CHAPTER FIVE
Health Care Delivery in Orissa: A Look at Standards

The thrust of the chapter is to explain how health care delivery system works at different levels in the state of Orissa. To go into the details about health care delivery mechanism, before that one has to explain the background of the state and health sector reforms and also context of rights issues which is the major focus of the chapter. One of the prime objectives of any health system is to provide quality health care to its citizens. This is primarily done by strengthening the service delivery mechanism and improving systems and processes. In spite of this, the quality of the state health care varies widely across geographic areas, populations, and levels of care. The health policy 1983 and 2002 has emphasized on improving the health status of the people by creating efficient and effective public provisioning of health care in the country. Many studies, particularly, the RCH- facility surveys have revealed the inadequacies of public health facilities and how the public health system has become inaccessible to majority of its citizens. Among many other factors the inadequacies at the facilities affect the outputs and these are policy induced and states with improved output indicates sound and organized transmission mechanism than others.

Given the backdrop, this chapter examines the nature and quality of health care delivery facilities in Orissa. It also discusses the governance process and transmission mechanism of service delivery in the state. It looks into the infrastructure, tools and equipments and manpower in the health care facilities and how this functions to improve the service delivery at the primary and secondary level. The other side of the issues has been discussed in the light of organizational structure and institutional arrangements made to strengthen the service delivery system.

This is based on review of primary data collected from sample health care institutions in one district of Orissa. The two hospitals have been selected on the basis of Human development Index (HDI) and one hospital with highest HDI and other lower HDI have been selected. Among the hospitals two blocks have been chosen on the basis of distance as criteria because Bhore committee report suggests that every village where 10,000 to 20,000 thousands people are living that village should have at least PHC with a doctor for that reason distance has been taken as a parameter. From each block,
headquarter institution and 50 percent of the PHCs and 30 percent of the sub centers have been selected. Information were collected through a structured questionnaire on different aspects of functioning of health care institutions, constraints faced and steps taken to fill the gap. In order to find out the changes in the system and processes, a series of discussion were held with the key officials and chief district medical officers and other functionaries in the district. It is significant to note that the state of Orissa’s brief background and location is relevant to the present study.

Despite gradual improvement in health status over many years, preventable mortality and morbidity in Orissa are high. The root causes of poor health continue to be poverty, social deprivation, low levels of literacy and inefficient health systems and infrastructure for health care and control of diseases, particularly communicable diseases. Socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate geographic spread of service outlets and poor quality health care reduce access to and effectiveness of public services.

**Organization of Health Services & Health Programmes in Orissa**

The Government of Orissa through numerous programmes in the health sector claims that it is providing adequate, qualitative, preventive and curative health care to the people of the State as well as to ensure health care services to all, particularly to the disadvantaged groups like Scheduled Tribes, Scheduled Castes and the backward classes. It also aims at providing affordable quality health care to the people of the State not only through the Allopathic system of medicine but also through the Homeopathic and Ayurvedic systems; to ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units.

**Genesis of Health Sector Reforms in Orissa**

Interest in health sector reform in Orissa began in the mid-1990s. Earlier phase of health sector in Orissa through a planned process since 1947, there has been an expansion in infrastructure and systems for providing health care services throughout Orissa. Orissa has adopted Central Government norms, guidelines, policies and programmes for this development. Since the year 1947, there has been a gradual improvement in the health status of the population due to several factors including
developmental and educational interventions, economic improvement and better health care services. While the Infant Mortality Rate (IMR) has declined from 135 in 1981 to 97 in 1989, it is still one of the highest in India – much above the national average of 70. Indicators of nutritional status among women and children and burden of diseases indicate a substantial higher proportion of morbidity and mortality. The people of Orissa experience a large number of disasters – about 40 major disasters in 50 years – that adversely affect health and development and health care services.

This was propelled by the occurrence of two events, (1) the formation of a Committee of the Orissa Legislature chaired by the Health Minister (called the House Committee) which looked into three important aspects of health care and in 1995-96 recommended, cost recovery through user charges in hospitals, granting of autonomy to be given to district and tertiary hospitals and abolition of private practice by doctors. These recommendations coincided with the evaluation by DFID, which stated, that in order to ensure effective health care delivery, the Government of Orissa needs to:

- Make funds available for maintenance of buildings and equipment
- Make funds available for medicine (i.e. drugs and consumables)
- Make funds available for transport (i.e. mobility)
  - especially for health care delivery and supervision.

These reports served as an impetus for health sector reforms in Orissa. In the five years or so following these two events, a number of reforms, both large and small, have been introduced in the health sector in Orissa. Some of them relate to changes in administrative and operational systems, some to changes in personnel policies including skill development for better service delivery, and some were aimed at giving a minimum health guarantee to the people.

**Orissa Health & Family Welfare Reform**

After Phase I & II of the DFID supported study, Phase III (1997-2001) was implemented with a project outlay of Rs. 14.55 crore. This study sought to fill the gaps in terms of maintenance of buildings, mobility and medicines with a view to providing quality primary health care at the village level in two demonstration

---

1 Orissa Health Report, Published by Government of Orissa, Bhubaneswar, 2007
districts of Balasore and Bhadrak. It also aimed to identify areas and mechanisms to ensure community participation and to address the health needs of the disadvantaged population, particularly, the needs of women. Under the reforms, petty maintenance has been made the responsibility of Medical Officers and Waste Management in Primary Health Institutions has been introduced. The Zilla Swasthya Samitis (ZSS) or District Health Societies have been made functional and the project activities are implemented through the ZSS. Repair and maintenance of health institutions and assets is also taken up through the ZSS. Provision of adequate quantities of quality drugs in primary health care institutions is being ensured.

**Orissa Health Systems Development**

The Orissa Health Systems Development (OHSD) is under implementation since September 1998 with the assistance of the World Bank. It seeks to improve health care delivery in selected primary and secondary hospitals in the State; increase efficiency in the allocation and use of health resources and address systemic, broad-based problems faced at the first referral and community levels. Furthermore, it seeks to strengthen systems including overall management, procurement of drugs and equipment, referral, health management information system (HMIS), surveillance of major communicable diseases, health care waste management and equipment management system. A Policy and Strategic Planning Unit (PSPU) has been established to provide strategic planning support to the study and to push the health sector reform agenda.

