CHAPTER V
Introduction:

In this chapter we have discussed about the experience of reforms in health sector in the state of Orissa. While in chapter IV we have discussed about health sector reforms in the form of OHSDP, here we have also classified health sector reforms in Orissa according to our new definition. Further this chapter has analyzed our broad objective of 'process and experience' of health sector reforms in Orissa. Here the interviews with the health bureaucracy of the Orissa government at different levels and the perceptions of donor agency officials in Delhi and Bhubaneswar have been reflected.

Among the various donor agencies interviewed, there was a consensus among all these players that the state has to create more space for the private sector in the delivery of health care. In terms of thinking at the top level it was quite clear that these organizations had set their priorities in terms of achieving the targets of Millennium Development Goals. These were targets to be achieved by the year 2015. The World Bank has identified the means to achieve these goals in the field of health. The 1993 document of the World Bank titled investing in health has acted as a frame of reference for the donor agencies in Orissa. This has happened against the backdrop of annual documents of the World Bank, which have off late advocated an increasing role of state in health care provisioning and financing.

The background:

There were two events, which were supposed to have started the systemic changes as well as the reforms in health sector in the state of Orissa in late 1990s. One was the formation of a House Committee of Orissa State Legislature, which looked into different aspects like; rising of resources for the ailing health care sector, introduction of user

261 The larger goals of development as identified and prepared by UNDP or United Nations Development Programme known as Millennium Development Goals.

262 See the World Development Reports published by the World Bank annually since the year 1993 to 2004.
charges in medical colleges and district hospitals and on the issue of abolition of private practice by government doctors. The second event was an evaluation by the UK development agency DFID about its earlier two projects in Orissa.\textsuperscript{263}

However the single connecting thread to these separate events was the effort to privatize the health services sector in the state. For this to happen there was a wider atmosphere of economic reforms initiated by the central government and various fiscal measures being adopted by the state government. Hence reforms in health sector need to be contextualised in the framework of economic reforms.

Now let us have a look at some of the reform initiatives being taken in the state.\textsuperscript{264} The two events that helped in bringing the systemic changes had also acted as a catalyst for reforms in the health sector in Orissa. Therefore the process of reforms in the state had been closely associated with the systemic changes.

\textit{Health sector reforms:}

Let us first see the elements of health sector reforms being introduced in Orissa.

\textit{Creation of PSPU}\textsuperscript{265}: The Policy Planning or Strategic Unit has been started with the initiative of DFID\textsuperscript{266} of UK in Orissa. The entire funding was being done by the DFID. This unit would act as a think tank for the Ministry of Health and Family Welfare, government of Orissa. It would help in programme design, implementation, monitoring and revision of health initiatives by the health department. Although the entire funding of this institution would be done

\textsuperscript{264} The various reform measures in health sector in Orissa were drawn from Meena Gupta’s Paper, from Orissa Vision 2010 document and with various interviews with donor agencies and the State government officials. Further according to the new definition we have given in our present study, other initiatives in the Orissa health sector has been identified as reforms for the first time in this study and many initiatives which have been interpreted as ‘reforms’ by other studies have been excluded in our classification, because these failed to fulfill the criteria of reforms according to our new definition.
\textsuperscript{265} It refers to Policy Planning and Strategic Unit, Government of Orissa.
\textsuperscript{266} During field visit senior officials of the Health and Family Welfare Department, Government of Orissa observed that the construction work of medical institutions such as District Headquarter Hospitals, Sub Divisional Hospitals, CHCs, PHCs were mostly taken up by DFID and OHSDP in Orissa.
by the DFID, its entire expenditure would be shown in the regular government budget. The staff would be both from the government as well as from outside.

During the field visit it was observed that this unit was trying to define its role and hence was at the level of conceptual formation. The DFID and the government of Orissa have been trying since 2002-03 to make this unit fully functional. However as building any institution takes time, the PSPU has also been taking its own time. Interestingly it was also known as the ‘Reform Office’. Through interactions with a senior World Bank official it was revealed that the World Bank was also trying to play a greater role through this agency. Therefore once this unit becomes functional, the World Bank would have a more decisive effect on the policy-making aspects with regard to health sector in Orissa. Also it would be for the first time in the state that donor agencies like DFID and the World Bank would be playing a direct role in health policy making.

**OHSDP:**

There has been another major reform initiative in terms of the Orissa Health Systems Development Project or OHSDP, which was wholly funded by the World Bank but surprisingly it has not been included as a reform initiative. In Chapter IV a detailed analysis of OHSDP has been made along with the State Health Systems Development Projects. This project carried a lot of significance because of two reasons. One was the involvement of the World Bank. Because the World Bank has got tremendous influence in economic policy making in India and as well as in the health sector, specifically after the 1991 economic liberalization by India. The second reason was the amount of money being involved in this project was quite big and in all the 157 institutions being upgraded under this project; user fees have been introduced to meet the maintenance expenditures.

The structures have been created in all these institutions. There has been some training of staffs in different categories undertaken in this initiative. The creation of contractual posts and the training of contractual staffs, introduction of user fees in these institutions

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267 These institutions were mostly secondary level institutions, however the three medical colleges and the Capital Hospital, Bhubaneswar was also included.
were part of reforms in the health sector. Due to the amount of funding which has gone into this project, it would act as a force multiplier for increasing the reforms in the health sector. The World Bank was also planning to do a second phase of this project.

The Sector Reform Cell:
The European Commission in the state was funding this office. It was part of the Health and Family Welfare Ministry, Government of Orissa. The European Commission was entirely funding this office and the expenditure incurred by this office was shown in the regular Health Budget of Orissa. This cell was created with the purpose that “Each of the non-SHS participating States would create or so designate an existing body as the State Health & Family Welfare Sector Reform Cell or SH&FWSRC. This Cell was created with the idea that it would have the mandate, authority and autonomy to drive the sectoral reform process and to take all actions necessary in pursuance of that objective. The SH&FWSRC was supposed to be chaired by the Principal Secretary or Secretary in overall charge of the H & FW Sector of the State.

Thus the Sector Reform cell was to be created in those states where there were no State Health Systems projects going on. Thus it could be assumed that this Sector Reform Cell in Orissa was created with the assumption that the state would not go for an OHSDP project in future. It was also assumed that SHS projects would create an institution, which would facilitate the reform process in a systematic way. Further the Sector Reform Cell was to be created to drive the sectoral reform process through an institutional mechanism, because in the absence of institutional mechanism, ‘reforms tend to become a series of individual initiatives, sporadic in nature and fragile.'

Further clearly identifying its domain of action it was observed “The SRC is additional capacity of the State Department of Health & FW for generating, prioritizing, advocating and assessing reform proposals in the health & family welfare sector across the State. Reforms would cover State-wide as well as district-specific aspects/activities, including

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268 Here the term SHS refers to State Health Systems Development Projects being financed by World Bank in different states of India.
270 Ibid.
donor supported activities.”

Therefore the Sector Reform Cell was supposed to generate, prioritize, advocate and assess various reform proposals in the health sector of a state and also in different districts within a state.

Ironically the role identified for SRC would now be fulfilled by DFID funded Policy Planning and Strategic Unit or PSPU in Orissa, although the scope of PSPU was little bit larger. Therefore during field visit to the state, the senior officials at SRC Orissa said that the main aim of this office had been to implement the health projects of European Union in Orissa. It was also observed that this office was engaged in selecting NGOs who could be involved in various health related IEC activities in the state. It was also engaged in selecting NGOs who could be given responsibility to operate single doctor PHC institutions in the state. Off late this office had come out with a draft plan about public private partnerships in the health sector of Orissa. There were people both from the government as well as from outside government of Orissa, working as consultants.

**Handing over PHCs to NGOs:**

It was introduced on a pilot basis to see whether this new arrangement works out or not. This measure was introduced in 1997. In remote and difficult areas it has been difficult to manage the PHCs, as the medical officer in charge remains absent for most of the time. There was also problem of maintaining the morale of the other staffs in these institutions. As a result the essential primary health care services were not available to the people in these areas. To address this situation, Government of Orissa came out with this innovative idea. Under this scheme one or two single doctor PHC institutions or PHC (New)'s were handed over to the NGOs. However it could not succeed due to the lack of resources and expertise on the part of the NGOs.

**NGO Coordinator:**

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271 Ibid.

272 As we have mentioned above that the PSPU intended to act as a think tank for Ministry of Health and Family Welfare, Government of Orissa. So it would mainly focus on larger policy issues, including health sector reforms. Therefore the creation of PSPU had clearly marginalized the Sector Reform Cell in increasing its influence in shaping the future health policy making in Orissa.

273 This was the view of senior officials of Health Directorate as well as of the officials from donor agencies.
The state government had also created a post of NGO coordinator, who would directly help the health secretary in coordination of different NGOs across the state. The NGO coordinator had been given charge of identifying mother NGOs\footnote{The mother NGOs were very big NGOs, under whom some small NGOs work or these NGOs had to be the bigger one's in terms of their operation in one district or in more than one district.} in the state who could be involved in various health programmes in the state. During the field visit it was told that these NGOs would be involved in implementation of National Rural Health Mission. Interestingly, while the NGO coordinator had been provided with an office in the Health Secretariat, no support staffs were provided and most of the time the office of the NGO coordinator used to remain closed.

It needs to be mentioned here that the NGOs in Orissa were involved after the 1999 super cyclone for relief and rehabilitation measures in the coastal districts on a large scale for the first time. However there were allegations of corruption against the NGOs. Therefore now even the government officials see them with suspicion\footnote{This was the view of one of the officials dealing with NGOs at Sector Reform Cell in Orissa.}. Further the NGO sector in Orissa was also very weak. There were no activists NGOs in the state. Except some grassroots level NGOs, they hardly did exist anywhere in the state. In this scenario the idea of involving them in the implementation of National Rural Health Mission seems quite surprising.

*Introduction of user charges:*

This was introduced in 1997 in medical college hospitals, all district level government hospitals and in the Capital Hospital, Bhubaneswar. The idea was to generate some funds for maintenance of equipments and furniture in these institutions. User charges have been introduced with the exemption for people living below the poverty line. For which services or for which diagnostic categories user charges would be charged, has been left for each institution to decide. For the district level hospitals, the money collected through user charges was kept in a fund under the Zilla Swasthya Samities or district health societies. After the 'success' of introduction of user fees at various district level hospitals, Government of Orissa was trying to introduce it to the sub divisional level hospitals. The user fees had been interpreted as a success story by the officials interviewed at various
levels. They were of the opinion that for petty maintenance of health institutions it had helped them a lot. However the questions with regard to exemption of the poor, the total amount of money collected compared to the total annual budget of an institution and users perception etc. need to be studied in detail.

Creation of contractual district cadre for paramedics:
Earlier the paramedical staffs were recruited by the state government and were assigned to different districts. However the staffs from coastal areas were unhappy to be posted in Western Orissa or to the interior parts. As most of the paramedics were female they had also the difficulties of staying away from their families. To address this situation Government of Orissa created district cadres for paramedics, where to be a paramedic in a district one had to be from the same district. However these staffs were now recruited on a contractual basis. One senior official in the Directorate of Health Department, Orissa was of the opinion that the creation of contractual posts would make the staff work better as they don’t feel the responsibility to work when they are in a permanent post. However another senior official of the nursing department in the Health Directorate, Orissa was of the opinion that it had acted as demoralizing factor for the cadres.

Privatizing cleaning in government hospitals:
Initially it was introduced in the Capital Hospital, Bhubaneswar and later it has been extended to three medical colleges and to some district hospitals. In these institutions government was no longer recruiting new sweepers. However the old staffs were retained and after their retirement no recruitment was done to fill these vacancies. Hence the idea was to give the cleaning aspect to the private sector.

Multi-skilling of health personnel:
This reform measure was introduced to utilize the existing capacity of the Lab technicians fully. Before the introduction of this new measure, a lab technician for TB used to look after only the TB slides and not for malaria or leprosy. This was thought to be a waste of human resources and also as unnecessary expenditure to recruit another lab technician for the same lab. This measure was introduced in 1998 all over the state. One
of the purposes of this initiative was to cut costs and use the existing resources efficiently and the utilisation of manpower effectively. Because this initiative talks about cutting costs and using resources effectively within the larger frame of fiscal austerity by the state government, it has been included as a reform initiative.

**Orissa Economic Review Package:**

This was not a reform initiative; however it has acted as a catalyst for health sector reforms in Orissa. The government of Orissa had taken loan from the World Bank under the Orissa Economic Review Package. Earlier it was named as Orissa Economic Revival Package. The aim of this Review package was to help the state of Orissa reduce its fiscal deficit. Under this measure the state government has banned any new recruitment either in health or in the education departments. It has to be remembered here that in Orissa, the government was the dominant job provider. Unlike western states like Maharastra and Gujarart, there was lack of a vibrant private sector, due to historical reasons in Orissa. In this scenario, people look upon the state as the sole provider of job opportunities. By adopting the World Bank policy of ban on recruitment, the state in most probability would ruin the education and health sector, which were already in a collapsing state. The sectors like education and health need more personnel unlike other sectors. The World Bank’s unified policies have already created havoc in countries of Sub Saharan Africa, where the basic health care structure got destroyed and now the HIV/AIDS was threatening to wipe out a generation of entire population in these societies.

