CHAPTER II
Chapter II
Methodology

Conceptualization:
The cutback on public spending on health was a global phenomenon of the 1980s and 1990s. During this period the public sector was seen as insignificant and any investment in it was assumed as wasteful expenditure. The eighties saw the thrust on privatization as the solution for the inefficient functioning of the public sector. Economists, Public Health scientists and even the United Nations contested this unquestioning faith on the process of privatization. However the need to selectively invest in public health services was emphasised by institutions like World Bank. There was also the question about improving the public health systems. The dominant view was to restructure the public institutions through the introduction of market mechanisms in order to improve efficiency and cost-effectiveness.

The context:
In the decade of eighties and nineties India and many other developing countries took loan from International Monetary Fund (IMF) to deal with the fiscal crisis. The World Bank had recommended for cutting back on public expenditures in social sectors and this affected investments in health sector across developing countries. The negative impact of SAP, in terms of increase in unemployment and poverty and reduction in health status among the poor in different countries has been observed by various studies. The focus of health care reform as could be seen from Cassels definition has only been on health services financing. It does not include other components like wages, employment, food security, housing, water supply etc., which play a crucial role in improving health status of populations. Studies which have tried to review the experiences of privatization of health care in both developed and developing countries show that the principles of equity and universal access was undermined by adoption of a market model in achieving health targets.\(^{55}\)

The role of World Bank:
The Structural Adjustment Programmes\textsuperscript{56} suggested by the World Bank in the eighties and nineties had an impact in health sector at the global level, across different continents. The World Bank document titled ‘Financing Health Services in Developing Countries’\textsuperscript{57} was one of the first to argue for a change in the role of government in terms of financing. It argued about introduction of user charges in government health care facilities, involvement of NGOs in generating resources and decentralization of planning. The nineties also saw a shift in pattern of international funding in health care. Until the eighties bilateral agencies were the dominant player in terms of health funding and in this type of arrangements individual countries had the freedom to chose their priorities according to their own historical contexts. However due to the fiscal crisis generated by oil shock in the late seventies the number of bilateral funding in health sector declined across the developing countries and World Bank emerged as a major financier for health care in the decade of nineties. Due to this nature of change in the funding, the developing countries had very little choice for bargaining in terms of their priorities\textsuperscript{58}.

The World Bank funding came along with certain conditionalities. In the case of countries from Latin America and Africa this was the scenario\textsuperscript{59}. The experience from these countries show that the reform measures suggested by World Bank gradually crippled the public structures of provisioning and an alternative structure also could not come up. For example the introduction of user charges generated very few resources in countries like Zambia.\textsuperscript{60}

\textsuperscript{56} These were meant for opening up of the economy to the world market, reducing the role of the state to be the regulator of the economy and to a large extent increasing the role of the market.
\textsuperscript{57} The World Bank, 1987.
\textsuperscript{58} The emergence of World Bank in the nineties as the single largest financier of health services for developing countries has replaced the bilateral donor agencies, which played a substantive role in the eighties in health sector. But unlike the bilateral donor agencies, which were only supportive of specific health sector interventions, the World Bank also decides the priority areas of interventions.
\textsuperscript{59} In the eighties the World Bank had emphasised on blanket privatization for the health sector in Africa and Latin America, which created adverse impact on the health status of these countries. For example, the child mortality and morbidity for most age groups rose, suggesting inequities of access to health care.
\textsuperscript{60} P. Nanda, 2000.
The World Bank (1993) annual document titled *Investing in Health* argued for improving government spending on health, which would help the poor. This document has been seen as a blueprint for reforms in the health sector of developing countries. To attain these objectives it suggested some measures like reduction of government spending in tertiary sector and in specialist training, introduction of user charges in government hospitals, introduction of essential clinical package to make the health care system more ‘efficient’ and ‘effective’. For improving the management services in the government health care structure, it suggested measures like decentralization of administrative and budgetary authority and contracting out of services. In a way this document suggested a *greater role for the private sector* in tertiary and specialist training. By asking for introduction of user fees in government hospitals for the affluent sections, it was suggesting that these institutions become financially independent in the long run.

The World Bank in its 1993 report\(^6^1\) for developing countries had mentioned the broad outline for health sector reforms. These measures were:

1. Cutback on tertiary medical care in the public sector.
2. Private sectors to play a more prominent role in providing care.
3. Introducing cost recovery mechanisms in the public sector.
4. Implementing an "essential clinical package for primary level care."\(^6^2\)

The reasons for the growth of World Bank as the single largest financier in health sector were: one- To protect the vulnerable sections from adverse impact of SAP and two- The World Bank’s effort to be seen as addressing the problem of inadequate investment in the social sector.\(^6^3\)

In the eighties the World Bank had emphasized on blanket privatisation for the health sector in Africa and Latin America, which created adverse impact on the health status of these countries. For example, in Child mortality and morbidity for most age groups rose, suggesting inequities of access.\(^6^4\) The dominant philosophical approach for the health

\(^{6^3}\) Baru; 2002.  
\(^{6^4}\) Creese, 1994.
sector reform in the nineties was the utilitarian perspective, which tried to maximise output with least input. This perspective had certain inbuilt assumptions regarding issues of efficiency, quality and effectiveness of public and private provisioning.

The new perspective placed more faith in private and voluntary sectors. The inherent assumptions were that the private sector was more efficient, cost-effective and could provide better quality care than the public sector. These assumptions were not based on any empirical evidence. Baru has suggested that there were methodological problems in evaluation and drawing comparisons of quality and efficiency between public and private health care. For example, the public sector by its very nature tries to provide universal access to health care and also it provides a range of services. The basic motive has been to provide everyone a healthcare system without taking into account one’s ability to pay. On the other hand the private sector is motivated by profit. As various studies show that private sector goes to those areas where it could have profit. There is a tendency among private health care sector to concentrate on developed regions. They provide a limited range of services to make their venture a profitable one. Also their focus is on curative rather than on preventive health care. The patterns of financing and investments also differ between the public and private sector and thus making comparisons in cost of care a difficult job. Further studies on quality of services in private sector were problematic due to its heterogeneous nature.\(^{65}\)

Different country experiences show that the reforms in health sector seem more interested in cutting costs and reducing state involvement in health care. Thus it undermines the principles of equity and universal access, which are essential for public health. In this backdrop the present study intends to look at implications of health sector reforms for the health services system in a state like Orissa from a systemic view. A systemic approach looks at linkages between various levels of providers, inter-sectoral approach to health and rational use of technology. It locates the healthcare and health status of a community within the socio-political and economic context of a society.

