CHAPTER-8

PROBLEMS AND CHALLENGES FACED BY HEALTH SECTOR IN PUNJAB

Introduction

It is a well recognised fact that the system of public delivery of health services in India today is in crisis. The public health care system is inadequate in quality as well as in quantity. India’s economic growth is bringing with it an expected “health transition”, in terms of shifting demographics, socio-economic transformations and changes in disease patterns- with increasing degenerative and lifestyle diseases and altered health care behaviour. The growing demand for the quality health care and the absence of matching delivery mechanisms pose a great challenge. Recent analyses show that high absenteeism, low quality in clinical care, low satisfaction levels of quality care (clinical and with regards to courtesy and amenities) and rampant corruption plague the system. This has led to mistrust of the system, rapid increase in use of the private sector and attendant problems, high out of pocket expenditure that take a serious toll on families and quality of care. A weak voice and low accountability between public sector employees and citizens in the health care sector is the key binding constraint to effective delivery.

Health care at its essential core is widely recognised to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market. Nor it can be established on the considerations of utility maximising conduct alone. In influencing the choices that make for better health and lowered financial burden of ill-health, the society is typically faced with three key challenges. The first
has to do with controlling the cost incurred in the provision of health interventions that it supports—be it care, health care regulation, or provision of insurance—given that resources are limited and face competing demands for their use. The second is to achieve an equitable distribution of the financial burden of ill-health and morbidity. There is a direct consequence of the fact the societies are concerned not just about improvements in “average health” but also, especially, about the health and economic welfare of the socially and economically marginal groups in society. The third issue is to ensure the quality of medical care that is provided, because of its central importance to people who need care, and also because of its direct link to the cost-effectiveness of care provision.

Some of the major issues of concern in the health sector of India can be discussed below:

1. **Low Public Health Expenditure**

Public health expenditures have been historically very low. Public spending on health in India is amongst the lowest in the world (about 1 per cent of GDP), whereas its proportion of private spending on health is one of the highest. Households in India spend about 5-6 per cent of their consumption expenditure on health (NSSO). The cost of health services in the private sector makes it unaffordable for the poor and the underprivileged. The India Health Report (IHR) also points out that the biggest problems with the Indian health system are the lack of government’s spending in the health sector (0.9 per cent of GDP against an average of 2.2 per cent by lower-middle income countries) and the inefficiencies and the misuse of the available meagre resources. Since 84 per cent of healthcare is out-of-pocket expense, the system is set up to favour those who can pay (Kumar. R, 2008). At present adequate health care is unaffordable for the vast majority of
India’s population. Current funding is being used sub-optimally and is not directed to maximizing health gains. Significant disparities exist between urban and rural areas, between different states and between poorer and wealthier segments of the population. So far as the public healthcare system in India is concerned, paucity of funds is only one of the factors responsible for its present state. Systematic neglect of the institutions and infrastructure over the years is the second and lack of accountability to local self-government bodies is the third. It is these factors which need to be addressed first, otherwise there is no guarantee that any increase in funding will necessarily have the desired health impacts.

The commitment to the health sector by the central government is reducing but there is no evidence to show that state governments are gearing up to take the additional burden. The economic reform process initiated in the country in the late 1980s has led to a decline in state’s expenses on health care making it more opportune for the private players to have higher stakes in the health care of the country. Health care is passing in the private hands. This has resulted in spiralling medical care costs and even indebtedness. Despite the provision of free or low-cost services at the government health facilities, demand for public sector outpatient services are low even amongst that part of the population which falls below the poverty line. The poor are increasingly turning to private providers of health care, even for treatment of infectious diseases such as HIV, TB and malaria, which are designated as primary responsibilities of the public health system. This is because of the reason that most of the staff in public health care institutions is either absent from duty or unhelpful (Kumar, R, 2008).

Unethical practices such as unnecessary investigations and surgeries and kickbacks for referrals are rampant in the private sector. Many private
hospitals over-charge and deny the patient information about diagnosis and treatment. Though medical services were recently brought under the Consumer Protection Act, there are no enforceable standards for private hospitals. Regulatory bodies such as the medical councils are unwilling to fulfil their responsibilities, the legal system is ill-equipped to handle the burden of medical litigation, and aggrieved patients and their relatives cannot afford the costs.

