Chapter – 2

Organization and Functions of Health Department of Punjab
India is one of the largest democracies in the world with a federal set-up having a unitary spirit. The recent amendments to the Indian constitution have aimed at further strengthening the federal set-up through democratic decentralization of responsibilities and authority. The role of the government in the development of health services is specified in the constitution. Different layers of the government have varying contributions to the development of health services in a federal set-up in the Indian context, for example, even though health is considered as a state subject, the union Government is seen as keen to take interest in the development of different types of health services.

ROLE OF THE UNION GOVERNMENT

The union Government, as per the distribution of powers, is concerned only with international health matters, coordinating health activities amongst various States establishing standards, promoting research and professional education through the establishment of institutions of national importance in different areas of health, assisting states through National Health Programmes and providing guidance to State health systems. Most of the other health matters are thus reserved for the States and their health departments, though a few, such as mental health, food adulteration, drugs and vital statistics are on the concurrent list. The 42nd Amendment of the Constitution has made "Population Control and Family Planning" a concurrent subject and this provision has been made effective from January 1977. The two Health Survey Committees (Bhore and Mudaliar) reporting in 1946 and 1961, did not recommend an amendment to the Constitution although it was stressed that the Central Government should have greater role and powers to coordinate the activities of the State authorities dealing with health related matters.

Many eminent persons, from time to time, have stressed that the Ministry of Health should be given more powers to deal with such matters. Pt. Jawaharlal Nehru
said: The Central Health Ministry is the pivot round which all the major schemes for improving the standards of health of the nation revolve. All major schemes have necessarily to be sponsored and encouraged by the Central Ministry.

Speaking about the role of the Central Health Ministry, Rajkumari Amrit Kaur, Minister for Health (1947-57) observed: "Health in India is a State subject and the Union Government has mainly an advisory and coordinating function to discharge. The Central Ministry of Health in pursuit of its objective, health for all, has had to initiate countrywide programmes and to coordinate the activities of the various participating States and to see that no State lags behind for lack of current aid whether in the matter of material or human resources or of technical know-how. In doing so, the Centre has not arrogated to itself any power of overall control but has maintained the coordinating and advisory function through the Central Council of Health.

The Union Ministry of Health and Family Welfare plays a vital role in the Government effort to enable citizens to lead a healthier and better life. The functions of this Ministry have been increasing to a great extent through all these years because of the limited resources and expertise available with the State health departments and the need of coordination among the States, as the diseases know no barriers.

Ministry of Health and Family Welfare operates through its three departments-Health, Family Welfare and Indian System of Medicine and Homeopathy. The policies of Health and Family Welfare Department are implemented through Director-General of Health Services, an attached office of the Ministry and various subordinate offices.

We have already the tools to prevent most of the today’s biggest killers. Yet, while knowledge and technology continue to advance, fairness is lost when their benefits are distributed. There is a widening gap between urban and rural areas and among population groups within the specific province.
Chart 2.1

Synoptic View of Health System in India

Health System Infrastructure

National Level Ministry of Health and Family Welfare

States (27); U.T. (7) – Department of Health and Family Welfare

District Health Organization and Basic Specialities, Hospitals District

Community Health Centres

Selected Specialities

Primary Health Centre

Sub Centres

Health Workers (M)

Health Workers (F)

Villages

Health Guide

Trained Dai

People 1,027,015 million

Sub-District Taluk Hospital

1/80,000 to 120,000 (Being Converted into)

1/10,000,000 (old PHC)

1,30,000 (New PHC)
Health, according to the Constitution of India, is a State subject. The main responsibility for providing health services to all the people lies with the State Health Department with the assistance of local health organizations wherever these exist e.g. Corporations, Municipalities, Panchayati Raj, ad-hoc Statutory Bodies like Mines Board of Health, Employees State Insurance Corporation and so on.

The executive machinery of the government at the State level is headed by the Governor, Article 163 of the Constitution Provides for a Council of Ministers with the Chief Minister as its head to aid and advise the Governor. The business of the government of the State (viz. law and order administration, the developmental functions like general administration, local government, public works, irrigation, health, education, cooperation, etc.) is allocated by the Governor amongst the Ministers in accordance with the provisions contained in Article 166(3) of the Constitution.

We shall now discuss the organization of State Health Department in one State of the Indian Union i.e. Punjab.

**ORGANIZATION OF STATE HEALTH DEPARTMENT (See Organgram Charts.)**

In the State of Punjab, a Minister of a Cabinet rank is the political head of the Health Department supported by Parliamentary Secretary. He has to bear a heavy responsibility for formulating policies and monitoring the implementation of these policies and programmes.

The Health Minister has to perform both types of activities, viz., political as well as administrative. These can be broadly discussed as follows:

(i) As a member of the State Legislature, it is his duty to support and safeguard the total policies of the government because of the collective responsibility of the cabinet.

(ii) As a member of the Ministry, he brings all the bills pertaining to his Department for the approval of the legislature.
Discussion with the Patient regarding availability of various health facilities.

Doctor Examining the Ward.
(iii) As political head of the Health Department, he acts as an executive and administrator. He has to see that the policies approved by the legislature are faithfully implemented.

