headed by Prant Officer – Petlad to conduct an enquiry in this regard. The report of the inquiry committee is still awaited (November 2017).

Supervisory lapses of the DPO in inspecting the works as envisaged in the MPLADS guidelines led to poor quality of works, non-completion of works and fraudulent payment. Since the tendering process, scope of work awarded and payment processes were violated, therefore audit is of the view that these works are susceptible to fraudulent and irregular payments. Audit recommends that the State Government should investigate all the works carried out by the NGO and fix responsibility on the Government officials responsible for the negligence.

The matter was reported to the Government (September 2017). Reply is awaited (February 2018).

HEALTH AND FAMILY WELFARE DEPARTMENT

3.3 Mukhyamantri Amrutum Yojana and Mukhyamantri Amrutum Vatsalya Yojana

3.3.1 Introduction

The State Government launched (April 2012) "Mukhyamantri Amrutum (MA) Yojana" with an objective to provide cashless quality tertiary medical treatment to people living below the poverty line (BPL). The scheme envisaged cashless treatment for 544 predefined procedures in 11 clusters[44] of catastrophic diseases throughout the State both in Government and Private empanelled hospitals. It also envisaged treatment of pre-existing diseases from the day of enrolment under the scheme. The State Government subsequently launched (August 2014) "Mukhyamantri Amrutum Vatsalya (MAV) Yojana" with the objective to extend the benefits of the scheme to all poor families with an annual income up to ₹ 1.20 lakh[45]. The schemes provided coverage for meeting expenses of hospitalization and surgical procedures up to ₹ 2.00 lakh per year per family of five members[46] on a floater basis[47]. The reimbursement of the claim is made directly to the empanelled hospitals by the State Nodal Cell established in June 2012 through e-payment without involvement of any insurance company. The department has used the data of BPL and non-BPL poor families of 2002-03 and has not updated the data as per Census 2011.

3.3.2 Implementing Stakeholders

State Nodal Cell (SNC) is headed by the Principal Secretary (Health and Family Welfare Department) and is responsible for the overall implementation of the scheme. At district level, the SNC is assisted by the Chief District Health Officers (CDHOs) who are responsible for the overall monitoring of the enrolment at district and taluka levels and for redressal of grievances of the beneficiaries. To facilitate the implementation of the scheme in the State, the SNC also engaged (July and October 2012) two agencies *viz.* M/s. (n)Code

44 (1) Burns, (2) Cardiology, (3) Cardiothorasic Surgery, (4) Cardiovascular Surgery, (5) Genitourinary Surgery, (6) Neuro Surgery, (7) Paediatric Surgeries, (8) Poly Trauma, (9) Medical Oncology, (10) Radiation Oncology and (11) Surgical Oncology.

45 Revised to ₹ 2.50 lakh per annum from October 2017

46 Head of the family, spouse and up to three dependents

47 Utilisation limit of ₹ 2.00 lakh (fixed) by any member of a family in a year

Solution, Ahmedabad (NCS) and M/s. MDI India Healthcare, Pune (MDI) as Implementation Support Agency (ISA). NCS was engaged for development of a comprehensive IT solution for enrolment of the beneficiaries. MDI was engaged for networking/empanelment of the hospitals, facilitating for treatment at the hospitals, processing of claims, *etc.* The claims finalised by MDI was further scrutinised by SNC for final payment to the hospitals.

3.3.3 Data Analytics Methodology

Audit has used data analytics to support the processes of planning, sampling, guidance to field parties and reporting. Data analytics was used to get insights into focusing on areas of audit and to extrapolate the audit findings to arrive at impact on a macro level. The insights have been used for predictive analysis and reporting to the State Government.

- ***Collection and Analysis of Data***

Audit collected SQL dump data relating to the scheme from the department for the period 2012-17, maintained by NCS (Enrolment data) and MDI (Hospital transaction data). Analysis of the SQL dump data was done by using Computer Assisted Audit Tools[48] (CAATs) for determining risk areas and selection of districts and hospitals for audit.

3.3.4 Audit Objectives, Sample and Procedures

Audit was conducted with the objective of deriving an assurance about the efficacy in promotion and implementation of the schemes in the State during the period 2012-17. Audit commenced with an entry conference with Additional Director (April 2017) wherein the audit objectives, scope and audit criteria were discussed and the inputs from the department were obtained. Audit also involved scrutiny of the records for the period 2012-17 maintained at SNC, Commissioner of Health, District Coordinators office of ISA and CDHOs of 16 selected districts[49] (selected on the basis of enrolment and hospitals claims in the district). Audit also conducted joint visit (May to August 2017) of 27 hospitals in test-checked districts with the district representatives of ISA to observe the standards of delivery of the healthcare services.

Audit findings

MA/MAV schemes require enrolment of beneficiaries, empanelment of hospitals, management system for providing quality medical treatment to the beneficiaries as envisaged in the scheme and payment to the hospitals. Audit findings on implementation of MAA and MAV schemes are discussed in the succeeding paragraphs -

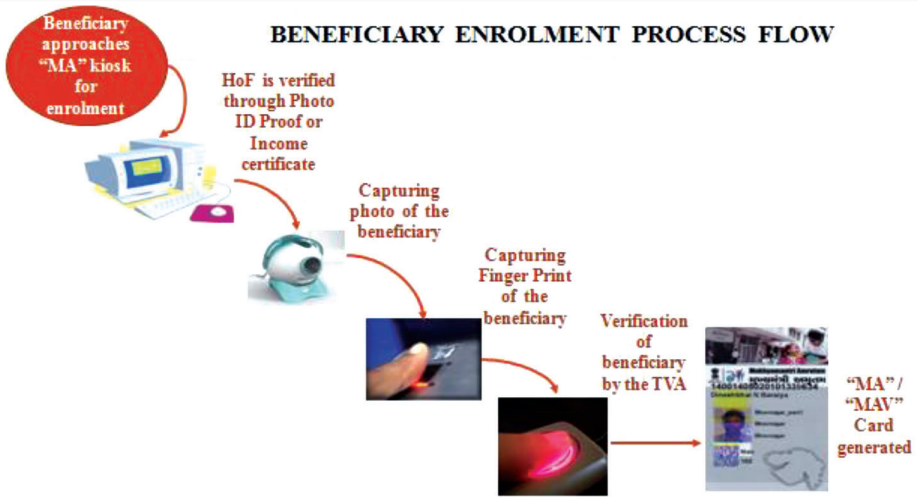
3.3.5 Enrolment procedure

As per the scheme guidelines, enrolment kiosk set-up at taluka level is the focal point for the enrolment of beneficiaries under the schemes. The beneficiaries are

48 IDEA, Tableau and other available audit tools

49 (1) Ahmedabad, (2) Anand, (3) Aravali, (4) Banaskantha, (5) Bhavnagar, (6) Dangs, (7) Devbhumi Dwarka, (8) Jamnagar, (9) Mehsana,(10) Narmada, (11) Navsari, (12) Patan, (13) Rajkot, (14) Sabarkantha, (15) Surat and (16) Vadodara

required to submit their documents such as ration card, income certificate and identity proof of the Head of the Family (HoF) at the Taluka kiosk. The Taluka Kiosk Executive[50] (TKE) captures all the documents, photos and fingerprints of all individuals of the family. The Taluka Verification Authority (TVA) after verifying the documents captured by TKE accords approval for issue of MA/ MAV cards to the beneficiaries and uploads the data to the main server for activation. The enrolment process is shown in **Picture 1**–



Picture 1: Enrolment process under MA and MAV schemes

3.3.5.1 Enrolment trends

The main objective of the scheme is to provide cashless medical treatment for catastrophic diseases[51] to the BPL beneficiaries in the State. To cover maximum number of BPL beneficiaries under the scheme, the State Government engaged Accredited Social Health Activist (ASHA) workers to bring the BPL families to the kiosk centre for enrolment. The ASHA workers were responsible to distribute brochures/pamphlets and make the beneficiaries aware about the enrolment process, benefits of the scheme and details of empanelled hospitals. They were also required to motivate the beneficiaries to get enrolled under the scheme. As per information provided by the department, total number of BPL families in the State was 41.50 lakh as of March 2017. The details of total number of non-BPL families having annual income upto ₹ 1.20 lakh in the State were not available with the department.

