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West Bengal: Health Policy Note

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Acknowledgements

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West Bengal Health Policy Note

Background and Objectives

1. As preparatory work for a possible future state health systems project in the state of West Bengal, the World Bank has decided to develop a Policy Note, in collaboration with the Government of West Bengal (GoWB). The decision to write the Note follows a request from the Government of India, Department of Economic Affairs (DEA), dated 05/23/2003, for the World Bank's assistance to the Government of West Bengal in developing a health sector project.
2. This Policy Note is meant to be a discussion document, to be used to set out the options for future development of the health system together with the Department of Health and Family Welfare, based on an analysis of existing data on health outcomes, health financing, utilization of current health infrastructure in the public and private sector, a description and assessment of the GoWB's current policy developments, and of donors' recent investments and plans for the future. The purpose of this Note would be to set the evidence basis for identifying key strategic directions for reform of the health sector.
3. In the course of drafting this note, the team had extensive discussions with various health sector stakeholders in West Bengal. The authors were provided with documentation by officials of World Bank supported Health Systems development Project (WBHSDP-II). Other key reports produced in collaboration and with the support of the United Kingdom Department for International Development (DFID) were also consulted, including: The Strategic Framework and Health Sector Reform, the Integrated Financial and Economic Plan for Health Sector in West Bengal (referred as IFEP, 2003), and the Health Financing in West Bengal (Structures, Challenges and Options), by IHSD (we will refer to it as HFWB, 2002), and other important support documents (see references). The analysis of the principal health issues, of health system performance and of health financing is based on the analysis of data from the National Family Health Surveys I and II, the Reproductive and Child Health Survey (RCH) and the National Sample Survey 52nd round (NSS), complemented by information received from the strategic planning cell, Department of Health and Family Welfare.
4. The specific objectives of this policy note are as follows:
 - to analyze existing evidence on health outcomes, health financing, utilization of current health infrastructure in the public and private sector,
 - identify the health system's strengths and weaknesses,
 - review recent innovations in the health sector,
 - outline key strategic options and recommendations that would improve the health outcomes in the State.
5. The structure of the report is as follows:

I	Current Health Status
II	Health Care Financing
III	Health Delivery Systems
IV	Health System Performance

V Review of recent reforms in the Health sector
VI The Way Forward

I. Executive Summary

What do we have?

6. With respect to health outcomes, West Bengal has set its priority health objective as the reduction of:
 - maternal mortality,
 - child mortality,
 - the burden of communicable, non-communicable diseases, and
 - nutrition-related disease and disorders.
7. These goals are appropriate given the current disease burden, which is still dominated by communicable diseases and malnutrition, particularly in children, and unacceptably high maternal mortality.
8. Despite being an average state in India in terms of economic development ¹, West Bengal records a fairly positive health performance compared to the Indian average for some key health outcomes (NFHS-II, 1998-99). However, during the last decade progress toward improving these outcomes has been uneven, and, in many cases, slow:
 - IMR has decreased more than the all-India performance – now at the stage where neonatal mortality constitutes two-thirds of the total;
 - key health system performance indicators, such as coverage of immunization and institutional deliveries, have improved in line with the rest of country, but treatment of both ARI and diarrhoea in young children has decreased;
 - malnutrition has improved, but remains unacceptably high, and
 - modest improvement in the other main health outcomes have occurred, similar to the National average.
9. The main intervention by the state government is the establishment, maintenance and staffing of an extensive publicly funded network of health facilities and staff.
10. For women, the performance of this public system leaves many gaps to be filled –only 40percent of deliveries are in health institutions, only two-thirds of women use any contraceptive method and those who do are heavily reliant on sterilization; other aspects of the system perform much better – coverage of antenatal checkups and tetanus toxoid is high.
11. For children, public system performance is also sub-optimal - less than half the children are fully vaccinated, about half are malnourished, only half of children with ARI or diarrhea are taken to a health care provider, and this proportion has fallen in the last decade for both conditions.
12. Some improvements have occurred in the performance of the public delivery system, but still much needs to be done:

¹ West Bengal ranks 8th among the country's 16 major states in terms of human development index and human poverty index; about 60 percent of women are literate (against national average of 54 percent).

- Absenteeism, especially of doctors but also of other staff, is high (see Chapter 3 and 4).
 - Urban bias exists in distribution of facilities, and hospitals are used more by the upper income groups than by the poor (see Chapter 4).
 - Primary Health Centres and Auxiliary Nurses Midwives are not always effective – they lack drugs and staff are frequently absent; health care obtained from these institutions is not free as drugs must be purchased and staff may demand compensation; the qualitative aspects of working force, especially motivation and attitude, are also an area of great concern: staff does not always show commitment to the communities which they should serve, and is often rude.
 - Public health activities, such as disease prevention and health promotion activities, are neglected.
13. The network of publicly funded institutions and staff has been further expanded over the last decade. However, the share of both ambulatory care and inpatient care for the public sector is decreasing, and currently the private sector is the place of choice for almost all ambulatory care and increasingly for hospital care as well (NSS 1985-86 and 1995-96):
- more than 85 percent of all ambulatory care is provided by private practitioners, both formal and informal qualifications, and
 - as much as 30 percent of hospital care is provided by the private sector – all indications are that the private sector share is increasing.
14. Although we know that the private sector has the dominant position in ambulatory care and it is increasing its importance for hospital care, the state knows little about the details of the private sector, its size, the nature and distribution of the practitioners (including a large force of informally qualified practitioners), and the quality of services they provide. By and large the state still does not take the private sector into account when it sets the vision for the future, or when it plans and operates its health programs.