(I) Public Private Partnership

**A. Handing over PHCs to Private or Non-state Actors**

The handing over of PHCs to non-state actors was experimentally tried out in two tribal districts as the government was finding it difficult to provide health personnel in single doctor PHCs in remote locations. The Government of Orissa entered into partnership with a view to ensure provision of better health care to the people in remote areas. Under the agreement, the PHCs were to be managed and run by private parties. This experiment did not run for very long and the private parties handed the PHCs back to the government after sometime. An evaluation of the initiative revealed that the terms of reference and modalities of transfer were inadequate and the private parties did not have the resources and ability to run the institutions.
The evaluation report recommended trying out the experiment in more places with suitable modifications. Presently, public private partnerships are being implemented for safe abortion services and social marketing of disposable delivery kit (DDK). Parivar Seva Sangh and Population Services International are being taken as agencies of implementation under the Sector Investment Programme. Also, facilities for 24-hour drug counter have been established by private agencies inside the hospital campus. Presently, discussions are being held between representatives of non-state actors and government and terms of reference are being developed with a view to initiate such public-private partnerships.

It is significant to bring out the argument relating to the process of globalization and its impact on health sector. Globalisation has evolved out of a gradual progress of progressive integration of the world economies through falling trade barriers, greater exchange and mobility of capital and labour. The process further facilitated by a number of developments in international cooperation, emergence of international institutions and the continued advances in information and communication technologies also paved the way for global governance. The new globalisation environment has driven several developing countries with a sizeable public sector to adopt policy reforms including macroeconomic and financial stabilization policies, creation of market-oriented environment and more space for the private sector. This goes hand in hand with increasing internationalization of goods, services, labour and capital, and exchange and exposure of human beings for development oriented programmes. However, such a process is likely to have far reaching effect on health sector both direct and indirect particularly in developing countries, where health attainments are low and majority of population lack resources to finance their healthcare needs.

B. Outsourcing of Cleaning in Hospitals

Given the lack of cleanliness in government hospitals, in July 1997, an experiment was carried out wherein the cleaning work of District Head quarter Hospital, a major hospital, was contracted out to a private agency – viz, Sulabh International at a negotiated price. It was agreed that the existing cleaning staff (i.e. the government employees) would be engaged in other work in the hospital. The state government’s
finance department required that while no retrenchment need take place, existing vacancies of cleaning staff be abolished and any new vacancies occurring as a result of retirement or death not be filled up. Initially there were some protests from the Class IV employees union, but since no retrenchment of staff was involved, the protests did not gather momentum. The contracting-out of select services has led to proper maintenance of hospitals, proper management of waste and better care for patients and their attendants. Some of the challenges faced included resentment from the regular cleaning staff, non-utilization of existing staff and problems in ensuring timely payment to the agency.

Thereafter, other hospitals also sought to contract out the cleaning services in their institutions. Since funds were a constraint, this could not be done, at once, in a large number of hospitals. However, in September 1998, further contracts were signed with Sulabh International for the cleaning of one ward of the SCB Medical College, Cuttack, and six wards of the MKCG Medical College, Berhampur. Subsequently, this was extended to four district hospitals. Presently, contracting out is being carried out on an experimental basis in some of the districts. In addition to this, security services in Capital Hospital, Bhubaneswar and other such larger hospitals have also been contracted out in the state.

Following a recent State Government decision, the costs of cleaning and sanitation are to be made out of the user fees generated through the ZSS. In case of disputes and controversies in selection of the contractors, the matter is to be referred to State Director and Government for final decision. The hospital cleaning and sanitation is supervised by the Hospital superintendent and the payments are passed through the ZSS. It is proposed that catering and laundry services are also contracted out.

In contracting out of cleaning and sanitation of hospital, the selection of the contractor is made through a tender procedure. Experiences in hospital cleaning and sanitation, solvency of the contractor, availability of assets, location of contractor’s office, tax clearance certification, registration number, etc are taken into consideration by the tender committee. This committee is headed by the District Collector (Chairman) and the CDMO or Addl. CDMO or ADMO (PH) as members. Tender notices are
published in the newspapers and the Collector of the district is the final authority in selecting the contractor.

(II) Decentralization

A. Initiatives in Decentralization

In the state of Orissa, there has been a move towards decentralization, wherein the districts and the health institutions have been granted the authority to plan, budget and implement its own health programmes. They are also able to generate their own resources, within the purview of the broad government guidelines. Moreover, financial and administrative powers have been delegated to the district administration and the block health administration. The programme officials opine that in terms of success, lessons and challenges, delegation of financial and administrative power has led to improvement of quality of services to staff like timely payment of entitlements, positioning the right person in right place, better control on sub-ordinate and minimization of workload in the Directorate. However, some challenges remain. The delegation of power to block level has not been supplemented with training of MOs in administrative and financial matters. There is no provision made for attached support staff. Another area, which requires strengthening is establishment of inter departmental harmony. Another development in the realm of decentralization has been the formation of ZSS.

(i) Formation of Zilla Swasthya Samitis

With the increasing emphasis on decentralization, ZSS were developed as an important district level functionary for implementation of health related programmes and activities. The ZSS was initially formed in 1993 as registered societies in five districts of Orissa, with a view to implement the DFID assisted Area Development Project, Phase II. Subsequently, such societies were formed in all districts to implement the various Government of India supported health programmes. Earlier, separate district level societies were established for malaria, tuberculosis, blindness, leprosy and AIDS, wherein each society was operating and implementing specific health programmes under the chairmanship of the District Collector. With a view to reduce the multiplicity of committees and societies at district level, the government issued an order leading to merger of all existing societies into one society- the ZSS and the subsequent modification of by-law of ZSS to this effect. Subsequently, all the
CDMOs were asked to dissolve the existing societies in the district and merge them with the ZSS. Also, on merger, the existing assets and liabilities of the merged societies devolved on the ZSS. Autonomy has been given to all hospitals under the jurisdiction of the ZSS / DHH in particular. For large hospitals, the hospital society has been constituted with powers and functions like the ZSS.

