Appendix I

LIST OF MAJOR PHARMACEUTICALS COMPANIES

List of companies:

1. Intervet India Pvt. Ltd.
2. Ranbaxy Laboratories Ltd.
3. Emcure Pharmaceuticals Ltd.
4. Hindustan Antibiotics Ltd.,
5. Litaka Pharmaceuticals Ltd.
6. Wockhardt Ltd.
7. Serum Institute of India Ltd.
8. Cipla Ltd.
9. Prophyla Pharmaceuticals Ltd.
10. Fresenious Kabi India Pvt. Ltd.
11. Briocia Pharmaceuticals Ltd.
12. Glenmark Pharmaceuticals Ltd.
13. Dr. Reddy’s Laboratories Ltd.
14. Nicholas Piramal India Ltd.
15. Aurobindo Pharma Ltd.
16. Glaxo SmithKline Ltd.
17. Lupin Laboratories Ltd.
18. Sun Pharmaceutical Industries Ltd.

19. Cadila Healthcare Ltd.

20. Allegran Ltd.


22. Aventis Ltd.
APPENDIX NO. - II

SELECTED DOCUMENTS & RELATED LITERATURE

HEALTH FOR ALL BY 2000 A.D.:

An International Conference on 'Primary Health Care' was held in Alma Ata on September 1978. Several declarations as well as some recommendations were issued calling for urgent and effective national and international action to protect and promote the health of all the people of the world by 2000 A.D. These have been reproduced from Health For All, published by the World Health Organization, Geneva, 1984.

**Declarations:**

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within
countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basil importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be attainment by all people of the world by the year 2000 a level of health that will permit them to lead a socially and economically productive life.
VI

Primary health care is the key to attaining this target as part of development in the spirit of social justice. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary Health Care :

1. Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. Includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national
and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. Should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health
by people in anyone country directly concerns and benefits every other country. In this context, the joint WHO / UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allowed its proper share.
Recommendations Made During International Conference on Primary
Health Care, Alma Ata, USSR, 6-12 September, 1978

1. Interrelationships between health and development:

   The Conference, recognizing that health is dependent on social and
economic development, and also contributes to it, recommends that
governments incorporate and strengthen primary health care within their
national development plans with special emphasis on rural and urban
development programmes and the coordination of the health-related
activities of the different sectors.

2. Community participation in primary health care:

   The Conference, considering that national and community self-
reliance and social awareness are among the key factors in human
development, and acknowledging that people have the right and duty to
participate in the process for the improvement and maintenance of their
health, recommends that governments encourage and ensure full community
participation through the effective, propagation of relevant information,
increased literacy, and the development of the necessary institutional
arrangements through which individuals, families, and communities can
assume responsibility for their health and well-being.
3. The role of national administration in primary health care:

The Conference, noting the importance of appropriate administrative and financial support at all levels, for coordinated national development, including primary health care, and for translating national policies into practice, recommends that governments strengthen the support of their general administration to primary health care and related activities through coordination among different ministries and the delegation of appropriate responsibility and authority to intermediate and community levels, with the provision of sufficient manpower and resources to these levels.

4. Co-ordination of health and health-related sectors:

The Conference, recognizing that significant improvement in the health of all people requires the planned and effective coordination of national health services and health-related activities of other sectors, recommends that national health policies and plans take full account of the inputs of other sectors bearing on health; that specific and workable arrangements be made at all levels—in particular, at the intermediate and community levels—for the coordination of health services with all other activities contributing to health promotion and primary health care; and that arrangements for coordination take into account the role of the sectors dealing with administration and finance.
5. Content of primary health care:

The Conference, stressing that primary health care should focus on the main health problems in the community, but recognizing that these problems and the ways of solving them will vary from one country and community to another, recommends that primary health care should include at least; education concerning prevailing health problems and the methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and provision of essential drugs.

6. Comprehensive primary health care at the local level:

The Conference, confirming that primary health care includes all activities that contribute to health at the interface between the community and the health system, recommends that, in order for primary health care to be comprehensive, all development-oriented activities should be interrelated and balanced so as to focus on problems of the highest priority as mutually perceived by the community and health system, and that culturally acceptable, technically appropriate, manageable, and appropriately selected
interventions should be implemented in combinations that meet local needs. This implies that single-purpose programmes should be integrated into primary health-care activities as quickly and smoothly as possible.

7. **Support of primary health care within national health system**:  

The Conference, considering that primary health care is the foundation of a comprehensive national health system and that the health system must be organized to support primary health care and make it effective, recommends that governments promote primary health care and related development activities so as to enhance the capacity and determination of the people to solve their own problems. This requires a close relationship between the primary health-care workers and the community and that each team be responsible for a defined area. It also necessitates reorienting the existing system to ensure that all levels of the health system support primary health care by facilitating referral of patients and consultation on health problems; by providing supportive supervision and guidance, logistic support, and supplies; and through improved use of referral hospitals.

8. **Special needs of vulnerable and high-risk groups**:  

The Conference, recognizing the special needs of those who are least able, for geographical, political, social, or financial reasons, to take the
initiative in seeking health care, and expressing great concern for those who are the most vulnerable or at greatest risk, recommends that, as part of total coverage of populations through primary health care, high priority be given to the special needs of women, children, working population at high risk, and the under-privileged segments of society, and that the necessary activities be maintained, reaching out into all homes and working places to identify systematically those at highest risk, to provide continuing care to them, and to eliminate factors contributing to ill health.

9. Roles and categories of health and health-related manpower for primary health care:

The Conference, recognizing that the development of primary health care depends on the attitudes and capabilities of all health workers and also on a health system that is designed to support and complement the frontline workers, recommends that governments give high priority to the full utilization of human resources by defining the technical role, supportive skills, and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives,
physicians, and, where applicable, traditional practitioners and traditional birth attendants.

10. Training of health and health-related manpower for primary health care:

The Conference, recognizing the need for sufficient numbers of trained personnel for the support and delivery of primary health care, recommends that governments undertake or support reorientation and training for all levels of existing personnel and revised programmes for the training of new community health personnel; that health workers, especially physicians and nurses, should be socially and technically trained and motivated to serve the community; that all training should include field activities; that physicians and other professional health workers should be urged to work in underserved areas early in their career; and that due attention should be paid to continuing education, supportive supervision, the preparation of teachers of health workers, and health training for workers from other sectors.

11. Incentives for service in remote and neglected areas:

The Conference, recognizing that service in primary health care focused on the needs of the underserved requires special dedication and motivation, but that even then there is a crucial need to provide culturally
suitable rewards and recognition for service under difficult and rigorous conditions, recommends that all levels of health personnel be provided with incentives scaled to the relative isolation and difficulty of the conditions under which they live and work. These incentives should be adapted to local situations and may take such forms as better living and working conditions and opportunities for further training and continuing education.

12. Appropriate technology for health:

The Conference, recognizing that primary health care requires the identification, development, adaptation, and implementation of appropriate technology, recommends that governments, research and academic institutions, nongovernmental organizations, and especially communities, develop technologies and methods that contribute to health, both in the health system and in associated services; are scientifically sound, adapted to local needs, and acceptable to the community; and are maintained by the people themselves, in keeping with the principle of self-reliance, with resources the community and the country can afford.

13. Logistic support and facilities for primary health care:

The Conference is aware that the success of primary health care depends on adequate, appropriate, and sustained logistic support in thousands of communities in many countries, raising new problems of great
magnitude, recommends that governments ensure that efficient administrative, delivery, and maintenance services be established, reaching out to all primary health care activities at the community level; that suitable and sufficient supplies and equipment be always available at all levels in the health system, in particular to community health workers; that careful attention be paid to the safe delivery and storage of perishable supplies such as vaccines; that there be appropriate strengthening of support facilities including hospitals, and that governments ensure that transport and all physical facilities for primary health care be functionally efficient and appropriate to the social and economic environment.

14. Essential drugs for primary health care:

The Conference recognizing that primary health care requires a continuous supply of essential drugs; that the provision of drugs accounts for a significant proportion of expenditures in the health sector; and that the progressive "extension of primary health care to ensure eventual coverage entails a large increase in the provision of drugs, recommends that governments formulate national policies and regulations with respect to the import, local production, sale and distribution of drugs and biologicals so as to ensure that essential drugs are available at the various levels of primary health care at the lowest feasible cost; that specific measures be taken to
prevent the over utilization of medicines; that proved traditional remedies be incorporated; and that effective administrative and supply systems be established.

