3.3 Karnataka Health Systems Development Project

Highlights

The Karnataka Health Systems Development Project (Project) was launched in April 1996 with the assistance of World Bank at an estimated cost of Rs.546 crore to strengthen the secondary level of health care by providing in-patient and out-patient care with diagnostic and treatment facilities that were not available at the primary level. The project was to become operational by the end of 2001-02. Due to slow progress, however, the implementation of the project was extended by two years. The project is expected to be completed by March 2004.

Cost of civil construction works such as renovation and expansion of existing hospital buildings increased by Rs.234.42 crore due to changes in scope of work after the works were started/under execution.
(Paragraph 3.3.6)

Deviations to original plan of procurement, distribution and poor utilisation of equipment and non/short procurement of drugs affected adversely the delivery of health care services to the needy. Vehicles like jeeps and cars were procured in contravention of prescribed norms while ambulances for 24 hospitals were not procured.
(Paragraph 3.3.7)

Ineffective functioning of referral system in the first referral hospitals and non-availability of an IEC (Information, Education and Communication) strategy failed to educate and inform the public of the facilities and the extent of health care service available in these hospitals.
(Paragraph 3.3.9)

Lack of adequate training to the staff to handle sophisticated equipment in the first referral hospitals resulted in non-utilisation of available equipment. In other cases, managers and physicians trained abroad on teaching skills were not utilised for the benefit of the project.
(Paragraph 3.3.13)

Monitoring and evaluation of project performance was not effective.
(Paragraph 3.3.15)

3.3.1 Introduction

The National Health Policy (1983) emphasises the role and responsibility of the State Governments in providing basic health facilities. The Public Health Care services in Karnataka consist of three tiers viz., primary, secondary and tertiary. Primary Health Centres (PHCs) provide basic health services at grass root level with emphasis on prevention. The secondary level of health services consists of hospitals located at community, area, sub-divisional and district levels. These are also called first referral hospitals, which provide in-patient and out-patient care with the diagnostic and treatment facilities that are not available at the primary level. Tertiary hospitals at the top of the structure

are staffed and equipped to provide more specialised treatment and include teaching hospitals also.

As facilities available at first referral hospitals remained poor, people were compelled to proceed to higher level hospitals for availing treatment that could otherwise be made available at first referral hospitals. Realising the need to strengthen the vital link of referral care, Government of Karnataka launched (April 1996) a programme called 'Karnataka Health Systems Development Project' (KHSDP) with the assistance of World Bank at an estimated cost of Rs.546 crore for implementation over a period of six years.

3.3.2 Objectives

The broad objectives of the project are:

- Improving the health care system through improvements in the quality, effectiveness and coverage of health services at 204 secondary or first referral hospitals through expansion/renovation.
- Strengthening management and implementation capacity.
- Improving referral mechanism and linkages with primary and tertiary level.
- Improving access for disadvantaged sections of society.
- Achieving better efficiency in the allocation and use of health resources.

In order to achieve the above objectives, the project envisaged providing adequate financial resources to the health sector, introduction of annual health check-up programmes to Scheduled Caste and Scheduled Tribe population, up-gradation of clinical and support services by outsourcing, collection of user charges for augmenting resources for health care besides imparting training to project staff in clinical skills.

3.3.3 Organisational set-up

A Project Governing Board (PGB) was established for taking major policy decisions, developing broad outlines for project implementation, reviewing and monitoring the over all project progress. A Steering Committee headed by the Secretary to Government, Department of Health and Family Welfare was constituted to undertake planning activities for the project and to carry out the functions of the PGB. A Project Administrator is in overall charge of the project and is assisted on technical side by an Engineering Wing headed by a Chief Engineer and on hospital side by an Additional Director/Joint Director, supported by four Deputy Directors and on Administration/Finance by a Chief Administrative Officer/Chief Finance Officer with supporting staff.