Health financing

15. Out-of pocket expenditure (OOP) accounts for at least 2/3 of the total health expenditure, with public expenditure accounting for the balance. Other sources of revenue, such as health insurance, are still underdeveloped.
16. It is estimated (NSS 1995-96) that 81.4 percent of OOP is spent on medicines and private providers. According to the Studies on Health Financing in West Bengal, 2002, the most important item of private expenditures is drugs, accounting for 75 percent of total OOP expenses for minor conditions and 64 percent for major conditions.
17. As in the rest of India, public spending on health in West Bengal is low, approximately Rs 175 per capita in 2001-02.
- The share of health in the state budget has decreased from 5.8 percent in 1996-97 to 4.2 percent in 2003-04.
 - The central government contributes approximately 14 percent of total public expenditure on health.
 - Secondary and tertiary care account for approximately two thirds of total public expenditure on health, with only one-third going to primary health services.

- Inequity characterizes the distribution of public funds across districts, with a bias in favour of better-off and urban areas and against poorer, rural areas.
 - Most public money is spent on salaries, more than 80 percent of recurrent expenditure; and expenditure on other key items such as drugs is insufficient (approximately 6 percent of total in 2003-04).
 - The overall financial impact of externally supported health projects in the 1990s, which concentrated on capital expenditure, was to increase recurrent costs, including for salaries, by as much as 10 percent.
18. The state is under considerable fiscal stress and there is unlikely to be a significant increase in the state allocations to health in the medium term as the state recovers from its current situation which has resulted in a fiscal deficit of 9 percent of NSDP and interest payments which are now 40 percent of revenue receipts. The state has drafted a Medium Term Fiscal Recovery Program which aims to reduce the fiscal deficit to 2 percent of NSDP and remove the revenue deficit by 2005-06.

Where to go from here, and how to get there?

19. West Bengal recognizes the need for change: the state has recently formulated a State Health Sector Strategy 2003-2012 to respond to the situation, has clearly specified its priority health outcomes and strategies, and has undertaken certain important reform initiatives. The priority health outcomes for the state are to:
- decrease infant and child mortality,
 - decrease maternal mortality and
 - control infectious diseases.
20. In recent years the state has also introduced some health improvements through projects with various donors. These have led to renovation and upgrading of selected hospitals and health centers, introduction of quality improvement programs for hospitals, some improvements in the efficiency of hospital management, and introduction of certain reforms in governance at the district level. There has been an increase in utilization of secondary and tertiary public facilities, and some perceived enhancement in quality of care. However, it is unlikely that these developments have produced a significant impact on the priority healthy outcomes.
21. At the same time important reform initiatives have been undertaken, to strengthen engagement of private providers (not for profit and for profit) and to enhance community participation in the delivery of essential services, and to experiment innovative delivery systems (based on outreach activities) for covering underserved areas (mobile clinics in the Sundarbans region).
22. The strategy being developed by the Department of Health and Family Welfare (DHFW) during the last two years represents a further positive development (see Chapter 6). However, the strategy being formulated by the State government for achieving the ambitious targets set for the priority outcomes risks to essentially reflect an intensification of the past approach, characterized by an almost exclusive focus on the public sector, except for some involvement of NGOs and few other initiatives, and by a top-down, rigid approach to planning and resource allocation.

23. Previous attempts to strengthen the current approach have not been successful. Thus, in order to succeed, the new State Health Strategy needs to introduce courageous and quite radical reforms, which represent a challenging agenda of reorientation of the public sector. They require changing the way many staff within the public health sector function and address their roles and responsibilities. Reforms must represent the recognition that government has a stewardship role to play for ensuring both the public and the private health systems operate and interact in such a way that all parts of society and particularly the most vulnerable parts of society have access to affordable good-quality essential services. How to do this at a time of severe fiscal constraints is the challenge of course.
24. Identifying more effective approaches will involve addressing questions such as: how to make a better use of the existing out-of-pocket (OOP) expenditure, so that it contributes more effectively to achieving the proposed health targets? Focusing on government expenditure, do public interventions address market failures, do they improve equity, and are they feasible and cost-effective? Are they adequately funded? Which activities and programs are more directly related to the priority health outcomes, and what funds can be reallocated from lower priority activities and programs? How to develop and implement a better process of planning and performance management with the following characteristics: a) driven by local initiative, whereby proposals are initiated by PHC teams and consultations take place with the Panchayati Raj organizations, b) annual cycle including a rigorous output monitoring (review) feature, and c) tight coordination between the state and the district level?
25. In developing a new strategy it is also important to distinguish more clearly between problems which have efficacious interventions exclusively as part of ambulatory care services – such as the life-threatening illnesses and communicable diseases – and those which do not, such as reducing maternal and neonatal mortality. The former can be addressed exclusively by actions to affect services at or near community level. The latter typically require also higher level services, usually beyond those that can be adequately financed or provided at the primary health center level.
26. To improve post neonatal and child mortality indicators, control communicable diseases, and prevent non-communicable diseases, the focus needs to be on ambulatory care, nutrition, and on diseases prevention and health promotion activities. The targets must include interventions which will: increase coverage of immunization; prevent those diseases for which there are already good preventive interventions; recognize at an early stage and promptly and effectively treat life threatening illnesses (especially ARI, diarrhea and malaria); and improve child feeding practices to prevent malnutrition².
27. For maternal and neonatal mortality reduction, improved antenatal care and referral system, increase coverage of supervised deliveries, and improved postnatal care are essential. First referral units need to play a critical role by providing 24/24 access to high-quality emergency obstetric care services.
28. Concrete options for reform are presented in the final chapter (Chapter 6) and include:
- Improving stewardship and management in government. This would include improved planning, implementation and evaluation of state and central level projects,