\(^{65}\) Baru: 1998.
Why Orissa:

Socio-Economic Background:

Orissa was chosen as a field of study because of several reasons. According to 1991 census of India, Orissa’s population compared to the total population of India was 3.74 percent constituting 316,597,36 in numbers. Out of its total population, Scheduled Castes constituted about 16.20 percent and Scheduled Tribes constitute about 22.21 percent. Thus together, scheduled castes and scheduled tribes constituted about 38.41 percent of Orissa’s total population. These two sections constituted the bulk of the poor in Orissa and lived in remote and hilly areas. Almost 81% of the SC/ST population was landless laborers with very little assets. The large number of scheduled tribes in the state also results in different understanding of notions of good health. This cultural difference was a significant barrier for promoting universal health care. As a result in tribal areas it has been observed in many cases that while health care infrastructure was available, utilization was very low. Also women from these two groups suffer from disadvantages of income, caste and gender discrimination in every aspect of life.

In terms of literacy rate total literacy was 49.09 percent. Out of this male literacy was 63.09 percent and female literacy was 34.68 percent.

The census figures showed that more than half of Orissa’s population was illiterate. Significantly female illiteracy was more than 65 percent of its female population. Coupled with this, near about 48 percent of Orissa’s total population lived below the poverty line. As we know from various studies that health status of a population was determined by overall socio-economic conditions. Therefore if near about half the percentage of total population was living below the poverty line that means malnutrition was very high among its population. This could have an adverse impact on the health status of Orissa’s population.

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70 The poverty line in India has been conceptualised by the Planning Commission of India in terms of Calorie intake per day. While for rural areas it has been fixed at 2400 Kilo Calories per person per day, for urban areas it has been fixed at 2100 Kilo Calories per person per day.
Orissa was also a state where the growth of private health care in terms of hospitals and beds had actually declined during 1973 to 1996. Here public health care services were utilized by most of the population. Therefore the health sector reforms that advocates more roles for private health care, and introduction of user charges for secondary and tertiary levels of care in public sector, has serious implications for a state like Orissa.

Epidemiological situation in the state:
Communicable diseases like malaria, tuberculosis and leprosy continued to be major public health problems in the late twentieth century Orissa, apart from filariasis in the coastal districts. According to one estimate more than 60 percent of the diseases prevalent in Orissa were water related. Communicable diseases like diarrhoea and dysentery, worm infections and typhoid were present throughout the year. The state still shared largest number of deaths due to malaria in India. Malnutrition continued to be a major public health concern. The data from NFHS II showed that while 54 percent of the children under age 3 were underweight, 44 percent were stunted (height/age) and 24 percent were wasted (weight/height).

According to one estimate Non Communicable Diseases or NCDs constituted 22 percent of morbidity in the state and 16 percent due to accident and injuries. Besides, diabetes, cardio vascular diseases, chronic bronchitis, asthma and mental illness constituted major NCDs in the state. Apart from these, natural disasters like floods, droughts and cyclones in the coastal areas create havoc and increases morbidity and mortality among the large sections of its population.71

Health care services structure72:
Before proceeding further let us have a look at the organizational chart of health care services structure in Government of Orissa. The Ministry of Health and Family Welfare

71 NFHS II, Orissa.
72 The structure means that all the elements constituting the structure should be working toward achieving a common aim. However in later chapters we have discussed as to how the structures created by for example OHSDP, has bypassed the line departments of the Health Directorate, Government of Orissa.
was the nodal ministry for the health care services in the state. At the top of the hierarchy was the Minister of Health and Family Welfare. Under him/her was the principal secretary to the government of Orissa, Health and Family welfare department. There were four secretaries to assist him. They were in the hierarchical order of Additional, Joint, Deputy and Under secretaries. Apart from these four secretaries, the project director OHSDP or Orissa Health Systems Development Project was of the rank of Additional secretary. There were six technical directors who directly come under the Principal Secretary. These directors were mostly from the health care services cadre and hence having a medical background. These six directors were Director of Medical Education and training or DMET, Director Health Services or DHS, Director Family Welfare, Director of SIHFW or State Institute of Health and Family Welfare, Director Drugs control and Director of IM and Homeopathy.

In terms of functions the Medical and Nursing colleges comes under DMET. The Health care services cadre comes under the DHS. The Director of Family welfare looks after the Family Welfare program in the state. The role of SIHFW has been to recruit and train staff for different health programs in the state. It has recently been given the status of Regional Training Center to train health personnel from Jharkhand and Chattishgarh apart from Orissa.73 The Chief District Medical Officer or CDMO who was in charge of a district comes directly under the control of DHS. Director Drugs Control was the nodal agency for checking the quality of drugs in the private sector in the state through its drugs inspectors. It also issues licenses to Private health care sector in the state. At the district level ADMO Public Health, ADMO medical and ADMO Family Welfare assist the CDMO. The CHCs and PHCs come under the control of CDMOs. The director of Health and Family Welfare controls 30 CDMO’s in 30 districts of Orissa74.

As per norm while CHC’s cater to the services of more than one lakh population in a block, the PHC’s cater to the services in a block having less than one lakh population. At the CHC level there was a Medical Officer in charge who was a junior class I officer.

73 This was known from interview with a certain official in SIHFW, Bhubaneswar.
74 See annexure 1.
Then there was a second medical officer who was a class-two grade officer. Then there was a pediatric specialist and a Gynecologist. At the PHC level there was a Medical Officer in charge, who was a class II officer and a second medical officer who was also a class II grade officer. Each CHC/PHC had under its control 4 to 12 Primary Health Center New or PHC new institutions. PHC New was a single doctor medical institution previously known as Dispensary or Additional PHC or subsidiary health center or mobile health unit. Each PHC New had under it 4 to 6 sub-centers. One female health worker or ANM who was assisted by one health worker male were supposed to be in each sub-center. A supervisor supervises them who in turn were accountable to his/her sector medical officer at PHC (N). An Anganwadi worker\(^{75}\) who was given charge in a village with population of 1’000 also assists each health worker female.

At present the government of Orissa was planning to convert all PHC (N) to PHC and to promote all PHCs at block level to CHCs. At the CHC/PHC level, Departmental Review Meeting in the block and sub-divisional level were held at each month. For the CHCs and PHCs, the Medical Officer in-charge was responsible for all health activities in his/her block. Each health worker female or HFW was also assisted by auxiliary nurse/midwifes, who were non-government health workers.

