakarbha	Akkal garah	185
7	*Annona squamossa* Linn. . . .	—	Sitaphal	
8	*Asparagus racemosus* Willd . .	satavari		1,898
9	*Agadirachta indica* A Juss. . .	nimba	Neem leaves	60
10	*Benincasa hispida* (Thumb) Cog. .	kusmanda	Kadoo	3,992
11	*Berberis aristata* DC. . . .	daruhardra	Berberis bark Rasavanti	3,000
12	*Brassica campestris* Linn. Var. rapa (Linn) Hartm.	sarsapa	Mustard dall	70
13	*Buchana nialanzan* spreng. . .	priyala	Charoli	1,061
14	*Butea monosperma* (Lam.) Kuntze .	palasa	Kesuda flower	425
15	*Carum carvi* Linn.	Krsnajiraka		
16	*Cassia absus* Linn. . . .	chaksoo		9,308
17	*Cassia angustiforia* Vahl. . . .	swarnapatri	Sona mukhi	9,655
18	*Cassia esculenta*		Sapta rangi	503
19	*Cassia Fstula*		Aragwadh	5,085
20	*Celastrus paniculatus* Willd. . .	jyotismati	Malkangni	1,280
21	*Cholorophytum tubarosum* Dalz. . .	musali	Salam musali	500
22	*Cichorium Intybus*		Kasani	350

1	2	3	4	5
23	*Cinnamomum Cassia Blume & Eberm.* .		Cassia bark	5,000
24	*Cinnamomum tamala* Nees & Eberm.	tejapatra	Tamal patra	1,944
25	*Cinnamomum Zeylancium* Blume .		Taj Deshi	1,000
26	*Cocus nucifera* Linn. . . .	narikela	Coconut peds	
27	*Colchicum luteum*		Suranjan Sheeren	300
28	*Coleus vettiverides* K.C. Jacob .	hrivera	Hirabor Sugandbala	5,813
29	*Commiphora mukul* (Hook ex Stock) Engl.	guggulu	Googal	545
30	*Crataeva narvala* Buch. Ham. . .	varuna	Vaurina	5,000
31	*Croton tiglium* Linn. . . .	jayapala	Jamlgoda	2,170
32	*Cucumis sativus* Linn. . . .	trapusa	Magas Khira	2,078
33	*Curcuma amada* Roxb. . . .	kapura haridra	Amba Haldar	215
34	*Cydonia oblonga*		Bedana	398
35	*Cynodon dactylom* (Linn.) Pers. .	durva	Doob	2,000
36	*Cyperus rotundus* Linn. . . .	musta	Nagamottihe	28
37	*Embelia ribes* Burn. f. . . .	vidanga	Vavding	5,207
38	*Emblica Officinalis* Gaertn. . .	amalaki	Hamla	300
39	*Euphorbia dracunculoides* Lam. . .	Saptala	Chikaki	185
40	*Foeniculum Vulgare* Mill. . . .	madhurika	Badian	50
41	*Fumaria parviflora* Lam. . . .	parata	Shahatara	200
42	Gardinia gummifera . . .		Dikamali	
43	*Glycyrrhiza glabra* Linn. . .	yasti	Jethiamadhshiro	300
44	*Hedychium spicatum Ham ex Smith* .	sati	Kachuro	3,020
45	*Hemidesmus indicus* R. Br. . .	sveta sariva	Anantmul	2,250
46	*Holarrhena antidysenterica Wall* .	kutaja	Inder Jav	3,060
47	*Hordeum vulgare* Linn. . . .	yava	Javasha	25
48	*Hyoscyamus Niger* (leaves) . .		Parsik Yavani	2,185
49	*Hyssopus officinalis*		Gilai Zoofa	
50	*Indigofera tinctoria*	nili		300
51	*Lallemantia Royleana* . . .		Tukhme Balunga	5,105
52	*Linum usitatissimum* Linn. . .	atasi	Alsi	80
53	*Litsea Chinensis* Lam. . . .		Mehda Lakadi	10,65

1	2	3	4	5
54	*Madhuca longifolia* (Linn.) Maebriden	madhuka	Mahua (Ful)	178,850
55	*Mallotus philippinensis* Muell. Arg. .	kampilla	Kapilo	430
56	*Melia azedarach* Linn. . . .	mahanimba	Sweet Neem leaves.	25
57	*Mesua ferrea* Linn. . . .	nagakesara		3,340
58	*Mimusops elengi* Linn. . . .	atmagupta j	Kavchi	100
59	*Musa paradisiaca* Linn. *Var. Sapienum* Kuntze.	Kadali (Stem)	Banana	1,054
60	*Myristica Malabarica* . . .		Ramparti (Marathi)	415
61	*Nardostachys jatamansi* DC . .	jatamansi j	Jatamanshi	9,331
62	*Nelumbo nucifera* Gaertn. . . .	kamala		
63	*Nerium indicum* Mill. . . .	karavira	Thevetia j Nerifolia (Seeds)	1,725
64	*Nigella sativa* Linn. . . .	upakunchika	Kalijiri	7,551
65	*Nymphaea alba* Linn. . . .	kumuda	Lotus Pods	9,010
66	*Onosma bracteatum* Wall. . . .	gorhva	Gavagean	
66-A	*Operculina turpethum* Linn. . .	trivrit	Turbud	3,150
67	*Paeonia essicinalis*		Udaslib	1,060
68	*Pandanus tectorius* Solan ex Parkinson	ketaki	Poppy heads broken	
69	*Papaver somniferum* Linn. . .	ahiphena	Khas Khas	450
70	*Parmelia perforate*	saileya	Chelilo	7,776
71	*Paspalum scrobiculatum* Linn. . .	kodrava	Kodra	1,800
72	*Phyllanthus niruri* Linn. . . .	bhumyamalaki		2,000
73	*Picrorhiza kurroa*, Royale ex Benth .	katuki		5,000
74	*Piper cubeba* Linn. f. . . .	kankola	Chinikabal	1
75	*Piper longum* Linn. . . .	pippali	pipplamul	1,560
76	*Piper nigrum* Linn. . . .	marica		
77	*Pistacia integerrima Stew ex Brandis* .	karkatasrngi	Karkafa-kus-ringi	600
78	*Pistacia lentiscus*	mastaki	Mastaki Rumi	250
79	*Plumbago zeylanica* Linn. . .	citraka		1,505
80	*Psoralea corylifolia* Linn. . .	bacuki	Bowchi	56,986
81	*Pterocarpus marsupium Rob* . .	asana	asan	417

1	2	3	4	5
				Rs.
82	*Pueraria tuberosa* DC . . .	vidari	Vidari Khard	10
83	*Punica granatum* Linn. . . .	dadima	Anardana	9,601
84	*Randia dumetorum* Lam. . . .	madana	Manfal	150
85	*Raphanus sativus* Linn. . . .	mulaka	Muli Bij	1,000
86	*Rosa Centifolia* Linn. . . .	sarapatrika	Rose flower dried	1,838
87	*Rubia cordifolia* Linn. . . .	manjistha	Majitha	502
88	*Saliva haematodes*;		Bahaman Surkh	600
89	*Santalum album*		Sandal wood (deoiled flakes)	5,080
90	*Sapindus mukorossi* . . .		Aristaka	203
91	*Scindapsus officinalis* Schott. . .	gajapappali	Gaj Thiappilli	600
92	*Sesbania grandiflora* (Linn.) Pers. .	muni	Munny grass	7,186
93	*Simlax china* Linn. . . .	madhusnuhi	Chop Chini	100
94	*Smilax ovata*		ushba	500
95	*Stephania glabra* (Tubers) . .		Puraha (Dehradun)	320
96	*Swertia chirata* Buch. Ham. . .	kiratatikta	Kiryato	16
97	*Symplocos racemosa* Robx. . .	lodhra	Lodhor	63
98	*Terminalia belerica* Robx. . .	bibhitaka	Beda	1,006
99	*Terminalia chebula* Robx. . .	haritaki	Bal Harda	30,849
100	*Tinospora cordifolia* (Wild) . .	gudchi	Galo	
101	*Trachyspermum ammi* (Linn.) . .	vavani	Ajwain	32,229
102	*Trachyspermum roxburghianum* (DC) Sprague	ajmoda	Ajmoda	100
103	*Trapa bispinosa* Robx. . . .	srngataka	Singoda	50
104	*Tribulus terrestris* Linn. . . .	goksura	Gokiru	610
105	*Trigonella foenumgraecum* Linn.	methi	Methidal	286
106	*Valeriana wallichii* DC . . .	tagara	Velerian Roots	67,373
107	*Vinca rosea* (leaves) . . .		Tatanjot	24,431
108	*Viola odorata* Linn. . . .		Banfsa	4,000
109	*Woodfordia fruticosa* Kurz . .	dhataki	Dhavaniful	1,221
110	*Zizyphus jujuba* Lam. . . .	Kola	Unnab	36
111	*Asphaltum*		Silajit	10
112	*Plumbi oxidum*		Mardarsingh	4,905

Point : 67 :

(a) Please state what facilities have been afforded to the doctors in the three hospitals for undertaking research work and what is their programme during the year 1976-77.

(b) In which field have the doctors of these hospitals conducted research so far?

Answer:

The basic responsibility of doctors of the three hospitals is service to the patients, both indoor and outdoor, and accident and emergency. The teaching and research responsibility of the three hospitals is only secondary and is as usual carried out by the staff in these hospitals who have teaching designations. All the three hospitals have the facilities for clinical research.

Research activities are undertaken in various departments of the Safdarjang and Willingdon Hospitals with a view to promote knowledge in the field of medicine. No regular provision for research is allocated for these hospitals.

At Irwin Hospital, which is under the administrative control of the Delhi Administration, no research programme as such is carried out. Since both Irwin and G. B. Pant Hospitals are part of Maulana Azad Group of Hospitals, the Dean, Maulana Azad Medical College, coordinates research activities in the entire complex. The research activities undertaken by various departments, students and staff are on individual basis for their academic needs. Research enquiries are also received at these hospitals from various agencies such as I.C.M.R., University Grants Commission, Bombay Hospital Trust, etc.

A statement containing information regarding the fields in which the doctors in Safdarjang, Willingdon and Maulana Azad Medical College and Associated Irwin and G. B. Pant Hospitals have undertaken research during 1976-77 is attached.

