34

STANDING COMMITTEE ON DEFENCE

(2016-2017)

(SIXTEENTH LOK SABHA)

MINISTRY OF DEFENCE

PROVISION OF MEDICAL SERVICES TO ARMED FORCES INCLUDING DENTAL SERVICES

THIRTY FOURTH REPORT

LOK SABHA SECRETARIAT

NEW DELHI

August, 2017 / Shravana, 1939 (Saka)

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Presented to Lok Sabha on 10 .08. 2017

Laid in Rajya Sabha on 09.08. 2017

LOK SABHA SECRETARIAT

NEW DELHI

August, 2017 / Shravana, 1939 (Saka)

CONTENTS

COMPOSITION OF THE STANDING COMMITTEE ON DEFENCE (2016-17)

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Lok Sabha

2. Shri Dipak Adhikari (Dev)
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22.** Shri G Hari
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24.♠ Shri Gaurav Gogoi

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10. Dr Subramanian Swamy
11.@ Shri Om Prakash Mathur

*** Nominated w.e.f on 13.02.2017**
**** Ceased to be Member of the Committee w.e.f. 13.02.2017**
$ Ceased to be Member of the Committee w.e.f. 23.11.2016
 # Nominated w.e.f. 02.01.2017
@ Ceased to be Member of the Committee w.e.f. 10.10.2016
^ Nominated w.e.f. 10.10.2016
♠ Nominated w.e.f. 28.03.2017
♦ Sad Demise of Member on 27.04.2017
+ Ceased to be Member of the Committee w.e.f. 28.03.2017

SECRETARIAT

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2	Shri T G Chandrasekhar	-	Director
3	Smt Jyochnamayi Sinha	-	Additional Director
4	Smt Rekha Sinha	-	Sr. Executive Assistant

INTRODUCTION

I, the Chairperson of the Standing Committee on Defence (2016-17), having been authorised by the Committee, present this Thirty-Fourth Report on 'Provision of Medical Services to Armed Forces including Dental Services'.

2. The subject 'Provision of Medical Services to Armed Forces including Dental Services' was selected for examination during the year 2016-17. The Committee took evidence of the representatives of the Ministry of Defence and Department of Armed Forces Medical Services on 17.06.2016 and 25.05.2017. The draft Report was considered and adopted by the Committee at their Sitting held on 02 August, 2017.

3. The Committee wish to express their thanks to the officials of the Ministry of Defence, Armed Forces Medical College(AFMC), Pune and Artificial Limb Centre(ALC), Pune for furnishing the requisite material and information which were desired in connection with examination of the subject.

4. For facility of reference and convenience, Observations/Recommendations of the Committee have been printed in bold letters in Part II of the Report.

New Delhi;
04 August, 2017
13 Shravana, 1939(Saka)

MAJ GEN B C KHANDURI, AVSM (RETD)
Chairperson
Standing Committee on Defence

REPORT

PART- I

Introductory

Armed Forces Medical Services (AFMS) is an inter services organization headed by the Director General Armed Forces Medical Services (DGAFMS) who functions directly under the Ministry of Defence. It is responsible for providing health care services to Armed Forces personnel, their families and other beneficiaries as mandated. The present shape and structure of the AFMS was given by the Armed Forces Medical Services and Research Integration committee chaired by Dr BC Roy in 1948. Based on the recommendations of this committee the Government of India integrated the Medical Services of the Army, Navy, and Air Force and created the appointment of DGAFMS on 18 August, 1948 in the rank of Lt Gen and equivalent. The Director General, Armed Forces Medical Services is the Medical Adviser to the Ministry of Defence and is also the Chairman of the Medical Services Advisory Committee (MSAC). Also, the DGAFMS is the cadre controlling authority for the AFMS.

Structure

1.2. The medical components of the three wings of the Armed forces have their Medical Directorates headed by the Director General Medical Services (DGMS) in the rank of Lt Gen (& equivalent). The DGsMS function under their respective Service Chief in matters of day to day administration, operational commitments and logistics and are responsible for the day to day administration and proper functioning of the Service under them. Any matter with inter services bearing is referred to the DGAFMS. Coordination between the medical services of the three wings of the Armed Forces as well as the DGAFMS is mediated through the Armed Forces Medical Services Advisory Committee (MSAC). The MSAC is chaired by the DGAFMS and has the DGMS (Army), DGMS(Navy), DGMS (Air) and the Director General Hospital Services (Armed Forces) (DGHS(AF)) as its members.

1.3. The Director General Dental Services (DGDS) and the Additional Director General Military Nursing Services (ADGMNS) are invited to attend meetings of MSAC when any aspect related to their respective Service is discussed.

1.4. The DGAFMS is the advisor to the Ministry of Defence (MoD) on all health issues of the Armed Forces. The primary responsibilities of DGAFMS include enunciation of policy on all medical matters of the Armed Forces, cadre management of the AMC, ADC and MNS, training of medical, nursing and paramedical personnel, medical research, provisioning and procurement of medical stores and equipment, and matters related to disability pensions of Armed Forces personnel.The personnel of the Armed Forces Medical Services (AFMS) consist of: -

(a) Officers of the Army Medical Corps (AMC) including AMC non-technical officers, officers of the Army Dental Corps (AD Corps), Officers of the Military Nursing Services (MNS), AMC and AD Corps officers seconded to the Navy and the Air Force and probationer nurses.

(b) Junior Commissioned Officers (JCOs), Other Rank (OR) and the AMC, Medical Assistants of the Navy and Medical Assistants of the Air Force.

(c) Civilians of categories sanctioned periodically by the Government.

Officers of the AMC are allotted to either the administrative or specialist cadre in accordance with terms and conditions sanctioned by the Government from time to time.

Ranks

1.5. Medical Officers from the Armed Forces Medical College are commissioned as Lieutenant (and equivalent). On completion of internship training, they are promoted to the rank of Captain (and equivalent). Doctors from Medical Colleges other than AFMC are commissioned in the rank of Captain (and equivalent). All permanent commission Medical Officers are promoted to the rank of Major (and equivalent) and Lt Col (and equivalent) on the basis of time scale. They may then be promoted up to the rank of Lt General (and equivalent) on select grade basis. Dental Officers are commissioned as Captain (and equivalent). All permanent commission Dental Officers are promoted to the rank of Major (and equivalent) and Lt Col (and equivalent) on the basis of time scale. They may then be promoted up to the rank of Lt General (and equivalent) on select grade basis.

The Medical Services Advisory Committee is responsible to the Chiefs of Staff Committee. It may make any recommendation on matters of medical organization or policy to the Government, through the Chiefs of Staff Committee. The MSAC will be responsible for the co-ordination of the overall medical policy of the Government, the

implementation of which will be the responsibility of the Director Generals Medical Services (DGsMS) concerned.

CHAPTER-II

ROLE AND RESPONSIBILITIES OF AFMS

The Primary role of Armed Forces Medical Services (AFMS) is to provide comprehensive health care including combat and operational medical support to the serving Armed Forces personnel, their families and dependents.

2.1 The AFMS was established to provide comprehensive health care to only the serving Armed Forces personnel and their families (wife and children) at the time of independence. Over the years, its role and responsibility have expanded considerably with its services having been extended to parents of service personnel (in 1965) Initially, field units consisted of medical battalions and all Command Hospitals had a training reserve. The AFMS cater to an ever increasing clientele. In 1962, the AMC catered to a clientele dependency of 20 lakhs. The total number of beds allotted to AFMS hospitals in 1965 were 24,996. During the corresponding period 3,353 Medical officers were held on the strength of AFMS. (around 596 persons per doctor) As on 01 October 2016, the authorization of Medical Officers is 7,000, whereas the dependency is approx 2.5 crore for inpatient/outpatient care. This gives an average ratio of 01 doctor per 3961 dependent clientele.

2.2 Although the expansion in the role of AFMS and manpower are not commensurate, there have been significant efforts towards enhancement of the strength of the AFMS. Over the years, augmentation of technical medical manpower to the tune of 10,590 medical personnel including 1224 doctors has been authorized. The recruitment against the same will be over by 2018. The proposal of Training, Draft, Leave, Reserve (TDLR) for 557 medical and dental personnel (525+32) for making up deficiency of doctors/dentists proceeding on long courses like PG/Super specialization as well as lady doctors/dentists moving on maternity leave has been approved.

Coordination

2.3 There are separate DGMS for Army, Navy and Air Force with medical infrastructure under them. The Committee desired to be apprised about the mechanism of co-ordination amongst them and at different levels. In this connection, the Ministry of Defence furnished as follows:

> 'The Medical Services of the Army, Navy, and Air Force are headed by the respective DGsMS who exercise operational control over the medical infrastructure under them. The Medical Services Advisory Committee (MSAC) is the highest decision making body of the Armed Forces Medical Services. The DGAFMS is the Chairman of the Medical Services Advisory Committee. The DGsMS of the Army, Navy, and Air Force are members of the MSAC. The coordination amongst the three DGsMS on issues having a tri-service impact, is maintained by this committee. The DGsMS obtain technical advice from the DGAFMS. In addition, policy on all matters that have a tri-service bearing, is formulated by the DGAFMS.'

CHAPTER - III

Manpower

The Committee were given the following details with regard to the existing authorization and strength of the various categories of manpower under AFMS:

Army Medical Corps(AMC)
(As on 01 Nov 2016)

	Auth	Held
Army	5399	4845
Navy	694	669
Air Force	772	740
Total	6865	6254

Army Dental Corps (ADC)

	Auth	Held
Army	628	571
Navy	34	31
Air Force	38	32
Total	700	634

3.2 With regard to the dental care in AFMS, the Committee were further apprised that the Dental care in Armed Forces is provided at different Dental Centers of Army, Navy and Air Force respectively. In Army, the peace time Dental Services are provided by Dental establishments located at different stations and the Dental Section of Field Hospitals provide cover to troops deployed in operation locations. During war, the Dental Sections of the medical echelon provide basic dental and surgical care and support the mission of conservation of manpower and preservation of life. Naval Dental Services are integrated with Naval Medical Services for providing dental cover to personnel in war and peace. In Air Force, the Dental cover is provided by the respective Dental Centers co-located at the designated Air Force bases.

3.3 The authorised and posted strength of Dental Officers in Command Military Dental Centres and Field units is as given below:

Command Military Dental Centres		**Field Units**	
Auth	Posted	Auth	Posted
71	64	262	252

Military Nursing Services (MNS)

	Auth	**Held**
Army	4082	3379
Navy	382	288
Air Force	479	369
Total	4943	4036

AMC(NT)

	Auth	**Held**
Army	370	352
Navy	-	-
Air Force	-	-
Total	370	352

General Duty Medical Officers

Auth	**Held**
4360	3978

Specialist & Super Specialist

Specialist		**Super Specialist**	
Auth	Held	Auth	Held
2295	2068	210	208

3.4 Specialists/Super Specialists are authorized to AFMS based on Bhardawaj Committee report as applied by GoI letter No-10040/IX/DGAFMS/DG-

1D/108/2002/D(Med) dated 17 Jan 2003. The sanction for the current pool of specialists in the AFMS is for 2295 posts as laid down vide Govt of India letter No 10040/IX/DGAFMS/DG-1D/869/16/D(Med) dated 04 May 16. The number has been arrived at on the following basis:

(a) Number of specialists based on bed strength	1342
(b) Number of super specialists	210
(c) 5% cushion for future unforeseen requirement	78
(d) Annotated appointments	665
Total	**2295**

A Board of Officers had been ordered for revision of pool of specialists. This is also linked with revision of staffing norms for the AFMS, which is under consideration.

3.5 Further on the issue of availability of specialty and super specialty facilites, the Committee were furnished the following information:

'Specialist facilities are provided in service hospitals taking into account the number of beds in the particular hospital. The following is the general rule:

Specialist Facilities in Hospitals

Sl	**Number of Beds**	**Specialities**
1	76 - 100	Medicine, Surgery, Anaesthesia
2	101- 200	+ Obstetrics and Gynecology
3	201- 400	+ Radiology, Pathology
4	Zonal hospitals (401-600)	+ Psychiatry, Dermatology, Eye, ENT, Paediatrics , Orthopedics
5	Command hospitals and AHRR > 600	+ Superspecialities – Cardiology, Neurology Nephrology, Urology, Reconconstructive Surgery, Oncology, Joint Replacement, Gastroenterology, Endocrinology

2. Notwithstanding the above general rule, specialist facilities are provided at smaller hospitals if they are justified for the dependent population. The Armed Forces Medical Services has a well established referral system where patients needing specialist and super specialist care are referred or transferred to hospitals with the requisite facilities when needed.

3. Super specialist care needs not just trained manpower but also equipment and support infrastructure. The AFMS rationalizes the provisioning of such services so that all available resources are optimally utilized.'

3.6 The Committee desired to be enlightened on extension of super specialist facilities like Cardiology and Neurology in all zonal hospitals and induction of adequate number of Specialists in peripheral hospitals so that soldiers and officers get proper medical care in their vicinity. In this respect the Ministry of Defence submitted as given:

'Super specialist facilities need adequate basic specialty support in order to be effective. The distribution of super specialists at Armed Forces hospitals is a function of both requirement as well as availability of support staff and infrastructure. Extension of specialities like Cardiology and Neurology to zonal hospitals is considered based on above factors and is not rigidly bound by hospital class (Number of beds).The facility of super specialist care is being extended to zonal hospitals of Army Medical Corps in a phased manner for selected super specialities depending on patient work load.

At present, Cardiology and Neurology super specialist facility is available at Base Hospital (BH), Delhi Cantt and Military Hospital (MH), Jalandhar. Adequate numbers of Specialists are posted to various peripheral hospitals to provide quality medical care to troops and families in remote and far flung areas. All peripheral Indian Air Force hospitals situated across the country have been posted with specialists of basic specialities.

Zonal hospitals of the Air Force like 7 AF Hospital and 5 AF Hospital have been provided super specialist services like Cardiology, Gastro-intestinal surgery,and Oncology.

In the Navy, INHS Sanjivani, a 439 bedded zonal hospital, is being upgraded to include all major super specialities.'

3.7 The Committee further desired to be informed in detail regarding various specialty services being provided under the purview of AFMS. Also, the kind of difficulties being faced in provision of specialty sections in medical institutes and increasing number of seats in medical colleges. In this regard, the Committee were submitted a detailed note as follows:

'**Orthopedic**

The number of orthopedic specialists in the AFMS is presently 57 which is adequate to meet our current requirements. The numbers being trained annually is a function of service requirement and availability of training capacity is not a constraint in this case. Seats offered to service candidates are based on vacancies arising due to retirement/release and requirements of service. The number of service specialists being trained in Orthopaedics in various AFMS institutes is as follows:-

2014-17	2015-18	2016-19
09	07	04

Neurology

Presently, there are 18 Neurologists and 20 Neurosurgeons in AFMS. The number of specialist officers being trained in Neurology and Neuro Surgery in the last 03 years is as under:-

	2014	2015	2016
Neurology	02	02	01
Neuro Surgery	02	02	01

3.8 On the issue of authorised number of specialists/super specialists required in the Armed Forces *vis-a-vis* present strength, the Ministry further furnished to the Committee as follows:

'Specialists/Super Specialists are authorised to AFMS based on Bhardwaj Committee report as approved by GoI letter No 10040/IX/DGAFMS/DG-1D/108/2002/D(Med) dated 17 Jun 2003 in a Specialists pool. Breakup of the pool is as follows:-

Category	Authorization	Held
Specialists	1342	1342
Super Specialists	210	201
Annotated Appointment	665	519
*Additional for unforeseen (5%)	78	-
Total	**2295**	**2062**

Requirement of Specialists has been worked out in the form of Staffing Norms which will be applied prospectively to all new service hospitals. Currently, the proposal is under submission to Ministry of Health and Family Welfare for vetting.