**Utilization pattern:**

The 42\(^{nd}\) and the 52\(^{nd}\) rounds of NSS showed that Orissa was a state where there was higher utilization of health care services by both the poor and the rich from the government sectors. This was due to the larger presence of the government sector in health care in the state and also due to the absence of a private sector in a strong way as it has been seen in other states. As per March 2005, Orissa had 158 CHCs, 1349 PHCs and 5927 sub centers. There were in total 181 hospitals. This includes 3 medical college hospitals, 31 District Headquarter Hospitals, 21 Sub Divisional Hospitals and 126 other hospitals.\(^{76}\) The absence of private sector in the state could be explained by the fact that Orissa was not a developed state. Most of its population lived in rural areas with low per

\(^{75}\) Who comes under the centrally funded scheme of Integrated Child Development Program or ICDS.

\(^{76}\) Data collected in the year 2005 from the Directorate of Health Services, Govt. of Orissa.
capita income and almost fifty percent of its population lived below the poverty line. Hence the purchasing power of the people was very low. Therefore people would try to look for avenues of health care where they could afford at a lower cost. As the private sector in health care was oriented to make profit, it was not profitable for it to invest in a state like Orissa at a large scale. In these circumstances we could draw an inference that there was very little incentive for the growth of the private sector in the state. As studies by Baru and others have shown that the private sector has a tendency to move to the developed areas or developed regions and it was purely guided by the profit motive. As a result it not only focuses on select geographical areas, it also provides a narrow range of services.

Thus we saw that in case of Orissa the state has played a dominant role over the years in terms of provisioning of health care services. To provide health care to the different sections of the population the health care services structure has also expanded in the state over the years. But still a lot was there to be done. For example field visits to different single doctor PHCs showed that there was absence of doctors and the pharmacists mostly ran these institutions. Many of the single doctor PHCs and the sub centers were run in rented buildings.

All over India it has always been difficult for the state governments for retaining doctors in rural and remote areas, where there is absence of proper transportation and communication and other infrastructure facilities. This problem was also there in Orissa but in an acute form. Apart from other reasons, the major reason was that there has almost always been political interference in posting and transfer policy and according to

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77 This was the view of many officials in the state about the absence of a strong private sector in Orissa.
78 For example the Health Survey and Planning Committee observed, "Of the 47,400 doctors available in the country only about 13,000 are reported to be on the staff of medical institutions maintained by government and other agencies. The remaining medical men must therefore be in private practice. The tendency for the latter is to concentrate in urban areas. For instance in Bengal, the ratio of doctors to the population is three and half times more in urban than in rural areas. In Sind the doctor to population ratio in urban centers being about 49 times that for the rural areas." The committee further noted that "In Orissa average population served by a medical institution in 1942 in rural areas was 52,548 and in urban areas 15,276". Report of the Health Survey and Development Committee, Volume I, Manager of Publications, Delhi; Calcutta, 1946.
79 Known as PHC (New). The other staffs were one pharmacist, one ANM and a sweeper.
informed sources it has turned out to be a lucrative industry.\textsuperscript{80} However those with bureaucratic or political connection connections while do benefit from this system, it has demoralized the doctors at every level. This has significant implications for delivery of health care at the periphery level institutions. Many observers were of the opinion that the periphery level institutions have almost ‘collapsed’. This has serious implications for accessibility, availability and quality of services as well as performance of various national programmes.

\textit{Hypothesis:}

In this background the present study intended to suggest some hypothesis. They were: 1- The health sector reform process in the long run would undermine the universality of health care which was an essential feature of public health.2- The public health services in the long run would try to withdraw from provisioning of the secondary and tertiary level care, this would weaken the sustainability of primary level care.3- With increasing privatization of health care the cost of care would go up, this would affect the poor most and would also affect their overall quality of life.

\textit{Overall Objective:}

To examine the process and experience of Health Sector Reforms in Orissa.

\textit{Specific objectives:}

1. Trends in public financing in Orissa relative to India since mid- eighties.
2. To examine the trends in growth of public health services at the primary/secondary/tertiary level in Orissa during the eighties and nineties.
3. The trends in quantum, source and agencies providing external assistance to the health services system in Orissa during these two decades.
4. To study the perception and experience of bureaucracy dealing with the health sector and the experience of health sector reforms in Orissa.
5. How they perceive the shifts in financing, provisioning and manpower of health services during these two decades and its implications for equity.

\textsuperscript{80} This was known through interaction with various officials at different levels of the Health Services Structure in the Govt. of Orissa.
Methodology and Design of Study:

This study was designed to examine the process and experience of reforms in the state of Orissa. Due to the qualitative nature of the study, in-depth interview and direct observation were adopted as key methodological tools to interact with the key actors in both the donor agencies as well as in the government. A pilot study was conducted in one of the districts before going to the field with interview schedules. Apart from this the interviews with senior officials of the donor agencies and review of literature of different country experiences did help in preparing the interview schedule and an insight into the nature of problem that might be confronted in the field. An ethnographic approach to the study was adopted to bring out the actors perspective with regard to the process and experience of reforms.

Quantitative vs. qualitative methods:

It has always been a subject of debate as to whether to study a social phenomenon we should use quantitative or qualitative method. Those who have advocated quantitative

81 “How does the researcher formulate items in areas where the literature is inadequate? The answer lies in pilot study. …After the literature has been carefully studied and experts consulted, the researcher may still have only a rather vague idea of what are the crucial elements in his problem. A pilot study may then be launched as a step preliminary to the formulation of a schedule”. P- 146, Methods in Social Research by William J. Goode and Paul K. Hatt, McGraw-Hill Company, 1981.

82 We have discussed about ethnographic approach in the later part of this chapter. However we can say that ethnographic approach has been traditionally used by Anthropologists. “Anthropology, which was closely linked to colonization, directed its attention to people who were different from the researchers, tending to become above all study of otherness. Accordingly Anthropologists have been described as people who chose the exotic as their profession. The gap between the ethnological researcher and the people he studied was often accentuated by the fact that the latter were illiterate and lived in a pre-modern, tribal society” p- 219 in Anthropology and Colonialism in Asia and Oceania ed. By Jan Van Bremen and Akitoshi Shimizu, Curzon Press, 2000. In recent times the use of ethnographic approach has been used in different contexts apart from using it in closed societies.

