CHAPTER IV
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SAP and Health Sector Reforms in Orissa

Introduction:
India opted for the liberalisation of its economy in 1991. This was due to the balance of payments crisis that the country faced at that time. With the liberalisation process in the economy the role of market was given a greater share and along with this the role of Indian state also changed. The concept of welfare state changed to the state having more of a regulatory role while creating an atmosphere for greater competition among the private players. This larger trend in the economy was also reflected in the social sector and within it the health sector has also been influenced by this process.

The involvement of the World Bank in the health sector began with population and nutrition programs during the late seventies and early eighties. It was with the Structural Adjustment Programmes or SAPs in Africa and Latin America, the World Bank and IMF moved into policy issues concerning health financing, which advocated state withdrawal from social sector. This approach was described as their agenda for reform of the health and allied sectors. The privatization policies in health were to increase the role of market in curative services, reduce public investments in health, introducing cost recovery mechanisms in public institutions through user fees and community financing. The emergence of World Bank as a lead financier of health care also promoted concept of a unified model of development.

In this chapter we have discussed in general about the role of World Bank in the health sector of India, in terms of its involvement through population and nutrition programs and the disease control programs in the early 1990s and with a particular emphasis on the State Health Systems Development Projects in the late 1990s. Before discussing in detail about the Orissa Health Systems Development Project, an overall picture of ongoing donor agency led various health projects in Orissa have also been discussed. Broadly the SHSDPs and the OHSDP have been contextualised within the framework of ‘fiscal crisis’ debates. The other areas of involvement by the Bank like public-private partnerships,
introduction of user fees, new ways of financing health care in terms of health insurance, training of Indigenous Service providers, etc. have also been discussed.

*SAP and the disease control programs in India:*
Due to adoption of Structural Adjustment Program or SAP there was a huge cutback in public expenditure during the early nineties in the health services sector. This resulted in fall of central grant for disease control programmes. The poorer states, which depended more on central outlays, suffered the most. Some of these cutbacks were restored during 1992-93 through World Bank loans for specific disease control programmes. This restoration of cutbacks for communicable diseases was done to offset outbreak of several epidemics resulting in a large number of deaths. The deaths due to plague epidemic in Surat and malaria in western Rajasthan in 1994 were attributed to two reasons, one was the cutbacks for communicable diseases in early nineties and the second reason was declining standards of public health in general.\(^{199}\)

The central grant for disease control programmes fell from 41 percent in 1984-85 to 29 percent in 1988-89 and further down to 18.5 percent in 1992-93. The poorer states suffered the most as they were much more dependent on central outlays. Some of the cutbacks were restored through World Bank loans during 1992-93 on specific disease control programs. Out of this, 34 per cent increase was attributable for AIDS control and a marginal increase for TB and blindness control programs. There was a marginal increase for malaria during 1993-94 but spending for other communicable diseases registered a decline. Some of these cutbacks were restored after a large number of deaths occurred due to outbreak of communicable diseases.

*Restructuring of state level health care:*
The state health systems project intended to strengthen the state health systems by making them more efficient and cost effective.\(^{200}\) In order to improve quality, efficiency and effectiveness of public hospitals it proposed for:

\(^{199}\) See Qadeer et.al, 1994, as cited in Baru 2001.
"- Cutback of secondary and tertiary spending and channel it into effective interventions at the primary level;
- Contract out ancillary services in public hospitals to private contractors.
- Involve private providers in National communicable disease programs.
- Institute user charges in all public hospitals.
- Encourage private sector growth at secondary and tertiary levels by instituting regulations; and
- Initiate decentralization measures.²⁰¹

Theref ̄ore what these new measures suggested was that the limited resources in the public sector should be used judiciously and hence it advocated for more investment in the primary level care by the state and opening more space for the private sector in the secondary and tertiary levels of care.

The World Bank led reform of the public sector was initiated in 1995 in Punjab, West Bengal, Karnataka and Andhra Pradesh, which opted for state sector adjustment loans. Both the India country Document 1991 and World Development Report 1993 had articulated the need to limit the role of public sector and to encourage the private provisioning of medical care.²⁰² They argued for cutback in secondary and tertiary levels of care, which could be channeled into the primary level care. The state health systems project was based on this understanding.

While ten state governments had submitted project proposals for the SHSDPs, West Bengal, Karnataka, Andhra Pradesh and Punjab were chosen on the ground that "they capture the heterogeneity of this country in terms of epidemiological profiles, levels of economic development, health services development, and political structures."²⁰³

The State Health Systems Development Projects:

Now let us look at the state health systems development projects, which were primarily intended to strengthen the secondary levels of health care in various states.

²⁰¹ Ibid P-223.
²⁰² See Baru 2001.
²⁰³ Interviews with a senior official of the World Bank, New Delhi.
A brief history:

Describing the brief history about the State Health Systems Development Projects a senior official of the World Bank said, “First came Andhra Project, which was State Health Systems Project-I. Then came Karnataka, Punjab and West Bengal, which was known as State Health Systems Project-II. This was a single project. After that came Orissa, which will end by march next year and then Maharastra, which will close in August this year, than UP and Uttaranchal, than Rajasthan and Tamilnadu, which has just begun.” Therefore projects in six states were nearer to completion and in another four states it had just begun. So was there any similarity among these projects? To this the official said, “All these projects were similar in nature. But the new ones, Rajasthan and Tamilnadu are different from old projects.”

Replying to a question about how many SHSDP projects have been completed and how many were ongoing the official said, “At present four projects have finished. Ongoing projects are Orissa, Maharastra, UP, Uttaranchal, Rajasthan and Tamilnadu.” Thus the four projects finished were in Andhra Pradesh, Karnataka, Punjab and West Bengal.

Rationale of SHSDPs:

When asked about the rational of SHSDP, the official said, “In the early 1990s, before the Andhra Project had started, the World Bank was looking at what are the areas that the Bank should look at. It had prepared a report on the basis of its earlier activities. Before that historically the World Bank had been funding mainly population programmes like family planning and family welfare. We did what we call India Population programmes, under this there were nine different projects. Then we supported the nutrition programme, the ICDS programme of the country”. Therefore at the initial phases the World Bank was involved with population and nutrition projects in India.

204 Thus in six states the State Health Systems Project was going on at that time.
205 State Health Systems Development Projects. Here we have described about the World Bank’s involvement in earlier health projects in India in brief and hence a separate section for it has not been added in this chapter.
206 Integrated Child Development Programme.
"Besides that after this report was produced, we said that we would support individual states to develop and upgrade their health systems across the state. So it was a kind of reform from the states' perspective but it was looking at state health systems development and Andhra\textsuperscript{207} was the first one. And based on the discussion and analysis with the states it was found out that the primary level care had relatively good resources from the national programmes, from the Family Planning programme and the disease control programmes. Tertiary level care was supported by the individual states because it is important; secondary level care was not receiving enough resources and enough attention, even the hospitals those were there, over time nobody had given them maintenance budget. So, over time they had deteriorated. So that was the need of that state at that time," said the official. Hence after the analysis of the then existing situation in different states it was concluded that the primary and tertiary levels of care were funded well but the secondary level of care was neglected and so it was decided that an intervention was required at this level.

Continuing with her narrative the official said, "So one of the things we did in these states was upgrading those secondary level facilities or the \textit{first referral level facilities}. looking at what is it or what is the kind of services a district hospital should provide... So rationalizing \textit{what kind of services} a CHC should provide or what kind of services a sub district or area hospital\textsuperscript{208} should provide and what kind of services a district hospital should provide. Then discussing with states that to providing such kind of services \textit{what kind of manpower} it is important to place there. Then looking at \textit{what kind of equipments} would be required and wherever there were gaps say in equipments to be funded then we also set up systems for equipment maintenance, equipment repairs, those kind of thing were never there." Therefore three things were focused at the secondary levels of care. They were rationalizing the kind of services a secondary level institution should provide; the required manpower for providing these services and the third was to make available the required equipments in these institutions.

\textsuperscript{207} Here Andhra means Andhra Pradesh.
\textsuperscript{208} Area hospitals were generally 30-bedded hospitals.
“So across the states what we did was to support the health care waste management because while these projects were going on the Supreme Court ruling came in the form of bio medical rules. Before that it was not existed. Than we started supporting Health Management Information Systems or HMIS mainly hospital based but computerization, looking at the data, validity of the data and finally looking at how the data collected at the hospital level could be used for management purposes,” said the official. Another two aspects covered were health care waste management and supporting HMIS for utilisation of data generated at the hospital level.

However the hospital data was also used for other purposes. Elaborating about different aspects focused by SHSDPs in different states the official said, “We also went beyond that in some of the states where using the data there was grading of hospitals. So there was a kind of performance grading of hospitals, which finally led to a part of quality improvement or quality assurance. That we did across states. Than we looked at entire human resources issues in the states. As resources are a constraint, what kinds of resources are required like training of doctors, nurses and technicians etc? Then we looked at the services norms, so rationally what should be the referral system? A person should be referred from where? Where should a service be available? How is the referral follow up and referral loop completed? Then equipments, maintenance and repair and the whole issue of quality assurance came up.

At the same time we had dialogue with the states about increasing the total resources for the health sector,\(^{209}\) from total budget and also relative to that the total amount that goes to the primary and secondary levels relative to the tertiary levels... that we have not had too much success in too many places, because all the states themselves went through financial crunch because of the fifth pay commission. So, that...\(^{210}\) we could not push. But that much we could bring to their knowledge... But what we did look at was that

\(^{209}\) This was about states themselves increasing their budgetary allocation for health sector.

\(^{210}\) Here the official was referring to states incapacity to increase overall budgetary allocation for health sector.
they in some ways maintain the drug budget; maintain the maintenance budget... issues like that.”

On defining the secondary level care:

But how does the Bank define the secondary level care? To this the official responded, “It goes from the CHC usually till the district hospital. And there is a wide range between them because different states have different nomenclatures. So it usually ranges from 30 bedded to 400 bedded institutions.”

Selection criteria of states for SHSDPs:

What were the selection criteria of states for State Health Systems development Project? To this question the official said, “Selection criteria has changed over time. When the project begun the selection criteria was, which states were really interested and which states were committed to some level of health sector reforms and they were asked to send proposals. Because the Bank funds, only when a proposal comes either from a state or from the central ministry and then it is forwarded through the department of economic affairs to the Bank and then the Bank reviews it. Our criteria now, in recent times has changed because now we are looking at... because we did two years back a study which looked at Millennium Development Goals and what it will take India to achieve the Millennium Development Goals and that study is basically showing that there are certain states and even in certain states there are certain districts which are lagging behind and if those states do not achieve Millennium Development Goals, India itself may not be able to achieve Millennium Development Goals. So our focus is on working with those states on a long-term basis like Orissa, Rajasthan, UP... we have not worked in Madhya Pradesh so far but MP, Bihar that is our focus.” Therefore the selection criteria for states eligible of SHSDP has changed from the states own interest and their commitment to some level of health sector reforms to the assessment of different states by the World Bank about their capacity to achieve Millennium Development Goals. It needs to be mentioned here that after the Millennium Development Goals were agreed upon by most

211 Here it refers to states.
212 Which was the first referral unit.
213 Here the Bank means the World Bank.
214 MP refers to Madhya Pradesh.
of the countries at United Nations in the year 2000, almost all the donor agencies have shifted their priorities to achievement of these goals in different countries.