Through interactions with senior officials in World Bank it was known that the World Bank was able to push for health reform in the state due to leverage they got with the

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276 Fiscal Deficit of a state suggests that its expenditure is more than its revenue. So, the fiscal austerity measures suggest that the state should be able to meet its expenditure through generating new income and cutting costs and by reducing the wasteful expenditures and subsidies in the social sectors like health and education. The idea is that the subsidies should be better targeted to the poor and the needy.

277 Of India.

278 For example if the higher education were not well funded, then where would the teachers for secondary education come from? And if secondary education were not well funded where would the teachers for primary education would come from? This was the view of a technical committee meeting, which was held at National Institute of Educational Planning and Administration, New Delhi in the month of August 2004.
state government through this package. It needs to be mentioned here that there was an element of secrecy about the nature of agreement between the government of Orissa and the World Bank officials about the nature of this package. This secrecy was emphasised both by the state government officials as well as from the World Bank. This particular aspect was seen as a matter of serious concern by many observers who say that while on the one hand the World Bank talks about transparency, in its own functioning it prefers to remain opaque.

There were other measures, which have been termed, as 'reforms', but has not been included here as 'reform'. We have termed these as systemic changes, according to our new definition of health sector reforms.

*Systemic changes:*
As we have already discussed that systemic change was a response by a system to remain effective for a new situation. Let us have a look at the different initiatives for systemic changes taken by the state of Orissa.

*Disease Surveillance programme:*
This was a major initiative taken in terms of surveillance of diseases in Orissa. Earlier the data related to outbreak of diseases were collected in an irregular fashion. Therefore timely interventions were not possible. However the situation changed after the 1999 super cyclone in Orissa. “With the help of World Health Organisation and Medicines Sans Frontiers and UNDP, Disease Surveillance Programme was started in 1999. Initially reporting was done on a daily basis. The UN volunteers were placed at the block level and later moved into the district level. The WHO was providing the technical expertise and Medicines Sans Frontiers was helping in streamlining data management system.

However once the severity had reduced, reporting started once in a week for ten diseases. These diseases were identified on the basis of burden of disease study

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279 One volunteer each for 10 districts and another two volunteers in two blocks. So 12 volunteers in total were provided by UNDP.
280 Like snake bite, skin infections, diarrhoea, acute jaundice syndrome, suspected malaria, suspected meningitis, measles, acute respiratory infections, unusual syndromes etc.
conducted by ASCI or Administrative Staff College of India, Hyderabad in 1997. Except for malaria other diseases were not included, to avoid duplication. Also vertical programmes have inbuilt surveillance mechanisms. Provisions were made that daily reporting would be done during natural disasters or outbreaks of epidemics. To identify the diseases WHO case definitions were used.

This whole initiative got reviewed by the health department and the DFID. Disease Surveillance mechanism initially started in coastal districts and later between January to July 2001, it was extended to the whole state and it was funded by the DFID. A second evaluation was done by DFID in 2002,” said one senior official in the state who had been closely associated with this program. However later the World Bank also provided some funding for this initiative under its OHSDP project.

Unique features:

About the Disease Surveillance Program the official further said, “The unique features of this initiative were, one- reporting at sub center level and two- entire rural health machinery was being involved. The report goes from sub center to the block PHC level and from there it goes to ADMO public health at the district level. From there the report is sent to the State Disease Surveillance cell, which is chaired by joint director public health.

Earlier there was a monthly communicable diseases statement report for 17 diseases and it was done at the upwards to the block PHC level. At the end of every month a pharmacist used to send a monthly report from block PHC to the district level. There were no definition of diseases nor there were records maintained as to how this data was compiled.” The official said, “The incubation period for many communicable diseases is 10 to 15 days and hence one month was not enough to check any outbreak... In this entire process OHSDP also joined hand in 1997. They provided hardware in terms of providing computers to districts, data entry operators at the districts and at the state surveillance cell. They also provided the software component in the form of Health

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281 Here it refers to Ministry of Health and Family Welfare, Government of Orissa and DFID of the Orissa unit.
Management Information System, which was developed by TCS\(^{282}\). It was put in place in 30 districts and in the state disease surveillance cell. All information at district level was computerized. Reports were sent by e-mail from 20 of the districts and another 10 by fax. Also there are well defined deadlines."

Further the official added, "Every Saturday ANMs bring reports to their sector level meeting at block PHC. One paramedic was to send the report from block to the district level. This was arranged by OHSDP. The paramedic concerned was given some honorarium. This was withdrawn in April-March 2003 and from then onwards the report was sent by phone or fax."

The official further added, "At the district level, there is a post of Assistant Health Officer who investigates outbreaks of epidemics and to analyse data on a regular basis. The data entry operator compiles the data, enters in the computer and takes print outs and transmits it to the state level. Thus ADMO Public Health, Assistant Health Officer and the data entry operator act as a team at the district level... In fourteen to sixteen districts data analysis is done once in a week. The government of Orissa is planning to introduce in all the districts the post of Assistant Health Officer or AHO. The existing AHOs get training at National Institute of Epidemiology, Chennai according to WHO guidelines. Besides the OHSDP has supplied vehicles and mobility support for the disease surveillance programme."

The official said, "Most of the Health Systems Development Projects has an inbuilt disease surveillance component. However this component has not done well in other states. Three things, adequate training, technical support\(^{283}\) and facilitation are required for its success."

About the training of the staff for this program the official said, "In the last round of training 4600 to 4700 medical officers and 15,000 paramedics were trained in periphery

\(^{282}\) Tata Consultancy Services.

\(^{283}\) Which was at present being provided by the World Health Organisation in Orissa.
level health services. The team at the district level was given technical support by UN volunteer doctors. One UN volunteer is at present managing two districts. Later on one volunteer at the state level will manage all the districts. At present there is one WHO health coordinator is there at the state level for this disease surveillance programme. Due to this programme we have now data of last four years.”

Mentioning about the State Surveillance Cell the official said, “Here weekly meetings are held every Friday when the technical committee constituted by Joint Director Public Health, State Surveillance medical officer, State Epidemiologist, an expert from WHO or UNDP and another health consultant from OHSDP held their meeting.”

The introduction of disease surveillance mechanism in the state was being seen by many as a success story. However there were some questions, which need to be answered satisfactorily before we could make any judgement about this program. The first and a major question were about the aspect of ANMs’ collecting data from the field. As we have discussed earlier that the periphery level institutions in Orissa had almost collapsed, so how the data collected in these circumstances could be relied upon? During the field visit it was also observed that due to structural constraints, the ANMs used to visit the fields rarely and many of them were found to be ignorant about various national programs. Therefore even if an ANM has collected some data with regard to different diseases, could it be said with certainty that the diseases had been identified correctly? So was there a gap in this program in not identifying this structural problem?

New Drugs Policy:
The basic driving force behind this new initiative was to cut costs and to make available quality drugs to the people who utilize government health care services. The new drugs policy was introduced in 1998 and it was from the adoption of Tamilnadu model. The principal features of this policy were: central procurement of drugs, adoption of an

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284 Periphery level health institutions were CHCs, PHCs, PHC (New) s and Area Hospitals and sub centres etc.
285 UN volunteer doctors were mostly fresh medical graduates with willingness to work in Public Health. They were attached to ADMO Public Health and the CDMO at the district level.
essential drugs list from WHO and shifting from brand drugs to generic drugs. After these new measures the drugs were purchased at the central level through an open tendering system and distributed to the districts. This helped in reducing corruption to a great extent. Thus with the new drugs policy the cost of drugs got reduced and the quality of drugs available in the government run health services institutions improved.

It has to be remembered that these initiatives in the drugs sector was applicable only for the government health care sector. WHO had conducted an impact study of this new drugs policy in the state and their study found that drugs were available in more than 85 percent of the government institutions.286

*Pancha Byadhi Chikitsa Scheme:*

The above term in Oriya means treatment for five diseases. This scheme was introduced in 1999 and it had identified five diseases like, *leprosy, malaria, acute respiratory infections, scabies and diarrhoea*, which would be treated free of cost at any government institution287 and medicine would also be provided free. After doing an epidemiological study it was found that these diseases were the major reasons for more than 70 percent of morbidity and mortality in the state. Hence this scheme was introduced.

*Petty Maintenance for Buildings at PHC headquarters:*

Here Rs 10,000 per year was to be given to the Medical Officer in-charge at the block headquarter PHC to spend for petty maintenance expenditures in his or her own discretion. This has not been included as a reform measure in this study because this initiative tried to improve the functioning of a government periphery level institutions and it did not fulfill our definition of reform.

*Mandatory Pre-PG rural service:*

Under this scheme any medical graduate aspiring for a PG degree from any government medical college must serve for one year in rural and remote areas after getting selected

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286 This was revealed by senior officials involved in new drugs policy of Orissa.
287 Starting from a sub centre to PHC, CHC, Sub Divisional Hospital, District Headquarter Hospital and Medical Colleges.
for a PG course. This was introduced to address the absence of doctors in rural and remote areas in periphery level institutions like PHCs.

**Internship training for medical graduates:**

This scheme was introduced in the year 2000 to train medical graduates for Social and Preventive Medicine course under the guidance of a CDMO. This new measure was introduced to give exposure to the medical students about how the periphery level institutions like PHCs and CHCs function at the grassroots level. This was a revised course curriculum for the medical students to give them a comprehensive training about the preventive aspects of health care.

**Creation of Zilla Swasthya Samities**[^288]:

Earlier there were different societies for different diseases like malaria, TB etc to manage them at the district level. Funds were also maintained separately. However to improve the better management of different societies, it was decided to amalgamate all these societies and to create a new society in its place with District collector as the chairman and the CDMO or Chief District Medical Officer as the secretary. This scheme was introduced in 1999. This new scheme also aimed about making effective the district level societies. For example if the funds under TB had been almost zero and there was a case of TB outbreak in the district, then under this new mechanism, funds under other head could be transferred to meet the demands of the situation and later when the funds for TB comes, it would be transferred to the head from where it was drawn. This facility was earlier not available. Interacting with officials at different levels in the state it was learnt that creation of ZSS has helped a lot in addressing emergency situations.

**Criteria for reform elements:**

In this study we have defined health sector reforms in terms of an element of private participation in the changes introduced in health sector in the state. Using these criteria we have selected the above elements as reforms and those, which could not fulfill these

[^288]: See the structure of ZSS in the annexure of this chapter.
criteria, has been termed as systemic changes. However in both the cases we have looked at the structural constraints in implementation of these new initiatives.

The above criteria of selection of different initiatives as reform or not has significant repercussions. For example the new drugs policy could not be accepted as a reform initiative. Why? The reasons were that all the three new elements introduced in the drugs sector in Orissa, namely, central procurement of drugs, adoption of an essential list from the WHO and shifting from brand names to generic names, were basically measures aimed at improving the quality of drugs available at government institutions and reducing the cost of drugs purchased by the government from the private parties to be made available at government institutions. Hence here hardly any element of 'reform' according to our definition was there. However this new drugs policy by the state government could be termed as a measure towards improving the system of drugs supply while ensuring the quality drugs being supplied to the public from a government health institution. These changes could at best be termed as revisions by a government department to improve its performance and to respond in a better way to the needs of the public. On the other hand terming these initiatives as 'reforms' was not appropriate.

Any system tries to respond to the new challenges that it faces in its day to day functioning. With due course of time many of its elements, which were created with a particular set of purposes in mind, are not able to respond to the new challenges and hence these elements need to be replaced by other elements which could cope with the new challenges in a better way. Those changes, which have been termed as reforms, were in fact an attempt to make the system respond to the new challenges. However terming these changes as a reform initiative was problematic.
The process and experience of reforms:
In this section we would be discussing about the process and experience of reforms from the field interviews with government officials as well as from the donor agencies in Delhi and in Bhubaneswar, the capital of Orissa. In the context of Orissa it was clear that to understand the process and experience of health sector reforms, we need to also look at the processes which initiated systemic changes, because at the policy making level these were not separate processes.

On the process of reforms:
Talking about the process of reforms in health sector in Orissa, one former senior official from the government of Orissa said, “We undertook broad reforms. There are large reforms and there are small reforms. These reforms are changes in the system rather than temporary change. A much better system of health care was the intended outcome. The quality of health care was intended to be changed. With these objectives the reforms were started.” Therefore the changes introduced were not temporary changes and they were intended to improve the quality of health care available in the government health care institutions.