83 In recent times the use of quantitative method has been used as synonymous with scientific method. In this context it is worthwhile to look at the observations in this regard Goode and Hatt had made. They observed, “Science itself rests upon a series of postulates, or assumptions, which are themselves fundamentally unproved and unprovable. We can assert that these postulates are true; but we cannot prove them. They represent those areas in the philosophy of science, which is usually called epistemology.” P- 20. Opt. Cited. Similarly Kapil Raj observed in a lecture that, “The kind of people working in one laboratory is different from kind of people working in another laboratory. They compete with each other to certify their knowledge before others. That’s why knowledge is local”. Dr. Kapil Raj was giving a lecture in SSS II, JNU on 9th September 2005 about how scientific knowledge is generated. He was a visiting professor from École Institute, Paris, France.

84 For example in December 15-17, 2003 in a seminar on Monitoring Shifts in Health Sector Policies in South Asia conducted by Center of Social Medicine and Community Health, JNU, the use of quantitative vs. qualitative method became a subject of debate. While some of the participants were arguing for
methods do so in the faith that there were underlying laws or truths in a social phenomenon just as there were laws of the nature. Their point was that because there were underlying laws, it could be discovered through rigorous use of quantitative methods, which could be verified and thus the result would subject itself to test by peers.

On the other hand those who argue for a qualitative method say that 'human beings attach meaning to their actions'. And hence any comprehensive understanding of human action must have a place for the understanding of underlying meanings to it. Commenting on the methods of natural sciences Jurgen Habermas said that while using the methods of natural sciences we have been able to get control over the physical world; however it has its obvious limitations.

quantitative methods as valid method of research, others were arguing about the significance of qualitative methods as a tool of data collection in Public Health.

85 Let us have an interpretation about how truth is constructed in different settings, "Is there such a thing as truth? Foucault’s main tenet is that societies produce ‘regimes of the truth’. This means that every society at specific historical periods produces an all-enveloping ‘truth’ to which people in that society adheres. This is their ‘reality’, but it has been constructed and produced by people in that society themselves. The ‘truth’ therefore is not a universal or everlasting entity; it is a product.... Foucault than goes on to describe the transmission of this truth through a variety of ‘discourses’. A discourse is a set of ideas, practices and beliefs, which coalesce to produce an overarching picture of reality. In the eighteenth century, religion was the dominant discourse in European societies through which a ‘truth’ was constructed. But with increasing industrialization and technological advance, modern societies developed other more powerful discourses: science and medicine. These discourses, with another set of practices, beliefs and sites of operation, produced a new regime of the ‘truth’."

87 As German sociologist Max Weber had famously said in his theory of social action.

Those who argue for a Marxist or a Parson's approach to the social phenomenon try to give these interpretations as the power of natural science, which could not be questioned.\(^8^9\) These have been the dominant interpretations of the social phenomenon. The idea that the study of social phenomenon could be undertaken by using the methods of natural science was based on the desire to make a scientific study of society. However, with the critical reflections on universal theories like Marxism or systems theory by Parsons, there was a wider understanding that there were multiple realities.\(^9^0\) That means there could be various interpretations of the same phenomenon by different individuals. Thus coming to an understanding of reality could happen through *communicative action*\(^9^1\) and not necessarily with the interpretations by experts in a particular field.

This way of interpretation of the social phenomenon does not necessarily lead to conflict of different interpretations. Rather a decisionistic model could resolve these tensions. For example in case of a policy decision a politician could choose from different interpretations of the same phenomenon and the same could be applied for a researcher also.\(^9^2\)

Arguing a case for a qualitative method in this thesis, an effort has been made to give the meaning of actors in our analysis of a social phenomenon and in this case to study the perception and experience of health sector reforms from the providers' perspective. While the success and failure of a program or a project could be learned from statistical figures, the internal dynamics, which determined these outcomes, could only be known from the actors' point of view. In the case of process and experience of reforms in the health sector, the *ethnographic method* gives an insight not only to the internal dynamics of inter-personal relationship within the *rationalist bureaucracy*,\(^9^3\) it also brings out those aspects which would have never come into the open through a quantitative method, although it was vital for a total understanding of the phenomenon intended to be studied.

\(^{8^9}\)This has been well argued by Foucault in his book *History of Sexuality*.

\(^{9^0}\)As advocated by the Post modernist school. The post modernists believe that there was not a single path of progress but there were multiple paths and also multiple goals for progress of different societies.

\(^{9^1}\)Again see Habermas in his various writings.

\(^{9^2}\)Ibid.

\(^{9^3}\)This term has been borrowed from German Sociologist Max Weber.
Due to the nature of the study, ethnographic approach was the main tool used in gathering information from the field. However statistical data have also been collected both from the government and donor agencies to give as much comprehensive picture about the phenomenon as possible. In some places qualitative method has been used without giving a quantitative verification and at other places it has been done. It was hoped that the mixture of these two methods would help in bringing the different aspects of reality to the fore.

What is ethnography?

"The growing interest in ethnography stems largely from a disillusionment with the quantitative methods that have for long held the dominant position in social sciences. ... There is a disagreement as to whether ethnography's distinctive feature is the elicitation of cultural knowledge or the detailed investigation of patterns of social interaction or holistic analysis of societies. Sometimes ethnography is portrayed as essentially descriptive or perhaps as a form of story telling; occasionally by contrast, great emphasis is laid on the development and testing of theory."  

In this study we have used ethnography as a descriptive method of study to get the actors perspective of their world. Here the actors were the government officials and the officials from the donor agencies in health sector.

Ethnography is a basic form of social research and it does not have a long social history. But it bears a close resemblance to the routine ways in which people make sense of the world in everyday life. Some commentators regard this as its basic strength and some as a fundamental weakness of ethnography. However once one recognizes the reflexive character of social research, that it is part of the world it studies, many of the issues

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94 This thesis was looking at the perceptions of the providers about the health sector reform process.
96 Here an inspiration has been drawn from German Sociologist Max Weber according to whom, social action which is oriented to others by their very nature should be the study of social phenomenon.
97 P-2, opt cited.
thrown up by the dispute over positivism become easier to resolve and the specific contribution to be made by ethnography emerges more clearly.98

The argument of the positivism was that the social phenomenon could be studied as natural phenomenon and hence the methods of natural sciences could be applied in social sciences. However ethnography argues that the character of social research was reflexive in nature and that means when a researcher studies a social phenomenon he or she was also part of that phenomenon and hence the construction of reality depends on intersubjectivity.