15. Administration and management for primary health care

The Conference, considering that the translation of the principles of primary health care into practice requires the strengthening of the administrative structure and managerial processes, recommends that governments should develop the administrative framework and apply at all levels appropriate managerial processes to plan for and implement primary health care, improve the allocation and distribution of resources, monitor and evaluate programmes with the help of a simple and relevant information system, share control with the community, and provide appropriate management training of health workers of different categories.

16. Health services research and operational studies:

The Conference, emphasizing that enough is known about primary health care for governments to initiate or expand its implementation, but also recognizing that many long-range and complex issues need to be resolved, that the contribution of traditional systems of medicine calls for further research, and that new problems are constantly emerging as implementation proceeds, recommends that every national programme should set aside a
percentage of its funds for continuing health services research; organize health services research and development units and field areas that operate in parallel with the general implementation process; encourage evaluation and feedback for early identification of problems; give responsibility to educational and research institutions and thus bring them into close collaboration with the health system; encourage the involvement of field workers and community members; and undertake a sustained effort to train research workers in order to promote national self-reliance.

17. Resources for primary health care:

The Conference, recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health, recommends that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors.
18. National commitment to primary health care:

The Conference, affirming that primary health care requires strong and continued political commitment at all levels of government, based upon the full understanding and support of the people, recommends that governments express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socio-economic development, with the involvement of all sectors concerned; to adopt enabling legislation where necessary; and to stimulate, mobilize, and sustain public interest and participation in the development of primary health care.

19. National strategies for primary health care:

The Conference, stressing the need for national strategies to translate policies for primary health care into action, recommends that governments elaborate without delay national strategies with well-defined goals and develop and implement plans of action to ensure that primary health care be made accessible to the entire population, the highest priority being given to underserved areas and groups, and reassess these policies, strategies, and plans for primary health care, in order to ensure their adaptation to evolving stages of development.
20. Technical cooperation in primary health care

The Conference, recognizing that all countries can learn from each other in matters of health and development, recommends that countries share and exchange information, experience and expertise in the development of primary health care as part of technical cooperation among countries, particularly among developing countries.

21. International support for primary health care

The Conference, realizing that in order to promote and sustain health care and overcome obstacles to its implementation, there is a need for strong, coordinated international solidarity and support, and welcoming the offers of collaboration from United Nations Organizations as well as from other sources of cooperation, recommends that international organizations, multilateral and bilateral agencies, nongovernmental organizations, funding agencies, and other partners in international health acting in a coordinated manner should encourage and support national commitment to primary health care and should channel increased technical and financial support into it, with full respect for the co-ordination of these resources by the countries themselves in a spirit of self-reliance and self-determination, as well as with the maximum utilization of locally available resources.
22. Role of WHO and UNICEF in supporting primary health care:

The Conference, recognizing the need for a world plan of action for primary health care as a cooperative effort of all countries, recommends that WHO and UNICEF, guided by the declaration of Alma Ata and the recommendations of this Conference, should continue to encourage and support national strategies and plans for primary health care as part of overall development.

Recommends that WHO and UNICEF, on the basis of national strategies and plans, formulate as soon as possible concerted plans of action at the regional and global levels that promote and facilitate the mutual support of countries, particularly through the use of their national institutions, for accelerated development of primary health care.

Recommends that WHO and UNICEF continuously promote the mobilization of other international resources for primary health care. The health status of hundreds of millions of people in the world today is unacceptable. More than half the population of the world does not have the benefit of adequate health care. There is a wide gap between the developed and developing countries in their levels of health and in the resources they are devoting to the improvement of health. Moreover, within individual
countries, whatever their level of development, analogous gaps are commonly evident between different groups of the population.

The Declaration of Alma Ata, adopted on 12 September, 1978 by the International Conference on Primary Health Care, which was jointly sponsored and organized by WHO and UNICEF, clearly stated that primary health care is the key to attaining the target of health for all by the year 2000 as part of overall development and in the spirit of social justice. The Declaration called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as a part of a comprehensive national health system and in co-ordination with other sectors. The Declaration also called for urgent and effective international-in addition to national action to develop and implement primary health care throughout the world, and particularly in developing countries.

The key to attaining the goal of health for all by the year 2000 is, in the view of the Alma Ata Conference, primary health care. Primary health care is essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Related sectors should also be
involved in it, in addition to the health sector: At the very least it should include: education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; promotion of adequate supplies of food of proper nutrition; provision of sufficient safe water and basic sanitation; maternal and child health care, including family planning; prevention and control of locally endemic diseases; immunization against the main infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.

Primary health-care is the central function and main focus of a country's health system, the principal vehicle for the delivery of health care, and an integral part of the social and economic development of a country. The form it takes will vary according to each country's political, economic, social, cultural and epidemiological patterns. To be successful, it needs individual and community self-reliance and the maximum community involvement or participation; that is to say, the active involvement of people living in a community in the planning, operation and control of primary health care, using local, national, and other resources.

Health for all does not mean that in the year 2000, doctors and nurses will provide medical care for everybody in the world for all their ailments
and that nobody will be sick or disabled. It does mean that health begins and is fostered at home, in schools and in factories, where people live and work. People will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and have better ways of growing up, growing old and dying indignity. Essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. There will be an even distribution among the population of whatever resources for health are available and people will realize that ill-health is not inevitable and they themselves have the power to shape their lives and the lives of their families, free from the inevitable burden of disease. In the process of formulating strategies, especially the setting of national targets, some countries may concentrate more on the health status of the population, while others may concentrate more on the provision of health services. Interpretation of what is an acceptable level of health may vary from country to country. In addition, widely different approaches could be used, such as providing the full range of services required, starting with those in greatest need and progressively reaching the whole population, or providing limited services to the total population from the beginning and progressively extending the range of these services.
International collaboration and support will be needed to meet this world wide social goal of health for all. In view of this, strategies should be formulated by the countries. Regional and global strategies would then be developed collectively on the basis and in support of national strategies and plans of action. National policies, strategies and plans of action and regional strategies will vary widely in accordance with the aspirations and capabilities of countries. At the same time, if the goal is to be attained by all the countries of the world, acting collectively as well as individually, there is a need for a common framework.

The Declaration of Alma Ata and various doctrines that have been built up by member states through the World Health Organization and other international agencies embody a number of fundamental principles of health development. Among these are: the responsibility of governments for the health of their people; the right and duty of people individually and collectively to participate in the programmes for health care; the duty of governments and the health professionals to provide the public with relevant information on health matters so that people can assume greater responsibility for their own health; individual, community and national self-determination and self-reliance in health matters; the interdependence of individuals, communities and countries based on their common concern for
health; more equitable distribution of health resources within and among countries, including their preferential allocation to those in greatest social need so that the health system adequately covers all the population; emphasis on preventive measures, well integrated with curative, rehabilitative and environmental measures; the pursuit of relevant biomedical and health services research and the speedy application of research findings; the application of appropriate technology through well-defined health programmes integrated into a country-wide health system, based on primary health care and incorporating the above concepts; the social orientation of health workers of all categories to serve people and their technical training to provide people with the services planned for them.

Primary health care forms an integral part of the country's health system. It is also an integral part of overall social and economic development of the community. For these reasons, the concept of primary health care, as decided in Alma Ata, should be the driving force behind the determination of policies and should be kept in mind when formulating strategies and plans of action. Primary health care requires the support of the, rest of the health system and of other social and economic sectors concerned. Health system support includes facilities for consultation on health problems, referral of patients to local and more specialized health
institutions, provision of supportive supervision and guidance, and logistic support and supplies. As for the other sectors, particular emphasis will have to be paid on such sectors as education, agriculture, animal husbandry, food, water resources, environmental protection, housing, industry, public works and communications.

The Alma Ata Declaration stated that at least the following should be included in primary health care:

Education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

The planning, organization and operation of primary health care is a long-term process and total population coverage by it may have to be achieved in stages. An essential feature is that it should be extended progressively, in both geographical coverage and content, until it covers the entire population with all essential components.
While inaugurating a national workshop on 'Human Resource Development in Hospitals' organized by the Academy of Hospital Administration in collaboration with the Department of Hospital Administration at the All India Institute of Medical Sciences, New Delhi, on 6 April, 1988, Shri L.P. Shahi, the then Union Minister of State for Culture and Education said:

Challenges that lie ahead in meeting the commitment of 'Health for All by 2000 A.D.' can only be met effectively and efficiently if the human resource in health sector is developed fully to work competently, committed and with missionary zeal. Hospitals are complex organizations with wide variations in staffing pattern due to various reasons which has resulted in the multiple categories of workers that exist today which calls for rationalization and standardization to optimize the utilization for high quality care. Aspirations of the large work force in 8,000 hospitals and 125 medical colleges in the health sector of the country needs to be looked into to provide better opportunities and job satisfaction. Increasing technological innovations, rapid introduction of sophisticated gadgetry in the medical field demand performance of a high order which needs development of well-trained manpower in hospitals to take full advantage of new developments in meeting the health-care demands of society.
Only a few months are left to touch the target date of health for all by 2000 A.D. The member states of the World Health Organization have pledged themselves to work together so that, by then, all people everywhere will have at least such level of health that they will be capable of working productively and taking an active part in the social life of the community in which they live. The author is of the opinion that it is not only the government that is responsible for maintaining the health of the people, but people too has the right and the duty to take an active part in maintaining their own health and when they are ill, of looking after themselves. They have the same duty with respect to their families, their work-mates, their neighbors, etc.