APPENDIX III

Conclusions/Recommendations

S. No.	Para No.	Ministry/ Department concerned	Conclusions/Recommendation
1	2	3	4
1	1.57	Deptt. of Health	The Committee note that the expenditure on each of the three hospitals *viz.*, Safdarjang, Willingdon and Irwin, has progressively increased from year to year. They find that the expenditure in 1975-76 in these hospitals has increased from Rs. 202 lakhs in 1972-73 to Rs. 316 lakhs (*i.e.* 56.5 per cent) in 1975-76 in Safdarjang Hospital, from Rs. 106 lakhs to Rs. 1.70 lakhs (60.4 per cent) in Willingdon Hospital and from Rs. 163 lakhs to Rs. 264 lakhs (62 per cent) in Irwin Hospital. The increase in expenditure over these years is more significantly marked under various heads such as Establishment Charges, Medicines, Diet, X-ray and Linen, as will be seen from the following observations made by the Committee. (i) The expenditure on Establishment Charges in Safdarjang, Willingdon and Irwin Hospitals had increased from 1972-73 to

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			1975-76 by 74 per cent, 86 per cent and 80 per cent respectively. The reason for highest increase of expenditure in Willingdon Hospital as compared to the other hopitals is stated to be due to increase in bed strength of Willingdon from 679 to 730 during 1972.
			(ii) The expenditure on medicines in Safdarjan Hospital and Irwin Hospital from 1972-73 to 1975-76 had increased 44 per cent and 42 per cent respectively whereas the expenditure during the same period in Willingdon Hospital had increased 100 per cent. The abnormal increased in Willingdon is stated to be due to increase in prices of drugs and increased expenditure on medicines in Nursing Home.
			Similarly, it is observed that while the expenditure on medicines increased from Rs. 51 lakhs in 1972-73 to Rs. 64 lakhs in 1974-75 at Safdarjang Hospital and from Rs. 19 lakhs to Rs. 36 lakhs in Willingdon, it remained at Rs. 33 lakhs in 1972-73 and 1973-74 and increased only to Rs. 35 lakhs in 1974-75 in the case of Irwin, though the cost of medicines has been consistently going up in the market. The reasons for more or less stationary expenditure on medicines in Irwin Hospital, as stated by the representative of the Delhi Administration, is due to default in

the allocation of funds under various heads of expenditure within the budget allotments during these years.

(iii) In 1975-76 the expenditure on linen in Irwin hospital (Rs. 2 lakhs) was the lowest as compared with Safdarjang (Rs. 3.57 lakhs) and Willingdon (Rs. 3 lakhs), although the bed strength in Irwin hospital (1175) during the year was more than in Willingdon (730) and marginally less than in Safdarjang (1207). The wide gap in expenditure in Irwin hospital as compared with other to hospitals is stated to be due to paucity of funds.

(iv) Whereas the expenditure on diet has shown a slight increase during 1975-76 in Willingdon (from Rs. 7 lakhs in 1974-75 to Rs. 8 lakhs) and Irwin (from Rs. 10 lakhs in 1974-75 to Rs. 11 lakhs in 1975-76), which appears to be justified due to increase in number of inpatients, the expenditure in Safdarjang hospital has come down (from Rs. 12 lakhs in 1974-75 to Rs. 10.67 lakhs in 1975-76) though the number of inpatients there was the highest during the year as compared with Willingdon and Irwin hospitals. This decrease in expenditure is stated to be due to a marginal reduction in quantum of diet given to patients in Safdarjang hospital.

(v) While in Safdarjang and Willingdon hospitals, the expenditure on X-rays (including the cost of films and chemicals) has remained almost the same from 1972-73 to 1974-75, it has risen from Rs. 10 lakhs in 1974-75 to Rs. 16 lakhs in 1975-76 in Irwin and from Rs. 3 lakhs in 1974-75 to Rs. 8 lakhs in

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			1975-76 in Willingdon Hospital. The reason for abrupt rise in exenditure in Irwin hospital was that the cost of new X-ray machine, costing about Rs. 7.5 lakhs is included in the figure of Rs. 16 lakhs.
2.	1.58	Deptt. of Health	The Committee have dealth with the above aspects extensively in the subsequent Chapters of this Report. What they would, however, like to emphasise here is that the Ministry should go into the rationale of the expenditure incurred by the three hospitals under various heads during the last 5 years or so, to see as to how far it has been in consonance with the requirements of the hospitals, with particular reference to their bed-strength. The Ministry may also lay down norms and guidelines for bringing about uniformity in the working of these hospitals as far as possible, so as to provide a common approach for tackling the problem of these hospitals in a co-ordinated manner.
3.	2.52	Do.	Emergency service of a hospital is assuming increasing importance on account of the stresses of modern living in urban conditions where the people are subject to different types of accidents which require immediate attendance and medical care. With ever-increasing tensions leading to cardio-vascular and cerebral diseases in the community, there is a growing pressure in the casualty and emergency wings of the Delhi Hospitals. In order that the emergencies are attended to quickly and effectively, it is necessary to have an efficient set up, well-knit with other departments of the hospitals

with well-laid out procedures and work distribution. While reporting on the Casualty and the Emergency services in the three Delhi Hospital, *viz.* Safdarjang, Willingdon and Irwin, Audit have observed that 'the hospitals do not have a separate strength of doctors for manning the emergency services'.

4. 2.53 Do.

For providing medicare in the wards and the O.P.Ds, each discipline in the hospital has been divided into three/four compact units of doctors headed by Professors, Consultants or Specialists. According to the Government's own calculations, the reasonable number of patients that can be left to the care of a doctor and a nurse in the Emergency Wards of a hospital should be 1:10 and 1:5 respectively. Whereas the strength of doctors and nurses in Irwin Hospital appears to be somewhat satisfactory, the Doctor-patient ratio and nurse-patient ratio in the Emergency Wards of Safdarjang and Willingdon Hospitals during April 1975 to June 1975 were 1:16, 1:23 and 1:33 and 1:19 respectively which are in no way near the norm of Doctor-patient ratio of 1:10 and Nurse-patient ratio of 1:5.

5. 2.54 Do.

The significant difference in the strength of doctors in Irwin Hospital as compared with the other two hospitals has been explained by the Ministry of Health by the fact that the Irwin Hospital, being a teaching Hospital, has got a large number of House Surgeons, Interns and Registrars which is not the case with Willingdon and Safdarjang Hospitals. The Committee are of the opinion that as the average daily number of patients in Emergency Wards in Safdarjang Hospital (99) and Willingdon Hospital (135) far exceeds the number of patients in Irwin Hospital (29); the strength of doc-

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			tors in the Emergency Wards of a Safdarjang and Willingdon Hospitals needs to be reviewed and refixed on the basis of well determined norms so as to enable them to render satisfactory service to patients admitted in these important wards. The Committee are of the view that the Casualty and Emergency Wings should provide the best possible service in a hospital as it is here that a patient and his relatives first come into contact with the doctors under emotional strain and anxiety. It is, therefore, imperative that the Casualty and Emergency Wards are manned by experienced and competent doctors who may render effective and timely medical aid and win the confidence of the anxious patients and their relatives.
6.	2.55	Deptt. of Health	The Committee have been informed that norms have been laid down for the provision fo nurses in the hospitals by the Nursing Council which were accepted by the Government. In view of the fact that the nurse-patient ratio excluding the specialised departments, is 1:33 in the Safdarjang Hospital and 1:19 in the Willingdon Hospital as against the ideal ratio 1:5, the Committee feel that there is considerable shortage of nurses for manning the Emergency and Casualty Services in the three hospitals. It is necessary to work out the revised strength of nurses in all the three hospitals on the basis of norms laid down for the purpose so that the patient-care does not suffer in any way.
7.	2.56	Do.	The Committee find that the National Institutet of Health Administration and Education, in its study of the working of various hospitals in 1972 had

			revealed that 43.3 per cent of the available time of the duties of nursing staff is utilised in non-nursing activities. The Medical Superintendent of Willingdon Hospital also conceded during evidence that "a lot of the time of nurses is wasted in getting the stock of medicines, linen, etc."
8.	2.57	-do-	The Committee understand that some additional nursing staff has been sanctioned in the Casualty and Emergency Wards of Safdarjang and Willingdon Hospitals. The Committee desire that there should be no further delay in rationalising the duties and responsibilities of the nursing staff so as to see that they devote practically their whole time attention to nursing duties proper in the Casualty and Emergency Wards and not allow peripheral administrative duties to take away their precious time.
9.	2.58	-do-	The Committee are perturbed over the alarming number of nurses who had resigned during the 5 years from 1972 to 1976, presumably for availing of opportunities offered to them for service abroad. It is observed that in Safdarjang Hospital alone the number of nurses who had resigned during the above period was 329. While no particulars of nurses who had gone on foreign assignments was maintained in Irwin Hospital (as foreign assignment was not mentioned in resignations) the number of resignations during the above period was 306. Similarly, in the case of Willingdon Hospital 158 nurses had resigned during 1972-76, presumably for going abroad. The Secretary, Ministry of Health, conceded during evidence that "somehow or other they slipt out."
10.	2.59	-do-	The Committee are not able to understand how such a large number of nurses have been allowed to leave the hospitals without the problem having

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			been analysed in depth and remedial measures taken. Apart from the preventive measures to discourage nursing staff to migrate abroad, it is essential that the working conditions, housing and environment for them should be improved so that the service of efficient and devoted nursing staff, which is essential for the satisfactory running of hospital services, is maintained. The Committee also desire that the question of augmenting the facilities for training of nurses may be gone into on an urgent basis so that nurses in adequate numbers are turned out not only for meeting the country's requirements but also to avail of the employment opportunities which may be available outside the country.
11	2.60	Deptt. of Health	A study of Emergency and Casualty Department in Irwin Hospital was conducted by a Study Team of the National Institute of Health Administration and Education, New Delhi in April 1971. The Study Team investigated the functioning of the Emergency Services Department in terms of the existing policies and procedures, lay-out, work-load, staffing pattern and physical facilities, identified the areas needing improvement or better utilisation, and suggested changes to solve these problems without involving any substantial additional expenditure. The Study Team suggested that all the casualty and emergency services operating in the hospital except those of maternity should be brought under one roof. The composite casualty and emergency department with the O.P.D. should form a single department under the charge of a full time administrator preferably the Deputy Medical

Superintendent of the hospital. He will be in entire charge of this department in terms of planning, guiding, directing, controlling and supervising the work concerned with this department. The Study Team also suggested that there should be a Coordination Committee with the Medical Superintendent of the hospital as the Chairman and Heads of the Departments of Anaesthesiology, Medicine, Surgery, Orthopaedics, Paediatrics, Ophthalmology, ENT, Radiology etc., Nursing Superintendent of the hospital, Officer incharge of the Stores, Officer incharge of Central Transport Unit of the hospital as members and the administrator of this Department as the Member-Secretary. In order to help improve the functioning of the various categories of employees in the department, the Study Team stressed the need for their training before they are posted to the Casualty and Emergency Departments. The training should primarily revolve around their functions, improvement of their role in the total spectrum of their departmental efficiency, policies and procedures of the department and need for team work for efficient job performance and job satisfaction.