However there has been some disagreement over whether ethnographic theories can be proved valid, and in fact it seems that they cannot: there is always the possibility that new facts will appear in the future that will disprove them. The most elegant attempt to resolve this problem is the work of Karl Popper who argues that while theories can never be proven true, they can be falsified since only one contradictory example is required for this. On this view the defining feature of science is the attempt to falsify theories.99

Therefore the argument that the ethnographic theories cannot be proved valid holds true also for other sciences, including the natural sciences. Thomas Kuhn in his Structure of Scientific Revolutions said, the most striking feature of normal research problems... is how little they aim to produce major novelties, conceptual or phenomenal. Sometimes, as in a wavelength measurement, everything but the most esoteric detail of the result is known in advance... Therefore bringing a normal research problem to a conclusion is achieving the anticipated in a new way.

But the question arises as to what happens when the existing paradigm is faced with a new fact? To this Kuhn says confronted with anomaly or with crisis, scientists take a different attitude toward existing paradigm, and the nature of their research changes accordingly.... Hence at a given point of time a theory may be able to explain a larger set

98 Ibid.
99 P-20 opt cited.
of phenomenon than other theories and when a new phenomenon was discovered which
could not be explained by the old theory than a new theory emerges. This was true in case
of both the natural and social sciences. Therefore as the theories change, the method of
investigation also changes and hence the dispute over quantitative or qualitative method
was totally misplaced. One method may be suitable for a particular kind of study and
another for another type of study.

In the present study:
To address the objectives 4 and 5 in this study we have used the ethnographic approach to
understand the providers' perspective at different levels of the government and the donor
agencies with the use of in-depth interview methods.

These interviews were conducted with the help of an interview guide. The interviews
were conducted at two levels. One, the key persons at different levels in the Government
of Orissa health sector were interviewed. For example in the Directorate of Health and
Family welfare, Government of Orissa, all the six directors at different departments were
interviewed. Two, in the donor agencies both multilateral like UNFPA, UNDP, UNICEF
and the World Bank and bilateral agencies like European Commission and the DFID
were covered. These donor agencies were interviewed in both the state and at the central
level, where their head offices in India were located.

On the part of the state government it had also instituted some reform offices like Policy
and Strategic Planning Unit or PSPU with the help of British funding agency DFID.\textsuperscript{100}

\textsuperscript{100} The role of this agency was being worked out when this researcher was visiting the state for fieldwork.
However interviews with the DFID officials and the existing staff of the PSPU revealed that this reform office would help the ministry of Health and Family welfare, Government of Orissa, in Policy formulation and Planning for the overall health services sector. It would also act as a coordinator between the different donor agencies in the state. The staffs were sent in deputation from the Health Department to the PSPU and the entire funding was done by the DFID and this office directly comes under the Ministry of Health and Family Welfare, Government of Orissa. Thus DFID was closely related with the reform process in the state. During the field visit it was observed that, the PSPU officials were quite busy with their plan of presentation for the visiting DFID officials from Delhi. They were literally on their toes. It was found that the current Director of the PSPU was an Indian Administrative Service officer from the state cadre. Apart from directly funding the PSPU, the DFID had a state office, which looked after the broader dimensions of development in the state. Here the staffs were recruited on a contractual basis. There were consultants for different projects. It was found that the consultants from the DFID had easy access to Health Department
Other reform office was the Sector Reform Cell funded by European Commission. It was looking after the projects funded by European Commission.\textsuperscript{101}

Thus the directors at both the PSPU and the Sector Reform Cell were interviewed. Besides, some consultants and key persons, who have been closely involved with the reform process, were also interviewed from these two reform offices. Interviews were also taken from the director, Orissa Health Systems Development Project or OHSDP, which was being funded by the World Bank and a key official who has been there since the beginning of this project.

Interview was also conducted with the then additional secretary Health and Family Welfare Department, Government of Orissa. While the former health secretary could be interviewed, the incumbent health secretary said that the directors could give a better picture about the reform process and the health minister said that as he was new to his post, he wouldn't be able to reflect much. However the interaction with the additional secretary, Health gave an insight into the current thinking of the government of Orissa with regard to the issues of health services in Orissa and ongoing health sector reforms process in the state.

In Delhi interviews were also conducted with the donor agencies like World Bank, DFID and European Commission as these organizations were closely involved with the health sector reform process in the state of Orissa.\textsuperscript{102}

\textsuperscript{101} This office came under the direct control of Health and Family welfare department, Government of Orissa. Similar to the PSPU, the staffs in the Sector Reform Cell were mostly from the Health Department, Government of Orissa. They also had consultants hired on a contractual basis.

\textsuperscript{102} It has to be mentioned here that the Orissa Vision 2010 Document, which was published in the year 2003 by the Health and Family Welfare Department, Government of Orissa, was completed with the inputs from different donor agencies in the state. During the field visit it was mentioned by different donor agencies that the earlier health secretary was quite eager to involve different donor agencies on the issue of health in the state, while the present health secretary was not only ignorant about different issues, but he was also very reluctant to take interest on health issues. The vision document 2010 has identified different features of health reforms, which we have discussed later chapters.
To address the objective one, Annual Plan documents and the Tenth Plan document of the government of Orissa, RBI reports and CMIE reports were referred. To address the objective two, official published and unpublished documents from the directorate of health services, government of Orissa and from the department of statistics, government of Orissa were referred. To address the objective three documents of the various donor agencies were referred.

**Districts chosen:**

At the district level two districts *Sundergarh* and *Khurda* were selected through *purposive selection*. The idea behind the use of purposive selection was that the districts chosen should have some functioning health care infrastructure. While Sundergarh district was situated in the northwestern part of Orissa, Khurda district was situated in the coastal belt. These districts were among the five most developed districts in the state. The district of Khurda was second most developed district in Orissa and the district of Sundergarh was third most developed one according to one report by National population commission.\(^{103}\)

In these two districts, the respective chief district medical officers as well as the other supporting officers were interviewed in a group interview. In these interviews CDMOs were taking the lead in most of the times. Besides in the Sundergarh district the district headquarter hospital was visited to get a first hand view of the implementation of the user charges. This was also done in case of Capital Hospital, Bhubaneswar where some of the staffs and patients were interviewed to know about their perception of the privatisation of cleaning and the introduction of user charges.

