CHAPTER - IV

MANAGEMENT AND ADMINISTRATION OF PUBLIC HOSPITAL
4.1 INTRODUCTION

"There is a shared belief that the hospital exists for the care of the sick and injured people. All other activities, whatever they may be, are secondary to this and each and every management process must have the patients at its heart". (Tabish, 2005). The services of public hospitals cater to the need of the targeted public only when these are properly managed and administered. The healthcare management requires planning of healthcare delivery which takes accounts of the needs of the patients in terms of quality care by doctors, nurses and paramedical staff who are all experienced in dealing with both the patient's clinical condition and with the type of care required at that moment in time. They must be involved in each process of management (Marquis, 2000). The researcher tries to highlight the pattern of administration of public hospitals and the management of healthcare resources in Orissa. This chapter also focuses on the problems that ail the public hospitals in our state. Apart from that, a subtle touch has been given on the planning and development of human resource in health sector in our state. The poor health infrastructure, inadequate budgetary allocation and unplanned spending behaviour of the Government of Orissa together have deprived its people of their due right to healthcare which their counterparts in other Indian states are enjoying. Also in this chapter, discussion has been made about government financing of public hospitals through annual budgetary allocations.

Health and development are symbiotically linked. Health has long been regarded as a priority for sustained development at the individual, community, national and international levels. Therefore, massive efforts and resources have been pumped into programming and implementation of health and family welfare programmes over the past plan periods in the county. Acceptable and satisfactory levels of health, adequate nutrition and educational achievement are not merely inputs that can raise wage earnings, enhance productivity and bring about the development in the quality of human resources, but are themselves critical facets of
the living standards of the people, especially the poor and the disadvantaged (Tandon, 1985).

4.2 HEALTH SECTOR ADMINISTRATION IN INDIA

Health System of India comprises of a Central Organ, and a State apparatus extending to district, subdivision, block and further peripheral levels. Indian constitution has provided that states are largely independent in matters relating to providing healthcare services to people. The State’s involvement in health matter is an issue that developed since Montague-Chelmsford Reforms, 1919, It has further strengthened in the 3 lists of over constitution, i.e., Federal, State and Concurrent. The state list confers responsibility of providing healthcare and preventive health services to the people. The Constitution of India continues the same status of health system, i.e., the state continues as ultimate authority for health services operating within its own jurisdiction.

The Central Organ at national level consists of the Union Ministry of Health and Family Welfare; the Director General of Health Services and the Central Council of Health and Family Welfare. The Union Ministry of Health and Family Welfares’ functions are clearly mentioned in the Seventh Schedule of Article 246 of Indian Constitution under the Union List and Concurrent List. The Directorate General of Health Services has the job of surveying, planning, coordinating, programming health and it recommends broad outlines of health policy, health related legislation etc. The central agencies are not superior authorities over State health apparatus. They have only an advisory role towards the state-level health agencies.

The medical services are very broad in our country and cover almost all aspects of human life from cradle to grave (Banerji, 1980). The medical system in our country has five major sectors. They are:
(a) Programmes relating to Disease Control, Medical Relief, Hospital Management, Infrastructure Maintenance, Health Technology Mission and the likes.


c) Management of Medical Institutions, Medical Education, Medical Research, Medical Training, Medical Universities, Medical Colleges, Medical Training Schools for medical and para medical staff, various kinds of Clinical Training Programmes, Training Camps, Training Tours etc.

d) Public health activities.

e) Indian System of Medicines and Homeopathy that looks after indigenous medical systems like Ayurveda, Siddha, Yoga, Pranayam, Naturopathy, Unani and Homeopathy.

Each sector, with its sub-sectors, has its own multifarious duties to perform and responsibilities to discharge. Each has its own organization to operate, own infrastructure to maintain, own hierarchy or chain of command and control to observe. Each has its own presence in the district level.

In India, we have mainly two categories of hospitals, classified on the basis of management principles. One is the government managed or Public sector hospitals and the other is the corporate managed or Private sector hospitals. Some of these are super-speciality hospitals owned and managed by national and international organizations or MNCs. These are fairly large, advanced and specialized. Some of these are General Hospitals operating in the district headquarters; and some are dispensaries which operate just under the district headquarter hospitals. Also, there are Municipality hospitals owned and managed by the municipal bodies or municipal corporations. But the highest number of health care institutions in the public sector is the community health centres (CHCs), primary health centres (PHCs), the additional primary health centres etc. which function in the rural areas.
or the block levels. These are mainly meant for mother and child care and the routine treatment of general patients from among the rural mass.

4.2.1 Management and Administration of Health Care in Orissa

Orissa, as a State of Indian Union, has its own health management system with a State Health Department and Health Directorate. The Health Directorate has its administrative infrastructure with ramifications in the levels of districts, subdivisions, blocks and villages. The Minister of Health and Family Welfare Department heads this organization. The Health Department in Orissa is headed by a senior IAS Officer assisted by a number of administrative and secretariat officers. An additional secretary is also there in the Health Department who belongs to the category of Orissa Medical Services.

**ORGANOGRAM**

Source: www.govt.of.orissa.co.in, H&FW Department.
Director of Health Services is the chief technical advisor to state government in all matters of medical and public health. He is the organizer and director of all health activities of the state. Growth of family planning activities and expansion of medical education have resulted in creating two more directors in Health Directorate such as Director of Family Welfare and Director of Medical Education and Training to look after their respective fields of health administration. Conventionally, the post of Director of Medical Education and Training is meant for a senior teacher from medical colleges of Orissa and Director of Health Services and Director of Family Welfare are selected from Orissa Medical Services cadres. The Drug Control Unit of Orissa which is also under the administrative control of the H.&F.W. Directorate is entrusted with responsibilities for granting licences for manufacture of drugs. The State Institute of Health and Family Welfare (SIHFW), Orissa has the objective to develop the skill of health personnel in Health and Family Welfare Department. The Public Health Engineering organization which is virtually a part of Public Health System is a separate department in Orissa like other states of the country.

There are 3 Medical Colleges in Orissa for medical education and training: Srim Chandra Bhanja Medical College, Cuttack, Maharaja Krishna Chandra Gajapati Medical College, Berhampur and Vir Surendra Sai Medical College, Burla. The medical colleges have multiple faculties and the clinical ones are the ultimate referral units for the patients in the state.

At the district level, the Office of the Chief District Medical Officer is an integrated set up of curative and preventive wings. The Chief District Medical Officer (CDMO) is the chief of the office assisted by 3 Additional District Medical Officers (Medical, Family Welfare and Public Health). The District Headquarters hospital has specialists in different subjects like Medicine, Surgery, Orthopedics, Obstetrics and Gynecology, Pediatrics, Eye, ENT, Psychiatry, Anesthesia and Dental with outdoor, indoor and emergency treatment facilities. Immunization Clinics, Rabies Clinics, Sanitary activities, etc are part of preventive health services. Family welfare activities are decentralized to the level of Primary Health Centers. The Additional District Medical Officer in charge of family planning plays a supervisory role.
At the level of revenue subdivision, there is Sub Divisional Medical Office and Sub Divisional Hospital headed by Sub Divisional Medical Officer (SDMO). The SDMO looks after the health institutions under his jurisdiction. The Sub Divisional Hospital has 50 beds on average with specialist facilities in subjects of Medicine, Surgery, Pediatrics, Obstetrics and Gynecology.