12. 2.61 -do- The National Institute of Health Administration and Education made a similar study of the existing facilities and working pattern of Casualty and Emergency department of Safdarjang and Willingdon Hospitals in June, 1976.

13. 1.62 -do- The Study Team of the Institute had *inter alia* observed that facilities in waiting space were quite inadequate in both the hospitals for the patients and attendants; toilet facilities for relatives of patients were absent in Safdarjang Hospital whereas in Willingdon Hospital they were inadequate, the number of trolleys and wheel chairs was inadequate; the number of ancillary workers, like sweepers, nursing orderlies and stretcher

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			bearers was inadequate; staffing position in respect of nurses was inadequate in both the hospitals; medical staffing was also insufficient while availability of consultant services needed much to be desired; a systematic emergency tray system of drugs was not maintained properly; linen supply was inadequate in both the hospitals etc.
14.	2.63	Deptt. of Health	The Committee are greatly concerned that in spite of the recommendations of the Study Team of the National Institute of Health Administration and Education which gave their Report on the Emergency and Casualty Departments in Irwin Hospital in April, 1971 and Safdarjang and Willingdon Hospitals in June, 1976, conclusive action has not been taken to rationalise and reinforce the services in the Emergency and Casualty Wards so as to ensure proper and adequate service being rendered to those who repair to these wards in emergency. The Committee would like Government and other authorities concerned to take conclusive action in the light of these recommendations so as to ensure that improvements in the Casualty and Emergency Services in the three hospitals, which have to cater to a very large number of casualties and emergency admissions, are effected without further delay. The Committee would like to be informed of the concrete action taken and improvements effected within three months of the presentation of the Report.
15.	2.64	-do-	From the material made available to them, the Committee note that the cases in Casualty Department are attended to by the Casualty Medical Officer

round the clock. The less serious cases are, after preliminary treatment, sent back home with instructions to attend O.P.D. the next day and the cases of serious nature are admitted in the Emergency Ward where they are usually kept for a maximum of 24 hours. Thereafter, either they are discharged or transferred to the respective wards.

16. 2.65 -do- During April 1975 to June 1975, the average daily number of patients as per midnight statistics in Emergency Ward of Safdarjang and Willingdon Hospitals were 99 and 135 as against bed strength of 62 and 124 in the respective hospitals. As a consequence, many patients had to be accommodated on the floors whenever the number of patients exceeded the bed strength.

17. 2.66 -do- In Irwin Hospital, there had been no occasion when the average number of patients (29) in the Emergency exceeded the available bed strength (32) because the Medical Officer on emergency duty ensured that less serious patients were transferred to the general wards at the earliest and only serious patients were kept in Emergency Wards.

18. 2 67 -do- The Committee are concerned to note that whereas the bed strength in the Casualty and Emergency Wards has increased from 124 in June 1975 to 163 in May 1976 in case of Willingdon Hospital, 32 to 48 in case of Irwin Hospital, the increase in the case of Safdarjang Hospital has been only from 62 to 69 beds during the same period. The Committee find that there appears to be no discernible norm in the provision of bed strength in the Casualty and Emergency Wards as compared to the total bed strength in the hospital. For example, while in the Willingdon Hospital as against the total

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			strength of 730 beds, the number of beds in the Casualty and Emergency Wards is 162 representing 22.3 per cent. in Safdarjung Hospital and Irwin Hospital such percentage is 5.7 and 4.1 respectively. The result of this unbalanced strength of beds in Casualty and Emergency Wards, particularly in Safdarjang Hospital, has been that a large number of patients in Casualty and Emergency Wards were not provided with beds at all.
19.	2.68	Deptt. of Health	The Committee find that in Safdarjang Hospital during July, 1976 alone against 2475 patients admitted in Casualty and Emergency Wards as many as 1008 (40.7 per cent) were not provided with beds. The Committee stress that having regard to the area served by each of the hospitals, the type of cases which have been gaining admission to the Casualty and Emergency Wards, the total strength of the beds in the hospital, etc., norms may be laid down and concerted efforts made to bring up the position to the expected norm. In particular, the Committee would like to point out the need for taking urgent measures to bring up the strength of the beds in the Casualty and Emergency Wards of the Irwin Hospital which serves a very large areas of the old city and is gravely short of the requisite number of beds.
20.	2.69	Do.	Another significant feature which the Committee have noted is that in Safdarjang Hospital though the number of beds in Emergency-A (Medical) (30) was less than those in Emergency-B (Surgical) (35), the number of patients admitted (1733) in July 1976 in the former was more than twice the

number of patients admitted (742) in the latter during the same month. The Committee would like the authorities to keep the detailed requirements in view while allocating beds for medical and surgical cases. This may be specially taken into account when the additional accommodation for Casualty and Emergency Wings becomes available on completion of the new construction which has been sanctioned.

21	2.70	-do-	The Committee note that as against 272 posts recommended for creation and 95 posts recommended for abolition by the Staff Inspection Unit in August 1973 in Safdarjang Hospital, 221 posts were created and 82 posts abolished in February and May 1976 respectively. It is further noted that out of the additional sanctioned posts, 108 posts only have been filled so far and in the case of abolition one more post has since been abolished and one has been agreed to by the Staff Inspection Unit for continuance. The remaining 11 posts of Registrars, House Surgeons, etc. have not been abolished because against these, 37 posts of House Surgeons etc. which were to be created have still not been created. The Committee are unhappy to record that a majority of the posts recommended in 1973 for creation have still not been filled up. Even more regrettable is the fact that it took nearly three years to sanction even 108 posts which have been filled up so far. The Committee are not convinced by the plea that the recruitment rules and UPSC stood in the way of filling up the remaining posts as they feel that these administrative details could and should have been resolved with a sense of urgency instead of allowing the matter to drag on for years. The Committee would like Government to review the matter and take urgent and effective follow-up measures to fill up the remaining posts without further loss of time. The Committee stress that the procedure

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			regarding recruitment of staff etc. in the hospitals may be streamlined in consultation with the concerned authorities so to obviate such heavy delays in future.
22	2.71	Deptt. of Health	Though the air-conditioning facilities in the hospitals are considered necessary for management of certain conditions like heatstroke cases etc., the Committee understand that there is no immediate prospect of air-conditioning of the Casualty Ward of Safdarjung Hospital as it continues to be located in barracks. As the construction of new building for Casualty Ward may take sometime, the Committee would suggest making of some alternate arrangement, like provision of coolers etc., so that the ward is kept cool at least during the hot months of the year.
23	2.72	-do-	The Committee regret to note that in the case of Willingdon Hospital though the air-conditioning of the casualty ward was agreed to in principle in 1975, the details are still being worked out by the CPWD. The Committee would like the authorities concerned to draw up a time-bound programme for providing this essential facility and inform the Committee of it.
24	2.73	-do-	The Committee regret to note from the observations in the Audit paragraph that important medicines including certain life saving drugs were not available with the Emergency Wards in the three hospitals at certain times. In Safdarjung Hospital, Ampicillin Clauden and Adernalin

			Injections were not available in the Casualty and Emergency Wards during the period from 4 June 1975 to 22 September 1975. The Committee understand that injection Ampicillin was available in the stores of Safdarjung Hospital. The Committee have been informed that injections Ampicillin and Adrenalin were not available because in the former case the firm with which DGS&D had concluded a contract did not supply the injections and in the latter case the item was not available with the Medical Stores Depot, Karnal. Though the position in this regard is stated to have been satisfactory during the first half of 1976, the Committee would still like to stress the need for better coordination between the hospitals and the two main suppliers of medicines, *viz.*, DGS&D and Medical Stores Depot, Karnal, so as to ensure that the patient care is not allowed to suffer in any way because of the non-availability of certain medicines.
25.	2.74	Do.	The Committee would also urge that the formularies of the hospitals may be reviewed from time to time so that the latest medicines/drugs of proven effectiveness are included therein. The Committee have made detailed observations on the subject elsewhere in the Report.
26.	2.75	Do.	The Committee note that one Hypotermea machine meant for regulating body temperature purchased in 1964 and another machine Earoxemeter also purchased in 1964 used for measuring oxygen tension have been lying out of order in Irwin Hospital since 1973 and 1969 respectively and no steps were taken all these years to get them repaired. It appears that it was only on receipt of the Audit paragraph that the authorities realised the need of taking action in the matter. These two machines were repaired and recommissioned in May 1976, the Earoxemeter has, however, again gone out of order and has outlived its life.

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27.	2.76	Deptt. of Health	The Committee would like the hospital authorities/Ministry to go into not only the question of maintenance and use of these two machines but also other life-saving equipment and machines which have been purchased from time to time in the hospital so as to make sure that there are adequate arrangements for their maintenance and that these machines which have been purchased at considerable public cost are put to the best use in the interest of the patients. It may be worthwhile to maintain a history of each of these machines and review the position from time to time to see that the objective underlying their purchase is being subserved and to take remedial measures as necessary.
28	2.77	Do.	The Committee note that in Safdarjung Hospital all the three oxygen tents meant for giving oxygen-rich environment, purchased at a cost of Rs. 20,000/- have been out of use since January 1973 (two) and December 1974 (one) because of the non-availability of canopy which is an imported item.
29.	2.78	Do.	The Committee are unable to accept this plea and desire that if the canopy is essential for the working of the oxygen tents which were purchased in the interests of saving the lives of patients, it should have been possible to arrange most expeditiously for the canopies whether from indigenous sources or from abroad. Canopies may be arranged without further delay and the Committee informed of the dates when these three oxygen tents have again been pressed into service.