3.3.4 Audit coverage

Records maintained at Project Administrator's office, Chief Engineer's office, three Engineering Divisions, five District Health and Family Welfare Offices (DHFWO) were test-checked during December 2002 to May 2003 from

inception of the project to March 2003 besides conducting review at 50 hospitals. The findings of the review are discussed below:

3.3.5 Project cost and time schedule

The project was undertaken (April 1996) with the assistance of World Bank at an estimated cost of Rs.546 crore and was proposed to be implemented in six years (March 2002). Due to slow progress in implementation of the project, World Bank agreed to extend assistance for two more years (March 2004). The cost of the project was revised to Rs.595 crore (February 2002) and an expenditure of Rs.582.12 crore was incurred up to the end of March 2003. The original cost, the revised cost of the major components and the expenditure thereof are as stated below:

(Rupees in crore)

Sl No.	Project component	Original cost	Percentage of the original project cost	Revised cost	Percentage of the revised project cost	Expenditure up to March 2003
1	Investment costs Civil works (Renovation and expansion)	120.58	22.09	355.00	59.67	336.53
2	Goods and equipment	160.12	29.34	113.00	18.99	96.55
3	Consultants, studies, training	30.06	5.51	23.30	3.92	15.94
4	Recurring costs	99.32	18.20	103.60	17.41	133.10
5	Physical contingencies and price escalation	135.72	24.87	-	-	-
GRAND TOTAL		545.80		594.90		582.12

3.3.6 Programme implementation

The programme implementation consisted of execution of civil works to renovate and expand the first referral hospitals, and upgrading clinical services through procurement of equipment, drugs, ambulances, vehicles, furniture, etc.

Civil works

Cost of civil construction works such as renovation and expansion of existing hospital buildings increased by Rs.234.42 crore due to changes in scope of work after the works were started/ under execution

The Staff Appraisal Report (SAR) on the project estimated the cost of civil works involving renovation and expansion of 204 hospitals at Rs.120.58 crore. However, on detailed re-estimation, the cost went up by 84.94 *per cent* to Rs.223 crore, which was further revised to Rs.355 crore in the revised project cost (February 2002). Out of 204 hospitals taken up for renovation and expansion, 186 hospitals were completed (March 2003) and 166 of them had been handed over, even though the project originally contemplated completion of all civil works by 2000.

The abnormal increases in the cost of civil works were due to inaccurate estimates at appraisal stage and change in scope of works after tendering, leading to additional quantities of work and extra items of work, payments at current schedule of rates plus tender premium quoted by contractors etc. Finalisation of designs and drawings, preparation of plans and estimates including Bill of Quantities of work to be included in the tender agreement were entrusted to empanelled architects at a cost of Rs.7.49 crore (out of which Rs.5.79 crore had been paid to the end of March 2003). However, owing to preparation of designs, drawings, plans and estimates by architects without reference to the actual site conditions, large scale deviations were noticed and the additional quantities and extra items of work were executed

involving an extra expenditure of Rs.68.32 crore. In view of this, payment of consultancy charges to empanelled architects proved to be unproductive.

Some of the other irregularities noticed in the execution of civil works were as follows:

- During the renovation and expansion of Taluk Level Hospital (TLH) at Hungund, there was delay in deciding, after the award of work to an agency, as to whether the building should be constructed in the existing premises or at a new site. This resulted in avoidable extra cost of Rs.21 lakh being payment at revised rates as per the terms of agreement.
- The High Level Working Committee of the project had prescribed norms for providing space in each category of hospital. Accordingly, the total plinth area to be constructed for eight new hospitals was 17,859 sqm. However, the actual area constructed was 28,580 sqm involving an extra cost of Rs.7.40 crore. No reasons were assigned for constructing plinth area in excess of the prescribed norms.
- An expenditure of Rs.1.34 crore had been incurred on renovation and expansion of District Hospital, Gadag, which was situated on land belonging to a trust.
- Guidelines of World Bank allow execution of works on 'Force Account' (based on local quotation) only when the value of work to be executed did not exceed Rs.18 lakh. In six cases, it was noticed that Force Account was invoked even when the value of works executed exceeded Rs.30 lakh individually (totalling Rs.2.15 crore). Failure to follow prescribed open tender procedure resulted in the project losing the benefit of prevailing competitive rates.
- About Rs.one crore was spent on construction of Office buildings for Superintending Engineer and Chief Engineer at Bangalore, Divisional Office at Mysore and renovation of Project Office, which were not covered in the scope of the project resulting in irregular diversion of funds of Rs.one crore.
- Extra items of work in 31 works were carried out without approval of competent authority, despite instructions of Project Governing Board (October 2000) to that effect. The total expenditure incurred on such irregular works was Rs.16.89 crore.