Two events:
The official added, “There were a lot of interests in the reforms. DFID has been supporting health programmes in Orissa since 1980s. But at that point of time … the state evaluation showed that while structures had been put in place, quality had not improved. That was because certain systems were faulty. There were some clear problems in certain areas. They identified three areas called three M’s…medicine, maintenance and mobility. Medicines…generally availability, cost appropriateness etc. Maintenance of vehicles, of buildings, of equipments etc. which had broken down. Mobility…there was not enough money for TA, for supervision.” Therefore the initiatives for reforms in health sector started with these changes. Although these changes were systemic in nature they paved the way for reforms in the health sector.
What the interviewee was trying to say was that the UK funding agency DFID was involved in the infrastructure projects in the state since early 1980s. Although investments were made in the building of primary health centers and sub centers in different districts, the maintenance was in bad shape. Hence a stock of the then existing situation was taken by DFID. The second event was, “The Orissa Legislature set up a house committee. They also found various problems in the health sector. So the time was ripe for health reforms. When I joined in 1996 as health secretary, I thought that situation was right to introduce a number of reforms because the political atmosphere was also there and various evaluation reports had also come up. One of the things in any reform... because you have to study the situation, plan it out... all that...but there is also the other side of it. If you don’t start...then you plan, you examine, you study and by the time you start, may be you get transferred. So there is nobody then to champion that. So my feeling was that small or big, the study should be done very quickly and the reform should be started very quickly. Of course the situation had to be studied about what would work and what would not work.

But I do not think that the study should be very detailed or over a period of time, because by that time the momentum is lost and the person who is pushing it may have been transferred. Every reform has to have a champion. Reform will never be brought about if you are not passionate about it. If you think that let’s do something, ok... we will have it...five different people will decide...it never happens. Reforms have to have a champion in my view and that champion has to push it very hard. So, since tenures are uncertain in the states and you can never be sure... once you got your department that you will stay there for a certain period of times...two years...three years...four years, long enough to study it, examine it and then initiate it. My view was that we should take opportunity as and when it comes and with some preparation you should start. With this in mind I had taken up various reform initiatives in the state.”

Therefore the observations of the respondent here were very significant because here the respondent was mentioning about the constraints of initiating reforms in a democratic set

\[289\] At that time it was known as ODA or Overseas Development Assistance.
up like India could occur, where a bureaucrat could be transferred at any moment. Therefore even if an initiative had been taken it would just remain there and when a new person comes in nobody knows what might happen. Thus on the one hand to initiate reforms one need to study the ground situation because then only one could expect that the initiatives taken could have an impact in the field. But on the other hand the relationship between a bureaucrat and a politician in Indian context was such that if one goes for an intervention which was supported by well researched study then by the time the findings were published, the person who might have taken the interest in these reforms would get transferred. But here the question arises that why this kind of situation occurs at all? Was it the case that there was no consensus among the political leadership for reforms in health sector? Therefore from what the respondent was talking about it seems that reforms in health sector in Orissa were initiated half hazardly. Or could we say that in a democratic set up like India it was very difficult to start a reform process with broad political consensus?

On preparing the vision document:
But how the vision document was prepared in the first place? Was their wider consultations held?290 “It was entirely in-house. It was not done by donors. It was entirely written by us. Then after it was ready, we gave it to the donors also and to various government departments in the state and we did all kinds of consultations.....We had consultations with doctors association, nurses association, multipurpose health workers association and other group workers...why things are not functioning as far as they are concerned or are not functioning as they should? So all this we did. Then we redrafted the document many times and then we prepared the vision document, which we got approved by the cabinet291. But the vision document was also drawn up from my seven years of being in the health department and from the reform experiences. All this was used to form the vision document,” said the official. Thus the vision was prepared by consulting various levels of health officials within the government of Orissa health services

290 This question was asked because one of the senior donor agency officials had claimed that donor agencies were consulted prior to the creation of Orissa vision document 2010.
291 Here the term ‘cabinet’ refers to the Orissa state cabinet ministers.
structure. This document could also draw from the years of experience of various officials at various levels before it was passed by Orissa cabinet.

Here the respondent was mentioning about the wider consultation process held with different stakeholders in the health care system of Orissa. However these consultations were not systematically held and were selectively conducted by the top officials from Health and Family Welfare Department, where the need for the consultation was felt from a particular section. Because from the interviews with CDMOs in two of our study districts it was revealed that there was no consultation with them and they also had said that they had no knowledge that other CDMOs were consulted about the reform process initiated in Orissa.

Need for a vision document:
But the question arises as to what was the necessity for introducing a vision document? “What we did after that was...you know the vision document sets out what needs to be done. There are a number of donors also working in Orissa and we wanted to present this vision document to them. Then what we thought was that once we have a vision document, then donors don’t come out with their own programmes. Prior to that particular donor says ‘I am interested in women’s health so I will have a programme on women’s health.’ Somebody else come up and says, ‘no I am interested in upgrading hospitals, as buildings are very bad... so let us have hardware, like your equipments need upgraded etc.’ Somebody else comes up and says ‘we will build ANM centers.’ So each donor used to come with its own interests, which was partly dictated by its own mission.

But what we thought was that it was not always what we needed. And therefore once you put a vision document, which lists out all the things that the state needs, then the donors can read that document and can say, ‘ok my interest is in this part.’ They don’t come readymade with an idea that I want to work on women’s health. They will look that ‘yes women’s health is a problem and that’s my interest and I will support.’ Somebody else looks at the document and says, ‘communicable diseases are an important part I am interested.’ It’s not that they come in and the state accommodates...ok you want to have
programme for AIDs... we will support or you want to have programmes for tuberculosis... you want to have programme for building sub-centers... Instead of that what’s the state’s requirement and the direction in which the state wishes to move... What is it the state wishes to achieve? Where does the state wishes to be in certain number of years and how does it wish to do that? What is the path it wishes to take and then any donor who wishes to work in the health sector can read the document and say, ‘well this part of the document concern my mission statement, my objectives, therefore I will work in it.’ Or ‘this part of it reflects my interests, which is poverty alleviation and by doing this health programme we feel that poverty will be addressed.’

So by making the document we spell out how the state wants to do and then donors who wish to support can come in... can support any part of that document. That was the intention. *It will not then be donor led but it will be state led.*

So here by explaining the rationale of a vision document the official was mentioning about the way donor agencies function in a state like Orissa. These were practical difficulties about coordination of donor interests with the interests of a particular state. Because each donor have their own mission statements and accordingly they try to implement their programs to achieve some targets. But the state also has its own priority areas where it needs to intervene. Therefore if a vision document of a state was there then the donors could choose from this document and accordingly go for an area of their interest. This was an important initiative by the state of Orissa because the idea was that the democratically elected state government had a better understanding of the realities of Orissa health sector and hence if they come out with a vision document then it would not only help in donor coordination but it would also help the state in better utilisation of its limited resources in terms of priority areas of interventions.

“Of course there are many things also beyond that. *If you have too many donor programmes, it becomes very difficult to manage because each one has their own reporting system.* You know, DFID has their own reporting manner, DANIDA will want in a certain periodicity or in a certain pattern. EU will want in a certain pattern. So each
one has different criteria," said the official. Therefore this different reporting pattern also puts burden on the state to provide data about the impact a particular intervention might have made, to a particular donor agency.

“What we also hope would happen\textsuperscript{292} is then everybody supports the Orissa health plan, which is part of the vision document and without saying that, ‘I am supporting the TB programme and you report to me about the TB programme.’ ...I am supporting let’s say family welfare programme or immunization programme and you report to me on that. Instead of that they look at the vision document and say that yes we will support this and this... but individual reports will not go. This is called sector wide programme, where everybody supports the sector but not specific parts of it...may be it’s specific but not segmented with different norms of reporting. That’s an ultimate kind of hope because the management of so many different donors, so many different kinds of reporting, and so many different kinds of programmes is very difficult. Each one starting at a different year, some going on for five years, some for seven years, some in three districts, some in eight districts... you know all kinds of combinations... all kinds of programmes.”

Therefore here the respondent was trying to put the point in a very straightforward manner. It was suggested that if all the donors would support the vision document and choose their areas of intervention from this document then it would not lead to overlapping of programs and the present system of different types of reporting for different donors, which takes a lot of time won’t be required. During the field visit it was observed that donor agencies had taken up few districts to present their success story as a role model, which could be replicated by the state in particular, and also by the adjoining states. Their aim was to show some results. But they were not functioning to fulfill the larger health goals of the state.\textsuperscript{293}

\textsuperscript{292} This hope was based on the publication of Orissa Vision Document 2010, which was supposed to act as a guideline for donor agencies operating/interested to work in Orissa.

\textsuperscript{293} For example the work of UNICEF and UNFPA in Orissa fall in this category, where they were trying to intervene in certain selected districts to show results to their own funding sources as well as to the state governments. The whole point was about making their presence in the state a legitimate one. But in this process the larger picture was being missed.
Continuing with her views the official said, “So if you have one document first of all they will select what you think as important and what you have put up and ultimate objective is that then they don’t have individual donor problems. They support the health sector. The report will go to all of them, one common report; because they have to of course meet… their constituency…money is coming from their taxpayers. Therefore they will have to show to their taxpayers that this is what we have done. So some kind of reporting is required. But we don’t have to have different kinds of reporting to different donors. So this will ultimately happen…not an easy thing. But certainly the state could say that this is where we want to go. This is where we want to go in medical education. This is where we want to go to family welfare, in child health, in infant mortality, in communicable diseases, in aurveda, in traditional medicines and homeopathy. All these things and taking into account the problems that the state has…certain constraints the state has. For instance the state has a problem in getting enough doctors…don’t have enough graduates…they do not want to go to remote places. We had taken up many reforms to address that but this is a long-term thing and not something, which you can do today and feel that it is solved. It’s a major problem. What do you do about things that ANMs stay in their fields they are posted…? So we looked into the constraints of the state. We looked into what could be done and we looked into the needs of the state and then prepared the vision.”

Hence if a single report was prepared by the state and then it was circulated among the donor agencies, it would fulfill their criteria of showing some outcomes of the money they had invested and it would also be helpful for the state concerned. The interviewee was also mentioning that in case of Orissa the vision document 2010 was prepared keeping in view the structural constraints of the state, like where the strengths of the health services in the state was, which areas would require more attention, which areas would require more time for achieving any health outcomes etc.

*Reasons for formation of the House Committee:*
The formation of House Committee in the Orissa legislature in 1996 had been mentioned as the factor, which paved the way for initiating reforms in health sector in the state. So
the question arises as to why this house committee was formed at that time? "The House Committee\textsuperscript{294} also made recommendations on the attendance of doctors and cleanliness of hospitals etc.\ldots. Health is something, which affects everybody and in Orissa unlike other states, most of the health is government provided or most of the health providers are government institutions. Very few private hospitals\ldots.at best few mission hospitals. In Cuttack and Bhubaneswar also big hospitals are few. They are mainly small nursing homes\ldots.now Kalinga hospital is there. So private health care is practically missing\ldots.ok \ldots.individual doctors are there. In the rural areas individual private doctors are hard to find. The government doctors who are there mostly do the private practice\ldots. Because health is generally provided by the state and health affects every human being, every citizen of the state. Hence it is natural that people get agitated with any problem in health\ldots.quality not so good\ldots. and people's representatives\ldots. MLAs\textsuperscript{295} reflects the people's wish and therefore this committee was formed. So the climate was right for change and we took that opportunity to bring about a large number of changes," said the official.

This was a very significant observation. The officials said that Orissa was a state where the presence of private sector was almost non-existent and in cities like Cuttack and Bhubaneswar there were small nursing homes and only few big hospitals exist in these cities, otherwise it was the government sector which was having presence everywhere. Therefore it was quite natural that when this government health system was not functioning in certain aspects than the people's representative had to raise the issues of availability and quality of care in Orissa Legislature.

For our purpose it was important to notice that the argument for more private participation in Orissa health sector by the donor agencies as well as by the government health officials at different levels of health services structure in Orissa, misses this important point that Orissa was a state where not only the government sector was the major provider of health care, the presence of private sector was almost negligible even in cities like Bhubaneswar, the capital of Orissa. Therefore the question arises as to

\textsuperscript{294} Of Orissa Legislature.
\textsuperscript{295} Members of Legislative Assembly in the state.
whether the arguments for creating more space for private sector were influenced by a uniform model of reforming the health sector?