*The definition of Health Sector Reforms*\(^{215}\) *by the World Bank:*

But the question arises as to how the Bank defined the HSR?\(^{216}\) To this the official said, “It was defined, one- in terms of commitment of increasing resources for health sector per say; increasing resources for the primary and secondary level care. Their\(^{217}\) willingness to look at the whole issue of human resources, how the postings are done? What are the criteria? Is there transparency in that? ...Then there is whole issue of user fees, cost recovery, but exemption of the poor to these facilities. To ensure that the poor are exempted form the services, to ensure that the poor receive all these services. Because studies have shown that in spite of everything, in spite of government services supposed to be completely free, the lowest quintile or the poorest quintiles do not access these services...are not able to access these services. So it was these kinds of issues that at that time we were talking about... and basically a commitment from the states to want to reform, the need for it; for them to justify it and write a proposal for it.” Hence from the World Bank’s point of view the health sector reforms involved, use of resources judiciously apart from increasing them where required and the state’s willingness to remove structural constraints to achieve better health results. The official was of the view that for the World Bank to make an intervention, the states’ themselves should feel the need for such kind of changes in the health services sector.

*Why the three states*\(^{218}\) *were taken as a single project?*

Coming back to the rational of SHSDP, it was asked as to why the three states of Karnataka, West Bengal and Punjab were chosen initially? Replying to this question the official said, “Because at that time all three states had come up with their proposals. We had just started with our experience of Andhra Pradesh. We thought we learnt a lot from

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215 Here the viewpoint of the World Bank official has been provided about the World Bank’s understanding about the concept of ‘health sector reforms’ because the World Bank considered the SHSDPs as part of health sector reforms.
216 HSR stands for Health Sector Reforms.
217 Here it refers to the states.
218 Karnataka, Punjab and West Bengal.
our experience of Andhra Pradesh. All these three states were committed to it and had good proposals and so we went for it.” And why was Andhra chosen earlier? To this the official said, “Because it was ready at that time…the government had shown commitment.”

Reference to Mexico and Vietnam:
It was observed that the World Bank had taken the experiences of Mexico and Vietnam in its analysis of the reform experiences in the four states.219 Therefore a question arises as to why these two countries were specifically chosen for evaluation of SHSDPs in India? Responding to this question the official said, “There was no specific reason. It was just that we wanted to share…. the states had been telling us; government of India had been telling us that they would like international experience. Our colleagues in these countries had experiences and they were forthcoming. They were willing to share it with us and so we thought that it would be useful to share what they had done.” So, what were the positive outcomes of reform initiatives in these two countries? “They were basically looking at ways of community health insurance or exemptions... so that did relate to what we are doing just right now in this country. But that just gave options. Because one of the things we were looking at is how to ensure the poor from going into debt… from accessing health care services,” said the official. Therefore the reference to these two countries was based on the availability of expertise on community health insurance and about exemption of the poor for paying the premiums for these insurance schemes.

“So those are the different kinds of options tried like using health voucher220, health insurance...so we just brought that experience to share with the government here. Health insurance in India is still at a rudimentary stage. So just to tell them what is happening at other places and share it,” the official said. The sharing of the experiences of Vietnam and Mexico was significant because this has the potential to create health insurance schemes in India on a large scale, either by the states or by the Indian union. Because

219 These four states were, Andhra Pradesh, Karnataka, Punjab and West Bengal.
220 A piece of paper that may be exchanged for particular kinds of health services.
more the Indian state withdraws from the financing aspect of health care\textsuperscript{221}, the more it would look for alternative strategies of financing and one of them could be introduction of insurance schemes for different sections of the population.

\textit{Positive outcomes of reform initiatives:}

When asked about the positive outcomes of the reform initiatives in the four states where the State Health Systems Projects have been completed, the official said, "One, they did find was that the dialogue among higher state level authorities, in the importance of health resources even if they had not been able to ensure it. They all found that what we had done for HMIS,\textsuperscript{222} for health care waste management, for quality assurance, for referral, training of manpower and upgradation of facilities... it’s a result of which they have found marked increase in in-patient attendance, out patient attendance, lab investigations, radiological investigation and access to poor and women at these facilities...their data shows that." Thus the initiation of health reforms in these four states increased dialogue among inter-departmental higher state level authorities. This helped in understanding the issues in a better way. According to the official the reforms also helped in improvement of health care facilities, which was reflected in increasing utilisation of services in in-patient and out patient departments. Besides, the access to poor and women had also increased.

However it needs to be mentioned here that while assessing the reforms in health sector, caution should be adopted in terms of what have been the achievements compared to different targets. As the Orissa experience, which we have discussed in the later parts of this chapter, shows that the expected outcomes have not been achieved. The question of exemption of the poor from user fees was very much doubted by even the senior health officials in the state. While the institutions might have been built up it was very difficult to say that these were being accessed by the poor for the simple reason that the institutions might be inaccessible through roads or communication facilities from distant areas or people may not be aware at all about the existence of these institutions.

\textsuperscript{221} This has been one of the major arguments of health sector reforms that the state should gradually reduce its role from financing of health care in general by selectively focusing on certain areas of the health sector.\textsuperscript{222} Health Management Information Systems.
Health Management Information Systems or HMIS:

But what was HMIS? “Because these earlier projects\(^{223}\) focused on hospitals, mainly secondary levels...so we looked at hospital data, hospital activity data, in-patient, out patient, individual departments output, patient satisfaction, all those. And it was routinely reported but not in a systematic way, so we tried to help them systematize it much more, to computerize it, to have actually reports going to managerial level for them to look at and then see what happens to it. So you actually had in West Bengal and Punjab people down from the health minister downwards...these reports are produced every month...going down for these reports in visits and saying ok these are your problems. Why is it? Why you are not performing in surgeries or in this particular area? Are there some genuine problems or what is it because of it...sometimes there were some genuine problems...sometimes equipments not working. Then who repairs the equipment? What is the equipment downtime?\(^{224}\) So it was all those issues, which earlier were not being asked because data were not being looked at. So we got into the system, looking at data, analyzing it and using it for management purposes. And this I think is one of the biggest contributions of the project.” Therefore what the Health Management Information System did was to strengthen the already existing hospital data for better feedback and strengthening the services in these hospitals.

“We tried to build on what was in different states...drug management systems are different in different states...very very different. But what we did support was to look at it regularly, to ask questions when they looked at the data and issues like that” said the official.

But then the question arises as to whether there was any link between management of warehouses for drugs and the Health Management Information Systems? Responding to this the official said, “The data management for drugs through ware housing and the HMIS, they are linked in some states but not all. But HMIS is basically hospital based. So it would look at drug availability but it would not link up to what was happening at the

\(^{223}\) The projects in the four states of Andhra Pradesh, Karnataka, Punjab and West Bengal.

\(^{224}\) That is how long the equipment is supposed to function.
drug warehouse. In Orissa, basically the drug warehouses were supported by DFID and few of our earlier projects. So that link is not there very strong. In Orissa, HMIS has not been successful for many reasons, though they are also now collecting some manual data. All the facilities are reporting on manual data. The computerization part we have not been able to do because of some technical reasons.”

Public Private Partnerships:
Introduction of the concept of public private partnerships have been one of the elements of reform formulated by the World Bank. There have been discussions about public-private partnership by the Bank. So what were its different elements? Replying to this question the official said, “The World Bank definitely supports it. When we begun eight or nine years back, in all these projects we talked about public-private partnership...the whole attitude of government was resistance because the interpretation of the word public-private partnership was very threatening...that we are asking them to privatize the public hospitals. But that was not the case. The whole essence of public-private partnership came into because lot of data showed that 70 to 80 percent of services are still provided by the private sector, especially ambulatory care, in-patient care is about 50 percent. And the poor in spite of being poor are not able to access public facilities but go to private facilities of different qualities. And the private sector here means, right from the unqualified person to the highly super specialized hospital. So, it’s the whole thing. So we were encouraging individual state governments to look at how they could best utilize the resources in the private sector to their benefit. And the first thing that we begun with...because that was also new to everybody...private partnership for non-clinical services. So they began with contracting with the private sector for cleaning of hospitals, for diet, for laundry, for security and there they found extremely positive results. They found that hospitals once contracted out for cleaning services was much cleaner than when it was not. But they could not get rid of class IV, so some of the states innovatively trained class IV for other things. So, their motivation level also increased.” Therefore here the official rightly mentioned that by public private partnerships it has

225 The 157 secondary level institutions supported by World Bank as part of Orissa Health Systems Development Project.
226 Various states adopting SHSDPs.
been assumed in India, privatizing the public hospitals. So what the official was mentioning was that in case of India already the presence of private sector was large enough and hence there was need for involving the private sector for better achievement of health results like many public hospitals have given responsibility to private parties in the cleaning aspect. However there was another dimension to it. The talk of public private partnership also has included the terms like handing over PHCs to NGOs as it was observed in case of Orissa. And when one looks at these initiatives an impression was generated that private sector was inherently seen as more efficient than the public sector in health care provisioning.

Continuing with her narrative the official said, “But the big lesson that we have learnt is that governments are still not entirely proficient in how to write contracts with the private sector or the NGO sector. So that is something we have learnt and in our newer projects we are trying to bring expertise for that...how actually you write a contract so that you actually ensure that what you want from the private sector or from the NGO you get it...define the contract in those terms. That is still one part where lot of capacity building is required. So we began with that and told them... ok look at different options. ...In remote areas public sector is just not working, can you collaborate with the NGO or the private sector and that is what happened at West Bengal. In West Bengal, in Sunderban areas, which is very remote, where you can go by launches, there we began by collaboration with one NGO and asked that NGO to provide services like out patient, in-patient and finally they found it successful and today they have contracted five NGOs and now they are doing it with their own money because the project is finished. So they are continuing that because they have found that kind of collaboration very useful. So West Bengal is one of our best examples of NGO collaboration to provide services in remote areas. Similarly on a smaller scale basis we are encouraging them to look at collaboration with the NGO and the private sector to provide even the clinical services.” So here what the interviewee was saying was that in case of West Bengal the handing over of PHCs to NGOs in remote areas of Sunderban have succeeded but when we look at the Orissa experience the same experiment failed. Hence it was important to know that uniform models of private sector participation were not possible in different places.
It needs to be mentioned here that by private sector the official was also including the supposedly non-profit making sectors like NGOs. However the term private sector is widely used as a profit making sector. Hence a question was asked as to whether the official was making a distinction between NGO and the Private sector? Replying to this question the official said, “ Distinction in the sense that they are all in the non government sector…distinction in the sense that initially the government to work with the NGO sector and than gradually move on to the private sector. The biggest constraint that is there in working with the private sector is the lack of regulation. We don’t have regulation. What we would be finally looking at if services were not available…if we were looking at health insurance at 10 facilities, in an area both public and private are accredited and people can go to anybody with say health vouchers. But that is still…we don’t even have regulation for the public facilities. Then regulating the private sector and ensuring quality services…because until and unless that is done... The whole definition of private sector is wide. Like in Orissa, we are trying to work with the informal service providers, what they call quacks or whatever and trying just to increase their skills a little bit... not giving the medicines but just that the lives are saved. So that if they know the early signs of obstetric emergency or a neo natal emergency or falciparum malaria, they can refer the patient first. And our initial data is showing that referrals from them have improved. But we still have to look at it more.” Therefore the official was mentioning about how this large private sector was unregulated and hence the quality of service it provided was very difficult to access. One important observation was that initially the NGOs were being involved and at later stages the private for profit sector would be involved for say insurance schemes, where people could go to these identified places with their health vouchers. Similarly the case of Orissa was mentioned to say that the indigenous practitioners were present in large numbers in the state and they also provide health care to people living in remote and hilly areas and hence rather than putting a ban on them, an attempt has been made in some districts to use them for referrals in cases of complicated pregnancy and malaria. It needs to be mentioned here that this approach toward indigenous practitioners was being widely accepted among the health officials at
different levels of health care services in Orissa as well as among the other donor agencies.227