The primary objective of ZSS is to provide the Health and Family Welfare Department, with increasing support for effective implementation of its ongoing programme such as population control, reproductive and child health, immunization, school health programme, control of diarrhoeal diseases, control of TB, leprosy, etc. The ZSS acts as a nodal forum for all health and family welfare activities to be undertaken in the district. Over the years, the range of activities to be undertaken by the ZSS has increased to include development and maintenance of health infrastructure, planning and implementation of effective IEC programmes, collection and utilization of user fees for various hospital services, operation of ambulances, procurement and distribution of drugs, delivery of various non-clinical services, provision of training to medical, paramedical and non-medical personnel, volunteers amongst others, ensuring community participation through the PRIs, publication of literature relating to health and family welfare programmes, undertaking research on issues related to health and family welfare, amongst others.

The ZSS is a society at the district level registered under the Society Registration Act, 1860. As per the recently amended MOU 9 of the ZSS, the District Collector is the co-Chairperson, while the CDMO is the Chief Executive cum Vice-Chairperson. The members of the general body include government officials like the Executive Engineer (R&B) / PWD, ADMO, ADMO (PH) / (Med) / (FW), PD (DRDA), amongst others as well as NGOs, representatives of donor agencies working in the district, etc. Additionally, there are patron members, ex-officio members, nominated and co-opted members. Any individual or institution with an interest in health activities and an aptitude for social work can become a member of the ZSS on request and by application, subject to the approval of the Executive committee.

A case study on ZSS was conducted. This study covered one sample districts of Balasore. It mainly involved discussion with the members of the ZSS, review and
verification of relevant documents, collection of available data on achievement and performance of the ZSS. The study recommended a set of strategic measures for functional improvement of the ZSS. These include inter-alia, the essentiality of developing and providing comprehensive operational guidelines for streamlining of bye-laws, consolidation of financial and accounting systems, especially in light of the need for amalgamation of all district level societies; sanctioning of maximum administrative authority to the CDMO as the ZSS activities pertain essentially to health related programmes and projects; need for appointment of full time senior officer to manage the ZSS activities; appropriate orientation and training to the staff, formation of performance monitoring indicators of ZSS, periodic review of the ZSS and need for better inter-sectoral and inter-departmental co-ordination so as to improve its service delivery performance.

(ii) Amalgamation of Zilla Swasthya Samitis
ZSS have been established to manage health care delivery system in the district in a co-ordinated way through involving government, private sectors and community. Earlier, besides a Zilla Swasthya Samiti (District Health Society) which had a variety of functions, a number of individual societies had been set up in the districts for each Central or donor funded programme. There were societies for Blindness, Leprosy, TB, Malaria, etc. The composition of almost all the societies was the same with the District Collector as Chairman, and the Chief District Medical Officer as Member Secretary. Hence, it was felt that such multiple societies should be amalgamated to form a single district health society. This was done in 1998 across the whole of Orissa and the amalgamated societies went by the earlier name of the Zilla Swasthya Samitis.

(iii) Reforms related to Human Resources
In 1996, as part of a strategic review of the health sector, undertaken by the Govt. of Orissa in partnership with the DFID, ‘in-service training of personnel’ was identified as one of the lacunae. Hence, reforms to strengthen and improve the capacity of health personnel were introduced. These included:
B. Mandatory pre-PG rural service

In face of the large number of vacancies of doctors in tribal and ‘difficult’ areas, the lack of adequate success in ensuring the presence of doctors in such areas, absence of rural orientation to the young doctors, an attempt was made to ensure that young doctors were posted to such areas and institutions. Under this scheme, which was introduced in 1998, all over the state of Orissa, eleven districts, to which doctors are generally unwilling to go to and which have consistently had a large number of vacancies, were selected, and health institutions were identified. The entrance examination for the medical post graduate (PG) courses was held one year ahead of the date of admission. Those who qualified were advised about the medical college and the discipline they would get, and thereafter assigned to one of the institutions in the 11 districts. Those who are not already in government employment were given contract appointments and assigned to these districts. Amendments were also made in the Orissa Medical Service Rules so as to make the first posting to rural areas mandatory. The doctors are required to work in these institutions for one whole year, and only after obtaining a certificate regarding completion of the period, are allowed admission into the PG course. Doctors were not willing to go to tribal areas and difficult area earlier, now government has taken the initiative that every newly appointed doctor has to go to difficult and remote areas. It is a part of the agreement while they are appointed.

C. Internship Training Programme for Better Community Health Orientation

In the past, medical interns were given community health training in three training centres (under the control of medical college) and their attached health institutions. They were trained in large groups of 25 or more, got hardly any exposure to real community health problems and the quality of the training was poor with little, or no, hands-on training. Further, the supervision was done entirely by the medical college teachers, who are themselves not very much in touch with community health conditions and developments. So, with an objective of improving the quality of community health training of medical interns, a new scheme was introduced in 2000 across the state of Orissa. Under the new scheme, the interns are sent in groups of two and three to community health centres under the control of the CDMOs for a period of three months to be trained in public health activities. They are exposed to real community health situations and get ‘hands on’ training. They are supervised both by
the medical officers in charge of the institutions as well as the medical college teachers.

D. Multi-Skilled Health Personnel
Given the lack of adequate skilled personnel like laboratory technicians, an attempt was made to utilize the existing personnel like the pharmacists, health workers, ANMs for different activities. Pharmacists and health workers have been trained in microscopy for sputum and blood examination, and deployed in the implementation of the Revised National Tuberculosis Control Programme (RNTCP) and the malaria programmes. ANMs have been trained as Directly Observed Treatment, Short-course (DOTS) providers and deployed in the RNTCP in addition to their own duties. This is being done since 1998 and is applicable to the entire state of Orissa.