The data relating to BPL and non-BPL families enrolled under MA and MAV schemes across the State were analysed. Data Analysis of the cumulative enrolment of BPL families under MA scheme during 2012-17 is shown in **Chart 1** -

50 Appointed by M/s. (n)Code Solution, Ahmedabad
51 As per the State Government Resolutions and tender document for empanelment of hospitals

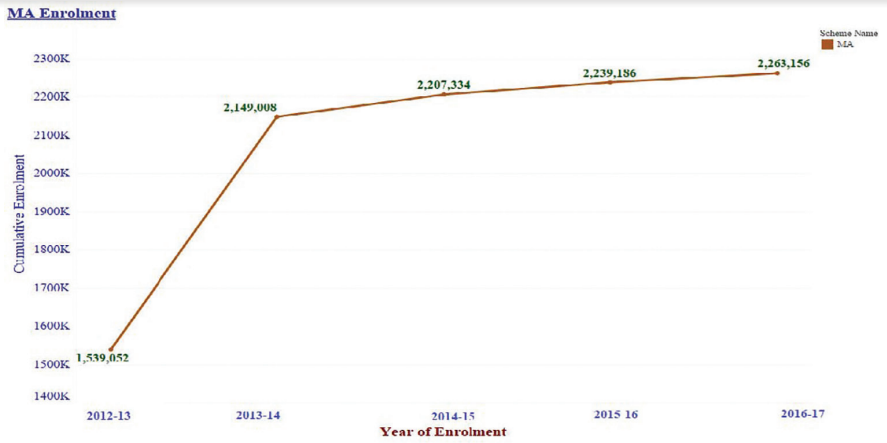


Chart 1: Chart showing cumulative enrolment of BPL families (2012-17)

The above chart signifies that only 22,63,156 out of 41,49,913 BPL families (54.54 *per cent*) in the State have been enrolled in MA scheme till March 2017. Detailed audit analysis revealed that the high percentage of BPL enrolment in 2012-13 (15,39,052) and 2013-14 (6,09,956) was due to issue of bulk printed cards (20,10,850 cards) for BPL families based on *Rashtriya Swasthya Bima Yojana (RSBY)* data as discussed in **Paragraph 3.3.7.1**. It was also observed that despite engaging ASHA workers on incentive basis (₹ 100 per BPL family) for mobilizing and bringing the remaining BPL families for enrolment to the kiosk centre, the enrolment during the subsequent three years was quite low (2,52,306 during 2014-15 to 2016-17). Thus, the efforts to motivate and enrol were ineffective. As such, the objective of providing the benefit of the scheme to BPL families of the State remained unachieved even after a lapse of more than five years.

The CDHOs of test-checked districts stated that the low coverage was due to non-matching of name and/or address of beneficiaries with the database of BPL families, migration of families, lack of awareness and motivation, *etc*. The Government stated (January 2018) that the major reason behind low enrolment was the BPL database provided by the State Rural and Urban Development Departments, as the same was of census 2002-03. Therefore, even after repeated rounds of village to village enrolments, only 50 *per cent* of BPL families could be enrolled. It was further stated that there is no fixed period of enrolment under MA scheme. Any beneficiary requiring tertiary care can get the MA card at any time and then avail the treatment. The reply is not tenable as in case of need for emergency treatment, the beneficiaries would not get free treatment unless the MA card is issued to them. Further, engagement of ASHA worker for enrolment of beneficiaries was also found deficient. Audit is of the view that the State Government may consider fixing a time line for coverage of all BPL families in the State and may consider the latest Census database to avoid non-matching of name and/or address of beneficiaries.

- ***Enrolment of BPL families in the districts***

The percentage of enrolment of BPL families across the State under MA scheme stood at 54.54 *per cent* of the total BPL families as on 31 March 2017. Analysis

of district-wise data of BPL enrolment revealed that the percentage of BPL enrolment in 11 districts[52] were even lower than the State average percentage as shown in **Chart 2** below-

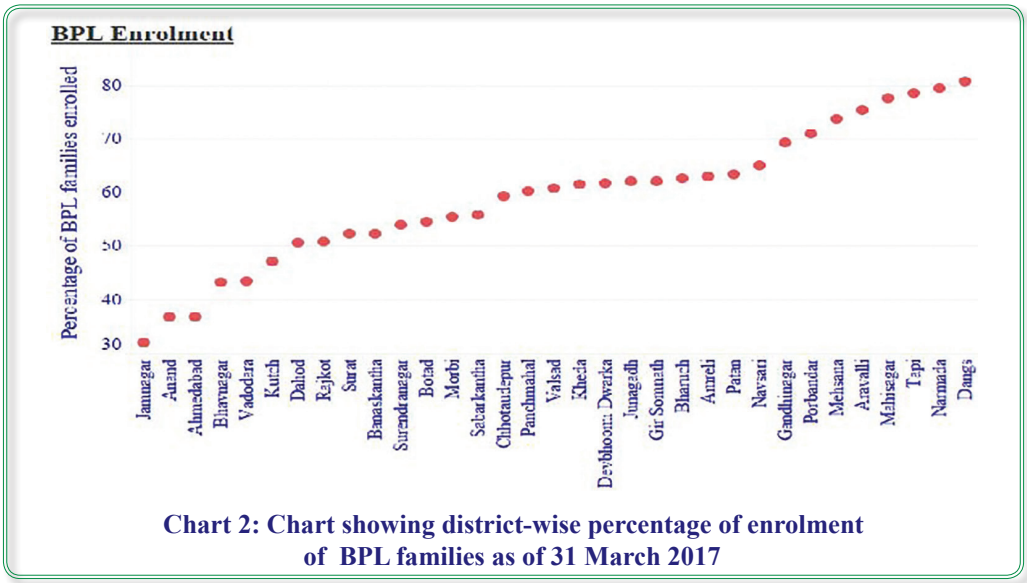


Chart 2: Chart showing district-wise percentage of enrolment of BPL families as of 31 March 2017

The above chart shows that the percentage of enrolment in these 11 districts, ranged from 32 *per cent* (Jamnagar district) to 54 *per cent* (Surendranagar district) as on 31 March 2017. Audit observed that the State Government had released (2012-17) ₹ 1.30 crore to 21 districts for organizing mega camps to create public awareness about MA scheme. However, despite availability of funds, the camps were held in only 13 districts during January to March 2014 (except for Dangs district held in 2012-13).