The negligence of Primary level care:
Thus in the SHSDP projects the Bank’s focus had been on the secondary level care assuming that once these institutions were well equipped with manpower, medicines and equipments people would use the services available. But “to go to the primary level care people should have knowledge that such facilities do exist and they must have easier transportation facilities”228 This has been the lacunae of the projects of SHSDPs. They just build up the institutions without looking into the aspects of structural constraints the people might face to use them.229 Therefore a question arises as to why not the Bank’s focus was on the primary level care? “Primary level support is there. We support the entire Reproductive and Child Health Programme at the national level...full support we are giving. Our second RCH project is going to the board. Than we support the nutrition programme. That is again at the primary level. Then we support TB, HIV/AIDS and Malaria. So these are separate programmes where we work with the Centre and all that basically go to the primary level because those programmes are implemented at the primary level. But now in our newer states we are also looking at supporting the primary level. Looking at the gaps and whichever gaps are not being filled even looking at that. That’s why when we have discussion with a state, we say that you must ensure that you maintain or increase both the primary plus secondary as compared to the tertiary level budgets because if we do not look at the primary level the millennium development goals will not be achieved” said the official. Therefore here an acknowledgement was made that while the Bank has been funding projects like RCH and nutrition where the money directly goes to the primary level care, still the state health systems projects should have taken into account the accessibility of people to these primary institutions so

227 This observation was made from interaction with officials at different levels during the field visit to Orissa.
228 This was the view of another senior official of the World Bank.
230 Rajasthan and Tamilnadu.
that referrals from here could be sent to the secondary level institutions. Because as we have discussed earlier in this chapter that now achieving the targets of Millennium Development Goals have been the priority of donor agencies like World Bank and without improving the facilities and accessibility to primary level care these targets won’t be achieved.

**What the SHSDPs Lack:**
The projects in the four states have come to an end. So from the experiences of these four states what were the areas that you found, where if interventions were made than the output of the project would have been better? Replying to this question the official said, “One, we need is much more focus on health financing. How do we ensure that adequate... the state is committed to health and Millennium Development Goals and that adequate resources are provided for it. Then a big big issue is human resources in health care sector. Sending doctors and other para medical staff to remote areas from the public sector is difficult...in some places almost impossible and that is where positive way of looking at the private sector, the NGO sector comes in ... thus broadening the scope. Then actually measuring that whatever you are doing, you are increasing access of the poor and utilisation by the poor of health services, so that actually the full focus of whatever the state does should be improving health outcomes for the poor and the disadvantaged. That focus should be there much more.” So the interviewee was of the view that given a chance the SHSDPs would have liked to increase the spending of resources in health care for better achievement of results and in remote areas where it has been difficult to retain the manpower from the public sector and the involvement of NGOs and the private sector should be thought out.

However as the field visit to Orissa show that the main problem why medical officers refused to stay in remote and difficult areas was because of lack of a transparent transfer and postings policy. Hence in states like Orissa where the public sector was the dominant provider of health services and where the presence of private sector was very weak it was important to make transfers and postings transparent, so that the remote posts were filled up. And equally important was to understand the fact that in these circumstances if rather
than addressing these structural issues a case was being made for involvement of the NGOs or private sector, it won’t address the issue\(^{231}\).

**Health financing:**

As the official concerned mentioned about the need for increasing financing for the health care services, so it was asked as to what could be the different ways of health financing? To this the official said, “The state is there, the government budget is there. So what we need to say is one- if they *free up the subsidies from agriculture and power*, only then they can invest in health and education. So looking at that and having a dialogue at higher level\(^{232}\) and then looking at other health financing options like health insurance and risk pooling at the community level. So that the poor at least do not go into debt because of …when they need health care and that is something, which we are still looking at. We are also learning. That is why we brought international experience. But it is a gradual process. Even politically to convince governments it is a very sensitive issue.” Here the official was giving the viewpoint of the World Bank about the different ways of financing health care by the state when there were limited resources at its disposal. The official further added that the idea of common health insurance and risk pooling should be explored in Indian context to generate more resources. So it was being argued that if subsidies could be freed up from the agriculture and power sector than additional money could be generated. However these were very sensitive as well as debatable issues for even the European countries were refusing to reduce subsidies in agriculture in WTO negotiations to keep their advantages in agricultural exports. And while in Europe less than 10 percent of people depend on agriculture for their livelihood, in case of India it was nearer to 70 percent of its population and in states like Orissa 85 percent of its total population depend on agriculture as their main source of livelihood.

\(^{231}\) We have discussed about this aspect in detail in chapter III.

\(^{232}\) At the Central government level. In fact this was an ongoing process for the World Bank. In case of Orissa, a senior official of the World Bank said that with the Bank’s suggestion the government of Orissa has put a ban on new recruitment of new staffs in the education and health care services. These would have serious consequences for the health and education of millions of Indians in the coming decades. Now the debate in the economic sector was about reducing subsidies from the agriculture and power sector. This has been a national debate in India and various states and the central government were toying with the idea of reducing subsidies in these two sectors. These initiatives have clear indications that World Ban was playing a significant role in shaping policy decisions in India.
About the question of reducing subsidies from agriculture, USA and Europe were providing their farmers with billions of dollars in subsidies and which has depressed the international prices of agricultural products and harming the poorer countries more. Therefore the arguments for reducing subsidies in agriculture to generate more resources reflect two things, either one was insensitive to the Indian context or one was just trying to implement a uniform model to generate new sources of financing.

Question of fiscal crisis:
Fiscal crisis, which puts a constraint on the state’s capacity to finance health care and in a federal set up like India the nature of financial relations between the Center and the states have a larger role to play. So if somebody prescribes the state to amend their financing, they have very few leverages. To this concern the official said, “True, there are few leverages. In fact in several states we have done what we call mid-term plans for financing or MPPFs. What has come out is 80 percent of government spending is not flexible because it is for salaries. So the flexibility that you have is about 20 percent. At that flexibility is also there, but what happens is the finance department has to give that flexibility to individual departments. And what they find difficult is that they say if we give it to the health department then we can’t give it to only one department. We have to give that kind of flexibility to all departments and that’s where it runs into troubles. And politically they are very sensitive issues, like you cannot say that ok in that remote area the government PHC will never work. So, let us close it down and transfer those resources to something else. Now, that is a very sensitive area. But if those kinds of decisions are taken and they are beginning to be taken …even the government is taking those bold decisions and say ok that area we are leaving for the NGOs to do. They are doing a good job let them do it. And our whole thing is to ensure that the poor get services, which sector they get it from we will not worry about that, but we will ensure quality. We will ensure regulation...all that. So the government has to change its role from actual provision to actually looking at more broader issues of policy, regulation, accreditation...those kinds of things.” Here the interviewee was mentioning about the difficulties the states face in terms of financing for health care. The official was of the view that only 20 percent of a government’s spending has flexibility, as the rest 80 percent was given in terms of salaries. Besides, there were structural constraints like working in difficult areas and hence here it was proposed that the remote PHCs could be handed over to the NGOs. Significantly this line of argument was also been forwarded by some of the government health officials in Orissa. However as we have discussed earlier the solution was not that easy. The suggestion that the government should move from

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233 In a state like Orissa NGOs were nearly absent and few of those which existed lack in expertise and resources. After the 1999 super cyclone, lot of NGOs had sprung up and they were asked to get involved with relief and rehabilitation activities by the state government. But there were allegations of misuse and mismanagement of funds and as a result the NGOs were seen with suspicion by the state. In this scenario the talk of giving responsibility to NGOs to the remote and difficult areas means that one was out of touch with reality.

234 This was like paying lip service to the poor.
provisioning to look at broader issues of policymaking, regulation of the both private and the public sector health care and accreditation of institutions was a significant observation. However in a state like Orissa where the presence of private sector\textsuperscript{235} was very small; how could one imagine involving them in remote and difficult areas? On the other hand this line of argument suggests a unified approach of the World Bank.

Has off late effort been made from the side of the Bank to look at the constraints the states face in terms of fiscal crisis to raise their health care expenditure? To this question the official said, "We are looking at it. That’s why we have changed our perspective. That’s why our newer projects both Rajasthan and Tamilnadu look different a little bit and a new project, which will come for Karnataka, will look very different. Because that is a kind of dialogue we are having. But it’s a gradual process." However what was that changed perspective, was not elaborated further.

In case of Orissa, there was Orissa Economic Review Package, which had hardly any linkages with the Orissa Health Systems Development Project. Replying to this observation the official said, "We are trying to. Because in the next phase in Orissa we are trying to really link up with what DFID is doing, what the economic people\textsuperscript{236} will be doing and what the health\textsuperscript{237} will do and trying to ensure that they have a close link up between them. Because, those are all the lessons that we have learnt." Here the official was mentioning about the initiatives by the World Bank to be taken in the next phase of the OHSDP in Orissa. So there would be interlinkages with PSPU or Policy Planning and Strategic Unit being funded by DFID, which would look at the larger issues of health policies in Orissa. Thus it would work as a think tank. Similarly the loans for OHSDP would be attached with the loans by the state under Orissa Economic Review Package. However here a question arises that the effort to link funding for the second phase of the OHSDP with larger loans by the state from the Bank, would it really be helpful for the health care delivery system in the state? Would it lead to a unified model of health care delivery system? If the World Bank was looking forward to put pressure on the state government through the PSPU, than would it not be equivalent to interfering in the policy making process in the state?

In the first phase of OHSDP, institutions have been built up and people have been manned in these institutions. During the field visit it was observed that the state government was not increasing its share of expenditure each year and hence most likely it would become essential for the state to depend on the World Bank for sustainability of these structures. In this scenario the Bank was planning to invest in the second phase of this project. Therefore the question arises as to what kind of control the state government would have on these institutions in future? So could it be said that in the long run these secondary level institutions would be handed over to the private sector because, already user charges have been introduced in all these 157 OHSDP institutions.

\textsuperscript{235} We have discussed about the presence of private sector in various states, including Orissa in Chapter VII.
\textsuperscript{236} Here it refers to Orissa Economic Review Package.
\textsuperscript{237} Health refers to OHSDP.
Donor agency supported health projects in Orissa:

Before we discuss about different aspects of OHSDP, let us have a look at the various donor agency supported health projects in Orissa, which were going on during our field visit. The table below gives a picture of donor agency supported various health projects in Orissa. It gives the list of donor agencies like DFID of UK, World Bank, DANIDA of Denmark, UNICEF, WHO, UNFPA and SIDA. It has mentioned about four different aspects of these projects. These were nature and level of involvement in health, the agency involved, area of operation and the period of operation of these projects.