2. Vanishing Public Sector

The major responsibility for maintaining the 3-tier primary health care system rests with the states and they have been suffering from a resource crunch due to structural adjustment programme (SAP). They had not received and released sufficient funds to maintain health centres (NCMH, 2005). This resulted in a situation, where health centres are without staff, equipment lying unutilized, no medicines and hence a falling ability to make any meaningful intervention.

The endemic shortages in the public health sector have not been removed. As per 2001 population norms there is a shortfall in the number of sub-centres (13.16 per cent), PHCs (18.46 per cent) and CHCs (40.87 per cent). In the case of manpower, till September 2004 there were 633108 doctors registered with different State Medical Councils in India. This gives a doctor-to-population ratio of 1 for 1676 persons in India (or 59.7 physicians for 100000 population). In comparison, physicians per 100000 population in Australia, Canada and United Kingdom and United States were 249.1, 209.5, 166.5 and 548.9 respectively. Further, the doctor-to-population ratio in India is skewed - rural, tribal and hilly areas are undeserved as compared to urban areas; and better performing states gave thrice the number of doctors compared to those performing poorly (NCMH,
Only 1.3 lakh doctors work in the public sector.

3. **Rural-Urban Disparities in the Availability of Health Services**

Rural-urban disparities prevail in the case of availability of health services. Most of the specialised health centres like district hospitals, or CHCs are located in urban or semi-urban areas. In the rural areas where the major chunk of population lives, the main source of health care is the government health centres that include PHCs and sub-centres, traditional healers, quacks and the private practitioners. The quality of government services in the rural areas has deteriorated to a great extent making these health centres dysfunctional due to lack of medicines and medical staff. Instead, 75 per cent of the health infrastructure and medical personnel in India are concentrated in the urban areas (Patil et al, 2002). Public health care system in rural areas in many states and regions is in shambles. Extreme inequalities and disparities persist in terms of access to health care. This large disparity across India places the burden on the poor, especially women, scheduled castes and tribes. Rural infrastructure, apart from being grossly inadequate, is also wasted because of the pressures to promote family planning instead of providing comprehensive health care. Overall, it can be said that there is gross lack of accountability in both the public and private health sectors.

4. **Factors that Limit the Ability of the Health Sector**

Besides the above mentioned issues of concern, there are various factors that limit the ability of health sector to improve the health of the people. The factors include illiteracy, poverty, lack of access to sanitation and water. Even more than sixty years after independence about 35 per cent of the population still remains illiterate in India. Illiteracy reduces the capacity of people to work productively while education helps them to
understand the importance of health. Another major factor responsible for deteriorating health condition in India is poverty. Almost a third of Indian population lives in poverty. The effect of poverty on healthcare and vice-versa is significant. India is also home to the largest number of under nourished people. The high prevalence of under nourishment in India is the result of chronic poverty, lack of purchasing power of the poor and high growth rate of population. High prevalence of chronic and acute hunger is undoubtedly the cause of the continuing high mortality and high morbidity load in the country.

Lack of access to sanitation and water is one of the major failures of the health system in India. According to Human Development Report, 2004, the extent of sanitation coverage was only 28 per cent of population while it was 94 per cent and 40 per cent in Sri Lanka and China respectively. Besides it has been observed that in 2000, 16 per cent of population was not using improved water resources. Children are the most severe victims of water borne diseases resulting in high mortality and morbidity.

HIV/AIDS has emerged as one of the main health challenge of the 21st century, killing or infecting more than 60 million people during the short period of just two decades. According to global estimates, India (5.1 million) has 97 per cent of the HIV/AIDS population in South Asia followed by Pakistan (74000), Nepal (61000), Bangladesh (13000) and Sri Lanka (3500). Bhutan and Maldives have less than 100 cases each (Human Development Report, 2004). Thus, HIV/AIDS is a major burden on our health system. It has increased the demand for health care services. It is also a burden on the budget of the country.