² Even though malnutrition is the underlying cause of up to sixty percent of all infant and child deaths, only limited progress has been made in improving the nutrition situation (children malnourished decrease from 56.8 to 48.7 of the total between 1992 and 1998).

improved managerial capacity at the state , district and facility level, and improved capacity of the state to monitor and evaluate the outputs and outcomes of the its health investments, with continuous evaluation of existing programmes.

- Improving efficiency and effectiveness of public sector primary health services, utilizing of the ongoing decentralization process to improve accountability, and promoting civil service reforms for health sector workers.
- Strengthening disease prevention and health promotion activities, and intersectoral links with nutrition, education, and water and sanitation programs.
- Strengthening initiatives to enhance quality of primary care services in the private sector, taking advantage of contracting out to private sector providers. In rural areas, not-fully qualified practitioners provide most of the ambulatory care to low income groups. Thus, any initiative to improve quality of care needs to take them into account.
- In secondary care, consolidating improvements in public facilities, and make a more effective use of the capacity developed by the private sector in secondary health care.
- Strengthening Health Care Financing, by:
 - creating fiscal space for public expenditure on high priority health outcomes;
 - making allocation of public expenditure more transparent, and more pro-poor.
 - Drafting (Department of Health and Family Welfare and Department of Finance) of a financing plan for the health sector through 2012. This will emphasize that achieving the priority health outcomes requires that more resources be allocated to them, will identify where the funds for these high priority activities will come from, and will ensure that they are protected over the next decade.

I. Health status in West Bengal

29. Despite being an average state in India in terms of economic development, West Bengal records a **fairly positive** health performance compared to the Indian average for some key health outcomes. For instance, IMR, at 48.7 in 1998-99, is the fourth best recorded in India after Kerala, Maharashtra, and Tamil Nadu.

Table 1.1: Key Development and Health Outcome Indicators (1995-1998)

	Per capita income (Rs current prices 2001/02)	Poverty Headcount Ratio- (1999/00)	Infant Mortality Rate- (per 1,000)	U5 Mortality Rate (per 1,000)	Maternal mortality rate (per 100,000)	Percentage of children U3 stunted-
All India Average	20,198	26.1	67.6	94.9	453	45.5
Marahastra	29,873	25.0	43.8	58.1	336	39.9
Kerala	26,603	12.7	16.3	18.8	87	21.9
Tamil Nadu	23,414	21.1	48.2	63.3	376	29.4
Karnataka	22,816	20.0	51.5	69.8	450	36.6
West Bengal	20,039	27.0	48.7	67.6	389	41.5

Source: State GNP and poverty count: WDI; 2002; IMR, U5M, percent children stunted: NFHS-II, 1998/99; MMR, The progress of Indian states, UNICEF, 1995

30. However, nutrition, reproductive health, and morbidity indicators are similar to the India average.

Table 1.2: Selected Nutrition, Reproductive Health and Morbidity Indicators. West Bengal and all India average

Indicator	West Bengal	All India
Nutrition indicators		
percent of children aged 6-35 months with any anaemia	78.3	74.3
percent weight for age – 2SD	48.7	47.0
percent height for age – 2SD	41.5	45.5
Reproductive health		
percent of women reporting at least one reproductive health problem	45.3	39.2
average age at first birth	19.0	19.2
birth interval (months)*	33.6	30.8
TFR (40-44y)	4.3	4.5
Morbidity indicators		
Number of persons per 100,000 population suffering from Asthma	2,593	2,468
Number of persons per 100,000 population suffering from TB	492	544

*Includes only second and higher order birth

Source: Census 2001, SRS and NFHS-II 1998-1999, RCH-RHS 1998-99, "Health on the March" (West Bengal HMIS data 2001-02); HFWB, 2002.

31. The state is characterized by wide disparities in health outcomes between urban and rural areas, and between different socio-economic groups. West Bengal is still a

predominantly agrarian state, with 72 percent of its estimated 80.78 million population (fiscal year 2001-02) living in rural areas, and one of the highest proportions of citizens designated as belonging to Scheduled Castes, Scheduled Tribes and contextually disadvantaged groups³. For example, 52.8 percent of children living in rural areas, and almost 66 percent of those belonging to the poorest 20 percent households, are malnourished, while for those belonging to urban households and the wealthiest 20 percent the proportion malnourished are respectively 31.8 and 19.3 percent. A tribal districts survey found that in these districts IMR is equal to 73 per 1,000, against a state average of less than 50, and that MMR is 711 per 100,000, more than twice the state average (SIP, European Commission).