Table: 4.1: Donor agency supported health projects in Orissa

<table>
<thead>
<tr>
<th>Nature and Level of Health</th>
<th>Project in Operation</th>
<th>Area of Operation of the Project</th>
<th>Period of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td>DFID Phase III</td>
<td>Bhadrak and Keonjhar</td>
<td>1997 to 2000</td>
</tr>
<tr>
<td>Rehabilitation and</td>
<td>DFID</td>
<td>14 district, CHC/Block level PHC</td>
<td>2000-2004 in the</td>
</tr>
<tr>
<td>Reconstruction in cyclone</td>
<td></td>
<td>- in 130 Blocks and below</td>
<td>pipeline</td>
</tr>
<tr>
<td>affected areas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening of Sector</td>
<td>DFID</td>
<td>30 district</td>
<td>2001-2006 in the</td>
</tr>
<tr>
<td>Development of Health</td>
<td></td>
<td></td>
<td>pipeline</td>
</tr>
<tr>
<td>care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary and Primary</td>
<td>World Bank</td>
<td>156 Institutions all over the</td>
<td>1998-99 to 2004</td>
</tr>
<tr>
<td>Health Care Project</td>
<td></td>
<td>State</td>
<td></td>
</tr>
<tr>
<td>(Health Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development Project)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproductive Child Health</td>
<td>WB/GOI,</td>
<td>State Wide - Sub-project</td>
<td>1997-2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kalahandi, Koraput, Nawrangpur,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malkangir, Rayagada</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>World Bank</td>
<td>158 Blocks in 21 districts</td>
<td>1998-2004</td>
</tr>
<tr>
<td></td>
<td>through GOI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>DANIDA/GOI</td>
<td>Keonjhar, Sambalpur and Mayurbhanj district, 11 district to be include</td>
<td>Dec. 1996-Dec 2001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blindness</td>
<td>WB &amp; GOI</td>
<td>All districts of the State</td>
<td>1.4.94 to 31.3.2001</td>
</tr>
<tr>
<td>AIDS</td>
<td>WB through NACO</td>
<td>All districts of the State</td>
<td>June 1999-2004</td>
</tr>
<tr>
<td>Leprosy</td>
<td>DANIDA</td>
<td>Cuttack, Jagatsingpur, Jaipur,</td>
<td>1987 - Contd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kendrapara in Phase I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DANIDA</td>
<td>Sambalpur, Jharsuguda, Deogarh,</td>
<td>1991 - contd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bargarh in Phase II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lepra Mission</td>
<td>State in Phase III</td>
<td>1997 - contd</td>
</tr>
<tr>
<td></td>
<td>Lepra-India</td>
<td>Rayagada, Nuapada, Umerkote</td>
<td>1997 - contd</td>
</tr>
<tr>
<td></td>
<td>WB</td>
<td>Sonipur, Bolangir, Junagarh,</td>
<td>1994- 1999</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Udala Jasipur (MBJ)</td>
<td></td>
</tr>
</tbody>
</table>

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Hoina Phulbani, Kalhandi, Sundergarh, 1991
Keonjhar, Boud, Gunupur, Muniguda

WHO Ganjam 1983

SIDA Ganjam 1983

UNICEF Puri 1985

Integrated population development (IPD) project

U.N.F.P.A. In the districts of Koraput, 1999-2003
Rayagada, Malkangiri, Nawrangpur.


It shows that DFID was involved in Phase III of Primary Health Care Project in Bhadrak and Keonjhar districts during 1997 to 2000, rehabilitation and reconstruction in cyclone affected areas of 14 districts in 130 block PHCs and below, during 2000-2004 and it was also involved in strengthening of sector development of health care in 30 districts since 2001-2006. The last two projects of the DFID were in the pipeline.

Similarly World Bank has been involved in secondary health care project to upgrade 156 health institutions in Orissa during 1998-99 to 2004. It was also involved in RCH phase I along with government of India, which was involved across the state and a sub-project was also going on in Kalahandi, Koraput, Nawrangpur, Malkangir and Rayagada. The RCH Phase I went on since 1997 to 2002. Besides, the World Bank was also involved in malaria control programme along with government of India in 158 blocks of 21 districts since 1998 to 2004. In blindness control programme also the World Bank has been involved with government of India, which was being implemented across the state since 1994 to 2001. In leprosy control mission also World Bank has been involved in four districts of Sonepur, Bolangir, Junagarh and Mayurbhanj. The World Bank had also been involved in National AIDS Control Programme through NACO, which was being implemented all over the state since June 1999 to 2004.

DANIDA was involved in Tuberculosis programme along with government of India in 14 districts since 1996 to 2001. It was also involved in leprosy programme Phase I in four districts of Cuttack, Jagatsingpur, Jaipur, Kendrapara since 1987 and Phase II in four districts of Sambalpur, Jharsuguda, Deogarh Bargarh, since 1991 and Phase III in three districts of Rayagada, Nuapada, Umerkote since 1997.
For Leprosy programme WHO had been involved in Ganjam district since 1983, SIDA had been involved in the same district since 1983 and UNICEF had been involved in Puri district since 1985. UNFPA on the other hand has been involved in four districts of Koraput, Rayagada, Malkangiri and Nawarangpur since 1999.

The analysis of ongoing projects suggested that Orissa has been a donor driven state. This was because of various reasons like; it had almost 48 percent of its population living below the poverty line; the scheduled castes and scheduled tribes in the state constitute about 39 percent of its total population; the state had more than 85 percent of its population living in rural areas, that means economy was predominantly agricultural and the state was frequently visited by droughts, floods and cyclones. Therefore Orissa has been seen as an ideal place for the donors to invest their money and resources. “However due to this donor driven projects in Orissa for a long time, people have become dependent on donors”. 238 “To get funds from donors the Orissa government had been approaching them with ‘begging bowls’ like we are a poor state please help us. But the situation is changing now. In last meeting the Orissa Chief Minister presented his case by saying that we are a reforming state and a performing one too... so the language has changed”.239

Even during the field visit in the state many of the officials conceded that many times they just show poor indicators to get more funds from donor agencies.

However the involvement of donors has not helped the state in addressing its health concerns in a significant way, because donors have always come with some projects of their own, with their own agendas. This has resulted in many donors working in the same programme and even in the same district but without having any coordination among them. There were also different styles of report writing, which makes it difficult to assess the impact of these projects. One senior official of the state was of the view that to avoid this piecemeal approach by donors the state came out with a vision document240 in 2003. The idea was that the donors could look into the vision document and identify their areas of interest from it and then can work there. This would help in avoiding duplication of work and in better coordination between the Health and Family Welfare department and among the donors. However during the field visit in the state it was found that the situation had not changed at the ground. This aspect has been discussed in detail in chapter V. Now let us have a look at Orissa Health Systems Development Project in detail.

**Orissa Health Systems Development Project:**

The Orissa Health Systems Development Project or OHSDP could be termed as a major reform initiative in Orissa, which was wholly funded by the World Bank, but surprisingly it has not been included as a reform initiative by either the Orissa Vision document 2010 or by the observers of health reforms in the state.

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238 This was the view of a senior official of a donor agency.
239 This was the view of a senior official of a donor agency.
240 This refers to Orissa Vision Document 2010.
Aim of OHSDP:

It was an Rs415 crore project wholly funded by the World Bank. So what was the aim or what were the objectives of this project? Responding to this question a senior official in the OHSDP, Orissa said, “For strengthening secondary level health care institutions is the aim of this project.” Therefore the project intended to strengthen the secondary level institutions in the state. In the earlier sections we have already discussed about what does the Bank identifies as secondary level institutions. And what about the duration of this project? “This project was introduced in 1998. This was a five year project and now has been extended to one year and would be completed by 1st March 2005” said one senior official of OHSDP.

Table: 4.2 OHSDP at a Glance

| Date of commencement: | 18th September 1998. |
| Date of Completion: | 31st March 2005. |
| Project Cost: | Rs 415.58 crores. |
| Share of Loan amount: | Rs 348.75 crores. |
| Share of Grant: | Rs 66.83 crores. |
| Total expenditure upto 15.02.2005: | Rs 210.76 crores. |
| Reimbursable amount claimed to World Bank: | Rs 163.03 crores. |
| Reimbursement received from World Bank: | Rs 141.55 crores. |


As the above table shows, initially the project period was 1998–99 to 2003–04, which was later extended to 31st March 2005. The project commenced on 18th September 1998 with the project cost of Rs 415.58 crores. Out of this total amount the loan component was Rs 348.75 crores and the grant amount was Rs 66.83 crores. The total expenditure upto 15th February 2005 was Rs 210.76 crores, out of this the reimbursement claimed to World Bank was Rs 163.03 crores and the reimbursement received from the World Bank was Rs 141.55 crores.

Project Institutions:

Now let us have a look at the health services institutions, which OHSDP intended to cover. The table shows that in total 157, mostly secondary level institutions have been
covered under this project to ‘improve efficiency and effectiveness of health care delivery system in these institutions.’

**Table: 4.3 OHSDP financed institutions**

<table>
<thead>
<tr>
<th>Project Institutions</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DHH (District Headquarter Hospitals)</td>
<td>30+2 (One Capital Hospital and another Rourkela Government Hospital)</td>
</tr>
<tr>
<td>Sub Divisional Hospital</td>
<td>20</td>
</tr>
<tr>
<td>Area Hospitals</td>
<td>19</td>
</tr>
<tr>
<td>CHC I</td>
<td>37</td>
</tr>
<tr>
<td>CHC II</td>
<td>48</td>
</tr>
<tr>
<td>SIHFW (Annex)</td>
<td>1</td>
</tr>
<tr>
<td>Total Number of Institutions</td>
<td>157</td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*

Out of these 157 institutions, 30 were District Headquarter Hospitals, One Capital Hospital, One RGH, Rourkela, 20 Sub Divisional Hospitals, 19 Area Hospitals, 37 CHC I institutions, 48 CHC II institutions and the annex of SIHFW or State Institute of Health and Family Welfare, Bhubaneswar.

**Components of OHSDP:**

So what were the components of OHSDP? Responding to this question the official said, “Broadly there were seven components of OHSDP. The different components of OHSDP are:

1- Infrastructure development: Under this 157 institutions are included.
2- The second component was provision of diagnostic and surgical equipments and furniture.
3- The third component was provision of ambulances for mobility support.
4- The fourth component was in-service training. There are three components in it.

They are:

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242 The ‘Capital Hospital’ was the name of a Hospital at Bhubaneswar, the capital of Orissa. It was not one of the hospitals in the capital of Orissa!
243 Area hospitals were not below sub divisional hospitals but they were 16, 20 or 30-bedded hospitals in Orissa.
i- Induction training for newly recruited medical officers. Here preventive and promotive aspects are emphasized. This goes on for 3-4 weeks.

ii- Management development programme for health managers. Here the in-charge of CHCs, sub divisional hospitals and the CDMOs are trained. The aim is to develop managerial skills in them.244

iii- Clinical updation training for specialists and clinicians in institutions where advanced treatment is given, as they need training regularly. This is given to clinicians of different disciplines. Earlier this was not done in a systematic manner.