*The Primary Health Centre (PHC)* is the throbbing centre of health activities of the rural areas in general. Bhore Committee introduced the concept of PHC in Indian healthcare system in 1946. Central Council of Health in 1953 modified this concept to cater to the health needs of community development block area which consists of average 100 villages and 1,00,000 population with single medical officer and limited staff. At present, the PHC at community block level has the staffing pattern of 2 Medical Officers, Pharmacist, Nurse, Midwife and Auxiliary Nurse (male), Health Assistant (female), Laboratory technician, some office employees. The Medical Officer of PHC is the captain of the health team who devotes his afternoon for supervising fieldwork. He visits each Sub Centre of the PHC at fixed time. One monthly staff meeting is held at PHC for the review of family welfare, immunization, and sanitation activities. He ensures that the National Health Programme is implemented satisfactorily in his area. It is the leadership of PHC Medical Officer which is responsible for the success of health programme at the block level. His job is technical, supervisory as well as coordinative.

Each Primary Health Centre has a number of health sub centers, usually one per every 10 thousand population and approximately 8 in number under a PHC. The staffs present at the health subcentres are: Health Worker (female), Health Worker (male) and voluntary workers recruited from among the public.

*Community Health Centers (CHCs)* are upgraded erstwhile PHCs with a catchment population of 80,000 to 1,00,000 in a community development block. The CHCs are provided with 30 beds and specialists in Medicine, Surgery, Obstetrics and Gynecology, Pediatrics with X-ray and laboratory facilities. The peripheral medical institutions those were earlier operating in Orissa in the names of Dispensaries, Medical Aid Centers, Subsidiary Health Centers, etc. have been
restructured with the nomenclature of PHC (new). The PHCs at the community block level continue as PHC though some of these have been elevated to CHCs on population basis.

Table 4.1

Beds available in government hospitals in 2006

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Medical Institutions</th>
<th>Nos.</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medical College, Hospitals</td>
<td>3</td>
<td>2861</td>
</tr>
<tr>
<td>2.</td>
<td>District Head Quarters Hospitals</td>
<td>32</td>
<td>3923</td>
</tr>
<tr>
<td>3.</td>
<td>Sub-Divisional Hospitals</td>
<td>22</td>
<td>985</td>
</tr>
<tr>
<td>4.</td>
<td>Other Hospitals</td>
<td>124</td>
<td>2001</td>
</tr>
<tr>
<td>5.</td>
<td>CHCs</td>
<td>231</td>
<td>3520</td>
</tr>
<tr>
<td>6.</td>
<td>PHCs</td>
<td>114</td>
<td>726</td>
</tr>
<tr>
<td>7.</td>
<td>PHCS (New)</td>
<td>1164</td>
<td>150</td>
</tr>
<tr>
<td>8.</td>
<td>Mob. Health Units</td>
<td>14</td>
<td>–</td>
</tr>
<tr>
<td>9.</td>
<td>Total</td>
<td>1704</td>
<td>14166</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Orissa, Bhubaneswar, 2007-08.

The Orissa Health Systems Development Project is operative in the State since 1998 with an aim to improve efficiency in the allocation and utilization of health resources to rejuvenate the existing healthcare system by quality, efficiency and coverage. Health camps in tribal districts and Mobile Clinics in inaccessible pockets of 5 tribal districts (Mayurbhanja, Sundargarh, Kandhamal, Gajapati and Keonjhar) are organized under this scheme. In spite of this, there are problems faced in health care administration in Orissa some of which are listed below:

4.2.2 Problems in the Healthcare Administration of Orissa

On interacting with health administration, staff of various PHCs, sub-centres, CHCs of both rural and urban areas and the district headquarters hospitals and medical centres, this researcher has noticed the various problems of health care in Orissa which are outlined below:

- Large population and health emergencies of natural disaster
• Malarial Endemic and Huge Toll
• High Rural-Urban proportion of Orissa making lesser penetration of healthcare facilities
• Huge Tribal Population and geographical barriers
• Delivery Care Lapses and High Infant Mortality Rate
• Low Literacy and Health Awareness in the state
• Health personnel management and less number of doctors in tribal tracts
• Low Doctor- Population Ratio and non-availability of ancillary staff in Orissa

In Orissa, with about 3.3 cores of population in 30 districts of the State, there is a lack of required number of doctors in tribal districts where healthcare is needed most. With growth of population and advancement of medical science, there is need for a better healthcare management with a special attention on its health personnel and infrastructure.

4.3 ROLE OF MEDICAL OFFICER IN MANAGEMENT AND ADMINISTRATION

The term “management” is used in many senses. It is sometimes confused with administration and sometimes with organization. Some equate the terms management and administration. Others view it as a technique of leadership. The widely prevalent view is that administration broadly means “getting things done” and management is “the purposeful and effective use of resources – manpower, materials and finance – for fulfilling a pre-determined objective”. In theory, management consists of four basic activities, i.e., planning, organizing, communicating, controlling, etc. The current emphasis by WHO and many governments is on improving the efficiency of the health care delivery systems through the application of modern management methods and techniques based on principles of behavioral sciences as well as quantitative methods. Primary Health Centers (PHCs) are the nucleus of community organization to provide basic health care services to the community. Hence, they need proper administration.
In a PHC, the medical officer is the officer-in-charge for all purposes and activities. There are male and female Health Supervisors, ANMs, Health Worker (M) and Staff Nurses under the Medical Officer to provide various services to patients in hospitals and in their houses. As the manager of the PHC, the Medical Officer is responsible for managing and motivating all staff to carry out the job assigned to each of them in an effective manner. For motivating the staff, the Medical Officer of a PHC tries to get a clear picture about the health workers in respect of their fundamental needs, i.e. the need to belong, the need for respect and the need for a sense of achievement.

4.3.1 Management by Objectives (MBO) in Public Hospitals

The Medical Officer also takes up the following jobs beyond his routine activities for helping his staff to improve their performance and competence.

i) Identifying the need for information on the community being served, the health problems, the goals, methods and structures of the programmes; and, the standards to be attained.

ii) Identifying the skills needed for patient care, management, information, communication, education, training; and problem-solving.

iii) Deciding jointly on the learning methods by which the health workers can make up deficiencies by referring to private studies, case studies, discussion groups etc.

iv) Setting up a continuing education programme which will meet the workers' needs for improvement of their skills.

v) Identifying the workers' basic needs, i.e., need for security, social needs, need for respect / self-esteem and need for achievement.

vi) Selecting and planning the appropriate methods of management and training through consultation, incentives, changes in the style of leadership etc.

vii) Identifying particular needs for logistic or financial support.
viii) Discussing and intimating suggestions to the higher authorities for remedial actions.

ix) Conducting meeting of the staff and deciding the future course of action and implementing the objective decided.

x) Reviewing the proceedings of the meeting.