30	3.42	Do	The Out-patient Department is the most important and an accepted constituent unit of the hospital where nearly all patients suffering from diseases of minor, serious, acute and chronic nature report first. There is a shift from the traditional inpatient care to the ambulatory care. It is here that a patient forms his first impression of the type of service, that he should expect to get in the hospital. The value of an efficient out-patient department in treating minor illnesses and avoiding unnecessary admissions to hospital is enormous. It is, therefore, of utmost importance that adequate diagnostic and a full spectrum of services be provided at a place that is reasonably accessible with a minimum waiting time, with courteous behaviour apart from good medical care.
31	3.43	Do	A study of the National Institute of Health Administration and Education (NIHAE) in 1976 reveals that OPD attendance in Safdarjung Hospital has now touched the million mark from just two lakhs in 1958 without a corresponding increase in facilities and equipment etc. Earlier, a similar study by the Department of Administration Reforms in Safdarjung and Willingdon Hospitals in 1972 had shown that on an average the total waiting time of a patient at the point of registration and doctor's cubicle was about 150 minutes. It was also observed that 31 per cent of the patients referred to laboratory and X-ray unit had to make second trip on the next day mainly due to the reason that the registration for clinical tests used to close before the closing hours of OPD. The Committee, during their visit to Willingdon Hospital on 23rd August, 1976, were also informed that on an average a patient has to wait for two hours for his turn.

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32	3.44	Deptt. of Health	From Audit para and from what has been tendered before the Committee during evidence, the Committee have every reason to believe that even now in all the three hospitals under examination the patients advised for X-ray and/or Laboratory tests often have to re-visit the next day since these departments close their registration at 11.30 A.M. whereas the OPDs work up to 1 P. M. The Committee have been informed that in order to reduce over-crowding the scheme of evening OPDs was started. While in Irwin Hospital the evening OPD started in December, 1973, such departments in Safdarjung and Willingdon Hospitals were started in July, 1975. This scheme, however, has not proved a success due to some inherent shortcomings. Notwithstandingly all the shortterm steps taken by the hospital authorities overcrowding in the OPDs thus continues to pose a problem. The Committee feel that this problem has to be tackled boldly and effectively so as to minimise the inconvenience and irritation caused to patients and also to restrict undue strain on meagre hospital resources, insanitary conditions and dilution in patient care which arise as a result of overcrowding.
33	3.45	Do	The Committee are surprised to note that the number of patients treated in Irwin Hospital is less as compared to Safdarjung Hospital although the former is located in the heart of the city and is close to most thickly populated area of Delhi. They find that the number of out-patients treated in Irwin Hospital during 1974-75 and 1975-76 was 7,23,633 and 9,04,328 as compared to 9,92,208 and 11,31,382 in Safdar-

jung Hospital during the same period. The reasons for this varying feature, as advanced by the Ministry of Health that the Safdarjung Hospital draws all the Central Government employees and their dependents which is not the case with the Irwin Hospital and in the Safdarjung Hospital a very large number of people are attracted from the rural areas does not sound convincing as the Willingdon Hospital where patients treated in OPD are less as compared to Irwin Hospital also caters to the needs of the CGHS beneficiaries and a large number of rural patients also visit the Irwin Hospital. It has been stated before the Committee during evidence that some costly and brand drugs are not given to the out-patients in the Irwin Hospital. The Committee would like the Ministry to investigate whether the smaller number of out-patients treated in Irwin Hospital as compared to Safdarjung Hospital is due to the inadequate medical facilities provided to the out-patients.

34. 3.46 Do.

The Committee note that as a result of over-crowding in the hospitals, the patients in the out-patient departments have to wait for a considerable time for their turn. In this regard, a study carried out by the National Institute of Health Administration and Education as far back as in 1967 in the Orthopaedic Department of Safdarjung Hospital revealed that there was a waiting time of about 120 minutes and several improvements were suggested to tackle the problem of excessive waiting time. The Committee feel concerned that in spite of recommendations made by NIHAE in 1967 and some measures suggested by the Department of Administrative Reforms in 1972 to minimise the excessive waiting time, no marked improvement in the average waiting time of the patient has been achieved. What has caused more concern to the Committee is the

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			further finding of NIHAE in their study of OPDs of Safdarjung and Willingdon Hospital in 1976 that the problem of excessive waiting time of out-patient departments of both the hospitals is to some extent due to lapses of administrative procedures at each step. The Committee are of the view that although certain delays are inherent in the situation and thus are inevitable, yet to a certain extent these can be overcome by rationalising the existing procedures and strengthening the organisations where necessary. The Committee need hardly stress that a senior faculty member may be assigned the charge of OPD services in each hospital who with the help of the Public Relation Officer may look into the difficulties of the patients and the staff with a view to reviewing the overall functioning of the OPD from time to time and suggest measures for effecting improvements. A board showing the name, designation and telephone of such an officer may be displayed at a prominent place near the Out-patient Department of each hospital so that the patients may contact him for guidance and redressal of their difficulties. The Committee also suggest that accredited social workers should also be associated with the hospital authorities to provide necessary guidance and help to the needy patients.
36.	3.47	Deptt. of Health	The Committee have been informed that in order to reduce the excessive waiting time of the patients the actual registration now starts 30 minutes before the doctors start examining the patients and the system

			of distribution of medicines is being modified so that a patient is not required to stand in different queues for different types of medicines. In this connection, the Committee desire that all possible efforts should be made to issue all types of medicines from the same counter. In case there is a long queue of patients, the number of such counters may be increased to two or three, but these may be side by side so that the rush is equally balanced on all the counters.
36	3.48	Do.	The Committee also note that it is also proposed to start 'screening clinics' in the OPDs. Under this scheme, the general duty medical officers will be able to screen and provide treatment for minor ailments etc. and those needing specialist services will then be sent to the concerned consultants in the OPDs. In this connection, the Committee agree with the views expressed by NIHAE in their study in 1976 that provision of screening clinics within the OPD may not be the answer to reduce overcrowding in both the hospitals as they fear that probably the waiting time will increase since the patient has to be screened first in the screening clinics and then to be referred to respective OPDs where again the patient will have to wait for his turn. The Committee desire that this matter should be looked into in depth.
37	3.49	Do.	In a study by Department of Administrative Reforms of the Outpatient Departments of Safdarjung Hospital in 1972, it was revealed that "patients start arriving from 6 A.M. onwards and nearly 63 per cent of the new patients and 49 per cent of the old patients are in the queue before the commencement of the registration." The Committee find that more or less the same situation continues in the OPDs of the three hospitals, thus resulting in over-crowding particularly during the first two

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			hours of the usual OPD timings of four hours. Therefore, the Committee feel that additional doctors may be made available during the first two hours at each OPD of the hospitals, and the process of examination of old and new patieits so rationalised that the waiting time is considerably minimised. The Committee also observe from the Audit para that a new and old patient normally spent about 105 and 58 minutes respectively for registration and 50 and 115 minutes more in waiting for consultation. The ratio of new and old patients coming to OPD for treatment was 56 : 44. The Committee feel that it would be more appropriate if the strength of the doctors is also fixed taking into account the ratio of new and old patients. In fact, the Committee consider that there should be an in-built organisational arrangement to deploy more doctors if and when there is unusual rush. Norms should be laid down on the number of patients a doctor can conveniently examine per hour and accordingly the strength of the doctors may be suitably fixed so as to bring down the maximum waiting time of out-patients to half an hour at the most. The Committee would like to emphasise that Ministry should not sit on the fence when human sufferings continue to mount. If need be the strength of doctors should be suitably augmented without any loss of time so that the social benefits of the hospitals percolate to the lower strata of the population in and around Delhi.
38.	3.50	Department of Health	The Committee note that the clinical laboratories in the three hospitals work from 9 A.M. to 4 P.M. with an hour lunch break from 1 to

2 P.M. The specimens for investigation in the laboratory and the patients in the X-ray unit are received upto 11.30 A.M. only although patients are seen in OPDs up to 1 P.M. As a result, of this, sometimes the patients coming after getting the slip from the doctors find that the counters for registration in laboratories and X-ray units are already closed, with the result that they have to come the next day which causes a lot of irritation and wastage of their time. The Committee, agree that certain investigations such as blood test in which case the patient has to come with empty stomach, stool test, etc. cannot be conducted the same day but at the same time they feel that it may be possible to minimise the percentage of the patient's making re-visits the next day to a greater extent if the working hours of the laboratories are changed from 10 A.M. to 5 P.M. instead of present working hours from 9 A.M. to 4 P.M. with specimens collection time staggered from 11.30 A.M. to 1 P.M. In fact, the secretary of the Ministry has assured the Committee during evidence that "we will try to close laboratory as and when hospital closes. We will keep it open for receiving samples upto 1 O'clock if it can be arranged by adding equipment and man-power." The Committee would like the matter to be gone into in depth and the Committee informed of the improvements effected including change of time.

39	3.51	-Do-	The Committee would like to point out that NIHAE in their study of 1976 have already made a number of concrete suggestions which can be implemented without much hesitation, to improve the working of OPDs in the hospitals. The Committee agree with their views and would like to reiterate that—

(i) to encourage polite and courteous behaviour of the staff to-

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			wards the patient, orientation and in-service training opportunities should be provided to the staff. (ii) Out-patients should be properly guided by the doctors issuing prescriptions regarding the procedure to be followed to get their blood, urine, stool, etc. samples tested. (iii) Laboratories may be modernised and out-dated equipment replaced as early as possible so as to improve the accuracy of the test results because these tests form the basis of the medical treatment which the patients are to be imparted. (iv) OPDs in the three hospitals should have separate laboratories with adequate staff for their exclusive use.
40	3.52	Department of Health	The Committee note that in order to cope with the increasing rush in the OPDs of the respective hospitals, the evening OPD was started in the three hospitals. This scheme, however, has not proved a success as is evident from the fact that the average daily number of patients who were attended to by the three main disciplines of medical, surgery and paediatries in the evening OPDs of the Safdarjung and Willingdon Hospitals during the six months from January, 1976 to June, 1976 comes to 41 in Safdarjung and 54 in Willingdon as against daily average of 2500 to 3500 out-patients visiting the OPDs of these hospitals respectively. It was stated during evidence that the workload was fairly heavy in the beginning but slowly it dwindled off. The Committee would like the