Burden of Disease

32. **Communicable diseases and malnutrition are still a major issue.** Using population and census data from 1991, and Sample Registration Scheme (SRS) data from 1990, 1991, and 1992, a burden of disease analysis⁴ estimated that West Bengal lost 17.3 million DALYs (or 248/1000 population) in 1992. This places West Bengal behind Maharashtra but ahead of states such as Karnataka and Andhra Pradesh. The study also indicated that at the beginning of the '90s, the major cause of lost DALYs in West Bengal was still communicable diseases.
33. Table 1.3 below indicates the relative burden of disease caused by type of disease. Group I diseases include pre-transition disorders such as communicable diseases, maternal, peri-natal and nutritional deficiency. Group II include non-communicable diseases, and group III injuries and accidents.⁵

³ 37 percent of the population belongs to SC and ST, while the all India average is 29 percent.

⁴ Comparative Assessment of the Burden of Disease Across Selected States in India, Administrative Staff College of India (ASCI) Research Paper Series, September 2001.

⁵ Ibid.

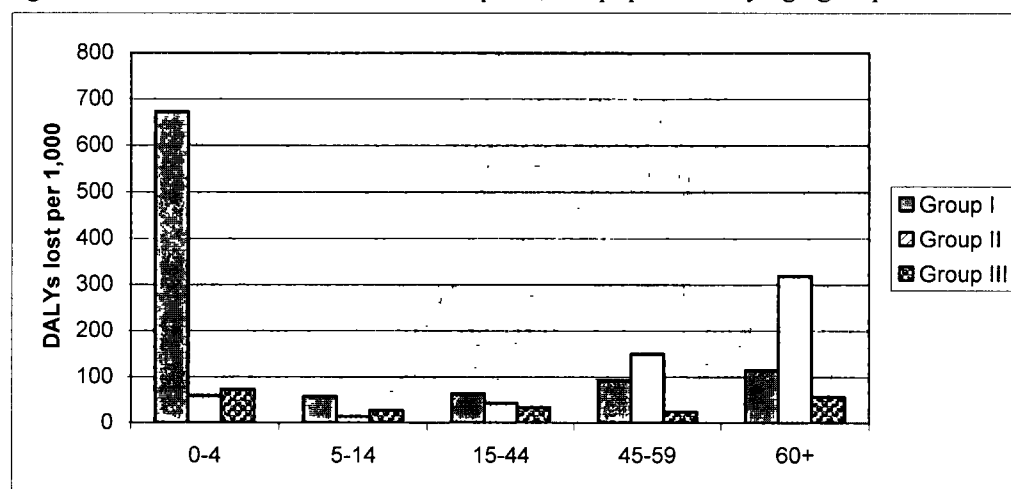
Table 1.3 : DALYs (Disability adjusted life years) lost per 1,000 population by major cause groups in rural and urban areas, 1991-92

State	DALYs lost per 1,000 Rural			DALYs lost per 1,000 Urban		
	Group I	Group II	Group III	Group I	Group II	Group III
Punjab	134.41	73.51	43.86	114.39	56.15	32.08
Maharashtra	148.29	72.25	41.54	100.74	47.87	18.31
Karnataka	165.56	72.78	43.24	109.90	50.27	22.13
West Bengal	164.6	69.14	44.03	96.66	53.84	20.29
Andhra Pradesh	160.04	81.46	47.23	97.67	74.25	30.45

Source: ASCI 2001.

34. **Non-communicable diseases are relatively more important in urban areas.** The table indicates that in rural areas, West Bengal still suffers mostly from communicable diseases. In urban populations the epidemiological transition is under way, and the burden of disease is shifting towards non-communicable diseases. Note the stark rural-urban inequality, with urban populations enjoying much better health outcomes for all types of diseases. Note also the much higher levels of injuries and accidents in rural areas.
35. **The greatest disease incidence was in the 0-4 year category⁶.** At the beginning of the '90s, the incidence of DALYs lost per population was highest among children, reflecting a high number of infants succumbing to communicable diseases (see Figure 1.1). As expected, chronic and degenerative diseases become more important among middle and old age groups.

Figure 1.1: Distribution of DALYs lost per 1,000 population by age groups



Source: ASCI 2001

36. Evidence from NFHS-II, 1998, indicates that neonatal mortality accounts for 2/3 and post neonatal for 1/3 of total IMR. Low birth-weight, poor nutrition, and post-birth infectious

⁶ The measure, Disability Adjusted Life Years (which at first approximation can be described as the sum of the years lost due to premature mortality, and of the "years" lost due to disability) lost per 1,000 population allows reasonable comparisons of profiles of disease burden or incidence between different states and countries.

diseases are the main proximate causes of neonatal deaths. Among the underlying causes of neonatal death, poverty, and 'age at marriage' play a critical role.

II. Health Financing

2.1 Total Health expenditure

37. It is difficult to put an accurate figure on total health expenditure in West Bengal, as households out-of-pocket expenditure (OOP) on health care is not well documented. On the basis of NSS data 1995-96, we estimate that total per capita health expenditure for the fiscal year 2001/02 was approximately equal to Rs. 700 (US\$ 14.7). This was 3.62 percent of estimated per capita Gross State Domestic Product (GSDP).