*5 percent cushion for future unforeseen requirement after obtaining prior approval of MoD and MoD (Finance).'

3.9 The Committee were keen to know whether there is a necessity for improving the staffing pattern, particularly in specialists and Super-specialist cadres. To this

pointed query, the Ministry of Defence affirmed that yes, there is a need for improving the staffing pattern. The proposal for improving staffing pattern has been submitted to Ministry of Health and Family Welfare (MoF & FW) for vetting in Jan 2016. The proposed pattern has been approved by a board of officers including Senior Consultant Medicine and Senior Consultant Surgery. The template used by the board was IPHS norms (Indian Public Health Services).

3.10 The Committee desired to know whether there is any policy to ensure availability of specialists/ super-specialists at all times in critical areas. In this connection, the Ministry replied that the Regulation for Medical Services of Armed Forces (RMSAF) is the authority for placement of Specialists and Super Specialists in critical areas. Major General(Med)/Chief Medical Officers (CMOs)/Principal Medical Officers (PMOs) at Command level and DGsMS at Central level exercise judicious control to ensure specialist /super specialist cover to troops.

3.11 The Committee were keen to know about the impact of shortfall of super specialists in offering services to the clientele of the AFMS. On this matter, the Ministry informed that the AFMS has a minimal deficiency of super specialists and specialists. The current overall deficiency of Medical Officers is 611 (As on 01 Nov 2016). The number held is not constant due to retirement/release, promotion, move to annotated appointment and fresh inductees. Impact of deficiency of superspecialist is felt in terms of extended man-hours, rationalized leave and frequent move on temporary duties. Emergency care of patient is not hampered due to the deficiency of superspecialists. Further, Constant vigorous efforts are being made to reduce the deficiency to minimum levels.

3.12 Further the Committee enquired whether any study has been conducted to identify the number of deaths that may have occurred in Armed Forces due to non-availability of timely expert treatment. To this query, the Ministry replied as given:

'No such study has been conducted till date.AFMS ethos dictates that if a patient is unable to reach a doctor, the doctor reaches out to him/her whether by land or air or sea. The Senior Medical Officer (SMO) in the station ensures that timely medical cover is given. Due to natural reasons like extremely rapid deterioration of a patient or weather related inability of casualty evacuation, some deaths do occur. However, these are very few and the cause is pin pointed in every case. Hence a separate study to identify the number of deaths occurring due to lack of timely expert treatment has not been considered necessary by the Services.'

Deployment in tough terrains

3.13 While taking cognizance of various media reports that many soldiers who were injured during terrorist attack in Jammu and Kashmir or cross border firing had died after admission in the hospitals, during their treatment, the Committee desired to be provided detailed information about such soldiers who died during treatment after reaching hospitals including the name of the hospital, kind and level of injury and whether their treatment faced lack of any equipment, medicine, or specialist doctors. The Ministry stated as under:

> 'From 01 Jan 2016 to 31 Jan, 2017 04 soldiers died during treatment after reaching the hospital who sustained injuries during terrorist activities in J & K. The soldiers had sustained multiple splinter injuries and Gun Shot Wound in head, neck and chest. 01 soldier expired at 92 Base Hospital and 03 soldiers expired at Army Hospital (R&R). Their treatment did not face a lack of any equipment, medicine and specialist doctors.

Sl	No, Rank & Name	Age	Unit	Diag	Date & Time of injury	Place of incident	Hosp where initially admitted	Hosp where eventually expired	Date of death
1.	2801206X Nk Panduranga Gawade	33	41 RR	Gunshot wound (Head)	21052016 1300 Hr	Kupwara (J&K)	168 MH	92 MH	22052016
2.	3393369F Hav Devender Singh	28	17 SIKH	Gunshot wound (Lt side of neck & Rt side of femur)	08082016 0525 Hr	Khanbal (J&K)	92 BH	AH (R&R)	19082016
3.	4288168A Sep KV Janardhan	20	6 BIHAR	Gunshot wound (Abdomen & Lt side of neck)	18092016 0530 Hr	Uri (J&K)	92 BH	AH (R&R)	19092016
4.	4280144X Nk Raj Kishor Singh	33	6 BIHAR	Multiple Gunshot wound (Chest & pelvis)	18092016 0530 Hr	Uri (J&K)	92 BH	AH (R&R)	29092016

3.14 However, it has been ensured that all fighting formations particularly those on the Northern and Eastern theatres, have been provided with their full complement of authorised medical staff (including Medical Officers) to cater for their medical needs.

3.15 The following detailed information on the number of doctors, supporting staff working in the Field Hospitals in the North-eastern states, Rajasthan border etc. along with the criteria followed by the Ministry for posting of doctors and supporting staff in far flung and border areas were furnished to the Committee:

> '(a) Doctors and supporting staff are authorised to Field Hospitals. Border static hospitals/fighting formations as per laid down scale based on the strength of the clientele and work load of the particular location.

(b) The number of doctors working in North Eastern States in all Field Hospitals is as under :-

(i) Total authorised : 177
(ii) Total held : 177

(c) The number of doctors working in Rajasthan Border Areas in all Field Hospitals :-

(i) Total authorised : 62
(ii) Total held : 55

(d) This figure is dynamic and varies according to tactical deployment of troops.

(e) Adequate medical staff is available to cater to their needs.'

3.16 The Committee desired to know whether there is any policy to ensure availability of specialists/ super-specialists at all times in critical areas. In this regard, the Ministry of Defence stated that **t**he Regulation for Medical Services of Armed Forces (RMSAF) is the authority for placement of Specialists and Super Specialists in critical areas. Major General(Med)/Chief Medical Officers (CMOs)/Principal Medical Officers (PMOs) at Command level and DGsMS at Central level exercise judicious control to ensure specialist /super specialist cover to troops.

Manpower in Command Hospitals and Field Units

3.17 The Committee wished to be apprised about the authorized and held strength of doctors and paramedical staff (all categories) in Command Hospitals and Field units. In this regard, the Committee were furnished the following information:

'The authorised and held strength of Medical officers of Armed Forces Medical Service at Command Hospitals and Field medical units is as under:-

(As on 01 Nov 2016)

	Command Hospitals		Field Units	
	Authorised	Held	Authorised	Held
Army	435	571	378	390
Navy	121	113	186	169
Air Force	71	86	434	349

The apparent excess of posted over authorised strength at Command Hospitals and apparent deficiency of posted strength at Field units is a conscious decision. The medical services follow the system of referral of patients from a peripheral medical facility to a higher echelon. Patients requiring a higher level of care are transferred to a higher center which has more specialists and specialized facilities for investigation, therapy and techniques. Therefore, Command Hospitals have been provided with a little excess which has come from the field units.'

3.18 The authorised and held strength of Paramedical Staff of Armed Forces Medical Services at Command Hospitals and Field Medical Units is as under:

(As on 01 November, 2016)

	Command Hospitals		Field Units	
	Authorised	Held	Authorised	Held
Army	22918	22991	35380	36464
Navy	412	412	284	284
Air Force	356	548(276+272*)	3779	3191
*Additional 272 Med Assistant are undergoing Diploma Courses at CHAFB				

Posting/transfers

3.19 The Committee enquired about the basis of posting of AFMS officers/staff in various units. To this, the Ministry replied as given:

> 'The basis of posting of Specialists and Super Specialists is as under:-
> (a) Revised Peace Establishment (PE) of various hospitals w.e.f. 2014.
> (b) Bed occupancy of various hospitals.
> (c) OPD workload.
> (d) Medical Council of India (MCI) /DNB guidelines for teaching programme.
> (e) National Accreditation Board for Hospitals (NABH) accreditation.
> Based on all 5 factors mentioned above, DGsMS decide posting of Specialist and Super Specialist in consultation with DGAFMS. This results in a flexible specialist cover and maximum clientele satisfaction.'

Periodic Revision of Manpower

3.20 The Committee wished to be apprised whether there is any regular revision in authorization of strength in hospitals at all levels. On this point the following information was given to the Committee:

> 'The authorization of medical and paramedical personnel in the AFMS has been revised from time to time. The AFMS was granted an additional authorization of 10590 personnel including doctors nurses and Paramedical Staff (Combatants and Civilians) in three phases as a consequence of the Standing Committee of Parliaments report of 2006. Currently, the third phase of the augmentation is being recruited.
>
> In order to meet clientele expectation as well as optimize human resources deployed in hospitals, DGAFMS has evolved Staffing Norms for various hospitals based on bed strength. The module used is based on IPHS (Indian Public Health Standard) Norms.
>
> The Ratio of doctor: bed suggested in AFMS norms varies from one General Duty Medical Officer per 15 beds in peripheral hospitals to one General Duty Medical Officer per 46 beds in large hospitals. For specialists, the suggested AFMS norm is one specialist per 20 beds in peripheral hospitals to one

specialist per 14 beds in large hospitals. The number of nurses and paramedical staff in AFMS hospitals is less than civil hospitals as is evident from the table below: -

Hospital	Beds	Total Doctors	Total Nurses	Doctor Bed Ratio	Nurse Bed Ratio
AH (R&R)	995	347 (incl PG trainees)	214	1:3	1:5
AIIMS	2424	625	3125	1:4	1.2:1
Apollo	650	550	1100	0.8:1	2:1

Doctor-patient ratio

3.21 The Committee enquired about the basis of calculation of the ideal doctor-patient ratio and the steps being taken to improve the doctor-patient ratio. The Committee were given the following information:

'Calculation of ideal doctor patient ratio is based on a large number of factors namely:-

(a) Whether the doctor is a General Practitioner or Specialist.
(b) General condition of patient.
(c) Availability of the doctor in man-hours.
(d) Administrative duties assigned to the doctor.
(e) OPD workload of the doctor
(f) Lead time of patient waiting area.
(g) Clientele satisfaction feedback.
(h) Leave requirement of doctor.
(i) Teaching commitments of doctor.

This ratio is different in different settings, however, an average of 1 : 4 is applied in All India Institute of Medical Sciences (AIIMS) and most corporate hospitals like Sir Gangaram Hospital. Steps being taken to improve doctor patient ratio are as under:-

(a) Flexible medical cover: - DGsMS place MOs/Specialist and Super specialist as per patients requirement.

(b) The proposal for 557 Medical officers (Army: 445, Air Force: 80 and Army Dental Core: 32) for Training, Drafting, Leave, Reserve (TDLR) has been approved by Government of India.

The present doctor-patient ratio is one doctor per 10-12 individuals against an ideal ratio of 1:4.'

3.22 The Committee wanted to know how does the Ministry plan to mitigate this deficiency. In this connection the Ministry furnished that the held strength is a dynamic figure. The apparent shortage is due to factors like officer's Release / Superannuation, resignation, promotions and move to annotated appointments. Further, the Ministry of

Defence added that current authorization of Medical officers is 6605 and the physical deficiency is 570. This number is labile as officers are superannuating, retiring prematurely and being commissioned on a regular basis. Along with this deficiency, there exists a functional deficiency due to doctors being unavailable to the organization while undergoing in-service training courses like MD/MS, Diploma of National Board (DNB) and Super specialization as well as mandatory military courses. This results in a deficiency of about 1700 per year in a staggered fashion. Hence, total deficiency works out to 1270 or 19.2%. The physical deficiency mitigation is a constant process as medical officers are commissioned every year to fill physical vacancies.

3.23 The functional deficiency of officers will be met by the advent of Training, Drafting, Leave Reserve (TDLR) to the tune of 1229 Medical Officers, 77 Dental Officers and 169 members of MNS. However, the proposal for 557 medical officers (Army: 445, Air Force: 80 and Army Dental Core: 32) has been approved recently by the Government of India.

CHAPTER-IV

MODERNIZATION AND INFRASTRUCTURE UPGRADATION

Modernization of equipment at Armed Forces Hospitals is affected through Annual Acquisition Plans (AAPs). Proposals for new equipment are sent by hospitals through staff channels. The proposals are vetted by Expert Committees and Senior Consultants. Cases are processed through MoD. Approximately Rs 100 Cr is spent on equipment modernization annually.

4.2 On long term plan projection particularly with regard to upgradation of the existing facilities the Committee were furnished the following details through written reply by the Ministry of Defence:

'The long term projection is given below:-

Army

(a) To provide comprehensive medical support, Army Medical Corps has identified the existing voids and has proposed for raising of 07 x Military/ General hospitals and upgradation of 04 x Military/General hospitals. These have been done with the aim of ensuring requisite medical cover to the entire Indian Army.

(b) The raising of 03 x Military hospitals and upgradation of 02 x military/General hospitals in border areas has been sanctioned by Govt of India, MoD as part of Capability Development Plan for Northern borders. Hospitals are being raised/ upgraded as per Capability Development Plan for orthern Borders which is as under:

(i) **Military Hospitals (MH) to be raised.**

S No	Command	Medical Unit	Place of Raising	Location	Year of Raising
(aa)	Eastern	188 MH (200 beds)	Rangapahar	Likabali	2017-18
(ab)	Eastern	189 MH (200 beds) with Military Dental Centre (MDC) for 17 Corps	Panagarh	Panagarh	2018-19
(ac)	Eastern	MH 75 beds with MDC	To be confirmed	To be confirmed	2020-21

(ii) **Military Hospitals to be upgraded.**

Sl No	Command	Medical Unit	Location	Year of Raising

(aa)	Eastern	Upgrade 180 MH from 148 to 250 beds.	Misamari	2019-20
(ab)	Northern	Upgrade 153 General Hospital (GH) from 200 to 300 beds.	Leh	2018-19

(c) **Long Term Perspective Planning (LTPP) 2017- 2032**.The projection of raising/upgradation of military/General hospitals have been made in the LTPP 2017-32 for Indian Army. The details of proposal made are as under: -

Sl No	Command	13/14/15th Plan
(i)	Southern	225 bedded Military Hospital (MH) for Jaisalmer.
(ii)	Eastern	50 bedded MH at Chungthang.
		49 bedded MH at Borarupak (Near Likabali).
(iii)	Northern	Upgradation of MH Kargil from 44 to 149 beds.
		200 Bedded MH for Eastern Ladakh.
(iv)	South-Western	Upgradation of MH Jaipur to 600 bedded Command Hospital.

Navy

Periodic review is being carried out regularly of the facilities available invarious hospitals and the need for upgradation of some of these hospitals, which is based on operational needs and clientele requirements. INHS Kalyani, Sanjivani, Nivarini, Patanjali, Dhanvantrari, Navjivan and Karanja arecurrently under various stages of upgdation.

Air Force

(a) Policy Page revision of Air force Hospitals have been completed with comprehensive review of all the required facilities.

(b) 7 AFH Kanpur has been authorised Cardiology Centre, Gastroenterology Centre, Gastrointestinal Centre and Urology Centre.

Enhancement of the facilities at Air Force Hospitals is an ongoing process. The Policy Page revision of Air force Hospitals which gives the authorization of manpower has been completed with comprehensive review of all the required facilities.

7 AF Hospital, Kanpur has been authorised Cardiology Centre, Gastroentenrology Centre, Gastrointestinal Centre and Urology Centre.

A proposal for upgradation of 11 and 12 AFH from peripheral hospital to Zonal hospital is under consideration.'

Upgradation of super-speciality facilities

4.3 The specialist facilities are being provided taking into account the number of beds in the hospitals. Medicine, surgery and Gynaecology are categorised as basic specialists facilities while ENT, Orthopaedics, Skin are available only in zonal

hospitals. Please state why ENT, Orthopaedics, Skin are not categorized as basic specialist facilities and made available in all hospitals.

4.4 The AFMS Specialist Services currently work on the paradigm of specialist pool. Depending on requirement of specialists, based on bed strength of hospitals and Strength of garrison, specialists are posted to various hospitals. This optimizes use of specialists. Those patients requiring services of other specialist are currently being referred / evacuated to the hospitals holding the concerned specialist. Medicine, Surgery and Gynaecology can handle life threatening emergencies related to all other specialties and super specialties, hence they are considered basic specialties.