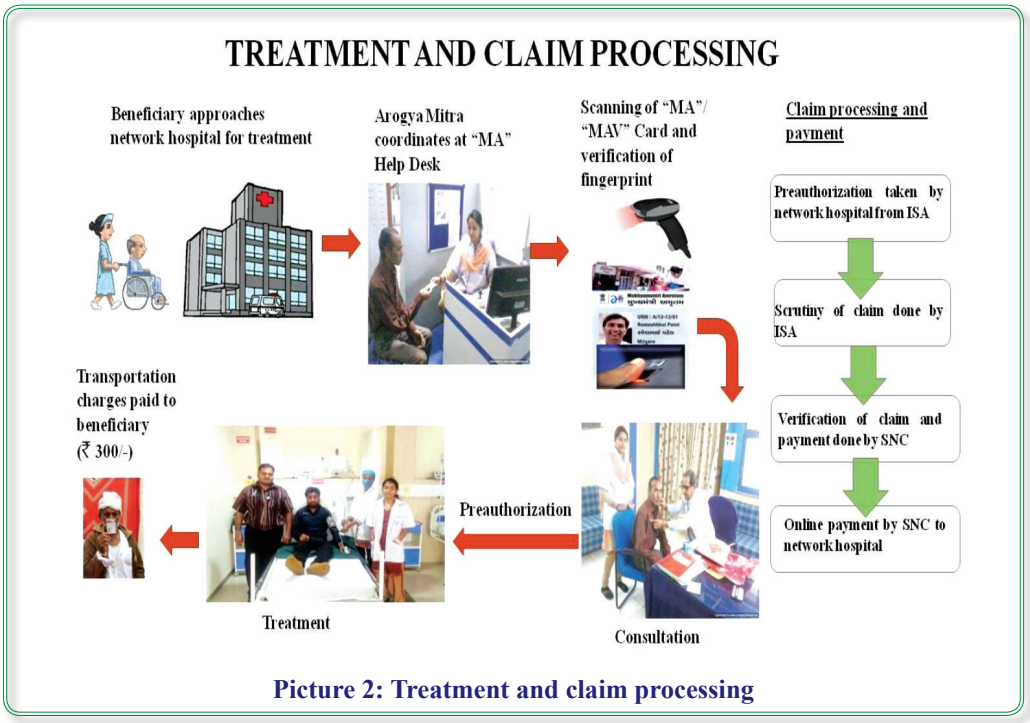
The Government attributed (January 2018) (1) the use of BPL census of 2002-03, (2) non-fixing of time line for enrolment and (3) BPL families not turning out for enrolment as main reasons for low enrolment. It was further stated (January 2018) that conduct of mega camp was not compulsory and from September 2012 to March 2014, various Information, Education and Communication (IEC) Activities such as advertisement in Television, Radio, Newspaper and Bus panel were done. Audit observed that the funds for organizing mega camp had been released to the districts based on their demand. However, the reasons for non-conduct of mega camps by remaining eight districts have not been addressed in reply to audit observation. Audit further observed that in addition to above ₹ 1.30 crore, the State Government had released ₹ 1.26 crore for IEC activities under the scheme to all 33 districts in the State during 2012-17. However, district-wise details of IEC activities done and expenditure incurred for it was not provided to Audit. Audit is of the view that the State Government may engage Anganwadi workers, Non-Government Organisations, Corporate Bodies located in the district or adjoining areas, *etc.* to achieve enrolment of all BPL families and may cross-check the data with Aadhaar Card to avoid non-matching of name/address of BPL families during enrolment process.

52 (1) Ahmedabad, (2) Anand, (3) Banaskantha, (4) Bhavnagar, (5) Dahod, (6) Jamnagar, (7) Kutch, (8) Rajkot, (9) Surat, (10) Surendranagar and (11) Vadodara

3.3.6 Medical treatment and financial assistance

For availing treatment, the beneficiary has to approach an empanelled hospital. The Arogya Mitra (AM) appointed by the Implementation Support Agency (ISA)[53] verifies the fingerprints and photo of the beneficiary with the central data server and facilitates in undergoing preliminary diagnosis. The hospital, based on the diagnosis, admits the patient and sends preauthorization request to the ISA for approval. On receipt of approval from ISA, the hospital extends cashless treatment to the beneficiary.

The hospital after discharge of the beneficiary, forwards the claim for processing and settlement. ISA scrutinises the claims and forwards the payment request to the State Nodal Cell (SNC). The SNC after verification of the claim makes direct payment to the hospital through electronic transfer. The treatment and claim processing is shown in **Picture 2** below –



Picture 2: Treatment and claim processing

3.3.6.1 Availability of empanelled hospitals in districts

The scheme guidelines provide that the department shall invite proposals for 11 clusters from hospitals providing tertiary care health services for empanelment under the scheme. The empanelment of the hospitals is done on cluster basis consequent on the fulfillment of minimum criteria of availability of beds, diagnostic and laboratory services, super specialists, *etc.* Analysis of district-wise and cluster-wise empanelment of hospitals in the State as on 31 March 2017 is shown in **Chart 3** -

53 M/s. (n)Code Solution, Ahmedabad and M/s. MDI India Healthcare, Pune

Empaneled Hospitals

Speciality Name

1 — 14

Sr. No.	District Name	Total Empaneled Hospitals	Cluster-1 Burns	Cluster-2 Cardiology	Cluster-3 Cardiothoracic Surgery	Cluster-4 Cardiovascular Surgery	Cluster-5 Genitourinary Surgery	Cluster-6 Neuro Surgery	Cluster-7 Paediatric Surgery	Cluster-8 Polytrauma	Cluster-9 Medical Oncology	Cluster-10 Radiation Oncology	Cluster-11 Surgical Oncology
1	Ahmedabad	25	4	11	11	4	14	9	5	4	4	2	6
2	Vadodara	16	6	7	5	4	8	8	3	7	7	3	10
3	Surat	13	3	5	6	2	4	5	2	5	2	1	3
4	Rajkot	9	2	2	3	2	5	1	1	2	1	1	1
5	Mehsana	5	1	1	1	1	5						1
6	Gandhinagar	5	2				4	1		2	1	1	2
7	Kutch	5	1	1			4	3	1	1	1		1
8	Navsari	5	1	2	2	1	4	1		1	2	1	2
9	Bhavnagar	4	1	3	2	1	3	2		1	1		1
10	Kheda	4		2	2		2						
11	Bharuch	3	1	1			1						1
12	Patan	3	1				3			2			2
13	Anand	2		2	1	1	1				1	1	1
14	Banaskantha	2	1	1			2						1
15	Sabarkantha	2	2	1			2		1	2			
16	Valsad	2	1				1			1	1		1
17	Amreli	1					1						
18	Jamnagar	1	1				1			1	1		1
19	Narmada	1					1			1			
20	Panchmahal	1					1						
21	Porbandar	1					1						
22	Surendranagar	1					1						
23	Tapi	1					1						
	Grand Total	113	28	39	33	16	70	30	13	30	22	10	34

Chart 3: District-wise and Cluster-wise empanelled hospitals in the State as on 31 March 2017

The above chart shows that only 23 out of 33 districts in the State have empanelled hospitals. Remaining 10 districts[54] having enrolment of 9,52,793 families (20.31 *per cent* of total enrolment) under the scheme had no facility of empanelled hospitals. Further, seven out of 23 districts (from Amreli to Tapi) had only one empanelled hospital and in the remaining 16 districts, the availability of empanelled hospitals was between two to nine hospitals (except Ahmedabad, Vadodara and Surat districts).

The chart also signifies that only four (Ahmedabad, Rajkot, Surat and Vadodara) out of 23 districts have empanelled hospitals for all the 11 clusters envisaged in the scheme. Of the remaining 19 districts, six districts[55] with one empanelled hospital was providing treatment for only dialysis cluster while remaining 13 districts provided treatment for two to 10 clusters. Paediatric cluster is empanelled only in six districts.

As a result, the beneficiaries of these districts were not getting requisite scheme benefits within the district and were forced to travel to other districts for availing the treatment under the scheme.