5- The fifth component was Health Management Information System. Here the information from the periphery institutions is streamlined and the data is computerized. This helps to make the feedback faster. Under the existing system the data is not collected or forwarded and hence any analysis becomes difficult. Manually to manage this information is not possible now.

6- The sixth component was Disease Surveillance and Quality assurance. Prior to this project, disease surveillance was done just before an epidemic and not as a regular phenomenon. Disease Surveillance is a continuous process and this requires monitoring at every level. Now this system has been fully established.245

7- The seventh component was Hospital Waste Management. Now it has been made as a legal requirement. The project is providing technical and financial support.”246

It needs to be mentioned here that the Health Management Information System or HMIS in Orissa was little different from elsewhere in India. Whereas at other places HMIS was synonymous with hospital data management, in Orissa it has looked at collecting data from periphery level institutions like PHCs and CHCs and processing these to higher levels as feedback. However due to lack of computerization at periphery levels the HMIS initiative has not been successfully implemented so far.

244 It has to be mentioned here that the doctors in medical colleges were trained only for the clinical aspects and the preventive and promotive aspects were generally neglected, which was required in the district, sub divisional and the block level health services structure.
245 In chapter V we have discussed in detail about disease surveillance mechanism established in Orissa.
246 The concerned official had a field experience of 22 years in Orissa as a medical officer and was now on deputation to the OHSDP.
The components of inductive training for newly recruited medical officers and the health management component for senior officials were two very significant steps taken toward addressing the issues of training medical officers for management of PHCs, CHCs, sub divisional Hospitals and effectively taking care of the needs of a district by CDMO. For in medical colleges this preventive aspect of training has been the most neglected one and although different initiatives like, internship training for medical graduates, have been taken from time to time but the situation has not improved at all. Therefore if this initiative by the World Bank succeeds than it would really be a big step forward.

The clinical updation of training for specialists and clinicians was another important initiative because it has been observed that the medical officers hardly keep themselves informed about the latest developments in their respective fields. And most of the time the only way they could get any information in these aspects was from the medical representatives from pharmaceutical companies trying to promote a particular drug. Therefore if specialists were updated with their skills then it would help in strengthening the referral services from the periphery institutions.

The Hospital Waste Management component was another important reform initiative because the public sector health services structures lacked the cleanliness aspect. It was almost becoming synonymous with public institutions that ‘they do not maintain cleanliness.’

*Motivation for reform in the form of OHSDP:*

To the question that what was the motivation for initiating a project like OHSDP, the official said, “Any funding agency is interested to provide funds. States decide the priority areas according to health indicators. Orissa has a very poor health status and the state finance is not in a position to cope with the demand. Hence the World Bank was approached. While the priority areas are decided by the group of planners in the state, the investment and expected outcomes and the co-relation between these two are decided by World Bank experts.” Thus the official was of the view that while the priority areas were
decided by the state government planners, the required investment and the expected outcome was decided by the World Bank.

*The consultation process*:

So the question arises as to whether consultations were held with different levels of health services personnel before initiation of this project? Replying to this the official concerned said, “Consultations were held with health department, urban development department, engineering department, CDMOs, Director Health Services. Thus service providers, planners and policy makers were consulted. When project formulation was done, people below CDMO level were consulted. However there was some opposition from people below CDMO level.” Thus mentioning about the consultation process the official was of the view that consultations were held at different levels. However during field visit to two districts, the CDMOs said that they were not at all involved in this process.

*Informal service provider programme*:

One of the major initiatives with the potential to affect the provisioning of health care services was the idea about involvement of indigenous services providers for referrals in remote and hilly areas. Describing about this program one senior official at OHSDP said, “The involvement of Informal Service Providers in health delivery system is implemented in Mathalput block of Koraput district on pilot basis since October 2003. The IPD project has taken over this activity for implementation in other blocks of Koraput and the districts of Malkangiri, Nawrangpur and Rayagada and it would also be implemented in Rayagada block of Gajapati district. Further it is proposed to be implemented in all the tribal blocks of rest of the districts like Kandhamal, Sundergarh, Mayurbhanj, Gajapati, Keonjhar, Kalahandi, Balasore and Sambalpur. The CDMOs of these eight districts are to identify one ISP from each village of the tribal blocks and finalize the list in their ZSS meetings.”

*Defining ISPs:*

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247 We have also discussed about this consultation aspect in Chapter V.
Before asking in detail about this program how the indigenous service providers were defined was important to know. Responding to this query, the official said, "Informal service providers are those who live in that village. Their main occupation is not medicine. However they advise people in cases like, snake bite, pregnant women, risk pregnancy etc." Thus the indigenous service providers were residence of that village where they provided their services in cases like snaking bite, pregnant women and risk pregnancy. It needs to be mentioned that in those remote areas where malaria was endemic, the indigenous service providers were also treating these cases.

Why the Programme was started:
To the question why the program of ISP training was started, a senior official of the World Bank said, "What we are finding is that people are dying from malaria because they go to the traditional practitioners at village. If the person has got fever, they do what they have to do but in time they do not refer the person or a pregnant lady if she has complications, in time they do not refer. So what we are saying is that we should work with them, involve them and tell them that you are also part of the system. Probably we will make malaria drugs available to them. In some way there has to be some incentive for them also...so tell them... do what you want but tell them that in time please refer... For referrals transportation will be made available... so at least we can avoid deaths. But that is their livelihood, if we ban them they will go underground but they still will be working. So we are saying do what you are doing but please refer in time in case of fever or complications in pregnancy. They also have to be made aware about where health care facilities are available. In tribal districts we are having workshops. The district collector is actually organizing this. We have not even finished the first round. From the little bit of data we are getting, it shows that the number of referrals has increased, which is a good sign." Therefore the official was of the view that if we ban the indigenous service providers they would go underground and it won't solve the problem and hence they need to be involved in referrals to nearby health center and they also need to be made aware about the facilities available in a health center. However the idea of providing them drugs for malaria was a serious matter and concern was shown by officials at different levels about this proposal.
Another senior official at OHSDP, Bhubaneswar said, "The idea was to identify some people in village areas who will be liaisoning between community health needs and services institutions. This program was started in 2003 in few blocks of Koraput, Gajapati, Keonjhar and Phulbani districts on a pilot basis. These are tribal districts and are most inaccessible. In these districts the population is scattered and health institutions are widely dispersed. From each district two blocks were identified and from each block one or two informal services providers were selected. These services providers are asked to refer patients to nearby PHC or to the ANM.\footnote{There was a provision that all pregnant women should be registered with the ANM.} One follow up program is done in Koraput district and the outcome was very good. However it has to be critically verified in the field and lot of field supervision and monitoring is required for this. In the pilot study it was found that informal service providers were using injections for easy delivery. This was discouraged in workshops. Because of this practice there are lot of deaths of pregnant mothers and their children. In Orissa one can purchase drugs without prescription. This is not possible in Hyderabad."\footnote{Hyderabad is the Capital of Indian state of Andhra Pradesh.}

Therefore the experiment, which was conducted in a pilot basis, had been showing positive results. But the official raised an important policy issue here about the availability of drugs without a prescription and this was one of the major causes of deaths of pregnant women in remote and difficult areas. Therefore there was need for discussion at various levels about the necessity for bringing in legislation in Orissa to make it mandatory that without prescription one cannot purchase drugs.

Nature of the Project:

When asked about the nature of the project, the official at the OHSDP said, "This is a reimbursable project. The expenditure is through Government of Orissa budget. Money for the project is budgeted in the state budget, hence government of Orissa finance rules are applicable. Any financial loss or fraudulent activity is subject to audit. Government of Orissa makes budgetary support for OHSDP. Along with activities the five-year project
money has also been finalized. Implementation plan for the project was done by health department with the help of World Bank.” Therefore care was taken to ensure that a parallel system does not arise due to this project. That means the line departments should be the controlling authority of this project because ultimately these departments would have to run these project institutions i.e. once the project period comes to an end.

The official further said, “The loan money is for a particular period. The recurring expenditures are gradually withdrawn from the project. In first year entire manpower budget is reimbursed by the World Bank. Next year the state government has to take responsibility for 25 percent manpower. In the third year another 25 percent and likewise in the last year of the project the state government is sharing 75 percent of the budget and the World Bank reimbursing 25 percent of the project. If it happens like this than in the last year of the project, it won’t be difficult for the state government to sustain the project assets.”

However this was not happening in case of OHSDP. “In OHSDP, in the first year there was no post created, in the second year there was no post created, in the third year some new posts were created to manage the newly created institutions. Hence salary portion in first and second year was not utilized and in third year it was partially utilized. Therefore if in third and fourth year posts are filled than all of a sudden 75 percent of the burden, the state has to bear, which has happened in this case.” Therefore the posts were created in the third year only and due to this implementation process at the end of fourth year the state government had to bear all of a sudden 75 percent of the total cost of this budget. Therefore it has not been possible for the state government to increase its share over the years. However these issues were related to structural aspects of project implementation and hence it would be judgmental to fix responsibility on one party only.

Organizational structure of OHSDP:

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250 It was important to mention here that the structure of OHSDP was same as in nine other states in India. This was informed by the official concerned.
Once the project had been formulated and the budget amount decided it requires an organisation for implementation of the project. Describing about the organizational set up for OHSDP the official said, “At the top is the Project Management Cell or PMC, headed by Project Director.251 There are three units in it. These are: Health Unit, Finance Unit and the Engineering Unit.” See the picture below.

**Figure: 4.1: Project Management Cell**

```
PMC
/  \/
Health Unit Finance Unit Engineering Unit
```

“The project director heads the PMC or project management cell. A joint director heads the health unit. One executive engineer heads the engineering unit and one financial advisor, who is a chief accounts officer, heads the finance unit. In OHSDP maximum components come under the health unit. The engineering unit looks after the construction,” said the official.

He further added that under OHSDP, “the key posts are government posts. Consultants and the support staff are on contractual basis, which will terminate with the end of the project. Once the project is over, only the officer on deputation from government of Orissa will remain.”

Elaborating about the implementation aspects, the official said, “All the projects are falling under mainly the health and finance units. The implementation is done at the district level. The CDMO reports to the Director Health Services and also to the OHSDP director regarding project implementation.”

For the smooth implementation of the project “There are three committees are there in the project. The first is Project monitoring committee or review committee. The secretary health is the chairperson and the members are, Directors of DHS, DMET, DFW,

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251 The Project Director was of the rank of additional secretary and he had been posted on deputation form the government of Orissa.
SIHFW\textsuperscript{252} and the Director OHSDP is the convener. The committee should meet once in every month when the implementation progress of all the project activities is monitored," said the official.

The second was the \textit{steering committee}, "which looks after construction, administrative aspects and expenditures for more than Rs10 lakhs. Chairman is the health secretary; all the directors of the health directorate are its members, and one representative each from the finance and works department. Decisions requiring approval for more than Rs10 lakhs goes to steering committee and some administrative and engineering approval go here."

"The third is the policy review committee. This is the highest decision making body. It takes decisions according to the changing circumstances. The Chief Secretary Government of Orissa is the chairman. The members are, Finance secretary, Revenue secretary, Works secretary,\textsuperscript{253} Health secretary, Women and Child department secretary and Urban Development secretary."