4.4 HEALTH MANAGEMENT AND COMMUNITY PARTICIPATION

It has been very encouraging when our New Prime Minister has spoken of making India "world class". We really need a country where irrespective of caste, creed, religion and socio-economic status, our basic needs for living a quality life must be fulfilled. Health being the key indicator of quality life, needs to be addressed properly. Health care services need to be improved in all perspectives.

Our health policy is not thrust upon the centre only. We also have our state health policy. Perhaps we have designed the health programmes and developed the health manpower and infrastructure without looking to the emotion and need of the community. In order to address this issue, community participation is needed. Community participation doesn’t lie only in consulting a few influential persons in the community. It is truly some thing different which we need to rethink and redesign. For health and development, the most valuable resource is the "community itself". India, being the second largest populous country in the world has a vast community. Proper channelisation of this potential human resource is the biggest challenge in front of us today. Empowering community is the key for health promotion and developmental initiatives. In a good community based programme, the following principles are to be followed:

• Going to people.
• Living with them.
• Leaving from them.
• Serving them.
• Beginning with what they know.
• Build on what they have.

Alma Ata declaration in 1978 – “Health for all by 2000 AD” is the first people-oriented Global Health Policy and the center stage of this policy is primary health care where community participation is a key component. India was the signatory to this declaration and it was the main theme in the National Health Policy 1983.

Before the Alma Ata global declaration, the Bhore Committee report had also given similar people-centred concept of public health. To achieve the goals of National Policy 2000 and National Health Policy 2002 in respect of Maternal and Child Health services, it has been envisaged that without community participation, it would be next to impossible to achieve these goals.

In RCH Programme, the main thrust is given on Community Needs Assessment Approach (CNAA) where people have to identify their own needs and resources, determine priorities, plan agenda and programme of services, implement activities, monitor and finally evaluate their own efforts/success. The Sub-Center Action plan, PHC plans and CHC plans under RCH programme envisage community participation and client satisfaction. Orissa, though rich with natural resources, is far behind the human development index of the country. Community awareness level and right based quality health care availability is very low. The socio-economically poor communities in the state have no other way than to depend upon the public health system.

4.4.1 Reasons of low community participation in health sector in Orissa

In Orissa, community participation in health services is low due to the following reasons:

• Community has not intended health as its right.
• There is lack of transparency in public health system which leads to low level of community participation.
Community has suspicion on the quality of public health service system. There is no proper human environment to receive the patients and clients by the health sector which is essential for any human being to have faith on a system. Grass root level health service providers do not have decision-making power to meet the need of the community. There is no systematic or scientific planning by the health system for adhering to the public health needs. Health providers have the attitude that community is only the passive receiver. They do not tolerate if the community evokes demand or rights. There are several pleas to deceive the public about the quality health care.

The Tenth National Plan document promises community participation in developing local level ownership of programmes and achieving plan objectives. Accordingly, the Government of Orissa is committed to develop a system for “Community Participation” in primary healthcare. The community level organizations that would stimulate the community to participate in health service are: Panchayati Raj institutions, Mahila Mandal, Mahila Swasthya Sangh. (MSS), Link women, Mothers’ group, Village cooperatives, Self Help Group, Youth Clubs, NGOs, Anganwadi workers. (AWW), etc.

Now the target-based activity has been changed to target free approach. This is named as Community Need Assessment Approach or CNAA which addresses client centred, demand driven and quality service programmes. CNAA is a positive development to involve community for decentralized and participatory planning.

4.5 PANCHAYATIRAJ INSTITUTIONS AND HEALTH MANAGEMENT.

Panchayati Raj Institution (PRI) is the constitutionally amended local government which is very close to people. This body promotes the concept of “Think, Plan and Act locally and Support nationally”. A special subcommittee is formed within the Panchayat body which has to identify the gaps in the needs for reproductive health services and prepare a need based, demand driven and socio-
demographic plan at the village level. This plan aims at identifying and providing responsive people-centered and integrated health care.

Table 4.2

Coordination between Health and Panchayat authorities at different levels

<table>
<thead>
<tr>
<th>Various levels</th>
<th>Panchayat Institutions</th>
<th>Health Institutions</th>
<th>Panchayat Authorities</th>
<th>Health Authorities/ Functionaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Level</td>
<td>Zilla Parishad</td>
<td>District Hospital / Dispensaries</td>
<td>Chairman Zilla Parishad</td>
<td>Chief Medical Officer (CMO)</td>
</tr>
<tr>
<td>Block / Intermediate Level</td>
<td>Block Samiti</td>
<td>Community Health Centre (CHC) / Primary Health Centre (PHC)</td>
<td>Chairman Panchayat Samiti or Bock Samiti</td>
<td>Senior Medical Officer (SMO)/ Block Medical Officer (BMO)</td>
</tr>
<tr>
<td>Panchayat Level</td>
<td>Gram Panchayat</td>
<td>Health Sub-centre</td>
<td>Sarpanch or Pradhan</td>
<td>Health Worker (Male and Female)</td>
</tr>
</tbody>
</table>


In the design of the Panchayat body, we have 33 percent reservation for women representatives. If these representatives are properly oriented and sensitized, they can take the leadership to address the gender issues in health care services. Gram Panchayats (GPs) undertake health activities with active community involvement. The community level organizations/groups like Self Help Groups (SHG), Mahila Mandal, Mahila Swasthya Samiti and Youth clubs etc are the key contributors to such efforts.

4.5.1 GP Level Health activities

1. Water and sanitation.

2. Transport facility to the health care delivery system in emergency situations like delivery, complicated pregnancy, accidents, any fatal disease, snake bites, accidents etc.
3. Registration of marriages, pregnancies, birth and deaths.

4. Adopting small family without sex discrimination.

5. Supplementing to promote the health initiatives taken up by public health system.

6. Adopting strategies to reduce maternal and infant mortality.

7. Food for work to maintain the food security to everyone.

The Health Sector plays a vital role for this by ensuring right-based orientation to PRI members, village health volunteer team and leaders of the SHGs so as to enable them to undertake community based activities and Sub-Center Action Plan.

4.5.2 GP Health planning methods

There are several methods which are usually adopted for GP health planning. These are Participatory Resource Appraisal (PRA), Participatory Learning and Action (PLA), Participatory Resource Mapping (PRM) etc. which mainly focus on group discussion with the community. While doing such exercises, health activities are enlisted for which individuals, families and community use to take various responsibilities.

4.6 PUBLIC PRIVATE PARTNERSHIP (PPP) IN HEALTH SECTOR

The NRHM advocates for suitable public-private partnership to meet the deficiencies in the public health delivery system. Guidelines are being developed for accreditation of private health providers. Pilots are run on social franchising, contracting etc in selected districts, and based on the outcome, they would be implemented on wider geographical area. Government of Orissa has time and again articulated the need for collaborating with NGOs and private agencies to provide and facilitate the use of health service delivery in hard to reach and underserved areas. The collaboration with NGOs will ensure promotion of people oriented policies of the Government of Orissa, Department of Health & Family Welfare and
provide a platform to manage PHC and implement curative, pro-motive and preventive health services for the untouched community groups.