Besides HIV/AIDS, cancer is also posing great challenges for India. In India cancers account for about 3.3 per cent of the disease burden and
about 9 per cent of all deaths. These estimates will, however, surely change as many of the common risk factors for cancers, such as tobacco and alcohol consumption, continue to become more prevalent in India. It is estimated that the number of people living with cancers will rise by nearly one-quarter between 2001 and 2016. Nearly 10 lakh new cases of cancers will be diagnosed in 2015 compared to about 807000 in 2004, and nearly 670000 people are expected to die (Ministry of Health and Family Welfare, 2005).

India’s health care system needs a lot of improvement, is a well accepted fact. Government has the constraint of funds, whereas private sector is out to make only profits. Voluntary sector is more of a tokenism. There is an urgent requirement of wide ranging and sweeping reforms in this sector to provide a responsible universal health care delivery.

There are many infirmities in the existing health infrastructure. Reforms in health are vital to secure India’s future. The Indian health system has to make available affordable, quality health care to a population that is growing from one billion now to one and a quarter billion in fifteen years time. It has to care for life threatening diseases that affect a large number of underprivileged, while simultaneously addressing life style diseases that impact a large number of relatively well-off people. If India has to provide health for all, public expenditure has to be significantly stepped up and focussed on the poor and indigent groups. At the same time, there has to be a greater role for private participation in the health sector. Several innovative financing mechanisms have to be institutionalized. The current health systems needs to be overhauled, both in terms of financial and human resource. Policy makers need to define realistic goals and allocate much higher levels of resources for the health sector. These resources should not be allowed to fritter away or siphoned out. This will require strict
monitoring, so as to ensure that funds are being utilized for the purpose they were meant for.

Problems and Challenges Faced by Health Sector in Punjab

It can hardly be denied that a sound health along with adequate food, clothing and shelter is vital for human beings to enjoy their lives. Being an element of intrinsic and instrumental value to human life, the level of health in society should increase, if not proportionately, with economic growth. By virtue of the robust economic growth attained by Punjab, one might have expected it to do better in other dimensions of utmost significance for human life as well. Unfortunately, it has not been so. The state, given its factor endowments, could have done much more if it had applied the wisdom and policies adopted by Kerala- a state well known for its social sector development even at lower levels of per capita income.

There has been no major increase in the number of government owned health institutions in Punjab since the 1990s. On the other hand, due to the collapse of administration and weak monitoring mechanism during the period of militancy, the rent-seeking behaviour of most of health sector employees has become the hallmark of the health delivery system in the state. Due to lack of state support and funds and initiation of Structural Adjustment Programmes (SAP) of World Bank, the potentials of public health infrastructure, particularly in rural Punjab, have not been optimally utilized. Infact it has deteriorated during the time period of the 1990s and onwards. There have been glaring deficiencies in machinery, equipments, appliances, buildings and residential accommodation, etc. in public health institutions.
Decentralization has not taken place and there is no community participation. The private or corporate sector-owned hospitals bear the entire burden of critically ill patients. In the past the natural priority of such patients were hospitals or hospitals attached with medical colleges in the state, but presently these institutions do not have adequate funds, nor these are equipped with the latest technology/appliances and, therefore, not preferred by the rich and middle-class people as revealed through health care seeking pattern of patients in various studies. The 52\textsuperscript{nd} Round of the NSSO reveals that there are relatively few people, who rely on public health sources for their hospitalized and non-hospitalized treatment in both rural as well as urban areas. The utilization of public health infrastructure or the strength of public health services can be indicated through bed-occupancy ratio. The bed-occupancy ratio in the state, has however, shown a dismal picture. The bed-occupancy ratio in district hospitals was around 100 per cent between the year 1970 and the year 1985, but has shown a downward trend since then and has reduced to around 58 per cent during the year 2001. Even hospitals attached with state medical colleges providing tertiary care in Punjab have witnessed a fall of about 50 per cent in bed-occupancy, mainly due to deterioration in quality care and introduction of user charges since May 1999. Consequently, patients who have the ability to pay prefer to avail private health services (Gill, S.S. et al, 2010)

The global forces have opened up the public domain health services to the private investment and introduction of high users’ charges, but these measures have failed to increase health services for the poor or to bring about greater efficiency in the delivery of health services in the state. Infact, these measures have led to a rise in the cost of public health care in such a
way that the poor patients are deprived of accessing the low or subsidized but quality care supposed to be provided by the publicly-owned health services.