3.3.7 Upgrading clinical effectiveness

The upgrading of clinical services includes supply of equipment, drugs, ambulances, vehicles, furniture etc., for which a provision of Rs.160.12 crore was made in the original project estimate. This was scaled down to Rs.113 crore in the revised project estimate, for which reasons were not assigned.

Review revealed non-utilisation or underutilisation of equipment, non-procurement or short procurement of drugs, ambulances and excess procurement of vehicles. The shortfall/deficiency noticed in audit in each category are detailed below:

Equipment – Procurement and utilisation

A High Level Working Committee prescribed norms for equipment and furniture to be provided in each type of upgraded hospital based on bed strength. A procurement plan was prepared by the consultants after assessing the requirement of each hospital. However, scrutiny of records revealed that:

Deviations to original plan of procurement, distribution and poor utilisation of equipment and non/short procurement of drugs adversely affected the delivery of health care services to the needy

- There were deviations to original procurement plan. While equipment worth Rs.1.06 crore were procured in excess of the assessed requirements, a number of other essential items (X-Ray machine, emergency resuscitation kits, autoclaves, opthalmoscopes, generators, ventilators) were either not procured or were procured short of assessments made despite adequate allocation of funds. Thus, the benefits of upgraded facilities at first level referral hospitals did not accrue to the public.
- Scrutiny in 50 test-checked hospitals revealed that in four hospitals, major surgeries could not be performed due to short supply/non-supply of essential equipment. Consequently, the cases were referred to other hospitals. In the test-checked hospitals, equipment such as ECG machines, ultra sound scanners, dental units etc., worth Rs.1.65 crore procured between 1997-98 and 2001-02 remained unutilised for two to five years due to non-availability of specialists/doctors/trained staff and incomplete infrastructure. In five test-checked hospitals, the equipment procured between April 1998 and December 2002 were yet to be unpacked (June 2003).
- It was noticed that purchase of equipment was not synchronised with the creation of related infrastructure (1996-99). An amount of Rs.18.26 crore was spent on procurement of equipment even before providing the basic infrastructure. Equipment worth Rs.94.00 lakh were later diverted to other major hospitals not covered under the project during 1997-2003. No reasons were given for such diversions.
- While procuring 29 Ultrasound Scanners at a cost of Rs.1.50 crore through HCL Packers Limited (October 1997), the project authorities did not avail customs duty exemption despite availing the services of procurement consultants. This resulted in an avoidable extra expenditure of Rs.48.00 lakh. The project authorities had also not obtained refund of Rs.five lakh being unutilised balance of Letter of Credit (LoC) opened with bankers. Similarly, unutilised balance of Rs.10.00 lakh out of the LoC opened for procurement of 26 Ultra Sound Scanners through Wipro GE Medicals during 1999-2000 had also remained unclaimed.
- Maintenance of sophisticated equipment in hospitals is covered by Annual Maintenance Contract (AMC), which are renewed periodically. Project Steering Committee had suggested to do away with AMCs and instead involve the technical staff available in the equipment maintenance workshops for maintenance work. Despite these instructions, the project authorities extended the AMC beyond one year, incurring an avoidable extra expenditure of Rs.27.00 lakh (2001-02). Further, a central equipment workshop with office was also constructed at a cost of Rs.65 lakh at Bangalore. However, maintenance of equipment was not referred to central workshop since most of them were covered under Annual Maintenance Contract.