			Ministry of Health to investigate the specific reasons for this decline in workload in spite of initial good start and take suitable remedial measures.
41	3·53	-do-	The Committee are unhappy to note that although the proposal for additional staff for the evening OPD in the respective hospitals was under active consideration in December, 1975 it has not yet been sanctioned as it is being contended that the evening OPDs are on experimental basis and the necessary measures in this direction will be taken if it is to be kept on a permanent basis. The Committee feel that the reasons for poor response in the evening OPDs are non-existence of essential facilities like X-ray units and laboratory facilities because of shortage of staff and equipment. Further, the specialist services are also not available in the evening. The Committee are not convinced by the reply of the Ministry that creation of laboratory facilities in the evening has limited utility as patients are not in a position to give blood on empty stomach, stool, etc. because these difficulties are experienced in the morning OPDs also. The Committee feel that more and more patients can be attracted to avail of the evening OPD facility by strengthening the laboratory and radiological services and extending specialist services. Further, to make it more popular adequate publicity of the availability of these services also needs consideration. These steps may be taken as the saturation point has already been reached in the morning and an effective decentralisation of the services being the long term solution, is the need of the hour.
42	3·54	-do-	The Committee feel that one of the reasons for over-crowding in all the three hospitals is the fact that a large number of patients are attracted from the peripheral areas in the adjoining States to these main hospitals

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			in Delhi because of inadequate hospital facilities and poor quality patient care existing in those areas. The Committee find that as short term measures the evening OPDs have been started, though without much success, in the three hospitals; additional staff has been sanctioned for the Safdarjung and Willingdon Hospitals construction of two additional floors over the OPD in Willingdon Hospital has been sanctioned and administrative measures like the extension of registration time at laboratory, X-ray unit etc. have been taken to reduce over-crowding by providing quicker services. The Committee further note that a hospital with 30 beds has been opened in R. K. Puram, New Delhi and another 30 beds are going to be provided in this hospital. The Committee would like the Government to take a stock of the improvements which have been effected or are likely to be effected as a result of these measures so that an over-all view of the situation may be taken to take further remedial steps in the matter.
43	3.55	Department of Health	The Committee have been informed that some long-term measures have been taken or are proposed to be taken to reduce the over-crowding in the Delhi hospitals. These measures are (i) setting up of a Delhi Hospital Board with the Lt. Governor as the Chairman to coordinate the functioning of various hospitals in Delhi, particularly in the areas where hospital facilities are not adequate; (ii) proposals to open six 100-bedded hospitals in the rural areas of Delhi to correct the imbalances and to avoid rush from the rural areas and neighbouring States to the main hospitals. In addition, two 500-bedded hospitals are proposed to be opened,

			one at Shahdara and the other at Hari Nagar; (iii) Provision of 30-bedded Nursing Home in Irwin Hospital; (iv) Addition of 70 beds in General Ward and 96 beds in the Nursing Home of Willingdon Hospital; and (v) Establishment of Eye Centre as an adjunct to the Irwin Hospital. The Committee welcome these measures and would like the Government to take urgent and concerted steps to expedite the implementation of these proposals, within a time-bound programme. The Committee, however, need hardly stress that greater emphasis should be laid on the provision of hospital facilities in the rural areas in general and re-settlement and jhuggi-jhonpri colonies in and around Delhi in particular. The hospitals so set up should be self-contained so that the flow of patients from these areas to the main hospitals in Delhi is contained satisfactorily. For this purpose, the Committee would like the Government to set up a team of experts with members drawn from the Ministry of Health, Ministry of Finance, Delhi Administration and Public representatives so as to go into the question of adequacy of existing medical facilities in and around Delhi and recommend remedial measures in this respect on which follow up action may be taken without delay.
44	3.56	-do-	The efficiency of Yoga in promoting health and building up resistance to disease has been widely demonstrated and recognised. The Committee need hardly point out that when patients flock to OPD's of hospitals for treatment, they are anxious not only to get well but also to take recourse to such treatment and measures which would help them to build up resistance against recurrence of the disease. This receptivity of mind could well be taken advantage of by the authorities to provide knowledge of cheap easily available health building diets and Yoga exercises. Practical demonstration in Yoga exercises could be given by persons who are well-

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			versed in this ancient science in close coordination with the medical authorities. The Committee suggest that the matter may be gone into carefully and the scheme sincerely tried out on pilot basis in Irwin Hospital; care being taken to publicise the facility amongst the outdoor patients so as to rouse and sustain their interest. The Committee would like to be informed of the action taken in pursuance of the recommendations and the result of the experiment.
45	4·49	Department of Health	The Committee note that the cost of diet in the General Wards though supplied free of cost varies from hospital to hospital. During 1974-75 the average cost of diet in Central Wards in Safdarjung, Willingdon and Irwin Hospitals was Rs. 2.81, Rs. 2.95 and Rs. 2.30 respectively. The Ministry have stated that the difference in cost on diet in one hospital as compared with the other is sometimes due to such factors as location, nearness to market, contracts offered, facilities provided, etc. Another reason contributing to this variation in costs which has been put forward by the Ministry is that in Willingdon Hospital, non-vegetarian diet is also provided along with vegetarian diet whereas Safdarjung and Irwin Hospitals provide only vegetarian diet. It has also come to the notice of the Committee that as a measure of economy in Safdarjung Hospital the prescribed quantum of diet has been reduced from 400 gms. to 300 gms. whereas no such reduction has been carried out in the other two hospitals. The Committee cannot but conclude that no uniform system in the quantum and type of diet is being followed in the three hospi-

			tals. From the facts disclosed the Committee are led to the conclusion that there is no rational approach in regard to the dietary in the three hospitals. For the health and well-being of the patients the hospital authorities should have settled in consultation with expert dieticians the contents and quantities of diet keeping in view its calorific and therapetic value.
46	4.50	-Do-	The Committee are concerned to note that on the plea of economy, the quantum of diet in Safdargung Hospital was reduced from 400 gms. to 300 gms. Any reduction in diet for the sick and the needy should have been preceded by an expert examination of the issue from the nutritional point of view. The Committee, however, note in this connection that the Secretary, Ministry of Health has assured during evidence that the Director General, Health Services, the Adviser (Nutrition) and the three Medical Superintendents would jointly work out a formula so that the procedure regarding diet could be systematised and followed uniformly in all the hospitals of Delhi. The Committee woud like to be informed of the outcome of the joint discussions.
47	4.51	-Do-	4.51. The Committee further note that the number of excess diets issued as compared to the number of patients accounted for during mid-night Census in Safdarjung, Willingdon and Irwin Hospitals in 1974-75 was 40,254, 32,743 and 24,856 respectively which represented 9.9, 17.0 and 6.0 per cent. The reason for excess diets in Irwin Hospital is stated to be on account of large number of patients on the floor having been not shown in the mid-night census. In the case of Willingdon Hospital it has been stated that though Medical Officer concerned issues the discharge slip in the morning the patient is removed only in the evening with

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			the result that he takes extra lunch. The Committee are not convinced by the plea advanced by the Ministry as in Safdarjung Hospital, where the percentage of excess diet is 9.9 as compared to 17.0 in Willingdon Hospital, large number of patients come to the hospital, from the outside and when they are discharged in the morning they leave the hospital. The Committee emphasise that the matter should be gone into in depth and the problem resolved. One method to achieve the purpose is to fix norms which should be strictly adhered to. The Committee are constrained to note that whereas economy in expenditure on diet is being thought of by reducing quantum of diet, other measures to effect economy without diminishing the quality and quantity of diet such as plugging leakages of diet, have not been given the attention they deserved. In the opinion of the Committee the leakages of diet may possibly be one of the reasons for issue of excess diets over the census figures. Therefore, it is necessary that institutional arrangements are made to which that leakages of diet and dietary materials do not take place. The Committee would like to be informed about the measures taken and proposed to be taken in this regard.
48.	4.52	Department of Health	The Committee note that cost of diet per patient per day in Nursing Home and General Wards is Rs. 13.59 and Rs. 2.95 respectively. The Committee further note that the calories supplied through the diet in General Wards and Nursing Home are 2450 and 3950 in case of vegetarian diet and 2650 and 4400-4500 in case of non-vegetarian diet respec-

			tively. Though to some extent it may be desirable that the patients coming to the Nursing Home, where charges are levied for diet, be served better food the Committee feel that large gaps in the calorific values of diets served to the patients in the Nursing Home and General Wards may be avoided. It should be ensured that so long as a patient is in Hospital he should get diet which is therapeutically necessary. The Committee would like the Government to review the position and apprise them of the decision taken in the matter.
49.	4.53	-do-	The Committee are concerned to note that although the expenditure on diet cost per patient per day in Nursing Home came to Rs. 13.59, only Rs. 7 (fixed in 1954) were being recovered as diet charges both from CGHS beneficiaries and the members of the public making use of the Nursing Home. What is more distressing is the fact that the question of revision of the rate of Rs. 7/- has been under consideration since July, 1974 and it was only in April 1976 that orders for revision of the rates that is Rs. 10/- per day for vegetarian and Rs. 12/- for non-vegetarian diet, were issued. The Committee find no justification whatsoever for giving gratuitous benefits to the affluent sections of the society who could afford to pay for a higher food bill, by recovering a paltry sum of Rs. 7/- as diet charges from patients admitted to the Nursing Home. It is inexplicable how a rate fixed in 1954 should have continued without a change till 1976. The special consideration shown to a special class of patients is indefensible.
50.	4.54	-do-	The Committee note that patients from the general public can make use of 10 per cent of the rooms in the Nursing Home on payment of room rent and clinical charges. With the augmentation of accommodation in

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			the Nursing Home, as mentioned in the previous Chapter, the Committee hope that it would be possible to admit a larger number of patients from the general public. The criteria of admission should be not the social status of the patients but the gravity of the illness. The Committee desire that a set of guidelines governing the admission to the Nursing Home should be worked out for general application.
51.	4·55	Department of Health	The Committee note that in case of Blood Bank in Willingdon Hospital, a test check of indents for blood from the Bank during the period from January to July, 1975 had revealed that against 18 units of blood recommended by the doctors in the Nursing Home 18 units of blood were actually supplied while dealing with most urgent cases whereas in General Wards only 14 units of blood were supplied against 40 units recommended by the doctors. Similarly, in routine cases also all the recommended units of blood were supplied in Nursing Home whereas in General Wards only 4 units of blood were supplied against a demand of 8 units.
52.	4·56	-do-	As the life of a patient whether in General Ward or in Nursing Home, is equally precious, the Committee feel that no discrimination may be made while supplying the recommended units of blood. To overcome the problem of deficiency of blood in the Blood Banks, the Ministry should in cooperation with voluntary organisations and with the Red Cross mobilise public opinion for donation of blood to the blood banks.