Analysis of data of hospital claims revealed that due to inequitable availability of healthcare services in the State, beneficiaries of districts having no empanelled hospital and districts with less number of empanelled hospitals have moved to other districts for availing medical treatment. The beneficiaries preferred treatment mostly in four major cities (Ahmedabad, Rajkot, Surat and Vadodara) having adequate number of empanelled hospitals **(Chart 4)**.

54 (1) Aravalli, (2) Botad, (3) Chhotaudepur, (4) Dahod, (5) Dangs, (6) Dwarka, (7) Junagadh, (8) Mahisagar, (9) Morbi and (10) Somnath

55 (1) Amreli, (2) Narmada, (3) Panchmahal, (4) Porbandar, (5) Surendranagar and (6) Tapi

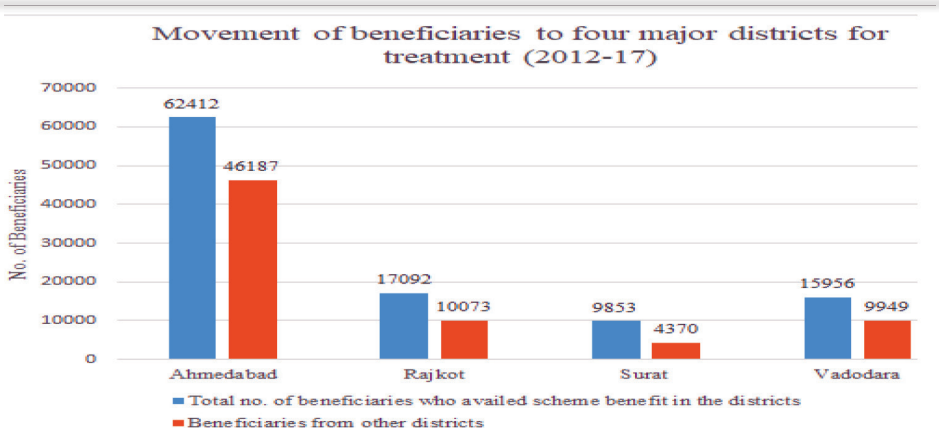


Chart 4: Beneficiaries moving to four major districts for treatment (2012-17)

The Government stated (January 2018) that establishing multi-specialty hospital with tertiary care services in each district was beyond the purview of MA Yojana. However, the distance which the BPL persons were travelling before the launch of MA Yojana has definitely been reduced from 500 to 100 kilometres (kms.) and even lesser in some districts due to empanelment of hospitals. The reply is not tenable as Audit analysis revealed that only 11 out of 22 District Hospitals (DHs) have been empanelled under the schemes and these DHs have been empanelled only for Dialysis under Cluster 5. Further, only four out of eight Gujarat Medical Education and Research Society (GMERS) have been empanelled under the schemes and have been empanelled only for Clusters 1, 5 (only dialysis) and 8. Therefore, beneficiaries moved to other districts for availing treatment due to non-availability of empanelled hospitals for all clusters in their own district as discussed in the succeeding paragraphs.

- ***Movement for treatment for different clusters of diseases***

The data analysis in Audit of the movement of beneficiaries from their own districts to other districts for availing treatment is shown in **Chart 5**–

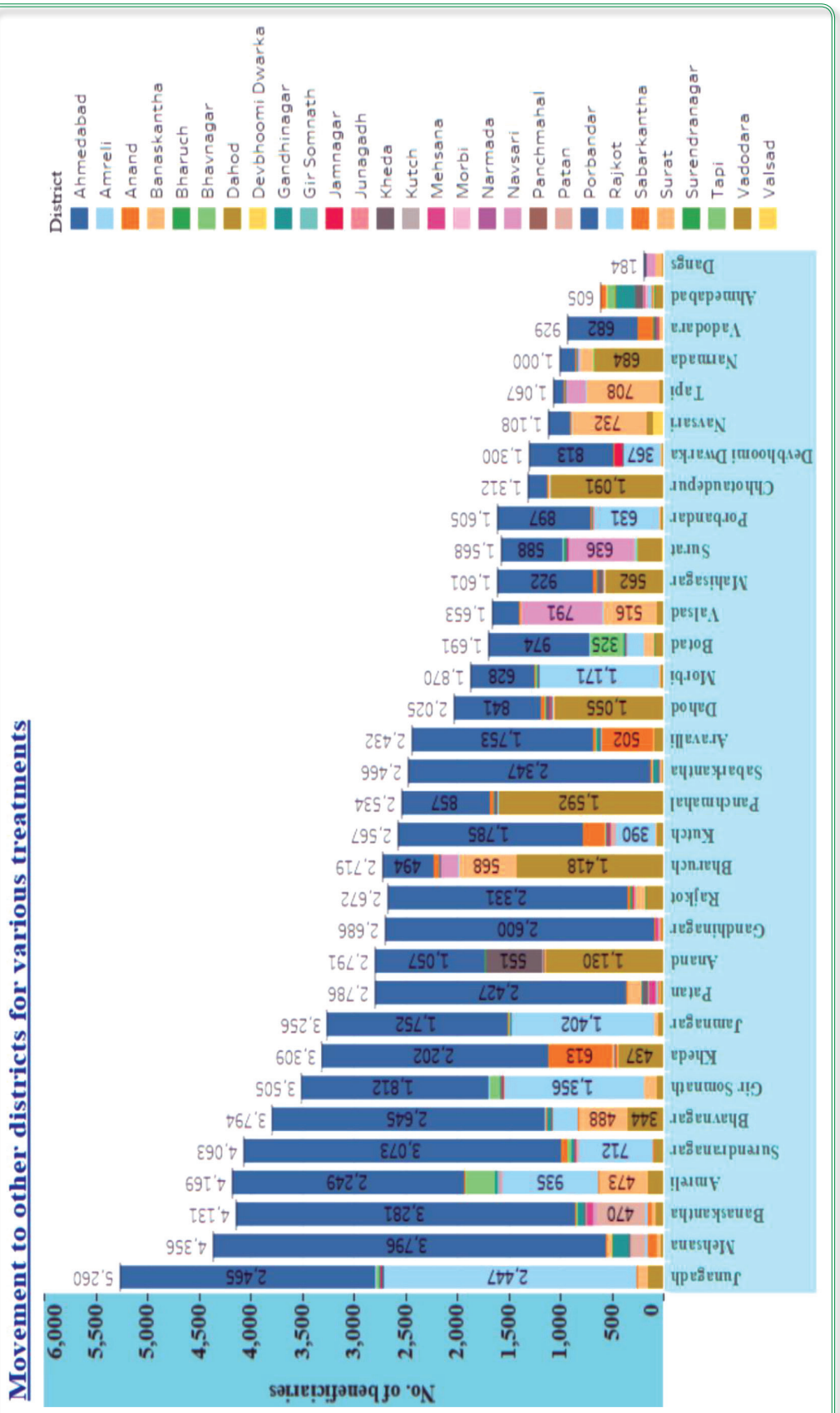


Chart 5: Beneficiaries moving to other districts for various treatments (2012-17)

The above chart shows that the patients from all over the State moved to Ahmedabad city for availing treatment under the scheme. The percentage of movement of beneficiaries from other districts to Ahmedabad, Rajkot, Surat and Vadodara districts for availing treatment was 74, 59, 44 and 62 *per cent* respectively. This was mainly due to non-availability of empanelled hospitals for all clusters in other districts. The percentage of movement of patients out of their own district for taking treatment ranged from 3.56 *per cent* (Ahmedabad) to 100 *per cent* (Dangs). The least movement out of Ahmedabad highlights the unequal distribution of hospitals across the districts of the State.