E. Short-Course Training in Anaesthesia Administration
The shortage of anaesthesia specialists, short course training in anaesthesia administration was introduced in 1999, as a pilot programme with a view to enable doctors in CHCs to administer anaesthesia in emergency obstetric care. Doctors from the field were given three months training in anaesthesia administration. However, the numbers trained are, so far, very small. The scheme, which was discontinued, is proposed to be restarted.

F. Appointment of staff on a contractual basis
In face of lack of adequate personnel, Medical Officers (MOs) have been appointed on a contract basis in the vacant posts. These appointments are made after conducting walk in interviews at the district level with due concurrence of the Director of Health Services. Similar appointments are being made for health worker (female), staff nurse and pharmacist as also for support staff like clerks and drivers against the existing vacant posts.

G. Formation of District Cadres for Paramedics
Prior to the formation of district cadres, most paramedics such as ANMs, nurses, pharmacists, laboratory technicians were employees of the state and were expected to work in any part of the state. They were also subject to transfers from one place to another. As paramedics are mainly low-paid government workers, mostly women,
these conditions of service caused considerable hardship and expense. Besides, the workers, who were from the more developed coastal districts were reluctant to go to the remote and unpopular districts and remained on leave on some pretext. Consequently, many posts in these areas remained vacant. Hence, in 1998, a decision was taken to form district cadres for the paramedics. The existing personnel in the state cadre was divided and allotted to different district cadres. Currently, the districts are responsible for all the new recruitments made. During such recruitment, preference is given to candidates belonging to the same district. It was envisaged that this measure would result in better availability of paramedics in difficult areas, less hardship for personnel due to transfers, and consequently better service to the public.

(iv) Changes in Financing Methods

a. User Fees

The system of user fees was in existence in Orissa in the government hospitals prior to 1997 for certain items such as accommodation in cabins, use of ambulance, X-ray and few other investigations. The fee was extremely low and only a fraction of the cost or market prices of the corresponding service. Moreover, the amount paid went to the government coffers and not to the hospital, hence there was little motivation to collect it. However, following the recommendations of a committee constituted by the Orissa Legislative Assembly to review the health system in three medical colleges, the user fees were revised. In keeping with the recommendations of the committee and with a view to generate additional resources to supplement the budgetary allocation, improve and extend the scope of the medical facilities, the Government of Orissa (Government of Orissa) passed an order dated 24th June 1997, revising the existing user fees and including more items under the purview of user fees such as transportation, accommodation, diagnosis and medical investigations. Initially, these rates were applicable to the three medical colleges, the district headquarter hospitals, the Capital Hospital Bhubaneshwar and the Government Hospital, Rourkela. For the purpose of collection, the State was divided into A, B and C categories, depending on the levels of development and differential rates were levied with lower rates being levied in the less developed and tribal districts. User fees were initially levied for diagnostics, special accommodation and for use of transport (e.g. ambulance, hearse, etc). The user fees were deposited into the accounts of the Zilla Swasthya Samiti (District Health Society) in the case of district hospitals and into the accounts of
specially constituted hospital societies in the case of the medical colleges. From this beginning, the user fees initiative has grown and spread.

Presently, user fees are levied in all medical colleges, headquarter and sub-divisional hospitals and some area hospitals for diagnostic purposes like pathology, biochemical, radiological, ultra-sonography, colour doppler, CT scan and other such investigations. In addition to this, some designated hospitals have pay cabins or clinics. Pay clinics have been established on an experimental basis at dental college, Cuttack wherein the treating doctor also gets a percentage of the benefit shared by the government. Further, in medical colleges, facilities for Intensive Care Unit (ICU) are available on payment as also the ambulance services. User fees are collected from IPD and OPD patients in some headquarter hospitals, so as to involve the community in the development process. In all cases, the money collected as user fees is spent at the point of collection for improvement of the particular institution. The collection of user fees is limited to families above the poverty line (APL). Families below poverty line (BPL), national health programmes, emergencies and medico-legal cases are exempted from user fees. Furthermore, if necessary, the cost of treatment for the diseases enlisted in the Panchabyadhi Chikitsa Scheme is reimbursed from a fund placed with the ZSS for the patients.

At the point of initiation of user fees, the government had also decided to form hospital level societies to collect and utilize the collected funds. In 1993, District Health Societies known as ZSS were formed and registered as societies under the Societies Registration Act 1860. These societies were responsible for management of the health care delivery system in a district and in a coordinated manner. Collection and utilization of user fees for all institutions in the district is one of the responsibilities of the ZSS. The ZSS is also free to decide the method of collection and its subsequent utilization, except for spending on employment of personnel. The funds collected are utilized essentially for the maintenance and improvement of respective hospitals/institutions.

In this context this user fee has been brought to the scene in the process of globalization and World Bank and World Trade Organization play key role to introduce in the third world countries. Critical evaluation is needed to substantiate the
above argument. Is it an ominous development that the government is in posing over the citizens an increase in user fees at public hospitals? Government has been keeping away from crucial free health services and raising the prices of an array of tests and services that users already pay for.

Across the world there is more or less a policy consensus that health care is a common good and not a market commodity and that state expenditure in public health care has far-reaching redistributive effects. According to the World Health Organisation, more than 100 million people slide into ever deeper poverty every year. The out-of-pocket expenditures on health care for a family member causes undue burden. Given this reality, providing free universal health care in a state like Orissa could have a tremendous positive impact of preventing tens of thousands of families from sliding deeper into poverty and debt as a result of a single disease or accident. What this also implies is that when families demarcated by their income level and some other indicators to be exempted from user fee, one has to analyze with lens of equity and more of human rights particularly right to health.