2.2 Where does the money come from?

38. The two main sources of health financing are households' out-of-pocket (OOP) expenditure and government expenditure. According to NSS estimates (1995-96), **households total OOP health spending was equal to Rs 193.7 per capita in 1995**. This was slightly less than the all India average of Rs. 222 per capita per year (see Figure 2.1 below). Projecting the above estimate to fiscal year 2001-02, under the assumptions of an income elasticity of demand for health services equal to 1.2, would give an OOP health expenditure equal to Rs. 489.4 per capita. This estimate is very similar to that by the Indian Institute of Health Management Research (IIHMR), 2002 study⁷. Our estimate is that out-of-pocket health expenditure accounts for approximately 67.5 percent of total health expenditure⁸.
39. The second source of financing is government, and within public sources, the most important source is the state. In fiscal year 2001-02, the last year for which we have actual figures, the State Government Health Expenditure (SGHE)⁹ was equal to Rs. million 14,132.1, equal to Rs. 174.9 per capita.

⁷ This study estimates OOP health expenditure equal to Rs. 479.4 per capita (Indian Institute of Health Management Research, 2002, *Studies on Health Financing in West Bengal*. Draft. Jaipur, India).

⁸ The estimate is that total private health expenditure (TPHE) is equal to 69 percent of total health expenditure. TPHE is calculated by adding to households out-of-pocket expenditure: (i) the amount spent by private firms on their own facilities or health insurance, which is estimated to account for 1.5 percent of total health expenditure, (ii) NGO financing, which is estimated equal to 0.6 percent of total health expenditure, and (iii) the amount spent by individuals on insurance premiums, estimated at 0.4 percent of total health expenditure (according to the IIMR study, 2002 only 4.2 percent of households had some form of insurance in West Bengal).

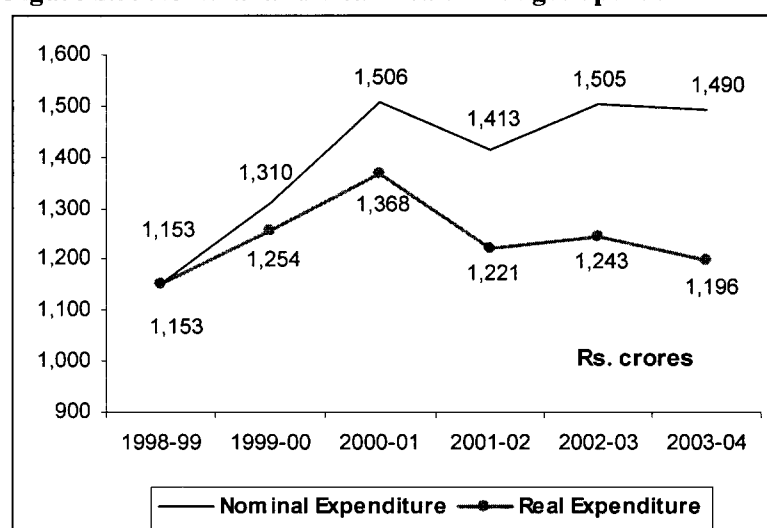
⁹ In fact, this includes also state expenditure on Family Welfare, which in fiscal year 2003-04 was equal to Rs. 1,110 million. An additional Rs. 360 million for family Welfare was committed from the Central government (see text).

Table 2.1: State Government Health Expenditure. Total¹⁰ (Rs. million):

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Budget Estimate	9,737.1	13,114.4	15,646.5	16,807.8	16,399.7	14,904.4
Revised Estimate		13,400.0	15,809.7	16,038.3	15,052.3	NA
Actual	11,489.1	13,101.9	15,059.9	14,132.1	NA	NA
Actual Revenue Expenditure	11,320.8	12,274.9	13,766.1	13,227.8	14,149.7	
Actual Capital Expenditure	168.3	827.0	1,293.8	904.3	NA	NA

Source: GoWB budget document, various years

40. State government health expenditure (SGHE) has remained constant in real terms since 1998-99, and has declined since 2000-01, reflecting the deteriorating fiscal situation in the state (see Box 2.1). In 2000-01, SGHE was equal to 0.91 percent of Gross State Domestic Product. The following figure 2.1 from IFEP, 2003, shows the trends in nominal and real state health expenditure on health over the last few fiscal years.

Figure 2.1: Nominal and Real Health-Budget Spends

Source: IFEP, 2003

41. **The share of state expenditure on health and family welfare over total state expenditure has declined over the last few years, from 5.8 to 4.2 percent in the period comprised between 1996-97 to 2003-04¹¹.** This share is comparable to the National average, but lower

¹⁰ The following section draws from two key documents, the Financial and Economic Plan for Health Sector in West Bengal, still in draft form (referred as IFEP, 2003), and the Health Financing in West Bengal (Structures, Challenges and Options), by DFID HSRC (we will refer to it as HFWB, 2002)

¹¹ Spending in social sectors as a share of the total is currently 24 percent, and has also declined quite significantly from a level of 38 percent in 1999-2000. Health and family welfare takes approximately 17.5 percent of the total expenditure in social sectors, which include, education, urban development, water and sanitation, , and welfare of scheduled caste and tribes.

than the targets set out in the National Health Policy, 2001, which demand states to increase allocation to health to 7 percent of their total expenditure by 2005, and to 8 percent by 2010.