4.5 The new staffing pattern proposed by AFMS has suggested the inclusion of ENT, Orthopaedics and Skin in all hospitals of bed strengths having more than 100 beds. The proposal for new staffing norms is under consideration in the Ministry of Defence in consultation with Ministry of Health & Family Welfare.

4.6 The specialist facilities of Cardiology and Neurology are available only in Command Hospitals. The Committee wished to know why these are not made available in zonal hospitals. The Ministry of Defence replied as under:

'Cardiology and Neurology departments involve the availability of the following :-

Cardiology:		Cardiac catheterization lab
Requires		Interventional Cardiology
	:	2D Echo Cardiography
	:	Cardiac anaesthesia support
	:	Cardiology trained doctors and paramedical staff.
Neurology	:	CT/MRI with neuro imaging and interventional
Requires		neurology facilities
	:	EEG lab
	:	Neurology trained doctors Paramedical staff
	:	Physiotherapy department

This trained manpower and infrastructure have to be created out of AFMS resources. It takes years of training and investment in training as well financial investment to create a cardiac catheterization lab. For example, a basic catheterization lab will cost Rupees six crores in initial investment and about Rs two - three crores recurrent yearly costs excluding manpower. A 256 slice CT or latest MRI costs upward of Rupees four crores as initial costs followed by trained radiographers, radiologists and finally neurology trained nursing assistants and finally the neurologist. Each of these super speciality centres does not exist in isolation. They need good intensive care facilities as well as a competent laboratory and a medical store with enhanced capabilities. Hence, the overall investment is to the tune of Rupees ten crores upward with recurrent costs.

At the same time casualty evacuation facilities for patients by land, air or sea are good in the Armed Forces, hence any patient requiring cardiology or neurology opinion is stabilized by the medical specialist available and transferred to the concerned Command Hospital by the fastest possible means.

Also, each Command Hospital caters to a large catchment area hence the super specialty services are used by a larger clientele.'

Mobile Medical treatment facilities

4.7 The Committee desired to be updated on provision of mobile medical treatment facilities for the field military personnel. The following information was submitted:

'(a) Primary Healthcare facilities including mobile medical treatment to field military personnel are provided by the Regimental medical officers and paramedical staff through infrastructure inherent within the field military units and Field Hospitals. There are presently 98 Field Hospitals existing in the Indian Army. These are medical units that provide sector wise medical cover to the respective army formations both during war and peace. To accomplish this role, the Field Hospitals have the capability of establishing various detachments viz. Medical Aid Posts (MAP), Advance Dressing Station (ADS) and Forward Surgical Centre (FSC). These units have the capability to hold and treat casualties and also to evacuate them rearwards to different medical establishments, if required. Secondary and tertiary level healthcare facilities are provided through the network of Border Static Military/General hospitals and Base Hospitals located in field areas.

(b) To facilitate provisioning of mobile medical treatment facilities in far forward areas, the following procurement proposals are also being progressed:
(i) **Mobile Disaster Relief Equipment (MDRE)**. To build up the capability of Army Medical Corps to provide improved medical support in combat zone and forward areas, procurement of 05 sets of 10 bedded MDRE as a Capital acquisition has been included in the 12th Army Plan. These can be transported by road/rail/air/sea. The Request for Proposal (RFP) is being progressed by Indian Navy, being the lead service.

(ii) **Mobile Casualty Clearing Station (MCCS)**. Proposal for procurement of 50 bedded containerised and soft shelter based, rapidly deployable medical facilities through Capital Route has been included in the Recast 12th Army Plan. Formulation of QRs for the same is in progress.

(c) Besides providing medical care to the combatants and their dependents, these medical units also provide various treatment facilities to civilian population residing in these areas along with provision of medical camps. Medical facilities are also provided to civil administration during disasters and whenever requisitioned by civil administration.

(d) Medical services of the Armed Forces (Army, Navy, and Air Force) are not linked with any insurance schemes and no such services are provided.

(e) Air Force stations are static in nature. All Air Force Stations have Station Medical Centres which provide primary health care for all personnel and families. Cases requiring specialist cover are referred to Armed Forces Hospital. All Naval units have sickbays which function in a similar manner.

(f) Ambulances, Critical Care Ambulances, Disaster Relief Vans, Mobile Disaster Relief Equipment (MDRE) are all in the different stages of procurement. These will be providing mobile medical treatment facility for the field military personnel as well as the civil society residing there. '

Air Ambulances

4.8 During the deliberations, the Committee desired to be informed about the need for air ambulances in AFMS. To this, the representatives of AFMS deposed before the Committee that there is no doubt that an army like us requires, say, ambulance fleet perhaps, if the budgetary constraints do not come in the way. As of now, the Air Force and the Army Aviation are doing an exemplary job of providing us air effort whenever it is required. The only difference will be that here you will have pre-equipped aircraft which will already have intensive care of material inside, monitors, ventilators and all so they can be immediately flown in. Here, normal aircrafts are taken and we put in the equipment as and when required. As of now, we are doing it but if you ask me for a wish list, certainly, air ambulances would be in order.

4.9 Further on the issue of modernization the Ministry of Defence apprised the Committee that there is a need for modernization of hospital infrastructure, renovation / reconstruction of hospitals, Air Evacuation Facilities including a dedcated air ambulance fleet, a hospital Ship, Logistic Support Units. Also, the Committee came to know that there are only two transfusion centres – AFTC, New Delhi and transfusion centre, Kolkata.

CHAPTER-V

FUNDING

The details of Budget allocation and utilization for procurement of medical stores / equipment both capital and revenue for the last 10 years are as under:-

'CAPITAL BUDGET (Rs in Crore)

Financial Year	Projection	Allocation	Expenditure
2007-08	60.00	70.00	78.44

2008-09	50.00	60.00	63.75
2009-10	60.00	70.00	77.47
2010-11	70.00	100.00	107.23
2011-12	85.00	123.00	121.79
2012-13	125.00	120.00	132.75
2013-14	140.00	110.90	111.2912
2014-15	200.00	100.00	102.4059
2015-16	115.00	115.00	114.1879
2016-17	100.00	100.00	85.6509 as on 31st October, 2016

REVENUE BUDGET

Financial Year	Projection	Allocation	Expenditure
2007-08	440.00	430.00	431.16
2008-09	455.00	440.00	446.63
2009-10	486.00	452.00	442.69
2010-11	526.00	510.00	506.00
2011-12	567.00	553.23	557.99
2012-13	604.00	591.23	581.22
2013-14	704.00	695.4450	710.4991
2014-15	820.00	780.8400	796.4346
2015-16	476.5000* 421.00** 897.5000(Total)	489.0970* 417.80** 906.8970 (Total)	876.6800
2016-17	558.4800* 463.00** 1021.4800(Total)	915.6500* 438.00** 1353.6500(Total)	402.2366 Crore till 31st October, 2016

*DGAFMS Only
**DGMS(Army)

Note: Till the Financial Year 2014-15, the entire procurement was being done by the office of DGAFMS. From FY 2015-16 onwards, the allocation for procurement for the Army is being made to DGMS (Army).'

5.2 Further, with regard to the budgetary support the following information was furnished to the Committee:

'Sufficient funds have been made available for the Armed Forces Medical Services for discharge of their duties. The DGAFMS also has important roles like medical research, training and international collaboration. Currently, budgetary support for all functions other than procurement of medical stores and medical research comes from the Army budget and is controlled by the Army FP Directorate. Budget for Medical Research comes from DRDO. This arrangement places constraints on the efficient and smooth discharge of

functions other than procurement of Medical stores. Top level budget control by the DGAFMS will improve overall financial management of AFMS.'

5.3 The Committee desired to be apprised about the opinion of the Ministry of Defence in making the Capital Fund for AFMS non-lapsable. On this, the Ministry intimated that there is no proposal to make the Capital Budget non-lapsable and roll-on. However, during the last five years, on no occasion was any substantial amount of surplus funds available for rolling over.

5.4 The Capital Budget for next financial year is projected in the month of September of the current financial year depending on the utilization trends of the last three financial years and also the projects which are likely to fructify. The Capital projects have a incubation period ranging any time between 180 to 270 days and it is prudent to project for a provisional Budgetary Estimate considering that not all projects are likely to fructify in the same financial year. The total value of Annual Action Plans (AAPs) for the Financial Year (FY) 2013-14, 2014-15 and 2015-16 was approximately Rs 329.49 Cr, Rs 225.81 Cr and Rs 503.45 Cr respectively. The fructification of AAPs cases has been analyzed and it is seen that only 20-30% cases materialize due to extended timelines involved in capital procurement process. This becomes a constraining factor in projected budget figure. In view of the facts stated above, a Budget Estimate of Rs 100.00-115.00Cr is being projected every year for Capital procurement.

CHAPTER- VI

ALTERNATE MEDICINE

Ayurveda clinics with 10 beds each at Base Hospital Delhi Cantt and Command Hospital, (Southern Command), Pune were sanctioned vide GOI, MOD letter No. 10(2)/2004/d(Med) dated 15 March 2004 on an experimental basis for one year. The service was reviewed after one year and then shut down.

6.2 Efforts for integration of AYUSH system have been initiated once again by appointing a committee with DGHS(AF) as Presiding Officer and reps from AYUSH Ministry and service Headquarters. Based on the recommendations of the committee, actions have been initiated for opening of two AYUSH life style centres at AH(R&R), Delhi Cantt and Air Force Hospital, Hindon on trial basis.

CHAPTER - VII

PREPAREDNESS FOR NUCLEAR, BIOLOGICAL CHEMICAL WAR

There has been an increasing threat of non-conventional war i.e. Nuclear, Biological and Chemical war in the future. The Committee were informed that with regard to Chemical Biological Radiological Nuclear Bio Warfare (CBRN), till now there is no experience. However, training module has been started and preparation is on. While elaborating on the fundamental features of design of the training module the Ministry of Defence submitted the following:-

'(a) The Chemical, Biological, Radiological and Nuclear (CBRN) Training curriculum is designed to assist Armed Forces Medical Services to improve their emergency preparedness and response arrangement, complement national training systems and improve co-operation between first responders of Armed Forces, Paramilitary Forces and civil administration. The fundamental features of the design of the training module are as under:-

(i) Adaptable and flexible to accommodate different emergency management structures within the country.
(ii) Modular and focussed on key functions of the immediate or short-term elements of the medical response.
(iii) Dynamic, to incorporate best practices and lessons learnt.
(iv) Standardisation and uniformity in the Training curriculum of CBRN training at various training establishments.
(v) Correct selection of course participants for basic orientation course, training the trainers course for rapid capacity building and refresher course.
(vi) Integration of civil-military CBRN training.

(b) The course content of different courses are designed taking into account the basic qualification of the participant as well as organisational aspirations and expectations. A proper training need analysis is ensured for optimal uptake of knowledge by the course participants. The training course curriculum for CBRN medical preparedness is primarily based on understanding of the following learning objectives:-

(i) The security context behind National and International CBRN preparedness and response.
(ii) The methods employed to recognise a CBRN incident.
(iii) Protection of responders and safety of victims.
(iv) Decontamination options at a CBRN incidence.
(v) Medical and psychological considerations in relation to CBRN incidents
(vi) Principles of casualty evacuation and hospital medical preparedness.
(vii) Command and control in relation to CBRN incidents.
(viii) Operational implications between civil-military interfaces.

(c) The training of medical officers and paramedics of Armed Forces are conducted at following locations:-

(i) Head Quarter Integrated Defence Service (HQ IDS) (Med) – Conducts 02 x Medical Officer and 02 x Paramedics courses in a year.
(ii) Faculty of CBRN Protection, College of Military Engineering (CME) Pune.
(iii) Nuclear Biological Chemical Warfare & Disaster Management (NBCD) School at Lonavala for Navy.
(iv) Armed Forces Institute of Nuclear Biological & Chemical Protection (AFINBC(P)) at Air Force Station Ayanagar.
(v) Army Medical Corps (AMC) Centre and College, Lucknow.
(vi) Armed Force Medical College (AFMC) Pune.
(vii) Bhabha Atomic Research Centre (BARC), Mumbai - preparedness and response to Radiation, Emergencies for Medical Officers.

The research inputs for such preparation are received from following:-

(a) Ministry of Health & Family Welfare (MoH&FW),
(b) National Disaster Management Authority (NDMA),
(c) Defence Research & Development Organisation (DRDO) Labs under DG Life Sciences,
(d) Bhabha Atomic Research Centre, Mumbai,
(e) Relevant research inputs from Service Directorates and HQ IDS (Operations /Logistics).'

7.2 With regard to the present position of preparedness of AFMS to deal with CBRN warfare, the Committee were apprised that AFMS is presently responsible for conduct of training of medical officers and paramedics as part of capacity building for CBRN preparedness. A data bank of CBRN trained manpower in AFMS has been prepared. Command, Corps and Division level training are also being conducted periodically. Procurement issues and replenishment of Individual Protective Equipments (IPEs) and CBRN equipment for medical units are being managed as per Equipment Management Policy issued by Directorate General Prospective Planning (DG PP) (CBRN) vide their letter No A/12047/GS/PP(CBRN)/Lgs dated 07 Oct 2013. The mother depot of all CBRN equipment is Stores Depot at earmarked Forward Medical Stores Depot (FMSDs)/Advance Medical Stores Depot(AFMDs)/Field Hospitals under the overall arrangement of DGMS (Army).

CHAPTER - VIII

TRAINING

The number of Post-Graduate (PG) seats offered in various AFMS training institutions in the last three years is as under:-

S.No	Years/Session	Service Residents	Other than Service Residents*
(a)	2014-17	89	213
(b)	2015-18	128	151
(c)	2016-19	118	196

* PG seats are also allotted to :-
(i) Foreign Medical Officers
(ii) Officers from Paramedical Forces and other Government Organisations
(iii) Ex Short Service Commissioned Officers
(iv) Civilian Candidates

The training capacity for various specialties and super specialties in different AFMS training institutions is more than adequate for our own requirements. The number of medical officers detailed for this training depends on the service wise requirements in the AFMS. It is submitted that beyond the requirements of the Armed Forces, remaining seats are fully utilised thereby creating a national asset in the form of specialists in the service of the nation and no seats are wasted.

Nursing

8.2 There are six Colleges of Nursing (CoN) and one School of Nursing (SoN) to impart training to nursing students. The six Colleges of Nursing under AFMS are at AFMC Pune; CH (EC) Kolkata; INHS Asvini Mumbai; AH (R&R) Delhi Cantt; CH (CC) Lucknow and CH (AF) Bangalore. The school of Nursing is at CH (WC) Chandimandir.
(b) All the Colleges are imparting BSc (Nursing) degree under respective Universities and are duly recognized by the Indian Nursing Council and State Nursing Council. The School is imparting General Nursing and Midwifery diploma under DGAFMS Examining Board.

(c) The training is effective with 100% students being commissioned into Military Nursing Service after successful completion of course.

(d) In order to strengthen the training and to have better medical services in the hospitals, the upgradation of various Schools to Colleges was undertaken in phased manner with CH(AF), Bangalore being the latest upgraded from School of Nursing to College of Nursing in October, 2016.

(e) The above mentioned institutions are with the Command Hospitals of AFMS.

Para-medical Staff

8.3 Training of Para-medical personnel of the AFMS is carried out at the following institutions:

(a) The Institute of Paramedical Sciences (IPMS), AMC Centre & College, Lucknow,
(b) School of Medical Assistants (SOMA), Mumbai,
(c) Medical Training Centre (MTC) Bengaluru,
(d) AFMC Pune.