One of the major objectives of the NRHM is also to operationalise the Community Health Centers (CHCs) / PHCs / First Referral Units (FRUs) with prescribed Indian Public Health Standards (IPHS) which are being currently developed for which PPP is required.

4.6.1 PPP Initiatives in India

- Contractual appointment of health care personnel and hiring of Private practitioners for providing services in the CHCs/PHCs have been attempted to fill the gaps in underserved areas in most states.
- Handing over the management of Public sector health facilities to the private sector, NGOs, preferably to corporate sector. (Orissa, Gujarat etc)
- Private Sector Industry providing health care to the tribal population as done by Tata Steel and some other companies.
- Contracting of services in the area of diet and catering, laundry, security and IEC programmes is being implemented in many States like Maharastra, West Bengal, Orissa, etc.

4.6.2 Contribution of PPP in the PHC Management

NGOs effectively supplement the public health system by assisting in:

- Increasing use of family planning methods.
- Dispelling myths and misconceptions associated with contraceptive use.
- Building awareness and mobilizing community on programme issues.
- Identifying and addressing local needs in a customized manner.
- Extending services to remote areas.
- Providing an effective platform for a range of activities such as Tetanus Toxoid (TT) campaigns, Reproductive and Child Health (RCH) camps.
4.6.3 Management of PHC through PPP model

Partnership with CBOs and NGOs are a significant step in this direction. The Government encourages participation of these grass root level organizations in the delivery of health care services. These organizations work even in remote rural areas where access to RCH services are difficult.

Patterns of Commitment / Resources sharing to run PHC under PPP

A. Budget

Government contributes Rs. 6 lakh per year to NGO / Hospital Management Committee (HMC). 10 percent additional budget can be considered to be provided based on the recommendation of HMC in case the area serves vulnerable population.

NGO / Private Agency has to contribute 25 percent of the total budget (i.e., Rs.1,25,000/-) either in cash or kind as partner (organizational, material or financial). NGO gets just the running cost from Government. The cost of innovations, capacity building monitoring / supervision would be borne by the NGO. NGO can mobilize resources from local MLAs/MPs and other philanthropists who are interested the betterment of their local PHCs.

B. Duration of the Partnership

Initially, it is for three years which may be renewed on the recommendation of HMC and District Health Authority. Government may terminate the partnership at any time with one month prior notice to NGO.

NGO may mobilize budget from outside agencies to sustain the partnership beyond the project period. NGO may withdraw from the partnership with one month notice to State Government.

C. Human Resources

The existing staff already appointed by Government will continue to work under the PHC and will be responsible to HMC and NGO. Government may decide to transfer the existing staff based on the recommendation of HMC. In case of any vacancy due to retirement etc., Government will fill-up the post within two months.
NGO will appoint the additional staff if required any out of its own fund. In case of vacancy where Government is not able to appoint, the NGO/HMC may fill up through fresh appointment out of the project budget. A Coordinator to monitor the progress of the programme will be appointed by NGO/HMC under the scheme. The salary of the coordinator will be paid by NGO. NGO having doctor and other medical staff and infrastructure of its own will be given preference for this partnership.

D. Equipments

The existing equipments available in the PHC will be provided to NGO/HMC for use during project period. Additional equipments if required any would be supplied subject to availability of fund with Government.

NGO may purchase additional equipments if required any out of the project budget or from NGO own resources. NGO may approach private/corporate agencies for support for additional equipments etc. which would be the property of PHC after project period.

E. Building

The existing Government building for the PHC will be utilized for the purpose. Government from time to time will renovate the building and will go for additional accommodation/space. Existing labour room will be utilized under the programme. If there is no labour room or OT, the same will be built by Government in due course.

NGO, basing on the recommendation of HMC, may renovate the PHC building. NGO may mobilize additional resources from outside to have boundary wall and plantation. NGO may approach for MP/MLA / Panchayat fund and other funding agencies for additional health services facilities including construction of additional rooms etc.
F. Drugs / Medicines

Government will provide the drugs and medicines as per Government of Orissa Rules.

NGO may purchase additional medicines if required any out of its own resources. NGO may open a medicine store in PHC campus to provide low cost medicines, contraceptives and other health items. NGO has to implement social marketing of contraceptives.

G. Staff Quarter

At present, most of the PHC (N) does not have staff quarter. Government will consider the proposal in future for staff quarter.

NGO has to arrange the accommodation of the Doctor, ANM and other staff members either in the campus of the PHC or in nearby villages to provide 24x7 hour services in the PHC.

H. Management

Government has developed guidelines for management of PHC through Hospital Management Committee consisting of following members:

1. CHC MO 1/C - Chairperson
2. PHC MO 1/C member
3. One local PRI-Member / Sarapanch member
4. One Local Teacher Manager
5. One local Ngo or CBO – member
6. NGO President / Secretary – Member Secretary

The HMC may include other reputed persons of the area as members of HMC.

NGO has to facilitate the management of PHC under the overall supervision and directives of HMC. NGO will assist HMC for developing PHC operational policy for smooth management or PHC. NGO will assist HMC for developing PHC operational policy for smooth management of PHC.
I. Monitoring & Evaluation

Government has an inbuilt monitoring system for functioning of PHC. Government will conduct medical audit of the PHC annually under the programme.

Hospital Management Committee (HMC) will monitor the day to day activities of the PHC through NGO. MO, CHC I/C will monitor the progress of the PHC. CDMO as the doctor's representative will conduct quarterly review meeting with HMC / NGO. State NGO-P3 Cell or RRC will review and monitor the activities of PHC and document the good practices. NGO will provide quarterly progress report to CHC M/O, CDMO and Mission Directorate. Evaluation of the programme will be made by RRC or outside agency after one year and three years.

4.7 MANAGEMENT OF RESOURCES IN PUBLIC HOSPITALS

Resources are needed to meet the vast health needs of a community. No nation, however rich, has enough resources to meet all the needs for the health care of its people. Therefore an assessment of the available resources, their proper allocation and efficient utilization are important considerations for providing efficient health care services. The basic resources for providing health care are:

(i) Human resource.
(ii) Money and material; and.
(iii) Time.

4.7.1 Human Resource Management

The term “human resource” or “health manpower” includes both professional and auxiliary health personnel who are needed to provide the health care. An auxiliary is defined by WHO as “technical worker in a certain field with less than full professional training”. Health manpower requirements of a country are based on health needs and demands of the population; and desired outputs. The health needs in turn are based on the health situation and health problems and aspirations of the people.

