HEALTH AND FAMILY WELFARE DEPARTMENT

3.3 Rural Health Services

Highlights

The review, interalia, highlights irrational establishment of rural health centres, irregular deployment of medical and paramedical staff, poor outturn of indoor patients, cases of diversion of funds, injudicious/unproductive expenditure and idle outlay, which adversely affected the delivery of health care services to the rural population.

There was irrational and excess establishment of rural health institutions in contravention of norms.

(Paragraph 3.3.12.1)

There was idle stock of health care kits worth Rs.41.19 lakh.

(Paragraph 3.3.13.1)

Rupees 27.72 lakh pertaining to rural health care services was diverted to urban health services.

(Paragraph 3.3.13.2

Rupees 25.71 lakh was paid to a supplier on the basis of fictitious stock entry before actual receipt of the medicines.

(Paragraph 3.3.13.3)

3.3.1 Introduction

The delivery of primary health care is the foundation of Rural Health Care System and forms an integral part of the National Health Care System. In Arunachal Pradesh, health care services in rural areas are provided through a network of Health Sub-Centres (HSC), Primary Health Centres (PHCs) and Community Health Centre (CHCs). The programme is funded by the Central and the State Governments.

The three tier health implementation programme (HSC, PHC and CHC) is based on rural population norms. According to the GOI's norms, in hilly and tribal areas, one HSC, one PHC and one CHC are to be set up for every 3,000, 20,000 and 80,000 population respectively. Each PHC with four to six beds and one medical officer is to cover six HSCs. Each CHC with 30 beds and four medical officers and other ancillary staff is to serve as a referral institution for four PHCs.

A sub-centre, manned by one multi-purpose worker (male) and one multi-purpose worker (female)/ANM, is the most peripheral contact point between HSC and the community.

A PHC, manned by one Medical Officer supported by 14 paramedical and other staff and having four to six beds, is the first contact point between the village community and Medical Officer. It acts as a referral unit for six sub-centres. The aim and objectives of a PHC involves curative, preventive, promotional medicare and family welfare services.

A CHC manned by four Medical Specialists supported by 21 paramedical and other staff and having facilities of 30 in-door beds with one OT, X-ray, Labour room and Laboratory, is the crucial First Referral Unit (FRU) which serves as a referral centre for four PHCs.

3.3.2 Audit objectives

The audit objectives were to assess whether:

- the policy formulated was based on prescribed norms;
- assessment of requirement of medical specialists and paramedical staff to run the rural health centres was made as per norms fixed;
- requisite manpower has been deployed in rural health centres;
- funds provided were used economically and efficiently to achieve the desired objectives; and
- the monitoring system evolved was effective and evaluation had been done to assess the achievement of the desired objectives.

3.3.3 Audit criteria

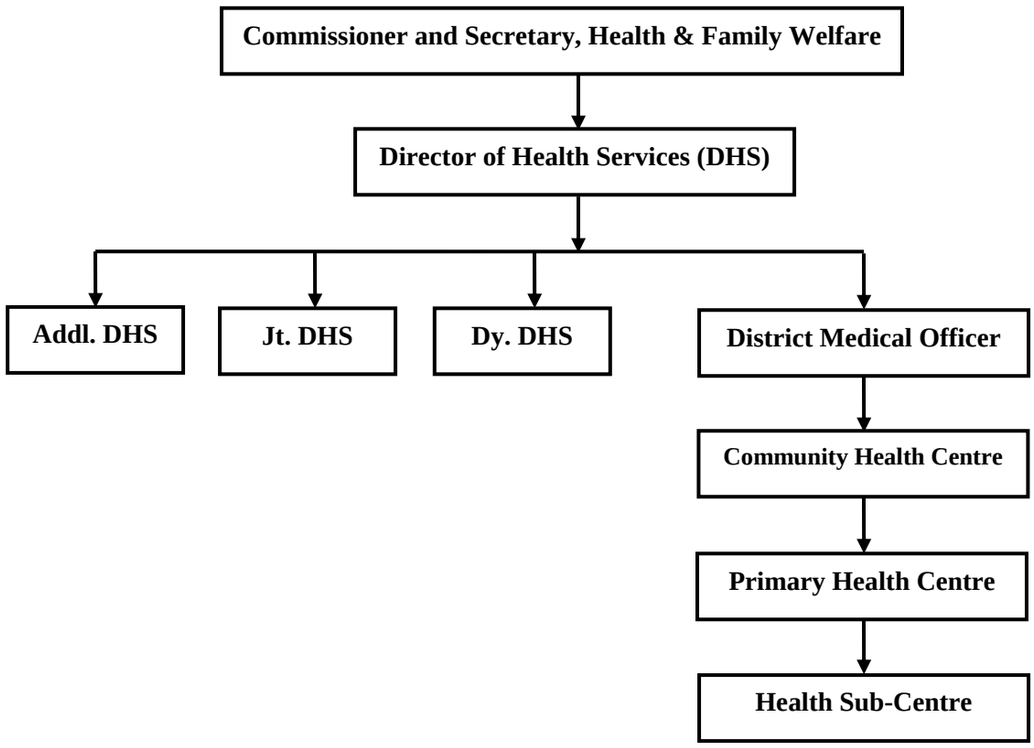
Audit examination was based on the following criteria:

- prescribed norms for establishment of health centres;
- targets fixed for setting up of health centres;
- Government orders regarding implementation of various health schemes and health centres;
- norms prescribed for proper functioning and delivery of rural health care services; and
- prescribed monitoring mechanism.

3.3.4 Organisational set up

The Organisational setup of rural health services in Arunachal Pradesh is given below:

Chart – 3.6



3.3.5 Audit coverage

Activities of rural health services in the State during 2001-02 to 2005-06 were reviewed in audit through a test check (March-June 2006) of the records of the Director of Health Services and DMOs of five districts out of 16 districts (31 *per cent*) viz. Papumpare, Lower Subansiri, Changlang, Tirap and West Siang and expenditure of Rs.73.60 crore (33 *per cent*) out of the total expenditure of Rs.225.49 crore was covered in audit.

3.3.6 Audit methodology

The review commenced with an entry conference with the Department of Health and Family Welfare, Arunachal Pradesh in February 2006 in which audit objectives, scope, criteria and methodology were explained. The districts were selected by stratified random sampling method and rural health centres were selected for test check on random sampling basis.

3.3.7 Financial management

The budget provision *vis-à-vis* expenditure for the five year period ending March 2006 was as under:

Table – 3.9

(Rupees in lakh)

Year	Provision			Expenditure			Excess (+) Savings (-)
	Plan	Non-Plan	Total	Plan	Non-Plan	Total	
2001-02	1188.17	2989.24	4177.41	1185.68	2891.17	4076.85	(-) 100.56
2002-03	1232.53	2896.99	4129.52	839.92	2932.93	3772.85	(-) 356.67
2003-04	1155.85	3240.59	4396.44	1187.67	3336.63	4524.30	(+) 127.86
2004-05	1031.56	3484.39	4515.95	1477.28	3631.77	5109.05	(+) 593.10
2005-06	652.85	4143.48	4796.33	719.04	4029.70	4748.74	(-) 47.59
Total	**5260.96**	**16754.65**	**22015.65**	**5409.59**	**16822.20**	**22231.79**	**(+) 216.14**

Source: Detailed Appropriation Accounts and information furnished by the DHS.

Reasons for excess/savings were neither on record nor stated (July 2006).

3.3.8 Diversion of fund

Pradhan Mantri Gramodaya Yojana (PMGY) was launched during 2000-01 with the objective of achieving sustainable human development at the village level. In order to complement the resources of the State Government to achieve the objectives of the programme, Additional Central Assistance (ACA) under PMGY was provided during 2002-03 to the State Government to gear up the primary health system. As per the guidelines for implementation of PMGY during 2002-03, the Planning Commission specifically directed the State and UTs to ensure that there is no diversion of funds to non-PMGY sectors. It was, however, seen in Audit that during 2002-03, Rs.27.26 lakh was diverted to urban health services, out of ACA under PMGY for procurement of medicines for General Hospitals at Naharlagun and Pasighat (Rs.18.55 lakh and Rs.8.71 lakh).

It was stated (May 2006) by the Deputy Director (S&T) that although the General Hospitals at Naharlagun and Pasighat fall under urban area of Arunachal Pradesh, they cater to specialised medical treatment to patients from rural areas. The reply is not tenable as diversion of funds is against GOI guidelines and the General Hospitals fall under urban health services and specific provision is separately made by the State Government for procurement of medicines for them. Further, the Department failed to produce any record to indicate the number of rural population to whom specialised treatment was provided.