\(^{43}\) The selection of these two districts was based on National Population Commission’s ranking of all India districts. The national population commission on the basis of twelve indicators had ranked these districts. The indicators used were: Percentage decadal population growth rate; Percentage of birth order three and above; Percentage of current users of family planning methods; Percentage of girls marrying below 18-years of age; Sex ratio [females per 1000 males]; Percentage of women receiving skilled attention during deliveries; Percentage of children getting complete immunization; Female literacy rate; Estimated percentage of villages not connected with pucca roads or all weather roads; Estimated percentage coverage of safe drinking water [habitations]; Estimated percentage of births registered. Estimated percentage of deaths registered.
In Orissa at the block level, in some places while the PHCs were headquarters\textsuperscript{104} and in other places CHCs were the headquarters. The bed strengths at the block headquarter PHCs varied from 16 to 30 beds. During the field visit to the state it was known that the government of Orissa was planning to convert all the existing PHCs into CHCs and the PHC (New) s into PHCs. The PHC (New) s' were the single doctor PHCs with other staffs comprising, one pharmacist, one ANM and a sweeper. It was found that under a block PHC there were 3 to 5 PHC (New) s' and then there were sub centers where one ANM was placed at each sub center. The ANM was supposed to be accompanied by a multi purpose health worker male. But in these two districts from the field survey it was found that there was shortage of MPHPW (M).\textsuperscript{105} This was the case all over Orissa.

At the block level the entire health care services structure was studied. Thus in each district two blocks were selected with random sampling procedure to eliminate bias in selection of blocks. An intensive study was done at the block level using interview schedule and in-depth interviews. Interviews were also conducted with two district CDMOs and in each district two PHCs/CHCs were covered. At the PHC level interviews were taken from Chief Medical officers and weekly meetings at the PHC level were attended to get a feeling about the working of the PHC staffs and group discussion and individual interviews were also held with ANMs or auxiliary nurse/midwives\textsuperscript{106}. At the district level monthly meeting was attended in Sundergarh district, which helped in getting an overall picture of health services in the district. It has to be mentioned here that to attend the monthly meeting the permission of the CDMO was required, which was not possible in case of Khurda district. The monthly meetings were not originally intended to be covered, however in the field it was felt that it might give good first hand information about the functioning of health services in the district. In one of the PHCs of the Khurda district, monthly meeting was attended. This gave first hand information about the actual ground situation in the block in terms of functioning of the health care institutions and the disease burden in that block.

\textsuperscript{104} This was in the majority of cases.
\textsuperscript{105} Multi Purpose Health Worker (Male).
\textsuperscript{106} At the PHC level in weekly meetings all the staffs under that block PHC gather and discuss about various health issues and immediate public health challenges in that block.
Overall we have looked at the health sector reforms at the district level from systems approach.

Pilot study:
Before going for field work in Orissa a two-week pilot study was done in Sundergarh district. During this time one CHC and the district headquarter was visited. One Community Health Center was studied in detailed. Here interviews were conducted with various staffs and the medical officer in-charge about the different aspects of health care that CHC was dealing with. The nature of problems various staffs faced in day to day functioning, the epidemiological challenges of the CHC concerned, the overall atmosphere of work in that CHC and the idea about reform initiatives in health sector they had etc. was covered. In the district headquarter the CDMO was interviewed on a range of issues like the strengths and weaknesses of the health care services structure in the district, whether the CDMO was aware of health sector reforms process in Orissa and whether he was involved in that process, what were the reform initiatives taken in the district etc. A detailed statistics of the health care services structure of the district was also collected from here.

Once this much data was gathered it was used as a feedback in preparing the interview guide. However as we have mentioned earlier with each interview our interview guide was improved or modified according to the emergence of new facts. The pilot study also helped in getting an idea about the structure of health care services at different levels in Orissa.

Sampling:
As time and resources were limited in nature, sample was used to study the universe\textsuperscript{107}. And in case of a study like the present one, which was not only interested to explore the field but also to get an academic degree and hence sampling had to be used.

\textsuperscript{107} "Ideally the researcher would like to observe the entire population to add more weight to the findings. Limited resources, time and money frequently preclude a study of the entire population. Subsequently, a
Sample Size:

In any kind of research sample size has been emphasised to ensure that the universe being studied has been adequately represented. The size of the universe varies according to the nature of the study. However in the zeal to give representativeness to the sample size the larger question of nature of study has been found to be neglected in most of the studies. As we have observed that our overall objective tried to examine the process and experience of health sector reforms in Orissa, therefore the nature of study suggested that the data to be collected was qualitative in nature and hence the sample size need not had to be large like a quantitative study. The size of a sample also depends on the homogeneity and heterogeneity of the universe to be studied. If the universe to be studied was homogeneous then even a sample size of one is sufficient. However this is a theoretical possibility, in actual field it would most probably be heterogeneous in nature.

Nature of the Universe:

However the sample size also depends on the nature of universe to be studied. In this case the universe of study was the health bureaucracy in both government and donor agencies who were closely involved with policy formulation and its implementation. Besides we have interviewed key officials who have been involved over the years, while the initiatives for health sector reforms were being taken in Orissa. To get a comprehensive picture of existing health care services officials with more than fifteen years of field experience in Orissa were also interviewed.

Different officials interviewed:


108 Reflecting on the sample size, Neutons and Rubinson observed, “The determination of the sample size usually perplexes many researchers because they often have no conception of a minimally adequate sample size. They need to understand that correct sample size is dependent on both the nature of population and purpose of the study. An ideal study would have a sample large enough to represent the population so generalization may occur, yet small enough to save time and money as well as to reduce the complexity of data analysis.” They further added, “It is a popular misconception that a sample is a small carbon copy of the original population, identical in every way.... One can never be certain of representativeness unless the entire population is used. An obvious deduction at this juncture is that larger the sample, the greater the likelihood of representativeness i.e greater the heterogeneity, the greater the necessity for a larger sample. For populations in which there is no heterogeneity on a variable (of complete homogeneity), a sample size of one would suffice” p. 125. Research Techniques for the Health Sciences, Second Edition, James J. Neutons and Laurna Rubinson, Allyn Bacon, 1997.
The table below gives a picture of number of officials contacted and numbers interviewed at the central, at the state and at the district level. While both the donor agency and government officials were interviewed at the central and state level, at the district level only the officials from the government departments were interviewed.

**Table: 2.1 Number of Officials contacted and interviewed:**

<table>
<thead>
<tr>
<th>Actors (Central level)</th>
<th>Numbers contacted</th>
<th>Numbers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilaterals like EEC, DFID</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>World Bank</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>MOHFW</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actors (State level)</th>
<th>Numbers contacted</th>
<th>Numbers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Family Welfare Department, Govt. of Orissa.</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>OHSDP</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bilaterals like EEC and DFID</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>UN agencies, Orissa</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Orissa state level academics</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>34</td>
</tr>
</tbody>
</table>

**District Level:**

<table>
<thead>
<tr>
<th>CDMO’s and allied staff</th>
<th>Numbers contacted</th>
<th>Numbers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block PHC MO’s</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Field work, 2005.