In Punjab, private sector health clinics/hospitals have grown at a greater speed. And, among the private hospitals/nursing homes in the state, many have sophisticated technology and equipments. Moreover, with the advent of various new medical technologies, the patient’s first priority is the hospitals where these facilities are available on demand. That is why the corporate entrepreneurs like Ranbaxy, Oswal, Fortis, Escorts etc. are entering the health sector in a big way in urban Punjab, mainly to generate high profits. The Punjab Government is also providing them support by offering land at concessional rates in the PUDA-developed colonies.

Further the grim picture of public health institutions can be estimated from the large number of sanctioned posts of doctors, paramedical staff and district-level officers lying vacant. The sanctioned posts in Punjab’s health department are deliberately kept vacant by imposing a ban on new recruitments, not because of non-availability of qualified health personnel, but largely due to pressures of globally determined economic policy and resource crunch faced by the state.

The state has failed in delivering the necessary health care to its people mainly due to poor governance, dysfunctional role of the state and the lack of strategic vision. Although there are many reasons for poor public health sector performance almost all of them stem from weak stewardship of the sector.
The main reasons for poor public health sector performance can be discussed as under:

1. **Existence of a smaller number of public health institutions than their actual requirement.**

   In the rural areas of Punjab, there are only 2,858 sub-centres (SCs) against the requirement of 3,219 (according to population estimates of 2001 census), 484 PHCs against the requirement of 537 and 126 CHCs, whereas 134 are required (Table 8.1). Moreover, the number of health institutions in rural areas of the state has not increased and has remained more or less stagnant over the years, which highlights the poor commitment of state governments. The actual requirement of medical institutions, on the basis of projected population estimates of rural Punjab for the year 2008 is much higher-nearly 3693 SCs, 615 PHCs, 154 CHCs are required which outstrips the actual availability of these institutions (Singh, Narinder Deep, 2010). That is why, these institutions in rural areas are over burdened in terms of both area and number of persons dependent on them.

### Table 8.1: Availability and Requirement of Medical Institutions in Punjab

<table>
<thead>
<tr>
<th>Particulars</th>
<th>SCs</th>
<th>PHCs</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Availability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Ninth Plan (1997-2002)</td>
<td>2,852</td>
<td>484</td>
<td>105</td>
</tr>
<tr>
<td>(b) Tenth Plan (2002-2007)</td>
<td>2,858</td>
<td>484</td>
<td>126</td>
</tr>
<tr>
<td>(c) Eleventh Plan (up to March 2008)</td>
<td>2,858</td>
<td>484</td>
<td>126</td>
</tr>
<tr>
<td>2. Requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) As per 2001 population</td>
<td>3,219</td>
<td>537</td>
<td>134</td>
</tr>
<tr>
<td>(b) As per 2008 population estimates</td>
<td>3,693</td>
<td>615</td>
<td>154</td>
</tr>
</tbody>
</table>

Source: Rural Health Statistics, 2009

2. **Lack of some basic facilities in government health institutions**

   Some of the basic facilities in the government institutions are not available, such as electricity (404 SCs and 5 PHCs), water (389 SCs and 24 PHCs) and all-weather motorable roads (134 SCs and 10 PHCs) (Table 8.2).
Table 8.2: Facilities in Public Health Institutions in Rural Punjab (as on March 2008)

<table>
<thead>
<tr>
<th>Particulars</th>
<th>SCs</th>
<th>PHCs</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total number of institutions</td>
<td>2,858</td>
<td>484</td>
<td>126</td>
</tr>
<tr>
<td>b. Institutions without electricity</td>
<td>404</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>c. Institutions without regular water supply</td>
<td>389</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>d. Without all-weather motorable roads</td>
<td>134</td>
<td>10</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Rural Health Statistics, 2009

3. **Manpower shortage in the health institutions**

The availability of government doctors and paramedical staff in rural health institutions is very much regressive. Acute manpower shortages exist in the health institutions. A shortage of 283 and 294 doctors in PHCs and CHCs (i.e., nearly 60 per cent shortage), 1380 health workers, 650 health assistants/auxiliary nurses midwives (67.2 per cent shortage), 340 laboratory technicians and 342 nurses/staff nurses exist in these institutions (Table 8.3). It is difficult to understand whether this high percentage of vacancies is a deliberate strategy to reduce the budgetary burden or simply a result of administrative inefficiencies.