The public sector health care is indeed in shambles. It is being argued that it is rife with corruption and neglect. This cannot be good enough argument to corporatise health care. On the contrary it should institutionalize reforms which ensure more accountability and better services. We see it fit to oppose, in the harshest possible terms, what can only be the government’s first step to abdicate its central responsibility in providing universal free health care to its citizens by introducing the concept of user fees in health care, which typically precedes a gradual retreat from provision of such services. Such a move is immoral in that it accentuates the deep-seated inequities that already characterise in the society, and will likely exacerbate poverty, undoing considerable good achieved by government and non-state actors-run anti-poverty programmes of the past decades.

b. Establishment of a State Health and Family Welfare Society

In light of the problems faced with routing of all funds through the budget (i.e. the government system) such as cumbersome withdrawal and accounting procedures, unavailability of funds on time, a method was devised to ensure availability of funding for health care activities as and when required through the establishment of a
State Health and Family Welfare Society in 1998, throughout the state of Orissa. With the establishment of the State Society, all non-budgeted funds were received, channelized, and utilized through the Society. To facilitate accounting and to meet the reporting requirements of donors, separate accounts are maintained for each programme. The benefits of having a State Society (and a single society for all the extra-budgetary funds received) were several. Funds could be easily accessed and were available for specific purposes at the time of need; there was flexibility of use; and the funds could be accessed to manage any sudden crisis or contingency. This is well devised system in the state.

c. Development of a Pancha Byadhi Chikitsa Scheme (Five Diseases Treatment Scheme)
In face of lack of any clear policy specifying the type and quantum of drugs which would be made available to every person visiting a public health institution, lack of uniformity in dispensing of drugs in public health institutions, patient being asked to purchase drugs from the open market in spite of availability of drugs at the institution, tendency towards over-prescription, high cost of medical care borne by the poor, a need was felt to ensure that every patient approaching a public hospital was guaranteed treatment free for certain major diseases. Hence, a scheme called, ‘Pancha Byadhi Chikitsa’ (Five Diseases Treatment) was developed in 1999, to cover the whole state of Orissa. As a first step, an attempt was made to identify the major diseases prevalent in the population, especially amongst the poor. Using indicators of incidence, hospital attendance, cost and ease of treatment, five diseases were identified. These were malaria, leprosy, diarrhoea, acute respiratory infection, and scabies. Thereafter, treatment protocols were developed, estimation was arrived at for the quantum of drugs required, medication was ordered and distributed to all the public healthcare institutions, with instructions to the medical personnel for free provision of the same. A media campaign was also carried out to inform the public about the scheme campaign was also carried out to inform the public about the scheme. The benefits of the scheme were that it created a health entitlement and risk protection guarantee for the poor; it curbed the tendency of doctors to prescribe medicines unthinkingly. It addressed the commonest diseases that affect the largest number of people.
The scheme was started initially for six months, and was to be evaluated thereafter. However, it came to a halt after six months because of the super cyclone which occurred a few months later and the preoccupation with cyclone restoration work. It is proposed to be re-started shortly. It was clarified that in case any patient was required to purchase medication from the market, the cost of the same would be reimbursed. These prescriptions in turn would be examined during the clinical audit and action would be taken on erring doctors. The scheme created a health entitlement and risk protection guarantee for the poor; it addressed the commonest diseases that affect the largest number of people; and curbed the tendency of doctors to prescribe unthinkingly. The scheme was first started in 1999 experimentally for 6 months. With the super cyclone striking Orissa in late 1999, attention got diverted and the scheme did not get extended. Subsequently, it was restarted as a major state-wide programme in mid 2001.

**Human Rights Standards: Search for Justice**

Medical profession is one of the oldest professions of the world and is the most humanitarian one. Inherent in the concept of any profession is a code of conduct, containing the basic ethics that underline the moral values that govern professional practice and is aimed at upholding its dignity. Medical Ethics underpins the values at the heart of the practitioner-client relationship. Medical negligence and malpractices by doctors were the grey areas in health care where legal issues operated. Some of the cases have been selected on the basis of random sampling particularly patients chart and also some cases chosen to strengthen the argument which have been drawn from the National Human Rights Commission, Supreme Court cases and also relevant patients profile. During the field study the researcher met different types of patients on the basis of their diseases and experiences in hospital and outside to analyse the individual cases in the scope of health and human rights. The following cases are representing the health scenario of the state and nation. Given the health scenario, some of the cases went to the judiciary. The constitutional and judicial processes highlight the crisis of standards and struggle for enforcement standards. In a way this is the search for justice.
**Case: I**

The National Human Rights Commission has recommended a monitory relief of Rs. 5, 00, 000/- to Mrs. Binapani Khatua of Orissa in a case of medical negligence due to which she suffered physical pain for four years and now cannot bear children. The Commission started the proceeding on 15.06.2007 in the matter on the complaint of Director, Collective Initiation for Social Solidarity (CISS).

The complainant said, Mrs. Binapani Khatua w/o Mr. Pratap Khatua of Radharamur Village under Athagarh Police limit in the District of Cuttack (Orissa) was admitted in Athagarh Hospital four years ago for safe delivery of her first issue. After gynecological operation a male child was born but died after four days. The complainant alleged that a surgical scissor was left inside the abdomen of Mrs. Khatua by the concerned surgeon during the operation period. Since that day, the victim suffered medical negligence causing terrible pain on the right side of the abdomen. She consulted several doctors, but none diagnosed the cause of her pain properly except prescribing irremedial medicines. In the meantime, Mrs. Khatua gave birth to a girl child who is alive. But during post delivery, severe bleeding started and her abdominal pain increased. The unbearable pain landed the couple in a private hospital in Cuttack, where Mrs. Khatua again underwent a surgical operation following which her uterus was amputed. She could no more bear a child now. However, even after this surgery she did not get relief from the pain. The couple spent a lot of money on the treatment leading them to a stage of bankruptcy. In the course the couple came in contact with Dr. P.C. Sahoo, who suggested for an X-ray of the belly of the patient. It was found from the X-ray that a surgical scissor was lodged in the belly which was removed by an operation at General Nursing Home (Private Clinic) in District Headquarter. The complainant prayed for inquiry, justice to the victim and action against surgeon responsible for the laps.