To an audit query, it was contended that the continuance of AMC was inevitable, as the available technical staff was not adequately trained. It was also stated that it would take five to six months of training to be imparted by the Bio-medical Engineers on contract basis. Had the technical staff been trained during the first year of AMC, the expenditure on AMCs could have been avoided.

Procurement and supply of drugs

Non-availability of essential drugs/medicines was identified as a major constraint in utilising facilities by patients at first referral hospitals. The project cost of Rs.41.81 crore for supply of drugs/medicines was reduced to Rs.26.61 crore in the revised estimate for which reasons were not forthcoming.

During 1996-97, Government Medical Stores procured drugs worth Rs.6.02 crore by irregularly debiting the project funds under 'retroactive financing' activities, as retroactive financing permitted only pre-project activities like initial technical survey of existing hospitals, preparation of preliminary designs etc.

Lack of a consistent procedure in the procurement of drugs resulted in non/short supply of drugs and time barred drugs

During 1997-99 and 2001-02, drugs worth Rs.17 crore were procured for project hospitals. It was observed that no consistent procedure was followed in the procurement of drugs. These were despatched directly to project hospitals in 1997-98, while in 1998-99, the respective District Health and Family Welfare Officers (DHFWOs) were made consignees for receiving the drugs and distributing them to the hospitals. In 2001-02, the supplies were routed through Government Medical Stores instead of DHFWOs. Procurement of drugs/medicines without indents and frequent changes in the supply procedures resulted in:

- Drugs/medicines on verge of expiry being transferred from six hospitals to 15 PHCs.
- Short receipt of drugs worth Rs.4.01 lakh in 20 DHFWOs.
- Issue/administration of a time barred injection (Tetanus Toxide) in three hospitals[3].
- Eightyeight thousand and five hundred ampules of Injection Diazepam were procured by project authorities during March 1999 and supplied to 88 hospitals. The Drug Controller declared them as substandard quality during October 1999 by which time about 52,000 ampules of this injection had already been administered in various hospitals. Action taken against the firm for supplying substandard drug was not forthcoming.

[3] District Hospital-Hassan, Community Health Centre-Kutta and General Hospital-Nanjangud

Vehicles

Vehicles like jeeps and cars were procured in contravention of prescribed norms while ambulances for 24 hospitals were not procured

The project envisaged procurement of vehicles (jeeps, cars and ambulances) for which Rs.16.17 crore was allocated. Scrutiny of records revealed that project authorities procured vehicles more than those envisaged under the project. As against 184 jeeps and 10 cars, the project authorities procured 242 jeeps and 13 cars. Thus, an extra expenditure of Rs.1.62 crore was incurred on purchase of vehicles against the prescribed norms. One Maruthi Bolero (value: Rs.6.72 lakh) was allotted to Hon'ble Health Minister (1999) and one car each was allotted to the Chairman, Task Force, Chief Financial Officer and Under Secretary. On the other hand, ambulances to 24 hospitals had not been supplied. Besides, 37 jeeps valued at Rs.1.06 crore and four workshop maintenance vehicles valued at Rs.12.00 lakh were allotted to hospitals/units/ officers not covered under the project.

Lack of prioritisation in procurement of vehicles resulted in avoidable extra expenditure of Rs.1.62 crore besides denial of ambulance facilities in 24 hospitals.

3.3.8 Shortage of specialists and para medical staff

Due to shortage of specialists and para-medical staff at first referral hospitals, there was low bed occupancy in these hospitals

As against total requirement of 1981 doctors/specialists in project assisted hospitals, only 1,632 were in position, as of January 2003. Shortages affected services in 147 out of 204 hospitals. Available doctors/specialists were also not judiciously posted to all hospitals, which led to the following disparities/ mismatches:

- Against the norm of providing five specialists[2], 25 hospitals of 30 to 50 beds had no specialists while excess number of specialists had been posted in 26 hospitals.
- No surgeons were available in 73 hospitals. In 19 test-checked hospitals, 23 Operation Theatre facilities provided at a cost of Rs.62 lakh remained idle/underutilised.
- Five[3] hospitals were managed by single Doctors.
- While Anesthetists were not available in many of the 50/100-bedded hospitals, four Anesthetists had been posted in four 30 bedded hospitals where no such posts were sanctioned.
- There were shortages in the para-medical staff (Pharmacists 361; X-Ray Technicians 120; Lab Technicians 223; Staff Nurses 717) as of January 2003. Availability of only one staff nurse was noticed at TLH Hukkeri, Ramdurg and Magadi with occasional deputation of additional staff nurse from other places. There were no X-Ray Technicians in 21 hospitals.
- Due to shortage of specialists and para-medical staff at first referral hospitals, the objective of the scheme to improve effectiveness of health

[2] one Physician, one General Surgeon, one Gynaecologist, one Dental Surgeon and one general duty Doctor

[3] ED Hospital, Mysore, TLH at Nargund, Hungund, Kannangi and WCH at Ranebennur

services was not achieved, as evidenced by the low bed occupancy, as detailed below:

No. of hospitals having low bed occupancy (in terms of percentage)				
Bed strength	0 < 20	20 < 30	30 < 40	40 < 50
30	38	14	6	9
50	9	11	8	13
100	3	7	1	2

The low occupancy was more pronounced in 30 and 50 bedded hospitals.

3.3.9 Ineffective functioning of referral system

Ineffective functioning of referral system in the first referral hospitals and non-availability of a IEC strategy failed to educate and inform the public on the facilities available in these hospitals

The project implementation laid greater emphasis on improving the existing referral system through a well defined network, under which the first referral hospitals would provide clinical and technical support to PHCs. The measures to strengthen the referral system included introduction of referral and feed back cards to patients, providing incentives to patients who follow referral procedures, preparation of a 'zoning system' i.e., linking identified PHCs/ Community Health Centres with particular Taluk Level Hospitals, etc. The project guidelines also prescribed that an Information, Education and Communication (IEC) strategy should be drawn up to provide information to the targeted group about availability of public health services at various levels especially on referral mechanism and facilities for disadvantaged sections of society (Yellow Card Scheme).

Audit scrutiny however, revealed that the objective of strengthening the referral system could not be achieved due to reasons such as non-availability of specialists, technicians and upgraded facilities, shortage of drugs, longer waiting periods. There was an increase in the number of cases referred out to higher level hospitals especially under surgery and medical categories. The project authorities did not introduce the referral and feedback cards as well as zoning system as contemplated. No action was taken to implement IEC strategy also to provide information to the needy persons. Consequently, over crowding of patients at District Hospitals and Tertiary Hospitals could not be avoided.

3.3.10 Yellow Card Scheme

The implementation of yellow card scheme providing for a free but compulsory annual health check-up of all Scheduled Caste and Scheduled Tribe persons in the State was not encouraging

In order to provide free medical checkup, treatment and supply of essential medicines for Scheduled Caste and Scheduled Tribe persons in the State, Government initially introduced (October 1995) the 'Yellow Card Scheme' in selected five districts[4] and later extended it to all the districts (August 1997). The system provides compulsory health checkup on a biannual basis in respect of Scheduled Caste and Scheduled Tribe families residing in rural areas. This checkup at sub-centre/village level would screen the targeted population so as to identify and treat diseases at the onset. The scheme also envisages an extensive IEC campaign to secure total participation of the beneficiaries.