Audit analysed the movement of patients from one district/region to others for availing treatment under different clusters. Major observations revealed from the analysis are discussed below -

- ***Movement for Cancer treatment***

The details of beneficiaries having availed treatment of cancer outside their district based on data analysis is shown in **Chart 6** below –

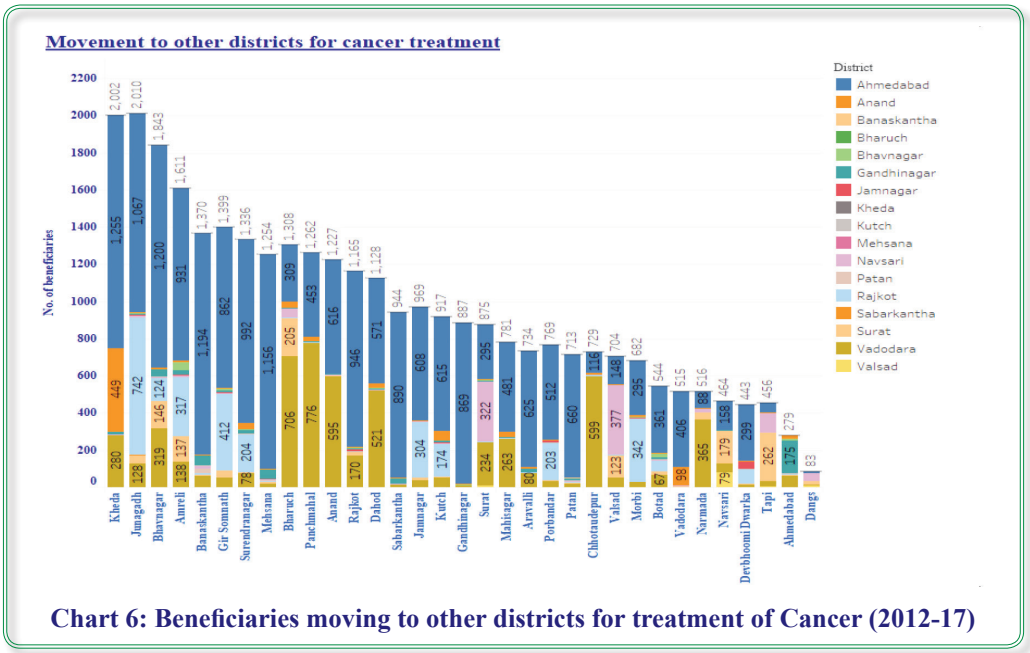


Chart 6: Beneficiaries moving to other districts for treatment of Cancer (2012-17)

The above chart shows maximum movement for cancer treatment was from Saurashtra region, Kheda and Banaskantha. Saurashtra region consists of 11 districts with total enrolment of 13,99,338 beneficiaries (MA and MAV) as of March 2017. The region has only two empanelled hospitals for cancer treatment (one for medical and radiation oncology; and the other for surgical oncology), both of which are located at Rajkot district. Out of total 14,114 patients for cancer in Saurashtra region, who availed the benefit of the scheme (2012-17), 8,072 (57.19 *per cent*) beneficiaries had moved to Ahmedabad for the treatment of cancer due to non-availability of adequate number of empanelled hospitals for cancer treatment in the region. These patients travelled about 220 kms. (Rajkot) to 450 kms. (Devbhoomi Dwarka).

- ***Movement for cardiac treatment***

The data analysis revealed high movement of cardiac patients from Mehsana, Junagadh, Surendranagar, Banaskantha, Bhavnagar, Patan, Amreli and Jamnagar

districts to the cities of Ahmedabad, Vadodara and Rajkot. The beneficiaries of Rajkot city moved to Ahmedabad district while beneficiaries of nearby districts of Rajkot district moved to Rajkot city for availing treatment. Out of total 17,873 cardiac patients in these districts, who availed the benefit of the scheme (2012-17), 11,994 (67 *per cent*) beneficiaries had moved to other districts for availing cardiac treatment. Audit observed that the reasons for movement were mainly due to non-availability of empanelled hospitals for cardiac treatment.

- ***Movement for paediatric treatment***

The data analysis revealed that 379 out of 557 beneficiaries (68.04 *per cent*) who availed the benefit of the scheme had moved to Ahmedabad city for availing paediatric treatment. Audit observed that the movement was mainly due to inadequate number of empanelled hospitals. Only six districts in the State have empanelled hospitals for paediatric treatment under the scheme.

The above illustrative analysis shows that the empanelled hospitals are concentrated in a few districts of the State thereby forcing beneficiaries to travel long distances for availing treatment under the scheme.

The Government stated (January 2018) that a policy has been launched to provide assistance in procurement of equipment, establishment of new super-specialty and new medical college especially in remote areas. The beneficiaries would have to travel to the nearest hospital empanelled under the scheme till the time these hospitals are constructed. The reply is not tenable as the ISA appointed for empanelment of more number of hospitals failed to empanel private hospitals in districts having no empanelled hospital. Further, it was observed that the State Government empanelled only six Civil Hospitals (CHs) for all clusters and ignored the 22 Government district hospitals to provide super speciality services at least in a few clusters which could also have avoided extensive lateral movement of the patients for availing medical treatment. Clustering of specialized areas of treatment and corresponding criteria for empanelment is leading to cross movement of patients apparently with catastrophic diseases.

3.3.6.2 Trend of treatment in Government and Private Hospitals

Analysis of hospital-wise treatment data under the scheme indicated that the beneficiaries preferred to get treatment from private hospitals (77.71 *per cent*) than Government hospitals (22.29 *per cent*) as shown in **Chart 7** -

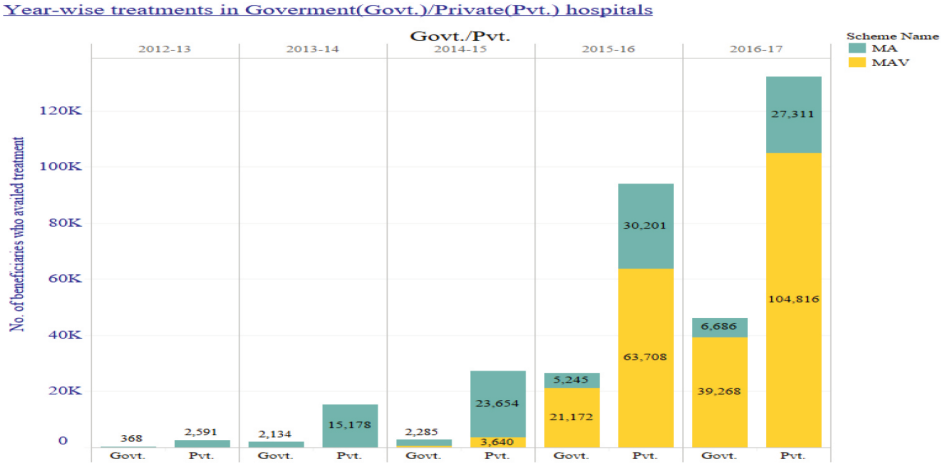


Chart 7: Chart showing beneficiaries preferred private hospitals

Audit observed that out of total claim amount of ₹ 557.70 crore for treatment provided to the beneficiaries under the scheme during 2012-17, the claim made by private hospitals was ₹ 433.39 crore while the claim by Government hospitals was only ₹ 124.31 crore. It was observed that the medical facilities provided by Government hospitals were not adequate to cater to the medical needs of the beneficiaries under the scheme as discussed in the succeeding paragraphs.