(iv) He is the custodian of the interests of the people in general and of his constituency in particulars.

(v) As a member of the Government, he performs ceremonial duties.

As far as the administrative functions of the Minister are concerned, we find that for a number of reasons these activities do not receive the time and attention they deserve. Being busy with political activities, the Minister does not find enough time for administrative works. Lack of professional knowledge and lack of aptitude are the other contributory factors.

It was also pointed by the Administrative Reforms Commission that there was a growing feeling among the public that most of the ministers lacked interest in efficient discharge of their administrative duties and did not possess the aptitude required for the purpose. The Administrative Reforms Commission in its report on State Administration recommended that, “the head of council of Ministers (the Chief Minister) should, in selecting his colleagues, give special attention to considerations of political stature, personal integrity, intellectual ability and capacity for taking decisions and sustained application to work. Further, in assigning a portfolio, due regard should be paid to the aptitudinal capacities of an incumbent”. The suggestion of ARC must be accepted by the Chief Ministers to bring about innovations in political leadership.

**Administrative Head:**

**Secretary Health & Family Welfare (SHFW):**

SHFW is the overall In-charge of the department. By virtue of his posting, he is also Vice Chairman of the Punjab Health Systems Corporation, Chairman of Punjab AIDS Control Society, Chairman SCOVA (RCH Society), TB society and Leprosy Society.

**Secretary Health cum Managing Director –PHSC:**

SH cum MD-PHSC is assisting the SH&FW in connection with the administrative issues concerning to the PCMS doctors, which include Recruitment, Posting, Transfers, Disciplinary
Actions, Service Rules etc. In addition to this, he has also been designated as Head of Department (HOD) of Government Mental Hospital, Amritsar. He is assisted by Superintendents of Health –I & II Branches of the Department.

**Special Secretary Health (SSH) cum PD-PSACS:-** SSH is assisting SH&FW in connection with all other administrative issues concerning to the Department i.e. Policy Issues, Coordination, Planning, Budget Estimates (Plan & Non Plan), Issuance of Budget Sanctions, Opening of New Institutions & Upgradation, Food & Drug Issues, Disease Control, Immunization and Family Welfare Programmes, Administrative Issues of paramedics. All the issues of PHSC, Family Welfare, ESI, Homeopathic, Ayurveda Department etc.

**Under Secretary Health :-** He assist SSH in finalization of the issues allocated to him. USH is supported by Superintendents of Health-IV, V, VI & VII Branches.

**DIRECTORATE OF HEALTH SERVICES (DHS):**

DHS is supported by different Programme Officers, which include Joint Directors, Dy. Directors and Assistant Directors in implementation of National & State Health Programmes. DHS is also Ex-officio Chief Registrar Births & Deaths and Local Health Authority for the implementation of Registration of Births & Deaths and Prevention of Food Adulteration Act.

**At District Level:** DHS is supported by Civil Surgeon (CS), who take care of implementation of various National and State Health Programmes, Implementation of Registration of Births & Death Act and Prevention of Food Adulteration Act. District Health Officer assists the CS in the implementation of the Disease Control Programmes.

**At Block Level:** CS is supported by Senior Medical Officer I/c of PHCs and Medical Officers I/c of SHCs in implementation of various National and State Health Programmes at grassroots level.

**DIRECTORATE OF FAMILY WELFARE (DFW):**

DFW is supported by different Programme Officers, which include Deputy Director, Assistant Directors, Administrative Officer, and State Mass Media Officer in
enforcement of (i) PNDT Act as State Appropriate Authority and implementation of MTP Act. (ii) Implementation and coordination at district level of different schemes in the State under National Family Welfare Programme.

**At District Level:** DFW is supported by CS in enforcement of PNDT Act as District Appropriate Authority and implementation of different schemes in the District under National Family Welfare Programme through District Family Welfare Officer & District Immunization Officer.

**At Sub Divisional Level:** CS is supported by Senior Medical Officer I/c Civil Hospitals in enforcement of PNDT Act as Sub-Divisional Appropriate Authority and Implementation of different schemes in his area under National Family Welfare Programme.

**At Block Level:** CS is supported by Senior Medical Officer I/c PHC in implementation of different schemes in the PHC area under National Family Welfare Programme.

**At Subsidiary Health Centre Level:** Senior Medical Officers are supported by Medical Officer I/c SHC: in Implementation of different schemes in the SHC area under National Family Welfare Programme through Multipurpose Health Worker (Male & Female)

**PUNJAB HEALTH SYSTEMS CORPORATION (PHSC):**

The State Govt. through a special Act of legislation i.e. Punjab Health Systems Corporation Act of 1996 incorporated the Punjab Health Systems Corporation for establishing, expanding, improving and administering secondary level medical care in the State of Punjab. The PHSC consist of the Chairman, the Vice Chairman, a Board of Directors and the Managing Director who is a Executive Officer of the corporation to implement the decision of the Board of Directors and exercise such other powers and perform such other actions, as may be delegated to him from time to time by the Board of Directors. The Managing Director is supported by the Director (Hospital Services), Additional Director (Admn. & Audit), General Manager (F&A) and other Programme Officers.
**District H.Q. level:** CS look after the hospital services and is supported by Deputy Medical Commissioner (DMC). DMC look after the hospital services in District Hospitals, Sub Divisional Hospitals, and Block level Community Health Centres, which are headed by Sr. Medical Officer or Incharge of the hospital. In two special hospitals, i.e. MKH Patiala and Civil Hospital Jalandhar, there are Medical Superintendents who directly report to H.Q. Apart from this, two Principals i.e. Principal, State Institute of Health & Family Welfare, Mohali and Principal, State Institute of Nursing and Paramedical Sciences, Badal directly report to MD-PHSC through Director (HS). Director Institute of Mental Health i.e. Govt. Mental Hospital, Amritsar report directly to the Managing Director.