There were deficiencies in financial management, leading to excess expenditure and diversion of funds. There were also instances of idle expenditure, diversion of funds and extra expenditure as would be evident from the observations made in the succeeding paragraphs.

3.3.9 Planning

Effective implementation of the programme for delivery of rural health services depends on proper planning for establishment of health centres and provision of requisite manpower and infrastructure.

It was noticed that though the Department established the centres, the aspect of providing requisite medical and paramedical staff was never taken into consideration before setting up the centres. There was no plan or policy formulated in this regard and as a result, many HSCs established were functioning with only one health worker against the norm of two.

3.3.10 Audit findings

A HSC constructed at a cost of Rs.4.92 lakh in the test checked Tirap district could not be made functional despite shortage of HSCs in the district. Also, Rs.27.26 lakh pertaining to rural health care services was diverted to urban health services for procurement of medicines (Para 3.3.8) and there was idle stock of health care kits worth Rs.40.38 lakh. These have been discussed in detail in the succeeding paragraphs.

3.3.11 Implementation

3.3.11.1 Establishment of rural health centres – targets and achievements

The targets *vis-à-vis* achievements in establishing CHC, PHC and HSC during the five years ending March 2006 were as under:

Table – 3.10

Year	Target			Achievement			Shortfall (-)Excess (+)		
	CHC	PHC	HSC	CHC	PHC	HSC	CHC	PHC	HSC
2001-02	1	7	11	1	7	4	-	-	(-) 7
2002-03	5	8	24	5	7	12	-	(-) 1	(-) 12
2003-04	1	5	16	1	5	2	-	-	(-) 14
2004-05	4	11	42	4	11	11	-	-	(-) 31
2005-06	1	1	50	1	1	8	-	-	(-) 42
Total	**12**	**32**	**143**	**12**	**31**	**37**	**-**	**(-) 1**	**(-) 106**

Source: Information furnished by the Directorate of Health Services.

The above table shows that during 2001-02 to 2005-06, the Department could establish only 26 *per cent* of the targeted HSCs which are the basic contact point between the primary health care system and the rural community. The reasons stated for shortfall in achieving the targets were paucity of funds and lack of manpower. Failure to establish these basic contact points reveals deficient and improper planning and implementation.

3.3.12 Infrastructural facilities

The minimum infrastructural facilities that are expected to be available in the rural health centres are medical and para-medical staff, hospital beds, furniture, X-ray machines, mobile facilities, testing and diagnostic facilities, etc. Deficiencies in infrastructural facilities noticed during audit are indicated below:

3.3.12.1 Irrational establishment of rural health institutions

According to GOI norms for establishment of rural health centres in hilly and tribal areas, one HSC, one PHC and one CHC are to be established for every 3,000 population, 20,000 population and 80,000 to 1,00,000 population respectively.

Test check of records and information collected from the DHS revealed the following position with regard to establishment of rural health centres as on 31 March 2006, the rural population being 8.68 lakh as per the 2001 census.

Table – 3.11

Centres	Requirement of Centre as per GOI norms	Actual number of Centres established	Excess (+) shortfall (-)	Percentage of excess (+)/ shortfall (-)
HSCs	290	266	(-) 24	(-) 8
PHCs	43	83	(+) 40	(+) 93
CHCs	13	32	(+) 19	(+) 146

Source: Information furnished by Director of Health Service.

As regards CHC and PHC it was observed that there were already seven CHCs and nine PHCs in excess in 14 districts till March 2001. However, further 12 CHCs and 31 PHCs were set up in those districts as of March 2006. On the contrary, there was a shortage of 61 HSCs till March 2001, against which only 37 HSCs were set up as of March 2006, leaving a shortage of 24 HSCs and thus, denying basic primary health care facilities to 0.72 lakh (24 x 3000) rural population. Setting up of excess CHCs and PHCs over norms was not justified as discussed in paragraphs 3.3.12.2 and 3.3.12.3.