- ***Treatment at Government Civil Hospitals***

In Gujarat, tertiary healthcare services including super specialty services are provided by six Civil Hospitals[56] (CHs) which are attached with medical colleges. All the CHs have been empanelled since launch of the scheme.

The details of number of beneficiaries who have availed treatment under the scheme from the CHs in the State during the period 2012-17 is shown in **Chart 8** below -

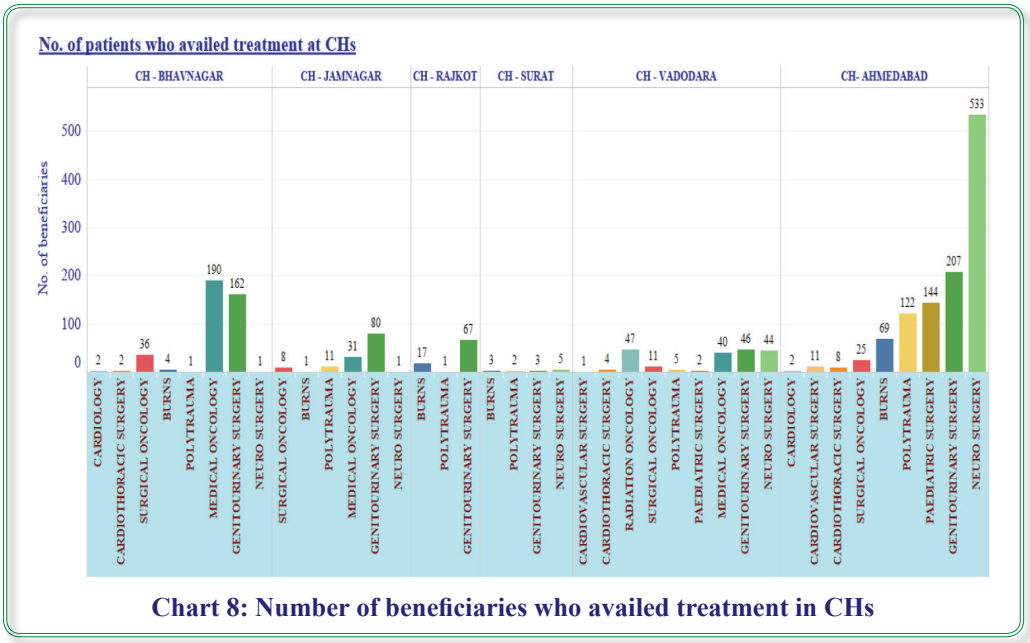


Chart 8: Number of beneficiaries who availed treatment in CHs

The above chart shows that the CHs have not provided treatment to the beneficiaries for all 11 clusters, which ranged between three (CH Rajkot) and nine (CH Vadodara) clusters.

The Chart 7 also shows that the beneficiaries preferred availing treatment in empanelled private hospitals than in CHs. Audit observed that this was mainly due to non-availability of specialist doctors and infrastructure in CHs as shown in **Table 1**–

56 (1) Ahmedabad, (2) Bhavnagar, (3) Jamnagar, (4) Rajkot, (5) Surat and (6) Vadodara

Table 1: Details of availability (✓) of specialist doctors and infrastructure in CHs as of August 2017

Cluster No.	Specialist/Infrastructure	CH Bhavnagar	CH Jamnagar	CH Vadodara	CH Surat	CH Rajkot
	Specialist					
01	Plastic and Cosmetic Surgeon			✓	✓	✓
02	Cardiologist				✓	
03	Cardiothoracic Surgeon					
04	Cardiovascular Surgeon					
05	(i) Nephrologist			✓	✓	
	(ii) Urologist	✓		✓	✓	✓
06	Neuro Surgeon	✓		✓	✓	✓
07	Paediatric Surgeon			✓		✓
08	Polytrauma Surgeon	✓	✓	✓	✓	✓
	Orthopaedic Surgeon	✓	✓	✓	✓	
09	Medical Oncologist		✓	✓		✓
10	Radiation Oncologist		✓	✓		
11	Surgical Oncologist			✓		
Others	General Surgeon	✓	✓	✓	✓	✓
	Anaesthetist	✓	✓	✓	✓	✓
	Infrastructure					
	Mammography for Surgical Oncology	✓	✓	✓	✓	
	PET Scan for Surgical Oncology			✓		
	Cobalt Radiation for Surgical Oncology		✓	✓	✓	
	Brach Radiation for Surgical Oncology		✓		✓	
	Linear Accelerator for Surgical Oncology					
	Cathlab for Cardiology					
	Operation Theatre for Cardiovascular			✓		

(Source: Information provided by Civil Hospitals)

During test-check, Audit observed that at CH Bhavnagar, 18 MA beneficiaries were referred to other CHs for treatment due to non-availability of specialists and infrastructure in the hospitals. This indicated that the CHs have been empanelled under the scheme without assessing the availability of required infrastructure and specialist doctors for respective clusters as envisaged in the guidelines. Further, even after lapse of more than five years since launching of the scheme, the State Government has not taken any action for enhancing the facilities in the CHs to provide treatment to the beneficiaries.

The Government stated (January 2018) that under Chief Minister Setu's program, the Government hospitals have been instructed (October 2016) to hire

specialist doctors for providing treatment to the patients. The fact remained that despite issuance of instructions by the department, the hospitals failed to hire specialist doctors. The Government further stated that to enable easy access of quality treatment to the beneficiaries, availability of specialist doctors and infrastructure for all clusters in the CHs or tying up hospitals on Public Private Partnership (PPP) mode in remote districts would be ensured. This indicated that allocation of health budget is not allocated in a manner to improve infrastructure and efficiency of CHs and DHs which resulted in non-appointment of specialist doctors under Chief Minister Setu's program and not empanelling of district hospitals for more clusters.

3.3.7 Control Mechanism for enrolment process

3.3.7.1 Printing of the MA Cards

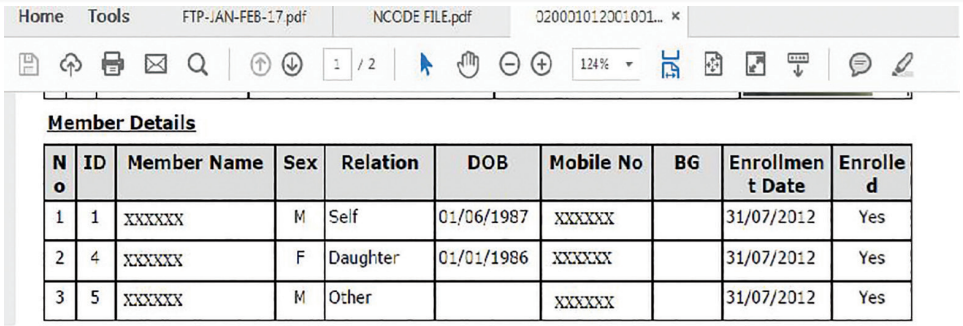
As per the scheme guidelines, enrolment kiosk set-up at taluka level is the focal point for the enrolment of new beneficiaries under the scheme. The cards have to be issued only after verification of documents and authentication by the Taluka Verification Authority (TVA) at the enrolment kiosk.

Audit observed that the department had not followed the enrolment procedure prescribed in the scheme guidelines. The data of 20,10,850 BPL beneficiaries registered under *Rashtriya Swasthya Bima Yojana* (*RSBY*)[57] were used for bulk printing of MA cards for these beneficiaries. These bulk-printed MA cards were delivered to the Chief District Health Officers (CDHOs) for onward delivery to the beneficiaries. On scrutiny of records in test-checked CDHOs, it was observed that out of 2,20,378 pre-printed MA cards in four test-checked CDHOs, 8,797 MA cards[58] (four *per cent*) have not been delivered to the concerned beneficiaries till date (August 2017) due to non-printing of photos/names, incorrect address, *etc.* on the MA cards. While remaining 12 test-checked CDHOs had not maintained the records of number of MA cards received and distributed to the beneficiaries. As a result, Audit could not vouchsafe whether all the cards received have been delivered to the concerned beneficiaries.