[4] Bijapur, Hassan, Kolar, Mysore and Raichur

Audit scrutiny however, revealed that coverage ranged between 0.85 to 33.90 *per cent* of the total Scheduled Caste/Scheduled Tribe population during 1997-2002 as detailed below:

Sl. No.	Name of the Division	SC/ST population (in lakh)	1997-98		1998-99		1999-00		2000-01		2001-02	
			A	B	A	B	A	B	A	B	A	B
1	Bangalore	31.60	1.72	5.44	3.77	11.93	4.08	12.91	3.64	11.52	4.35	13.77
2	Mysore	17.49	1.93	11.03	2.43	13.89	4.36	24.93	2.25	12.86	5.93	33.91
3	Belgaum	16.57	1.75	10.56	2.50	15.09	2.35	14.18	4.66	28.12	3.33	20.10
4	Gulbarga	21.19	0.18	0.85	2.60	12.27	3.20	15.10	3.05	14.39	3.77	17.79
Total		86.85	5.58		11.30		13.99		13.60		17.38	

A – Number of persons examined in lakh; B – Percentage of coverage

The progress achieved in test-checked hospitals was found to be not encouraging. In Chamarajanagar District, the progress was 2.41 to 7.76 *per cent* during 1998-2002. In Tumkur District it was between 2.41 and 9.89 *per cent* and in Kolar District having highest SC/ST population in the State, it was 1.04 to 7.73 *per cent*. The coverage varied between 1.09 to 16.65 *percent* of the population. In seven Districts, no camps were held during 2002-03. The reasons were not forthcoming.

Poor achievement was attributed to holding camps at village headquarters, belated release of funds and lack of transportation facilities. Monitoring of the progress of implementation was also inadequate.

A survey of the scheme conducted by an external agency (ORG-MARG) highlighted poor attendance owing to ignorance in the community about the camp date and venue (55 *per cent* of the beneficiaries were not aware of the programme). The report also highlighted absence of doctors, lady medical officers, lab technicians in camps, lack of lab testing materials, absence of trained ANMs[5] (only 49 *per cent* were trained) etc., which affected the functioning of the camps.

3.3.11 Collection and utilisation of user charges

The project envisaged collection of user charges for augmenting public resources for health care specially for funding non-salary recurrent costs like repairs, maintenance of equipment, vehicles, purchase of drugs/x-ray films.

Between 1997-2003, out of an amount of Rs.8.50 crore collected in 170 hospitals, an amount of Rs.4.41 crore only had been utilised in 128 hospitals. The balance funds are kept in bank accounts in the names of the Chief Executive Officer/Zilla Panchayat and the District Surgeon. Efforts made to maximise the collection of user charges and ensure their optimum utilisation were not forthcoming.

[5] Auxiliary Nursing Maids (Junior Health Assistants-Female)

3.3.12 Contracting of non-clinical services

Non-clinical services were contracted out injudiciously, although enough work force was available with the Department

The project contemplated outsourcing of selected health services on contract basis. Initially contracting of non-clinical services was taken on experimental basis in Devanahalli hospital, which was later extended to 172 hospitals at an average cost ranging from Rs.7,750 to Rs.1.92 lakh per month.

A Committee under the Chairmanship of Secretary to Government of Karnataka, Health and Family Welfare Services decided (August 1999) that non-clinical services may be contracted out where large number of vacancies in Group 'D' cadre existed. However, the project authorities failed to evolve proper criteria for contracting out non-clinical services, and the facility was extended to all hospitals mainly on account of reluctance of the Group 'D' officials to do house keeping jobs. It was observed in audit that in 37 hospitals where vacancy of Group 'D' was even less than 30 *per cent,* the services were contracted out at an expenditure of Rs.1.51 crore. Project Administrator during his inspection (2002) of TLH, Magadi also observed that non-clinical services had been contracted although enough work force (Group 'D' staff) was available with the department and requested for review of position in other hospitals. No action had been taken to review the situation.

3.3.13 Training

Lack of adequate training to the staff to handle sophisticated equipment in the first referral hospitals resulted in non-utilisation of available equipment. In other cases, managers and physicians trained abroad on teaching skills were not utilised for the benefit of project

The project envisaged comprehensive training programmes based on the recommendations of working groups constituted to ensure upgrading of skills at rural, sub-divisional and district hospitals on hospital management. However, such a comprehensive training was yet to be given to the project staff.

The project also provided for short term training abroad to improve the teaching skills of managers and physicians. It was observed that in four cases, the services of the officers trained abroad at a cost of Rs.17.56 lakh were not utilised in the project, as they were transferred outside the project. Consequently, Rs.17.56 lakh spent on their training abroad proved unfruitful.