New Drugs Policy:

In case of Orissa the first thing, which was thought to be requiring urgent attention for intervention was the then existing, drugs policy. This was mentioned as a priority area requiring intervention by the DFID report at that time. The new drugs policy in Orissa has also been widely appreciated and has been termed as a success story. So the question arises what were the changes made in drugs policy at that time? Responding to this the official said, "Now in this system what happened...we were ordering but it was being verified in the district level. So at the state level we were telling the districts that we have ordered one lakh of these tablets for you and it is being delivered by such and such persons and we also test the quality. Once it goes to the district, the district sends us the sample. It is not that I am not taking samples, which the manufacturer gives...may be he is giving me few good samples...I am saying it very good.... It is going to the districts and districts are sending the samples to us. If the district feels that it's the bad quality and...that they are sending and we are testing it. Now, if I send one lakh tablets of a particular kind, until the district certifies that...yes, one lakh tablets have been received then I am not making the payment. Main advantage of this system is that...one; you don’t have multiple points of ordering and multiple points of payments, which lead to increase in costs. Suppose I am a drug supplier, if I have to get 30 different orders for 30 districts and then for three medical colleges...then 33 orders I have to get. Then every order will be small and the interior districts will be very small. So I will not go at all...why should I take the trouble of sending small quantities there? Because I will go to Cuttack, I will go to Khurda, I will go to Berhampur and I will say you buy...and I am not bothered about whether Malkangiri gets or not. Because profit is very less and what happens when there are 33 different purchasers... There are so many drugs. Now which drugs to buy, it was up to the CDMO... Now... the CDMO does not have the time

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296 While in the earlier section of this chapter we have discussed about the new drugs policy in brief, here we have discussed about the process involved in formulation of new drugs policy in Orissa.
297 It needs to be mentioned here that Orissa had 30 districts in total.
298 Cuttack, Khurda and Berhampur were among the developed districts of Orissa.
299 Malkangiri was one of the poorest districts in Orissa with very low health indicators.
to write to 50 different people.\textsuperscript{300} So what would happen is that, one particular drug...suppose I am the supplier of one particular drug or two drugs and I go to the CDMO...give me contract. So the CDMO thinks that my money will lapse by 31\textsuperscript{st} March and the list was usually ready by let's say December-January. So I have only three months...by the time I order, I won't be able to give the payments. So let me give order to this person or to five people... I don't buy all the medicines that I require and there is no assessment of quantities of medicine."

So what were the changes made in the new drugs policy? First the new system introduced central quality checks. So the drugs were purchased centrally after quality tests by the state government and then they would send the required quantities to districts and ask the districts to report them whether the drugs were of good quality or not. After the districts mentioned that the drugs were of good quality then only the payments were made to the manufacturers. But if the districts mentioned that the drugs were not of good quality then they would send some samples to the state government for further verification. The second aspect was about purchasing of drugs centrally which was in contrast to multiple points of orderings and payments. In the earlier system it was not financially profitable for the manufacturers to send drugs in smaller districts as well as to districts having bad road connectivity and also as their volume would have been very small. So these districts used to suffer due to lack of adequate and quality drugs supply. The new system addressed these lacunae. Thirdly it also addressed the issue of structural constraints the CDMOs used to face in purchasing drugs.

"We changed all that. We reduced the list. Earlier we had huge list of several hundred drugs.... We took the WHO list, got all the doctors, asked them what are the drugs required. We got all the requisitions from the districts and then we came down to the minimum. So first we reduced the list and then made a central drugs list and then made an assessment of the quantities required...then we got the tenders and finalized the bids...then we ordered the medicine.... But we said, so much in Sundergarh, so much in

\textsuperscript{300} About the required necessary drugs in the district.
Sambalpur, so much in Nuapara, so much in Gajapati\textsuperscript{301}...and when they delivered...and they\textsuperscript{302} would give an acknowledgement and then we paid. So there is no way of cheating. Because...suppose I have an agreement with the drugs supplier and say that instead of one lakh tablets you give me fifty thousand and I will pay you for one lakh and you give me a kickback...The man at Sambalpur, he is not going to write one lakh when fifty thousand tablets have been given. Is not it? There are so many checks. There are 30 districts and 3 medical colleges. Why would everybody agree to write a false thing? So...there is no way they can tie up with the manufacturer...also because they\textsuperscript{303} are not paying. So suppose a manufacturer gives them... instead of one lakh, fifty thousand and they write one lakh...then the manufacturer will not be paid by him; he will be paid by me.\textsuperscript{304} So there is no guarantee that the manufacturer will go back to him and say ok, you wrote a higher amount and this is your kickback. Why? Because he does not have any control on him. So, there are checks and balances,” said the official. Therefore first the drugs list was reduced by following the WHO guidelines for essential drugs and this was being supported by feedback from districts and various medical officers’ opinion about essential drugs required. As payments were made centrally there was no question of misuse of money by the CDMOs as it was earlier the case.

*Ensuring quality:*

But what about the quality of drugs being procured from the manufacturers? Continuing with her narratives the official said, “And then the quality is very important. Earlier what people doing were...they were all ordering, as time was limited. All these small-scale industries were going and they were giving rotten medicines...I mean absolutely third rate. What we did was that every batch of medicine we tested. We got samples from all the districts and the same batch we sent samples to two private laboratories about which nobody knew. If the laboratory says it’s good, then it’s ok. If they say it’s sub standard, then we send the same batch of samples to two more laboratories. If one of them again says it is bad then we ask the supplier to take back the entire batch.... But what I am

\textsuperscript{301} Sundergarh, Sambalpur, Nuapara and Gajapati were the districts of Orissa.
\textsuperscript{302} Refers to the districts. That was when the drug supplier has delivered the medicines in a particular district; the CDMO would give them an acknowledgement of the medicines received.
\textsuperscript{303} The CDMOs.
\textsuperscript{304} Here it refers to the central purchasing of drugs.
trying to say is, we worked out a full proof system. And the supplier also...they could give us in much lower rates. Why? Because instead of going to 30 districts to collect their money... he goes to Sundergarh and says ok I have supplied so much and my bill is RS 2,500, please give me...How much manpower and how much time he requires to go to all these districts... Once you go the money may not have come, the allotment may not have come or may have exhausted. So they would have to make five trips. And therefore either they do not supply to the small districts or they make their rates very high. Because if I have to go five times to collect that money and I have to go to 30 places to collect the money, that means I will bill it all into my cost."

Therefore in the earlier system it was a cumbersome process for the manufacturers to approach 30 districts of Orissa and as a result it was also not cost effective for them. With the new system for quality checks a well laid out mechanism was created. Once the samples from different districts were received they were sent for quality tests to two private laboratories305 and if there was any doubts then again this batch of sample was to be sent to two more laboratories and if here also doubts were raised about the standards of medicines then the manufacturer would be asked to take back the entire batch of that medicine.

Continuing with her narrative the official said, “Here what we did was we paid at the central level. So, provided you have delivered, provided they have given an acknowledgement and say that you have delivered... we pay 90 percent and when we get the test report we pay the remaining debts. We also got the system evaluated by Delhi Society for the Promotion of Rational Use of Drugs. They said that it is such an excellent system that it should not only be emulated by other states but also by other countries.... Due to these new initiatives availability of drugs has increased tremendously.” So the new system not only ensured the quality of drugs being supplied it also helped in increasing the availability of drugs in government run health institutions.

305 Which were outside the state of Orissa and their whereabouts were kept secret.
“The other thing that we did was earlier what was happening...there is a community health center. Let’s say they get Rs 30,000 worth of drugs. When they ask for the drugs...so from the district they would say ok you take this and this and it is worth Rs30,000, so you take it. They did not have a chance to choose. So, they cannot say that I want A, B, C, D... and you give me this. The district would just say ok you need Rs 30,000 worth drugs... you take. Whether it was worth Rs 30,000 nobody knows. It may be more... it may be less. But it was not what the CHC or the PHC chooses.

Under the new system we give each of them a pass and we give them a list. Certain lists at primary level, certain lists at secondary level...and then they would write...we want this...we want this and it would go and then that they would be given. And because all these centers where we supplied...monitored over Internet by e-mail. So at any point of time we know how much drugs were available in a particular district store,” said the official.

So in the earlier system at the periphery level institutions like PHC or CHC they had no choice from the district headquarter about the type of medicine they required and they had no way to ascertain that they were getting this much amount of drugs. The new system provided them with a pass and a list of medicines they can get from their districts. And as all the drug stores in 30 districts were connected by Internet, the State Drugs Management Unit had information about the quantity and type of drugs available at each of these stores. So if a drug was available then they could not deny it to the particular PHC or CHC concerned. The pass system also ensured that these periphery level institutions could get their share of drugs.

How could new Drugs Policy succeed?
But the question arises as to why in spite of lot of opposition drugs reform\textsuperscript{306} could succeed? Replying to this question the official said, “Actually you know, for any change

\textsuperscript{306} It needs to be mentioned here that the interviewee was asked about ‘drugs reform’ and not about new drugs policy because the ‘drug reforms’ has been used as a conceptual category in this study and the respondent had termed this new initiative as ‘reforms’ in the drugs policy. Therefore it was deliberately
there will be opposition, even if it does not go against the vested interests. They are used to a certain way of doing things and somebody comes and says ‘no no this way not correct and actually may be other is better,’ but you are used to it and you don’t want to change. All change is difficult ...is opposed.” The official here was mentioning about the typical bureaucratic culture in countries like India, which was resistant to any kind of change.

“In drugs we got a major change. There was opposition. Interests were both... those who purchased at the district level and those who supplied...because there was no quality testing, so anything could be given. There was nobody else to check the quantity. I order you, you give me. I order Rs1lakh and agreement with you is Rs50,000 thousand and I sign for Rs1lakh. There is no third person coming. You give me Rs50,000 and I sign for a Rs1lakh,” said the official. Thus in the earlier system as there was no checks and balances, at the CDMO level corruption was rampant. Hence when the new system was introduced it was opposed by both the CDMOs and the local manufacturers as both of them were going to loose.

Continuing with her narrative the official said, “... The opposition was mainly from the people who purchased\textsuperscript{307} and the small-scale industries that were getting lots of benefits because they were giving sub-standard medicines. But it\textsuperscript{308} got approved initially. It’s only later that people got to realize that it was hitting them. So initially we had lots of opposition. In the Assembly they said, we were buying IV fluids for Rs 22 and now they are getting it for Rs 9, how is it possible? It must be just water. We said saline is only water and salt in a sterile condition! But the rate was high because you were making it very expensive for the person to supply it...We said that no, Tamilnadu gets even cheaper...Their system was better perhaps. We were just starting...So when they realized that availability of medicine was tremendous.... Doctors were also discouraging patients

\textsuperscript{307} Here it referred about the CDMOs.
\textsuperscript{308} Here the respondent was mentioning about the new drugs policy.
earlier...and would say that you purchase from outside as sub standard medicines were coming. Gradually the doctors found that no...it was of good quality.”

Therefore here a good example has been provided about carrying out reform process in a democratic set up like India. So those who were affected by this new drugs policy like the CDMOs and the local manufacturers, they approached their local MLAs to raise this issue in Orissa Legislative Assembly. But when the actual benefits of these new initiatives were argued then this opposition gradually had to yield.

The same question was asked to a person in Orissa who had been a part of drugs reform in the state. The official concerned said, “There was opposition from group of CDMOs, and few doctors instigated by local medicine shops, some drug companies and from within the department opposition was from the local drugs inspectors.” Therefore opposition was also from the local medicine shops and the drugs inspectors who could make money out of low quality drugs from the manufacturers. Another official in the PSPU who had been closely associated with drugs reform said, “Earlier the CDMOs were hand in gloves with the local manufacturers. Now neither the drug budget nor the weir houses have changed but 90% of the resources are being used. Earlier it was the reverse.”

The official further said, “Earlier the local manufacturers were providing very sub standard drugs with almost no quality checks. There were many repackaging industries that would be bringing medicines from Calcutta and Hyderabad and package and sell it where they had 10% profits. These local manufacturers have made lot of money through selling bad quality drugs to the state in connivance of the CDMOs. And they used to spend their holidays in Goa, Calcutta or Mumbai with this ill-gotten money. There was no way to check quality of drugs being supplied”.

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309 The official was giving an example that in case of bandage no supplier was complying with length and breadth. Earlier their profit was 500 to 1000 times. And in case of threads weight had been given so that it could not be manipulated.

310 PSPU or Policy Planning and Strategic Unit had started as a nodal agency by DFID to work as a think tank for the government of Orissa, for formulation of health policy and for implementation and monitoring of these policies.
So there were vested interests and still the reforms succeeded. So when this official was asked for reasons he said, “It’s very simple. The total amount of money for drugs in one year is Rs 10 crores. And this includes the money invested by donors like World Bank in the drugs. This is a very small amount compared to say construction of a road, where for one kilometers of construction work, Rs 1 crore is involved. Hence chances of making money are good. The second important reason was that the then health secretary was very much determined that the reforms should succeed”. So the new drugs policy could succeed although there was so much opposition because the total amount of money involved was very low and because of the backing of then top most official of Health and Family Welfare Department of government of Orissa.

Continuing with the narrative the official said, “Some politicians argued that the state is planning conspiracy against local manufacturers and some even went to the extent that the state will purchase drugs from the multinationals. To this we said that we would give preference to you while purchasing drugs, provided you apply through the tendering process and subject yourself for quality tests. The term quality test was anathema to them. They were not used to it!” Thus adopting a wider consultative process with all the stakeholders, like CDMOs, local manufacturers, Politicians etc. and keeping the door open for any suggestion helped in bringing the much needed changes in the drugs available in the government sector.