3.3.12.2 Irrational deployment of manpower

According to the national norms, there should be four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician and 21 paramedical and other staff in each CHC, one medical officer and 14 paramedical and other staff in each PHC and two health workers/ANM (one male and one female) in each HSC. The actual deployment *vis-à-vis* requirement of manpower in 11 CHCs, 30 PHCs and 71 HSCs in five test checked districts was as under:

Table – 3.12

No	Requirement		Actual deployment		Excess (+) shortfall (-)		Percentage of excess/shortfall	
	MO	Paramedical and other staff	MO	Paramedical and other staff	MO	Paramedical and other staff	MO	Paramedical and other staff
CHC								
11	44	231	37	365	(-) 7	(+) 134	(-) 16	(+) 58
PHC								
30	30	420	36	382	(+) 6	(-) 38	(+) 20	(-) 9

No.	Requirement	Actual deployment	Excess	Percentage of excess
	Health worker/ANM	Health worker/ANM	Health worker/ANM	Health worker/ANM
HSC				
71	142`	198	56	39

Source: Information furnished by the Department

It would be seen from the above table that in CHCs, there was 16 *per cent* shortfall in deployment of medical officers and 58 *per cent* excess deployment of paramedical and other staff. In PHCs, there was 20 *per cent* excess deployment of medical officers and nine *per cent* shortfall in deployment of paramedical and other staff. In HSCs there was 39 *per cent* excess deployment of staff. Justification for deviation from National norms was not available on record.

Besides, as per norms, HSCs are to be manned by two ANMs (one male and one female). It was, however, seen that in four out of five test checked districts, eight medical officers (including one homeopath) were deployed in excess in the HSCs viz. Papumpare (three), Changlang (two), Tirap (one homeopath), and West Siang (two). The services of medical officers could have been utilised by deploying them to the Centres which were running without medical officers. Justification for deviation from National norms was not available on record.

In Doimukh CHC under Papumpare District, there was deployment of 10 medical officers including two dental surgeons and 87 paramedical and other staff as against the norm of 4 medical officers and 21 paramedical staff in respect of CHCs, the percentage of excess deployment being 150 in respect of medical officer and 314 in respect of paramedical and other staff. Justification for deviation from National norms was not available on record.

3.3.12.3 Poor out turn of indoor patients

The PHCs and CHCs were established to provide health care facilities to both indoor and outdoor patients. The position of indoor patients in the PHCs and CHCs in the test checked districts was as follows:

Table – 3.13

Name of the district	Health centre (No. of beds)	Availability of beds in a year	No. of patients admitted during 2001-06	Average no of patients in a year	Percentage of beds occupied with reference to number of beds available	Shortfall of patients with reference to Col 3 (percentage)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Papumpare	Doimukh CHC (30)	10950	1387	277	3	10673 (97)
	Kimin PHC (14)	5110	17096	3419	67	1691 (33)
	Balijan PHC (6)	2190	6300	1260	88	930 (12)
	Basarnello PHC (6)	2190	2337	467	32	1723 (68)
Lower Subansiri	Old Ziro CHC (12)	4380	-	-	-	4380 (100)
	Yazali PHC (8)	2920	-	-	-	2920 (100)
	Yachuli PHC (8)	2920	-	-	-	2920 (100)
	Raga PHC (8)	2920	-	-	-	2920 (100)
Changlang	Miao CHC (30)	10950	4978	996	9	9954 (91)
	Nampong CHC (11)	4015	2043	409	10	3606 (90)
	Jairampur (6)	2190	1946	973	44	1217 (56)
	Kharsamg PHC (6)	2190	-	-	-	2190 (100)
	Namtok PHC (6)	2190	-	-	-	2190 (100)
	Khimiyong PHC (6)	2190	-	-	-	2190 (100)
Tirap	Longding CHC (16)	5840	12405	2481	45	3359 (55)
	Kanubari PHC (8)	2920	3110	662	23	2258 (77)
	Pongchau PHC (6)	2190	-	-	-	2190 (100)
	Laju PHC (6)	2190	-	-	-	2190 (100)
Along	Basar CHC (30)	10950	28881	5776	53	5174 (47)
	Likabali CHC (30)	10950	1768	354	3	10596 (47)
	Liromoba PHC (6)	2190	839	167	38	1351 (62)

Source: Information furnished by the concerned DMOs and MOs of the centres

The table indicates poor utilisation of facilities in the CHCs/PHCs. In the CHCs, the shortfall with reference to the number of beds available in a year ranged between 47 and 100 *per cent* while in the PHCs it ranged between 12 and 100 *per cent*. In the lone CHC (Old Ziro) as well as in three PHCs under Lower Subansiri district, no indoor patients were admitted during the period covered under review (2002-06). It was stated (May 2006) by the DMO, Lower Subansiri district, Ziro, that no indoor patient could be entertained in the health institutions under the district due to shortage of Medical Officers and lack of dietary facilities. Thus, due to lack of manpower and dietary

provision in the health institutions under the district, the rural population were deprived of indoor treatment facilities.