The NHRC taking it as a serious case of professional negligence issued notice to the Chief Medical Officer, Cuttack. Pursuant to the directions of the Commission the Chief District Medical Officer, Cuttack submitted a report dated 09.07.2007. On perusal of record the Commission observed that the case appeared to be a matter of serious professional negligence and violation of human rights due to negligence of Doctors which was confirmed in an inquiry caused by Chief Medical Officer, Cuttack.
The NHRC issued notice to the Chief Secretary, Orissa asking to show cause as to why monitory relief to the victim should not be recommended by the Commission. It also requested him to conduct an inquiry and take action against the negligent Doctors and take necessary steps to stop recurrence of such incidents.

Pursuant to the directions of the Commission, Commissioner-cum-Secretary, Government of Orissa, Health and Family Welfare Department furnished his response (dated 16.08.2008). His report stated that a specialist team was set up to inquire into the incident. The departmental proceedings were drawn up against the two Doctors*, namely, it also stated that the Government had taken steps to stop recurrence of such incidents but no direct responsibility could be laid on any one for the alleged lapse and pleaded that the proceedings be dropped.

The Commission on the basis of this reply observed and directed in its proceedings (dated 16.09.2008) that the reply to the show cause notice was silent about grant of monitory relief to the victim and the copy of the specialists’ team which conducted an inquiry into the case was not received in the Commission.

The NHRC sent a reminder to the Chief Secretary, Government of Orissa and the Commissioner-cum-Secretary, Government of Orissa, Health and Family Welfare Department in this regard. The Commission also asked for a status of departmental proceedings drawn up against the two Doctors. When no response was received within the stipulated four weeks on the issues from the concerned State Authorities, the Commission recommended a monitory relief of Rs. 5, 00, 000/- to the victim of medical negligence with the instructions for submitting a report on the action taken.

**Case: II**

Saroj Kumar Tarai and his family sought help from Orissa government because his life landed in a pathetic condition. He has been suffering from a dreaded disease called ‘Rheumatoid Arthritis’ since 16 years and in the absence of proper medical attention he is bed-ridden. Now, with all money spent on his treatment and no

* Dr. Sarojini Sarangi, Professor, O&G and Dr. Kirtirekha Mohapatra, Assistant Professor, O&G, SCB Medical College & Hospital, Cuttack for alleged lapse
financial support coming from anywhere, this dalit family from Damodarpur in Balasore town sought permission for a mercy death.

“My parents tried whatever they could; we don’t have enough money to avail better treatment. I don’t want to be a burden on my old-aged father, who is also a paralytic patient. With nobody to extend a helping hand, probably death is a wise option,” stated 40-year-old Saroj.

Saroj, once a good badminton player, fell victim to the disease when he was only 24-year-old. After finishing graduation he joined three-year law course. But while he was appearing for the final examination he fell victim to Rheumatoid Arthritis. He said “Despite continuous treatment in different hospitals, he didn’t get any relief,” he narrated this episode with tears rolling down his cheeks.

Being the eldest son of the six-member family Saroj’s first option was to search for a job but he is now a burden to 72-year-old father, old mother and two grown up sisters. “He can’t do his own work as his legs are not functioning. His father Siba Charan Tarai and mother Satyabati said “we have to attend to his works even though our health condition doesn’t permit”. In fact they failed to marry off their daughters due to their poor financial conditions.

Even though the district administration is aware of Saroj health condition, no help reached him yet. There are various government schemes for the upliftment of poor and dalits, but nothing has happened for this family.

“Not even pension for disable persons has been sanctioned, although he gave an application to the Collector three years back. He also told that “I am exhausted physically, financially and mentally, and now I am in total indigence”.

One of the letters sent to collector he urged him to kindly arrange for treatment through the benevolence at the earliest. Otherwise they should be allowed to end our lives in front of the district Collectorate.
Case: III
Shila Jana, a 35-year-old resident of Gobara village under the Ramnagar police station, was admitted in the clinic after suffering from severe infection in her uterus. The Balasore based city clinic and its owner Pratima Pradhan could not properly diagnose the problem but suggested to arrange some money for operation. The doctor operated on her and removed her uterus. The complaint was that the doctor has operated wrongly. Shila was taken to Vellore hospital in Tamil Nadu for treatment where it was found that during the operation a small hole developed in the urine bladder due to the carelessness of the surgeon.

Since, the complainant suffered due to the doctor’s negligence, she filed a case against the doctor in the district consumer redressal forum which fined the Balasore-based City Clinic and its owner Pratima Pradhan for wrongly operating on the uterus. The consumer forum slapped a fine of Rs.110, 000 on the private hospital which, however, cannot bring back her health.

Case: IV
A woman delivers child under a tree, a dalit woman of Jhimani village under Gopalpur police station in Balasore district gave birth to a child under a tree near Srijung hospital due to indifference of doctors and other medical staff. Shocked over the incident the state government asked the chief District Medical Officer (CDMO) to investigate and submit a report on the incident.

As per direction CDMO Sukdev Sethy inquired about the incident and confirmed that this incident occurred due to negligence of Dr. Abhay Das and Nurse Sukanti Panda. “He recommended disciplinary action against the doctor and nurse”. The report said that the dalit woman Ranju Sethy went to Srijung hospital to enquire about her delivery due date. Gynaecologist Dr. Abhya Das, on duty, examined and advised her for ultrasound test to ascertain the condition of child in the womb. He also prescribed a pain killer when she felt severe pain during the examination. After getting an ultrasound report Rahama Bajar, 12 km away from the hospital, connecting by a passenger bus, the doctor advised her to take admission in the hospital as the ultrasound report said she had completed 7 months of pregnancy and 1.5 kg weight child was in her womb.
As the woman came out from the hospital and when she was unable to take the pain gave birth to a child under a tree in front of the medical hospital. When asked Dr. Abhay Das clarified that he gave pain killer medicine to avoid her premature delivery but she did not take medicine. The matter of fact is that she gave birth to a baby under the tree.