Table 8.3: Manpower Availability in Rural Health Institutions in Punjab (as on March 2008)

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Required</th>
<th>Available</th>
<th>Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers (SCs) (male+female)</td>
<td>5716</td>
<td>4336</td>
<td>1380 (24.1)</td>
</tr>
<tr>
<td>Health Asst./ANMs (PHCs) (male+female)</td>
<td>968</td>
<td>318</td>
<td>650 (67.2)</td>
</tr>
<tr>
<td>Nurse/Staff Nurse (PHCs+CHCs)</td>
<td>1366</td>
<td>1024</td>
<td>342 (25)</td>
</tr>
<tr>
<td>Lab Technicians (PHCs+CHCs)</td>
<td>610</td>
<td>270</td>
<td>340 (55.7)</td>
</tr>
<tr>
<td>Radiographers (CHCs)</td>
<td>126</td>
<td>61</td>
<td>65 (51.6)</td>
</tr>
<tr>
<td>Doctors (PHCs)</td>
<td>484</td>
<td>201</td>
<td>283 (58.5)</td>
</tr>
<tr>
<td>Doctors (CHCs)</td>
<td>504</td>
<td>210</td>
<td>294 (58.3)</td>
</tr>
<tr>
<td>(a.) Physicians</td>
<td>126</td>
<td>56</td>
<td>70 (55.6)</td>
</tr>
<tr>
<td>(b.) Obst. And Gynaecologists</td>
<td>126</td>
<td>46</td>
<td>80 (63.5)</td>
</tr>
<tr>
<td>(c.) Paediatricians</td>
<td>126</td>
<td>39</td>
<td>87 (69.5)</td>
</tr>
<tr>
<td>(d.) Surgeons</td>
<td>126</td>
<td>69</td>
<td>57 (45.2)</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses are percentages
Source: Rural Health Statistics, 2009

4. **Absentee Doctors**

As regards the availability of doctors during the stipulated hours, the less said the better. It is difficult for the public sector to attract qualified
doctors to the rural areas. Although in theory medical officers are required to be present at the practice, many medical officers visit the PHC infrequently, and prefer to operate parallel private practices from their residences. In many cases, the absenteeism is in connivance with the senior officers and patronage of other influential and well-connected persons. When doctors are present, their discourteous behaviour discourages patients from approaching the PHC for health care.

5. **Inconvenient opening times**

The health institutions are underused by outpatients. The situation is even worse in case of inpatients because PHCs have limited opening hours and no one is available to attend to the patients in the evenings or during the weekends.

6. **Informal payments**

Although not officially sanctioned, most PHCs require patients to make small, informal payments before receiving treatment. After the costs of transportation and time taken to get to the PHC are factored in, this additional payment often makes the cost of public sector health care more expensive than low-cost private health care providers.

7. **Low public sector spending on health services**

One of the major reasons for the pathetic state of health care in Punjab is the ever-decreasing state government expenditure on health. The share of health sector in the overall budget as the state expenditure on health sector which was 7.19 per cent of the total budget in 1985-86 subsequently decreased over the years to 3.45 per cent in 2007-08 (GOP, 2008). Low public sector spending on health services results in the following problems:
(a.)  *Lack of medicines*

The amount available for essential drugs at a PHC is inadequate to ensure that sufficient drugs are available, especially if the PHC is staffed with dedicated health workers and able to attract a large number of patients.

(b.)  *Limited doctor salaries*

Low salaries act as an obstacle to attract qualified doctors to health institutions in rural areas, especially given the high costs that many students have to pay for their medical education and training.