53.	4·57	-do-	The Committee regret to note that an imported disinfector plant for mattresses, pillows and blankets, acquired by the Safdarjung Hospital in 1960 at a cost of Rs. 0.75 lakh worked erratically up to March 1974 and thereafter it went out of order for want of spare parts and non-availability of furnace oil. It has been stated that after acquiring the furnace oil storage tank of the capacity of 9000 litres in August, 1976 the plant has been again put into operation. The Committee need hardly point out that timely action should have been taken to put back into operation the disinfector plant. As matters stood, it is only after the Audit Report that the Ministry took corrective action.
54.	4·58	-do-	The Committee have been informed that in Willingdon Hospital, mattresses pillows and blankets are disinfected by exposing, them to Sun. In Irwin Hospital disinfection is done with steam by the mechanical laundries. In this connection, the Committee would like to point out that the Delhi Hospital Review Committee had recommended in 1968 that in order to reduce cross-infection in wards in each hospital mattress sterilizers must be provided and that blankets should be chemically sterilised. The Committee regret that although a decade has elapsed since the recommendations of that Committee were made, no provision of mattress sterilizers has been made in the hospitals. The Committee would like that the question of sterilization of hospital beds, etc. should be given a high priority and conclusive action taken to remedy the existing deficiencies in this regard.
55.	4·59	-do-	The Committee have given to understand that Group was constituted on 9 August, 1976 by the Ministry of Health to investigate the

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			appearance of Salmonella Newport in Delhi hospitals, its origin, the effect it had had in terms of mortality and morbidity and the measures that have been taken so far by the hospital authorities to check the spread of this infection. This Group is stated to have also been asked to assess the effectiveness of the machinery that exists in the hospitals to monitor and control the hospital cross-infection and to suggest measures for detection and control of such infections. The Committee would like to be informed of the findings of the Group and conclusive action taken in pursuance of its recommendations.
56.	4·60	Deptt. of Health	The Committee regard to observe that the medical check up of the stag in the kitchen and other staff handling food, required to be done once in six months, had not been done for 6 years in the Irwin Hospital. The plea of the Ministry that such check-up could not be done because the Staff surgeon was changed quite often is not at all convincing. If anything, it speaks poorly of the hospital administration. The Committee would like that medical check-up of the kitchen staff should invariably be done once a year and that responsibility for medical check up of the staff working in the hospitals should be fixed on the Administrative Officer in each hospital. The staff working in the hospital Kitchen should be provided with the requisite uniform.
57	4·61	-do-	The Committee are constrained to note that a survey conducted in July, 1975 by Nutrition Cell of Director General, Health Services, in Willingdon

			Hospital had found the washing facility inadequate for keeping utensils hygienically clean, clock room and sanitary conveniances dirty and poor. The Committee also noted on their visit to the Willingdon Hospital in August, 1976 that he kitchen needed adequate light and white washing. To the surprise of the Committee even the cooking utensils were not adequately nickel plated from inside. The Committee deplore the casualness on the part of the hospital authorities for not taking sufficient care to observe the basic precautions against infection and cross-infection due to unhygienic conditions in the kitchens.
58.	4·62	-do-	The Committee note that the kitchen in Willingdon Hospital which was constructed to meet there requirements of 250 patients, has to cater to the needs of the present bed-strength of 730. As a result of this, the unsatisfactory and congested conditions are bound to grow up in the kitchen itself. The Committee find that the proposal for building a new kitchen made in March, 1972, could not materialise for lack of funds in the Fifth Plan. The Committee need hardly stress that the construction of new kitchen in the hospital equipped with appropriate cooking facilities should be taken up on a priority basis.
59.	4·63	-do-	The Committee find that the present capacity of laundry to wash linen is 4000 pieces per day in Safdarjung Hospital, 1600-2000 in Willingdon Hospital and 2500—3000 in Irwin Hospital. The number of linen pieces washed during 1975-76 was 10.20 lakh in Safdarjung Hospital whereas 4.32 lakh and 7.14 lakh pieces of linen were washed in Willingdon and Irwin Hospitals respectively during the same year. Though the position has improved in 1975-76, still much remains to be done. The Committee

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			have been informed that a modern laundry is proposed to be set up in the Willingdon Hospital. The Committee would like the construction of the lanudary to be expedited. It should also be ensured that the existing capacities in the other two hospitals for washing are fully utilised.
60.	5.10	Department of Health	The Committee note that the Rehabilitation Department in Safdarjung Hospital helps handicaped patients to go back to their normal lives through its 5 Sections, *viz.*, Physiotherapy, Occupational therapy, Psychology, Vocational Centre and Work-shop. The utility of the Department can be judged from the fact that the number of patients attended to by it has risen from 71,430 in 1972 to 87,568 in 1975. The Committee are, however, surprised to find that no Department rendering such varied services to handicapped patients exists in Irwin hospital which caters to thickly populated areas of Delhi. With this consideration in view as also to reduce the overcrowding at the Rehabilitation Department of Safdarjung Hospital, the Committee need hardly emphasize that the feasibility of extending the existing physiotherapy Department in Irwin Hospital on the lines of Safdarjung Hospital may be examined so as to afford greater facilities to handicapped patients of Delhi city. The Committee are not happy about the accommodation provided to the Rehabilitation Department in Safdarjung Hospital. The rooms are crowded and congested and physiotherapy patients have to wait for long time for getting proper attendance. The Ministry should see that the Rehabilitation Department functions under

			more congenial environment and that overcrowding is avoided by quicker attendance and service to patients.
61.	5.11	—do—	The Committee regret to note that due to heavy workload in the workshop attached to the Rehabilitation Department of Safdarjung the patients had to wait for long time for getting their appliances. It is observed that 68 shoes and 56 jobs were pending in the Shoe and Leather Sections respectively as on 31 December, 1975. What is more regrettable is the fact that in spite of large number of pending orders in these Sections due to shortage of staff, out of 3 posts of Shoemakers one had been lying vacant since June 1971. It appears that it was only, on the receipt of Audit comments that the need of filling up the vacancies was realised and one Shoemaker on daily wages was appointed on 26 February 1976. The Committee have been given to understand that two additional posts of Shoemakers and 3 posts of leather workers have been filled up subsequently. As a result of these appointments it has been possible to reduce the average waiting time of patients seeking artificial appliances from 3-4 months of 4—6 weeks. The Committtee desire that in view of the urgency to rehabilitate the handicapped patients within the shortest possible time efforts may be made to further improve upon this average waiting time.
62.	5.12	—do—	It has come to the notice of the Committee that supply of artificial limbs and other appliances does not form a part of the treatment and as such they are not given free to any patients. It has, however, been stated by the Ministry of Health that they try their best to help poor patients by supplying these appliances at as low a cost as possible. The Committee desire that the patients seeking artificial appliances should be categorised

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			in different groups on the basis of their monthly income. For extremely poor patients the supply of these appliances may be treated as part of the medical treatment and such appliances supplied free of cost.
63.	5.26	Department of Health	The Committee are concerned to note a steep decline in the number of eyes collected and transplantation operations carried out in Irwin Hospital as they find that against 305 eyes collected in 1973, the number had fallen to 172 in 1974 and 105 in 1975. Similarly, against 289 eye transplantation operations conducted in 1973, the figures for the years 1974-75 were only 156 and 97. Though the position has improved in 1976 (as 107 eyes have been collected and 93 operations carried out upto September 1976), it is still far from satisfactory considering the gigantic magnitude of the problem. The Committee have been informed that the reasons for substantial decline in the number of eyes collected and transplantation operations carried in 1974 was that against the strength of 2 Professors (one Professor and one Assistant Professor) in the Eye Bank Unit, one Professor went on leave from May 1974 and resigned later in the year. The Committee are surprised that instead of filling up the vacancy, the lone Associate Professor was sent on training abroad for 4 months in 1975 without making alternate arrangement and this further handicapped the Eye Bank in its work. During their visit to the Irwin Hospital on 14 October 1976 the Committee were given to understand that there were more donors of eyes than the capacity of the Unit to handle

which was limited due to the paucity of the staff. The Committee feel that the delay in filling up the vacancy created in 1974 can not be the only reason for the declining trend in collection of eyes and carrying out operations during 1974 and 1975 as it can be seen from the fact that the position in this respect has improved in 1976 even though the Department still continues to function with one Associate Professor. The Committee would like the Ministry of Health to investigate the specific reasons for this decline and take suitable remedial measures in this behalf. In order that the Eye Bank and Keratoplastry Unit are able to serve a large number of patients, the Committee desire that the Ministry of Health should examine as to how the existing facilities can be augmented for the betterment of the community in general and the poorer sections of the population in particular.

64 5.27 —do—

It is a matter of great concern that there are over 45 million people suffering from visual impairment and over 9 million blind which include 5 million who can be cured by proper surgical interference. About 1.2 million intra-ocular surgical operations are required every year while there are facilities for about 5 lakhs operations only. The problem of curable and incurable blindness in this country is posing serious public health, social and economic problems.