**DIRECTORATE OF EMPLOYEE STATE INSURANCE:**
The Directorate of ESI is headed by Director Health Services (DSI). The Department has been divided into 5 Zones i.e. Amritsar, Jalandhar, Ludhiana, Mohali & Rajpura. The first two Zones are headed by Medical Supdt., of each ESI Hospital, Ludhiana Zone by separate Sr. Medical Officer and other two are headed by Incharge ESI Hospital, Ludhiana, Mohali and Rajpura. These MS/SMO/In-charges are supervising the activities of 68 ESI dispensaries.

**DIRECTORATE OF AYURVEDA:**
The Directorate of Ayurveda is headed by Director Ayurveda (DAY) who is assisted by two officers of District Ayurvedic & Unani Officer (D.A.U.O.) rank. The district level establishment of the department is headed by a D.A.U.O in each district except newly carved districts of Nawan Shahr, Moga and Muktsar. The DAY is also entrusted with the duties/functions of Licensing Authority for the state of Punjab. Licensing Authority is assisted by Drug Inspectors the functions of which are being performed by D.A.U.O in the State to control and regulates about 562 Drug Manufacturing Ayurvedic pharmacies in the public sector in the State.

**DEPARTMENT OF HOMEOPATHY:**
The State Govt. established a separate Homeopathic Department in the year 1980 (May 1980). Earlier it was under the Ayurveda Department. The Govt. at that time declared an IAS officer Joint Secretary Health as Head of Homeopathic Department,
Punjab and to assist him on Technical Side Assistant Director Homeopathy was appointed. Presently, the charge of the HoD of Homeopathy Department is with DAY. There are 14 In-charge district level dispensaries which coordinate the working of the department at district level.

**PUNJAB AIDS CONTROL SOCIETY:**

In order to strengthen the National AIDS Control programme management, the State Government established in 1998 their own managerial organization i.e. Punjab State AIDS Control Society (formerly, State AIDS cell), which constitute Technical Advisory Committee and Empowered Committee as per the guidelines of the National Aids Control Organization (NACO). The Chairman of the society is SH&FW who is supported by Special Secretary Health cum Project Director AIDS. Assistant Project Director (APD) provides technical support to PD. ADP is supported different Assistant Directors who look after various AIDS related programmes in the State.
ORGANOGRAM OF DEPARTMENT OF HEALTH & FAMILY WELFARE

Health & Family Welfare Minister

Parliamentary Secretary Health & Family Welfare

Secretary Health & Family Welfare

Special Secretary (cum Project Director/PHSC)

Secretary Health (cum Managing Director/PHSC)

Director Health Services

Director (S) Health

Director Ayurveda

Head of Department Homoeopathy

PHSC

Punjab Health Systems Corporation

PSACS

Under Secretary Health

Health - I, II, III, IV, V, VI & VII Branches

Appendix - A

Appendix - B

Appendix - C

Appendix - D

Appendix - E

Appendix - F

Appendix - G
Chart - 2.6

DIRECTOR FAMILY WELFARE

- Additional Director Family Welfare (Held in Ambiance)
- Deputy Director Family Welfare
- Assistant Director IUD
- Assistant Director SMMIEO
- Administration Officer
- Civil Surgeon (For functional activities)
- District Head Quarter at 'X'

Abbreviations:
- MCH: Maternal Child Health
- IUD: Intra Uterine Devices
- SMMIEO: State Mass Media Information and Education Officer
- ACFA: Assistant Controller Finance and Accounts
Social Insurance (ESI)

DIRECTOR (SI)

Deputy Director
Deputy Controller (Finance & Accounts)

Accounts & Audit Branch

- Medical Inspector
- ESI Hospital Hoshiarpur (50 bedded)

- Medical Superintendent
- ESI Hospital Jalandhar (100 bedded)

- In-charge
- ESI Hospital Mohali (30 bedded)

- No. of Dispensaries
- = 16

- ESI Hospital Phagwara (50 bedded)
- In-charge

- ESI Hospital Rajpura (30 bedded)
- No. of Dispensaries
- = 6

- Sr. Medical Officer
- ESI Ludhiana

- Medical Superintendent
- ESI Hospital, Amritsar (125 bedded)

- Mo. of Dispensaries
- = 10

-One 100-bedded ESI Hospital has been taken over by ESI Corp. w.e.f. 1.10.02

Chart - 2.7
Chart - 2.10

DISTRICT HEAD QUARTER

Deputy Director cum Civil Surgeon
[1 Post at each district]
(Total = 17)