3.3.12.4 Idle expenditure on construction of health centre buildings

It was observed that in Tirap District the requirement of HSCs was 33 against which 25 HSCs were functional. The records further revealed that a building for one HSC viz Pongkong sub-centre[33] was constructed at a cost of Rs.4.92 lakh during 1996-97. The HSC has, however, not been made functional due to shortage of manpower. Thus besides the rural population of the area being deprived of proper health care facilities, the expenditure of Rs.4.92 lakh on construction of the building which remained unutilised for the past ten years proved unproductive.

3.3.12.5 Lack of mobile facilities

For consolidation of PHCs, CHCs and hospitals in Arunachal Pradesh, a Draft Project Report (DPR) was prepared by the Department. The DPR, projecting a grant of one time Central Assistance of Rupees three crore, was sent to the Planning Commission. The proposed assistance included a sum of Rs.84.00 lakh for procurement of 21 ambulances for selected PHCs and CHCs. Accordingly, the Planning Commission released a sum of Rupees one crore as one time Central Assistance during 2001-02. It was, however, noticed in Audit that the purchase of ambulances could be finalised by the Department only in 2004-05. In the mean time, there was escalation of price and the Department could purchase only 19 ambulances instead of 21 ambulances with the allotted sum of Rs.84.00 lakh.

Thus, delay in finalisation of purchase led to two rural health institutions being deprived of the ambulance facility.

3.3.12.6 Delivery of dental care services

The delivery of primary health care is the foundation of rural health care system and forms an integral part of national health care system. Providing dental care at peripheral level is an integral component of primary health care.

Scrutiny of records revealed that dental surgeons were posted in CHCs viz., Doimukh, Basar and Miao with infrastructural facilities like physiological dental chairs etc. Apart from that, major CHCs/PHCs were neither equipped with infrastructure nor was any dental surgeon provided. This shows that delivery of dental facilities were partial in the state leaving a majority of the rural population without any dental care service.

3.3.12.7 Idle X-ray machine

For delivery of rural health care services, the Department provided X-ray machines to various CHCs. Out of 11 CHCs in five test checked districts,

[33] *Pongkong Sub-centre (Tirap District) Rs.4.92 lakh.*

X-ray machines were provided in seven CHCs all of which remained non functional as detailed below:

Table – 3.14

Name of the District	Name of Centre	Present Status	Cost (Rs. in lakh)	Reasons for non-functioning
Papum Pare	Sagalee CHC	Installed in May 1998, remained non functional till May 2000, again not functioning w.e.f. 22.7.03	5.36	Defect in the machine
Tirap	Longding CHC	Not installed	NA	Non-availability of X-ray room and Radiographer
	Deomali CHC	-do-	NA	-do-
Changlang	Miao CHC	Not functioning since 2000-01	NA	Defective machine
West Siang	Mechuka CHC	Not functioning since 1996	NA	Defective machine
	Basar CHC	-do-	NA	-do-
	Rumgong CHC	Not installed since receipt of the machine during Feb' 96	4.78	Defective machine

Source: Information as furnished by the Department

In all the above mentioned health institutions, the non-functioning of X-ray machines resulted in denial of X-ray facilities to the patients which was one of the main sources of diagnosis of diseases.

3.3.12.8 Deployment of idle radiographers

X-ray machine provided to Sagalee CHC under Papumpare District was not functioning since July 2003 and the Radiographer posted in the CHC remained idle since then. No action was taken by the Department either to get the machine repaired to make it operational or to transfer the Radiographer elsewhere for utilisation of his services. During the period from July 2003 to March 2006, the Department incurred an idle expenditure of Rs.1.80 lakh[34] on account of salary and allowances of the Radiographer. Similarly, Balijan PHC under the same district was not provided with any X-ray machine since March 2001, but a Radiographer was deployed in the PHC. Thus, deployment of idle Radiographer in the PHC led to unproductive expenditure of Rs.2.44 lakh[35] towards his pay and allowances for the period from March 2001 to March 2006.