The courses include:

(a) Specialist Nursing Asstt / Medical Asstt training in service,
(b) Advance specialist courses,
(c) Diploma courses,
(d) Bachelor of Paramedical Technology courses.

The in-service specialist courses vary from 14 Weeks to 58 weeks in duration depending on the type of course. The advanced specialist courses are of six months duration. The Diploma courses are typically of two years duration (Except Diploma in Physiotherapy which is of three years duration). The Bachelor of Paramedical Technology is a three year degree course.

The diploma courses run by the training institutions as mentioned above are recognised by statuary bodies as given below:

(a) Courses at AFMC Pune: Mahrashtra University of Health Sciences, Nashik
(b) Courses at MTC, Bengaluru: Paramedical Board of Karnataka
(c) Courses at SOMA, Mumbai: MUHS, Nashik

Courses for specific specialist Medical Assistants are recognised by bodies such as the Dental Council of India, Rehabilitation Council of India, and Pharmacy Council of India.

8.4 The Committee found that there is no formal recognition to the training being imparted to the Ex-Servicemen under Para medical forces. On the matter, it was

informed that a large number of the courses being run for paramedical personnel are recognised by the statuary bodies. However, in service courses conducted at AFMS Hospitals do not have formal recognition at present. The steps being taken in this regard are given below:

'Army

Army Medical Corps is processing the case for recognition of all courses that are not recognized by any council/University, by Jamia Millia Islamia University (JMIU).

Air Force

(a) An MoU was signed between MoD and Ministry of Skill Development and Entrepreneurship (MOSDE) on 13 July, 15 for identification and mapping the skills of defence personnel in conformity to National Occupational Standards. It is imperative that the civil equivalence of skill and experience gained by air warriors is identified and quantified by civil certification agency to help them in getting appropriate employment.

(b) In liaison with NSDC, IAF conducted the first Skill Certification course at premier Medical Training Centre, Air Force (Bengaluru) in December, 2015. Thereafter, two more courses have been conducted for retiring medical assistants

(c) The retiring Paramedical staff are issued a certificate of competence by Directorate of Air Veterans as per Govt. of India, Ministry of Labour letter No. DGET-5/1/03/VG (01) (NCO) dated 04 January, 03 for purpose of post retirement employment.

(d) In addition, Proficiency & Experience Certificate is also issued by Air HQ, to retiring medical assistants who have undergone in-service courses which is not recognised by Civil Certification Agency.'

8.5 As far as dental training is concerned, the Committee were intimated that there are only two institutes where training for dental services are imparted. One is Armed Forces Medical College, Pune and the second is Army Dental Centre, R&R which is located within the Army Hospital, R&R complex.

CHAPTER -IX

ARMED FORCES MEDICAL COLLEGE

The Armed Forces Medical college was established on 04 Aug 1962. The Mission Statement of AFMC is to provide comprehensive medical and nursing education to the cadets, students and student officers to ensure a holistic development of medical knowledge and skills with an aim to prepare technically competent medical professionals who are courteous, caring, compassionate human beings, conscious of social and environmental responsibilities. The Role and responsibilities are stated below:

- Provide educational opportunities to inculcate a high degree of discipline, value system and ethics
- Effective use of the abundant clinical material
- Use of active medical education system and modern medical education technology
- Provide opportunities for all round development by exposure to diverse curricular & extracurricular activities
- Faculty development

9.2 The Committee wished to be updated on the efforts being made by the Ministry to declare the Armed Forces Medical College and other such institutions as deemed Universities so that they may be enabled to grant recognition to the training being provided to Armed Forces personnel under para medical courses. In this regard, the Committee were intimated that currently there is no proposal for declaring the Armed Forces Medical College, or any other AFMS institution as a deemed university.

Retention

9.3 During deliberations on the subject, the Committee were informed by the representatives of the Ministry of Defence that around 20 per cent students leave the AFMC despite a bond amount of Rs. 25,00,000 at gratuate level and Rs. 28,00,000 at PG level. Another issue, appearing before the Committee was much lower number of girl cadets joining the AFMC. The Committee desired to be apprised about the reasons for drop out and also lesser number of girls intake in AFMC. In this regard, the representatives of AFMC, deposed as follows:

> `Madam, for MBBS all 100 per cent are civilians. The point that was mentioned here is that they will still join, especially parents of girls do not want them to come and join the armed forces, whereas once they come in, they see the environment and they see that it is such a wonderful place to work in and we

motivate them to join. So, if we make the deterrent so high, then we do fear that they will not come and the higher in merit when they know that the fees is Rs. 250 or Rs. 10,000 maximum in GS, they will prefer to go there. They will not come here when we say that they have to bond. So, we want them to come and then we want to have the opportunity to groom them and voluntarily wanting to join the armed forces. About drop out rate, we will compile it and give it to the Standing Committee and also the reasons for the drop out.

That is one thing. Second is the Army itself has started its own welfare medical college — the Army College of Medical Sciences —which is, as you know, located in Delhi Cantonment. As of now, the Arm. Forces, with the Ministry of Defence's approval, have been supporting this tnedical college by way of the Base Flospital, Delhi and for providing the additional faculty that they have not yet hired. Hundred seats are there out of which 19 are for the Delhi Government and 81 are with the Army. This is meant purely for Army wards. So, you have an entire medical college which is for this purpose. But the problem is that the Armed Forces Medical College is a national institute. While we did have reservation, but now when it comes to a level playing field, it is probably also appropriate because we are calling ourselves a national institute and, therefore, there should be equal opportunities for civilians also to get in.'

9.4 During the recently undertaken study visit of the Committee from 4 to 8 July 2017, they paid a visit to AFMC, Pune. During the visit the Committee were apprised that the case for increasing cadets intake to 150 is under process and pending approval from Maharashtra University of Health Sciences and Medical Council of India. Also, a Department of sports medicine has been started on Ad hoc basis. For this purpose, there is an increased requirement of trained doctors to improve fitness standards for the Armed Forces.

9.5 The Committee were further intimated by the representatives of AFMS that there is an urgent need to get PCI affiliation to department of Pharmacy which has been recognized since 2000. In this connection, affiliation from All India Council of Technical Education and Pharmacy Council of India are awaited.

CHAPTER - X

ARTIFICIAL LIMB CENTRE

Artificial Limb Centre was established at Pune on 01 January, 1948. The Centre was established with the primary objective of managing the Prosthetic and Orthotic needs of disabled personnel of the Indian Armed Forces especially of the World War II. Since 1951, the facilities were gradually extended to civilians. All Officers & Retired Officers, JCOs, ORs of Army and their equivalents in Navy and Air Force and their families are entitled for free issue of artificial limbs and appliances. Paramilitary Forces like BSF, CRPF, ITBP and Assam Rifles are provided with necessary prosthesis and orthosis on payment. Civilians are also provided these on payment. The money received from them is deposited in government treasury. Patients from neighboring countries like Nepal, Bhutan, Afghanistan and Bangladesh and also from a few African countries have been patients at ALC.

10.2 During the study visit of the Committee from 4 to 8 July 2017 to ALC, Pune, the Committee found that the existing infrastructure of ALC is very old. Further, the Committee were told that upgradation of infrastructure on polyclinic concept has been planned in approved Computer Aided Design and Computer Aided Manufacture building which will have the ultra modern facilities.

10.3 With regard to the Research and Development in ALC, the Committee were informed that there is no R&D set up in ALC. However, certain Armed Forces Medical Research projects have been undertaken by the officers posted to ALC from time to time. Also, ALC is in the process of collaborating with IIT Guwahati and BARC in development of economical, state of the art passive prosthetic knee joint and micro processor controlled hand, joint and feet. A very high level and sophisticated R&D is required to improve upon the existing carbon fibre foot and joints which is not possible in ALC. It was further informed that no separate budget is allocated to ALC for R&D. However, when it is undertaken research projects are forwarded to O/o DGAFMS, they are approved and work is carried out accordingly.

10.4 The Committee were informed that ALC is being supported by five Artificial Limb Sub Centres (ALSC) by providing facilities to clientele in other part of country.

CHAPTER - XI

MEDICINES AND MEDICAL STORES

AFMS is mandated to follow evidence-based medicine as practiced under 'Allopathic' system of medicine. The AFMS does not practice other alternate systems of medicine like Ayurveda / Homeopathy.

11.2 Medical stores have been divided into Scaled items called as Priced Vocabulary of Medical Stores (PVMS) and Non- Scaled items as Not in Vocabulary (NIV). There are about 11000 items included in PVMS out of which there are approximately 1250 drugs / medicines and vaccines which cover all illnesses / contagious diseases / epidemics, including emergencies and several complicated diseases like Cancers, AIDS etc. All allopathic medicines required for treatment of entitled patients are made available at AFMS hospitals in sufficient quantities.

Organization and Management

11.3 Medical stores are organised in AFMS to meet the objective of efficient and effective medical store supply chain management. Presently, four Armed Forces Medical Store Depots (AFMSDs) are functioning under this Directorate General i.e. AFMSD Lucknow, AFMSD Mumbai, AFMSD Delhi Cantt and AFMSD Pune. These depots are responsible for supply of Medical, Dental and Veterinary stores and equipment to all the dependant units within the area of responsibility besides provisioning of medical/ dental stores to all the ECHS Polyclinics under the area of responsibility. These depots are also responsible for Periodic checks, conditioning and preservation of stocked stores as well as for holding of additional medical and dental stores for any emergency in case of natural or man – made disaster. The above stores are presently housed mostly in old buildings which are not optimally equipped with modern storage and warehousing infrastructure.

11.4 The indigenous and import composition of the items procured under Capital budget head are elaborated in the table below:-

FY	Imported	Indigenous	Booked (Rs in Cr)
2010-11	78.80	26.60	105.40
2011-12	91.50	30.50	122.00
2012-13	99.56	33.19	132.75
2013-14	83.19	27.75	110.94
2014-15	76.80	25.60	102.40
2015-16	90.34	23.83	114.17

11.5 The following measures have been taken to ensure availability of medicines in all AFMS establishments including those in forward area:

(a) Well deliberated stocking policies are in place to ensure availability of medicines in sufficient quantities under all exigencies. The drugs / vaccines / expendables are classified as 'Short-life' items and 'Long-life' items, based on their shelf-life. Stocking policy dictates that 3 months / 6 months reserve stock to be maintained on the shelf and 3 months of running stock available for short-life and long-life items respectively.

(b) In addition, O/o DGAFMS has formulated Common Drug List (CDL) based on National List of Essential Medicines (NLEM) of Ministry of Health & Family Welfare. The CDL contains all the commonly used medicines and are of maximum utility. It has been endeavoured that AFMSDs will ensure maximum availability of these essential medicines to all hospitals / health care establishments (HCEs) of the AFMS as per their respective demands.

(c) Appropriate policies, guidelines and standard operating procedures have been formulated to ensure optimal stocking of medical stores at all echelons, based on a streamlined system of calculation and analysis of requirement. A sound mechanism of checks and balances at various levels is in place to ensure adequate coordination between planning, procurement, stocking, distribution and disposal of medicines.

(d) A proposal for increasing the financial powers of Senior Executive Medical Officers (SEMOs) was taken up by O/o DGAFMS and the same has been notified vide schedule 2 of DFPDS-2016. In addition, proposal relating to outsourcing of pharmacy from Authorised Local Chemist are under consideration.

CHAPTER - XII
DISASTER MANAGEMENT

The AFMS has been playing a major role in providing medical services in Natural Disasters. Standard Operating Procedures have been formulated for provisioning of medical relief in aid to civil authorities by AFMS during International and National Disasters. Quick Reaction Medical Teams (QRMTs) in each designated Command in the Army, Navy and Air Force are equipped with manpower and requisite stores. Disaster bricks both medical and surgical are adequately stocked in Armed Forces Medical Stores Depots (AFMSDs). Hospitals of Armed Forces are also well prepared to provide specialist medical and surgical teams during disasters.

12.2 Periodic training of medical officers and paramedical staff is being conducted at various unit and formation levels. Armed Forces Hospitals carry out regular disaster management drills. Humanitarian Assistance and Disaster Relief (HADR) exercises are conducted to maintain preparedness level at all times. Military-civil and multi-agency coordination with Civil Administration, Police, Fire Services and National Disaster Response Force (NDRF) are also periodically organized.

CHAPTER - XIII

CONTAGIOUS DISEASES

The medical preparedness to contain various types of contagious diseases in Armed Forces is as under :-

(a) Armed Forces have formulated policies with regard to contagious diseases in consonance with the National Health Programmes.

(b) Robust mechanism of surveillance and monitoring of the diseases are in place.

(c) Starting from unit level, health education is undertaken for troops and preventive measures are instituted for communicable diseases.

(d) In-built reporting mechanism and updation of health statistics by units, station health organisations, medical Directorates at various echelons and O/o DGAFMS ensures monitoring of the cases at all times.

(e) Data is held at nodal centers (hospitals, Formation HQ and Service HQrs) for interpreting, analysis and timely action.

(f) Station Health Organisations are upgraded and equipped for monitoring the cases.

(g) Notification of outbreaks is undertaken as per the national and international health regulations

(h) Armed Forces Central Epidemiological Surveillance Centre (AFCESC) at AFMC is the specialised nodal centre which undertakes surveillance.

(j) Constant liaison/interaction with Ministry of Health and Family Welfare/WHO for any changing new threats.

13.2 The Committee were keen to be apprised on whether Medicines/Vaccines are available in Medical stores in sufficient quantity to meet the threat of such diseases. To this pointed query, the Ministry of Defence replied in affirmation. Further stating that Medicines/ Vaccines are available in sufficient quantity to meet the threat of such diseases. In case the need arises, emergent procurement of required medicines / vaccine is resorted to at all echelons of health care under AFMS, to makeup the deficiency, if any. As per the immunization initiative of AFMS to combat the contagious / communicable diseases, vaccines are being routinely procured for diseases such as Typhoid, Tetanus, Rabies, Hepatitis B, Chicken Pox, Yellow fever, Meningococcal vaccine and Pneumococcal vaccine.

(b) In addition to above, the AFMS procures drugs and even vaccines where required to combat seasonal outbreaks of certain diseases. (e.g Tab Oseltamivir for Swine Flu).

High Altitude diseases

13.3 In the recent past many cases of casualties of soldiers have been reported from the high altitude areas like Leh and Ladakh. On the issue, the Committee were reported that as per morbidity data available, medical casualties have not shown an increasing trend since the past decade. All troops being inducted into high altitude and extreme cold climate areas undergo compulsory acclimatization as per extant army orders. This is followed by a detailed medical examination to assess the fitness for induction into those areas with hazardous climate.

Psychological disorders

13.4 The Committee wished to be updated on whether there is any report that the number of psychological cases are increasing in the Armed Forces due to posting or leave. On the question, the representatives of AFMS deposed as follows:

> 'We can send you the data, but offhand, I can tell you that we have not found any particular increase in psychiatric illnesses in the Army as compared to any other civil set up. Also, I must tell you that this is regarding suicides, which is what usually comes up. We have done a survey of this and we have found that the Indian Army has one of the lowest rates of suicides among all Armed Forces in the world. The American Armed Forces, the British Armed Forces has almost a two to three time rate than the Indian Army. Then, we have compared for the similar age groups of a comparative civil population with the Armed Forces and also found that the Armed Forces have a lesser amount. However, these instances are brought to notice, say, when it happens in Northern Command. Of course, there is a perception that so many suicides are taking place. When we have actually done a study, which we can send to the hon. Committee, these numbers are much lower than the others.
>
> We have something called a psychological autopsy that is done every time a soldier commits suicide. Many a time, I cannot give you exactly, 70 per cent may be are people either who have just returned from leave or, some of the times, they have been cited having long conversations on his mobile phone. Things like that have been cited in the medical autopsy. Rarely has there been a work stress that has been responsible. Most times, it is something in his domestic background that has caused him to commit suicide. One point, yes, is methodology of committing suicide. What happens is instead of hanging, probably, being the commoners, since some of these people are on guard duty and have weapons, you find some of the suicides are due to discharge of weapons. So, that may be the only difference that you can see. We will get you a detailed report, Madam.'