Health human resource management is an important aspect of community health planning. It is based on a series of accepted ratios. They are given in the table below. The country is producing annually, on an average 12,000 allopathic doctors;
3,763 Ayurvedic graduates; 785 Unani graduates; 150 Siddha graduates and 3490 Homoeopathic graduates (WHO, 1999, Health situation in South East Asia 1994-97, Regional Office for SEAR, New Delhi)

Table 4.3
Suggested norms of health personnel

<table>
<thead>
<tr>
<th>Category of personnel</th>
<th>Norms suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctors</td>
<td>1 per 3,500 population</td>
</tr>
<tr>
<td>2. Nurses</td>
<td>1 per 5,000 population</td>
</tr>
<tr>
<td>3. Health worker female and male</td>
<td>1 per 5,000 population in plain area and 3000 in tribal and hilly areas.</td>
</tr>
</tbody>
</table>


Although the averages are satisfactory on a national basis, they vary widely within the country. There is also misdistribution of health manpower between rural and urban areas. This misdistribution is attributed to absence of amenities in rural areas, lack of job satisfaction, professional isolation, lack of rural experience and inability to adjust to rural life.

As per Orissa State Integrated Health Policy 2000, the Human Resources Management in public hospitals aims at ensuring adequate staff strength; clear role assignment among staff; training for improving knowledge and skills; performance-linked incentives for enhancing motivation; inter-sectoral cooperation and coordination; qualified and committed managers; experts with skills to design, apply and evaluate specific interventions for communicable diseases. Manpower planning in public hospitals has been discussed later in this chapter.

4.7.2 Money and Materials

Since money and material are always scarce resources, they must be put to the most effective use, with an eye on maximum output of results for investment. Since deaths from preventable diseases such as whooping cough, measles, tuberculosis, tetanus, diphtheria, malnutrition frequently occur in developing countries, this case is strong for investing resources on preventing these diseases rather than spending money on multiplying prestigious medical institutions and other establishments which absorb a large portion of the national health budget.
Management techniques such as cost effectiveness and cost benefit analysis are now being used for allocation of resources in the field of community health.

4.7.3 Time

Time is money, someone said. It is an important dimension of health care services. Administrative delays in sanctioning health projects imply loss of time. Proper use of man-hours is also an important time factor. For example, a survey by WHO has shown that an Auxiliary Nurse Midwife spends 45 per cent of her time in giving medical care; 40 percent in traveling, 5 percent on paper work; and only 10 percent in performing duties for which she has been trained. Such studies may be extended to other categories of health personnel with a view to promote better utilization of the time resource.

Resources are needed to meet many health needs of a community. But resources are desperately short in the health sector in all poor countries. What is important is to employ suitable strategies to get the best out of limited resources.

4.8 MANPOWER PLANNING IN PUBLIC HOSPITALS

The core determinants of hospital staffing are quality and quantity of work, round-the-clock service, modern equipment, skill required for the job and optimum utilization of its personnel. The variables determining the quality of personnel are just and fair recruitment, selection, induction, training on the job, promotional avenues, decent remuneration with attractive perquisites, etc. Staffing norms should aim at matching the individual’s aspirations to the aims and objectives of the organizations. Hence the norms recommended for the number of personnel in different department of the hospital are only general guidelines to determine the manpower.

4.8.1 Objectives

Manpower planning could be short term or long term. Usually, manpower planning in a hospital has objectives to:

- Ensure maximum utilization of human resources;
- Assess future requirement;
- Determine recruitment sources;
- Identify training needs for staff development; and
- Have better employee-employer relationship.
4.8.2 Steps Involved in Manpower Planning

Manpower planning covers all activities related to personnel such as recruitment, selection, training, career development, staff appraisal. It involves the following steps:

1. Scrutiny of the present personnel strength.
2. Identification of manpower needs.
3. Investigation of turnover of personnel.
4. Planning job requirements and job descriptions.

4.8.3 Types of Personnel

Hospital staff can be categorized as:

- Medical.
- Nursing.
- Administration.
- Paramedical.
- Engineering.
- Unskilled.

The total number of staff can vary from 2 to 5 per bed depending on the degree of care, facilities provided and type of hospital such as maternity/orthopedic/infectious disease/general hospital, etc.

4.8.4 Identification of Needs

This would include:

- Identifying activities to be undertaken
- Listing each activity under specific heads such as pharmacy, laboratory, radiology, nursing, administration, etc.
- Breaking down each activity into different sub-activities.
- Listing out job requirement to meet each activity.
- Working out job-descriptions for each sub-activity.
4.8.5 Recruitment

Once manpower requirement has been determined, the recruitment process can begin. For recruitment in various departments, knowledge of the following ratios is important.

i. Doctor-bed Ratio

According to Indian Medical Council guidelines, the doctor-bed ratio should be 1:5 in medical college and hospitals where doctors are required to participate in teaching programme. However, it is recommended that the doctor-bed ratio should be 1:10 in general hospitals. A doctor-inpatient ratio of 1:10 implies an in built facility for examining approximately 30 outpatients.

ii. Nurse-bed Ratio

This ratio should be 1:3 according to the Indian Medical Council (Table 4). Thus, for every 100 beds, there should be 4 ward-sisters and 30 staff-nurses to cover a period of 24 hours; and for fractions of 100 beds, the staff should increase in the proportion of 1 ward-sister to 25 beds and 1 staff-nurse to 3 beds.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Nurse</th>
<th>Beds</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Casualty</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>4</td>
<td>If mothers are allowed to stay with the patients</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>If mothers are not allowed to stay with the patients</td>
</tr>
<tr>
<td>Obstetric and Gynecological</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour room</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Operation theatre</td>
<td>2</td>
<td>1</td>
<td>(per table, day shift)</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Well-baby nursery</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Special nursery</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

iii) X-ray Department

One X-ray technician can do about 30 X-ray investigations per day.

iv) Medical Laboratory

One medical laboratory technician can do approximately 35 tests per day.

v) Pharmacy

One pharmacist can dispense medicines to 150 patients per day. This excludes placing the order with the supplier, receiving supplies and making entries in the ledger but includes reading prescriptions, dispensing medicines and explaining the schedule of medicines to the patients. Thus, one pharmacist who works 8 hours a day can take care of 100 outpatients as well as 50 inpatients.

vi) Laundry

One laundry operator can wash the linen of 25-30 beds and one laundry orderly can assist in washing the linen of 50-60 beds. Thirty per cent of laundry operators and laundry orderlies should be kept as leave reserve. Some staffing norms based on the workload being followed at various hospitals are:

| Table 4.5 |
| Workload norms for laundry services |

<table>
<thead>
<tr>
<th>Name of the work</th>
<th>Workload</th>
</tr>
</thead>
<tbody>
<tr>
<td>One washer man can take care of</td>
<td></td>
</tr>
<tr>
<td>150 to 200 kg linen per day (This includes collection of linen from different places, washing, drying, folding, ironing and returning).</td>
<td></td>
</tr>
<tr>
<td>Each operation in the OT</td>
<td></td>
</tr>
<tr>
<td>7 to 8 kg of soiled linen</td>
<td></td>
</tr>
<tr>
<td>Each delivery in the Labour Room</td>
<td></td>
</tr>
<tr>
<td>7 to 8 kg of soiled linen</td>
<td></td>
</tr>
<tr>
<td>Each ward patient</td>
<td></td>
</tr>
<tr>
<td>5 to 6 kg of bed linen</td>
<td></td>
</tr>
</tbody>
</table>