Assistant Civil Surgeon  District Health Officer  District Immunization Officer  District Family Planning Officer  Deputy Medical Commissioner

Senior Medical Officers of PHC/SHCs

1 Primary Health Centre for appropriately (100,000) population
Total in the State 118
SMO - 1  MO - 2 at each PHC

SHC
(Subsidiary Health Centre/ Dispensary)
For 10,000 population each total in the State: 1200

Sub centre Total with State: 2858+ (5000 population)
LHV, Multi-Purpose Supervisor - For a Population of 30,000
(MPHW - M+F)

- LHV  (Lady Health Worker)
- M+F  (Male & Female)
- MPHW  (Multipurpose Health Worker)
- PHC  (Primary Health Centres)
- SHC  (Subsidiary Health Centre)
- SMO  (Senior Medical Officer)
ROLE AND FUNCTIONS OF THE DEPARTMENT
OF HEALTH & FAMILY WELFARE

Department of Health & Family Welfare is providing preventive, promotive and curative health care services in the State through a good network of Public Sector Medical Institutions.

Primary Level Preventive & Curative Care:

There are 2858 Sub Centres (each for population of 5000 manned by one Male and one Female Health Worker). This is the first contact point with the masses. Manpower deployed there support in implementation of (i) Universal Immunization Programme (DPT, Polio, BCG, Measles & TT for pregnant mothers). (ii) Maternal & Child Health (Antenatal Check Up, Institutional Delivery & Post Natal Check Up). (iii) Family Planning: Counseling/motivation. (iv) Management of diarrhea especially in infants. (v) Health Education: - educating the community about the various available services. (vi) Control of Acute Respiratory Infection especially in infants. (vii) Identify the women requiring help for medical termination of pregnancy and refer them to nearest approved institution. (viii) Health Survey.

There are 1200 Subsidiary Health Centres for the population of 10,000 having staff of one Medical Officer, one Pharmacist, one Sewadar, and one Sweeper. Through these institutions, all the above programmes along with curative health care (OPD) is being rendered.

There are 354 Mini Primary Health Centres for every 30,000 population having staff of one Medical Officer, one Pharmacist, one Staff Nurse, one Lab Technician, one Sewadar, and one Sweeper. 4-bedded institutions providing curative and preventive health care.

There are 130 Primary Health Centres / Community Health Centres for every 1,00,000 population having staff of one Senior Medical Officer, two Medical Officers, one Dental Doctor, two Pharmacists, one Block Extension Educator Officer, one Senior Malaria Inspector, four Staff Nurses, one Lady Health Visitor,
and other Para-medics and supporting staff. 25/30 bedded PHC/CHC providing promotive, preventive and curative health care.

**Secondary Level Curative Care:**
Under secondary level healthcare services, all type of curative treatment for various diseases is provided. All type of surgeries and other interventions are being carried apart from by-pass and transplantations, which are being carried in the tertiary level institutions (Medical Colleges). In these institutions, all the preventive healthcare services and other disease control programme are being taken care of. Presently, there are 164 secondary level hospitals in the State as per following details.

There are 16 District Hospitals having bed range of 50-400 beds. These hospitals are situated in all the districts except in Patiala.

There are 2 Special Hospitals i.e. Special Gyane Hospital Mata Kaushyla Hospital at Patiala having 200-beds and Special Children Hospital at Bathinda having 100-beds

There is one Special Mental Hospital at Amritsar having 400-beds, which has been reconstructed recently and is functioning under the name & style of “Institute of Mental Health” Amritsar.

39 Sub-Divisional Hospitals are there having bed range of 50-60 beds.

Out of 130 above-mentioned CHCs, 107 CHCs are managed by the Punjab Health Systems Corporation, (98 CHCs have been recently revamped under World Bank project along with all Districts, Special and Sub Divisional Hospitals). In these CHCs, apart from preventive healthcare services mentioned above, curative health services are being provided.

**Teaching and Training Institutes:**
There is one state level Regional State Institute of Health & Family Welfare Training Centre, at Mohali. There are 17 district level Training Centres. In the State level institution, apart from the monitoring the district level training centres, in-service training relating to various disease control programmes, RCH, TB, MCH and other management trainings are being given. Statutory trainings are also being given in the S.I.H.F.W. Mohali to the students of private schools of MPHW (M).
There is one State Institute of Nursing & Paramedical Sciences, Badal for the women. 3 Multipurpose Health Worker (Male) Schools at Nabha, Khanna and Amritsar and 6 Multipurpose Health Worker (Female) Schools at Gurdaspur, Bathinda, Nangal, Moga, Hoshiarpur and Sangrur. In these institutions, mainly Diplomas are being awarded.

**Drug & Food Laboratories:**
There are two Food Laboratories at Bathinda and Jalandhar, one Food & Drug Laboratory at Chandigarh and one Chemical Examination Laboratory at Patiala. In Drug & Food Laboratories drawn samples are being tested and in Chemical Examination Laboratory Patiala pathological medico-legal examination analysis are being done.