Further, Audit randomly test-checked few of the pre-printed MA cards and their relevant records in the MA database maintained by the Department. Few illustrative deficiencies noticed in the test-check are discussed below -

- The pre-printed MA cards lacked photographs and finger prints of individual members of the family. Therefore, the beneficiaries faced difficulty in getting immediate treatment as the cards required modification at the time of availing treatment.
- In 916 out of 1,270 test-checked records of MA cards, the date of birth of the family members were either missing or found incorrect as there were difference of only four to six years in the age between parents and their children.
- Besides, the data extraction conducted in Audit revealed that in 19,10,700 out of 46,38,884 cases (41.19 *per cent*), the relationship with Head of Family (HoF) with the family member was mentioned as "Others". An example of such a case is shown in **Picture 3** -

57 A Centrally sponsored medical insurance Scheme for BPL population
58 (1) Jamnagar (552 cards), (2) Mehsana (2,718 cards), (3) Patan (1,149 cards) and (4) Rajkot (4,378)



Member Details

No	ID	Member Name	Sex	Relation	DOB	Mobile No	BG	Enrollment Date	Enrolled
1	1	XXXXXX	M	Self	01/06/1987	XXXXXX		31/07/2012	Yes
2	4	XXXXXX	F	Daughter	01/01/1986	XXXXXX		31/07/2012	Yes
3	5	XXXXXX	M	Other		XXXXXX		31/07/2012	Yes

Picture 3: Incorrect date of birth captured in MA Card (as captured from the MA database on 13-04-2017)

The above instances indicated that the bulk MA cards were pre-printed by the department in haste, without ensuring the correctness/integrity/reliability of RSBY beneficiary data, which posed problems of authentication afterwards.

The Government accepted (January 2018) the above facts and attributed the reason to the utilization of RSBY data for MA enrolment purpose. It was further stated that to overcome such issues, enrollment kiosks at each taluka and civic centres were rectified and super kiosks have been established at designated hospitals for rectifying the error at the hospital itself. The reply is not tenable as the beneficiaries could face difficulty in getting immediate treatment in emergency cases due to above deficiencies in the card which required modifications.

3.3.7.2 Deficiencies in enrolment process

The Taluka Kiosk Executive (TKE) captures all the documents, photos and fingerprints of all the family members. The Taluka Verification Authority (TVA) after verifying the documents captured by TKE accords approval for issue of MA/MAV cards to the beneficiaries and uploads the data to the main server for activation. During test-check in Audit, following deficiencies were observed –

- The scheme guidelines provide enrolment of a family under MA/MAV scheme up to five members of a family. Data analysis revealed that in 149 cases, the system enrolled more than five members of a family *i.e.* up to eight members of a family. This indicated lack of validation and input controls in the system.

- As per enrolment guidelines, verification of physical records and data entered by TKE is to be authenticated by the designated TVA through his fingerprints. Data analysis of fingerprints of the TKEs and TVAs revealed that in 286 cases, the data entry as well as authentication was done by using the same fingerprint. This indicated that the data entry, its authentication for verifying the documents and uploading of data was done by a single person. Therefore, the system was fraught with risk.

- Irrelevant photos/logos of MA had been uploaded in place of scanned copies of ration card, voter-id, *etc.* as shown in **Pictures 4 and 5.**

Picture 4: Ration Card of MA Card Number 13004130500101556275

Picture 5: Death Certificate of MA Card Number 22001710100101506378

(as captured from the MA database on 27.06.2017)

These indicated that the TVAs had validated the enrolment done by TKEs without proper and adequate verification of the physical documents with uploaded scanned documents. Further, the works done by TVAs and TKEs had not been monitored at any level before activation of the MA Cards.

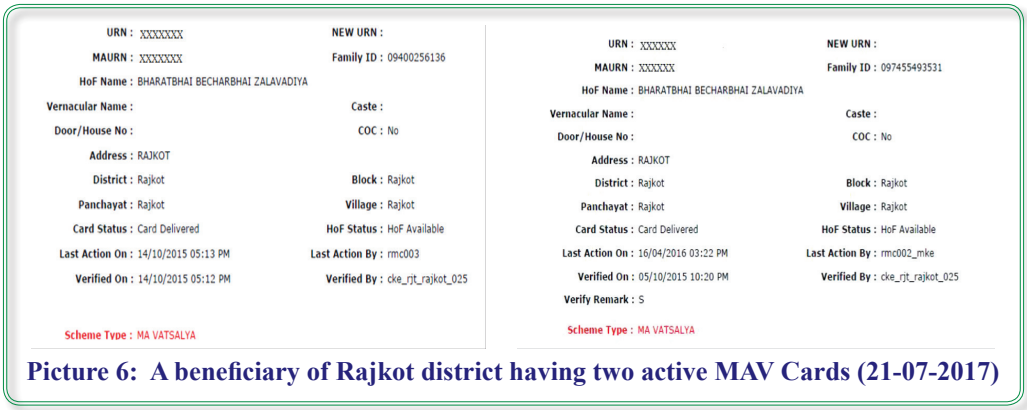
- The TKE at Modasa, Aravalli issued (2015-16) 2,291 MAV cards without following the prescribed procedure of enrolment process. The income certificates of these beneficiaries were not uploaded. The TKE himself had authenticated the enrolment through his fingerprints. Of these 2,291 beneficiaries, 26 beneficiaries had availed medical treatment (₹ 9.87 lakh) from various empanelled hospitals. It was observed that the State Government had issued orders (March 2016) for recovery of amount from the agency (NCS), however, the same could not be recovered till date (August 2017).

The Government accepted (January 2018) the deficiencies pointed out during the test-check in Audit and stated that these have been rectified. It was also stated that the software has been upgraded to prevent recurrences of such instances in future. However, subsequent online access into the system by Audit revealed (December 2017) that the above deficiencies have still not been rectified.

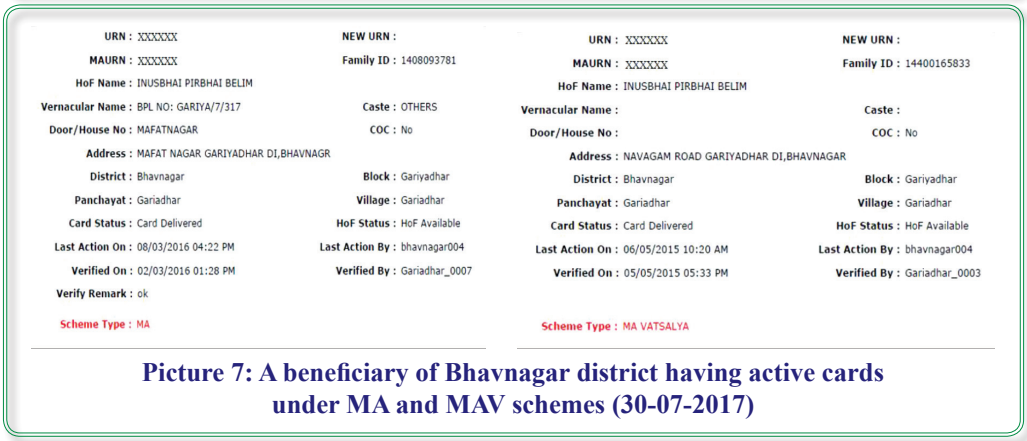
3.3.7.3 System to identify duplication in enrolment

To identify duplicate enrolment of beneficiaries and its deletion from the database, the State Government procured (2012-13) a '*de-duplication*' engine[59]. NCS was assigned the work to identify the duplicate entries by comparing the biometric fingerprint captured for each beneficiary. Audit observed that the said engine had not been put to use till date (August 2017) and the agency had not performed the said work despite issued (October 2016) instruction by the Executive Committee of SNC. Data analysis of 5,564 randomly test-checked cases in Audit revealed that 377 beneficiaries were having more than one active card *i.e.* two active cards under MAV or one active card in MA and one active card in MAV **(Pictures 6 and 7)**. This indicated that the system lacked adequate internal and validation controls to prevent enrolment of a person for more than one time and therefore was fraught with risk.