Borrowing from Tamilnadu Model:

Whether a part of the Tamilnadu model was adopted for drugs reform initiated in Orissa? Replying to this question former health secretary said, “No, it was the whole of the Tamilnadu model that we adopted. In preparation of protocol we had gone beyond Tamilnadu model. Protocol meaning how you treat a particular disease. Suppose it is diarrhoea, how you treat it? What is the appropriate treatment about which all the experts agree? Then you workout how many people suffer from diarrhoea and what would be the

311 The person concerned was a medical officer earlier in the State Drugs Management Unit or SDMU and currently was in the same post in Policy Planning and Strategic Unit or PSPU.
requirement of these medicines which are proposed? Your purchases are also done on that basis. So you can workout a requirement on the basis of the protocol. So the protocol...and we also had five diseases programme.\textsuperscript{312} That was an important innovation/initiative that we took."

So while the whole of Tamilnadu model was borrowed, another addition to it was made in terms of introduction of protocol for various diseases in Orissa. Therefore it seems that the new drugs policy was a major systemic initiative taken by the state government in the late 1990s.

\textit{The context of health sector reforms:}

Elaborating about the role of house committee in the state legislative assembly of Orissa, a senior official of DFID in Delhi said, "A son of a member of the House Committee had died in the Capital Hospital, Bhubaneswar, due to lack of essential drugs at right time. And that member was quite an influential person in the state legislature. And because of intervention from him the initiatives for reforms started in the state". This was an important observation from an official closely involved with health sector in Orissa. This reflects one of the unique aspects of beginning of health sector reforms in the state.

"Thus the reforms in the drugs sector started in Orissa in 1998. It was limited only to the government health care services,"\textsuperscript{313} said the official. Therefore we could say that to better understand the new drugs policy we could take the year 1998 as a dividing period. So let us look at the pre 1998 period and the post 1998 period.

\textit{Pre 1998 period:}

The system before 1998 was somewhat like this:

"i- The CDMOs used to purchase drugs from different sources in brand names. There were overlapping of drugs.

\textsuperscript{312} In Oriya called Pancha Byadhi Chikitsa.
\textsuperscript{313} The availability of quality drugs in the private sector was the responsibility of the Directorate of Drugs Control, Government of Orissa.
ii- Earlier there was no open tender system. So the price\(^{314}\) was very high.

iii- Purchases were from the traders and there were middleman\(^{315}\) involved.

iv- No control in expiry date of drugs.

v- Difficulties in procuring drugs for smaller districts due to low volume of requirements and the transportation costs on behalf of the manufacturers used to raise the cost of drugs.

vi- There was no need based procurements.

vii- No quality control measures and

viii- All the drugs were procured in loose.\(^{316}\)

After 1998 scenario:

"i- An essential drugs list was prepared with the help of WHO.

ii- All drugs were purchased in generic names.\(^ {317}\)

iii- There is an open tendering system.\(^ {318}\)

iii- Essential drugs list got updated in every two years in consultation with district authorities and specialists from all disciplines.

iv- Purchases were made on the basis of requirements.

v- The budget of drugs was divided into 80:20 that means 80% of the drugs budget was used for central procurement and the remaining 20% goes to the periphery\(^ {319}\) for emergency drugs, for oxygen and lab agents and for transportation of drugs from district to periphery.

vi- The drugs were available in competitive price due to bulk purchases and the cost was reduced by 40-50%.

vii- All drugs were supplied in strip or blister packing.\(^ {320}\)

viii- Maximum retail price is not mentioned over the strip and Orissa government supply not for sale is printed to avoid pilferage\(^ {321}\). This was one of the tender conditions.

\(^{314}\) Price of drugs.

\(^{315}\) Those who used to bargain price on behalf of manufacturers and the CDMOs.

\(^{316}\) Excerpts from an interview with an official who had been closely associated with Drugs reform in Orissa.

\(^{317}\) The price difference between generic and brand names was 50%.

\(^{318}\) Out of 290 items of essential list, 36 items were procured through small scale industries and 254 items were procured through the open tender. And 9% price preference was given to local industries. Because of this in every one crore rupees the state used to loose Rs 9 lakhs approximately.

\(^{319}\) Here periphery refered to the districts.

\(^{320}\) For better patient compliance and to ensure the quality of drugs.
ix- All drugs are received at the weir house at 5/6 of shelf life.

x- Providing slow moving essential drugs for smaller districts.

xi- Quality control measures by sending samples of drugs to outside state labs.

xii- The entire system has been computerized from the state to the district level and records are maintained on a daily basis."

What the drugs reform lack:

While the new drugs policy has been termed as a success story, let us see where gaps lie. The major lacuna was that the private sector in the state was excluded from its purview and it was the Directorate of Drugs Control, who through its drugs inspectors ensured that quality drugs were available in the market. But an interview with a senior official in the Directorate of Drugs Control suggested that there was acute shortage of drugs inspectors in the state. Further an official at PSPU said, “The report of the drugs inspector is final and hence there is quite a possibility that they can be bribed by the private clinics or private drug stores to give them a license”. Therefore not involving the private sector was a major gap in this new policy.

An official of DFID in Delhi office agreed that without regulating the private sector or bringing the private sector in the domain of reforms it would be difficult to control the quality of drugs available in the market.

However the initiatives introduced in the drugs sector was important for us for another reason because “the government of Orissa rather than rewarding the drugs department for saving drugs it punishes them by reducing the amount saved through reform measures taken. Thus suppose you have an annual budget of Rs100 crore for drugs and through reform measures you save about Rs30 crore than in the next year the drug budget is reduced to Rs70 crore. And the government will tell you that you do not need those extra

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321 Pilferage of costly vaccines like, anti-rabbies, anti snake and saline bottles etc.
322 For diseases like diabetes and for heart patients.
323 Here the term drug reform has been used to suggest popular use of the term by the officials of the state government and by the donor agencies. However we have put the reforms in the drugs sector as systemic change in this study.
This was a significant observation because in different aspects of health sector the government of Orissa has been introducing the concept of ‘effective’ and ‘efficient’ use of resources.

Why private sector was excluded?
As we have said that the new drugs policy only included the government system and the private sector was excluded. Replying to this question one former senior official said, “There was already a system. We have drugs controller. Every state has a drugs controller. And they look into the quality of drugs and there is a drugs control act, drugs and cosmetics act. All that is already established and there is nothing that we can do. I mean whatever we do... as per the act. Like spurious medicines are caught... combination medicines, which are not permitted, medicines being advertised as food supplements... So there is a big infrastructure, there is drugs controller, drugs inspectors. That goes on... All the quality control of those drugs, preventing spurious drugs from coming into the market or preventing higher rates being charged, all that is part of the drugs and cosmetics act.” Perhaps what the official was trying to say was that if initially the private sector had covered then it would have been very difficult to manage or implement this new policy on drugs.

The official also mentioned that the new drugs policy as it introduced generic drugs in place of brand drugs and as purchases were made in bulk the price of drugs also went low. “.... Why our rates were lower? One is, you buy in bulk. Two, you buy generic drugs and not brand drugs. There is big increase in price because of brand. If you buy Aspirin and not Aspro or Anacin or Disprine, then you get it much cheaper. Because Aspirin is generic drug, Aspro or Anacin are brand names. So... Penicillin, if you buy and if you buy brand names you pay more. So generic drugs.... it is also what WHO prescribes that you buy generic drugs.”

Pancha Byadhi Chikitsa:

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324 This was revealed through an interview with a senior DFID official in Delhi.
325 The official was referring about the private sector.
Along with bringing in new drugs policy another major systemic change introduced in the state was the Pancha Byadhi Chikitsa scheme covering five diseases. Continuing with her narrative a former senior official of Health and Family Welfare Department, government of Orissa said, “Through hospitals, primary health centers...the government system is expected to provide health care free, in actual fact nobody quite knows what he or she will get free. Now if a person from a village suffering from diarrhoea goes to the primary health center, then doctor will look at him and then say he needs A, B, C, D... Now out of that he may say A- you will get from the primary health center, B- you will have to pay, C- we will give you part of it from the hospital but after that you will have to buy, D...like that. So, if I am poor and sick, I do not know how much money will go from my pocket... So, what we thought was at least for the common diseases...nobody, no person in Orissa, no patient in Orissa, living in any part of Orissa and going to any government hospital should have to pay for these diseases. So, the person should know, the doctor should know, the health system should know ...and also we advertised it widely so that if I am a patient of diarrhoea or if I am a patient of acute respiratory infections, I know that if I go to any government hospital throughout the state, I will be provided free treatment. Not only for the doctor treating but I will also get the medicines.” Therefore here the official was mentioning about the structural constraints with regard to utilisation of health care services even when it was available free of cost. So the poor could not be aware about the health care facilities, which would be provided free of cost to them at government run health institutions. Hence this scheme was started to address this unmet need of the poor who were mostly suffering from these five diseases in the state.

“And we made the scheme and we made the protocols for these five diseases. So, the five common diseases, which usually affected the poor people, like diarrhoea, malaria, leprosy, acute respiratory infections and skin... We also wanted to include TB and worms later but as a start we selected these five. And what we also said was that if any patient was asked by the doctor...because we can’t really be sure that every doctor will give them the free medicine, because sometimes doctors have tie-ups with medicine shops... And will give a prescription and say, buy it from there... We said, if anybody has
to pay, they will give the prescription and the bill and we will reimburse it and then we will enquire against the doctor...why the doctor had prescribed? Was there a shortage of medicine? Why he prescribed and if he cannot give satisfactory explanation that money will be recovered from his salary," said the official. So the linkages between a medical officer and local medicine shops in many cases prevent the poor from getting the free medicines and to address this aspect they initiated a process of providing a bill and a prescription to the patient, so that if there was any wrong doing on the part of the medical officer then the reimbursed amount would be deducted from the medical officer’s salary.

“At the beginning when we started it... when we introduced the drugs system, we not only improved the quality but we gave it an appearance that it had improved. Like... earlier people were given medicines in the health center in loose. You know ten tablets will be taken in a piece of paper, folded up and given to them...no names, no proper packing, no coil packing. We gave in proper packing, coil packing and above it written Orissa Government Not For Sale. So if somebody has to be given, it was strip to be given. This was done otherwise they could take to the nearby medical shop. Retail price was cut out and there was expiry date. So that it was clear that it was only to be sold in a government institution,” said the official. Therefore under the new system the drugs were properly packaged, levels were put up and it was clearly written that Orissa Government Not For Sale so that the drugs could not be sold to the local medicine shops. Due to this packaging and prescription of expiry dates, the quality of drugs available from the government institutions had improved.

But the question arises as to why these diseases were selected for intervention and on what basis? Replying to this question the official said, “Some diseases we know are common, like diarrhoea. Every year lots of people fall in; a lot of our medicines go.... We also discussed with people in the field, when we went to the PHC...malaria we know is common...We also selected diseases which were widespread... but of which we could be sure of giving medicines like leprosy and malaria. Malaria of course we purchase medicines but some medicines come from government of India. Leprosy...the full amount comes from government of India. Respiratory infections and diarrhoea are very
common in Orissa. Scabies sometimes, which affect small children and all...so we discussed with doctors in the field. And there were actually seven diseases that were identified. The other two were TB and worms.” Therefore to identify these diseases wider consultations were held within the health system of Orissa.

Continuing with her narrative the interviewee said, “You see these affects the poor people. People who sleep in mosquito nets and sleep in air-conditioned rooms don’t get malaria. But who don’t take protective measures and live in stagnant waters, they get affected. Similarly leprosy not so much but scabies comes from... if you are not particular about some foods, it’s very contagious. Then in acute respiratory infections immunity is low, so that’s why this was a kind of self-targeting. We know that it affects the poor and we also know it is widespread in Orissa. Because we spend a lot of money on medicines and on treatment...every year in summer and during the rains we have diarrhoea outbreaks. So we selected on the basis...what affects most people and we also found that these diseases made up about 75 percent of the cases, which come to the primary health care.” Therefore the selection of the diseases was made after analyzing the epidemiological situation in the state.

Further the official said, “TB and worms we also wanted to add. But for TB there were three different kinds of treatment pattern at that time in Orissa. So, it was all going to be changed to multi drug therapy. But until the entire state followed one system of treatment, we did not want to take it on because our message would get mixed. Whatever we tried to tell people that you must come and you will get this treatment, it would not hold through326. Worms...also we thought let’s start with five and then worms can be treated in low birth weight babies...Depending on the state we selected this. If I were in Maharastra the diseases selected would have been different or in Gujarat, the diseases would be different. But in Orissa these we thought as most appropriate.”

326 Because then it would have led toward widespread abuse of drugs with regard to TB and it would have created conditions for new drug resistant variants of Tuberculosis.
However during the field visit to the four block level PHCs, the medical officers in-charge were of the opinion that the patients coming to the health centre were not aware about their rights under the Pancha Byadhi Chikitsa scheme. Interestingly in all these block PHCs advertisements for this five disease schemes were written in bold letters almost covering one side of a wall!