The official further said, "These are all facilitating bodies for smooth implementation of the project."

\textit{The project board:}
"There is a project board where decisions are taken to save time. Its chairman is health secretary. Members are directors from DHS, DFW, DMET, SIHFW and OHSDP and a representative of the finance department," said the official.

But what was the rationale for the project board when already the project management cell and the three review committees were already there? Responding to this query the official said, "In normal course file moves from health to finance department and from

\textsuperscript{252} DHS was Director Health Services, DMET was Director Medical Education and Training, DFW was Director Family Welfare and SIHFW was State Institute of Health and Family Welfare.

\textsuperscript{253} Works department looks after construction.
there the money is released. As it is a lengthy process, here the project board decides and the money is released immediately and hence it is a quick process."

**Reporting from the district level:**
To the question how and to whom the reports with regard to OHSDP institutions from districts were sent, the official said, "In the monitoring process at the district level, CDMOs report to project directors on various activities on an agreed format. Some are monthly reports and some are weekly reports."

**Involving the line departments**:\(^\text{254}\)
However as we have argued earlier that involvement of the line department was necessary for the successful outcome of the project, so what were the steps taken in this regard? Responding to this question the official concerned said, "It is not possible to involve the PMC to monitor every activity and hence line department is also involved. Here the joint directors under DHS and DFW have been allotted districts for supervision. They go to the districts every month. They supervise and monitor all health activities including OHSDP activities."

**Status Report:**
Now let us have a look at the existing status of the project in terms of its implementation at ground level. The table below gives the status report of OHSDP. It has looked into the key activities, the targets, achievements of those targets, sanctioned costs, expenditure made till now and what was the percent of this expenditure to the total cost of this project.

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\(^{254}\) Line departments suggest the regular departments of the Ministry of Health and Family Welfare.
### Table: 4.4 Status report, OHSDP Figures in Crores

<table>
<thead>
<tr>
<th>Key activities</th>
<th>Target</th>
<th>Achievements</th>
<th>Sanctioned costs</th>
<th>Expenditure and % to the total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Work</td>
<td>157</td>
<td>118</td>
<td>168.5</td>
<td>98.37 (58.37%)</td>
</tr>
<tr>
<td>Drugs and Consumables</td>
<td>--</td>
<td>--</td>
<td>16.21</td>
<td>16.21 (100%)</td>
</tr>
<tr>
<td>EIF</td>
<td>--</td>
<td>--</td>
<td>36.37</td>
<td>14.28 (39.26%)</td>
</tr>
<tr>
<td>Training (Inside Orissa)</td>
<td>2568</td>
<td>911</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Training (outside Orissa)</td>
<td>--</td>
<td>153</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Training</td>
<td>On going activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Waste Management</td>
<td>All project institutions covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Software activity</td>
<td>210 telephones, 30 each vehicles and equipments provided, 2 computers provided, AMC done in 32 units</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manpower support</td>
<td>1012 posts created and 660 filled on contractual basis. 65 posts created and 25 filled on regular basis. 461 posts upgraded and 90 filled up.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: -- means data not available.*

*Source: Fieldwork, 2005.*

The table shows that in Civil Works out of 157 targets, 118 have been completed with a sanctioned cost of Rs 168.5 crores; and in total Rs 98.37 crores had been spent, which was 58.37 percent to the total cost. Similarly for Drugs and Consumables out of sanctioned Rs 16.21 crore 100 percent had been spent. For equipments, instruments and furniture or EIF out of the sanctioned cost of Rs 36.37 crores, Rs 14.28 was spent which was 39.26 percent. For training inside Orissa, out of 2568 targets 911 had been completed and for training outside Orissa, 153 had been completed. The table also mentions that training was an ongoing activity of this project. Hospital Waste Management had been extended to all the 157 project institutions. In terms of software activity, 210 telephones, 30 each vehicles and equipments and 2 computers had been provided. In terms of manpower support 1012 posts had been created and 660 were filled up on contractual basis. Further 65 posts were created and 25 filled up on regular basis and 461 posts were upgraded and 90 posts were filled up.
**Posts created on a contractual basis:**

The table below gives the number of contractual posts created in various categories under OHSDP. It also shows the number of posts filled up and the number of posts yet to be filled up.

**Table: 4.5 Posts created under OHSDP (on a contractual Basis)**

<table>
<thead>
<tr>
<th>On contractual Basis</th>
<th>No. of posts created</th>
<th>Filled up</th>
<th>To be filled up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asst. Surgeon</td>
<td>124</td>
<td>124</td>
<td>0</td>
</tr>
<tr>
<td>Specialists</td>
<td>158</td>
<td>0</td>
<td>158</td>
</tr>
<tr>
<td>Dental Surgeon</td>
<td>18</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Radiographer</td>
<td>62</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>District Education Officer or DEO</td>
<td>30</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>535</td>
<td>438</td>
<td>97</td>
</tr>
<tr>
<td>Lab. Technicians</td>
<td>40</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Librarian</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>MPHW (F)</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Driver</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1012</strong></td>
<td><strong>616</strong></td>
<td><strong>396</strong></td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*

The table shows that 124 posts of Assistant Surgeons were created, out of which 124 had been filled up. Similarly out of 158 posts of specialists created, not a single post has been filled up. In case of dental surgeons, 18 posts were created and all the 18 had been filled up. Nine posts were created for Pharmacist, out of which 6 had been filled up and 3 posts were yet to be filled up. On the other hand out of 62 posts of radiographer created, not a single had been filled up. In case of District Education Officer while 30 posts were created, all had been filled up. Similarly 535 posts were created for Staff Nurse, out of which 438 had been filled up and 97 posts are yet to be filled up. However in case of Lab Technicians while 40 posts were created, not a single had been filled up. Librarian also while one post was created; it was yet to be filled. Nine posts were created for MPHW (F), out of which not a single had been filled up. In case of Driver 17 posts were created and here also not a single post had been filled up. Thus in total out of 1012 posts created, 616 had been filled up and 396 posts were yet to be filled.
The analysis of the table shows that the posts of Assistant Surgeons, Dental Surgeons, and District Education Officers had been 100 percent filled up. In case of Staff Nurse and Pharmacists also a large number of posts had been filled up. However, in case of Specialists, Radiographer, Lab Technicians, Librarian, MPHW (F) and Driver, out of the total posts created not a single had been filled up.

*Posts created on a regular basis:*

The table below shows post created under OHSDP on a regular basis. It gives a picture of total number of posts proposed to be created, the number of posts filled up and the number of posts to be filled up.

**Table: 4.6 Posts created under OHSDP (on a regular basis)**

<table>
<thead>
<tr>
<th>On a regular basis</th>
<th>Total posts</th>
<th>Filled up</th>
<th>To be filled up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing sister</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Technical Store Keeper</td>
<td>18</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Matron</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Asst. Matron</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>MPHW (M)</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
<td><strong>25</strong></td>
<td><strong>40</strong></td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*

The table shows that for nursing sister out of 7 total posts, all had been filled up. Similarly for Technical Store Keeper out of 18 posts, all had been filled up. However, out of proposed 6 posts of matrons, 17 posts of Assistant matrons and 17 posts of Multi Purpose Health Worker (Male) not a single had been filled up. Thus out of the proposed 65 total posts to be created, only 25 had been filled up and 40 posts were yet to be filled up.

*Upgradation of posts under OHSDP:*

Apart from creating regular and contractual posts, some posts were taken up for upgradation under this project. The table below gives a picture of posts proposed to be upgraded for Sr. Class I and for Jr. Class I.
Table: 4.7: Upgradation of Posts under OHSDP

<table>
<thead>
<tr>
<th>Posts upgraded</th>
<th>Total Posts</th>
<th>Filled up</th>
<th>To be filled up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. class 1</td>
<td>240</td>
<td>31</td>
<td>209</td>
</tr>
<tr>
<td>Jr. class 1</td>
<td>221</td>
<td>25</td>
<td>196</td>
</tr>
<tr>
<td>Total</td>
<td>461</td>
<td>56</td>
<td>405</td>
</tr>
</tbody>
</table>


Thus out of 240 Sr. Class I posts only 31 had been upgraded and 209 posts were yet to be upgraded. Similarly for Jr. Class I posts, out of 221 posts to be upgraded only 25 posts had been upgraded and 196 posts were yet to be upgraded. This shows that the upgradation of posts would be very difficult for the rest of the project period.

In-service training:

In-service training had been an important component of OHSDP. The table below gives a picture of how many number of persons had been trained in different areas like hospital management, nursing management, computer application, media activity and IEC action plan, clinical updatation of skills of specialists, skill updatation of assistant surgeons, Lab technician training in blood banking, TOT in hospital waste management, district health services management course, induction training of newly recruited medical officers, FMT programme at SIHFW and para medical training at Kalinga Hospital, Bhubaneswar.

Table: 4.8: In-service training, OHSDP

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Number Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Management</td>
<td>164</td>
</tr>
<tr>
<td>Nursing management</td>
<td>89</td>
</tr>
<tr>
<td>Computer application</td>
<td>39</td>
</tr>
<tr>
<td>Media activity &amp; IEC action plan</td>
<td>120</td>
</tr>
<tr>
<td>Clinical updatation skill of specialists in six disciplines</td>
<td>92</td>
</tr>
<tr>
<td>Skill updatation of assistant surgeons</td>
<td>171</td>
</tr>
<tr>
<td>Lab. Technician training in blood banking</td>
<td>53</td>
</tr>
<tr>
<td>TOT in hospital waste management</td>
<td>72</td>
</tr>
<tr>
<td>District health services management course</td>
<td>78</td>
</tr>
<tr>
<td>Induction training of newly recruited MOs</td>
<td>61</td>
</tr>
<tr>
<td>FMT programme at SIHFW</td>
<td>51</td>
</tr>
<tr>
<td>Para medical training at Kalinga hospital BBSR</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>1010</td>
</tr>
</tbody>
</table>

The table shows that in hospitals management, 164 persons had been trained and in case of nursing management, 89 persons had been trained. While in computer application, only 39 persons trained, in case of media activity and IEC action plan, 120 personnel were trained. For clinical updation skill of specialists in six disciplines, 92 personnel were trained and for skill updation of assistant surgeons, 171 personnel were trained. In case of Lab technician training in blood banking, 53 persons were trained and for TOT in hospital waste management, 72 persons were trained. In total 78 persons were given training for district health services management course and 61 newly recruited MOs were given induction training. Further 51 persons were trained for FMT programme at SIHFW and 20 para medics were trained at Kalinga Hospital, Bhubaneswar.

Analysis of different training programme showed that for skill updation of assistant surgeons highest numbers of personnel were trained, out of all the different training programmes followed by personnel trained for hospital management, personnel trained for media activity and IEC action plan, personnel trained for clinical updation of skills of specialists in six disciplines and nursing management.

In terms of lowest number of personnel trained, para medics training at Kalinga Hospital came first followed by, computer application, FMT programme at SIHFW, Lab technician training in blood banking and persons trained in induction training for the newly recruited medical officers.
OHSDP Expenditures:

The table below gives the expenditure incurred in this project over the years.