To achieve the goal of health for all by the year 2000, it is essential to have an adequate number of properly trained health workers. The provision of health workers, sufficiently trained to meet present and future needs for activities in the health and related sectors, is known as health manpower development. It involves the planning, production and management of health manpower-that is, the estimation of needs and the taking of steps to ensure that the health workers are properly trained, recruited or otherwise employed, adequately paid, and given career prospects that will keep them within the health system.
Financial Resources:

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities, it is planned, under the policy to increase health sector expenditure to 6% of GDP, with 2% of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7% of the Budget; and, in the second phase, by 2010, to increase it to 8% of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25% from the existing 15% by 2010. The provisioning of higher public health investments will also be contingent upon the increase in the absorptive capacity of the public health administration so as to utilize the funds gainfully.

Equity:

To meet the objective of reducing various types of inequities and imbalances-inter-regional; across the rural-urban divide; and between economic classes-the most cost-effective method would be to increase the
sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2002 sets out an increased allocation of 55% of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35% and 10%, respectively. The Policy projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

**Delivery of National Public Health Programmes:**

This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, malaria, HIV/AIDS, as also the RCH and universal immunization
programmes would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimization of outcomes through a convergence of all public health inputs. The Policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. The interventions of State Health Departments may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programmed implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making.

The Policy also highlights the need for developing the capacity within the State Public Health administration for scientific designing of public health projects, suited to the local situation.

The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programmed, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmed or other public health initiatives. It would be for the Head of the District
Health administration to allocate the time of the rural health staff between the various programmed, depending on the local need. NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented.

**The State of Public Health Infrastructure:**

As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraints, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services; so medical professionals and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in some States like the four Southern States Kerala, Andhra Pradesh, Tamilnadu and Karnataka is relatively better, because some quantum of
drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public Health facilities. In this backdrop, the Policy envisages kick-starting the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system. It is expected that the provisioning of essential drugs at the public health service centers will create a demand for other professional services from the local population which, in turn, will boost the general revival of activities in these service centers. In sum, this initiative under NHP-2002 is launched in the belief that the creation of a beneficiary interest in the public health system will ensure a more effective supervision of the public health personnel through community monitoring, than has been achieved through the regular administrative line of control.

This Policy recognizes the need for more frequent in-service training of public health medical personnel, at the level of medical officers as well as paramedics. Such training would help to update the personnel on recent advancements in science, and would also equip them for their new assignments, when they are moved from one, discipline of public health administration to another.
Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Table 3.5 gives statistics which clearly show that standards of health are more a function of the accurate targeting of expenditure on the decentralized primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Therefore, the Policy, while committing additional aggregate financial resources, places great reliance on the strengthening of the primary health structure for the, attaining of improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain second and tertiary public health care services, for those who can afford to pay.

**Extending Public Health Services:**

This policy envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. Simple services/ procedures can be provided by such practitioners even outside their disciplines, as part of the
basic primary health services in underserved areas. Also, NHP-2002 envisages that the scope of the use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. This would be on the lines of the services rendered by nurse practitioners in several developed countries. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training, and subject to the monitoring of their performance through professional councils.

NHP-2002 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under served areas. State Governments could also rigorously enforce a mandatory two-year rural posting before the awarding of the graduate degree. This would not only make trained medical manpower available in the underserved areas, but would offer valuable clinical experience to the graduating doctors.

**Role of Local Self Government Institutions:**

NHP-2002 lays great emphasis upon the implementation of public health programmes through local self-government institutions. The structure of the national disease control; programmes will have specific components
for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation, of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources normatively allocated for disease control programmes, will be provided by the Central Government.

**Norms for Health Care Personnel :**

Minimal statutory norms for the deployment of doctors and nurses in medical institutions need to be introduced urgently under the provisions of the Indian Medical Council Act and the Indian Nursing Council Act, respectively. These norms can be progressively reviewed and made more stringent as the medical institutions improve their capacity for meeting better normative standards.

**Education of Health Care Professionals :**

In order to ameliorate the problems being faced on account of the uneven spread of medical and dental colleges in various parts of the country, this Policy envisages the setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country. Also, it is envisaged that the Medical Grants Commission will fund the upgradation of the infrastructure of the existing Government
Medical and Dental Colleges of the country, so as to ensure an improved standard of medical education.

To enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact, this Policy identifies a significant need to modify the existing curriculum. A need-based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation. The Policy also recommends a periodic skill-updating of working health professionals through a system of continuing medical education.

The Policy emphasis’s the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research. The policy also envisages that the creation of additional seats for postgraduate courses should reflect the need for more manpower in the deficient specialties.

**Need for Specialists in 'Public Health' and 'Family Medicine':**

In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of 'public health' and 'family medicine', the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these disciplines in medical
training institutions, to reach a stage wherein ¼th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of postgraduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to 'public health' and 'family medicine'. Since the 'public health' discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors, but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

Nursing Personnel:

In the interest of patient care, the policy emphasizes the need for an improvement in the ratio of nurses’ vis-à-vis doctors/beds. In order to discharge their responsibility as model providers of health services, the public health delivery centers need to make a beginning by increasing the number of nursing personnel. The Policy anticipates that with the increasing aspiration for improved health care amongst the citizens, private health facilities will also improve their ratio of nursing personnel vis-à-vis doctors/beds.

The Policy lays emphasis on improving the skill-level of nurses and on increasing the ratio of degree-holding nurses vis-à-vis diploma-holding nurses. NHP-2002 recognizes the need for the Central Government to
subsidize the setting up and the running of training facilities for nurses on a decentralized basis. Also, the Policy recognizes the need for establishing training courses for super-specialty nurses required for tertiary care institutions.

**Use of Generic Drugs and Vaccines:**

This Policy emphasizes the need for basing treatment regimens, in both the public and private domains, on a limited number of essential drugs of a generic nature. This is a prerequisite for cost-effective public health care. In the public health system, this would be enforced by prohibiting the use of proprietary drugs, except in special circumstances. The list of essential drugs would no doubt have to be reviewed periodically. To encourage the use of only essential drugs in the private sector, the imposition of fiscal disincentives would be resorted to. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute.

The National Programme for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price. To minimize the danger arising from the volatility of the global market, and thereby to ensure long-term national
health security, NHP-2002 envisages that not less than 50% of the requirement of vaccines/sera is sourced from public sector institutions.

**Urban Health:**

NHP-2002 envisages the setting up of an organized urban primary health care structure. Since the physical features of urban settings are different from those in rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2002 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing an O.P.D. facility and essential drugs, to enable access to all the national health programmes; and a second-tier of the urban health organization at the level of the Government general hospital, where reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-government institutions and State and Central Governments.

The Policy also envisages the establishment of fully-equipped 'hub-spoke' trauma care networks in large urban agglomerations to reduce accident mortality.
**Mental Health:**

NHP-2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.

In regard to mental health institutions for in-door treatment of patients, the Policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

**Information, Education and Communication:**

NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the interpersonal communication of information and on folk and other traditional media to bring about behavioral change. The IEC programmed would set specific targets for the association of NGOs trusts in such activities. In several public health programmed, where behavioral change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious
and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioral change. The programmed will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmed on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups, who do not normally benefit from the more common media forms.

NHP-2002 envisages giving priority to school health programmed which aim at preventive health education, providing regular health check-ups, and promotion of health-seeking behavior among children. The school health programmed can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

Health Research:

This Policy envisages an increase in Government-funded health research to a level of 1% of the total health spending by 2005, and thereafter, up to 2% by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and malaria,
as also on the sub-types of HIV/AIDS prevalent in the country. Research programmed taken up by the Government in these priority areas would be conducted in a mission mode. Emphasis would also be laid on time-bound applied research for developing operational applications. This would ensure the cost-effective dissemination of existing/future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules/vaccines, inter alia, through fiscal incentives.