The table shows that at the central level out of 5 donor agency officials contacted 5 were interviewed and among the 3 MOHFW officials contacted only one could be interviewed. Similarly at the state level in Health and Family Welfare Department, Government of Orissa, out of 17 officials contacted 16 could be interviewed. In the OHSDP out of 3 officials contacted 3 were interviewed. Among the bilateral agencies like EEC and DFID and the UN agencies out of 5 officials contacted 4 were interviewed in each case. Finally from the state level academics one person was contacted and one could be interviewed. In total out of 39 senior officials contacted at the central and state level, 34 could be interviewed. At the district level among the CDMOs and allied staffs out of 8 officials contacted, 8 were interviewed. At the block PHC level out of 8 medical officers contacted, 8 were interviewed.
Sample Techniques:
To identify the officials in the government and in donor agencies both purposive selection and snowball sampling was used.

Purposive selection:
In purposive selection, 'the researcher employs his or her own discretion to select the respondents who best meet the purposes of the study. This is a great advantage to the experienced researcher who can apply prior knowledge and skill.'\textsuperscript{109} Thus officials were interviewed who were closely involved with the health sector reform process in the state of Orissa. This list was prepared also with the help of snowball sampling.

Snowball sampling:
'This is a multistage technique that literally snowballs. In the first stage of snowball sampling, a person possessing the requisite characteristics is identified and interviewed. This person then identifies others who may be included in the sample. The next stage is to identify these persons who in turn identify still more respondents who can be contacted and interviewed in following stages.'\textsuperscript{110} The requirement to use snowball sampling arises when the respondent to be studied or interviewed are not known easily. For example in the case of study of prostitutes, they are not identified in public. As a result a researcher interested to study their problem would have to use a snowball sampling method. In our case the personnel to be interviewed were mostly technical experts in their fields and hence to identify them snowball sampling was a useful tool. Thus few officials of the donor agencies in Delhi were identified in the initial stage and once interviewed; they were requested to mention other interviewees who could be approached for interview. Similarly in Orissa once some of the officials were interviewed, they referred to some other officials. This was the case about all the officials at Bhubaneswar, the capital of Orissa. At the district level the concerned officials were interviewed without using

\textsuperscript{109} P-125, Ibid.
\textsuperscript{110} P-125, Ibid.
snowball sampling. Here these officials were identified directly by visiting these institutions.

Techniques used for data collection:

Interview guide:
Interview guide consist of a set of broad outlines while conducting an interview. It is never exhaustive in nature in an open-ended interview technique. In this study different interview guides were used for different officials from the government as well as from the donor agencies. Before the interview a set of questions were prepared keeping in mind the broad and specific objectives of our study and specifically what objective a particular interview would address. For this an intensive Internet search about the department in which a particular official was to be interviewed was carried out and other relevant documents were referred. Once an interview guide was prepared it was rechecked several times before giving it a final shape. As we have mentioned earlier that most of the interviewees were interviewed more than twice, these interview guides were also modified after each interview. While an ordering of questions was there in an interview guide, it had almost in all the cases to be rearranged when the actual interview was going on. It needs to be mentioned here that while an exhaustive list of interview guides were prepared before going to the field; it was also modified to a large extent in the actual field interview.

Field notes:
Field notes were used in collecting data during field visit. 'Field notes contain anything and everything that observer feels is worth noting.' Brief notes were taken during the interview itself. Notes were also prepared at the end of everyday about the day’s developments. Thus the gaps in writing during interviews were filled up by memorizing the event. The field notes were both descriptive and reflective in nature. The descriptive aspect looked at the timing and date of interview, the place of interview, the name of the interviewee and about the surrounding place. By asking probe questions, by cross checking with other interviewees and wherever written records were available were

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referred, to verify the data collected through interview. The reflective aspects looked at this researcher’s impressions about the larger picture the interviewees were trying to provide and about the overall work atmosphere etc. It needs to be mentioned here that all the interviews were conducted during office hours at various office premises. This was true both in case of government and donor agency officials.

Tape recorder:
Prior consent of the interviewees was taken before using the tape recorder. Tape recorder was used because most of the respondents were senior officials in either the government and donor agencies. And as these interviews were on technical questions, it was thought as appropriate to use tape recorder so that not a single important point was missed. These records were transcribed regularly. While most of these interviews were conducted by using tape recorder, in some places the interviewees felt uncomfortable in the presence of a tape recorder and hence in these cases it was not used. Here field notes were used in the presence of the interviewee and also at the end of the interview the gaps were filled up by recollecting from memory. Later when the same interviewee was met for second time these opinions were cross checked again by asking probe questions. In most of the cases a respondent was interviewed for at least three times and this includes senior officials of the government and donor agencies.

Group interviews:
This was conducted only with the ANMs at the four block PHCs, which were covered intensively. These interviews were taken during the weekly Saturday meetings at the PHC level when all the ANMs gather at PHC headquarter to discuss about their field challenges. In all the cases interviews were conducted at the end of their weekly meetings within the PHC premises. Questions were posed and it was suggested that anyone could respond and in many cases on a single question many of them responded. Questions were framed with regard to their knowledge of various national programs, day to day field challenges etc.
Direct Observation:

Direct observation was used to understand the culture of work atmosphere in both the government and donor agencies. By the culture of work atmosphere we could say how the office was organized, what was the office arrangement, what was the surrounding of the office, the cleanliness in and around the office, whether the staffs were gossiping in official hours, whether the staffs were in their place during official hours, the arrangement of files and the morale of the staff etc. For example in government offices of Orissa, maintenance of files was manual in nature and not well maintained.

Most of the staffs in the Directorate of Health were observed to be either gossiping or most were not in their desk at official hours. Records of health statistics were not maintained properly. It was as if cleanliness was the last thing one could expect from a government office. There were lot of people moving around to get their work done and in some instances it was clearly observed that the staffs were responding to only certain selected people whom they either know or who had come with the direction of an influential person like a minister or an MLA. While the official work time was from 9 am to 5 pm, the staffs used to come to the office around 11 o’clock and would start their day with a cup of tea and after relaxing for half an hour or so would start work. In between gossiping would be a common feature. By the time it was 12.30 pm, the staffs would start leaving for their lunch and they would come to their desks at 3pm to 3.30 pm and by the time it was 5 in the evening they would start leaving. Only time when the staffs were getting active was when the officer in charge was either asking for a file or when the officer was supposed to visit them. The combination of all these factors was making the whole atmosphere very depressive.