42. **The second source of public financing for health is the central government.** This finances Centrally Sponsored Schemes, as well as health expenditure of other ministries, such as medical expenses of military stationed in West Bengal. During the 1990s the share of Central funding to the state for the health sector hovered around **14 percent** of State Government Health expenditure.
43. Other public sources of financing for health include local governments and state enterprises. There is no information about the total contribution to health financing from these other sources.
44. Sources of public funding also include external **multilateral and bilateral funds**, which account for a significant proportion of health expenditure. From 1996, the main externally supported project has been the World Bank funded State Health Systems Development Project (SHSDP II), which has recently reached its conclusion. The World Bank support has mainly been utilized to finance capital expenditure in the secondary care public sector. Other donors include GTZ and KfW, who are supporting a basic health project focused on primary care infrastructure and reforms in 7 districts, in coordination with the ongoing European Commission (EC) funded Sector Investment Programme (SIP), and DFID, which is supporting a ten-year Health Systems Development Initiative. Other agencies such as UNICEF/ICEF/NACO are also active in various areas of health improvement.¹² A more detailed presentation of these projects/programmes can be found in Chapter 5. On the basis of district level data from three districts (Hooghly, Purulia and Kochbihar) the IIHMR study, 2002, estimated that external sources accounted for 8.7 percent of total health expenditure.
45. **Note that the capital, mainly infrastructure investments financed by external donors in the past pose a serious sustainability issue.** Every additional capital expenditure brings forth additional future recurrent burden in terms of maintenance and other inputs. For instance, the IFEP document, 2003, estimates that the recurrent costs associated with the WB and the other externally supported investments amount to Rs. 1,100 million per year, equal to approximately 8 percent of total recurrent costs.

Additional sources of financing

- **User fees.** Revenues from user charges imposed on services in government secondary and tertiary facilities since the '80s have grown, but not up to the expected levels. In 2003-04 the budget forecast for user-fees revenues was equal to Rs. 218.7 million, or only 3 percent of the budget spent on secondary/tertiary hospitals¹³.
- **Cost recovery under the Employee State Insurance Scheme** for formal sector employees was equal to Rs. 657 million in 2003-04 and Rs. 620.2 million in 2002-03.

¹² The details of funding support from these sources could not be obtained at the time of writing this report.

¹³ In 2002-03 the revised budget estimates for UF revenue was equal to Rs. 183 million, and in 2001-02 the actual revenue collected was Rs 63.6 million.

2.3 Where does the money go?

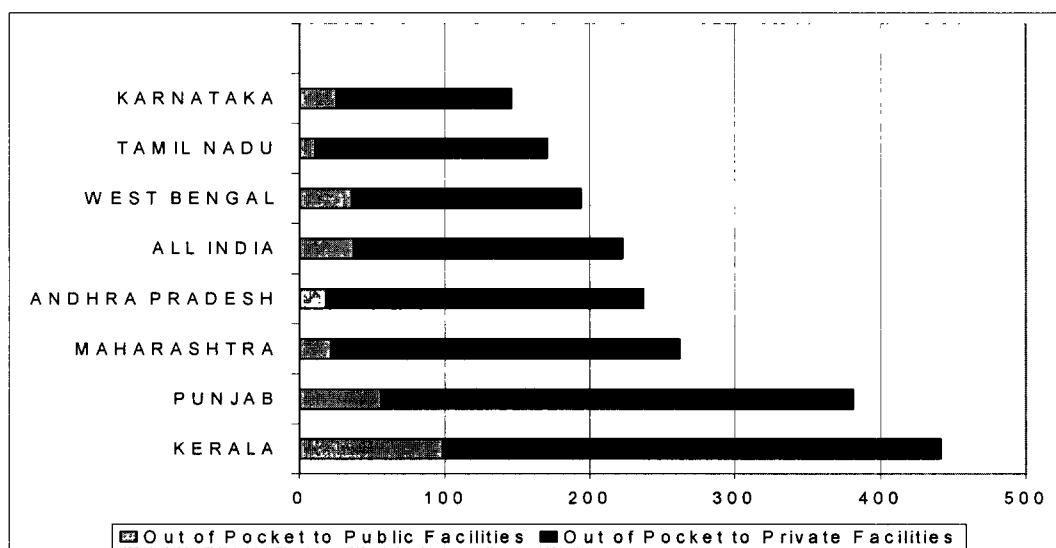
46. **The great majority of private spending is directed to private providers.** As table 2.2 and Figure 2.2 show, 81.4 percent of out-of-pocket expenditure is spent on medicines and private providers. According to the Studies on Health Financing in West Bengal, 2002, the most important item of private expenditures is drugs, accounting for 75 percent of total OOP expenses for minor conditions and 64 percent for major conditions.

Table 2.2 West Bengal: Total Out-of-Pocket Expenditure (Rs/person/yr 1995/6)

		Outpatient	Inpatient	Total	Share
West Bengal	Public providers	22.7	13.4	36.1	18.6%
	Private providers	137.3	20.3	157.7	81.4%
	Total	160.0	33.7	193.7	100.0%
India	Public providers	24.1	13.3	37.4	16.8%
	Private providers	146.1	39.1	185.3	83.2%
	Total	170.2	52.5	222.7	100.0%

Source: Mahal, 2001; based on NSS 1995-96

Figure 2.2: Total Out-Of-Pocket Expenditure in Various Indian States, 1995-96-Rs/Person/Year



Source: Mahal, 2001; based on NSS 1995-96

47. **Private OOP expenditure greatly varies by district and between urban and rural areas.** The IIMR study, 2002, estimated that total per capita OOP expenditure was 2.86 greater among urban compared to rural populations.