65 5.28 —do—

The Committee note that in order to prevent blindness in the country a national scheme for Prevention of Blindness included in the current five-year Plan has been cleared and taken up. Under this scheme there is provision for providing diagnostic and treatment facilities in the rural and taluka and even district hospitals. Mobile opthalmic units are to be estab-

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			lished in order to provide medical and surgical treatment, educate people in the methods of prevention of eye diseases and to take care of ocular health of school children. There is also a proposal for setting up regional institutions with a view to operating eye-banks, training opthalmic specialists and providing facilities for research in opthalmology. The Committee desire that the scheme for prevention of blindness should be energetically implemented so that there is a positive improvement within the shortest possible time in the ocular health of children both pre-school and school going, and vulnerable groups given top priority within time bound schedule. The Committee would like to be apprised of the progress made in this regard and results achieved thereof.
66	6.18	Department of Health	The Committee find that out of 5 X-ray machines having gone out of order in Safdarjung Hospital, two machines were repaired after a period of 3 to 4 months. One which went out of order in 1971 has been condemned now as its spare parts not available and the remaining two which went out of order in 1975 and 1976 have also been condemned as these have become obsolete. The failure of the hospital authorities to take timely action to get these machines repaired or to take concurrent action to obtain supplies of maintenance spares when the machines were purchased is regrettable. The Committee note that it was only after the Audit Report that action was initiated for getting the machines repaired. The Committee urge that a half-yearly review of the working of the X-ray machines in the

			three hospitals should be made so as to take timely action to rectify the defective ones. Urgent action may also be taken to dispose of the obsolete machines and to indent for the new ones in accordance with the procedure laid down for this purpose.
67	6.19	-do-	The Committee are concerned to note that patients have to spend a long time for getting themselves X-rayed in the three hospitals. According to the audit para the waiting time for barium meal and I.V.P. tests for out-patients in Safdarjung, Willingdon and Irwin Hospitals is 2 to 12 weeks, 8 to 12 weeks and 10 to 15 days respectively. The Committee need hardly emphasis that the hospital authorities should find ways and means to reduce the present waiting time so that early treatment of patients may be started. The Committee also desire that patients needing special tests should be given prior appointment so that they need not wait unnecessarily. The patient with prior appointment need not be registered again on the appointed date of visit so that his time is saved.
68	6.20	-do-	Since a number of patients are turned back during morning hours due to incapacity to serve them, the Committee recommend that afternoon timings of the main X-ray Unit which is generally used for inpatients only may be used since during this time the men and machines are idle for most of the time.
69	6.21	-do-	The Committee are distressed to note that in spite of the recommendations made by the Deputy Director General Health Services in his Inspection Report on his visit to Safdarjang Hospital on 5 September 1973 that to reduce long waiting time for the ward patients as well as O.P.D. patients, more staff should be attached with the X-ray units, no positive and conclu-

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			sive action appears to have been taken so far to review and augment strength of the staff of X-ray units of the hospitals. The Committee need hardly emphasise that the matter should be gone into urgently so as to effect qualitative improvement in the working of the X-ray units in the three hospitals. The usefulness of the available machines for diagnostic purposes and the manpower required to handle them should be critically gone into.
70	6.28	Department of Health	The Committee are distressed to note that three out of four artificial kidney machines which were imported for conducting haemodialysis at a cost of about Rs. 45 thousand each by Safdarjang Hospital are out of order. The GDR Machine purchased in 1966 went out of order in 1969; the Kill Machine (American) purchased in 1966 got damaged in 1971 and the Russian Machine bought in 1972 went out of order in 1973. The fourth machine which became unserviceable in April, 1973 could be repaired in October, 1975 only. Similarly, the GDR (Kedons) Machine purchased in 1959 for use in Willingdon Hospital is also out of order and is uneconomical to work. The Committee note that some of these machines have been declared irreparable due to non-availability of spare parts and are now being condemned. Since these costly and sophisticated machines had become unserviceable within a period ranging from one to five years from the date of their purchase, the Committee have a suspicion that no attention was being paid to their maintenance. As these machines have been lying out of order for a number of years, the Committee would like to know whether

			this matter was brought to the notice of the Ministry of Health for advice. In any case the Ministry may conduct a probe into the working of these machines since their purchase. The Committee may be informed about the findings.
71	6.29	do-	Since the procedure for haemo-dialysis has undergone improvement in recent years and sophisticated and easy to operate machines have come in the market, the Ministry should examine if newer machines could be acquired in place of those which have become obsolete. Alongside the acquisition of modern and sophisticated machines, the Ministry should take early action to build up a cadre of suitably trained persons to operate these machines. The D.G.H.S. should draw up a coordinated programme for the repair/replacement of sick/obsolete machines well in time so that the working efficiency of the various services/specialities of the hospitals does not suffer for want of equipment, machinery and necessary qualified staff to handle them.
72	6.30	-do-	The Committee also recommend that each hospital should maintain an inventory, which unfortunately was not being done, of sophisticated and costly machines including artificial kidney machines and the respective Hospital authorities should submit a half-yearly return to the Ministry regarding the working conditions of each such machine.
73	6.46	-do-	The Committee are unhappy to note that ambulances meant for bringing accident cases and patients suffering from serious ailments were not being maintained properly by the three hospitals. They also note that the number of ambulances maintained by the hospitals was not only inadequate but many of them were out of order for long periods. It is regrettable that

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			in the face of shortage of ambulances sometimes, these vehicles were being used as load carriers for bringing machines etc. from the depot, or for bringing doctors to hospitals from their residences. It is patent that hospital authorities had not taken sufficient care to ensure that the ambulances under their charge were being well maintained and were put to proper use.
74	6.47	Dept. of Health	The Committee have been informed during evidence that the Central Health Transport Organisation, which is responsible for carrying out repairs to ambulances, is "not doing very well" as it is not equipped fully, with the result that ambulances are not repaired in time. This Organisation has also not revolving fund to buy spare parts and as such the hospital authorities are asked every time to buy spare parts for their vehicles. This procedure takes a long time in carrying out the required repairs. The Committee need hardly emphasise that the working of the Central Transport Organisation may be reviewed urgently with a view to bring out deficiencies and short-coming, for remedial action. The Committee would like to be assured that this organisation has been provided with the requisite facilities for carrying out repairs to hospital vehicles promptly and efficiently.
75	6·48	-do-	The Committee also recommend that Government should urgently and seriously consider the feasibility of establishing an organised central ambulances service to meet the needs of people of the city. Such an organisation should have functional coordination with other bodies like Red Cross, Police, Fire Brigade etc. so that ambulances may be available from a num-

			ber of sources and patients may not suffer on this account. The Committee would like to be informed of the Government's decision in this regard. Incidently the Committee would like to stress that the ambulances should be road worthy at all times and their maintenance should be looked after by a senior functionary of the hospitals. This officer should maintain a proper log book and register for all the ambulances and also keep a record of distances covered and P.O.L. used.
76	6.49	-do-	The Committee note that of the three hospitals, only Irwin Hospital has one ambulance with medical equipments and life saving drugs to provide medical care to the serious patients during their removal to the hospital. The Committee desire that more such ambulances should be provided in other hospitals as well.
77	7.41	-do-	The Committee note that the three Government Hospitals, namely, Sardarjang, Willingdon and Irwin Hospitals procured medicines including surgical dressings to meet their requirements through the Medical Stores Depot, Karnal, firms on the DGS&D rate contracts and the open market. They are unhappy to find that due to the incapacity of the Medical Stores Depot, Karnal, to meet the demands which is the main supplier of medicines, these hospitals had to resort to open market purchases. It is observed that during 1974-75, the percentage of expenditure on purchases made on medicines from the open market as compared to the total expenditure incurred by Safdarjung, Willingdon and Irwin Hospitals was 57 per cent, 59 per cent and 83 per cent respectively. The extra expenditure incurred on purchase of medicines from open market was to the tune of Rs. 2.30 lakhs in 1974-75. During the same year, the three hospitals had indented 837 items of the value of Rs. 41.53 lakhs to the Medical Stores Depot,

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			Karnal, and the Depot had been able to supply in full only 341 items of the value of Rs. 10.45 lakhs; 209 items worth of Rs. 4.41 lakhs were supplied in part and the remaining 287 items (about 33 per cent) of the value of Rs. 18.54 lakhs had not been supplied at all. The reasons attributed for the non-supply or part supply by the Medical Stores Depot were stated to be (i) inadequacy of funds, (ii) dependence on the DGS&D for bulk purchases and (iii) policy of the Depot to achieve widest distribution of its available stocks giving preference to small units located in rural and semi-urban areas which constituted its vast clientele. The Committee have been informed that the Medical Stores Depot suffered from certain disabilities inasmuch as it has no revolving fund. The yearly allocation was exhausted during the first three months of the year on the purchase of medicines and whatever was received by way of sale of medicines was credited to the exchequer, with the result that for 6 months in a year there was hardly any medicines. To meet the situation it has now been decided to increase the allocation of funds from Rs. 10 crores to Rs. 15 crores.
78.	7·42	Dept. of Health	The Committee are distressed to note that the Medical Stores Depot with its inherent shortcomings had not been able to fulfil its obligations to meet the demands of the three hospitals, with the result that Government had to incur heavy expenditure on the purchase of medicines from open market. They are surprised to find that although the shortcomings noticed in the working of the Depot were in the knowledge of the Ministry for a

long time nothing was done to improve the situation. What is more disconcerting is that though the Administrative Staff College, Hyderabad who were asked in 1971 to study the working of the Stores Depots had recommended in May 1973 the conversion of the Organisation into a company, it was only in 1976 that Government could take a decision against conversion. Even the suggestions made then by the Ministry of Finance to effect improvements in the functioning of the Medical Stores Depot are still under consideration. The Committee take a serious view of the casual manner in which the vital question of streamlining the functioning of the Stores Depot has been kept in abeyance all these years. They, therefore, like that the reasons for the delay in taking an early decision in the matter should be identified and responsibility fixed for the delay. They would also like to know what specific improvements have been made in the functioning of the Stores Depot so as to ensure that the hospitals receive their supply of medicines without any interruption.