Source: Goyal, R.C. Handbook of Hospital Personnel Management. 1993
vii) Dietary Service

One dietary staff member (excluding supervisory staff) is required for approximately 15-20 patients.

viii) Sanitation and Housekeeping

A sweeper should be allotted a work-area of 1200 to 1500 sq. ft, keeping in view the work policies of the institution, the degree of cleanliness required, and the electrical cleaning-equipment used such as scrubbing machine, vacuum cleaner. However, for a nursing unit, one sweeper for 10 beds is recommended on the basis of round-the-clock services. The ratio is too low for an ICU or CCU because a higher degree of cleanliness is required.

ix) Security

The norm is that one security guard is required for every 20-25 beds of a hospital.

x) Central Sterile Supply Department (CSSD)

One person in the CSSD can take care of 30 beds.

xi) ECG Department

One ECG technician can take about 20 ECGs in one shift.

4.8.6 Developing Human Resources in Orissa Health Sector

The following reforms have been introduced by the Government of Orissa to strengthen and improve capacity of health personnel.

- Changed Internship training programme; for better community health orientation.
- Short-term training for general doctors in anesthesiology in CHCs.
- Multi-skilling of pharmacists as lab technicians for TB and malaria programme.
- Mandatory pre- PG service in remote districts helped fill vacancies, and provided a rural orientation.
Since 1999, this process has been taken forward by the current Orissa Health Sector Strategy Initiative.

In Orissa the total work force in the public hospitals provides health services numbering about 31,419 in different categories. More than 84 percent of the health budget is directed towards maintaining the workforce. The health department is very labour-intensive, largely because of the one to one nature of health service provision. The tables given below depict a picture regarding the staff strength and health manpower ratios to understand if health sector in the Government of Orissa is understaffed or overstaffed or staffed as required in effectively meeting the health needs of the people of the state.

**Table 4.6**

Vacancies position of H &FW Department of Government of Orissa (as on January, 2005)

<table>
<thead>
<tr>
<th>Post</th>
<th>Sanctioned strength</th>
<th>In position</th>
<th>Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopathic doctors (Peripheral cadre)</td>
<td>4217</td>
<td>3613</td>
<td>604</td>
</tr>
<tr>
<td>Allopathic doctors (Medical colleges)</td>
<td>820</td>
<td>637</td>
<td>183</td>
</tr>
<tr>
<td>Allopathic doctors (Harihar Cancer Institute)</td>
<td>33</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Ayurvedic doctors</td>
<td>650</td>
<td>612</td>
<td>38</td>
</tr>
<tr>
<td>Homeopathic doctors</td>
<td>594</td>
<td>569</td>
<td>25</td>
</tr>
<tr>
<td>Unani doctors</td>
<td>09</td>
<td>07</td>
<td>02</td>
</tr>
<tr>
<td>Staff nurses</td>
<td>2244</td>
<td>2154</td>
<td>90</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2040</td>
<td>1984</td>
<td>56</td>
</tr>
<tr>
<td>Health worker (Female) ANM</td>
<td>7126</td>
<td>6768</td>
<td>253</td>
</tr>
</tbody>
</table>

Source: Journal of Indian Institute of Public Administration, Regional Branch, Bhubaneswar, 2004-05, p.478.
Table 4.7

Staff of H and FWD including Medical Education

<table>
<thead>
<tr>
<th>Category</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors in Health Services</td>
<td>4107</td>
</tr>
<tr>
<td>Doctors in Medical Education</td>
<td>812</td>
</tr>
<tr>
<td>Nurses</td>
<td>2308</td>
</tr>
<tr>
<td>Female Health Workers</td>
<td>7121</td>
</tr>
<tr>
<td>Male Health Workers</td>
<td>4480</td>
</tr>
<tr>
<td>Male Supervisors</td>
<td>1019</td>
</tr>
<tr>
<td>Female Supervisors</td>
<td>1046</td>
</tr>
<tr>
<td>Other category of service staff</td>
<td>5976</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>26869</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>4550</td>
</tr>
<tr>
<td>Grand Total</td>
<td>31419</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Orissa, Bhubaneswar, 2007-08.

Important human power ratios in the state are shown in the table below.

Table 4.8

Health human power ratios

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ratios Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor – population ratio</td>
<td>1:6444</td>
</tr>
<tr>
<td>Doctor-Nurse ratio</td>
<td>1:0.469</td>
</tr>
<tr>
<td>Nurse – Bed ratio</td>
<td>1:5.97</td>
</tr>
<tr>
<td>Female worker population ratio</td>
<td>1:4452</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Orissa, Bhubaneswar, 2007-08.
4.8.7 Issues of developing health human resource in Orissa

An overview of the situation in the state leads to the identification of the following specific problems focused on HRD in the health sector in Orissa.

4.8.7.1 Planning issues

The following problems are faced in planning human resource in the public health service system in Orissa:

- Absence of appropriate body responsible for human resource planning and development
- Lack of accurate data on man power
- Weak capacity for strategic management of human resources
- Lack of clear policies
- Over-centralized system of personnel administration
- Non-transparency in implementation of rules and regulations in personnel administration.

4.8.7.2 Deployment Issues

Attention should be given on the following issues to develop human resource in the public health sector in Orissa:

- Mal distribution of staff
- Urban concentration of medical professionals

4.8.7.3 Service Related Issues

The issues that affect the quality of services in public hospital in Orissa are listed as under:

- Lack of clarity of roles of individual workers
- Improper supervision and communication
- Inadequate facilities and support system
- Relatively inadequate compliance practices
• Behavioral and motivational problems
• Lack of concern for human factors in work environment

4.8.7.4 Capacity Issues

In order to meet the various health needs of the common people, the following problem has to be addressed:
• Inadequate preparation to cope with the diverse nature of clientele

The Health Vision for 2010 envisages a health human power policy and human resource development strategy that would develop and nurture a health care service delivery team that would be adequately motivated, quality conscious, ethical, competent and socially oriented.

The objectives are directed at creating a band of committed and skilled providers, keeping their morale and motivation high all the time, and moulding doctors to make them efficient health managers.