48. **Public expenditure finances almost exclusively public facilities.** Contracting out to the private sector for service delivery is minor (there are some NGOs part of national programs against communicable diseases, and the urban slums NGO-led programme; see Chapter 5).
49. For the state component of government expenditure, we have more recent and precise information on its evolution over time, and its breakdown by level of care and by input.

Table 2.3 State Government Health Expenditure –total and break-down by levels of care

(Rs. Million)	1999-00 (Actual)	2000-01 (Actual)	2001-02 (Actual)	2002-03 (RE)	2003-04 (BE)
A. Revenue Expenditure	12,274.9	13,766.2	13,227.8	14,149.7	14,139.0
Primary Health Services	4,734	5,241.2	4,809.8	5,515.9	5,242.4
Share in Total Expenditure	36%	35%	34%	37%	35%
Secondary Health Services	5,532.3	6,100.6	6,241.3	6,199.5	6,482.4
Share in Total Expenditure	42%	41%	44%	41%	44%
Medical Education, Training & Research	907.0	1,093.6	1,071.4	1,208.4	1,132.2
Share in Total Expenditure	7%	7%	8%	8%	8%
Direction & Admin./Medical Stores Depots/ Health Statistics & Evaluation	1,101.6	1,330.9	1,105.3	1,225.8	1,282.0
Share in Total Expenditure	8%	9%	8%	8%	9%
B. Capital Expenditure	827.0	1,293.8	904.3	902.6	765.3
Share in Total Expenditure	6%	9%	8%	6%	5%
Total Expenditure (A + B)	13,101.9	15,059.9	14,132.1	15,052.2	14,904.3

Note: Figures for percent spent have been rounded to the nearest whole number and therefore do not exactly add up to 100 percent.

Source: IFEP, 2003

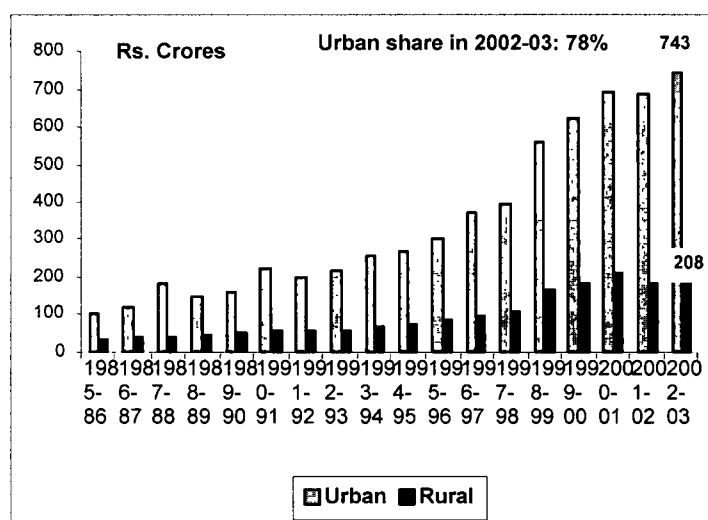
50. **Secondary care takes a large share of state government health expenditure.** Spending on primary care has been stable at around 35 percent of total spending. Note that for the share of expenditure in primary care over the total is lower than the target set in the National Health Policy 2002, which is 55 percent.
51. The state health budget is allocated among three major departments, or sectors: public health, family welfare and medical. **Expenditure on public health activities, such as disease prevention and control, has been slightly declining,** and it is now equal to approximately 10 percent of total SGHE (Rs. 1,450 million in 2003-04). The budget for the family welfare program, supported by Central Government funds, has also declined in proportion of State Government Health Expenditure from 12 percent in 1998-99 to 9.3 percent in 2002-03. Over the same period, the share of medical department has increased from 75 to more than 80 percent of the total.
52. **In terms of inputs, salary expenditures accounts for the lion's share of the total state health budget. In fiscal year 1999-2000 approximately 70 percent of total was spent on salaries¹⁴;** other essential inputs, such as medicines, are severely neglected. In 1999-00, the budget for drugs was equal to Rs. 924 million, which accounts for only 7.4 percent of total revenue expenditure. According to IFEP, 2003, the percentage of the total spent on medicines has decreased since then, and it was just above 5 percent of the total in last fiscal year. Also

¹⁴ According to HFWB, 2002 (p. 3), in fiscal year 2003-04 74 percent of total revenue expenditure, and more than 80 percent of the non-plan expenditure was spent on salaries.

the budgets of the departments of public health and family welfare are mainly spent on salaries and on curative care, while other inputs and preventive and health promotion activities receive a very small share of the total.

53. In the last few years, most of the capital expenditure has been supported by externally aided projects. State's expenditure on capital is quite erratic and it has been declining over time¹⁵.
54. **Financial allocations within the public sector tend to be non-transparent, and inefficient.** As stated in the Health Financing in West Bengal document: "Budgeting tends to be incremental with a high proportion of funding seen as precommitted. The current line item approach is extremely rigid offering little flexibility to budget holders. It provides little information which is useful for assessing the effectiveness of expenditure in the sector (HFWB, 2002, p. 3)". "Inefficiency in financial management at the district level is a serious concern. **There is a total absence of tracking the linkages between received funds and the consequent performance at all levels, including the district, in achieving health goals.** In other words, no formal mechanism could be found to identify the most cost-effective ways to spend the funds. A lack of flexibility in utilizing the fund is obviously a barrier to encourage the district officials apply more cost-effective approaches. Another important factor is the general aversion of health officials to financial figures, and leaving this exclusively to the accountants. This also creates problem in monitoring the efficiency in funds utilization (HFWB, 2002, p. 23)".
55. **Rural areas receive a disproportionately low and declining share of the total resources for health.** Allocations are biased against rural areas, which receive only 22 percent of TGHE¹⁶, in spite of the fact that 72 percent of the population still resides in rural areas (IFEP, 2003).