**Case: V**

Hakim Seikh fell off a train at Bhadrak station in Orissa on 8-7-2008 at 7.45 pm and suffered severe head injuries. When brought to the Primary Health Centre Bhadrak, he was referred to the sub-divisional Hospital or any other State hospital, as necessary facilities for treatment were not available at the Primary Health Centre. Then he was taken to as many as seven State hospitals, but was not given treatment on the ground of non-availability of bed though it was an emergency case. Ultimately he was admitted in a private hospital on 9-7-2008 and was treated till 22-7-2008. Feeling aggrieved by the indifferent and callous attitude of the medical authorities at the various State run hospitals in Orissa in providing treatment for the serious injuries sustained by Hakim Seikh, a petition was filed in the Supreme Court for compensation and appropriate directions. The Court held that failure to provide medical treatment to Hakim Seikh by the government hospitals had resulted in violation of his right under Article 21 to get adequate and timely medical treatment. Article 21 imposes an obligation on the State to safeguard the right to life of every person. It was held that in such cases adequate compensation can be awarded by the Supreme Court under Article 32 and the High Courts under Article 226, of the Constitution. The Court awarded compensation of Rs. 25000/- to the injured from the government.

**Case: VI**

Bruna, an 11 (eleven) years old girl whose parents work in paddy field was bitten by a stray dog. Immediately she reported it to her parents. Her parents wanted her to wait for some time and take her to Gunia (sorcerer or enchanter). Her parents were not serious about dog biting as they are illiterate and also ignorant. The gunia (sorcerer) gave the local treatment by giving her banana and assured that it would be cured and advised not to worry. After one and half months Brunda fell sick again and suffered from headache and joint pain. Her parents did not take it seriously.
For almost two months passed nobody in her village had advised the parents to go to hospital. Brunda became thin, weak and was unable to walk. One of her relatives got to know about the dog bite. He advised her father to take her to hospital and consult a doctor. Doctor checked her and demanded some money to give her admission. This was the place where the researcher met her. She was waiting for another doctor. They were advised to buy two injections. Finally Brunda got some treatment.

This is a case where the patient and her father and mother are all illiterate. Instead of she being brought to hospital, she was taken to sorcerer (Gunia). She stated that she should have had access to the doctor so that she could have been saved from all the pain and trouble. She complained that doctor had taken Rs. 200, for giving just the hospital bed. The case suggests that the basic rights of Brunda have been violated. It is significant to note that her father who is old and poor labourer had to pay money which they could hardly afford. The doctor has taken money literally from a pauper without any qualm. When researcher asked about the case she replied in anger “no body cares for the poor people”.

Case: VII
Lakshmi who is 45 year old, illiterate and married has been suffering from T.B, for seven months. Her husband Nidhiya is a casual labourer. They have four daughters. Lakshmi, although knew of her internal pain, she did not care about it. After three months when the pain further aggravated she informed her husband. The helpless husband who did not have money advised her to go to her parents which she did. Her father is a woodcutter and their family condition was no better. Her father took her to a primary health centre. In the first visit they could not meet the doctor and medical staff did not know where he was. Lakshmi visited the next day again but was unable to walk and not able to get a single cycle rickshaw. When the researcher enquired about her health, she was with full of emotions and tears. She finally met the doctor who advised her to go to district hospital and informed her that this disease was harmful and contagious and advised that she should stay in the hospital. But lakshmi’s father did not have money. Then they went back home and sold some trees at thrown away price. Lakshmi reached district hospital with some money and overcame a lot of hurdles. The chest specialist checked her and demanded five hundred rupees on the plea that it was not his working hours and suggested that she may go to his clinic with
money, she was helpless at that moment. She remarked “I heard from my mother doctor is a second image of God, but what kind of God he is?”. Here the point is that lakshmi instead of getting free bed in the government hospital, she got it after six days only after bribing the doctors.

This case highlights the poverty and deprivation of the patient at one level and the casualness and callousness with which the patients are treated in public hospitals.

**Case: VIII**
Banamali is 70 years old man suffering from joint pain and also muscle pain. He belongs to a poor family. During his ailments, he came to hospital walking eight K.M on bare foot. After check up the Doctor prescribed medicine and was advised to buy the medicine. But Banamali had no money to buy the medicine which he informed the doctor. The doctor said, “We cannot do anything”. Banamali had no way out as nobody was ready to listen to him. He says, “I do not have a son, if I have one, I would not have come to this hospital, I would have gone to a private hospital”. He adds, “I cannot afford the fee. At this point he broke down. One of his friends requested the doctor for some help. The doctor instead of responding to the plea remarked that “we do not have free medicine because government is not supplying”, “if you are a leader of these people then go to the Ministers and ask them why they are not providing funds for free medicine to the poor”.

Banamali was helpless because he does not have son and also money. After five days, he attempted suicide by hanging on the tree near a cow grazing field. At the moment he prepared to hang himself, one of villagers saw him and shouted then Banamali got disturbed and sat on the ground. This incident reveals the hapless condition of poor and underprivileged people, who cannot afford medical facility which is technically supposed to be free of cost. This is not an isolated case.

**Case: IX**
Asha Behera is a 65 year old woman struggling hard to eke out a living for herself in an helpless condition. Asha Behera of Tina village of Barunasigh gram panchayat under Balasore Assembly constituency was forced to work in a motel at the age of 60 after the death of her husband. She had no other option. She knew she had to work for survival. On August 14, 2007 everything changed for her. On that day, when Behera
and the motel owner Pravakar Sahoo of Redhua Bazar under Nilagir police limits were working, a gas cylinder exploded. Two persons sustained serious burn injuries. They were admitted to the Sri Ramchandra Bhanja Medical, Cuttack. After a few days of treatment, Pravakar succumbed to injuries on August 23. His family members brought his body to the village for cremation and Behera, who had till then not recovered from her injuries, was also brought back to the village. However, considering her critical condition, the villagers admitted her to Redha Public Health Centre, where there was no facility for treatment of burn injuries. With nobody to take care of her, the half-burnt Behera is waiting for slow death, lying over a mat on the floor of Redhua PHC. While government-supplied medicines are not available, she is surviving on food provided by the attendants in the PHC. The villagers have drawn the attention of the authorities concerned to initiate necessary steps for her treatment but nobody came forward to help.