**Role of Private Sector :**

In principle, this Policy welcomes the participation of the private sector in all areas of health activities-primary, secondary or tertiary. However, looking at the past experience of the private sector, it can reasonably be expected that its contribution would be substantial in the urban primary sector and the tertiary sector, and moderate in the secondary sector. This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/ medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period. With the acquiring of experience in the setting and enforcing of minimum quality standards, the Policy envisages
graduation to a scheme of quality accreditation of clinical establishments/medical institutions, for the information of the citizenry. The regulatory/accreditation mechanisms will no doubt also cover public health institutions. The Policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sectors under private health insurance packages.

In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector, would be the appropriate solution. The administrative and financial implications of such an initiative are still unknown. As a first step, this Policy envisages the introduction of a pilot scheme in a limited number of representative districts, to determine the administrative features of such an arrangement, as also the requirement of resources for it. The results obtained from these pilot projects would provide material on which future public health policy can be based.

NHP-2002 envisages the co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.
This Policy recognizes the immense potential of information technology applications in the area of tele-medicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

**Role of Civil Society:**

NHP-2002 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize their high motivational skills on an increasing scale, this Policy envisages that the disease control programmed should earmark not less than 10% of the budget in respect of identified programmed components, to be exclusively implemented through these institutions. The policy also emphasizes the need to simplify procedures for government-civil society interfacing in order to enhance the involvement of civil society in public health programmes. In principle, the state would encourage the handing over of public health service outlets at any level for management by NGOs and other institutions of civil society, on an 'as-is-where-is' basis, along with the normative funds earmarked for such institutions.
National Disease Surveillance Network:

This Policy envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programmed for setting up this network will include components relating to the installation of database handling hardware; IT inter-connectivity between different tiers of the network; and in-house training for data collection and interpretation for undertaking timely and effective response. This public health surveillance network will also encompass information from private health care institutions and practitioners. It is expected that real-time information from outside the government system will greatly strengthen the capacity of the public health system to counter focal outbreaks of seasonal diseases.

Health Statistical:

The Policy envisages the completion of baseline estimates for the incidence of the common diseases-TB, malaria, blindness-by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish, in a longer timeframe, baseline estimates for non-communicable diseases, like CVD, cancer, diabetes; and accidental injuries, and
communicable diseases like Hepatitis and JE. NHP-2002 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy-making.

Planning for the health sector requires a robust information system, inter alia, covering data on service facilities available in the private sector. NHP-2002 emphasis’s the need for the early completion of an accurate database of this kind.

In an attempt at consolidating the database and graduating from a mere estimation of the annual health expenditure, NHP-2002 emphasis’s the need to establish national health accounts, conforming to the 'source-to-users' matrix structure. Also, the policy envisages the estimation of health costs on a continuing basis. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision-makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

**Women's Health:**

NHP-2002 envisages the identification of specific programmed targeted at women's health. The Policy notes that women, along with other underprivileged groups, are significantly handicapped due to a
disproportionately low access to health care. The various Policy recommendations of NHP-2002, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health care. The Policy commits the highest priority of the Central Government to the funding of the identified programmes relating to women's health. Also, the policy recognizes the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner.

**Medical Ethics:**

NHP-2002 envisages that, in order to ensure that the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

By and large, medical research within the country in the frontier disciplines, such as gene-manipulation and stem cell research, is limited. However, the policy recognizes that a vigilant watch will have to be kept so that the existing guidelines and statutory provisions are constantly reviewed and updated.
Enforcement of Quality Standards for Food and Drugs:

NHP-2002 envisages that the food and drug administration will be progressively strengthened, in terms of both laboratory facilities and technical expertise. Also, the policy envisages that the standards of food items will be progressively tightened up at a pace which will permit domestic food handling/manufacturing facilities to undertake the necessary up gradation of technology so that they are not shut out of this production sector. The Policy envisages that ultimately food standards will be close, if not equivalent, to Codex specifications, and that drug standards will be at par with the most rigorous ones adopted elsewhere.

Regulation of Standards in Para Medical Disciplines:

NHP-2002 recognizes the need for the establishment of statutory professional councils for paramedical disciplines to register practitioners, maintain standards of training, and monitor performance.

Environmental and Occupational Health:

This Policy envisages that the independently-stated policies and programmed of the environment-related sectors be smoothly interfaced with the policies and the programmed of the health sector, in order to reduce the health risk to the citizens and the consequential disease burden. NHP-2002
envisages the periodic screening of the health conditions of the workers, particularly for high-risk health disorders associated with their occupation.

**Providing Medical Facilities to Users from Overseas:**

To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, NHP-2002 strongly encourages the providing of such health services on a payment basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives, including the status of deemed exports”, which are available to other exporters of goods and services.

**Impact of Globalization on The Health Sector :**

The Policy takes into account the serious apprehension, expressed by several health experts, of the possible threat to health security in the post-TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, this policy envisages a national patent regime for the future, which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The policy also sets out that the Government will bring to bear its full influence in all international, organizations like WHO,
WTO, etc. to secure commitments on the part of the Nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

SUMMATION:

The crafting of a National Health Policy is a rare occasion in public affairs when it would be legitimate, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP-2002, which, in fact, defines a vision for the future.

The health needs of the country are enormous and the financial resources and managerial capacity available to meet them, even on the most optimistic projections, fall somewhat short. In this situation, NHP-2002 has had to make hard choices between various priorities and operational options. NHP-2002 does not claim to be a road-map for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are also dynamic, as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy
components. Broadly speaking, NHP-2002 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the Policy is focused on those diseases which are principally contributing to the disease burden—TB, malaria and blindness from the category of historical diseases; and HIV/AIDS from the category of 'newly emerging diseases'. This is not to say that other items contributing to the disease burden of the country will be ignored; but only that the resources, as also the principal focus of the public health administration, will recognize certain relative priorities. It is unnecessary to labor the point that under the umbrella of the macro policy prescriptions in this document, governments and private sector programmer planners will have to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribals and other socio-economically underserved sections. An adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities.

One nagging imperative, which has influenced every aspect of this Policy, is the need to ensure that 'equity' in the health sector stands as an independent goal. In any future evaluation of its success or failure, NHP-2002 would wish to be measured against this equity norm, rather than any
other aggregated financial norm for the health sector. Consistent with the primacy given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities, including the new concept of the provisioning of essential drugs through central funding. The Policy also commits the Central Government to an increased under-writing of the resources for meeting the minimum health needs of the people. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby facilitating rational resource allocation.

This Policy broadly envisages a greater contribution from the Central Budget for the delivery of Public Health services at the State level. Adequate appropriations, steadily rising over the years, would need to be ensured. The possibility of ensuring this by imposing an earmarked health cess has been carefully examined. While it is recognized that the annual budget must accommodate the increasing resource needs of the social sectors, particularly in the health sector, this Policy does not specifically recommend an earmarked health cess, as that would have a tendency of reducing the space available to Parliament in making appropriations looking to the circumstances prevailing from time to time.

The Policy highlights the expected roles of different participating groups in the health sector. Further, it recognizes the fact that, despite all
that may be guaranteed by the Central Government for assisting public health programmed, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health levels would be significantly dependent on population stabilization, as also on complementary efforts from other areas of the social sectors-like improved drinking water supply, basic sanitation, minimum nutrition, etc. to ensure that the exposure of the populace to health risks is minimized.

Any expectation of a significant improvement in the quality of health services, and the consequential improved health status of the citizenry, would depend not only on increased financial and material inputs, but also on a more empathetic and committed attitude in the service providers, whether in the private or public sectors. In some measure, this optimistic policy document is based on the understanding that the citizenry is increasingly demanding more by way of quality in health services, and the health delivery system, particularly in the public sector, is being pressed to respond. In this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid
one. In the area of public health, an improved standard of governance is a prerequisite for the success of any health policy.

**HOW CAN AN ORGANIZATION MANAGE CHANGE SUCCESSFULLY?**

Management of change is a much talked about topic in all kinds of organizations. Change is happening at an accelerated pace. It can be due to any reason: (1) Organization development (2) Management development (3) Computerization (4) Automation (5) Introduction of new laws (6) Any other reason.

By now, this has become such an established issue that managers appear to be quite conversant with the nuances of effectively managing the process of change. To be successful, change has to be as unobtrusive as possible. This will obviously hurt the interests of the minimum number of people and, therefore, it will be easier to implement. There will be less resistance.
Secondly, change should not be introduced for the sake of change, but it should be introduced to enable an organization to operate in new, more exciting and more viable ways. In case of hospitals, change should be introduced so that patients stay and cost can be reduced and service improved.