*Consultation process in various reform initiatives:*

Asked about the consultation process before initiating different reform measures, the interviewee said, “We had brainstorming normally with a number of people in the health sector and including some advisors from outside, medical college people etc. But when we made the policy we had consultation with different associations. Some reforms which were personnel based, we discussed among ourselves. Some which were like cleaning of hospitals, we did not have a major consultation but we took the cue from the general public’s dissatisfaction with the cleaning system and therefore we went in for contract cleaning and the feedback we used as a way to decide and after that everybody wanted it. So obviously it was a popular measure…. So extent of consultation varied.”

Therefore the consultation process varied from one reform measure to another.

But what about the OHSDP? Responding to this question the official said, “In case of OHSDP what happened was, it was started first in Andhra Pradesh. A large number of states were interested. So they had a workshop in Goa, which all the states attended and after that we had a meeting in Delhi, where each state made its presentations. On the basis of our presentation the World Bank selected Orissa and after that they selected Rajasthan”.

However one of the major reform problems in Orissa has been that the government of Orissa was reducing the budget, for example in case of drugs, which has been saved through reform initiatives. In these circumstances how could the reforms succeed? Replying to this the official said, “Any decrease in drugs budget would not be because of

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327 According to different reform initiatives.
328 Here it refers to the World Bank.
reforms. It might decrease because budget has reduced. Let us say for this amount of medicines you need Rs 12 crores and now this year you are able to buy that amount of medicine for Rs 9 crores. So, I will reduce it to Rs 9 crores. This was not so. What may have happened, during my time OHSDP was putting in some money for drugs. Then this total budget remains the same and that could be reduced. I don’t know whether it was done or not done because there was some talk about it... So because this money is coming from World Bank already for drugs, so we won’t provide Rs 12 crores, so I will reduce four crores as you are getting the same amount from there. It has got nothing to do with reforms. It’s also is a temporary thing if they have done it because medicines requirement increases.... If today you have malaria or diarrhoea as a problem after certain years these may not be a problem rather cancer may be a problem and certainly if government is providing health care you are supposed to provide or take care of those diseases. The profile changes from infectious diseases to non-infectious diseases, from communicable to non-communicable diseases and accidents and injuries. That’s how the profile changes. And as you develop, you have less of communicable, more of non-communicable and accidents and injuries also. So certainly it’s not rationale to say that reforms have led to cut in drugs budget. Because more money was coming from other sources, there were chances that they might have reduced the drug budget.”

However as we have discussed above that some of the senior officials were of the view that as cost cutting was one of the priority areas of government of Orissa, the drugs example was a metaphor for the attitude of the government. For example the government of Orissa had taken a policy decision about not recruiting any manpower in near future and this also included health services sector. This perhaps may have been initiated with the objective of reducing the government’s spending on the salary component, which was more than 80 percent in case of health sector. On the other hand during the field visit many officials showed concern for the shortage of nursing staffs and ANMs in the state. Therefore a uniform policy on non-recruitment of manpower needs to be relooked. This policy was also one of the reasons behind creation of contractual posts for paramedics at the district level and most of the posts created by OHSDP project were also of contractual nature. So the question arises whether such steps were taken with an idea of
implementing a uniform model of reforms in health sector? And would not such a uniform model hamper in actual realization of health goals in the state? Therefore should not it have been reconsidered keeping in mind the context of Orissa?

**Contractual doctors:**

As we have discussed in chapter III, due to the financial crisis the state government had initiated schemes like contractual doctors and contractual paramedics. When asked about the rationale of this scheme, one former senior government official said, “Contractual doctors we had earlier also. Contractual doctors can be recruited by a PHC. But a PHC takes long time. By the time we write to PHC to recruit, let’s say 100 doctors, as it’s such a long drawn process that we have another 200 vacant. So we were recruiting contractual doctors earlier not by the CDMO but centrally. We were appointing people on contractual basis and posting them particularly in these remote areas.

Contractual doctors are not necessarily a bad thing, because when you get a regular government job then many people feel that I decide whether to go there or not there. If you are given a contract only... if you go to Kalahandi then you will work there. Once you get a regular appointment then people will put a lot of pressure, political pressure and say I will stay in Bhubaneswar, I will work in Capital Hospital etc. So we had allowed contractual doctors only in the periphery.... Contractual doctors or contractual paramedics are not necessarily a bad thing; in fact people work better, perhaps.”

This was an argument from one perspective and it was a point of view supporting the new idea of creation of more contractual posts. On the one hand if used in a limited way then it seems that the appointment of contractual doctors might help the periphery level institutions to address their immediate needs.

However it seems that in periphery level institutions where there have been problems of medical officers and paramedics staying, the entire posting were thought to be made as contractual. And it seems this logic had also been extended to hand over the NGOs to run

329 Posts of doctors vacant.
these periphery level institutions. These were halfhearted measures because we have mentioned earlier that it was a common agreement among the various levels of health care officials in Orissa that if the government was really interested to ensure that the periphery level institutions were not to remain vacant then the first thing they should do was about bringing in a legislation to make the transfer and postings policy of medical officers' a rule. Therefore it seems that these measures have not been initiated because of vested interests. And therefore the creation of contractual posts alone won't help in resolving the issue, because the structural constraints have not been addressed.

User charges:
During the field visit to Orissa, interaction was made with lot of senior officials in the government and in the donor agencies and they all privately acknowledged that user charges were not exempting the poor in reality. It was the rich and influential sections, which were getting benefit out of this. Thus observing on this aspect one former top health official in the state said, “It's a question of implementation. I don't think what you are saying is an uniform issue because in initial years we have been trying to follow...find out...because they have been given slips...so what percent of patients being treated free? And of course there may have been misuse of this for the people who could pay. Usually it would not be... but that's the implementation problem and not the problem of system as such. So if the CDMO or the person in charge of a particular hospital is particular and ensure it...and it's after all we have given clear instructions. Emergency is nothing...national programmes... no charges. It’s an implementation problem. In everything there would be implementation problem.” Further elaborating her point the official said, “If you say that you will admit people within the college with certain percentage of marks and you will find somebody with third division has been admitted, and then people say that he is a son of a minister and got it. That's an implementation problem. It's not a problem with the system. In every place system is abused.”

330 Here the italics have been provided to emphasise a point.
These were the candid views of a former official who was closely involved with the process and experience of health sector reforms in the state. The important point here being made was that those who could pay should be charged and if the poor were not getting exempted then it was an implementation issue. The aspect of user fees also has another dimension of users' perspective. But here as we have been primarily dealing with the provider's perspective, hence perception of introduction of user fees was gathered from officials at different levels of health care services in the state. It needs to be mentioned here that there was wider support for the introduction of user fees among the government and donor agency officials. However it was observed that important question which should have been asked by these officials have not happened. For example, what was the percentage of user fees collected to the total expenditure of an institution? What were the mechanisms to be devised if in reality the poor were not getting exempted? Could the introduction of user fees generate enough revenues in a state like Orissa where near about half of its population lived below the poverty line and near about 39 percent of its population constituted scheduled castes and scheduled tribes?

As we have mentioned earlier in chapter III that according to the senior officials in the state and at district level the CDMOs, the collection of user fees has helped institutions in repairing equipments and furniture, which has helped institutions a lot. Otherwise earlier they had to wait for funds to be available from the state headquarter.

*Referral cards:*

To the question whether there was plan to introduce referral cards by the OHSDP in project institutions in Orissa, a senior official at OHSDP said, “After the analysis of monthly reports on referral cases of project institutions it was found that out of the total cases referred from one tier to other, 50 percent of them were from District Headquarter Hospitals and Sub Divisional Hospitals to medical colleges. Most of these patients were referred in a small slip without detail address, clinical condition of the patient at the time of referral and the treatment offered to the patient.”
Further the official concerned observed, "Sometimes cases which could have been managed at lower level health facilities were referred to next higher levels due to lack of knowledge of service providers on clinical protocol and the services available in the nearby health institutions. Therefore most probably a referral card would be introduced in this project." Hence the idea of introduction of the referral card it seems was to utilize the existing resources 'efficiently'.

*Private practice by government doctors*:

The private practice by government doctors has always been a controversial issue in India. Hence many states have banned and allowed it many times. The heart of the controversy lies in the understanding that if a government doctor goes for private practice then he or she won’t be concentrating on his or her official job and the real sufferer would be those patients visiting the government institutions. Therefore this issue was raised before one of the former senior officials in the state. Responding to this issue the interviewee said, "We always allow... Only the medical college, they did not allow. Let me modify that. There have been many changes in policy. There was a time when they did not allow; Biju Patnaik’s time...I think they banned private practice. Then they found that some amount of money was being made but they were practicing anyway...No... they say some non-practicing allowance was being paid but they were still practicing. So take away the non-practicing allowance and allow them to practice. So there have been many flip-flops. Not only in Orissa, every state has this problem. Every single state in the Indian Union has had this problem. Sometimes they allow, sometimes they ban. If they ban, they say this is the advantage and therefore we will not allow. If they allow then they say, this is the advantage and therefore we will not ban. So I myself don’t know whether there is a solution to this but it is a question of ethos of the place. If in certain place you find everybody is doing private practice despite the ban and no action is being taken then everybody falls into that." Therefore here the official was mentioning

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331 'Private practice by government doctors' and the proposal to introduce 'referral cards' has been interpreted here as reform initiatives. Although private practice by government doctors had earlier many times allowed as well as banned subsequently; however as this measure was introduced in late 1990s we have included this as a reform initiative.  
332 Here the respondent was mentioning about allowance of private practice by government doctors.  
333 Biju Patnaik was the former chief minister of Orissa.
about the ethos of a particular place and thus if in a particular place most of the
government medical officers were going for private practice then others would also
follow the trend.

Continuing with the narrative the respondent said, “In case of Orissa, at some points of
time it was banned and at some points of time the ban was removed. So in Orissa
everybody is allowed to do private practice ...and these changes from time to time. At
one point of time everybody is allowed to do private practice and no non-practicing
allowance is given. And at another point of time nobody is allowed to do private practice
and non-practicing allowance is given. At still another point of time some people are
allowed to do private practice and no non-practicing allowance is given to them, whereas
other people are not allowed to do private practice and NPA334 is given to them. Even
when everybody is allowed there are some levels, which are not allowed. Directors335 are
not allowed, superintendents336 …they don’t allow. So it’s a mixed thing.” This was
another aspect of this issue. Hence while some medical officers were allowed private
practice, some others were not like, Directors, Superintendents etc.

Observing another important aspect of private practice by government doctors the official
concerned said, “Another thing is in a rural area, government doctors are the only doctors
and... in the middle of the night somebody falls ill and comes...he will come to the
government doctor. The government doctor cannot tell him, no go away, I will not treat
you. There is no other doctor! Now should the doctor not be compensated for that time?
At any time a patient can come to him...now he treats the patient well and if he is good
more people will come. Then he should be compensated for the extra hour that he is
putting... There I would say that private practice should be allowed.” So here the
interviewee was mentioning about private practice by government doctors in the context
of rural Orissa. Thus in rural areas of Orissa the government doctor was the only doctor
and hence if a patient comes after official hours to meet him or her and if the doctor treats
him or her then what was wrong in allowing the doctor for private practice? For the

334 Non practicing allowance.
335 Here ‘Directors’ refer to the senior most officials in the Health Directorate of government of Orissa.
336 In Medical colleges.
doctor was putting extra effort in his or her private times. Therefore in these cases also
one could argue that private practice by government doctors should be allowed. But here
the important aspects that need to be ensured was that the medical officers engaged in
private practice should be attending to their responsibilities in government institutions.

*District cadre for paramedics:*

As asked about her views about creation of district cadre for paramedics the official said,
"Earlier ANMs and multipurpose health workers had no tenure and they were transferred
to different districts. Hence the Orissa cabinet took a decision for district cadre for
paramedics and nurses. There were ten to twelve thousand nurses and most of them were
from the coastal areas. There was interference from MLAs. Once you have the district
cadre you limit the interference." Thus this decision was taken for operational reasons so
that the difficulties that paramedics used to face could be solved to a large extent. As
there were ten to twelve thousand nurses from the coastal areas there used be pressure
from the MLAs in their transfers and postings and hence once this new system was
introduced this interference could be reduced to a large degree.

Further the official said, "The ANMs must live with the community and should know
persons by name. Therefore they should not be transferred." This was a very important
observation, as the ANMs were supposed to develop contact with their allotted villages and
know persons by name and hence they should be allowed to stay in a particular place.
This could be mentioned as a very strong point for creation of district cadre for
paramedics.

"Similarly there is need for creating separate cadre for medical colleges as all wants to
come to Cuttack Medical College. If one is sure that one has to stay in one place than
only one will stay in a place. This could be compared with the tenure of IAS officers who
are sent to a state for two thirds of their career," said the official. Hence it was an
observation having practical implications. But to bring such a change, political will
would be required.