CHAPTER- XIV

DIGITIZATION

The Ministry informed that one important thing that they are presently undertaking is the task of digitization.

14.2 Further, on the matter, the Committee were informed that Digitization is being carried out in AFMS at 5 levels:-

(a) Human Resource (HR) Management,

(b) Patients and clinical processes data,

(c) Medical Stores Procurement,

(d) Military Stores,

(e) Recruitment and Training,

HR Management: -

(i) DGAFMS is tri-service organisation for the Army, Air Force and Navy and has its own HR database.

(ii) DGMS (Army):- AFMS officers with DGMS (Army) are all a part of System Application & Products/ Enterprise Resource Planning (SAP/ERP),which is based on Human Capital Management (HCM) Module and Military Management (MM) Module. This is to be linked to Material Information System (MIS) subsequently under aegis of Director General Information Services (DGIS).

(iii) DGMS (Navy) :- IHQ MoD(Navy)/ 'P' Branch utilizes a single HR Management information System called Integrated Human Resource Management System (IHRMS) developed for Indian Navy by Directorate of Information Technology.

(iv) DGMS (Air):- The database for HR Management Software for Medical and Dental Officers of Indian Air Force is maintained at Air HQ (R.K.Puram) since 2002 and is based on Microsoft Office Access programme. This software is not linked to any other service Head Quarters (HQs).

Hence the AFMS has an effective Management Information System for officers at DGsMS/DGAFMS level and Junior Commissioned officers (JCO)/ Other Ranks (ORs) at AMC Records level (for Army). HR management systems are 100% digitized by the use of Software like Human Resource Management System (HRMS) and Army Record Process Automation (ARPAN).

Patients and clinical processes data:-

(i) This is managed by Hospital information System of respective DGsMS. These form the most complex component and digitisation has been achieved to about 10%. The software used for this is 'Dhanwantri' in most of hospitals as well as AROGYA from Management Information System Organisation (MISO). As regards the development of an HIS (Hospital Information System) is concerned, the draft Request for Proposal (RFP) has been prepared after completion of an exhaustive User Requirement Specification (URS). The development is in conformity with the directives of 'Digital India, e-Kranti', i.e. to develop a HIS fully compliant with the National standards on Electronic Health Records (2013). A pilot project, as required under 'e-Kranti', has been approved under the annual plan of IT of the Army.

(ii) For maintaining data of patients in a data bank, Composite Smart Card is in the process of General Services Qualitative Requirement (GSQR) finalisation.

Medical Stores Management

(a) Supply Chain Management (SCM) of medical stores has been achieved to about 50% and is not yet one holistic chain. The software used for this is Medical Stores Inventory Management Software (MSIMS) in all hospitals. i-Aushadhi Software for automation of Armed Forces Medical Stores and Supply Chain Management has been developed and is being tested in five service hospitals.

Military Stores Management:-

Automation of medical units is being done and use of Wide Area Network (WAN)/Local Area Network (LAN) within domain of cyber security at unit and formation level is being achieved at a set pace. Digitisation of stores like vehicles, equipment, fuel and rations is governed by software like Four Monthly Vehicle Casualty Report (FMVCR) of MISO and various Operational Effectiveness (OE) software. This has been achieved to a tune of 50%.

Recruitment and Training

(i) Recruitment of AFMS officers from civil is done based on online applications followed by an online call letter on selection. Specified & separate criterion for recruitment of doctors, dentist and nurses is being followed.

(ii) For training purposes, applications for MBBS course to AFMC is made online, as is online application & counselling for admission to MD/MS at AFMC and other PG Training Institutes.

Different aspects of digitization have different percentage of digitization. A rough estimate of 60% digitisation exists across the board in AFMS.

14.3 While apprising the Committee on details of the target and achievements with regard to the facilities of telemedicines, the Ministry of Defence submitted the following:-

(a) Telemedicine Telemedicine to connect Regimental Aid Post (RAP) to Hospital and Navy ship to shore hospitals has been planned with Defence Bio-engineering and Electro-medical Lab (DEBEL). Currently, penetration testing at Army Cyber Group is under progress. If found suitable, trial will be carried out in 25 Div Area (Northern Command).

(b) ISRO Telemedicine Nodes. Tele-medicine is being implemented through two sources which are as under:-

(i) Static stations. Indian Space Research Organisation (ISRO) has provided 18 Tele-medicine stations which provide a link of about 384 kilo byte per second (kbps). Most of these stations had become non-functional but ISRO has recently started making all the stations functional. Currently, only 07 ISRO Telemedicine Nodes are functional in AFMS hospitals (Army-03, Navy-01 and Air Force-03). A case has been taken up with Development and Educational Communication Unit (DECU), ISRO, Ahmadabad for reactivation of remaining ISRO Telemedicine Nodes.

(ii) Mobile stations. This is in a stage of development. The project is under the supervision of HQ IDS. The project envisages mobile, ambulance based stations with satellite links. The development agency for the project is DEBEL, DRDO.

14.4 On this issue the representatives of AFMS further added that Now, there is DFPDS so that the speed at which most of the files are resolved has become faster. We have seen a sea change in the last one year and even the proposals that we sent to the Ministry have been sent back in .much less time than it was earlier. We are quite, at the moment, happy with the way we are functioning. Further work in the area include Automation / Digitization of Health Care Systems – Hospital Information Systems, Campus Wide Networks for Hospitals, Medical Stores Inventory Management, Linking of Armed Forces Medical Stores Depots and Telemedicine project for field formations

CHAPTER -XV

RESEARCH AND DEVELOPMENT

The Committee were apprised that for undertaking research activities for AFMC they are liaising with the DRDO who also extend financial assistance for the purpose. DRDO under the Ministry of Defence is mandated to conduct research to meet the requirement of Defence sector. Life Sciences Division of DRDO is authorised research funds for the purpose. Sanction was accorded to set up Armed Forces Medical Research Committee under DRDO under Ministry of Defence. The research funds for AFMS are thus allotted by DRDO.

15.2 The Committee desired to be informed whether the Ministry has explored the possibilities of dedicated funds for Research to AFMC. On this, the MoD apprised the Committee that the proposal to make DGAFMS, a direct budget controller as part of the revision of Delegation of Financial Power to Defence Services-2015 (DFPDS-2015) has not been included in the revised Delegation of Financial Power to Defence Services-2016 (DFPDS-2016). However, this proposal forms a part of the recommendations of the review committee submitted to the Hon'ble Raksha Mantri.

Budget for Research

15.3 The total budget allotted in last 10 years is Rs 61,66,14,824/- (Sixty one Crores Sixty Six Lakh fourteen thousand Eight hundred and twenty four rupees only). The annual allocation is given below:-

Year	AFMRC	HAMRC
2006-07	3,04,27,000.00	1,50,00,000.00
2007-08	4,83,00,000.00	1,50,00,000.00
2008-09	4,83,00,000.00	1,50,00,000.00
2009-10	4,83,00,000.00	1,50,00,000.00
2010-11	4,83,00,000.00	1,50,00,000.00
2011-12	5,95,00,000.00	6,00,00,000.00
2012-13	5,95,00,000.00	6,00,00,000.00
2013-14	9,35,00,000.00	6,00,00,000.00
2014-15	8,07,97,824.00	6,00,00,000.00
2015-16	6,21,90,000.00	6,00,00,000.56

The funds are currently allocated by DRDO.

Collaboration with International Research organizations

15.4 The AFMS conducts medical research in all medical fields with an emphasis on military medicine and combat medical support. The Armed Forces Medical Research Committee (AFMRC) headed by the DGAFMS is a committee of the DRDO which oversees all medical research in the AFMS. The current annual outlay for research is Rs. 09 crores. Approximately 125 projects are funded annually. The AFMS is planning to increase annual outlay to Rs. 12 crores, focus on fewer but more meaningful large scale multi-location projects, and to increase focus on Military Medicine. The AFMS also collaborates actively with the Indian Council of Medical Research (ICMR), Department of Biotechnology (DBT), Laboratories of Life Sciences Division of Defence Research Development Organisation (DRDO) Defence Institute of Physiology & Allied Sciences (DIPAS), Institute of Nuclear Medicine & Allied Sciences (INMAS), Defence Institute of Psychological Research (DIPR), Defence Bio-Engineering & Electro Medical Laboratory (DEBEL), Defence Research & Development Establishment (DRDE)}, and the Ministry of Health in the field of medical research. The AFMS is exploring ways and means to enhance international collaboration for medical research.

15.5 16 such breakthrough studies with translational outcomes have been conducted in all realms of medicine. Studies with international recognition and implementable recommendations results are listed below:-

(a) Nitric oxide was established as a treatment modality for High Altitude Pulmonary Oedema (HAPO) for the first time.

(b) Discovery of Sub-acute adult mountain sickness and consequent restriction of tenure in extreme altitude to 3 months.

(c) Findings of possible genetic adaptation of Ladhakis to altitude hypoxia and the suitability of their deployment at high altitude.

(d) Efficacy of cultured limbal stem cell transplantation in vascularised corneal opacities and ocular surface disorders by clinicohistological correlation.

(e) Study of the Pathogenic Factors underlying the Thrombotic tendency at High Altitude in Indian Soldiers.

(f) To evaluate functional accuracy of indigenous colour vision testing lantern with Martin Lantern for all grades of colour vision in various refractive error in relation to Armed Forces occupational and operational requirements.

(g) Study of the Methylene Tetra Hydro Folate Reductase (MTHFR), C677T polymorphism and plasma homocysteine levels as risk factors in coronary and cerebrovascular diseases in Indians: a pilot study.

(h) Comparative Evaluation of Peristaltic and Venturi Pump Based Phacoemulsification System in High Altitude.

(j) Effectiveness of Homocysteine Lowering Vitamins in prevention of thrombotic tendency at High Altitude Area: A randomized controlled field trail.

(k) A Comparative evaluation of pars plana clip glaucoma drainage implants over conventional glaucoma with corneal disorders.

(l) Study of the incidence of Heparin associated antibodies in patients undergoing open heart surgery and comparison of the functional and antigenic assays for diagnosis of Heparin induced Thrombocytopenia (HIT).

(m) Clinical evaluation of structural and functional changes in anterior segment of Eye in patients undergoing Assisted Reproductive Treatment (ART).

(n) A study of hepatitis A and E virus sero-positivity profile amongst healthy trainers and patients of the Armed Forces.

(o) Role of thrombo-prophylaxis in high risk surgical patient with special reference to orthopaedic [Total Knee Replacement (TKR) & Total Hip Replacement (THR)] Patient.

(p) Monitoring of Response to Therapy with Imatinib Mesylate In Chronic Myeloid Leukemia (CML) by Fluorescence Insitu Hybridization (FISH) and Real Time Quantitative Polymer Chain Reaction (RQ-PCR) for both Response and Relapse After Treatment.

(q) Establishment of reference values of weight for Armed Forces Personnel by Anthropometric assessment and formulation of Height and Weight chart for the Armed Forces.

15.6 On the query of the Committee about the procedure and level where the subjects for research are selected and prioritization of research projects is done, the representatives of AFMC submitted as follows:

'Broad guidelines issued by the O/o DGAFMS are followed in the procedure for prioritization of research project based on organizational requirement. The proposals submitted by all three service Directorates undergo a six step review starting from hospital to final approval of the proposal by a highly experienced professional committee of senior services and civilian experts during the annual Armed Force Medical Research Committee (AFMRC) Meeting. Budget is allotted to the approved projects.We have now also gone into an understanding with the DRDO to provide us the funds for the medical research. This Rs. 9 crore comes from the DRDO. It used to be Rs. 6 crore but that has been put up to Rs. 9 crore. Out of that about Rs. 60 lakh goes to high altitude medical research every year. Every year, they have projects on high altitude.'

15.7 With regard to Medical Research, the Committee were further intimated that Armed Forces Medical Research Committee (AFMRC) may be constituted. In addition to this current annual outlay: Rs. 6.60 crores may be increased to Rs. 12 crores. Moreover, approximately 125 projects are funded annually, so the focus should be given on fewer but more meaningful large scale multi-location projects. Also, an increased focus on Military Medicine research should be given.

PART - II

OBSERVATIONS/RECOMMENDATIONS

Role and Responsibilities of Armed Forces Medical Services (AFMS)

1. The Committee, while deliberating on the subject, observed that at the time of independence, the AFMS was established to provide comprehensive health care to only the serving Armed Forces personnel and their families (spouse and children). Over the years, its role and responsibilities have expanded considerably with its services being extended to parents of service personnel (in 1965) and its clientele is ever increasing. In 1962, the Service catered to a clientele dependency of 20 Lakhs. The total number of beds allotted to AFMS hospitals in 1965 were 24,996. During the corresponding period 3,353 Medical officers were held on the strength of AFMS. This comes to around 596 persons per doctor. As on 01 Oct 2016, the authorization of Medical Officers is 7,000, whereas the dependency is approximately 2.5 crores for inpatient/outpatient care. This gives an average ratio of 01 doctor per 3961 dependent clientele. The data reveals that there is a tremendous decrease in proportionate doctor to patient ratio in AFMS when compared from 1962 to the present situation (Six and a half fold decrease). The Committee feel aghast at the situation and feel that timely and necessary measures should have been taken by ensuring commensurate increase in Medical Officers in Armed Forces Medical Services to meet with the increased number of clientele. The issue of manpower and infrastructure deficit is discussed in detail in the succeeding paragraphs of the Report.

Shortage of Manpower

2. Manpower in medical services is a critical component having a direct bearing on patient care. Over the years the mandate of AFMS has been extended to include medical coverage for families and dependents of service personnel, paramilitary organisations and, from 2003 onwards, ex-servicemen and their dependents. There have been periodic revisions of manpower in AFMS based on

studies carried out by various committees, such as Lt Gen Foley Committee, Lt Gen Chandrasekhar Committee and Bhardhwaj Committee on the requirement of specialists and super specialists for AFMS. The report of the Parliamentary Standing Committee on Ministry of Defence, tabled in the Lok Sabha in August 2006 recommended, inter alia, appointment of a high level committee to comprehensively review and re-assess the overall increase in work and responsibilities of AFMS and to suitably recommend ideal strength for each cadre. The high level committee of DGAFMS, in its report of September 2006, after reckoning the limitations of the existing norms of manpower to adequately handle the workload and the requirement of specialties at peripheral and mid zonal hospitals and super specialties at different levels of hospitals, recommended an increase of 28,306 officers and personnel to be recruited in a phased manner. While approving in principle, an increase of 10,590 (3,348 Officers, 7,042 PBORs and 200 Civilians) the Ministry, in May 2009, authorised an increase of 3530 personnel in AFMS in the first phase.