3.3.12.9 Absence/inadequate testing facilities

Testing facility is an integral part of delivery of health care services. During test check of the records of five selected districts, it was seen that testing facilities in CHCs/PHCs were either not available or where available, were

[34] *Rs.4000 x 45 (July 2003 to March 2006) = Rs.1,80,000.*
[35] *Rs. 4000x 61= Rs.2,44,000.*

inadequate due to absence of laboratory re-agents and other required materials and absence/non-posting of laboratory technicians/assistants.

3.3.13 Procurement and distribution of medicines and equipment

Medicines were procured both by the DHS and the DMOs, machinery and equipment were procured by the DHS and then distributed to the DMOs. Irregularities noticed in procurement and distribution of medicines/ equipment/furniture are discussed in succeeding paragraphs:

3.3.13.1 Idle stock of health care kits worth Rs.41.19 lakh

In order to provide better health care coverage in rural areas (HSCs, PHCs and CHCs), kits worth Rs.140.57 lakh were procured during March 2004 out of PMGY funds. Records revealed that health care kits worth Rs.17.80 lakh were lying in the stock of DHS till date (June 2006) without being distributed to the rural health centres for which procurement was made.

The records of five test checked districts also revealed that health care kits worth Rs.23.39 lakh (Lower Subansiri: Rs.4.00 lakh, Papumpare: Rs.5.35 lakh, West Siang: Rs.3.91 lakh, Changlang: Rs.1.16 lakh, Tirap: Rs.8.97 lakh) received from DHS were lying in the stock of respective DMOs.

Since the health care kits are lying in the stock for a prolonged period, it is evident that the procurement was made without assessing immediate requirement of the materials.

3.3.13.2 Diversion of hospital furniture and medical/surgical equipment worth Rs.27.72 lakh

To make 30 PHCs fully functional, hospital furniture and medical/surgical equipment worth Rs.59.40 lakh was purchased from PMGY fund during March 2004. But it was seen that equipment worth Rs.27.72 lakh (@ Rs.1.98 lakh per centre) were issued to 11 CHCs and 3 HSCs. Thus, while the intention was to make 30 PHCs fully functional by providing the centres with hospital furniture, medical and surgical equipments, materials worth Rs.27.72 lakh was instead issued to 11 CHCs and 3 HSCs depriving 14 PHCs of the intended materials to make them fully functional.

Besides, it was seen that in case of Tirap district, hospital furniture and medical/surgical equipments worth Rs.4.73 lakh were lying in the stock of DMO, Khonsa without being distributed to the centres concerned. It would thus appear that the purchases were made without assessing the actual requirement since the materials were lying unutilised since the date of procurement (March 2004).

3.3.13.3 Payment to supplier based on fictitious entry

Between July 2005 and September 2005, the DHS made payment to a local firm against central procurement of essential and life saving medicines valued at Rs.1.93 crore on the basis of certificate of stock entry on the body of the bills. Out of the total procurement, 80 *per cent* was to be issued to the district against the indents placed by them and 20 *per cent* was to be retained in the headquarters as buffer stock.

Scrutiny of the delivery challans produced to Audit revealed that medicines worth Rs.25.71 lakh were supplied during November 2005 (Rs.1.25 lakh) and January 2006 (Rs.24.46 lakh) although payments were made during July 2005 to September 2005. On this, the Department stated (May, 2006) that verification of medicines would be done by the Board of the Directorate. Thus, it is evident that Rs.25.71 lakh was paid to the suppliers on the basis of fictitious entry on the bills as well as in the stock book.

3.3.13.4 Extra expenditure on procurement of hospital furniture and medical/surgical machinery and equipment

With a view to strengthen the existing facilities in Government hospitals and dispensaries in the State under a one time Central Assistance, a Purchase Board was constituted in March, 2004.