**Indian System of Medicine (ISM):**
The main function of this Department is to provide medical services through Ayurveda, Yoga and Unani system of medicine. This department extends these services through a net work of 5 hospitals, 17 Swasth Kendras and 472 Ayurvedic and 35 Unani dispensaries in the State. To encourage cultivation of the quality raw drugs, their conservation and optimum utilization by Drug Industries and also to encourage the farming community to adopt diversification of crops, the State Medicinal Plant Board constituted in the State under Health Department.

**Homeopathic:**
Under this system, at present there are 107 Homeopathy Dispensaries functioning in the State, which provide curative care in the rural and urban areas.

**Medical Services Under Employees State Insurance (SI):**
Under the Govt. of India / Employees State Insurance Corporation sponsored programmes to provide medical facilities to industrial and other workers (Insured Persons IP), there are six ESI hospitals, 68 ESI dispensaries one TB center (Amritsar). In these institutions, preventive and curative healthcare services are being provided to workers covered under this scheme.
CRITICAL APPRAISAL OF WORKING OF THE HEALTH ADMINISTRATION AT THE STATE LEVEL

We have already examined the organization and functions of the Punjab State Health Department. From the quantitative analysis, it becomes quite clear that the department is doing well. On qualitative examination, it appears that the progress is superficial, unplanned and not directed to the needs of the clients. We give here some facts and suggestions which can help in the improvement of the organization and functions of the health administration at the State level.

(1) Serious Imbalance between the Rural and Urban Areas:

There has been an imbalance in the availability of medical facilities and health manpower in rural areas. Rural people have become conscious of their rights. They demand and deserve good quality health services. Even the government itself is critical of this situation. It was stated officially that “it is an unfortunate fact that thirty years of health services development resulted in concentration of 80 per cent of medical manpower and facilities in urban areas where just 24 per cent of the total population resides. Paradoxically enough, Punjab’s rural areas where 76 per cent of the State’s total population lives were getting just 20 per cent institutional health services. Even 80 per cent of the total health budget was being spent on urban hospitals, etc. So the challenge of providing primary health care services to the ruralities was quite sizable in magnitude” ⁴.

What is being done to ensure health care to the rural people? The State Government are diverting more funds to develop infrastructure for providing healthcare to the rural people especially during the last five years. The basic question is how to ensure whether the rural people are being benefited or not. It is a common ill of Indian Administration that the people are not getting benefits because of the apathy of the personnel associated with the programmes. It is high time that we must ensure the fruitful working of our health schemes benefiting the villagers. Otherwise there is a likelihood of this imbalance increasing further. Health programmes could no more look mere political lollipops. These ought to be structured and designed in a fashion that meets the needs of the people. In the 21st century, we have to improve the health centre for the rural people otherwise there can be violence.
In the execution of health policy, programmes and activities, persons who have an exceedingly important role to play are the Directors of Health Services. Thus a great deal depends on their competence, method of approach and managerial ability. If they have the right kind of leadership qualities, there is no reason why they should not succeed in the implementation of programmes under their control. If one has to identify factors affecting the role of performance of a Director of Health Services at the State level, one can not possibly miss the most important factor related to his relative inferior position as compared to the prestigious position of the Secretary of Health Services. The Principal Secretary / Secretary / Special Secretary of Health Services as a rule is a senior member of the Indian Administrative Service. The Director is generally the senior most members belonging to the State Medical Service Cadre. The issue, which involve them in conflicts range from decision making regarding health programmes to their actual implementation in the field. The director often feels that by virtue of his professional knowledge and competence, his judgment is better than the judgment of his administrative senior. The domination of technocrats by the administrators in their day to day work has been debated in many national forums. The scientists feel that if they are given the freedom to decide, they can take much more interest and take rational decisions. The Administrative Reforms Commission (1666 – 70) pointed out: “An effort is needed to match jobs with the men possessing the needed qualifications, which means that the preference for the generalist, pure and simple should give place to a preference for those who have acquired competence in the concerned field”.66

The Fulton Committee, which was set up in Great Britain in 1966 and which submitted its report in 1968 similarly said, “Many Scientists, Engineers and Members of other specialist classes get neither the full responsibilities and corresponding authority nor the opportunities they ought to have. Too often they are organized in a separate hierarchy while the policy and financial aspects of the work are reserved for a parallel group of generalist administrators and their access to higher management and policy-making is restricted. In the new Civil Service a wider and more important role must be opened up for specialists trained and equipped for it”. 6
Mr. P. Lal in his article, “Saying Bye-Bye to Bureaucracy” in the Sunday Tribune rightly sensed the role of specialists in 21st century. To quote him: The bureaucratic system worked well when organizations were static, challenges small, expectations low, knowledge limited and information confined to local areas. Turnover of individual’s relations with people, institutions and ideas was also quite manageable. However, with the advent of the age of information technology some three decades back when computers came of age, knowledge burst upon the planet globally. What happens in one corner of the World now becomes known instantly in another. Internet has provided access to the common man, the information earlier available to specialists and professionals alone. High speed decisions are required to be taken by men and organizations.