4.9 BUDGETARY ALLOCATION FOR HEALTHCARE IN ORISSA

Money is an important resource for providing health services. Since, it is a scarce resource, it must be put to effective use by applying management techniques and budgetary allocations on the basis of cost effectiveness and cost benefit analysis. Health is an important indicator for the well-being of humanity. The various arms of Government of India and the States spend about 1 to 1.2 percent of nation's G.D.P in 1990 which rose to 1.25 percentt in the year 2000 and 1.39 percentt in the year 2006-07 which is about Rs.57,000 crores (Times of India dated 16.10.2007). India's health spending is routed through its State Governments through state level policies and programme, i.e., Cental Plan and Centre-Sponsored Plan. Government of India takes the recommendations of the Bhore Committee (1946) into consideration while allocating funds for health care during different plan periods. Orissa spends 3.57 percent on health of its total budget expenditure in 2007-08 which rose from 2.17 percent in 2003-04. The trend of government spending is exhibited in the tables shown below.
The focus in the health sector has been to improve access to health care for all with particular reference to the underprivileged segments of the population. Such low spending over the years has led to a network of ill-equipped government health services. Population in Orissa is increasing steadily and the government has been responding to the emerging health problems by allocating higher amount of funds which has also been exhibited in the table below. The percentage of total expenditure incurred on medical and public health services excluding water supply and sanitation in 2003-04 was 2.17 percent of the total government expenditure in Orissa. This rose continuously upto 3.57 percent in 2007-08. The per capita health related expenditure in 1991-92 was Rs. 35.01 at the all India level as compared to Rs. 29.17 in Orissa.

It goes without saying that states in India and particularly Orissa are aware of their commitments to provide good health and hygienic living to their people. A sustained improvement in the performance of the health sector will make a significant impact on human development. This calls for efforts to make health services accessible to people, particularly to the poorer households. At the same time individuals, families and communities must be aware of their role in building up a healthy society where people can make their utmost contribution to national development and social welfare.

The various tables given below show the budgetary allocations by Government of Orissa for health department for various years. A view at these tables presents the trend of financial provisions made by the state government to meet the health needs of its people.
### Table 4.9

**Government of Orissa budget on medical and public health (Revenue + Capital)**

(Rupees in crores)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Public Health</td>
<td>424.77</td>
<td>429.54</td>
<td>540.06</td>
<td>392.54</td>
<td>591.66</td>
<td>582.88</td>
<td>714.42</td>
</tr>
<tr>
<td>Non-Plan</td>
<td>353.97</td>
<td>347.70</td>
<td>357.13</td>
<td>532.59</td>
<td>508.00</td>
<td>509.58</td>
<td>571.08</td>
</tr>
<tr>
<td>State-Plan</td>
<td>54.35</td>
<td>78.55</td>
<td>174.76</td>
<td>−59.39</td>
<td>39.96</td>
<td>29.60</td>
<td>48.72</td>
</tr>
<tr>
<td>Central Plan</td>
<td>16.45</td>
<td>3.29</td>
<td>8.17</td>
<td>19.24</td>
<td>43.25</td>
<td>43.26</td>
<td>44.18</td>
</tr>
<tr>
<td>Centred-Sponsored Plan</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.44</td>
<td>0.44</td>
<td>0.44</td>
</tr>
<tr>
<td>of which</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Primary Health &amp; Prevention/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of diseases</td>
<td>159.06</td>
<td>132.36</td>
<td>193.00</td>
<td>231.81</td>
<td>257/52</td>
<td>261.60</td>
<td>261.25</td>
</tr>
<tr>
<td>Non Plan</td>
<td>136.74</td>
<td>124.17</td>
<td>168.54</td>
<td>197.92</td>
<td>223.34</td>
<td>223.74</td>
<td>246.99</td>
</tr>
<tr>
<td>State Plan</td>
<td>6.12</td>
<td>5.41</td>
<td>18.00</td>
<td>16.48</td>
<td>1.99</td>
<td>1.24</td>
<td>7.42</td>
</tr>
<tr>
<td>Central Plan</td>
<td>16.21</td>
<td>2.78</td>
<td>6.46</td>
<td>17.41</td>
<td>35.83</td>
<td>35.83</td>
<td>34.19</td>
</tr>
<tr>
<td>Centre-Sponsored Plan</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.44</td>
<td>0.44</td>
<td>0.44</td>
</tr>
<tr>
<td>ii) Others</td>
<td>265.71</td>
<td>297.18</td>
<td>347.06</td>
<td>192.35</td>
<td>330.06</td>
<td>321.63</td>
<td>425.38</td>
</tr>
<tr>
<td>Non Plan</td>
<td>217.23</td>
<td>223.53</td>
<td>188.59</td>
<td>243.67</td>
<td>284.66</td>
<td>285.84</td>
<td>324.09</td>
</tr>
</tbody>
</table>

100
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>iii) Family Welfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Plan</td>
<td>0.59</td>
<td>0.40</td>
<td>0.12</td>
<td>0.14</td>
<td>11.74</td>
<td>11.74</td>
<td>11.94</td>
</tr>
<tr>
<td>State Plan</td>
<td>9.16</td>
<td>13.32</td>
<td>10.74</td>
<td>9.07</td>
<td>1.06</td>
<td>1.06</td>
<td>1.82</td>
</tr>
<tr>
<td>Central Plan</td>
<td>62.79</td>
<td>56.59</td>
<td>79.94</td>
<td>65.23</td>
<td>100.44</td>
<td>101.65</td>
<td>110.80</td>
</tr>
<tr>
<td>Centre-Sponsored Plan</td>
<td>0.10</td>
<td>0.11</td>
<td>0.04</td>
<td>0.04</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>iv) Water Supply &amp; Sanitation</td>
<td>248.67</td>
<td>258.18</td>
<td>275.50</td>
<td>383.42</td>
<td>504.63</td>
<td>512.53</td>
<td>586.96</td>
</tr>
<tr>
<td>Non Plan</td>
<td>95.94</td>
<td>104.97</td>
<td>117.19</td>
<td>124.98</td>
<td>149.07</td>
<td>120.01</td>
<td>118.37</td>
</tr>
<tr>
<td>State Plan</td>
<td>83.07</td>
<td>78.13</td>
<td>94.57</td>
<td>148.67</td>
<td>191.18</td>
<td>159.89</td>
<td>271.02</td>
</tr>
<tr>
<td>Central Plan</td>
<td>0.00</td>
<td>1.67</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Centre-Sponsored Plan</td>
<td>69.67</td>
<td>73.41</td>
<td>63.74</td>
<td>109.77</td>
<td>164.38</td>
<td>232.63</td>
<td>197.57</td>
</tr>
</tbody>
</table>

Source: Orissa Budget (2007-08) at a Glance, Finance Department, Govt. of Orissa.
Table 4.10
Statement of total budget of Government of Orissa

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Budget</td>
<td></td>
<td>23026.29</td>
<td>17336.26</td>
<td>15746.36</td>
<td>19553.58</td>
<td>20421.78</td>
<td>23511.59</td>
<td>27948.49</td>
</tr>
<tr>
<td>Non-Plan Expenditure</td>
<td>–</td>
<td>19071.77</td>
<td>14324.98</td>
<td>12670.49</td>
<td>15445.92</td>
<td>15671.00</td>
<td>17517.28</td>
<td>19623.29</td>
</tr>
<tr>
<td>Plan Expenditure</td>
<td>–</td>
<td>3954.52</td>
<td>3011.28</td>
<td>3075.87</td>
<td>4107.66</td>
<td>4750.78</td>
<td>5994.31</td>
<td>8325.20</td>
</tr>
</tbody>
</table>

Source: Orissa Budget (2007-08) at a Glance, Finance Department, Govt. of Orissa.