The Board forwarded its recommendations to the Government for procurement of materials from the manufacturing companies as per the comparative rates quoted by the tenderers. But the Finance Department turned down the recommendations of the Board on the plea that after sale service clause had not been quoted by the recommended firm in the tender and directed the Department to procure the materials directly from the local dealer of the manufacturer. Accordingly, the Department procured (March 2005) 14 different items from a local authorised dealer and incurred an expenditure of Rs.74.04 lakh. Procurement of furniture/machinery and equipment from a local dealer at higher rates than those quoted by the manufacturing companies resulted in excess expenditure of Rs.9.84 lakh in respect of seven out of 14 items thus procured (**Appendix – XXIX**).

The distribution details of 14 items procured, revealed that medical equipment worth Rs.5.51 lakh procured for rural areas viz., PHCs & CHCs were diverted to an urban, the district hospital. It was further observed that the materials valued at Rs.3.15 lakh meant for PHCs & CHCs remained unutilised till the date of Audit (June 2006).

It was stated (June 2006) by the DMO Tirap District, Khonsa that the OT Improved and OT Light Medium meant for Longding CHC were not issued to the centre due to the absence of infrastructure and specialised manpower and the Binocular Microscope and Autoclave Vertical were not received by the staff of Panchao PHC as the centre was running without Medical Officer for

the past several years. The DMO West Siang District stated (June 2006) that the machinery and equipment worth Rs.2.17 lakh could not be installed at the rural health centres due to absence of infrastructure like electricity and manpower.

Thus, due to absence of proper planning and assessment of the ground level requirements by the Department, there was diversion, idle outlay of materials and excess expenditure on procurement of materials from local dealer. As a result the Department failed to deliver the intended benefits to the rural inhabitants of the concerned localities.

3.3.14 Monitoring and evaluation

Successful implementation of the programme depends upon proper monitoring and evaluation. According to the GOI's guidelines a three-tier system of monitoring viz, district, State and Central level needs to be devised and monitoring at the State level should be more detailed. There was however, no internal monitoring mechanism in the Department to oversee the performance in implementation of the programme under rural health services and the overall impact of implementation was not evaluated. Thus, the performance of the Department/Government towards delivery of rural health care services remained un-assessed.

3.3.15 Conclusion

The delivery of rural health care services was unsatisfactory in the State because of the failure of the Government in establishing the required number of HSCs, non functional HSCs, irrational deployment of manpower, lack of ambulance facilities, blocking and irregular diversion of funds, non functioning/non provision of X-ray machines, furniture etc. The impact of implementation of the programme was not evaluated and no monitoring system was in place, to oversee the performance of rural health care services.

The matter was reported to the Government/Department (August 2006); reply had not been received (November 2006).

3.3.16 Recommendations

On the basis of the shortcomings and deficiencies pointed out in the foregoing paragraphs the following recommendations are made for streamlining the system of health care services:

- **The State Government should devise norms for establishment of Rural Health Centres taking into consideration the ground realities of the State, in consultation with the GOI and strictly follow such norms for opening of Rural Health Institutions.**

- **The Government should ensure effective and efficient functioning of existing CHCs, PHCs and HSCs with requisite**

complement medical and paramedical staff including medicines before opening new CHCs or PHCs.

- **Utilisation of funds ear marked for rural health care should be strictly ensured.**

- **A comprehensive and effective and efficient monitoring and evaluation system to assess the performance should be established.**

- **The State Government should display information for all their projects as required under the Right to Information Act.**

APPENDIX – XXIX

Statement showing excess expenditure incurred on procurement of furniture and medical/surgical machinery and equipments

(Reference: Paragraph 3.3.13.4; Page 80)

(in Rupees)

Sl No.	Name of Machinery and equipment	Rate quoted as per limited tender (4% CST exclusive)	Procurement rate as per supply order dt. 24.3.05	Difference	Quantity	Amount
1.	Microscope Pathological	6,864	8,130	1,266	2	2,532
2.	Q.B.C. with Q.B.C. Haematology analyzer	9,20,400	9,36,000	15,600	1	15,600
3.	Suction apparatus	8,840	19,084	10,244	39	3,99,516
4.	O.T. light shadow less 28”	72,072	78,000	5,928	4	23,712
5.	Obstetric labour table	18,616	20,789	2,173	2	4,346
6.	Anaesthesia machine	2,56,880	3,75,000	1,18,120	4	4,72,480
7.	Generator 10HP	65,416	70,902	5,486	12	65,832
Total						**9,84,018**