As the governance and management functions require more and more of inputs from specialists – system analysts, computer programmers, engineering specialists operation researchers – the importance of the latter increases and their advice and opinion can not be brushed aside by the top management. Thus, they acquire a new decision – making function.

Says Professor William H. Read of the Graduate School of Business at McGill University, USA, “More and more of specialists do not fit neatly together into a chain of command system and can not wait for their expert advice to be approved at a higher level”. They assume the role of decision – maker, they may well consult the ground level worker but would merely inform the top-executive who nods and accepts as the system benefits the organization.

Thus, the specialists should be given parity with the Indian Administrative Service in the matter of conditions of service. Besides, they must be given top positions at the policy making levels in Government. This would raise the morale of the technocrats and would improve the efficacy of the Government.

(3) Absence of Comprehensive Health legislation

In the States, legal provisions in regard to health lies scattered over a number of Acts. At present, there is only one State – Tamil Nadu, which has a comprehensive Public Health Act satisfying reasonably the requirements of the modern health administration. The present corpus of health legislation is inadequate
resulting in piecemeal decision. Regulations are lacking in many vital subjects. In several respects the legislation is ineffective and outdated. There is a need for comprehensive legislation embracing all aspects of health in the State. This would result into good health policies and plans.

(4) Medical Education not Oriented to Rural Needs

A group on medical education and support manpower set up in 1974 noted with concern that “Medical Education in India over the years has been essentially urban oriented, relying heavily on curative method and sophisticated diagnostic aids, with little emphasis on preventive and promotional aspects of community health. Programmes of training in the field of nutrition, family welfare planning, maternal and child health have tended to develop in isolation from medical education and thus do not sub serve the total needs of the community. Although the number of doctors has speedily increased over the successive plan periods, the alienation of doctors from the rural environment has deprived the rural communities of total medical care. The same feeling was voiced in the 5th Five Year Plan. The 6th Plan also went on to point out that, the basic problems is to produce a doctor who will be able to provide good health care and medical service to the community and will be able to work effectively in rural areas. Thus, it is high time for the State Governments to take policy decisions to reorient medical education with a view to progressively make the training of the medical students more community based. It is suggested that the internship of Medical College students may be arranged in villages. The students may be asked to execute a bond to serve in the villages at least for a period of five years. The curriculum may be curtailed and may be oriented to the community needs.

(5) Lack of Community Health and health Administrative Researches

Huge sums of money are poured out annually on clinical hospital based research in most States of India. One would not under-estimate the importance of this type of research because it adds to knowledge. However, one has to think in terms of defining the priorities of research. A country, where the bulk of people are living in the rural areas, should normally involve the greater number of doctors doing researches in community health. India is one country, which can not boast of even a single good epidemiological study of such communicable diseases as

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tuberculosis, from which a sizable number of people suffer every year. In fact, the area of community health research does not encourage clinicians to work in the rural areas. The problems of community health, no doubt, are vast and intriguing. Yet, the country can not afford to ignore them. India lives primarily in the villages and it is the villagers who are the recipients of probably the poorest quality of medical care. The future of India also depends on the progress made in the villages, particularly in the area of health. One has to watch and see how different states plan and administer their health programmes so that their rural beneficiaries are not outnumbered by their urban beneficiaries. Thus the present trend of our spending on curative medical research has to change in favour of community health research particularly in the rural areas. This is a challenge which no State of Indian union can afford to ignore.

Further, the health administration at the state level is poorly equipped. Most of the health administrators have got no training in the modern knowledge of management. There is no effort on the part of the personnel working in health departments to use modern methods to improve health care delivery. Moreover, the Health Departments, Training Institutions, Medical Colleges, Nursing Colleges do not seriously concern themselves with finding methods for optimum utilization of resources. Health services research should be multidisciplinary, involving not only medical professionals and experts but also system analysts, operational researchers, social scientists, health economists, public administrators, anthropologists, etc. The State Health Department may encourage research in consonance with priority problems of its health care delivery system. The health department may encourage researches, which affect programme delivery. Some areas are mentioned below.

a) Health Manpower – Their training, development, utilization, availability, needs and demands, etc., including experimentation with the development of various categories of health manpower.

b) Equipment, materials etc., their availability, utilization, needs and demands.

c) Organizational and management process in health and family welfare services, their linkages etc. including referral systems.

d) Performance and impact of health and family welfare services.

e) Needs and demands of population for health and family welfare services.

f) Perception, attitude, utilization factors (Promoters and Barriers) effecting utilization etc. of population towards health and family welfare services.
g) Problems and bottlenecks in the existing organizational system and redesigning of existing systems to eliminate the same.

h) Information systems for health and family welfare.

i) Cost benefit and cost effectiveness analysis of health and family welfare services, programmes and projects.

j) Cost-analysis of health and family welfare services, programmes and projects.

k) Development and testing of technology suited to the Indian health scene and needs.

l) Studies focused on the interphone between community and health services organizations.

m) Studies on health status and social and economic development.

n) Materials management in a hospital.

o) Working of intensive care units.

p) Cost of running hospital services.

q) Staffing of emergency services.

r) Utilization of operation theatres.

s) Enlisting of community participation.

t) Development of planning and management techniques.

u) Identification of goals and priorities of the health services.