3. Against this backdrop, the Committee observe that in Army Medical Corps(AMC), as on 1 November 2016, the held strength is 6254 against a sanctioned strength of 6865. The shortage is to the extent of 611 personnel. The highest shortage is in case of Army, where the held strength is only 4845 against an authorization of 5399. In case of Navy, the held strength is 699 against the authorized strength of 694. With the Air Force, the held strength is 740 against the authorized strength of 772. On the basis of calculation of the ideal doctor-patient ratio and the steps being taken to improve the doctor-patient ratio, the Committee are apprised that 'Calculation of ideal doctor patient ratio' is based on a large number of factors. This ratio is different in different settings. However, an average of 1:4 is applied in All India Institute of Medical Sciences (AIIMS) and most corporate hospitals like Sir Gangaram Hospital in New Delhi. The present doctor-patient ratio is one doctor per 10-12 individuals against an ideal ratio of 1:4. On the matter of mitigation of shortfall in medical personnel, the Committee further learnt that over the years, augmentation of technical medical manpower to the tune of 10,590 medical personnel including 1224 doctors has been authorized. The recruitment against the same will be over by 2018. The functional deficiency of officers will be met by the advent of Training, Drafting, Leave Reserve (TDLR) to the tune of 1229 Medical Officers, 77 Dental

Officers and 169 members of MNS. In addition to this, the proposal of Training, Draft, Leave, Reserve (TDLR) for 557 medical and dental personnel (525+32) for making up deficiency of doctors/dentists proceeding on long courses like PG/Super specialization as well as lady doctors/dentists moving on maternity leave has also been approved. The Committee view the shortage of manpower seriously and strongly feel that the steps taken so far are inadequate and the process of recruitment is tardy. Therefore, the Committee recommend that the current recruitment should be completed in a time-bound manner to mitigate the shortages and to ensure adequate and timely services to its clientele.

Shortage in Army Dental Corps (ADC)

4. In case of Army Dental Corps (ADC), the authorized strength is 700 and the held strength is 633. The difference between the authorized and held strength is 66. In Command Military Dental Centres, the authorised strength is 71 while the held strength is 64. In Field Units, the authorisation is 262 dentists whereas actual posting is 252 against 262.

Shortages in Military Nursing Services (MNS)

5. The Military Nursing Service is intended to perform nursing duties in hospitals including family wards. MNS officers also perform administrative duties relating to their service in hospitals and formation HQ. Nursing Assistant (NA) and Nursing Technician (NT) in the rank of Personnel Below Officers Rank are also available for the performance of nursing duties in hospitals. In case of Military Nursing Services (MNS), the authorization is 4943 whereas the actual strength is 4036. In case of Army, the authorization is 4082 nurses while the held strength is 3379. For Navy, held strength is 288 against sanction of 382 and Air Force has on its roll 369 nurses against an authorization of 479.

Under MNS(NT) for Army, the authorization is 370 and held strength is 352. In case of Navy and Air Force there is no sanctioning of the posts. In case of General Duty Medical Officers, the authorization is 4360 while the held strength is 3978. For specialists, the authorization is 2295 and actual strength is 2068. The authorization for super specialty is 210 and held strength is 208. The number of nurses and paramedical staff in AFMS hospitals is less than civil hospitals. For the nearly 1000 bedded R&R hospital in Delhi, only 214 nurses are

available, which is 1 nurse for 5 beds. This is far less than the position in AIIMS or in comparison to a corporate hospital like Apollo. In case of AIIMS, the ratio is 1.2 nurses per bed and in Apollo it is two nurses per bed. The nurse bed-ratio, therefore, needs drastic improvement.

Shortage of Paramedical Staff of Armed Forces

6. The authorised and held strength of Paramedical Staff of Armed Forces Medical Services at Command Hospitals and Field Medical Units for Air Force services is 3191 against a sanction of 3779. It was also learnt that in case of Army, it is 36464 against a sanction of 35380. Therefore, the Committee strongly recommend that the Ministry of Defence should make all out efforts to recruit adequate number of paramedical staff and nurses to meet the growing number of patients. In any case, AFMS should not remain far behind in comparison to AIIMS and private hospitals such as Sir Ganga Ram Hospital. The Committee may be apprised of the steps taken in this regard.

Specialists/Super Specialists

7. The sanction for the current pool of specialists in the AFMS is for 2295 posts as laid down vide Govt. of India letter No 10040/IX/DGAFMS/DG-1D/869/16/D(Med) dated 04 May 16. 5% cushion for future unforeseen requirement has been provided which works out to around 78. However, presently there is no enrollment under this category. The Committee desire that efforts should be made to fill up these vacancies at the earliest. In case of annotated appointment, the authorization is 665 while held strength is 519. A Board of Officers has been ordered for revision of the strength of pool of specialists. This is also linked with revision of staffing norms for the AFMS, which is under consideration.

8. Further, the Committee found that Specialist facilities are provided in service hospitals taking into account the number of beds in the particular hospital. In case of 76-100 bedded hospitals, only medicine, surgery and anesthesia specialties are available. The super specialities like Cardiology, Neurology, Nephrology, Urology, Reconconstructive Surgery, Oncology, Joint Replacement, Gastroenterology, Endocrinology are available only in Command hospitals which have more than 600 beds. The Committee feel that the

specialties such as Psychiatry, Dermatology, Eye, ENT, Pediatrics and Orthopedics which are presently available only in zonal hospitals should also be extended to smaller hospitals, which have around 100 to 400 beds. Further, the Committee view that the specialties like Obstetrics and Gynecology, Radiology and Pathology which are presently available only in 'more than 100 bedded hospitals' need to be upgraded even in lower level hospitals which have less than 100 beds as these specialties are coherent with other levels of specialties treatment. Extension of specialties like Cardiology and Neurology to zonal hospitals is considered based on above factors and is not rigidly bound by hospital class (Number of beds). The facility of super specialist care is being extended to zonal hospitals of Army Medical Corps in a phased manner for selected super specialties depending on patient work load.

9. With regard to the specialties in AFMC, the Committee were given to understand that super specialist care not only needs trained manpower but also adequate equipment and support infrastructure. The AFMS rationalizes the provisioning of such services so that all available resources are optimally utilized. On extension of super specialist facilities like Cardiology and Neurology in all zonal hospitals and induction of adequate number of Specialists in peripheral hospitals in order to provide proper medical care to the soldiers and officers in their vicinity, the Ministry of Defence has admitted that super specialist facilities need adequate basic specialty support. The distribution of super specialists at Armed Forces hospitals is a function of both requirement as well as availability of support staff and infrastructure.

10. At present, Cardiology and Neurology super specialist facility is available at Base Hospital (BH), Delhi Cantt and Military Hospital (MH), Jalandhar. Adequate numbers of Specialists are posted to various peripheral hospitals to provide quality medical care to troops and families in remote and far flung areas. All peripheral Indian Air Force hospitals situated across the country have been posted with specialists of basic specialities. Zonal hospitals of the Air Force like 7 AF Hospital and 5 AF Hospital have been provided super specialist services like Cardiology, Gastro-intestinal surgery, and Oncology. In the Navy, INHS Sanjivani, a 439 bedded zonal hospital, is being upgraded to include all major super specialities.

11. With regard to the Extension of specialties like Cardiology and Neurology to zonal hospitals, the matter is considered based on above factors and is not rigidly bound by hospital class (Number of beds). The facility of super specialist care is being extended to zonal hospitals of Army Medical Corps in a phased manner for selected super specialities depending on patient work load. The Committee have been informed that the number of orthopedic specialists in the AFMS is presently 57. The numbers being trained annually is a function of service requirement and availability of training capacity is not a constraint in this case. Seats offered to service candidates are based on vacancies arising due to retirement/release and requirements of service. In the course of examination of the related issues, the Committee found that the number of service specialists being trained in Orthopedics in various AFMS institutes were 09 in number in 2014 batch, 07 in 2015 batch and only 04 in 2016 batch. The Committee take note of the decline in number of candidates and wish that such a trend should not be allowed. Even in case of Neurology, presently, there are 18 Neurologists and 20 Neurosurgeons in AFMS. The number of specialist Doctors being trained in Neurology and Neuro Surgery in the last 03 years is as 2 each in 2014 and 2015 batch while it was only 01 in 2016 batch.

12. The Committee were keen to know about the impact of shortfall of super specialists in offering services to the clientele of the AFMS. On this matter, the Ministry informed that the AFMS has a minimal deficiency of super specialists and specialists. Although the impact of deficiency of super specialists is felt in terms of extended man-hours, rationalized leave and frequent move on temporary duties, emergency care of patients is not hampered. Further, constant and vigorous efforts are being made to reduce the deficiency to minimum levels. The Committee feel that the issues like retirement, release, promotion etc. are well calculated in advance. Therefore, their recovery should be proactively planned and executed.

<u>Periodic Revision of Manpower</u>

13. In the light of the observations made in the preceding paras, highlighting in detail, the existing deficiencies pertaining to medical personnel, along with acute shortage of doctor-patient ratio as well as nurse-patient ratio, and ever increasing clientele, the Committee are of the view that the situation merits

immediate attention. Firstly, concrete steps should be taken towards filling up of the presently sanctioned strength under intimation to the Committee. In addition to this, the Committee are of the view that a 'cadre review' needs to be done in AFMS and there is an urgency for sanctioning of more posts under AFMS. The requirement being huge, the sanctioned strength size needs to be doubled in the upcoming years. The procedure must be initiated at the earliest and the Committee be informed accordingly.

Mitigation of Shortfall in manpower

14. During the course of deliberations, the Committee wished to be apprised about the Ministry's plan of action towards mitigation of the above noted deficiencies. In this connection the Ministry furnished that the held strength is a dynamic figure. The apparent shortage is due to factors like officer's Release / Superannuation, resignation, promotions and move to annotated appointments. Further, the Ministry of Defence added that current authorization of Medical officers is 6605 and the physical deficiency is 570. This number is labile to change as officers superannuate, retire prematurely and are commissioned on a regular basis. Along with this deficiency, there exists a functional deficiency due to doctors being unavailable to the organization while undergoing in-service training courses like MD/MS, Diploma of National Board (DNB) and Super specialization as well as mandatory military courses. This results in a deficiency of about 1700 per year in a staggered fashion. Hence, total deficiency works out to 1270 or 19.2%. The physical deficiency mitigation is a constant process as medical officers are commissioned every year to fill physical vacancies. The Committee were keen to know whether there is a necessity for improving the staffing pattern, particularly in specialist and Super-specialist cadres. To this pointed query, the Ministry of Defence affirmed that there is a need for improving the staffing pattern. The proposal for improving staffing pattern has been submitted to Ministry of Health and Family Welfare (MoF & FW) for vetting in Jan 2016. The proposed pattern has been approved by a board of officers including Senior Consultant, Medicine and Senior Consultant, Surgery. The template used by the board was IPHS norms (Indian Public Health Services). The Committee observe that there has been a lapse of one and half years since submission of the proposal for improving the staffing pattern. Every action should be taken up

to get the approval at the earliest and the Committee apprised about the same in the Action Taken Replies.

Upgradation of super-speciality facilities

15. The AFMS Specialist Services currently work on the paradigm of specialist pool. Depending on requirement of specialists, based on bed strength of hospitals and Strength of garrison, specialists are posted to various hospitals. This optimizes use of specialists. Those patients requiring services of other specialists are currently being referred / evacuated to the hospitals holding the specialists concerned. The specialist facilities are being provided taking into account the number of beds in the hospitals. Medicine, surgery and Gynaecology are categorised as basic specialist facilities while ENT, Orthopaedics, Skin are available only in zonal hospitals. Medicine, Surgery and Gynaecology can handle life threatening emergencies related to all other specialties and super specialties owing to which they are considered as basic specialties.

16. The new staffing pattern proposed by AFMS has suggested the inclusion of specialists of ENT, Orthopaedics and Skin in all hospitals of bed strengths having more than 100 beds. The specialist facilities of Cardiology and Neurology are available only in Command Hospitals. The Committee desire that the specialist facilities like cardiology, neurology and orthopedics should be extended even in zonal hospitals so that the immense burden on Command Hospitals is eased and also larger catchment areas are covered.

17. Further, the Committee enquired whether any study has been conducted to identify the number of deaths that may have occurred in Armed Forces due to non-availability of timely expert treatment. To this query, the Ministry replied that no such study has been conducted till date. AFMS ethos dictates that if a patient is unable to reach a doctor, the doctor reaches out to him/her whether by land or air or sea. The Senior Medical Officer (SMO) in the station ensures that timely medical care is given. Due to natural reasons like extremely rapid deterioration of a patient or weather related inability of casualty evacuation, some deaths do occur. However, these are very few and the cause is pin pointed in every case.

Hence, a separate study to identify the number of deaths occurring due to lack of timely expert treatment has not been considered necessary by the Services. While appreciating the ethos of AFMS, the Committee strongly urge that a record should be maintained in this regard.

Deployment in tough terrains

18. The Committee desired to be provided detailed information about such soldiers who died during treatment after reaching hospitals including the name of the hospital, kind and level of injury and whether their treatment faced lack of any equipment, medicine, or specialist doctors. It was found that during one period from Jan 16 to Jan 17, 04 soldiers who sustained injuries during terrorist activities in J & K died during treatment after reaching the hospital. 01 soldier expired at 92 Base Hospital and 03 soldiers expired at Army Hospital (R&R). Their treatment did not face lack of any equipment, medicine and specialist doctors. While going through the data, the Committee found that two Naiks, one Hawaldar and one Sepoy ranked personnel died on reaching hospitals due to bullet injuries after encounters. On this note, the Committee would like to observe that in case of a soldier being injured in encounters, depending upon the gravity of injuries, proper treatment which include air lifting, specialists etc should be provided without considering the ranks of the personnel. Also, there should be a policy in place to ensure availability of specialists/ super-specialists at all times in critical areas along with highest level of judicious monitoring.

Modernization and Infrastructure Upgradation

19. The Committee observe that modernization of equipment at Armed Forces Hospitals is affected through Annual Acquisition Plans (AAPs). Proposals for new equipment are sent by hospitals through staff channels. The proposals are vetted by Expert Committees and Senior Consultants. Cases are processed through MoD. Approximately Rs 100 Cr is spent on equipment modernization annually.

20. On long term plan projection particularly with regard to upgradation of the existing facilities, the Committee have been apprised that for Army, there are

plans to provide comprehensive medical support. Army Medical Corps has identified the existing voids and has proposed for raising of 07 x Military / General hospitals and upgradation of 04 x Military/General hospitals. These have been done with the aim of ensuring requisite medical cover to the entire Indian Army. The raising of 03 x Military hospitals and upgradation of 02 x military/General hospitals in border areas has been sanctioned by Govt of India, MoD as part of Capability Development Plan for Northern borders. Further, the Committee have been told that there are various projects going on which include raising three hospitals in the Eastern Command, one at Rangapahar and Panagarh, and the location for the third one is yet to be confirmed. Also, there are two up gradations again is Eastern Command at Misamari and one at Northern Command in Leh. Besides this, there is Long Term Perspective Plan, which include 225 bedded Military Hospital (MH) for Jaisalmer, 50 bedded MH at Chungthang and 49 bedded MH at Borarupak (Near Likabali). There is a proposal for Upgradation of MH Kargil from 44 to 149 beds and 200 Bedded MH for Eastern Ladakh. Upgradation of MH Jaipur to 600 bedded Command Hospital is also in pipeline. The Committee desire the Ministry of Defence to monitor all the projects mentioned here are progressed in target oriented manner and details of progress are submitted to the Committee in the Action Taken Replies.

21. In case of Navy, the Committee were assured that periodic review was being carried out regularly of the facilities available in various hospitals and the need for upgradation of some of these hospitals, which is based on operational needs and clientele requirements are carried out. INHS Kalyani, Sanjivani, Nivarini, Patanjali, Dhanvantrari, Navjivan and Karanja are currently under various stages of upgdation. The Committee should be provided details of progress made in each case.

22. With regard to Air Force, the Committee were apprised that Policy Page revision of Air force Hospitals has been completed with comprehensive review of all the required facilities. 7 AFH Kanpur has been authorised Cardiology Centre, Gastroenterology Centre, Gastrointestinal Centre and Urology Centre. Enhancement of the facilities at Air Force Hospitals is an ongoing process. A proposal for up gradation of 11 and 12 AFH from peripheral hospital to Zonal

hospital is under consideration. While taking note of the details, the Committee would like to be informed about the progress in this direction.