79.	7'43	-do-	The Committee have considered the plea advanced in favour of conversion of the Medical Stores Depot into a company and are of the view that in order to give greater flexibility and autonomy to the Organisation in its day-to-day dealings, financing as well as management matters, the question of conversion of the Stores Depot into a company set up under the Indian Companies Act, with a revolving fund at its credit, may be examined thoroughly in consultation with the Ministry of Finance and Planning Commission. The Committee would like to be apprised of the decision taken in this regard.
80.	7'44	-do-	The Committee have been informed that a proposal entitled 'Group Supply Scheme which aims at consolidation of demands from Delhi hospi-

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			tals/CGHS dispensaries has been drawn up and is under consideration of the Ministry of Health and Family Welfare. The Committee feel that the Scheme by ensuring common purchases of medicines at uniform prices by the three hospitals on a consolidated basis would wield better bargaining power than each unit making its purchases on its own and would be in a better position to purchase quality medicines at competitive rates. The Committee need hardly emphasise that the Scheme should be finalised and given a fair trial at the earliest. The Committee would like to be informed of the results which flow from its implementation.
81.	7.45	Department of Health	From the statement furnished by the Ministry of Health and Family Welfare, the Committee find that Safdarjung, Willingdon and Irwin Hospitals purchased a number of medicines/drugs from the open market by paying higher rates than DGS&D rate contract during 1974-75 and 1975-76. During evidence, the Committee have been informed that the Directorate General, Supplies and Disposals was not able to meet the requirements of the three hospitals as they were not able to force the firms to supply the medicines on rate contract as it was not legally binding contract. It has been stated that as a result of reorganisation of the working of DGS&D as well as of the Ministry of Health and Family Welfare in the matter of placing orders, instead of operating the rate contracts on a periodic basis, the latter are now formulating their requirements for six months and placing firm indents on the former who place *ad hoc* orders for firm quantities. This has ensured, as is claimed, to a large extent timely deliveries of the

			stores thereby resulting in the drop of direct purchases by various hospitals. The Committee hope that with the adoption of the new method of provisioning and procurement of medicines, the DGS&D would be able to supply medicines. the DGS&D would be able to supply medicines regularly at competitive rates to the hospitals where indents for supply are placed through them. The Committee would, however, like the Ministry to keep a constant watch over the situation and study the impact of the new procedure adopted by the DGS&D for taking further remedial measures, if necessary.
82.	7.46	-do-	The Committee have been informed in August 1977 that during the last three years the rate contract holders failed eleven times to fulfil the contractual obligations in regard to supply of medicines etc. The value of these eleven supply orders amounted to Rs. 2.89 lakhs. It has been stated by the Ministry that the matter has been reported to the DGS&D who are examining in consultation with the Ministry of Law the possibility of recovering damages from the firms concerned. The Committee would like to know within 6 months the decision arrived at in the matter and the conclusive action taken against the defaulting suppliers including the recovery of the damages from them.
83.	7.47	-do-	The Committee are distressed to note that certain medicines consumed by patients in the Hospitals were sub-standard. From the particulars furnished by Audit they observe that in Willingdon and Irwin Hospitals, samples of certain medicines were drawn for testing after their receipt in the hospitals and before the receipt of the test reports, a bulk of them had already been consumed. The Committee would like to have a full

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			explanation as to why these medicines were issued to the hospitals without proper testing and secondly why their consumption in the hospitals was not held in abeyance till the results of the samples drawn were known. They would like this matter to be fully investigated and responsibility fixed for the lapses. The Committee would also like to know what conclusive measures have been taken to ensure that only genuine and fully tested medicines/drugs are issued to patients in the hospitals.
84.	7.48	Department of Health	The Committee have informed during evidence that there is a lacuna in the law as even an entirely spurious drug is defined as an adulterated drug. It has been stated that Government have now been successful in defining a spurious drug and propose to bring a legislation whereby manufacturers of spurious drugs would be awarded life imprisonment. The Committee trust that the Government would bring the necessary Legislation without loss of further time and take stringent measures to see that medicines are available to the common man in adequate quantities and at reasonable prices. The Committee also feel that machinery in the States for ensuring production and marketing of quality drugs is rather weak and ineffective and needs to be strengthened.
85.	7.49	-do-	The Committee further note that there have been periodical reports of shortage of certain medicines time and it appears that no effective machinery exists to take notice of such shortages in time for remedial action in a coordinated manner. Though it was primarily the responsibility of

the manufacturers to ensure that shortages did not occur and that requirements of people were met adequately, the Committee would like to emphasise that necessary guidelines may be laid down in this regard and responsibility of the State Drug Controllers fixed so as to alert the Government if shortages of any medicines did occur in any part of the country.

86. 8.21 -do- The Committee note that the Indian Council of Medical Research which supports the medical research in the country serves as an apex body in this field. Besides, carrying out research through its 9 permanent institutions, the ICMR also helps to promote the research through various medical institutions and other organisations which have the capacity to do the research. The Committee have been informed that 60 percent of the budget of the Council is spent on research on communicable disease, another 30 percent on fertility control and only 7 to 8 per cent is earmarked for basic research. Though research on communicable and other diseases which take a heavy toll, is welcome, the Committee feel that there should not be any kind of rigid artificial compartmentalisation as between basic research and other kinds of research. The divisions should be more appropriately done on the basis of scientific evaluation and the health needs of the vast majority of the people.

87. 8.22 -do- The Committee have a feeling that research in the three hospitals is a secondary responsibility of the doctors and the service to the patients is one of prime importance. The research activities are undertaken in Safdarjung and Willingdon Hospitals by the staff who have teaching designations with a view to promoting knowledge in the field of medicine. No regular provision for research is allocated for these hospitals. In

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			Irwin Hospital no research as such is carried out there. Since both Irwin Hospital and G. B. Pant Hospital are part of the Maulana Azad Group of Hospitals, Dean, Maulana Azad Medical College coordinates research activities in the entire complex. The research activities undertaken by various Departments, students and the staff are on individual basis for their academic needs. These hospitals also attend to various agencies, such as Indian Council of Medical Research and University Grants Commission etc.
88.	8.23	Department of Health	The Committee are unhappy that the Indian Council of Medical Research has not been able to support much of the research project in Willingdon Hospital whereas it has supported 18 research projects in other two hispitals that is 7 in Safdarjung and 11 in Irwin. The reason that has been given is that the Willingdon Hospital is only a servicing hospital while the other two are both teaching and servicing hospitals. The Committee further find that in the case of Willingdon Hospital there is only a partial association with Lady Harding Medical College. The Committee are unable to understand how a large and effective medical institution like the Willingdon Hospital should be deprived of all opportunities of research work and should have no association with an academic institution and particularly when medical science, teaching, research and practice have all to go together. In fact, during evidence before the Committee, the Medical Superintendent, Willingdon Hospital has assured the Committee that "if we are given chance to teach and to undertake research in association with Lady Harding Medical College,

			we will definitely be able to do better." The Committee need hardly urge upon the Ministry to ensure that as far as possible, the hospitals should be linked with some academic institutions so that the doctors and other who are research minded are not inhibited from pursuing research of their own.
89.	8.24	-do-	The Committee find that during 1976-77 the research projects undertaken by doctors in Safdarjung Hospital include 7 Departments whereas in Willingdon Hospitals there are only 3 Departments. The Committee also find that during 1975-76 and 1976-77, the Indian Council of Medical Research has sanctioned 11 research enquiries to the various doctors of the Maulana Azad Medical College and associate Irwin and G. B. Pant Hospitals and for that a budget of Rs. 3,18,811 was sanctioned. Out of these 11 research enquiries only 3 are to be attended to by the Heads of the Departments of Obstetrics and Gynaecology and Paediatrics of the Irwin Hospital. The Committee desire that more and more time-bound and result-oriented research enquiries should be sanctioned to the various Departments of the Hospitals by the ICMR and other agencies. Great care should be taken in the matter of selection of the projects so that priority is given to research on diseases which are widely prevalent and for the prevention of specially the weaker sections of the society.
90.	8.25	-do-	In the opinion of the Committee the tempo of medical research and practical applications of results achieved in this field could be considerably intensified by the application of nuclear methods. As the medical research by nuclear methods is a fast expanding discipline and demands more facilities and more space, the Committee would like to urge upon the Government to enter into this particular sphere in an effective way

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			by starting more centres in the hospitals for conducting research. This is a field which could be pursued not only intrinscically for itself but also for the results which could follow.
91	8.26	Department of Health	The Committee find that the programme of exploiting medicinal herbs in the country has been taken up by the Central Council of Research in Indian Medicine and Homoeopathy, through survey of medicinal plants units and multi-disciplinary research schemes which envisages pharmacognostical, chemicopharmacological and clinical studies. The trials of certain drugs like Vidan-gandiyoge and Japakusum have shown promosing contraceptive potentiality and the usefulness of some other medicinal herbs in cases of mental retardation, respiratory diseases, joint troubles etc., has also been established. As the data collected by the different institutions working under the Council during the last 4-5 years is inadequate to come to any definite conclusion, the Committee urge that clinical trials of these drugs should be expedited. The Committee agree with the views expressed by the Ministry in this respect that the working pattern of the various research projects should be consolidated in a phased manner so as to obtain the optimum results with the available resources. Efforts should also be made to send special survey parties to the Medico-Botanical fields of the country to explore more and more medicinal plants. Extensive studies should be initiated on these plants with a view to evolving cheap remedies to the various diseases in the country. This can

			be achieved by bringing the scientists and disciplines under one roof to have co-ordination for better results.
92	8.27	-do-	The Committee learn that the All India Institute of Medical Sciences has done considerable work in the study of indigenous drugs and are presently engaged in carrying out chemical examination and trial of some of the indigenous drugs for treatment of heart diseases, joint diseases and hear diseases. The Estimates Committee (1975-76) in their 102nd Report (5th Lok Sabha) have suggested that lists of indigenous drugs standardised and tested should be prepared and furnished to all Government and local hospitals/dispensaries. The Committee hope that in the matter of research work in indigenous drugs, there would be complete co-ordination between Central Council of Research and Homoeopathy and the All India Institute of Medical Sciences so as to avoid duplication of effort in their research programmes.
93	8.28	-do-	The Committee find that no systematic efforts have been made for promotion of export of Indian herbs or for determining export potential of the Indian herbs. As the foreign countries importing Indian drugs do not utilise them exclusively for clinical purposes but also for chemical industries, the Committee desire that a special study to determine export potential of the medicinal herbs may be undertaken by Indian trade/ agencies abroad for the benefit of the overseas buyers. Considering the fact that 112 medicinal plants were exported during 1974-75, the Committee feel that there is a great scope for intensifying the export efforts.
94	8.29	-do-	The Committee are constrained to note that despite the recommendations made by the Health Survey and Planning Committee (1959—61)

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			and the Delhi Hospital Review Committee (April 1968) to appoint a medical audit committee in every hospital with a pathologist, a surgeon, a physician and a medical record officer to function as a patient care evaluation cell, no such committee has been constituted in any of the three hospitals so far. The Committee also note that the Ministry had informed the Audit in December 1975 that action was being taken to introduce medical audit committees wherever it was not done. As the appointment of such committees will ensure specific checks on the standard of the work performed in the hospitals, the Committee would like to be informed whether such committees have since been constituted in each of the three hospitals.
95.	9.10	Deptt. of Health	The Committee regret to note that although the recommendation of the Review Committee for carrying out hospital mortality review periodically was accepted by the Government in February 1970, it was only after a lapse of six years (May 1976) that the mortality review committee started functioning in Willingdon Hospital. The Committee hope that the deficiencies in documentation pointed out by the Review Committee would receive the careful attention of the concerned medical officers.
96.	9.11	-do-	While the Committee appreciate that resuscitation wards attached to the Emergency have been provided with necessary life saving equipments, they would suggest that patients in these wards should be examined by senior members of the faculty instead of senior resident doctors.

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