(6) Absence of Well – Designed Management Information System

Many state governments have performed the ritual of setting up statistical bureaus dealing with health. Huge health statistics have also been collected but these have been put to a bare minimum use in terms of utilizing this information for developing a realistic health care delivery system. Thus the ever-widening gap between accumulation of health statistics and their utilization for improving health services has of late acquired new significance. While in the developed countries management information system is increasingly being given the importance it deserved, in the developing countries it has not yet become an integral part of the state health system. It would indeed be very profitable for all the states to organize data banks and critically examine the quality of their health services. Because of the many uses of health statistics in scientific analysis, planning, administration and evaluation, the health statisticians must begin to think in terms of a fully coordinated
health information system, in which all relevant datas are collected, compiled stored, retrieved, analyzed and published.\(^7\)

    However, the Health Information System has to be planned properly. A Health Information System was defined by Conference on Health Information Systems held by WHO in Copenhagen from 18-22 June 1973, as,

    “A mechanism for the collection, processing, analysis, and, transmission of information required for organizing and operating health services and also for research and training”.\(^8\)

    We must ensure the accuracy of data, otherwise whole of our planning would go wrong. Goddard has rightly said, “One of the greatest possible contributors to wastage of our precious resources, whether at the local, national or international levels, is the failure of those at any level of administration, and, at all stages in the management of the activity, to base all decisions on verifiable facts. There should be no tolerating errors in administrative action, which occur because someone failed to get all of those facts. In the evolution, execution and control of work plans, obtaining the factual evidence should always be the first step.\(^9\) Mahdi Elmandjra in his article, informatics and telematics, the future in World Health, Aug/Sept. 1989 warns the use of borrowed systems. To quote him he says that knowledge which has become the most strategic raw material in all the domains of human activity is simply information produced by sound research and managed by people well trained in the pursuit of clear objectives and goals. Informatics is of course not a panacea especially if it is used as a purchased gadget and implanted as a foreign body in an environment which does not meet its minimum conditions. Yet it represents today the most efficient instrument which man has so far invented to help him to analyze and solve problems.

(7) **Inadequate Financial Resources**

    It is one thing to define health needs of a given population and another thing to adequately plan health services in accordance with their needs. No aspect of planning health services appears to be more important than the consideration of finance. The paucity of financial resources because of poor allocations has often proved to be a major obstacle in the execution of health programmes. With the
meager resources, one can not expect mush. At present, the Health Department of Punjab is being allocated only 3-4% of the total resource for the promotion of health. The task of providing health care to improve the quality of life of the people is challenging. The state governments must allocate at least 10% of their total budget for health. Besides, there is a need to make the best use of the resources already allocated.

However, financial resources mobilized through alternative mechanisms, such as cost recovery and user fees, are minimal at this stage, being less than 10% of the total recurrent health expenditure. It has, therefore, become increasingly difficult to meet the unprecedented rising costs of health care.\textsuperscript{10}

(8) Non availability of dedicated doctors/workers to serve in the villages

The doctors prefer to serve in the cities than in the villages. When they are forced to work in the villages, their mind is always in the cities. This results in lower efficiency of the Primary Health Centres. It is suggested that the Government while selecting the students for medical education must ensure that a large number of students should come from villages, i.e. rural areas. The missionary zeal may be cultivated among the doctors during their education so that they take up the rural assignments with dedication.

(i) Need for Human Resource Development to Inject Creativity and Dynamism among Health Personnel.

The provision of health care at lower levels is not a mechanical process, it is a human enterprise and its success will depend ultimately on the skill, the quality and motivation of the persons associated with it e.g. Medical Officers, Workers of health at the lower echelons of Health Administration are vital link between people and the health care system.

The quality of personnel appointed to take care of health related activities, levels of efficiency, motivation and enthusiasm have not been maintained at a high level and there is lack of devotion to duty on the part of the medical and paramedical personnel. Complaints by the citizens regarding inefficiency and lack of devotion to duty on the part of medical and para medical personnel have become quite articulate,
and, many people are even losing confidence in the existing primary health care system thereby widening the credibility gap.

HRD is concerned with organizing, in systematic fashion, the goals, objectives, priorities and activities of manpower development in order to ensure that the right number of staff with the appropriate skills are provided at the right time to meet the requirement of the work to be done.

There should be only one yard stick to judge the effectiveness of manpower development, namely, continuous improvement of the status and the quality of health of the population with the least friction to those who supply the services and the most satisfying to those who receive it. We have to achieve all this with the minimum cost and maximum efficiency.

(ii) Need of Developing Missionary Spirit among the Health Personnel

The problems of public health care challenging as it can be gauged from the statistics already enumerated. It is very difficult to solve these problems with bureaucratic and inhuman attitude. It requires hard work, sympathy and tolerance on the part of the health personnel engaged in this arduous and challenging task. Most respondents felt that the personnel working are fulfilling only their legal duties and that too reluctantly. We do not need highly specialized people in these areas. We, however, require dedicated people with missionary zeal to serve the people suffering from illness. Prof. J.S. Neki has rightly said in the context of health personnel which is true for all categories of personnel.