**Table: 4.9: OHSDP expenditures over the years**

<table>
<thead>
<tr>
<th>Expenditure during</th>
<th>Rs. In Crores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-99</td>
<td>05.42</td>
</tr>
<tr>
<td>1999-00</td>
<td>05.26</td>
</tr>
<tr>
<td>2000-01</td>
<td>34.01</td>
</tr>
<tr>
<td>2001-02</td>
<td>27.03</td>
</tr>
<tr>
<td>2002-03</td>
<td>25.60</td>
</tr>
<tr>
<td>2003-04</td>
<td>57.61</td>
</tr>
<tr>
<td>2004-05 up to 15.02.05.</td>
<td>55.83</td>
</tr>
<tr>
<td>Cumulative expenditure up to 15.02.05</td>
<td>210.76 or 50.71%</td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*

The table shows that expenditure in the first two years were below Rs 6 crores, however it suddenly increased to Rs 35.01 crores in 2000-01 and again declined to Rs 27.03 Crores in 2001-02 and further declined to Rs 25.60 crores in the next year. In the year 2003-04 the expenditure was more than doubled to Rs 57.61 crores and slightly declined to Rs 55.83 crores from 2004-05 up to 15.02.05. In a way we could say that expenditure has increased over the years. In terms of cumulative expenditure till 15.02.05, Rs 210.76 crores were spent, which was 50.71 percent of the total OHSDP budget. This shows that although the expenditure in this project has increased over the years almost 50 percent of the money could not be spent. Therefore it could be said that the project had not moved in a satisfactory way and there had been delays at many places.

Proposed Expenditure:

The table below gives an idea about the proposed expenditure from the year 2004-05 to 2006-07.

**Table: 4.10 OHSDP: Proposed expenditures**

<table>
<thead>
<tr>
<th>Proposed expenditure during</th>
<th>Rs. in Crores</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-05</td>
<td>259.97</td>
</tr>
<tr>
<td>2005-06</td>
<td>104.00</td>
</tr>
<tr>
<td>2006-07</td>
<td>51.61</td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*
It shows that for the year 2004-05 the proposed expenditure to be a whooping Rs 259.97 crores and for the following year the proposed expenditure were to be Rs 104.00 crores followed by Rs 51.61 crores in the next year. However if the previous expenditure records were of any indication, these estimates of proposed expenditures seem highly unlikely.

**Drugs and Medical consumables:**
The table below shows the status report with regard to drugs and consumables. It has given different aspects of it like, the provision as per Project Implementation Plan or PIP, orders placed till 15.02.05, expenditure till 15.02.05, procurement in process and the assessment of these expenditures by OHSDP.

**Table: 4.11 Drugs and Medical consumables under OHSDP**

<table>
<thead>
<tr>
<th>Provision as per PIP</th>
<th>Orders placed till 15.02.05</th>
<th>Expenditure till 15.02.05</th>
<th>Procurement in process</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.50</td>
<td>23.41</td>
<td>13.19</td>
<td>11.58</td>
<td>Bill pending with SDMU for balance payment</td>
</tr>
</tbody>
</table>

**Note:** SDMU- State Drugs Management Unit.

*Source: Fieldwork, 2005.*

It shows that out of Rs 29.50 crores proposed as per PIP, orders were placed for Rs 23.41 crores till 15.02.05, expenditure was Rs 13.19 crores and the rest of the amount of Rs 11.58 crores was in the process for procurement. Therefore it could be said that in this drugs and consumables segment, OHSDP had made good progress compared to other aspects.

**Equipments, instruments and furniture:**
The table below gives financial details with regard to equipments, instruments and furniture under the project OHSDP.

**Table: 4.12 Equipments, instruments and furniture**

<table>
<thead>
<tr>
<th>Provision as per PIP</th>
<th>Order placed till 15.02.05</th>
<th>Expenditure till 15.02.05</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>75.72</td>
<td>60.20</td>
<td>27.05</td>
<td>Balance bills pending</td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*
The table shows that out of Rs 75.72 crores of provision as per project implementation plan, orders were placed for Rs 60.20 crores till 15.02.05 and actual expenditure incurred was Rs 27.05 crores. Thus in terms of orders placed for EIF, it could be said that this component had made good progress.

*Anticipated expenditure under OHSDP:*

The table below gives an indication of anticipated expenditure under the project OHSDP till 31.03.2005.

**Table: 4.13 Anticipated expenditure in OHSDP up to 31.03.2005**  
Figures in Rs. Crores

<table>
<thead>
<tr>
<th>Civil works</th>
<th>9.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIF</td>
<td>21.5</td>
</tr>
<tr>
<td>Drugs</td>
<td>08.00</td>
</tr>
<tr>
<td>Salary</td>
<td>7.00</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3.21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>49.21</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>259.97</td>
</tr>
<tr>
<td><strong>Anticipated unspent balance as per PIP</strong></td>
<td>155.61</td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2005.*

It shows that with Rs 21.5 crores of anticipated expenditure EIF tops the list, followed by civil works with Rs 9.5 crores, drugs with Rs 08.00 crores, salary with Rs 7.00 crores and miscellaneous with Rs 3.21 comes at the bottom of the anticipated expenditure chart. The table further shows that, the grand total anticipated expenditure was Rs 259.97 crores and the anticipated unspent balance as per PIP was Rs 155.61 crores. As we have shown earlier that because of this huge anticipated unspent balance, it could be said that the project had faced many difficulties in its implementation phase.

*Proposed expenditure during 2005-06:*

The table below gives an indication of how the anticipated unspent balance of Rs 155.16 crores would be spent on different activities during the financial year of 2005-06.
Table: 4.14 Proposed expenditure in OHSDP during 2005-06  

<table>
<thead>
<tr>
<th>Description</th>
<th>Figures in Rs. Crores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance civil works (8DHH and 1SDH) and refund of security deposit</td>
<td>30.16</td>
</tr>
<tr>
<td>Repair and renovation of existing buildings in project and non-project hospitals</td>
<td>37.61</td>
</tr>
<tr>
<td>EIF or Equipment, Instruments and Furniture</td>
<td>30.95</td>
</tr>
<tr>
<td>Drugs</td>
<td>16.89</td>
</tr>
<tr>
<td>Salary and miscellaneous expenditure/ISP workshop</td>
<td>32.00</td>
</tr>
<tr>
<td>Maintenance of equipments during 2006-07</td>
<td>08.00</td>
</tr>
<tr>
<td>Total</td>
<td>155.61</td>
</tr>
</tbody>
</table>


Out of the proposed expenditure, highest amount would be spent on repair and renovation of existing buildings with Rs 37.61 crores, followed by salary and miscellaneous expenditure with Rs 32.00 crores and Rs 30.95 crores of expenditure in EIF. The fourth largest proposed expenditure would be in balance civil works and on refund of security deposits with Rs 30.16 crores, followed by Rs 16.89 crores of expenditures on drugs and Rs 08.00 crores of expenditure on maintenance of equipments during 2006-07.

Concerns:

So the project had been implemented, there was an organizational structure created for implementation of the project and mechanisms for inter departmental coordinations had been created. But was it the case that everything was functioning as planned or there were some areas of concerns too? Replying to this query the official said, “The CDMO conference is done usually twice a year. Here OHSDP activity is also one of the agendas. There is an interaction between the districts.” However the official said, “The structure is very good, arrangements are very good, but in real sense this is not happening. For example only 15-20 minutes is given to OHSDP activities in CDMO conferences. Sometimes OHSDP also calls CDMOs and ADMOs in small batches to discuss some issues.”

255 Additional District Medical officers.
The official further added, “Whether joint directors are giving importance to OHSDP in their districts or not needs to be verified. It began in the project very late.\textsuperscript{256} Another aspect is sustainability, which is part of the project. This was agreed at the time of approval of the project. Hence the state government should take appropriate measures to fulfill those commitments.”

The official mentioned, “The project objective is to take loan gradually, so that it does not become a burden on the state.”

\textit{Sustainability of the project:}

On sustainability of the project the concerned official said, “At present political commitment is lacking in Orissa”. He said, “World Bank gives loan to the government of India with 2-3% interest and the government of India gives to the state at 11% interest. This needs to be corrected. Further those who are capable should pay for health services. People will pay only when the credibility of that institution is there. It is after all a question of channeling funds with good governance.”\textsuperscript{257} This was a very important point mentioned by the official concerned in terms of Centre-state relations in dealing with donor funding. However the significant question was if the government of India gets loan from World Bank at 2-3 percent of interests, than why it charges from the state at 11 percent for passing the same loans? Therefore this aspect needed urgent attention. Another point that the official mentioned was about, charging those who could pay and this was the view of most of the government officials at different levels of health care services structure in the state. Therefore there was need for a study, which would look into the users’ perspective about user fees all across Orissa. Besides the different aspects should be taken into account, if such a fee was to be introduced across the state. For example, it needs to be ensured that the poor and marginalized sections of the population were exempted from paying fees in reality and not just as a promise to them.

\textsuperscript{256} The official was referring to the involvement of joint directors in the project.
\textsuperscript{257} In fact it needs to be mentioned here that there was support for private participation in health care at every layer of the government health services structure in Orissa.
Further the official concerned added, “At present projects are working more or less independently isolating the line department.\(^{258}\) They are not fully involved. There should be concrete steps to address these issues. External aid if it is to show output should be seen internal by the line department. The line department directors need to be involved. At present when procurement of equipment or construction goes on, inputs do not come from the directors. Now implementation is done by projects and later line directors are consulted. This should be reversed. Formulation and implementation should be done with line department and projects should play as facilitators. In this regard decisions have to be taken by the health secretary and the health minister otherwise line department directors will work as bureaucrats.” Further the official added, “Once a project is finished, the assets or manpower created out of it will be left with line directors. Hence, if they are not involved at project formulation and implementation phase, than it will lead to chaos. At present exactly this is happening and it has led toward the alienation of the line department directors. They felt left out of this whole process.” Therefore the official concerned mentioned a significant point about the negligence of line department directors in formulation and implementation of the OHSDP project. Therefore some questions need to be addressed in this regard. It was not enough to say that from next time the line department directors would be involved in project formulation and implementation processes. But the questions that should be asked were, why in spite of existing mechanisms for involving the line department directors at every stage, it could not happen? Who were responsible for this? Was it the case that there was something in the project component which was or which would have been opposed by the line department directors? Therefore these aspects need to be dealt with if the project has to show some outcomes.

Then there were also questions about why in CDMO conferences only for 15 to 20 minutes were spent about the progress of this project? While the provisions for Joint Directors in the Directorate of Health to monitor the project in different districts had been there, why it started late and even then questions were being raised about the actual

\(^{258}\) Line departments refer to the Director of Health Services, Director Family Welfare and Director Medical Education and Training etc.
situation in the field? Therefore this aspect also needed a deeper analysis. What were the reasons for which this could not be implemented? Where the structural constraints were there?

**Larger issues:**

The official further added, “In Orissa there is a myth that money is not there. It is rather the lack of political commitment.” This was a very important observation from a senior official in the state who had more than 20 years of work experience in various levels of health care services in the state. Infact this was also the observation at different levels in the state as well as from the senior officials of the donor agencies, that political will and commitment was lacking in Orissa, in improving the health care delivery structure in the state.