1. *Kaizen* Small changes up to big changes. The famous Kaizen technique can be and should be used to bring about small improvements in a number of areas so as to achieve sizeable improvements on an overall basis.

2. *Order* Non-controversial changes should be implemented first in order to enlist the support of people to the proposed changes. If the controversy is generated in the process of implementing a disputed change, it will hamper the implementation of other harmless and non-controversial changes too.

3. *Only necessary* while every effort should be made to implement required changes for the sake of change the good points of the existing system should be considered for retention.

4. *Shared vision* the power of shared vision is often emphasized when it comes to involving in the process of change. Though it is difficult to develop but when it is actually developed, it has the power to unleash changes of enormous magnitude and intensity.
5. **Corporate communication** the need for change and plan should be communicated effectively to the employees in order to remove misgivings, alley apprehensions and ambiguities with regard to proposed changes. Effective communication has to be initiated before the process commences, and it has to be sustained till it reaches its logical end.

6. **Identification of change-agents** Change-agents do play a crucial role in Implementing change. They should possess a high degree of team spirit and integrity. Solo prayers, however gifted they may be, are not likely to be good change-agents.

   Management of change has always been important and its importance will increase further in future. So, it is imperative that this important process be understood sufficiently in order to have a smoother and effective implementation of change. Hospitals are not exceptions to it.

**COMPUTERS IN PHARMACY DEPARTMENT:**

In the pharmacy department, a new information system reduces clerical tasks and enables the pharmacists to spare more time for reviewing patient profiles. The application of computers in the pharmacy department will, not only improve patient care and hospital efficiency, but reduce the storage problem and also reduce the money tied up in higher-than-required
stock levels. Over and above this, a proper and accurate inventory can be maintained, which is otherwise an uphill task.

**COMPUTERS IN HUMAN RESOURCE DEPARTMENT:**

Effective human resource management requires a great deal of information. Computer technology enables organizations to combine human-resource information into a single data base. A common computer-oriented information system used in the management of human resources is often referred to as a human-resource information system.

Any human-resource information system is logically an inventory of the positions and skills existing in a given organization. It is a mechanism for inventory control and accounting. It enables managers to establish objectives for the use of their organization’s human resources and to measure the extent to which those objectives have been achieved.

Among the many benefits to be gained from using computer technology, there are four key advantages.

1. The computer enables the human resource department to take a more active role in organization planning.

2. The computer integrates and stores in a single data base all personnel information previously filed in separate physical locations. Thus the human resource department can take a global view of its human
resource stock and interpret it in more meaningful ways. For example, data on career interests may be more easily matched with career advancement and training opportunities by creating a simple coding system that automatically identifies candidates. Generally, personnel data includes employees personal preferences, education and training and experience and skill. The position and personal data can then be used to make more effective internal selection and placement decisions and career development decisions that are beneficial to both the organization and the individual.

3. The computer speeds up the process of comparing costs and benefits.

4. Computer technology facilitates the easy storage and access of personnel records.

To comply with the law of the land, an organization must follow the Employment Exchange (Compulsory Notification of Vacancies) Act, 1959, Employees' Provident Fund Act, 1952, Income Tax Act, 1961, etc. Similarly, an organization must follow other state laws, if any. All these laws can easily be complied with, using computers.

A newer and much less common external method is the computerized recruiting service. This service works both as a place to list job openings and a place to locate job applicants. Thus, human resource officers can find the
right candidate for a particular job in just fifteen minutes. This service is available in India, and is becoming very popular and being commonly used in India.

Computer technology can play a significant role in the selection and placement of new candidates. Deciding which predictors are relevant (valid) for a particular case and administering a multitude of predictors (tests) is a complex task for the human resource department. Computer technology can enhance the ability of the human resource department to co-ordinate the scheduling, administration and evaluation of predictors, by processing the information rapidly.

A more-recent event in performance appraisal is the gathering of performance data by computers. Advances in computer technology make it possible for employers to collect and analyze information about work performance continuously; but no such programmed has been made so far in India.

In the area of training and development, the computer has been used to a great extent. There are computer assisted instructions that are widely used in training techniques. Computer assisted training instructions are the programmed learning methods. Under computer managed instructions, the trainees' competence is assessed by the computer before the start of the
training. The assessment continues till the end of the training. The assessment makes the trainer to modify the training contents to suit the trainees' needs. Under computer based training, the facilities of computer aided instructions and computer managed instructions are combined together. Being comprehensive, such training provides many advantages to the trainees as well as to the trainer. It provides immediate feedback; it is cost effective. The evaluation of trainees and training programmed can be made immediately available, which is not possible under other traditional training techniques. It is up to the organizations to make a choice of appropriate computerized training technique, depending upon the availability of funds.

Safety and health at workplace are essential. Healthy employees free from any disease are the assets of the organization. The organization having such employees, who are not only motivated and dedicated but also healthy and not suffering from any disease should be proud of itself. It deserves credit for excellent provisions in respect of safety and health of its employees. The Human Resource Department can develop software and maintain the records of various categories of occupational diseases, their dangers, how personnel suffer from them, methods of prevention, safety measures, etc.
Computer technology does not stop here. It can facilitate decision making in union management negotiations by maintaining a data base of information about other union settlements in the same or different hospitals. Relevant data that can be stored in a human-resource information system include salary and benefits data, productivity figures, data on general economic conditions and the cost of living. Management could then use this data to establish, compare and evaluate its offers to the union more quickly and easily. Thus computer technology can be applied in maintaining personnel files, attendance and leave records, organizing training programmed and in recruitment, selection, placement, transfer, promotion and union negotiations, preparing and maintaining of salary records and gathering of performance appraisal data in the human resource department of a hospital.

**Supreme Court Judgment on Medicos – Its consequences & Remedies:**

Four suggestions have been made in this section. The First suggestion has been made to the legislature to modify the Act so that all patients whether paying or non-paying fall within the purview of the Consumer Protection Act, 1986. The Second suggestion being made is to make the legislature understand that today certain elements in the public want to make a quick buck by hook or by crook not realizing that by filing false
complaints against doctors, they unnecessarily harass innocent medicos also who may not be at fault. Therefore, a duty must be cast on the judges of all the three forums not only to thoroughly scrutinize complaints by inviting comments of a specialist doctor at the time of admission but also by allowing another specialist doctor to join them at the time of hearing arguments, instead of issuing notices to medicos in routine. The third suggestion is to make the public aware that if frivolous complaints will be filed against doctors, naturally they will take defensive steps either by refusing to accept challenge of critically ill patients on one pretext or another, or by prescribing various expensive diagnostic tests, or by signing an arbitration agreement with patients and their heirs before treating them. The Fourth suggestion is that all Presidents and members of the District Forums, State Commissions and National Commission must be sent for one month to medium size hospitals to study hospital working and to know inherent risks faced by doctors and other staff members while treating patients. Though these suggestions are not a complete solution to the problem, yet doctors may feel comfortable psychologically and non-paying patients will also get an opportunity to get their grievances redressed.

In a recently-announced judgment, the apex court of India declared that 'patients' are 'consumers' and held doctors accountable for any act of
medical negligence. It ruled that they could be sued for compensation under the Consumer Protection Act, 1986. However, the court made it clear that doctors and hospitals that render service without any charge may not be sued for compensation. The said ruling was given by the court while disposing of a bunch of appeals and writ petitions, including one made by the Indian Medical Association, against judgments of the various High Courts and the National Consumer Disputes Redressal Commission.

Thus, the Hon'ble Court made a clear distinction that service rendered in the government hospitals and charitable dispensaries where no charges are realized from any person availing the service is outside the purview of the expression 'Service' as defined in the Consumer Protection Act, 1986, and service rendered at non-government hospitals or nursing homes, where charges are required to be paid, falls within the purview of the expression 'Service' as defined in the Act.

The Hon'ble Apex Court drew two more distinctions:

(i) Service rendered at a non-government hospital or nursing home where charges are normally required to be paid, but the service is rendered to a patient free of charge for some reason, would still fall within the ambit of the expressions 'Consumer' and 'Service' as defined in the Act; and
(ii) Service rendered at a non-government hospital or nursing home cannot be regarded as 'service' rendered free of charge, if the person availing the service has taken an insurance policy for medical care, where all the costs of his treatment, including consultation and diagnosis, are borne by the insurance company, and such service would therefore fall within the ambit of 'Consumer' and 'Service' as defined in the Act.

This is how the Apex Court has chosen to settle the controversy over the circumstances under which a patient is a consumer or not a consumer.