(c.)  *Poor condition of health infrastructure*

When government budget are under extreme pressure, the first area that is usually identified for cutbacks is the maintenance budget. The public health institutions are very poorly maintained. The poor condition of health infrastructure deters patients from seeking medical care there. Within such a context, it is important to focus on system reforms before considering any potential increase in budget.

From the 1990s onwards, when globalization gained importance and became indispensable in India, the health sector reforms have also been introduced to bring about strategic but favourable changes in the health care delivery system. Under the health sector reforms, cutbacks in public welfare expenditure, donor-driven priorities, techno-centric public health interventions and increasing reliance on private sector in providing health care have become the hallmark of new health strategy.

During the different five-year plans and annual plans, the government of Punjab has essentially focused on strengthening the health infrastructure in the form of buildings, machinery, equipment and manpower for primary health care. The department of health and family welfare is the prime
provider of public health services - preventive, promotive and curative in the state. The state of Punjab implemented various national health programmes for the diseases like tuberculosis, malaria, blindness, AIDS and leprosy etc.

**Genesis of Health Sector Reforms in Punjab**

The Government has been concerned with the increasing cost of health care delivery, especially since the health expenditure is growing at a faster rate than the growth rate of the economy. This is coupled with the demand for an increasing share of resources. In this context, the Government has been facing the problem of apportioning scarce public resources among competing demands. This situation is further worsened in case of the health sector, given the intangible output of this sector and the heterogeneity of patients seeking assistance. Further it was noticed that the standard of curative health services including diagnostic services in most of the district hospitals, sub-divisional hospitals and community health centres in Punjab was a source of inconvenience and dissatisfaction to the general public. Hence, the health needs of the community was re-evaluated, deployable resources in the health sector were assessed and the needs and resources were analyzed and reprioritized in order to initiate a process of reform. Thus the first initiative is related to the corporatisation of public health services in the state by establishing the Punjab Health Systems Corporation (PHSC) in the year 1996 by taking over 150 public hospitals ranging from district hospitals (17), sub-divisional hospitals (45) to CHCs/PHCs (92). The PHSC was incorporated with the objective to integrate and synergize the existing secondary level preventive, promotive and curative health services in the Punjab State since a healthy community holds the key to the socio-economic development of the country. This has been done with the help of World
Bank Loan of Rs. 422 crore. The reform initiative included:

(A) **Public Private Partnership**

(i) **Involving the private sector in service provision:**

This policy relates to the opening up of health care services to the private corporate sector. Private sector hospitals have been getting land and facilities at subsidized rates and are expected in return to provide free treatment to yellow card holders (people below the poverty line) up to 10 per cent of outpatients and 5 per cent of inpatients. Each year these hospitals are required to provide the details of their yellow card holder patients to the Punjab Urban Development Authority (PUDA), the organization that allotted land to these hospitals at subsidized rates. But the access of the poor to public health care services is constrained. It is mainly due to two factors - ignorance among the poor about the free treatment and the complex and cumbersome procedure for getting and renewing the yellow cards. Unfortunately, the benefits of this policy decision have not percolated down to the poor. The elite orientation of management, lack of awareness among the poor about free treatment in private hospitals and ineffective regulatory mechanisms are the major hindrances to free treatment for the poor in private hospitals.

(ii) **Outsourcing of Services**

The government has begun outsourcing of services in secondary level hospitals. The services relating to sanitation, ambulance services, dental services and services relating to security have already been contracted out. These policies have been adopted in view of the instructions issued by State Government in Finance Department. This policy calls for outsourcing hospital services,
health care extension services, diagnostic services to reputed professional service providers on the basis of monitorable performance criteria so as to ensure a high quality efficiency and standard of services at reasonable cost.

(B) **Decentralization**

(i) *Initiatives in Decentralization:* -

According to the 73rd constitutional Amendment Act, 1992, a three-tier structure of the Panchayati Raj Institutions (PRIs) namely, the Gram Panchayat, Panchayat Samiti and Zila Parishad has been established enabling them to assume the role of self-governing institutions for decentralized planning and management.

The Department of Health and Family Welfare decided to handover the subsidiary health centres and sub centres to PRIs. The Department prepared a schedule of administrative and financial powers to be transferred at each level of institution i.e. Zila Parishad, Panchayat Samiti and Gram Panchayat. It was proposed that all the services would be delegated to PRIs in a phased manner.