59 De-depulication is the processing of the biometric data of beneficiaries to remove instances of multiple enrolments by the same person.



Picture 6: A beneficiary of Rajkot district having two active MAV Cards (21-07-2017)



Picture 7: A beneficiary of Bhavnagar district having active cards under MA and MAV schemes (30-07-2017)

The Government attributed (January 2018) the reason for non-use of de-duplication engine due to long time taken by it for checking the duplicity which consequently resulted in delay in enrolment process. It was further stated that other control mechanism such as capturing of mobile numbers, ration card number, *etc.* has been implemented to restrain duplicity of enrolment.

3.3.8 Other findings

3.3.8.1 Revision of scheme benefit

The scheme guidelines provide (2012) reimbursement of expenses towards hospitalization and surgical procedures up to ₹ 2.00 lakh per year per family for 544 procedures for 11 clusters. The State Government revised (December 2015) the package rate of 544 procedures uniformly by 15 *per cent* which was further revised in May 2017. However, Audit observed that the State Government had not revised the scheme benefit/limit of ₹ 2.00 lakh despite increase in package rates of procedures. As a result, the beneficiaries could avail lesser benefits for the treatment under the scheme. Illustratively, the number of dialysis, a beneficiary could avail was 100 in pre-revised rate (₹ 2,000) which reduced to 87 dialyses after revision of package rates (₹ 2,300), within the overall limit of ₹ 2.00 lakh per annum.

3.3.8.2 Charging of money from beneficiaries

The scheme guidelines provide that in case of refusal of service or recovery of charges from MA beneficiaries or defective service and negligence by empanelled hospitals, the SNC may delist or de-empanel the hospital from the scheme. The SNC may also recover liquidated damages equivalent to 50 *per cent* of the Performance Security tendered by the empanelled hospital.

In three test-checked districts (Ahmedabad, Surat and Vadodara), Audit observed that nine hospitals had charged ₹ 9.23 lakh from 67 beneficiaries during 2012-17 as deposit and cost of investigation and medicines in contravention of the scheme guidelines. Hospitals of Vadodara district subsequently returned the money to 46 beneficiaries based on the instructions of CDHO (except for nine cases by a hospital[60]). Despite complaints made by the beneficiaries to the concerned CDHOs, the SNC had not taken any punitive/requisite action against these hospitals.

The Government stated (January 2018) that as there was no report of either charging money from the beneficiaries or denial of services by these hospitals, no action has been initiated. The reply is not tenable as the complaints received by concerned CDHOs had been forwarded to the SNC, however, action had not been initiated by SNC.

3.3.9 Monitoring and Grievance Redressal Mechanism

3.3.9.1 Taluka Level Grievance Redressal Committee

The scheme guidelines provided for constitution of Grievance Redressal mechanism at the State, district and taluka levels for monitoring the implementation of the scheme and redressal of the grievances of the beneficiaries. The State Government constituted (September 2012) State Level Grievance Redressal Committee (SLGRC) and instructed the district authorities to set-up the committees at district and talukas. The taluka committee was to ensure maximum coverage of BPL families of the taluka under the scheme. Audit observed that while district level committee had been constituted in all the districts, none of the talukas of the test-checked districts had constituted the committee till date (August 2017). This resulted in non-availability of redressal forum at taluka level for the grievances of the beneficiaries and non-monitoring of enrolment work at taluka levels.

3.3.9.2 Renewal of empanelment of hospitals

The scheme guidelines provide that each hospital shall enter into a service agreement with the State Government on empanelment, which shall be valid for a period of one year. The agreement had to be renewed every year. Audit observed that as of March 2017, the validity of service agreement had expired in respect of 40 out of 113 empanelled hospitals. As such, these hospitals were providing treatment to the beneficiaries under the scheme without valid service agreement since last one month to an year. This was fraught with risk because the bank guarantee (performance security) available with the Government against these agreements would have lapsed with the expiry of these agreements. As such, the same could not be invoked to safeguard the interest of the beneficiaries/ State Government in case of any lapse on the part of those hospitals.

3.3.10 Conclusion and Recommendations

3.3.10.1 Conclusion

The department could enroll only 54.54 *per cent* of BPL families in the State under the scheme as on 31 March 2017. No empanelled hospital was available in 10 out of 33 districts in the State. Only four districts in the State had empanelled

60 Himalaya Cancer Hospital, Vadodara

hospitals for all clusters, which forced the beneficiaries to move to other districts for availing treatment mainly for cancer, cardiac and paediatric. Seventy eight *per cent* of beneficiaries preferred to get treatment at private hospitals due to lack of adequate infrastructure and non-availability of specialist doctors in Government hospitals.

The department had not followed the enrolment procedure and opted for bulk printing of MA cards for BPLs already registered under RSBY scheme. These cards lacked vital information such as photographs, fingerprints, age, relationship, *etc.* which posed difficulties to the beneficiaries in getting immediate medical treatment.

Enrolment process at kiosks was also found deficient. Instances of non-monitoring of the work of TKE and authentication of the enrolment by TVA without verification of the records were also noticed. System to identify duplication in enrolment was not implemented which resulted in getting more than one active card by the beneficiaries.

Non-revision of financial limit available under scheme despite increase in package rates twice led to lesser benefits being available to beneficiaries. Instances of charging money by the empanelled hospitals were noticed which defeated very purpose of providing cashless treatment to the beneficiaries.

3.3.10.2 Recommendations

- ***Anganwadi workers, Non-Government Organisations, Corporate Bodies located in the district or adjoining areas, etc. may be engaged for creating more awareness to achieve higher enrolment of beneficiaries especially BPL families in the scheme.***
- ***Empanelment of more hospitals covering all clusters in the scheme may be explored besides improving medical facilities (infrastructure and specialist doctors) in the Government Hospitals to minimise movement of beneficiaries for treatment in other districts.***
- ***Monitoring mechanism for enrolment process may be strengthened to ensure issuance of cards to the eligible beneficiaries under the scheme duly authenticated by the Competent Authority.***

3.4 Unfruitful expenditure of ₹ 1.59 crore

Trauma Care Centre established at a cost of ₹ 1.59 crore could not be put to use due to non-appointment of Medical and Para-Medical Staff.

The Government of India (GoI) launched (2007-08) a scheme for development of network of Trauma Care Centres (TCCs) all along the East-West and North-West corridors of Golden Quadrilateral of National Highways during 2007-12. The scheme envisaged construction of TCC buildings, development of manpower, purchase of equipment, establishment of life support ambulances and communication system. The trauma care network has been so envisaged that no trauma victim has to be transported for more than 50 kilometers (kms.) and a designated trauma care facility is available at every 100 km. The Ministry of Health and Family Welfare (MOHFW) selected (October 2007 and August 2008)