However, on going through the 65-page judgment of the three-judge bench comprising Mr. Justice Kuldeep Singh, Mr. Justice S.C. Agarwal and Mr. Justice B.L. Hansaria of the Supreme Court of India, most of the legal luminaries are surprised that neither has the Hon'ble Court touched upon the aspect of discrimination between government and non-government hospitals, nor have they gone into the other constitutional aspects of the Consumer Protection Act, 1986. The author feels that all the objections raised by the counsels of both the sides should have been examined and decided, not in summary, but in detail, keeping in view the interest of the public and the doctors so that no discrimination is caused to anyone.
By excluding non-paying patients from the definition of 'Consumer', the Legislature has done great injustice to them. When the Legislature committed the error in excluding non-paying patients, the Supreme Court should have declared it unreasonable discrimination, but it did not do so. It is very surprising that the Legislature as well as the Supreme Court did not consider a non-paying patient as a consumer. If there is medical negligence in his case, he cannot seek justice from the Consumer Disputes Redressal agencies. In other words, the Legislature has ignored the value of his life and such a person has no right to seek justice under the Consumer Protection Act in case of medical negligence committed by a doctor of a government hospital or charitable dispensaries.

The author strongly feels that the apex court should have at least made the following three recommendations to the government to safeguard the interests of the non-paying patients and of the doctors so that both of them could get some relief from the judgment passed.

1. Patients who avail of free medical treatment either in the government hospitals or in charitable hospitals/dispensaries should have equal right to seek justice in case there is any medical negligence on the part of the doctors there. It is surprising that the legislature as well as the judiciary expect them to seek relief under the Law of Torts after
paying a court fee and engaging an advocate, instead of going to the Consumer Disputes Redressal Agencies where they can get relief without paying a court fee or engaging an advocate. If they had been in a position to pay, they would have paid, and sought medical treatment at non-government hospitals and nursing homes. The author believes that a lot of injustice has been done by excluding them from the definitions of 'consumer' and 'service' given in the Consumer Protection Act, 1986. After the legislature committed this error, it was up to the judiciary to see that it was unreasonable discrimination and to direct the government to include non-paying patients in the definition of 'Consumer' and 'Service'.

2. The Apex Court should have made recommendations to the government that it should make the following provisions in the Consumer Protection Act, 1986, as a special case to understand the point of view of doctors. These are necessary because medical science is a most complicated science.

(a) On receipt of complaints against doctors /nursing home / nongovernmental hospitals, the District Forums/State Commissions/National Commission must refer them to a doctor with the required specialization for comments, before issuing notice to the other party. If the specialist's
comments indicate so, the complaint should be entertained and notice be issued to the doctor/ nursing home or non-government hospital; otherwise it should be rejected. In the case of a complaint filed in the District Forum, it should be referred for comments to the District Hospital of the area; in case of complaints to the State Commission, to the Medical College of the Capital of the State, and in the case of complaints to the National Commission, to the AIIMS, New Delhi.

This is being suggested because there is a lot of scope for abuse in the Act. The first and foremost lacuna is the absence of any screening procedure in the Act. Every complaint is entertained irrespective of whether it has any substance or not. The Consumer Dispute Redressal Agencies issue, on the receipt of a complaint, a copy of the same to the opposite party directing him to give his version of the case within a period of 30 days. This is a purely mechanical procedure. No judicial mind is applied to see whether the complaint is worth adjudicating upon. The screening process can eliminate frivolous complaints at the very first stage. Thus doctors, who are quite sensitive about their reputation and practice, can be saved from dealing with frivolous, vexatious and baseless complaints. When the District Forum/State Commission/National Commission hears arguments on the complaint of patients, they must co-opt the services of a medical expert of the specialty
concerned. The medical expert should give his expert opinion at the time of argument to the members and President of the District Forum/State Commission/ National Commission.

Neither the legislature nor the judiciary thought about the problem which is bound to arise in cases of alleged negligence. There may be certain cases where the negligence is quite obvious, like amputation of the wrong limb, leaving a swab or a pair of scissors or forceps in the body, etc. Medical negligence in such cases is obvious even to a lay person. However, there maybe a number of cases where it will be impossible for the various Consumer Dispute Redressal Agencies which comprise of mostly non-medical persons, to detect negligence, for example, whether a doctor's decision to adopt the latest surgical technique is medical negligence, or error of judgment, or is simply the inherent risk which a doctor has undertaken while operating on or treating a patient.

In this context, the following points may be considered:

(i) Is a patient a consumer?

(ii) Inherent risks faced in treating patients’ vis-à-vis error of judgment in Delivering judgments, and

The author has tried time and again to bring to the knowledge of the Legislature that it is no mean task to detect latent medical negligence. Not to talk of the Hon'ble President and members of the Consumer Dispute Redressal Agencies, even an orthopedic surgeon cannot detect the surgical negligence of a general surgeon. This may be possible if the Consumer Dispute Redressal Agencies follow the lengthy procedure of civil courts and are assisted by a medical expert of the same specialty as in the relevant case. In this way the medical fraternity would have the satisfaction that they would not only be heard by the lay persons who constitute the District Forum/ State Commission/National Commission, but also by a person of the medical profession who will be able to give an expert opinion to the District Forum/ State Commission/National Commission before they give their judgment.

The same method of screening complaints using the services of an expert before issuing notices, and including an expert at the time of hearing arguments could be used in the case of complaints against other professionals such as architects, chartered accountants, etc.

3. If the Legislature does not agree with the above two suggestions, it should at least make a provision in the Act that where doctors/non-government hospital authorities on the one side, and patients/their heirs on the other side,
agree with their free consent to refer the matter of alleged medical negligence if any, to the arbitrator under the Indian Arbitration Act, 1940, the Consumer Dispute Redressal Agencies will not entertain complaints of such patients and doctors/ non-government hospital authorities.

In this way, the harassment being faced by the doctors/non-government hospitals and nursing homes as a result of the provisions of the Consumer Protection Act, 1986, can be avoided and any disputes regarding medical negligence can be settled amicably and peacefully by the parties with the help of the arbitrator chosen by the parties themselves. Thus time wasted in attending the dates in the Consumer Dispute Redressal Agencies can also be saved by both the parties.

4. "Fourth suggestion is to send all Presidents and members of the District Forums, State Commissions and National Commission to medium size hospitals for one month to study minutely hospital working and inherent risks faced by doctors and other staff members while treating patients. This suggestion can go a long way to pacify both doctors and patients in the sense that persons who decide their cases have not only the theoretical knowledge of medical negligence but also understand the working of the hospital and inherent risks faced by doctors and other staff members while treating patients. On the other hand, Presidents and members of the District Forums,
State Commissions and National Commission will feel more confident while deciding cases of medical, surgical and diagnostic negligence, and be able to distinguish between inherent risk and negligence in medical terminology."

The above four suggestions will help the patients of the government hospitals and charitable dispensaries by including them in the definition of 'consumer', and also the doctors of non-government hospitals and nursing homes who will feel more comfortable when complaints filed against them are screened by a specialist before registration, and arguments are heard in the presence of a medical expert. Thus, there will be justice to those patients who have not been included in the definition of 'consumer' and also solace to doctors who feel aggrieved at present by the judgment of the Consumer Disputes Redressal Agencies.

If none of the above suggestions fined favors with the legislature, they should at least make a provision in the Act whereby the complainant will have to pay 25% of the claimed amount to the respondent if his claim is found frivolous. This will discourage those complainants who not only want to make a quick buck by filing false and fabricated complaints, but also want to discourage those innocent doctors who really want to accept the challenge by treating critically ill patients.
Conclusion:

The presence of state govt. officials, social activities private health practitioner & representatives in the parliament will facilitate informed decisions mainly. Global experience has shown that quality of public health services reflected in attainment of improved public health indices to the quantum & quality of investment in public funding. The policy also lays emphasis on improving the skills from the level of hospital boys, male & female servants, nurse’s sisters, apprentices, assisting medical doctors to the level of medical practitioners. Health care also covers the special treatment to be given to women & children, irrespective of their income level so that easy availability of medicines with cheaper rate is the main task of pharmaceutical companies.
APPENDIX - III

QUESTIONNAIRE

GENERAL INFORMATION ABOUT THE ORGANIZATION :

Q. 1. Please specify nature of your industry?
   a. Automotive
   b. Pharmaceutical
   c. Steel
   d. Printing and publishing
   e. Electronics
   f. General Engineering
   g. Chemicals
   h. Any other please specify

Q. 2. Please specify about nature of your industry?
   a. Direct manufacturer
   b. Third party
   c. Loan Licence
   d. Any other