To help, to heal, to reconstruct, to comfort – and all along the line to act with compassion – all these bear testimony to the moral consciousness of the doctor. Whatever, the new strains imposed upon medical ethics, this structure will survive and continue to guide doctors in their professional conduct. Legal and Judicial obligations they have of necessity to fulfill. But these are not genuine ethics. Genuine ethics has to be ingrained into character and does not have to depend upon external controls."

Mr. R.S. Pathak, Former Chief Justice of India rightly mentions: “The vitality of an ethical dimension in the discharge of public responsibilities is essential
to a developing nation. In a developing nation, the release of nascent national energy is a great moment. It provides the power necessary for building of a nation.12

(9) **Under-Utilization of Indigenous Systems of Medicine**

Indian health problems are of such magnitude that if left only to the allopathic system of medicine, one can not possibly hope to achieve much success. In the past, a policy of drift has been followed with regard to Ayurveda and other Indian System of medicine. The supporters of Ayurveda and Homeopathy feel that this system could not get a chance to demonstrate its utility. It has been claimed by the practitioners of the indigenous system of medicine that the facilities provided to prove the true worth of the system. The Punjab Govt. has shown its keenness to promote the system but the tempo is very slow. The government should take a bold decision to encourage these systems, which can provide health care to a large number of people with little cost.

(10) **Unsatisfactory Management of Employees State Insurance Scheme**

Employees State Insurance Scheme has not been functioning well. The shortage of doctors and medicines is the common ill of these institutions. There had been complaints from the beneficiaries about the malfunctioning of these hospitals. It was mentioned in the Tribune by C.M. Kumbhkarni with reference to ESI hospital, Jalandhar.

The indoor patients take their meals like beggars on paper and towel. The hospital is to provide with stainless steel utensils but these are kept under lock and key.

Besides, it is widely felt that there is a large no. of cases of corruption among the doctors working in these hospitals. The State Govt. must tighten the control over these hospitals and monitor the reactions and feelings of the patients to streamline the functioning of ESI scheme.

(11) **Poor Nutritional Status of the people**

Punjab is an economically well off state, but the majority of the people suffer from diseases arising from nutritional deficiencies and malnutrition.
The following recommendations were made by the South East Regional Committee to solve the problems of nutritional deficiencies which needs the immediate attention of the State Health Department.

1. Nutrition activities should be recognized as crucial components of health programmes, particularly of those directed at the mother and child.

2. The nutrition activities of health programmes should be very clearly defined and their implementation at all levels and especially at the local level, should receive sufficient attention and allocation of resources.

3. In the package of services, nutrition should receive the same priority as other components, so that it is not relegated to a position of secondary importance as has been many times the case.

4. The delivery system for nutrition activities catering to the needs of the under served population should be rationalized applying the principles of primary health care and using primary health workers within the context of National Health Administration.

5. Nutrition education relevant to the local situation as a part of health education of the community and its inclusion in formal and non formal education need to be improved.

6. Service oriented nutrition research to solve public health nutrition problems must receive priority.

7. To fulfill the inter-sectoral and intra-sectoral responsibilities of health in nutrition, the role of the nutrition unit at the central level of the health services needs to be considerably strengthened with its increased participation in health planning and programming.

Finally, there are a large number of other problems in the areas concerning Health Planning, Health Manpower Planning, Health Project Management, Hospital Management, Administration of Health Education and Environmental Sanitation programme, which would be discussed in the relevant chapters.
Community participation is perceived as a dynamic partnership process that is reinforced by information feedback. Health personnel are responsible for explaining and advising and for providing clear information on health options. Community participation enables people to become agents of their own development, instead of being passive beneficiaries of development aid. The channeling of a community’s human resources generated by the health volunteer movement is advantageous to both the health care providers and the recipients. Volunteers in community health activities not only bring health services to the community, but also act as agents for health development.

Social preparation and capacity building in the community are prerequisites for mobilizing communities for health activities. This could be supported through information, education and communication (IEC) materials in both electronic and printed media, the formation of support groups, shared efforts of health volunteers through village exchange visits, and, the development of joint plans of action and intersect oral activities at village level.

Community health development through education is a critical issue that requires an investment of time and resources by the health care system.

In the new millennium, State Health Department must change its emphasis from merely examining files sitting in the offices but should ensure implementation of the programmes through personal visits, monitoring, regular guidance. We have to discard the old method of paper approach to action approach at least now. In the 21st century, health departments must be guided by the motto, words written or spoken are of no use unless put to action.

The big task in the new century is not only to enable change but to communicate it as widely as possible. Can the field functionaries dream what the headquarters policy-makers dream. Such congruence is sure to be a fillip to progress.

In this context, the State Government has to play a more dynamic role through Panchayati Raj System, Municipal Government in ushering new era of
health development by exploiting local resources. This can be achieved through transparency accountability and good governance. People’s empowerment is the only answer to solve many national and bureaucratic ills from which the system suffered.
Reference:

2. Ibid., p. 19
3. Government of Punjab, Department of Planning, Annual Plan, 1979-80, p. 112