As per the decision taken by the council of ministers on the memorandum brought out by the Rural Development and Panchayats Department, funds, functions and functionaries of Department of Health and Family Welfare were transferred to Panchayati Raj institutions and requisite notifications in compliance to the decision taken by Council of Ministers were issued.

(C) **Changes in Financing Methods**

(i) *User Fees.*

The user charges have been implemented at the rates adopted by the state government. It has been stressed that the principle of
implementing the user charges needs to be made more rigorous for both inpatient and outpatient diagnostic and treatment services in hospitals. In October 2000, the PHSC rationalized these charges for the secondary level hospitals by abolishing discretions and slab systems and in some categories enhanced the same. With effect from 1 September 2002, the PHSC decided to provide free treatment to poor deserving patients apart from yellow card holders, equivalent to 2.5 per cent of the collections.

Further, a need was felt to suitably revise the user charges in order to recover the direct operation and maintenance cost of these services. Additional revenue generated was to be exclusively used to improve the quality of services. The state government allowed the PHSC to retain the user charges collected from the patients at the point of collection and use it for non-salary non-recurring cost purposes to bring about greater improvement in the working of hospitals. In order to ensure effective utilization of the revenue, the financial powers were delegated to the concerned officers. It has been helpful in providing functional autonomy to the hospitals.

(ii) **Health Insurance**

The Department of Health through PHSC carried out a feasibility study for developing medical insurance scheme for government employees, pensioners and for people below poverty line to whom free medical services could be provided by the state. The study estimated to include about 4 lakh employees belonging to the government of Punjab, 1.25 lakh pensioners, and 3.88 lakh families living below poverty line. The benefits included the facilities like provision of free outdoor and indoor medical services to the people
possessing yellow cards, payment of Rs. 250 per month to every employee and pensioner as fixed medical allowance, reimbursement of indoor treatment to government employees and pensioners subject to some restriction and reimbursement of money actually spent on chronic illness to all government employees and pensioners. This system sought to address the unmet needs of all stakeholders and laid emphasis on developing a cashless, transparent, easily administrable and financially viable mechanism.

(D) Re-organisation and Re-structuring of Existing System

(i) Revamping of primary health care services.

The state government sought to fill the gaps in the health care system at primary health care level and also strengthen the linkages between primary and secondary system and ensure quality health services to maximum number of people. Under World Bank supported project, 154 health institutions have been revamped. The World Bank further stressed on the need to integrate primary and secondary levels of care in the delivery of health services in Punjab. The state government prepared a draft project proposal to address this issue. The proposal laid stress on improving vital health indicators, burden of communicable and non-communicable diseases etc. The Government of India, Planning Commission, as well as the State Government made provisions in the 10th Plan and in the Annual Plan 2004-05 to support this project.

(ii) Ensuring Health Care Delivery through Better Mobility

In order to ensure more effective utilization of the infrastructure existing in the state of Punjab, it was proposed to provide linkages between the primary and secondary sector institutions. The proposal
included introduction of fully equipped mobile clinics linking PHCs/SHCs with the CHCs, which would ensure quality services to large number of people, particularly in the rural areas. The proposal would also cover ayurvedic and homeopathic institutions by integrating their functioning wherever required.

(iii) Development of a Referral System

The referral system allows queue jumping and exemption from registration / admission / bed charges. For instance, according to this system a patient having a referral card would report to the senior citizen counter of the OPD, and an OPD ticket would be issued and stamped ‘referred-in’ and the consulting doctor may attend to the patient having an OPD ticket with the ‘referred-in’ stamp.

(iv) Development of Performance and Quality Indicators for Hospitals

The Hospital Management Information System (HMIS) has been designed with a view to provide core quality indicators for every hospital. This system assigns a mark against each indicator vis-a-vis set benchmarks on the basis of selected parameters related to inputs, processes and output. On the basis of the performance, every hospital is placed under one of the six categories, namely A+, A, B+, B, C+ and C. Besides, detailed performance reports for every hospital is also generated. Such a system helps in keeping a check on the performance of the hospitals.