Q. 3. Please write name of your product (s):

Q. 4. Please mention No. of employees in your organization till the Date
   a) Managers: Male Female :
   b) Supervisor: Male Female :
   c) Workers: Skilled Unskilled
   d) Contract staff: Male Female:

Q. 5. Please mention your turnover in the last accounting year ? Rs.

Q. 6. Did you make profit after tax last year ? Yes/ No
Q. 7. Where is your Head Office (Name of the city)
Q. 8. Are you collaborating with any foreign organizations? Yes/ No
Q. 9. If yes, give the name of your collaborator and country. Please enclose the organizational chart (if you have any)

**A. MANPOWER PLANNING:**

Q.10 Who estimates/ prepares manpower requirements of your organization? Tick the proper one?

a) Central Manpower Planning Department and strategic planning Dept
b) HRD Department
c) External Agency (Consultant)
d) Departmental In-Charge
e) Any other please specify

Q.11 Please specify about your method to determine the manpower requirements?

a) Work-study work sampling
b) Planned productivity estimation
c) Statistical Methods (Like regression, correlation etc)
d) Super annuation-cum replacement charts
e) Opinions/influence of managers of head of department

Q.12 Please mention frequency of analysis of manpower resources in your organization.

d) Continuously
e) Periodically
f) Whenever required

Q. 13. Which of the following factors are considered for manpower forecasting?
   a) Corporate business plan
   b) Corporate business plan, change in technology
   c) Corporate business plan, change in technology and trends in productivity, changes in Government Rules and regulation
   d) Any other factor please specify

Q. 14. State the job specification of each category?

<table>
<thead>
<tr>
<th>Category</th>
<th>Designation</th>
<th>Salary (P.M)</th>
</tr>
</thead>
</table>

Q. 15. Which of the following benefits are extended to the officers of your organization? (Tick as may as applicable)
   a) Housing loan
   b) Interest subsidy on housing loan obtained from other financial institutions.
   c) Medical reimbursement
   d) Conveyance reimbursement of
      a. Rs.________ for scooter, Rs. _________ for car
   e) Leave Travel Concession (Please give details)
   f) Children's education allowance
   g) Any other (specify)

Q. 16. What are the sources of manpower supply?
   a) Internal sources
   b) External sources
   c) Internal and external sources
   d) If any other please specify
Q. 17. Amongst the internal sources Which of the following is used in your organization ( tick as many as applicable )?

a) By internal advertisement  
b) By promotion  
c) By transfer from other units or departments  
d) Any other method specify

Q. 18. Amongst the external sources which of the following source is Suitable (tick as may as applicable)?

a) Through employment exchange  
b) Through open advertisement in leading news paper  
c) Through campus recruitment  
d) On deputation  
e) Ex servicemen agencies  
f) Any other method, please specify

Q. 19. Do you have a policy to transfer your managerial personnel from one unit to another unit ? Yes / No

**B. RECRUITMENT & SELECTION:**

Q. 20 Do you have the same method of selection for all categories of employees.

Q. 21 If the answer to Q. no.20 is No. Please elaborate following

<table>
<thead>
<tr>
<th>Category</th>
<th>Method of selection</th>
</tr>
</thead>
</table>

Q. 22 In the selection process, are the internal candidates preferred (within the organization )? Yes/ No

Q. 23 In the selection process, the abilities tested are ( tick as many as applicable -please indicate the order of performance )?
a. Subject knowledge
b. Work experience
c. Physical abilities (including medical etc.)
d. Psychological attitudes

Q. 24 Is the probation period before confirmation same for all categories of employees? Yes/ No

If the answer is No. Please give the details.

<table>
<thead>
<tr>
<th>Category</th>
<th>Period of probation</th>
</tr>
</thead>
</table>

Q. 25 Which of the following factors do you consider for regularizing the New appointed employees / Trainees

a. Completion of probation period
b. Satisfactory performance during the probationary period
c. Any other factor please specify

Q. 26. Do you get the verification of character of the candidate done before the appointment as per Government regulations? Yes/ No

C. PLACEMENT AND INDUCTION TRAINING:

Q. 27. Which of the following methods do you use for placement of selected candidates? (tick as many as applicable)

a. Differential placement
b. Single job placement
c. Job training

Q. 28. Do you offer formal/informal training to new entrants? Yes/ No

Q. 29. What is the duration of such training programmes Weeks Days.

Q. 30. Following are the different induction training objectives. Tick the ones which are covered during induction training in your (Tick as many as possible)
a) Introduction to the organization
b) Teach business ethics and sense of mission
c) Reflection on the ideals and the objectives of the organization
d) Initiate specific job training
e) Any other specify

Q. 31 Have you done any follow-up study to measure the effectiveness of induction training? Yes/No

Q. 32 Do you have induction training for all categories of employees? Yes/No

Q. 33 How do you prepare the executives/offices for new responsibilities (tick as many as applicable)
   a) In house training
   b) In house training with external consultants
   c) Training by external agencies
   d) On the job training.
   e) Send abroad for training
   f) Any other (specify)

Q. 34 How often do you review job description in your organization?
   a. Once in a year
   b. Every alternative year
   c. Every in 3 years
   d. Once in 4 years
   e. Every fifth year or more
   f. As and when required

Q. 35 Do you change in job descriptions lead to training of the employees? Yes/No

Q. 36 How do you prepare your executives for the technological changes in your industry?
a) On-the Job training
b) In house training programme
c) Specialised training with external agencies
d) Send abroad for training

**IV. HUMAN RESOURCES –INFORMATION:**

Q. 37. Do you have Human Resources information system Yes / No

If yes, following are the different contents of Human Resource Information. Tick the ones which are included in the format.

a) Personnel bio-data of officers
b) Training programme attended
c) Performance records
d) Potential appraisal
e) Accomplishments
f) Any other information -please specify

Q. 38. When is the following information is updated?

a) Continuously
b) Once in a year
c) As and when required

Q. 39. The data of Human Resources Information is utilized for (you can tick more than one )?

a) Increments
b) Consideration for special projects
c) Training requirements
d) Higher level job
e) Transfers
f) Planning human Resources Department activity
V. PERFORMANCE APPRAISAL:

Q.40. Company policy relating to appraisal as explicitly stated (in manual, circular or elsewhere in writing) please specify. If not explicitly stated, give the top management's news.

Q.41. Do you have a formal appraisal (like merit rating or Anchor chart recording method etc.) system in your organization for appraising managerial personnel? Yes/No

Your answer ________

Q.42. Who is responsible for initiating and ensuring the administration of performance appraisal?
   a. Immediate supervisor
   b. The next level of superior along with immediate superior
   c. Human Resource development department
   d. Committee
   e. If other please specify?

Q.43. What kind of performance appraisal system you follow for your organization?
   a. Common all levels of officers
   b. Different for different levels of officers

Q.44. If your response to Q. No.43 is (b) please specify the number of personnel Appraisal systems used and the levels covered by each form.

Type of personnel Appraisal system    Officer- level
Q.45. The periodicity of Personnel Appraisal in your organization is:
   a) Twice a year  b) Once in a year
   c) Any other periodicity (Please specify)
Q.46. While making appraisals does your company (you can answer
   more than one)
   a. Examine for qualitative characteristics or traits (qualitative
      characteristics like integrity, intelligence, honesty other
      attitudes abilities)
   b. Examine the quantitative characteristics or traits (means sales,
      achievement for sales executive, production achievement for
      production engineer)
   c. Examine development / training / future potential and/or
      growth or development achieved by an employee or
      development achieved by an employee during the period
      under consideration.
Q.47. The nature of performance appraisal system of your organization is
   a. Confidential appraisal system
   b. Open appraisal system
   c. Semi confidential appraisal system
Q.48. If the response to Q. No 47 is (c) please specify the information
   which is shared and kept confidential from the appraisee.
   a. Information which is shared with the appraisee
   b. Information which is kept confidential from the appraisee.
Q.49. The performance appraisal system in your organization is used for
following administrative decisions (tick as many as applicable)
a) Promotion
b) Salary decision
c) Transfer
d) Demotion
e) Job enrichment

Q.50. Does the performance Appraisal system in your organization provides opportunities for self appraisal to the apprises. Yes / No

Q.51. Are employees allowed to raise, with their superiors, questions regarding their evaluation? Yes / No

Q.52. If the answer to Q. No.51 is yes, with whom can they raise it?
   a. Immediate supervisor   b. Personnel Department
c. Committee d. anyone else -specify

Q.53. Does the superior holding the review have the authority to revise the earlier decision? Yes / No / Partly?