On the question that, suppose due to reform measures the drug department saves Rs30 crores out of its Rs100 crores budget, than next year Rs30 crores was reduced from its budget. In this situation how could reforms proceed? Responding to this the official said. “This is the real tragedy. Lot of donor money is coming to Orissa but where it is being spent has to be seen. There are lots of wasteful expenditures.” This is another important aspect of donor led funding in Orissa. During field visits one medical officer in charge of a block level PHC was of the opinion that “Suppose a program requires Rs 100 to be spent, for this the government of Orissa makes provision for Rs 60, but in case of a donor agency this amount reaches to Rs 160. Because they know that Rs 60 would go to the pockets of different officials!” This was a very honest observation but also serious one too to be taken note of because here the question was about misutilisation or misappropriation of program money. So the reasons need to be looked at. Therefore questions need to be raised as to why out of Rs 160, Rs 60 need to be taken by different levels of officials? So here the structural issues like amount of salary, working conditions, satisfaction at the job etc. for different levels of health personnel needs to be looked at.
To the question of sustainability of project assets once the projects comes to an end, the official said, “This is the real challenge. For example suppose the drug budget of Orissa is Rs4 crores and the World Bank gives another Rs4 crores to address the shortage in money with the condition that from next year the government of Orissa will increase its drug budget by Rs1 crore, so that after four years the state can sustain it. But it is not happening”. Than, why the state was drawing money for reforms from the donor agencies? To this he said, “The first thing is that there is lack of political will. The second thing is that donor coordination and plan coordination is lacking at the moment”. The lack of donor coordination and also the lack of donor and plan coordination is another important aspect we have dealt with in chapter V in detail.

Further he said, “In other states if a minister does not perform than he is sacked. But here in Orissa one goes on, even if he is inefficient.” The official further added, “Seminars and workshops are held but the reports produced out of it remains unutilized. The policy makers259 do not give it any importance.” This was another point to be taken note of because there was lots of money and resources were spent by different governments at the state and central level to conduct seminars and workshops, so that concrete input could be provided to implement a program. However if the reports produced out of these were not utilized then all these effort goes in vein. Therefore question arises as to why these reports lie unutilized? Is it the case that there are structural constraints so large that these findings could not be implemented and hence they lie unutilized? If it is the case than why at all these seminars and workshops conducted at all? Or there could be some other reasons?

Apart from these, another major reason cited by the official was that “However good a project or programme might be, in terms of its formulation, it fails when it comes to the issue of implementation, as they do not look into the aspects of health care delivery system.” He said, “The shortage of staff is faced from the Director Health Services to the CDMOs to the doctor at the CHC or PHC level. At the PHC level there are shortages of paramedics and at the sub center level there are shortages of ANMs.” He further added,

259 By that he meant health secretary and the health minister.
"Because of the arbitrary nature of transfer and postings it will be difficult to find a single doctor who has faith in the system." Therefore what was mentioned here were that the donor agencies do not take into account about the health care delivery structure through which a project was supposed to be implemented and hence from the beginning the failure of the project is almost certain! Therefore questions need to be asked as to why donor agencies do not take into account these structural issues? Is it because they try to implement a model, which has succeeded at another country?

Conclusion:
In this chapter we have discussed about the State Health Systems Development Projects being implemented by the World Bank in India and also we have discussed about the Orissa Health Systems Development Project in the context of India adopting Structural Adjustment Programmes in the nineties. We have learnt that the SHSDPs were initiated with the aim of upgrading the secondary level institutions; from CHCs to district headquarter hospitals, which were mostly 30 to 400 bedded institutions in different states.

Due to the initiation of Structural Adjustment Programmes various states in India faced shortage in funding for various communicable diseases from the centre. However as there were cases of plague in Surat and malaria in Rajasthan, these cutbacks were restored through donor agency funding like the World Bank. The World Development Report 1993 had emphasized the need to reduce public spending from secondary and tertiary levels of care and focusing the limited resources of the state on selective primary level care. Within this framework SHSDPs were introduced to strengthen the secondary level institutions and in the long run to make them self sufficient by introducing mechanisms like user fees.

The first group of states where SHSDPs were introduced was Andhra Pradesh, Karnataka, Punjab and West Bengal. These states were chosen on the ground that they represented the heterogeneity of India, in terms of its economic and political structures.

\[260\] It has been mentioned elsewhere that the transfer and postings were done in a very arbitrary manner in Orissa. This had almost demoralized the cadres at every level. This fact also came out during interaction with CDMOs and the medical officer in charge of block PHCs.
These were followed by Orissa, Maharastra, UP and Uttaranchal. The latest group of states to be included was Rajasthan and Tamilnadu. While the projects in first four states had been completed, it was going on in remaining states.

In the early nineties, the World Bank was involved with population programs, like family planning and family welfare and in nutrition programs like the ICDS in India. However after assessing its past activities, the Bank decided to upgrade the state health systems in different states of India. Their internal analysis showed that while the primary level care in India was supported by national programs like family planning and the disease control programs and the tertiary level care was mostly catered to by different states, it was the secondary level care which was the neglected area. As a result the secondary level institutions were not getting their annual maintenance budgets. This had affected the first level referrals.

Therefore the first thing that was done by the Bank was to identify the kind of services a secondary level institution like a CHC or a district hospital should provide. Hence an effort was made to rationalize the services available in these institutions. Once the services were identified, then the required manpower and equipments were also decided accordingly. Part of this project was introduction of health care waste management, under which cleaning aspect was privatized and health management information system was introduced, which tried to utilize the existing hospital data so that the limited resources could be used efficiently. In some states hospital data was also used to grade different hospitals in terms of their performance. The idea was that the grading of hospitals would improve the quality of care. In states like Punjab and West Bengal the hospital data generated was used as a feedback to upgrade the services.

Along with this an effort was made to identify what kind of personnel should be trained for these institutions and to rationalize the referral system. Further the states undertaking this project were asked to maintain the drugs and maintenance budgets systematically. So that the issues like where the resources were spent and whether these were spent judiciously could be analyzed.
The criteria to select the first group of states for SHSDP projects was that the states should show a level of commitment for health sector reforms and they had to be genuinely interested in this project. However in the later stages the criteria changed to those states of India which would be lagging behind in achieving the targets of Millennium Development Goals. We need to mention here that in recent times, most of the donor agencies all over the world have shifted their focus on achieving the targets of MDGs in various counties.

Further to evaluate the SHSDPs, the experiences from Mexico and Vietnam in terms of their community health insurance schemes were looked at. This was a significant development because the idea was to generate new sources of financing and to ensure that the poor were exempted through introduction of health vouchers.

While the officials interviewed claimed that the SHSDPs had introduced dialogue among various senior state officials, the Orissa experience suggested that the line departments were not consulted or were consulted very late in the implementation of this project. While the senior officials interviewed at World Bank were quite optimistic that this project had increased access for the poor and women, the officials in Orissa were very skeptical about this aspect. According to them, one of the major challenges of introducing the user fees was about exempting the poor in reality.

Along with the implementation of SHSDPs, the World Bank was also trying to encourage state governments to initiate public private partnerships and it begun with non-clinical services. The idea was to utilize the services available in the private sector effectively. One aspect of this was to give the cleaning aspect of various public health institutions to private parties. It was found that neither the government of India nor the states had the expertise to write contracts with the private sector. In terms of handing over PHCs in remote areas to NGOs, while it succeeded in Sunderban areas of West Bengal, the same experiment could not succeed in Orissa. This suggests that a unified model should be avoided. However one of the challenges of working with the private sector in India was
that there was no proper regulation for it and as a result there were no quality checks for the kind of services it provides. Another significant initiative in this direction was about involving informal service providers in referrals in cases of obstetric emergency or a neonatal emergency or falciparum malaria cases. The idea was that the policy of putting a ban on ISPs could not succeed and hence why not involve them in referrals.

The World Bank has been funding for various national programs in India like RCH, HIV/AIDS, Tuberculosis and Malaria, where the money basically went to primary level care. This was one of the reasons that SHSDPs focused on secondary level care. However the experiences from different states were showing that referrals from primary level care to these secondary level institutions had not improved. The reasons were, like people were not aware that such kind of facilities did exist and secondly there were no transportation facilities available for the people. Therefore in the next group of states like Tamilnadu and Rajasthan, the World Bank would also support the primary level care because it has been realized that without improving the primary level care the MDGs won’t be achieved. The experience from SHSDPs also suggest that health care financing needed more emphasis in terms of use of existing resources efficiently and generating new sources of financing, in terms of introducing various insurance mechanisms. For increasing public investment in health sector, the World Bank was involved in a dialogue with the centre and state governments to reduce subsidies in agriculture and power. However these were very sensitive issues in a democracy like India. Besides when the developed countries like US, Japan and countries from Europe were refusing to reduce subsidies they provide to their farmers, in WTO negotiations, how far it was justifiable to argue that a country like India should reduce subsidies on agriculture?

Another aspect which was emphasized was about utilizing the existing manpower efficiently. Here it was said that as in remote and difficult areas the medical officers and the other staffs from government were refusing to stay, why not involve the private sector. Therefore the argument was that the government should shift its role from actual provisioning of health care to issues of policy, regulation and accreditation. On the part of World Bank they were trying to interlink the question of fiscal crisis which various states
have been facing, with increase in health financing from the Bank. In case of Orissa the Bank was planning to link the Orissa Economic Review Package with funding for health sector. However this has policy implications in the form of people's representatives loosing their capacity to take independent decisions with regard to deciding priority areas of health interventions.

Our analysis showed that Orissa had a large presence of donors since 1990s. However multiple donors and their multiple projects have not really helped in meeting its various socio economic challenges. Rather it has created problems of donor coordination and in many cases the donor led projects were not matching with the health priorities being identified by the state in its vision document 2010. In this backdrop the World Bank led OHSDP project need to be analyzed.

During interviews, senior officials of the World Bank were of the view that because the government of Orissa was interested for OHSDP project, it could be proceeded with. The OHSDP was intended to strengthen the secondary level health care institutions in the state. The different components of this project were infrastructure development, provision of equipments and furniture, mobility support, in-service training, HMIS, ISP training, disease surveillance and quality assurance and hospital waste management.

While mechanisms were created for consultation process with the line department directors and the CDMOs in project formulation, implementation and monitoring, in reality the line departments were totally sidelined. This had implications not only for effective implementation and monitoring but also about the sustainability of the project institutions created. Further the state government was not increasing its share of expenditure each year as it was formulated in the beginning of the project. This was due to the fact that only in the third year of this project some posts were created, as a result all of a sudden in the third year the state had to bear the 75% of the total cost which was not possible.
Under this project while total number of contractual posts created was 1012, the regular posts were only 65. Out of the total contractual posts while 616 had been filled up, in case of regular posts only 25 had been filled up. The total number of contractual posts created suggests that the elements of private sector were being introduced in these secondary level institutions. Therefore if tomorrow the state was not in a position to provide funding for these institutions, then these staffs would have to go or alternatively, services in these institutions would have to be privatized. Hence it seems that in the long run the secondary level institutions might get cut off from the primary level institutions for referrals. This has serious implications for equity and universal access to health care.

The larger issues about donor funding that came up was that while the World Bank provided loan to government of India at 2-3% interest rates, the same loan was being passed to the states at 11% interest rates. This was putting a heavy burden on the state governments. However it was the lack of political will which was the biggest stumbling block in bringing about required changes in the health care system of Orissa.