Mobile Medical treatment facilities

23. The Committee came to know that there are presently 98 Field Hospitals existing in the Indian Army. These are medical units that provide sector wise medical cover to the respective army formations both during war and peace. To accomplish this role, the Field Hospitals have the capability of establishing various detachments viz. Medical Aid Posts (MAP), Advance Dressing Station (ADS) and Forward Surgical Centre (FSC). These units have the capability to hold and treat casualties and also to evacuate them rearwards to different medical establishments, if required. Secondary and tertiary level healthcare facilities are provided through the network of Border Static Military/General hospitals and Base Hospitals located in field areas. Further, to facilitate provisioning of mobile medical treatment facilities in far away forward areas, the procurement proposals for Mobile Disaster Relief Equipment (MDRE) are also being progressed. To build up the capability of Army Medical Corps to provide improved medical support in combat zone and forward areas, procurement of 05 sets of 10 bedded MDRE as a Capital acquisition has been included in the 12th Army Plan. These can be transported by road/rail/air/sea. The Request for Proposal (RFP) is being progressed by Indian Navy, being the lead service. Proposal for procurement of 50 bedded containerised and soft shelter based, rapidly deployable medical facilities through Capital Route has been included in the Recast 12th Army Plan. Formulation of QRs for the same is in progress. The Committee wish that the above mentioned proposals are progressed at a better pace and be informed about the progress made in each case.

Air Ambulances

24. During the deliberations, the Committee came to know that AFMS does not have an air ambulance fleet. On this issue, even the representatives of AFMS candidly deposed before the Committee that undoubtedly they would require an air ambulance fleet if the budgetary constraints do not come in the way. The Committee found that presently the Air Force and the Army Aviation are used for

providing air effort whenever it is required. An air ambulance will have pre-equipped aircraft with intensive care material, monitors, ventilators etc. so that they can be immediately flown in. In the opinion of the Committee, during critical times, especially in insurgent areas, every second is crucial. Therefore, a normal aircraft cannot serve as an alternative to an air ambulance. Therefore, the Committee recommend that necessary initiatives should be taken to acquire a fleet of air-ambulances in AFMS and the Committee be informed accordingly.

25. The Committee also found that there is only one ship with Navy which is being upgraded with all super specialities. The Committee desire that efforts should be made by AFMS towards development of one more Naval ship with all super specialties so that Indian Navy can have one ship on both Eastern and Western shores.

26. On considering the details provided by the Ministry of Defence, the Committee feel that there is a need for modernization of hospital infrastructure, renovation / reconstruction of hospitals. Steps should be taken towards achievement of this end in a phased manner. A comprehensive plan outlay may be made and the Committee be informed about the progress of the projects.

27. The Committee also came to know that there are only two transfusion centres with AFMC, one at AFTC, New Delhi and second at transfusion centre, Kolkata. The Committee recommend that at least two more transfusion centres be developed with one of them in Northern insurgent areas of the country and another in Southern Command so that larger catchment area is covered.

<u>Alternate medicine</u>

28. To the distress of the Committee, they were apprised by the Ministry of Defence that presently AFMS does not include alternate medicine in their regime. Ayurveda clinics with 10 beds each at Base Hospital Delhi Cantt and Command Hospital, (Southern Command), Pune were sanctioned vide GOI, MOD letter No. 10(2)/2004/d(Med) dated 15 March 2004 on an experimental basis for one year. The service was reviewed after one year and then shut down. Efforts for integration of AYUSH system have been initiated once again by appointing a committee with DGHS(AF) as Presiding Officer and representatives from AYUSH,

Ministry and Service Headquarters. Based on the recommendations of the Committee, action has been initiated for opening of two AYUSH life style centres at AH(R&R), Delhi Cantt and Air Force Hospital, Hindon on trial basis. In this case, the Committee feel that alternate medicine system is beneficial for preventive and basic healthcare. Also, the traditional system of medicine should be applied wherever suitably required. Therefore, steps should be taken in this direction in all earnest.

Preparedness for Nuclear, Biological Chemical war

29. The Committee were informed that with regard to Chemical Biological Radiological Nuclear Warfare (CBRN), as of now, AFMS has no experience. However, training module has been started and preparation is on. With regard to the present position of preparedness of AFMS to deal with CBRN warfare, the Committee were apprised that AFMS is presently responsible for conducting of training of medical officers and paramedics as part of capacity building for CBRN preparedness. A data bank of CBRN trained manpower in AFMS has been prepared. Command, Corps and Division level training are also being conducted periodically. Procurement issues and replenishment of Individual Protective Equipments (IPEs) and CBRN equipment for medical units are being managed as per Equipment Management Policy issued by Directorate General Prospective Planning (DG PP) (CBRN) vide their letter No A/12047/GS/PP(CBRN)/Lgs dated 07 Oct 2013. The mother depot of all CBRN equipment is Stores Depot at earmarked Forward Medical Stores Depot (FMSDs)/Advance Medical Stores Depot(AFMDs)/Field Hospitals under the overall arrangement of DGMS (Army). While appreciating the pro active approach of AFMS in this regard, the Committee desire that more comprehensive efforts are made towards research oriented study, training and development module to deal with CBRN threats as there has been increasing threat of non-conventional warfare.

Training

30. With regard to the training institutions under the purview of AFMS, the Committee found that there are six Colleges of Nursing (CoN) and one School of Nursing (SoN) to impart training to nursing students. All the Colleges are imparting BSc (Nursing) degree under respective Universities and are duly recognized by the Indian Nursing Council and State Nursing Council. In order to strengthen the training and to have better medical services in the hospitals, the upgradation of various Schools to Colleges is undertaken in phased manner. The details of up gradation of various nursing schools should be provided to the Committee in the Action Taken Replies.

31. On the issue of training of paramedical staff, the Committee found that there is no formal recognition to the training being imparted to the Ex-Servicemen under Para medical forces. Further, on the matter, it was informed that a large number of the courses being run for paramedical personnel are recognised by the statuary bodies. However, in service courses conducted at AFMS Hospitals do not have formal recognition at present. Steps should be taken in this regard under intimation to the Committee.

32. As far as dental training is concerned, the Committee were intimated that there are only two institutes where training for dental services is imparted. One is Armed Forces Medical College, Pune and the second is Army Dental Centre, R&R which is located within the Army Hospital, R&R complex. The Committee feel that just two institutions is too less and therefore, efforts should be made towards sanctioning and increasing the number of dental institutions.

33. On account of the above noted deficiencies, the Committee are of the view that in case of unavailability of any training facility in the AFMS institutions, the Defence Medical personnel may be sent to other training institutions/organizations functioning outside the purview of AFMS for attainment of necessary training/capacity building.

Armed Forces Medical College

34. The Armed Forces Medical college was established on 04 Aug 1962. During deliberations on the subject, the Committee were informed by the representatives of the Ministry of Defence that around 20 per cent students leave AFMC despite a bond amount of Rs.25,00,000 at graduate level and Rs.28,00,000 at PG level. The Committee wished to be provided with a report on reasons for drop out which was not readily available with the Ministry of Defence. The Committee desire that a report should be made available to them in this regard.

35. On the concern of attrition, the Committee desire that efforts should be made to enhance the retention rate and it should be reduced from current 20 percent to at least 10 per cent, if not lesser from the upcoming batches as huge

resources and time are involved in training of these cadets. One of the methods can be to increase the bond amount from Rupees Twenty-five lacs to one crore for MBBS and from Rupees twenty-eight lacs to two crore for Post Graduate students. Besides this, other motivational methods may also be fruitfully utilized. In this context, the representatives of Armed Forces Medical Services made an argument of that if the deterrence is made so high, then they do fear that students will not come and they may lose the merit. The Committee observe in this regard that India is hugely populated and there is no dearth of talent. Motivational service conditions publicized through various mediums of publicity may be used to approach the talented youth.

36. The Committee observe that AFMC, Pune was established in 1962. Since then, the needs of Armed Forces have augmented manifold. Therefore, there is a requirement for establishment of more colleges on the lines of AFMC which is a prestigious institution in the field of medical training. The Committee recommend that at least three more AFMCs may be established in various zones of the nation. In this regard, efforts should be made towards development of plan proposal and acquiring approvals from the Ministry of Finance. In addition to increasing number of colleges, more seats may also be sanctioned at AFMC, Pune. During the recently undertaken study visit of the Committee from 4 to 8 July 2017, to AFMC, they found that the present annual intake is 135. Out of this the number of intakes for boys is 105, girls is 25 and foreign students is 5. The case for increasing cadets intake to 150 is under process and pending approval from Maharashtra University of Health Sciences and Medical Council of India. The Committee desire that the Ministry of Defence should take necessary steps in this regard so that more seats can be created in AFMC, Pune and the entire process be expedited under intimation to this Committee. The Committee also recommend that some of the seats so created should be reserved for the wards of Ex-servicemen especially Junior Commissioned Officers and Non-Commissioned Officers.

37. During the aforementioned study visit, the Committee also came to know that there is an urgent need to get Pharmacy Council of India (PCI) affiliation to department of Pharmacy which has been in existence since 2000. In this connection, affiliation from All India Council of Technical Education and

Pharmacy Council of India are awaited. In this connection, the Ministry of Defence must speed up the necessary approvals and the Committee be informed about the action taken in this regard.

38. The Committee were further apprised that a Department of sports medicine has been started on Ad hoc basis. Such a department is first of its kind in any Government college. For this purpose, there is an increased requirement of trained doctors to improve fitness standards for the Armed Forces. These posts should be filled at the earliest.

39. AFMC, Pune is one of the premier institutions in the field of Medical Sciences. Therefore, efforts should be made in the direction of providing the national status to this institution at par with AIIMS, New Delhi.

40. Efforts should be made to augment the number of seats in various colleges of nursing, paramedical, medical and specialists so that they are matched with increasing requirement of manpower in Armed Forces Medical Services. Possibilities and limitations on the same may be furnished to the Committee in the Action Taken Replies.

Artificial Limb Centre

41. The Committee paid a visit to the Artificial Limb Centre, Pune on 5 July, 2017. The Committee are highly impressed with the kind of work this institution is carrying out and it would not be any exaggeration to call it God's Work. The Artificial Limb Centre has received ISO 9001:2000 certification. The motto of the centre is to "Make the Dream of Every Amputee to Walk Come True". During the study visit, from 4-8 July 2017, the Committee also visited Artificial Limb Centre, Pune and found that the existing infrastructure of ALC is very old. In this connection, the Committee were candidly informed that upgradation of infrastructure on polyclinic concept has been planned in approved Computer Aided Design and Computer Aided Manufacture building which will have ultra modern facilities. The Committee are keen that modernization work must be hastened up and developments be intimated to the Committee. In addition to this, the Committee recommend that a special team of experts may be

constituted and sent by MoD to ALC, Pune with a purpose of exploring further possibilities in enhancing the infrastructure and modernization of the centre.

42. With regard to the Research and Development in ALC, the Committee were informed that there is no R&D set up in ALC. However, certain Armed Forces Medical Research projects have been undertaken by the officers posted to ALC from time to time. Also, ALC is in the process of collaborating with IIT Guwahati and BARC in development of economical, state of the art passive prosthetic knee joint and micro processor controlled hand joint and feet. A very high level and sophisticated R&D is required to improve upon the existing carbon fibre foot and joints which is not possible in ALC. It was further informed that no separate budget is allocated to ALC for R&D. However, when it is undertaken, research projects are forwarded to O/o DGAFMS, for approval and work is carried out accordingly. The Committee observe that the officers posted at ALC have undertaken certain projects despite infrastructure deficit for the purpose. While appreciating this, the Committee want that a dedicated R&D centre must be opened up at ALC with direct funding. This will help in direct need oriented research and will also curb time lags in receiving various approvals and coordination. The research centre should be well equipped and necessary manpower recruited. Further, the Committee strongly view that the institution must be declared as a Centre of Excellence.

43. The Committee were informed that ALC is being supported by five Artificial Limb Sub Centres (ALSC) by providing facilities to clientele in other parts of the country. In the view of the Committee, the role and function of ALC is of tremendous significance and appreciable. The Ministry of Defence should take up the matter of expansion of ALC by way of opening up more ALSCs. A target of starting at least five more ALSCs may be taken up initially. In addition to this one more institution on the lines of ALC, Pune may be taken up for consideration by the Ministry of Defence. The possibilities and limitations in this connection may be apprised to the Committee in the Action Taken Replies.

Funding

44. The Committee desired to be apprised about the opinion of the Ministry of Defence in making the Capital Fund for AFMS non-lapsable. On this, the Ministry

intimated that there is no proposal to make the Capital Budget non-lapsable and roll-on. However, during the last five years, on no occasion was any substantial amount of surplus funds available for rolling over. The Committee observe that the Capital Budget for next financial year is projected in the month of September of the current financial year depending on the utilization trends of the last three financial years and also the projects which are likely to fructify. The Capital projects have an incubation period ranging any time between 180 to 270 days and it is prudent to project for a provisional Budgetary Estimate considering that not all projects are likely to fructify in the same financial year. The total value of Annual Action Plans (AAPs) for the Financial Year (FY) 2013-14, 2014-15 and 2015-16 was approximately Rs. 329.49 Cr, Rs. 225.81 Cr and Rs. 503.45 Cr respectively. The fructification of AAPs cases has been analyzed and it is seen that only 20-30% cases materialize due to extended timelines involved in capital procurement process. This becomes a constraining factor in projected budget figure. In view of the facts stated above, a roll on capital Budget will assist in unhampered procurements. The Ministry of Defence should look into the possibilities of making capital budget a roll on budget.

<u>Medicines and Medical Stores</u>

45. Medical stores are organised in AFMS to meet the objective of efficient and effective medical store supply chain management. Presently, four Armed Forces Medical Store Depots (AFMSDs) are functioning under this Directorate General i.e. AFMSD Lucknow, AFMSD Mumbai, AFMSD Delhi Cantt and AFMSD Pune. These depots are responsible for supply of Medical, Dental and Veterinary stores and equipment to all the dependant units within the area of responsibility besides provisioning of medical/ dental stores to all the ECHS Polyclinics under the area of responsibility. These depots are also responsible for Periodic checks, conditioning and preservation of stocked stores as well as for holding of additional medical and dental stores for any emergency in case of natural or man – made disaster. The Committee found that the above stores are presently housed mostly in old buildings which are not optimally equipped with modern storage and warehousing infrastructure. Therefore renovation and modernization of buildings and equipments is immediate need of the hour. Every

measure should be taken towards achievement of this and in a systematic and time bound manner. The Committee be apprised about the same.

Indigenization

46. The Committee found that the indigenous component of items procured by AFMS was much less than the import component. During the year 2015-16 the import component was to the tune of Rs. 78.80 crore where as the indigenous component was to the tune of Rs. 26.60 crore. In the year 2016-17, the imported component was of Rs. 90.34 crore while indigenous content was upto Rs. 23.83 crore. This amounts to a huge gap in both the ratios. The Committee desire that a series of steps should be taken to increase the indigenous content of procurement in AFMC and in the upcoming year it would be desirable to increase the indigenous component upto 50 per cent. The Committee would like to be updated on the initiatives taken towards this end.

Contagious diseases

47. The Committee during the course of examination of the subject came to know that various efforts are being made towards medical preparedness to contain various types of contagious diseases in Armed Forces. Some of these efforts include, formulation of policies with regard to contagious diseases in consonance with the National Health Programmes, Robust mechanism of surveillance and monitoring of the diseases, starting from unit level, health education is undertaken for troops and preventive measures are instituted for communicable diseases, In-built reporting mechanism and updation of health statistics by units, station health organisations, medical Directorates at various echelons, etc. The Committee observe that AFMS is responsible for provision of health facilities to Armed Forces and therefore it becomes utmostly important to take measures for checking contagious diseases as any such outbreak would lead to serious threat. While taking note of the various measures as stated above, the Committee desire that continuous efforts must be made for preventive and timely action.