Q.54. If yes or partly -please explain

Q.55. When is the action taken on the basis of appraisal report?
   a. Immediately on the receipt of the report
   b. At the time of considering the annual increments
   c. At the time of promotion

Q.56. What action does your company normally take on unfavorable Appraisal reports?
   a. Issue a warning the subject
   b. Withhold his annual increment
   c. Arrange for suitable training to be given to him
   d. Any other action -Please specify
Q. 57. Do you have any kind of training or discussion to develop evaluation / appraisal skills to those who are responsible for filling Personal Appraisal forms? Yes / No

Q.58. The extent to which you are satisfied with personnel Appraisal System of your organization
   a) Highly satisfied  b) Satisfied
   c) Dissatisfied  d) highly dissatisfied

VI. ON THE JOB AND CAREER DEVELOPMENT TRAINING:

Q.59. Do you have a separate training department? Yes/ No if yes, please Indicate.

Q.60. When was the separate training department established? Year

Q.61. The designation of the person in charge of separate training Department

Q.62. Staff strength in training department positions, Numbers (Hierarchy).

Q.63. If you do not have separate training department, please indicate who is in-charge of training?
   Designation

Q.64. To whom does the in-charge of training or training department report?

Q.65. The qualification of person in-charge of training / training department.
   Bachelor's degree/Master's degree/ Ph.D any other specify.

Q.66. The first formal degree of his is in Arts/ Agriculture/Commerce/ Engineering/Science/ Management/pharmacy/Medical/law/Social Work/ Llabour Welfare/ Any other specify
Q.67. How long has he been with your organization?

Q.68. How long has he been in-charge of training department.

Q.69. What other functions does the training in-charge performs?
   Please specify.

Q.70. Have you ever sent your training in-charge to external training programmes? Yes/No

Q.71. During the last accounting year how many in-company training programmes were organised in the training department?

Q.72. How many managers were trained in the last accounting year in in-company training programmes? (please indicate the number)

Q.73. Please give titles of in-company training programmes organised during the last accounting year
   Titles

Q.74. How much did you spent on training during the last accounting year?
   Rs.

Q.75. How is the volume of training budget decided?
   (a) By chief executives
   (b) By a team of top managers
   (c) By training in-charge alone
   (d) By training in-charge in consultation with chief executives
   (e) Any other (specify)

Q.76. Listed below are a number of training techniques. Please indicate those which were used for in-company training programmes during the last accounting year (tick as many as applicable)
   (a) straight lectures   (b) Lecture cum discussions
   (c) Role play   (d) Close video recording circuit
   (e) Educational films   (f) Case method
Q.77. What kind of training facilities do you have (tick as many as applicable)
(a) Full fledged training college .
(b) Library   (c) Just a class room
(d) Residential facilities
(e) Audio-visual equipment
(f) Trainers on the permanent
(g) Any other specify

Q.78. During the last accounting year how many employees were sponsored to external programme (exclude in- charge of training activity) Please indicate numbers against relevant agency.
(a) IIM Ahmedabad   (b) IIM Calcutta
(c) IIM Bangalore   (d) National productivity Council
(e) Local Management Associations
(f) All India Management Association
(g) Administrative Staff College
(h) Xavier Labour Institute
(i) NITIE    (j) IITS    (k) Other agencies -specify.

Q.79. During the last accounting year, did you sponsor employees to training programmes abroad? Yes/No
Q.80. If No, have you ever sponsored your employees to foreign training programmes. Yes/No

Q.81. How do you identify training needs of your Managers? (tick as many as applicable)
   (a) From performance appraisal reports
   (b) Through potential appraisal
   (c) During performance review meetings
   (d) Managers themselves indicate the nature of training needed
   (e) Subject to longer changes in the organization
       (growth/diversification etc)
   (f) Subject to changes in the task because of larger changes elsewhere
   (g) By doing frequent surveys of the training needs
   (h) Involving the external consultants
   (i) Another (specify)

Q.82. DO you ask executives to formally report their assessment of training programme? Yes/No

Q.83. Are the formal feedback reports by employees used
   (a) In deciding whether to repeat the programme
   (b) To change the duration of the programme
   (c) To modify contents
   (d) To drop the programme
   (e) To change the faculty.

Q.84. In the last few years has your organization undertaken a survey of estimating the effectiveness, of training activity? Yes/No

Q.85. If Yes, please give some broad conclusions

Q.86. What indicators are generally used to see if training has made a
difference for managers? Please Specify.

Q.87. Have you ever involved external consultants in evaluating training effectiveness? Yes/No

VII. CAREER PLANNING:

Q.88. Are the long range plans of the organization made known to the employees? Yes/No

Q.89. From the following, tick the career Planning opportunities offered to the employees in your organization
   (a) Sponsoring for higher educational programme
   (b) Training abroad
   (c) Coaching classes for professional Courses
   (d) Grant of study leave
   (e) Preference for internal candidates for the new projects etc.

Q.90. How do you reward your managers if they acquire additional qualifications pertaining to the field of their work?
   (a) Additional Increments
   (b) Monetary Incentives
   (c) Promotion
   (d) Letter of Appreciation
   (e) None

Below are 38 statements related to the HRD climate If an organization. Read through each carefully and give our assessment by encircling the appropriate number on as in scale. Please do not give a desirable response but not give what you actually feel about the climate in your organization.

5 Almost always true
4 Mostly true
3. Sometimes true
2. Rarely true
1. Not at all true

1. The top management of this organization goes out of its way to make sure that employees enjoy their work.

   5 4 3 2 1

2. The top management believes that human resources are an extremely important resource and that they have to be treated more humanly.

   5 4 3 2 1

3. Development of the subordinates is seen as an important part of their job by the managers/officers here.

   5 4 3 2 1

4. The personnel policies in this organization facilitate employee development.

   5 4 3 2 1

5. The top management is willing to invest a considerable part of their time and other resources to ensure the development of employees.

   5 4 3 2 1

6. Senior officers/executives in this organization take active interest in their juniors and help them learn their job.

   5 4 3 2 1
7. People lacking competence in doing their jobs are helped to acquire competence rather than being left unattended.

8. Managers in this organization believe that employee behavior can be changed and people can be developed at any stage of their life.

9. People in this organization are helpful to each other

10. Employees in this organization are very informal and do not hesitate to discuss their personal problems with their supervisors

11. The psychological climate in this organization is very conducive for any employee interested in developing himself by acquiring new knowledge and skills.

12. Seniors guide their juniors and prepare them for future responsibilities / roles they are likely to take up

13. The top management of this organization makes efforts to identify and utilise the potential of the employees.

14. Promotion decisions are based on the suitability of the promotee rather than on favoritism.
15. There are mechanisms in this organization to reward any good work done or any contribution made by employees.

16. When an employee does good work his supervising officers take special care to appreciate it

17. Performance appraisal reports in our organization are based on objective assessment and adequate information and not on favoritism

18. People in this organization do not have any fixed mental impressions about each other

19. Employees are encouraged to experiment with new methods and tryout creative ideas

20. When any employee makes a mistake his supervisors treat it with understanding and help him to learn from such mistakes rather than punishing him or discouraging him

21. Weaknesses of employees are communicated to them in a non-threatening way

22. When behavior feedback is given to employees they take it seriously and use it for development
23. Employees in this organization take pains to find out their strengths and weaknesses from their supervising officers or colleagues

24. When employees are sponsored for training, they take it seriously and try to learn from the programmes they attend.

25. Employees returning from training programmes are given opportunities to tryout what they have learnt

26. Employees are sponsored for training programmes on the basis of genuine training needs

27. People trust each other in this organization

28. Employees are not afraid to express or their feelings with their supervisors

29. Employees are not afraid to express or discuss their feelings with their subordinates

30. Employees are encouraged to take initiate and do things on their own without having to wait for instructions from supervisors

31. Delegation of authority to encourage juniors to develop handling higher responsibilities is quite common in this organization
32. When seniors delegate juniors use it as an Team spirit is o this organization

5 4 3 2 1

33. Team spirit is of higher order in this organization

5 4 3 2 1

34. When problems arise people discuss these problems openly and try to solve them rather than keep accusing each other behind the back

5 4 3 2 1

35. Career opportunities are pointed out to juniors by senior officers in the organization

5 4 3 2 1

36. The organization's future plans are made known to the managerial staff to help them develop their juniors and prepare them for future

5 4 3 2 1

37. This organization ensures employee welfare to such an extent that the employees can save a lot of their mental energy for work purposes

5 4 3 2 1

38. Job-rotation in this organization facilitates employee development

5 4 3 2 1
APPENDIX - IV

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