(v) Development of a Disease Surveillance System

The state selected 21 communicable and 12 non-communicable diseases for active surveillance. Surveillance Committees have been formed at district and village level and includes stakeholders beyond
the formal public health system. The data is collected from each of the hospitals and is consolidated at the district level, which is then analyzed at the state headquarter with the help of Geographical Information system (GIS). Attempts are now being made to link the surveillance system under the project with the larger public health system managed by Directorate of Health Services.

(vi) **Maintenance of Assets**

The PHSC has prepared a comprehensive scheme for maintaining assets by creating a special wing within the corporation, which would take care of renovations, extensions and maintenance of all health infrastructure in the state.

**A State-Specific Health Policy must for Punjab**

A state-specific health policy is the basic pre-requisite for health planning in the state. A health policy should capture a holistic view of the state’s health, identify requirements and priorities, set up objectives and ensure optimal utilization of the allocated resources, given the capacity and constraints of the health system. It should result in a qualitative improvement in health services for the people in general and vulnerable groups-weaker sections, women and children- in particular.

Punjab requires several things. Firstly, it requires a proper health management information system which is the back bone for immediate access to information on different health indicators such as birth rate, death rate, neo-natal, peri-natal, infant and child mortality rates, method-wise contraceptive prevalence rate, disease patterns etc. at the district level. New information technology can play a vital role in this regard.

As the existing number of medical institutions in the state are insufficient to meet the health needs of the people, the government must
enhance the health care facilities by establishing more medical institutions. Besides, efforts must be made to bridge the rural-urban gap in the availability of health services by having an equitable distribution of health services in rural and urban areas. The existing health care facilities must be optimally utilized, vacant positions in the health institutions must be filled and absenteeism of doctors must be checked. These measures could prove to be of great help in improving the health scenario in the state. Most health institutions, particularly the rural ones, continue to focus excessively on immunization and family planning activities, ignoring the curative aspects. Health policy should give due care to the curative aspects alongwith the preventive aspects. Some of the suggestions for improving curative services pertain to easy, queue-less accessibility, service-availability for longer duration, clean premises, provision of medicines, diagnostic services under one roof on no-profit no-loss basis with appropriate subsidies for economically weaker sections.

The policy should ensure regulation of both the public and private sector. At present, the state government is not even aware about the exact number of private clinics/hospitals/nursing homes and practitioners working in the state. While mandatory registration, service monitoring, fees regulation and rating are must for private health sector facilities, rationalization of postings, strict guidelines for deputations and priority settings in rural postings are must for public sector. No aspect of planning health services appear to be more important than the consideration of finance. The paucity of financial resources because of poor allocations has often proved to be a major obstacle in the execution of health programmes. Punjab government must allocate much higher levels of resources for the health sector. There is a dire need to enhance public investment in health
sector and health investment planning must be biased towards under-privileged areas and groups. Further, rising costs of treatment in both the public and private sector, warrant a viable health insurance policy.

Health policy should make efforts to provide diagnostic equipments at all referral hospitals from primary health centres (PHCs) onwards. In order to meet the financial limitations, such services may be outsourced to the private sector at government approved rates. This will promote public-private partnership, smash the nexus between doctors at public health facilities and owners of diagnostic centres and would result in stoppage of various malpractices.

The disease patterns have changed over the years. The growing incidence of life-style diseases such as cardio-vascular diseases, diabetes, gastroenteritis, urology and newly emerging diseases such as cancer, HIV/AIDS, dengue and bird flu are posing new challenges for the state. The policy should examine the feasibility of setting up special clinics at the district hospitals to deal with some of these problems. The health policy should also consider suitable nutritional awareness programme, initially at the school and Anganwadi level. Rising number of suicides in the state signify need for more mental health specialists too.

Punjab’s health policy also needs to spell out area-wise prevalence of tropical and other diseases, ensure optimal utilization of health manpower and resources, enhance availability of primary health care/ paramedical staff, set out strategies to cope with rising pressure on tertiary health care institutions and bring about awareness for a better quality of health care comprising environment and occupational health, adequate availability of drinking water, hygienic living conditions, nutritious food, removal of drug addiction and other health hazards.