Case: X
During the field study, researcher met Aruna Nath Mishra, who has been working on rehabilitation of AID’s patients. His experiences with patients may be relevant to the present study. He narrated a case of Basanti Jena who wished that she had died immediately after testing positive for HIV/AIDS rather than undergoing such disgrace, pain and trauma. This is much worse than death, laments Basanti Jena recalling her ordeal at the hands of her family and community members.

When 33-year-old Jena, who lives in a village near Rasalpur in Balasore district of Orissa, tested HIV-Positive she was driven out of the house, locked up in the family goat shed, denied adequate food and basic amenities. She was finally rescued by a local NGO working with HIV/AIDS. By then, she was delirious and infested with ticks and worms.

Case: XI
When plumber Maheshware Behera travelled to Surat from his native village Balasore district in search of better employment opportunities, he contracted HIV/AIDS from a local sex worker and returned to his village fearing ostracism from his fellow workers. Later, following AIDS-related complications (ARC), Behera sought medical help at hospitals in Balasore. But he was repeatedly turned away. Ill-treatment from his
family and exclusion from the community finally pushed him to suicide. Ostracism, humiliation and mistreatment at the hands of family members, community and the medical fraternity pressure and absence of organization care and support to people suffering from AIDS (PLWHAs) in the state are driven to despair resulting in suicide.

**Case: XII**

Shimla Devi, from Kashpa village underwent sterilization on 12th of February 2004. After the operation, she vomited continuously and no health worker came to assist her. Later she developed more complications and also hernia. On the 26th of June 2004, she underwent another operation and ended up spending Rs 5,000. Sulochana, from Balicharia village, was married as early as 13, gave birth at 14 was sterilized at 18 years and soon lost her husband. She has not received the family planning benefits that she was promised but continues to suffer from chronic ill-health.

There were many similar accounts. Kangali Das from Srijang, broke down recounting the story of how his daughter Sudha died after the doctors injured her intestines while doing her family planning operation. Stories from all parts of the district, pointed to how hundreds of family planning operations were being conducted on women with very little care for quality. This was done under the pressure of the meeting family planning targets, which were not a part of the National Population Policy.

Doctors often completed an operation in less than five minutes, throwing all norms to the wind. This meant that there were infection, complications, failures and even death, and there were no provisions within the programme guidelines to deal with these.

**Conclusion**

Quality of care provided by the health care delivery system has become the focus of this chapter. Since quality is a crucial factor in health care, initiatives to address quality of health care have become state-wide phenomena. Many districts are exploring various means to methods to improve the quality of health care services. In Orissa the quality of services provided to the population by both public and private sectors is questionable. The current structure of the health care delivery system does not provide enough incentives for improvement in efficiency. Mechanisms used in other states to produce greater efficiency compare to Orissa, accountability, and more
responsible governance in hospitals are not yet deployed in Orissa. The for-profit private sector accounts for a substantial proportion of health care in Orissa (50 per cent of inpatient care and 60 per cent to 70 per cent of outpatient care), but has received relatively less attention from the policy makers as compared to the public sector. Thus the private sector health care delivery system in Orissa has remained largely fragmented and uncontrolled, and there is a clear evidence of serious quality of care deficiencies in their practices we have already discussed it above. Problems range from inadequate and inappropriate treatments, excessive use of higher technologies, and wasting of scarce resources, to serious problems of medical malpractice and negligence. Current policies and standards setting process for health are inadequate or not responsive to ensure health services of acceptable quality and prevent negligence.

In the present situation there is a need to establish bodies and systems to set standards for clinical and non-clinical effectiveness of the services offered in the public and private facilities. It concerns about how to improve health care quality which have been frequently raised by the general public and a wide variety of stakeholders, including government, professional associations, private providers and financing health care agencies. They attempt to establish systems and process of standards setting that would ensure quality of health care.

The present study also makes a contribution to the wider literature regarding health care decision-making, in supporting the role of three major factors in influencing utilization of services: reputation, cost and physical accessibility. Reputation—in terms of perceived quality—has been found to be one of the main determinants of utilization of a particular health care provider, and ‘recovery’ is one of the most important criteria that patients use in order to judge the quality of services and choice of health service provision². Accordingly, non-utilization of a particular type of health provider is often related to a perceived lack of quality. It is found over three-quarters of the women utilizing private practitioners (rather than more generally proximal government practitioners) cited faith in the efficacy of their treatment as the basis for

incurring the additional costs of travel and consultation. Despite this last effect, the impact on utilization rates of a particular provider due to cost—indicated in this chapter—has also been widely documented: either through cost of medicines, consultations fees, travel or opportunity cost.

Health as a basic human right has come to be not only accepted but its scope is enlarged through judicial instruments. Now the standards set are quite high. The right to equality encompasses within itself the right of a poor to get adequate treatment and medicines from the State irrespective of their costs. The duties of the State and Municipal authorities can be enforced through the Courts whenever a breach occurs. It is in the enforcement of these obligations of the State and local authorities that the Courts play an effective role in safeguarding the rights of the citizens to prevent and cure diseases. The maintenance of sterile aseptic conditions in hospitals to prevent cross-infections should be ordinary, routine and minimal incidents of maintenance of hospitals. Purity of the drugs and medicines intended for human-use would have to be ensured by prior tests and inspection. However, “owing to a general air of cynical irreverence towards values that has, unfortunately developed and to the mood of complacence with the continuing deterioration of standards, the very concept of standards and the imperatives of their observations tend to be impaired”, laments the Apex Court. The remedy lies in the awareness and enforcement of the Health rights of the citizens through Courts, but it more lies in the cure of improper and corrupt approaches in the seemingly healthy ones whose obligation is to provide for adequate health care.

The twelve cases of varied forms of negligence and court verdicts present the evidence that how health as a human right and standard is violated. One has to revisit the concept of standards and norms of the society and draw a line between existing standards and even enlarging legal and constitutional standards in India.