Table 4.11
Demand-wise net provision in the budgetary expenditure for 2008-09
(Consolidated Fund)

<table>
<thead>
<tr>
<th>Category</th>
<th>Non-Plan</th>
<th>State Plan</th>
<th>Central Plan</th>
<th>Centre Sponsored Plan</th>
<th>Non Plan + Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Family Welfare</td>
<td>64169</td>
<td>0.00</td>
<td>641.69</td>
<td>182.14</td>
<td>1.88</td>
</tr>
</tbody>
</table>

Orissa Budget 2008-09
## Table 4.12
Demand-wise gross provision in the budgetary expenditure for 2008-09
(Consolidated Fund)

<table>
<thead>
<tr>
<th>Category</th>
<th>Non-Plan</th>
<th>State Plan</th>
<th>Central Plan</th>
<th>Centre Sponsored Plan</th>
<th>Non Plan + Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Family Welfare</td>
<td>64119</td>
<td>0.00</td>
<td>641.19</td>
<td>182.14</td>
<td>1.88</td>
</tr>
</tbody>
</table>

|                               | 1002.91  | 1.88       | 1004.79      |

Source: Orissa Budget 2008-09

## Table 4.13
Proportion of budget allocation on public health of total budget in Government of Orissa

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Public Health</td>
<td>429.54</td>
<td>540.06</td>
<td>392.54</td>
<td>591.66</td>
<td>582.88</td>
<td>714.42</td>
<td>-</td>
</tr>
<tr>
<td>Family Welfare</td>
<td>70.42</td>
<td>90.84</td>
<td>74.48</td>
<td>113.30</td>
<td>113.30</td>
<td>114.51</td>
<td>-</td>
</tr>
<tr>
<td>Health Budget (Total)</td>
<td>499.96</td>
<td>630.90</td>
<td>467.02</td>
<td>704.96</td>
<td>697.39</td>
<td>839.04</td>
<td>999.29</td>
</tr>
<tr>
<td>General Budget (Total)</td>
<td>23026.29</td>
<td>17336.26</td>
<td>15746.36</td>
<td>19553.58</td>
<td>20421.78</td>
<td>23511.59</td>
<td>27948.49</td>
</tr>
<tr>
<td>Proportion of Health BE on General BE (%)</td>
<td>2.17</td>
<td>3.64</td>
<td>2.97</td>
<td>3.61</td>
<td>3.41</td>
<td>3.57</td>
<td>3.54</td>
</tr>
</tbody>
</table>
4.10 HEALTH SECTOR REFORMS AND THEIR EFFECTS ON PUBLIC HEALTH SERVICES IN ORISSA

The health sector reform is defined as "A sustained process of fundamental change in policy and institutional arrangements of the health sector usually guided by the Government. The process lays down sets of policy measures covering the four main core functions of the health system viz., governance, provision, financing and resource generation. It is designated to improve the functioning and performance of the health sector and ultimately the health status of the people" (WHO, 1997).

Though there is gradual improvement of health status over many years, the preventable mortality and morbidity in Orissa are still high. The main causes of poor health are poverty, lower literacy rate, social deprivation, inefficient health system and infrastructure for health care and control of diseases mainly communicable diseases. Socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate geographic spread of service outlets and poor quality health care reduce access to and effectiveness of public services. Women, children, tribal and rural poor people are the worse affected.

In 1996, following the public debate and dissatisfaction with the health services, the house committee of the Orissa Legislative Assembly recommended three important aspects of health care:

a. The need for additional resource mobilization for the health sector.

b. The need for sustained effort towards autonomy for health institutions.

c. The need for abolishing private practice of Government doctors.

The DFID in partnership with Govt. of Orissa made a strategic review of the Orissa health sector. The major observations are:

- Utilisation of health infrastructure by the needy was less than adequate.
- Asset maintenance as far from satisfactory.
In-service training did not bridge these skill-gaps of service providers. Primary health care services were beset with major but removable constraints.

4.10.1 Reforms in Orissa

The Govt. initiated reforms in priority areas based on the above findings and recommendations. The health financing level which was low over the years was the major deterrent for any sweeping reforms initiative.

The following reforms were taken-up in a phased manner in Orissa:

i. Formation of Zilla Swasthya Samities (ZSS)
ii. Amalgamation of Zilla Swasthya Samities
iii. Establishment of State Health & Family Welfare Society
iv. Outsourcing of cleaning in hospitals
v. Mandatory pre P.G. rural service
vi. Internship training programme for better community health orientation.
Vii. Multi-skilling of health personnel:
VIII. Appointments of staffs on contractual basis
ix. Formation of district cadre for paramedics
x. User fees
xi. Centralised Drug Procurement and Distribution
xii. Panchabiyadi Chikista Scheme (5 diseases treatment)
XIII. Multi-disease surveillance system

4.10.2 Effects of Health Sector Reforms on health services in Orissa

A major assumption behind the Orissa Health Sector Reforms and Development (OHRD) is that the referral system would work with full efficiency at the level of PHCs and sub-centres. Focusing on upgradation of first referral units namely CHCs may be more cost-effective than improvement of facilities at the PHC level. But it may lead to ignoring PHCs altogether and undermine the idea of referral system itself. In general, it is important to understand the functioning and management of PHCs which can have a crucial bearing on quality of health care at that level and attempts to improve it. However, both the Project Appraisal Document
of OHDR (May 1998) and "Orissa Vision 2010 – A Health Strategy, there are no concrete measures spelt out for improving accessibility and quality of primary health care. Indeed, there is no assessment of the existing primary health care system in terms of certain well-defined quality parameters so as to identify the deficiencies of the system from the users’ as well as health providers’ points of view.

This is an important issue all the more because there is hardly any systematic study on quality of health care at the primary tier. There is one useful and rigorous study available on perceived quality of health care in terms of three broad indicators each of which is based on certain relevant parameters. The three indicators used are: health delivery quality (Hedelqly); health worker quality (Heworqly): and health facility quality (Hefacqly). Though data were collected for a wide variety of health providers, it is sufficient here to report the findings on PHC, Private Clinic and Public Hospital.

### Table 4.14
Quality Comparison

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rating of Perceived Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHC</td>
</tr>
<tr>
<td>Dedelqly</td>
<td>3.594</td>
</tr>
<tr>
<td>Heworqly</td>
<td>4.229</td>
</tr>
<tr>
<td>Hefacqly</td>
<td>3.967</td>
</tr>
</tbody>
</table>


As can be seen from the table above, PHC gets the worst rating for all the three indicators of quality (particularly unfavourable with respect to health worker quality (Heworqly). It may be noted that private clinics get the best ratings and public hospitals ratings are between those for PHC and private clinics.
REFERENCES


Different Aids for Public Hospitals & their utilization.. www. Govt. of Orissa.co.in., H & F.W. Department.


Hospital Administration, Officer Training School (2004) AMC Centre & School Lucknow, pp. 1, 6.