Contrary to the norms provided under training, a Deputy Director of the project was deputed in June 1998 for a regular PG Course in International Programme in Public Health Policy and Management at University of Southern California at an expenditure of Rs.20.11 lakh.

3.3.14 Consultancy contracts and professional services

The project authorities unjustifiably continued the consultancy contracts for Finance and Project Management despite having Financial Advisers and Project Management Experts

For smooth implementation of the project, services of consultants and professionals for various activities were also provided for in the project. Accordingly, consultants for finance and project management were engaged separately during the project period. Audit scrutiny revealed the following:

Finance Management Consultancy services were contracted initially for a period of one year in 1997 at a cost of Rs.15.00 lakh, which was later (January 1998) enhanced to Rs.25.50 lakh per annum and fixed at Rs.24.00 lakh per annum from February 2001. The consultants were required to deliver financial software and provide necessary training to staff. The decision to

continue the consultancy services beyond one year at a cost of Rs.56.33 lakh was despite existence of a full-fledged accounts wing headed by a Chief Finance Officer. The software belatedly delivered by the consultants had not been used in any of the divisions except in Bangalore in 2001-02.

Similarly, the services of STEM (Symbiosis of Technology Environment and Management) contracted for one year for project management activities, were continued for a further period of two years till December 2000 at a cost of Rs.33 lakh. It was so despite existence of a full fledged Engineering wing headed by a Chief Engineer and a Deputy Chief Architect, Joint Director (Equipment), Additional Director (Medical), Bio-Medical Engineers etc.

3.3.15 Monitoring and evaluation

Monitoring and evaluation of project performance was not effective

Monitoring the progress of implementation of the project was done at taluk levels, district levels and by a steering committee at central level besides review by PGB. In addition, sub-committees were also formed to monitor progress of referral system and yellow card scheme. Formats were also prescribed to collect data on various aspects of the project. However, due to various discrepancies and disparities in the data received from hospitals, the progress of project implementation could not be effectively monitored.

3.3.16 Other topics of interest

Diversion of funds

Funds to the extent of Rs.3.80 crore were unauthorisedly diverted for improvements, repairs and maintenance works to existing buildings (both residential and non-residential) such as staff quarters, office buildings, training centres, seminar hall and furnishing the conference hall and the offices of Health Department, which are not covered in the project activities.

3.3.17 Response of Government

Above points were referred to Government in August 2003 and their remarks are awaited (December 2003).

3.3.18 Conclusions

Lack of planning in the execution of civil works resulted not only in cost and time overrun but also reallocation of funds for civil works at the cost of other components of the project. Deviations to original plan of procurement, distribution and poor utilisation of equipment coupled with non/short procurement of drugs and deficiencies in deployment of doctors affected adversely the delivery of health care services. Ineffective functioning of referral system in the first referral hospitals and non-implementation of IEC strategy also affected adversely the delivery of medical services and achieving the envisaged objective of the project.

3.3.19 Recommendations

- Imbalances and mismatch in the posting of Doctors and para-medical staff and availability of drugs, equipment, ambulances etc., need to be corrected so as to strengthen the existing Referral System. Posting of specialists also needs to be rationalised in each category of hospital.
- Procurement of services of a professional agency may be considered for speedy implementation of IEC strategy to ensure optimum utilisation of the Referral System set up by the project.
- Financial resources of the project need to be strengthened by maximising the collection of user charges and by utilising them inter alia, for maintenance of equipment. Government may ensure optimum utilisation of the central equipment workshops set up in each district besides reviewing the continuance of AMCs.
- Government may investigate the reasons for poor coverage of Scheduled Caste and Scheduled Tribe population under the 'Yellow Card Scheme' and ensure effective implementation of the scheme so as to fully realise the intended objectives.
- A consistent procedure in the procurement and supply of drugs to hospitals may be followed for ensuring timely availability of drugs and proper control over inventory.