Contrary to this the surrounding of the donor agency offices was quite neat and clean. They were located in institutional areas or prime areas in the cities and this was true both in the state of Orissa and in their Delhi offices. The staffs were in their desks during office hours. There was no gossiping, files and records were maintained in computers and

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112 Direct observation is one of the important tools in an ethnographic approach to get a better understanding about the actors' perspective.
information was easily available. The offices had enough space and they were looking clean and properly lighted contrary to government offices, which were not properly cleaned, were congested and with many dark places. The atmosphere was looking very professional and the staffs were quick to respond to any request. The office buildings of the donor and multilateral agencies were also looking new and this suggested that the renovation work was done regularly.

At the district level the CDMO offices were well maintained in the two districts covered. The staffs were present and they were also quick to respond to any query. This may have been possible because of the instructions from the CDMO concerned. However the picture at the block PHC level was quite different. The medical officers in charge were not at all happy with their current positions. The PHC buildings were in bad shape in three cases out of four covered. While the beds in PHCs were available, during the field visit not a single bed was found to be occupied in the four block PHCs covered. The medical officers interviewed had their own private practice. In one block PHC the medical officer in charge was found to be absent most of the time and was busy in his clinic located in a nearby town. During the meeting with the CDMO concerned it was found that the CDMO was aware about this issue and had communicated his message to the medical officer. While some medical officers had their own clinics, others were doing private practice from their official residences. The problems at the PHC level when raised before the higher officials, it was known that they were very much aware but were helpless about it. There was consensus that the political will was lacking to correct these lacunaes.

Direct observation was also used in two cases at the two districts. In Khurda district, the monthly meeting at the PHC headquarters level was attended when all the staffs under that PHC gather to share their achievements during the last month and their likely targets for the next month. In Sundergarh district, the monthly meeting at the CDMO’s office was attended with the permission of CDMO, Sundergarh. Here all the medical officers in charge of block PHCs had gathered to discuss the specific challenges their blocks faced along with the CDMO and his allied staff. In both these cases while their proceedings
were going on this researcher was present noting down the proceedings and the issues those were raised. In the first case the meeting had continued up to four hours and in the second case the meeting had gone up to three and half hours.

**Structural constraints:**
The issue of structural constraints is significant in analyzing the implications of health sector reforms. The different aspects of structural constraints, which have been analysed in the context of present study were, the constraints within the health care services structure in Orissa, like the shortage of staffs at various levels, difficulties of retaining MOs and other staffs at periphery level institutions, inter departmental coordination, problem of inadequate training\(^{113}\) etc; In terms of donor agencies, the lack of donor coordination, difficulties for the Health and Family Welfare department in writing reports for different donors, in case of OHSDP the alienation of the Line departments etc; in the context of health sector reforms the lack of wider consultations; the involvement of indigenous services providers for referrals to nearest block PHC; the declining presence of private health care over the years and paradoxically the growing perception of government officials at various levels of health care services in favor of private health care; and the effort by the government to increase private participation in a state where public sector was the dominant health care provider and where near about half of its population lived below the poverty line and less than 15 percent of the state’s population lived in urban areas with scheduled castes and scheduled tribes constituted about 39 percent of its total population.

**Duration of field visit:**
In total eight months were taken for field study starting from December 2004 to July 2005. First two months were used in Delhi to contact and interview the senior officials of donor agencies and another four months were used for field study in Orissa. Then again coming back from Orissa another two months were spent in interviewing the donor agency Officials at Delhi. In Bhubaneswar itself near about two months were spent and in Sundergarh and Khurda districts one month each was spent. Here it needs to be

\(^{113}\) Like the MOs were mostly trained in curative care whereas they were supposed to respond to the requirements of preventive care.
mentioned that because at the district level the monthly meetings were to be attended it took a lot of time to wait for those meetings. Then there were weekly meetings at block PHCs to be covered so that group interviews with ANMs could be possible. On an average minimum three times one block PHC had been visited.

**Secondary sources:**
Data was also used from secondary sources like official records, published data of Directorate of Health Services, Central Bureau of Health Intelligence data, National Family Health Surveys, Census reports, Working Papers, Reports of donor agencies, Unpublished documents, Journals, Books etc.

**Chapterization:**
The thesis has been divided into eight chapters. They were:

**First Chapter:** It has discussed about review of literature. Here national and international experiences on health sector reforms have been documented.

**Second Chapter:** It has dealt with conceptualization, objectives and the methodology used in this study.

**Third Chapter:** It has given an overview of the health care services structure in Orissa. It has focused on the objective:

a-To examine the trends in growth of public health services at the primary/secondary/tertiary levels of care in Orissa during the eighties and nineties. It has also given a brief description about the growth of health care services structure in India.

**Fourth Chapter:** It has analyzed the SHSDPs and the OHSDP in the context of Structural Adjustment Program in India. Here we have interpreted OHSDP as a major reform initiative in Orissa. In this context we have described about some aspects of the process and experience of reforms in Orissa.
Fifth Chapter: This chapter gives a comprehensive picture about the process and experience of health sector reforms in Orissa. It has mostly dealt with objective: perception and experience of health bureaucracy dealing with HSR. It has also analyzed the perception of health bureaucracy about the shifts in financing, provisioning and manpower of health services during these two decades and its implications for equity.

Sixth Chapter: It has looked at the two study districts in terms of their socio-economic background and the process and experience of reforms.

Seventh Chapter: Here we have looked at the financing, structure and utilisation of health care services in Orissa, and some major states in India. Here we have also looked at the objectives: a-The trends in quantum, source and agencies providing external assistance to the health services system in Orissa during these two decades. b- We have also analyzed our first objective which has looked at the trends in public financing in Orissa, relative to India.

Eighth Chapter: This was the final chapter dealing with discussion and conclusion.
Annexure: 1

Organizational Chart

Minister of Health and Family Welfare, Government of Orissa

Principal Secretary, Health and Family Welfare Department

- Additional Secretary
- Joint Secretary
- Deputy Secretary
- Under Secretary

Project Director, OHSDP Bhubaneswar. Rank of Addl. Secretary

DMET

DHS

DFW

Joint Director

Director SIHFW

Drugs Controller Orissa

Director IM and H Orissa

Principal, Superintendent of three medical colleges.
Rural Health Centers
Principal college of Nursing

Joint and Deputy Directors

CDMO

Addl. CDMO

Sub Divisional Medical Officers

ADMO Public Health

ADMO Medical

ADMO Family Welfare

Medical Officers PHC/CHC

Source: http://orissagov.nic.in/health/organogram.pdf as on 23.06.2006.