High Altitude diseases

48. In the recent past, many cases of casualties of soldiers have been reported from the high altitude areas like Leh and Ladhakh. On the issue, the Committee were reported that as per morbidity data available, medical casualties have not shown an increasing trend since the past decade. All troops being inducted into high altitude and extreme cold climate areas undergo compulsory acclimatization as per extant army orders. This is followed by a detailed medical examination to assess the fitness for induction into those areas with hazardous climate. The Committee wish to be apprised about the details of medical care being taken and facilities being provided for checking high altitude diseases.

Psychological disorders

49. While examining the subject, the Committee found that there had been an increase in number of Psychiatric cases in Armed Forces. In this connection, the Committee were given to understand that the suicide or killing rates in Armed Forces are not abnormally high compared to other Armed Forces in the world. However, the Committee desire that a report may be submitted on reasons for stress, suicides and killings in the Armed Forces that have taken place during last ten years. Also, a policy for justifiable and fair transfers especially in tough terrain deployments must be kept in place. In addition to this, a mechanism to observe and identify Armed Forces personnel with psychiatric problems must also be formulated and timely psychiatric treatment provided. The Committee may be apprised about the action taken in this regard.

Digitization

50. The Committee were keen to have details on the status of digitization in AFMS. In this matter, the Committee were informed that different aspects of functioning have different percentage of digitization. A rough estimate of 60% digitisation exists across the board in AFMS. The Committee feel that digitization will help in curbing pilferage and other malpractices to a great extent along with providing more efficiency and accuracy. Therefore, vigorous efforts should be made towards achievement of 100 per cent digitization in AFMS. The

entire process of digitization in AFMS may be done keeping in mind the threats of cyber security.

Telemedicine

51. In the view of the Committee, one of the ways of tackling manpower shortage would be through augmenting telemedicine facilities in AFMS. Also, a dedicated mobile application for AFMS clientele may be formulated and started so that deficiencies in manpower can be tackled to some extent. Detailed note on efforts being taken in this direction may be submitted to the Committee.

Research and Development

52. The committee were apprised that for undertaking research activities for AFMC they are liaising with the DRDO who also extend financial assistance for the purpose. DRDO, under the Ministry of Defence, is mandated to conduct research to meet the requirement of Defence sector. Life Sciences Division of DRDO is authorised research funds for the purpose. Sanction was accorded to set up Armed Forces Medical Research Committee under DRDO under Ministry of Defence. The research funds for AFMS are thus allotted by DRDO.

53. The Committee desired to be informed whether the Ministry has explored the possibilities of dedicated funds for Research to AFMC. On this, the MoD apprised the Committee that the proposal to make DGAFMS, a direct budget controller as part of the revision of Delegation of Financial Power to Defence Services-2015 (DFPDS-2015) has not been included in the revised Delegation of Financial Power to Defence Services-2016 (DFPDS-2016). However, this proposal forms a part of the recommendations of the review committee submitted to the Hon'ble Raksha Mantri. The Committee wish that the matter should be pursued and dedicated funds for Research directly to AFMC may be considered.

Collaboration with International Research organizations

54. The AFMS conducts medical research in all medical fields with an emphasis on military medicine and combat medical support. The Armed Forces Medical Research Committee (AFMRC) headed by the DGAFMS is a committee of the DRDO which oversees all medical research in the AFMS. The current

annual outlay for research is Rs. 09 crore. Approximately 125 projects are funded annually. The AFMS is planning to increase annual outlay to Rs. 12 crore, focus on fewer but more meaningful large scale multi-location projects, and to increase focus on Military Medicine. The AFMS also collaborates actively with the Indian Council of Medical Research (ICMR), Department of Biotechnology (DBT), Laboratories of Life Sciences Division of Defence Research Development Organisation (DRDO) {Defence Institute of Physiology & Allied Sciences (DIPAS), Institute of Nuclear Medicine & Allied Sciences (INMAS), Defence Institute of Psychological Research (DIPR), Defence Bio-Engineering & Electro Medical Laboratory (DEBEL), Defence Research & Development Establishment (DRDE)}, and the Ministry of Health in the field of medical research. The Committee opine that the AFMS should explore ways and means to enhance international collaboration for medical research and technology.

55. With regard to Medical Research, the Committee were further intimated that the current annual outlay is Rs. 6.60 crore. The Committee feel that the said amount is not enough to meet the challenges of modern day research technologies and therefore the amount for research and development to AFMS may be increased to Rs. 12 crore annually.

56. The Committee were given to understand that approximately 125 research projects are funded annually by AFMS. In this connection, the Committee feel that emphasis and focus should be given on fewer but more meaningful large scale multi-location projects. Also, an increased focus on Military Medicine research may also be given.

NEW DELHI;
4 August, 2017
13 Shravana, 1939 (Saka)

MAJ GEN B C KHANDURI AVSM (RETD),
Chairperson,
Standing Committee on Defence.

STANDING COMMITTEE ON DEFENCE

MINUTES OF THE SIXTEENTH SITTING OF THE STANDING COMMITTEE ON DEFENCE (2015-16)

The Committee sat on Friday, the 17th June, 2016 from 1100 hrs. to 1320 hrs. in Main Committee Room, Parliament House Annexe, New Delhi.

PRESENT

MAJ GEN B C KHANDURI AVSM (RETD) - CHAIRPERSON

Lok Sabha

2. Shri Suresh C Angadi
3. Shri Shrirang Appa Barne
4. Col Sonaram Choudhary (Retd)
5. Smt Pratyusha Rajeshwari Singh
6. Shri H D Devegowda
7. Shri Sher Singh Ghubaya
8. Shri G Hari
9. Dr Mriganka Mahato
10. Shri Tapas Paul
11. Shri Rajeev Satav

Rajya Sabha

12. Shri A.U. Singh Deo
13. Shri Harivansh
14. Shri Vinay Katiyar
15. Shri Madhusudan Mistry
16. Shri Anand Sharma

SECRETARIAT

1. Smt Kalpana Sharma - Joint Secretary
2. Shri T G Chandrasekhar - Director
3. Smt J M Sinha - Additional Director
4. Shri Rahul Singh - Under Secretary

WITNESSES

REPRESENTATIVES OF THE MINISTRY OF DEFENCE

S No	Name	Designation
1	Shri G Mohan Kumar	Defence Secretary
2	Shri Ravi Kant	Addl Secy (R)
3	Lt Gen Rakesh Sharma	AG
4	Lt Gen NPS Hira	DCOAS(IS&T)
5	Lt Gen B K Chopra	DGAFMS
6	Lt Gen Pawan Kapoor	Addl DGAFMS (HR)
7	Lt Gen M K Unni	DGMS(Army)
8	Air Mshl Rajan Chaudhry	DGMS(Air)
9	Shri Rabindra Panwar	JS (O/N)
10	Maj Gen P K Singh	Addl DGMS(Army)
11	Maj Gen Rakhi Singh	Addl DGMS(E&S)
12	Surg RAdm VSSR Ryali	Addl DGMS(Navy) & Offg DGMS(Navy)
13	Air Cmde Rajesh Vaidya	Dy DGAFMS (Coord)
14	Air Cmde M V Singh	PDMS(P)
15	Brig S D Behra	Dy DGMS(Army)
16	Col CS Shaktawat	MA to DCOAS (IS&T)

2. At the outset, the Chairperson welcomed the Members of the Committee to the Sitting convened for examination of the subject 'Provision of Medical Services to Armed Forces'. The Committee then invited the representatives of the Ministry of Defence and Armed Forces Medical Services(AFMS). The Chairperson drew their attention to Directions 55(1) and 58 of the Directions by the Speaker, Lok Sabha regarding confidentiality of proceedings.

3. After the witnesses introduced themselves, the representatives of the AFMS made a Power Point Presentation and briefed the Committee on the said subject. As per the schedule planned initially, the presentation was to be made separately for each Service but considering the fact that a consolidated presentation would give a better overview of the medical services being provided to the Armed Forces, a single Power Point presentation was made by the Ministry.

4. Hon'ble Chairperson and Members of the Committee raised several issues/points as briefly mentioned below and sought clarifications/information thereon from the representatives:

i. Role of the Armed Forces Medical Services (AFMS) in maintaining peak medical fitness of Armed Forces personnel as well as preventive, curative and rehabilitative care;

ii. Professional Medical training under which postgraduate and undergraduate courses are organized for Doctors, Military Nursing Service and Paramedical staff;

iii. Availability of doctors and paramedical staff in the field and command hospitals;

iv. Facility to be introduced by AFMS in respect of tele- medicines and preparedness for Chemical, Biological, Radiological, Nuclear Bio Warfare (CBRM) etc;

v. Type of difficulties faced by soldiers in getting medical aid in the battle field as well as battalion, company and platoon level;

vi. The reasons for reducing disability pension from the level of 50 percent to 30 percent after seven years;

vii. Issues related to difficulties faced by Armed Forces personnel in getting appropriate nourishment when stranded in high altitude, desert or jungle areas;

viii. Non availability of ECHS polyclinics in some areas like in Rajasthan;

ix. Issue related to Physical and functional deficiency of Medical Officers, which is 20 percent and use of services of former Armed Forces Medical Services Officers;

x. Modernisation of hospitals and reduction in allocated budget of AFMS;

xi. Declining Doctor and Patient Ratio and measures to improve it;

xii. Need to separate the Budget for R& D activities of AFMS from that of DRDO;

xiii. Success rate of AFMS in treating vector borne and drug resistance diseases and research in the area of stem cell;

4. The representatives of the Ministry of the Defence then responded to the queries raised by the Members. The Chairperson directed the representatives of the Ministry to furnish written replies/information on the points raised by the Members, which was assured by the representatives.

The Committee then adjourned

5. A copy of verbatim record of the proceedings has been kept.

STANDING COMMITTEE ON DEFENCE

MINUTES OF THE TENTH SITTING OF THE STANDING COMMITTEE ON DEFENCE (2016-17)

The Committee sat on Thursday, the 25th, May, 2017 from 1100 hrs. to 1230 hrs. in Committee Room 'B', Parliament House Annexe, New Delhi.

PRESENT

SHRI SURESH C ANGADI - CONVENOR

MEMBERS

LOK SABHA

2. Shri Shrirang Appa Barne
3. Shri Thupstan Chhewang
4. Col Sonaram Choudhary(Retd)
5. Shri H D Devegowda
6. Shri Sher Singh Ghubaya
7. Shri B Senguttuvan
8. Km Shobha Karandlaje
9. Dr Mriganka Mahato
10. Shri Rodmal Nagar
11. Shri A P Jithender Reddy
12. Shri Ch Malla Reddy
13. Smt Mala Rajya Lakshmi Shah
14. Shri Partha Pratim Ray
15. Shri Dharambir Singh
16. Smt Pratyusha Rajeshwari Singh

Rajya Sabha

17. Shri K R Arjunan
18. Shri Harivansh
19. Shri Madhusudan Mistry
20. Shri Sanjay Raut
21. Smt Ambika Soni
22. Dr Subramanian Swamy

SECRETARIAT

1	Shri T G Chandrasekhar	-	Director
2	Smt Jyochanamayi Sinha	-	Additional Director
3	Shri Rahul Singh	-	Under Secretary

LIST OF WITNESSESS

Sl. No.	Name & Designation
1.	Shri Sanjay Mitra, Defence Secretary
2.	Shri S K Kohli, FA(DS)
3.	Shri Ravi Kant, Addl. Secy. (R)
4.	Lt Gen MK Unni, DGAFMS & Sr Col Comdt
5.	Lt Gen Venu Nair, DGMS (Army) & Col Comdt
6.	Lt Gen T Bandyopadhyay, DGDS & Col Comdt
7.	Smt DevikaRaghuvanshi, JS (N)
8.	Shri A N Das, Addl FA(AN)
9.	AVM RK Ranyal, ADG AFMS (HR)
10.	Surg RAdm Joy Chatterjee, ADG MS (Navy) &Offg DGMS (Navy)
11.	Maj Gen AK Hooda, ADG AFMS (MR, H&Trg)
12.	Maj Gen Madhuri Kanitkar, Dean AFMC, Pune
13.	Maj Gen Sushila Sahi, ADG MNS
14.	Brig SR Ghosh, Comdt ALC, Pune
15.	Shri Lal Chhandama, Director

2. At the outset, the Chairperson welcomed the Members and representatives of the Ministry of Defence, Ministry of Law & Justice and Election Commission of India to the sitting of the Committee. The Chairperson drew their attention to Directions 55(1) and 58 of the Directions by the Speaker, Lok Sabha regarding confidentiality of proceedings. The representatives of the Ministry of Defence and other stakeholders were requested to brief the Committee on the provision of Medical Services to Armed Forces including Dental Services with particular reference to Armed Forces Medical College and Artificial Limb Centre, Pune.

3. The representatives of the Ministry of Defence gave a power point presentation on the subject. The Committee had detailed deliberations on various issues in the context which included: -

(i) Clear guidelines for canvassing inside the Cantonments;

(ii) Beginning of new era in the Voting as first electronically transmitted postal ballot uploaded by the RO of 17 Nellithope Assembly Constituency in the bye election ;

(iii) Provision of EPIC (Electors Photo Identity Card) number to the Service Voters;

(iv) Security of aspect relating to the Server and e-Postal Ballot System;

(v) Sharing of details of proposed E-Postal Voting System run to be conducted on 19 November, 2016 by the Ministry; etc.

4. The Committee appreciated the efforts made by the Ministry of Defence, Ministry of Law & Justice and Election Commission of India, which resulted in bringing out the Gazette Notification to amend the Conduct of Election Rules, 1961 for enabling electronic transmission of ballot papers of Service Voters.

5. The representatives of the Ministry of Defence, Ministry of Law & Justice and Election Commission of India responded to the queries raised by the Members during the deliberations. As regards, the points on which the representatives could not readily respond, they promised to furnish written information at the earliest.

A copy of verbatim record of the proceedings has been kept.

The Committee then adjourned.

STANDING COMMITTEE ON DEFENCE

MINUTES OF THE TWELFTH SITTING OF THE STANDING COMMITTEE ON DEFENCE (2016-17)

The Committee sat on Wednesday, the 2nd August, 2017 from 1000 hrs. to 1020 hrs. in Committee Room`C', Parliament House Annexe, New Delhi.

PRESENT

Maj Gen B C Khanduri, AVSM (Retd) - Chairperson

Lok Sabha

2. Shri Suresh C Angadi
3. Shri Shrirang Appa Barne
4. Shri Thupstan Chhewang
5. Col Sonaram Choudhary(Retd)
6. Km Shobha Karandlaje
7. Shri Rodmal Nagar
8. Shri A P Jithender Reddy
9. Shri Ch Malla Reddy
10. Smt Mala Rajya Lakshmi Shah
11. Shri Dharambir Singh
12. Smt Pratyusha Rajeshwari Singh

Rajya Sabha

13. Shri K R Arjunan
14. Shri Rajeev Chandrasekhar
15. Shri Sanjay Raut
16. Smt Ambika Soni
17. Dr Subramanian Swamy

SECRETARIAT

1. Smt. Kalpana Sharma - Joint Secretary
2. Shri T.G. Chandrasekhar - Director
3. Smt. Jyochanmayi Sinha - Additional Director
4. Shri Rahul Singh - Under Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee and informed them about the agenda for the sitting. The Committee then took up for consideration the following draft Reports on:-

i) 'Creation of Non-lapsable Capital Fund Account, instead of the present system'

ii) 'Resettlement of Ex-servicemen'

iii) 'Provision of Medical Services to Armed Forces including Dental Services'

3. After deliberations the Committee adopted the above Reports.

4. The Committee, then, authorized the Chairperson to finalise the above draft Reports and present the same to the House on a date convenient to him.

The Committee then adjourned.