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337 In Orissa within a sub centre there were 5 to 6 villages were there on an average.
But the real question was whether the creation of contractual paramedics had helped in addressing these structural issues? Responding to the this question one senior official of a donor agency at Bhubaneswar said, "From the coastal areas people are moving to undivided Koraput and joining there as ANMs and through political connection they are getting on deputation to coastal districts... That is one ANM while has joined in Koraput, staying at Jagatsinghpur and drawing salary from Koraput!" Continuing with the narrative, the official said, "The earlier practice was like one would go and join in remote and difficult areas, where it was easier to get a job and from there getting transferred to a coastal district. But now this is not possible in pen and paper but in reality it is happening." Another senior official of health and family welfare department, government of Orissa said, "From coastal areas paramedics are going and registering with the employment exchange in KBK districts. The reason is that although due to the creation of district cadre for paramedics transfer is difficult, they can be deputed to other areas." Therefore it seems that the implementation aspects of the scheme of district cadre for paramedics have been neglected in Orissa.

Increasing role of the private sector:
Utilisation patterns in the state shows that both in urban and rural areas maximum number of people go for the public health care system. The presence of Private health care was also very low. There were private clinics and small nursing homes in cities like, Cuttack, Rourkela and Berhampur etc. and there were some private hospitals in cities like Bhubaneswar and Cuttack. However these were very small in terms of numbers and outreach to different sections of the state. One senior official was of the view that "as Orissa has dominant presence of Public health care system, the rich as well as the poor go for it. And as long as the influential sections have a stake in the public health care system the standards will not fall". What the official was saying was that the influential sections

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338 Jagatsinghpur is a district located in Coastal Orissa.
339 Reference to a paramedic.
340 KBK districts refers to Kalahandi, Bolangir and the Koraput districts of Orissa, where the phenomenon of drought in most part of the year force people to migrate to neighboring states of Orissa in search of employment and this also results in hunger deaths among the poorest section of the population.
341 This was evident from both the NFHS I and NFHS II data.
are generally aware about the standards of health care, about which the poor are generally ignorant. So as long as they have a stake, the quality of care in the public institutions could be maintained. In fact this has been the case with Orissa.

However interview with government officials at different levels of the health care services structure in the state showed that there was increasing acceptance of the larger role for the private sector in delivery of health services to the people. Senior officials in the directorate of health services in the state were of the opinion that as the government was in a fiscal crisis; increasingly the private sector has to be given a role for fulfilling the gap in resources and the needs of the people. Therefore this perception among these officials about the role of private sector in health care was significant. This would act as favorable factor whenever the government of Orissa decides to increase the space for private participation in different aspects of health care.

*Other reform initiatives:*

Now let us have a look at some reform initiatives by the state government, which has significant implications for different aspects of future health care provisioning in Orissa. It needs to be mentioned here that these initiatives have not been identified by the state government as reform initiatives. However we have included these initiatives as reforms according to the definition of health sector reforms given in this thesis.

*Three private medical colleges within five years:*

According to one senior official in the Ministry of Health and Family Welfare Department, Government of Orissa, “The Western Orissa Development Council\(^{342}\), has come off with plans for three Medical Colleges with private participation at Rourkela, Bolangir and Bhabanipatna within five years. The council will give Rs 10 crore and free land to the private parties. One GSL trust has been given the task for building medical

\(^{342}\) This council was created so that the development of Western Orissa could be undertaken in a focused manner. It needs to be mentioned that occasionally from the Western Part of Orissa one could hear about a movement for separation from Orissa and this movement was known as ‘Koshala Movement’. Therefore to address these regional grievances this council was created.
colleges at Bolangir and Rourkela. One Selvan Trust has taken the charge at Bhabanipatna.\textsuperscript{343}

However there was a gap in this initiative. The official said, "The Western Orissa Development Council\textsuperscript{344} budget is hardly Rs 40 crores. But to manage a medical college hospital they need Rs 100 crores." Therefore it seems a serious thought has not been given to this whole initiative.

\textit{Public private partnerships:}

There were some initiatives by the state government, which could be termed as public-private partnerships. These were in the form of joint ventures in medical colleges, joint operation of hospitals and introduction of private pay clinics in government medical colleges etc.

\textit{Proposals for joint ventures in three government medical colleges:}

Further the interviewee said, "Besides some private hospitals like Hi-Tech in Pandhra, Kitts at Shikhar Chandi and ITR in Kalinga Nagar has come up.\textsuperscript{345} In the three medical colleges\textsuperscript{346} joint ventures are being planned with the private sector. For example an MRI machine costs around Rs 4 to 5 crores. These are planned to be entirely managed by the private parties. The government will provide only space, water and electricity and if the staff is required it will be provided but the private party will do the running cost. There are also proposals like multi bedded hospitals and instruments to be maintained by the private parties but the staff will be of the government. These will be cutting edge hospitals with latest instruments. The proceeds will be shared in mutually agreed way. This is yet to be finalized."

The official further added, "In West Bengal and UP, private parties are running equipments like MRI, CT-Scan etc. and the government provides water, electricity and

\textsuperscript{343} This was the view of a senior official in the ministry of health and family welfare, Government of Orissa.

\textsuperscript{344} This was a statutory body.

\textsuperscript{345} These hospitals were located in and around the capital of Orissa, Bhubaneswar.

\textsuperscript{346} The official was referring to government medical colleges at Berhampur, Burla and Cuttack.
staff for which certain percent of money is provided to the government. Similarly here
the maintenance of instruments will gradually be privatized. Government will provide
electricity and water but these will be owned and maintained by the private parties. They
will provide their own staff."

Therefore the tertiary aspect of health care was being thought to be handed over to the
private parties, as these would be costlier to operate for the government. The idea of
providing staff, if needed, along with space, water and electricity, seems quite interesting
because the government of Orissa has put a blanket ban on recruitment of any new staffs.
So the question arises from where these additional staffs would come from?

_Private pay clinics in government medical colleges:_

Giving a rationale for introduction of private pay clinics in government medical colleges
one former senior official in the Health and Family Welfare Department, Government of
Orissa said, “For example even though you have a government hospital and you are
supposed to provide free care...ultimately they are used to channel people to their private
clinics because in their private clinics they make additional money over and above their
salary. So that’s one thing. You don’t have any expertise... In a city like Delhi, it’s
different. You have private hospitals but in Orissa it’s not like that. So the best eye
surgeon will be somebody in the Medical College. The best kidney specialist or urinary
surgeon, they all will be in the government. Now how do you get their services? You go
there in the hospital and he will have too many patients. So one thing which was tried
when I was there, was to have pay clinics. Now suppose you want to consult a particular
doctor ...you don’t want to line up in the morning and so you want to take an
appointment but she is not allowed to see you because she is not allowed private practice.
So in the morning and evening every day they hold a pay clinic. So you go to the doctor
and you pay. And that money, as he uses hospital premises, he uses the hospital staff,
nurses etc... certain amount goes to the user fund and certain amount they are allowed to
keep. So you get the attention of the doctor and because you pay the doctor is able to give

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347 Here the official was referring about the lack of medical expertise outside the government sector in a
state like Orissa.
you an appointment also. It's not that everybody...first come, first serve...doctors get motivated also. So they were experimenting with dentistry," said the official. This was an important point because the official was of the view that as in Orissa specialists were also in the government sector and hence in case of emergencies they had to be allowed for private practice. Extending this line of argument pay clinics had been started in medical colleges in the morning and evening hours when one could visit a particular medical specialist with prior appointment. In this system the medical officer attending a patient was paid some amount of the money, that he or she had generated out of this practice and the rest used to go to the user fund in medical colleges as the attending doctors were also using the services of staffs and nurses in this institution. Therefore in this context the introduction of pay clinics has some justification.

According to another senior official in the Health and Family Welfare Department, government of Orissa, “Private pay clinics at the dental wing of Medical Colleges have started. During holidays and in the extra times\textsuperscript{348} these operate. This has helped in availability of facilities to the patients at lesser price to the market prices. Out of the money collected, 50% of the money goes to the government and rest 50% goes to the doctors and this is subject to income tax. Many people have benefited out of this and they are also getting the services of the doctors of their choice”. Hence the pay clinics have been opened in the dental wing of medical colleges and as it was being interpreted as a success, it was most likely that they would start providing other services in coming years.

\textit{Joint operation of Hospitals:}

Another aspect of private participation has been the idea about creating new hospitals where both the government as well as the private sector would operate jointly. Thus one senior official said, “Now government is thinking in terms of joint ventures to set up hospital with private participation. They will set up the building and also provide equipments and the government will provide the staffs. There will be joint agreement on running the hospital. There will be pay beds. The scale of proceeds will be decided by mutual agreement.” Thus while the building and equipments would be funded by the

\textsuperscript{348} Here the term ‘extra times’ suggests that these pay clinics operated in morning and evening hours.
private sector the government would provide staffs. The concept of introduction of pay beds suggests that these hospitals were thought to be operating on a profitable basis.

Creation of a 600 bedded hospital at SCB medical college Cuttack:
The official further added, “At SCB medical college Cuttack, another 600-bedded super specialty hospital for Orthopedics, Pediatrics and Medicine will come up. In this regard the views of DMET and the principal of the medical college have been sought”. This hospital would run on a profitable basis.

Plan to create eight regional diagnostic centers:
This was an initiative to strengthen the government health care institutions in tertiary levels of care. Thus one senior official said, “There are plans to start eight regional diagnostic centers at three government medical colleges and five district head quarter hospitals. Each center will be given Rs 3 crores. In total Rs 24 crores has been provided by 11th finance commission. These are expected to run round the clock with facilities like radiology, X-ray, ECG, CT-scan and Ultra Sound etc.

At present for the diagnostic facilities in medical colleges, although diagnostic instruments are there, doctors refer the cases to outside, where for each case they earn Rs 500 from the private institutions. Hence to check this corruption there is need for round the clock diagnostic facilities.” This initiative has been taken with the proposal of 11th Finance Commission and hence from the government of India. However user fees would be introduced here for those who could pay. While on the one hand the government of Orissa has taken initiatives and planning to introduce measures for more private participation in tertiary levels of care, it would be interesting to see as to how these regional diagnostic centres would operate in this larger atmosphere.

349 200 bed each for these facilities.
350 Director Medical Education and Training, Government of Orissa.
351 We have included this initiative as a reform element because while the entire funding and operation of these diagnostic centres would be with the government of Orissa, user fees would be introduced for those who could pay.
352 Out of these five regional diagnostic centres four would be in the district head quarter hospitals of, Koraput, Kalahandi, Mayurbhanj, Sundergarh and the fifth one would be in the Capital Hospital, Bhubaneswar.
Other initiatives:

There has also been private participation in other fields. In this regard one senior official said, "...Besides Infosys\textsuperscript{353} has come up with 150 bedded pediatrics services in the Capital Hospital, Bhubaneswar, where it has spent Rs 2 to 3 crores. But unfortunately the government does not have the resources to maintain it. They have adequate staffs and equipments but they need little bit more money for maintenance." Thus while the new hospital has been created with the private money, for maintenance the government did not have any resources. Therefore it was most likely that in future a private party on a profitable basis would operate this wing of pediatrics service.

Private physiotherapy, speech and occupational therapy colleges:

To the question as to whether the government of Orissa had received any applications for establishment of private physiotherapy, occupational therapy and speech therapy colleges, the official said "We have received application for establishment of private physiotherapy, Occupational therapy and speech therapy colleges in the state but no action has been taken."

Opening up new government medical colleges:

When asked as to whether the government was planning to open new medical colleges, the official said, "There is no question about opening new government medical colleges, as government does not have enough money. Now the concept of privatisation has crept into the system." Therefore if the need arises in future about the creation of new medical colleges, it would most probably be started with the private initiative.

The emerging pattern:

So what was the emerging pattern, out of all these new initiatives for private participation in tertiary levels of care taken in Orissa? For the explanation we need to go back to the arguments being forwarded by donor agencies like World Bank and DFID that more than 50 percent of the budget of the government of Orissa was being spent on the tertiary levels of care, whereas the government should have focused more on primary and

\textsuperscript{353} The well known IT Company in India with head quarters at Bangalore, the capital of Karnataka, India.
secondary levels of care. These new initiative for private participation in Orissa clearly follow this line of argument and the state government was trying to reduce the role of state from the tertiary levels of care.

However the focus has neither shifted to either the primary or secondary levels of care. As we have argued earlier, in case of primary levels of care the government of Orissa had been thinking about handing over the PHCs to NGOs in remote and difficult areas. In case of secondary health care institutions we have seen that under the OHSDP project the 157 institutions upgraded had been introduced with user fees and the government of Orissa was also not increasing its budgetary allocation annually so that at the end of the project the government could take over these institutions. Therefore while the responsibilities for tertiary levels of care were being relinquished, inadequate efforts were being made to invest in secondary and primary levels of care.

Understanding of ‘reforms’ among the providers:

How the term ‘reform in health sector’ being interpreted by government as well as donor agency officials at various levels in the state of Orissa as well as at the central level? It was surprising that many could not provide any definition of health sector reforms and those who gave a definition, tried to interpret these in terms of a report published by WHO and Ministry of Health, Government of India, which was an outcome of a seminar held at India International Centre, New Delhi in 2003. Interestingly the report itself concludes with the note that the term ‘health sector reforms’ need to be defined, so that concrete policy initiatives could be taken by government of India and different states and then these could be included in the five year plans of India. While this was the understanding among the senior officials at Bhubaneswar, from district level and below the officials were at loss of words in defining this term. At their Delhi offices while different donor agency officials could give their own definitions, these were not at all helpful in classification of health sector reforms. In most of the cases the definitions

354 Here the term ‘providers’ suggest about the officials of the donor agencies, government officials at different levels in Orissa and at Delhi etc.

355 At the Delhi offices of the donor agencies.
given were trying to include almost every single initiative by the state government of Orissa and India since 1990s as a reform initiative.

Due to this lack of a definition of reforms in health sector, whatever new changes in the existing programs had been taken by the state government beginning with the decade of 1990s in health sector, has been interpreted as health sector reforms by influential documents in the state, like the Orissa vision document 2010. While the increasing private sector participation in health sector was not being openly acknowledged by the government of Orissa in public, but through various initiatives it has already started this process. Therefore while most of the officials at different levels of health care may not be aware about the larger picture but there were some top officials in the government Orissa who did understood what was going on.

Does it suggest that the reforms were not being implemented properly in the state because of this definitional confusion? The answer won’t be that easy because the officials at different levels were aware about various initiatives being taken by the Health and Family Welfare department of government of Orissa. Hence they were mostly involved with issues about whether these initiatives would succeed or not. Thus interacting with them, one would frequently come across issues about structural constraints in implementing these new or revised initiatives by the government of Orissa.

Therefore it could be said that the increasing space for private participation in health sector in the state was being pushed in the state with the knowledge of few top officials of the government of Orissa and from the donor agencies like World Bank and DFID and European Commission.

*Role of World Bank in Orissa:*

What about the role of World Bank in health sector reforms in Orissa? It was not that much a clear case that the World Bank was pushing for increasing private participation in health sector in Orissa. Because ultimately it was about the policy decisions that the state government takes, that matters. For example in case of OHSDP, it was the state
government, which had approached the World Bank for initiating this project in the state. Besides, after the 1991 economic liberalisation in India, the role of private sector has increased and this has also created an understanding among the politicians and the government officials that the private sector could fill up those gaps, which the public health sector could not address. Therefore a larger atmosphere in favor of private participation in health care does exist among the providers of health services.

On the other hand, it was also the case that the World Bank through its 'Orissa Economic Review Package' and OHSDP project was in a position to put pressure on the state government to bring in increasing role of private sector in those areas, which the World Bank thought as appropriate. There has been an increasing understanding within the World Bank, after years of working in Orissa, that if they want to get their desirable results in health sector, then they would have to link the financing for health projects like OHSDP to larger projects like Orissa Economic Review Package, which was intended to help the state from recovering from its fiscal crisis.

Therefore it was never the case that only the World Bank has been pushing for increasing private participation in health sector of Orissa. For within the state government there has been a wider constituency, who were directly responsible for health policy making and implementation, which were supporting the increasing role of private participation in different aspects of health care in the state. However what was observed from interaction with both donor and government officials was that this increasing support for private participation was not based on empirical data and was more a question of faith. It was like ‘we have tried and tested the role of public sector in health care, now let us give a chance to the private sector.’

While the solutions for the existing problems in the health care services structure in the state, was being seen in the private sector, by the government officials, they were not able to explain as to how more private participation would help in overcoming the structural constraints. Therefore in terms of explanations in support for increasing private participation, most of the arguments were coming more from the World Bank who could rely from their international experience. However this raises doubts about
implementation of a uniform model in the context of Orissa. To address the shortcomings of the public health care in the state required innovative solutions and not an act of faith in the private sector.

Conclusion:
In this chapter we have made a distinction between systemic changes and health sector reforms, in the context of Orissa, using our new definition. It has been argued that the phenomenon of health sector reforms could not be reduced to some technical terms like ‘efficiency’ and ‘effectiveness’, rather reforms in health sector were ideologically driven. It has to be seen in the larger context of economic reforms being introduced in India and the fiscal austerity measures being adopted by various states due to this.

Using our new definition of health sector reforms we have identified elements like, creation of PSPU, the OHSDP project, the Sector Reform Cell, handing over PHCs to NGOs, creation of the post of NGO coordinator, introduction of user charges, creation of contractual district cadre for paramedics, privatizing cleaning in government hospitals, multi-skilling of health personnel, plan to introduce referral cards, allowing private practice by government doctors, contractual district cadre for paramedics, introducing contractual doctors scheme at the block level, plan to introduce three private medical colleges, plan to introduce joint ventures in three government medical colleges, introduction of private pay clinics in government medical colleges, idea about joint operation of hospitals, creation of a 600 bedded hospital at SCB medical college, Cuttack; plan to create eight regional diagnostic centers etc. as health sector reforms.

Similarly using our definition we have also identified some of the initiatives by the state government as systemic changes, which were included as reform element by different observers. Thus the systemic changes were: establishment of disease surveillance programme, introduction of new drugs policy, Pancha Byadhi Chikitsa scheme, provision for petty maintenance of buildings at PHC headquarters, mandatory pre-PG rural service, internship training for medical graduates and creation of Zilla Swasthya Samities etc.
Here we need to mention that this distinction between health sector reforms and systemic changes were conceptual categories. This distinction was made to comprehend the phenomenon called ‘health sector reforms’ in a better way. The factors like the formation of House Committee of Orissa Legislature and the evaluation by DFID of its earlier projects led to an initiative toward a series of changes in health sector covering both systemic changes and health sector reforms.

In terms of the consultative process in various reform initiatives it was clear that selective consultations were held with health services personnel at different levels in Orissa. It was not a comprehensive consultative process. In case of consultation process with regard to OHSDP project, it was observed that only few senior officials were aware about it. The field experience suggests that at the district and block level even the senior officials were not aware about various reform initiatives undergoing in the state. This had implications for effective implementation and monitoring of various programs in the health sector.

We have said that while the Orissa Economic Review Package was not a reform element in health sector, still it had the potential to influence significantly the future health policy making in Orissa. Because the World Bank was planning to make conditional any new funding for health sector with the successful implementation of fiscal austerity measures, which this package was trying to address. While the Sector Reform Cell was only confined to implementing the European Commission health projects in Orissa; through creation of PSPU, the DFID and World Bank were trying to act as a think tank for the Ministry of Health and Family Welfare, Government of Orissa. With the implementation of OHSDP project in Orissa the World Bank had increased its influence in reorganizing the health services system in Orissa like never before. Therefore among the donor agencies the World Bank was playing the dominant role followed by DFID in the Orissa health sector.

However the presence of various donors in different aspects of health care in Orissa had created problems of donor coordination and it was also a burden for the Health and Family Welfare Department to prepare different categories of reports for different donors.
To address this issue, Orissa Vision Document 2010 was prepared with a wider consultative process within the government health sector in the state. The idea was that different donors could identify their areas of interest within this Vision document. However this could not bring any change in terms of better donor coordination.

In terms of major systemic changes, the introduction of new drugs policy, which was mostly borrowed from the Tamilnadu model, made changes in the quality of drugs available in government health care institutions and at a cheaper rate. The new elements introduced in this policy were, shift from brand names to generic drugs, adoption of an essential drugs list from WHO and central purchasing of drugs through open tender. This policy reduced corruption between CDMOs and local drugs manufacturers, who used to supply low quality drugs. This system also made available drugs to districts at a cheaper rate which had poor physical infrastructure and located at a distance from Bhubaneswar. One of the major drawbacks of this new policy was that it did not include the unregulated private sector. As there were shortages of drugs inspectors in the state, there were fewer quality checks for the drugs available in the private sector and also there were possibility of corruption by the drugs inspectors. In spite of opposition from a group of CDMOs, local manufacturers and some members of Orissa Legislative Assembly, the new drugs policy could succeed because there was political will and then health secretary was very committed to this process. Therefore for any reforms or systemic changes in health sector to succeed what was needed was a political will and a bureaucratic support in a democracy like India.

Besides, the introduction of Pancha Byadhi Chikitsa Scheme made it mandatory for all government institutions to provide drugs free of cost to patients for five selective diseases of diarrhoea, malaria, leprosy, acute respiratory infections and skin diseases in the state. However in our two study districts, the officials were of the view that patients were not aware about their rights under this scheme. The disease surveillance program which was initiated with the help of World Health Organization, Medicines Sans Frontiers and UNDP was another successful systemic change introduced in the state. Later the World
Bank also joined in this program through OHSDP. This program had helped the state in collecting epidemiological data systematically.

The creation of ZSS was another successful systemic change being introduced in the state which had helped in better coordination among various district societies and effective utilization of limited resources.

Under the scheme of petty maintenance of buildings at block headquarter PHCs the money supply was not regular and also there were allegations of misuse of funds by the medical officer in charge of these institutions. The mandatory pre-PG rural scheme was not functioning as expected, because it did not address the structural issues like, making the transfers and the postings policy of medical officers transparent. The internship training of medical graduates under the CDMOs also could not succeed because the CDMOs were not strict about it and due to a common apathy towards issues of public health among the health officers at different levels of health services structure.

Among the reform initiatives, one was the introduction of contractual doctors, who could be recruited by the block PHCs with the consent of the CDMOs. The idea was that in a contractual scheme medical officers would work better in remote and difficult areas. However our field experiences showed that only the retired doctors applied for these posts as most of them expected that they won’t have to visit their institutions regularly!

This was another scheme from government of Orissa, which did not address the structural issues facing the health care services structure in the state.

User charges had been introduced in all the 157 OHSDP institutions, which included the three government medical colleges, the Capital Hospital, Bhubaneswar and the 30 district headquarter hospitals. During the field visit it was known that the state was planning to introduce user charges at sub divisional level hospitals. While the introduction of user charges had helped in petty maintenance of institutions, the question of exemption of the poor from user fees had been sidelined. Some of the senior officials were of the view that it was a question of implementation issue. Further there were plans to rationalize the
referral system through introduction of referral cards at the primary and secondary level institutions.

While in the past, government doctors in Orissa had sometimes allowed and sometimes banned private practice, in the later half of 1990s when this was allowed, it became a significant reform initiative. One of the arguments for this initiative was that in villages and remote areas the government doctor was the only doctor and hence if patients approached them in unofficial hours then the doctor had a right to charge fees. Similarly in case of three government medical colleges, private pay clinics were introduced in dental wings, where the doctors were given a share of their treatment. It was argued that as the medical college doctors were the best doctors in the town and hence if some people were not interested to stand in a queue, then they could be given an appointment of a doctor of their choice.

The creation of district cadre for paramedics, addressed to some extent the availability of paramedics in interior districts. However the idea of making the entire cadre contractual was that, the staffs would be willing to work in remote and difficult areas. Therefore it did not address the structural issues like absence of sub centre buildings at many places, the existing sub centre buildings located in end of the villages and many in burial grounds etc. Besides, the lack of motivation among the paramedics was closely linked with the problems of medical officers and the dilapidated conditions of the infrastructure at periphery level institutions.

Further the effort by the state government to introduce three private medical colleges in next five years in Bolangir, Rourkela and Bhabanipatna with the initiative of Western Orissa Development Council was to increase the role of private sector in tertiary level care. However during the field visit it was clear that the council did not have enough money to run these medical colleges. Further the idea of encouraging the private parties to operate costly equipments in government medical colleges, the proposal of joint operation of hospitals and the plan to create 600 bedded hospital, at SCB medical college Cuttack, were other significant attempts to privatize the tertiary level care in the long run.
In this wider attempt to privatize the secondary and tertiary levels of care in the state the proposed eight regional diagnostic centers would most probably function on a profitable basis.

Similarly as the government of Orissa was not providing the maintenance cost for the 150 bedded pediatrics wards in the Capital Hospital, Bhubaneswar, created by Infosys and hence in the near future this entire ward could be run on a profitable basis. While there were no plans by the state government to introduce any new government medical colleges, it had received applications for creation of private physiotherapy, speech and occupational therapy colleges in the state.

There was not only this increasing effort by the state government to privatize the secondary and tertiary levels of care, but also the health officials at all the levels of health services structure were in favor of more private participation in different aspects of health care in the state. Their view was that the presence of private sector would bring much needed money, efficient use of resources and improvement in quality of care. However the larger question that was missing was how the poor would have access to health care?

In the next chapter we have discussed about process and experience of health sector reforms in our two study districts.
Annexure 1

**ZSS or Zilla Swathya Samiti (Structure)**

Chairperson: President Zilla Parisad.
Co-Chairman: Collector.
Chief Executive: CDMO or Chief District Medical Officer.

*Members:*

- ADMO- Medical and Public Health.
- DLO or District Leprosy Officer.
- DTO or District Tuberculosis Officer.
- DIO or District Immunization Officer

*Different Societies in the ZSS:*

- Malaria- Headed by District Malaria Officer.
- Leprosy- Headed by District Leprosy Officer.
- Tuberculosis- Headed by District Tuberculosis Officer.
- NPCB- National Blindness Control Society.
- DHH- For user charges.

Note: This structure was applicable all over the state of Orissa.