Figure 2.3 Evolution of public expenditure in urban and rural areas



Source: IFEP West Bengal, 2003

¹⁵ For fiscal year 2003/04, capital expenditure is budgeted at Rs.765 million (capital outlay was Rs.1,293.8 million in 2000-01, according to IFEP, 2003).

¹⁶ Secondary care takes 27 percent of the total, and tertiary care 17 percent of the TGEH

56. **The Central government funds, which are the second largest source of revenue for public expenditure, support family welfare programs and various disease control programs.** The financing of all these vertical disease control programs vary from scheme to scheme. Some schemes are fully financed by the Centre while others are partially financed on matching basis¹⁷. Some of the major disease control programs of the State currently are malaria control, leprosy control, filarial and TB control programs.

2.4 Prospects for the future

57. **In the near future, plans to increase state government's health expenditure will be severely restricted by existing tight fiscal constraints.** The GoWB is trying to respond to a deteriorating fiscal situation (see Box 2.1), and has thus agreed to a Fiscal Recovery Programme (MTFRP) with the Government of India. The implementation of the MTFRP may produce negative consequences on social sector and health expenditures. It is essential that the decline of state government health expenditure share over the total state expenditure observed during the last few years¹⁸ is reversed, and that protecting expenditure on health, education and other essential social services is made a state's priority.
58. In addition, there is still a large scope for improving resource allocation in health both in terms of equity as well as efficiency. The Integrated Financial and Economic Plan (IFEP) recently produced by the Department of Health and Family Welfare is an attempt to "provide a framework within which a realistic forward view of aggregate budgets spends can be aligned with the health mission and strategic goals (IFEP, p. iii)". The IFEP presents two scenarios: for the period 2004-05 to 2008-09 in terms of government health expenditure:
- Under *Scenario A*, SGHE is envisaged to increase from the base-year level of Rs. million 14,900 to Rs. million 22,920 in the fifth year reflecting a nominal growth of 9 percent, and a real growth rate of 4 percent per annum;
 - Under *Scenario B*, the optimistic scenario, budget outlay has been projected to reach a level of Rs. million 25,720, showing a real growth rate of 6.5 percent.

In addition, external support is expected to be, on the average, Rs. million 470 per annum.

59. **Within the above budget envelope, the IFEP suggests that efficiency and equity improvements may be achieved mainly by allocating more funds towards primary care, rural areas, and towards non-salary expenditure items.** Under both scenarios, the IFEP suggests a progressive increase in the proportion of the budget to primary care (from 35 to 44 percent according to scenario A), and a progressive increase in the non-salary expenditure

¹⁷ For example, while malaria program is funded near 100 percent by the Central government, leprosy control program receives less than 15 percent budgetary support from the Centre.

¹⁸ From 5.8 to 4.2 percent in the period comprised between 1996-97 to 2003-04.

Box 2.1 The deteriorating fiscal situation in West Bengal

Most Indian states have witnessed a deterioration of their fiscal balance during the last few years. According to the Health Financing in West Bengal document (p. 3), the phenomenon has been even sharper in West Bengal: between 1990-91 and 1999-2000, the revenue deficit (RD, i.e., the gap between the operating expenditures and revenues) rose from 3.0 to 6.7 percent of Net State Domestic Product (NSDP). Over the same period, the fiscal deficit (which adds loans and capital expenditures to the revenue deficit) in the state increased from 4.9 to 9 percent of NSDP, and the rate of growth of public debt in the state was 19 percent. The negative trend has accelerated at the beginning of the 2000s: the ratio of interest payments to revenue receipts, which was 31 percent in 1998-99, has recently approached 40 percent.

The causes behind this negative trend are the following:

- The revenue base of the state has been declining. The annual rate of growth of revenues during the decade of the 1990s was only 11.2 percent, against an all-India average of 14.1 percent. As a proportion of Gross State Domestic Product (GSDP), West Bengal's tax revenue has fallen from 6.60 percent in 1995-96 to 4.2 percent in 2000-01.
- During the last decade there has been a rapid growth of non-development expenditure, especially on staff costs. The level of salary and pension payments in West Bengal has been consistently high in comparison with other states. The ratio of these payments to revenue receipts has experienced a dramatic increase from 78 percent in 1990-91 to about 86 percent in 1998-99, primarily due to implementation of the recommendations of the Fifth Pay Commission.
- Another important factor contributing to the growing deficit rates are the heavy subsidies given to the poorly performing Public Sector Undertakings (PSUs). For example, the accumulated losses of four major PSUs in the state (WBSEB, Calcutta Tramways Corporation, Durgapur Projects, and Durgapur chemicals) in the year 1996-97 was estimated to be more than Rs. 100 billion (over 7 percent of State GDP), which outweighed the state's own tax revenue in that year.

Recently, the Government of West Bengal has drafted a Medium Term Fiscal Recovery Programme (MFRP) with the Government of India, which is meant to address the current budget unbalances through a programme of fiscal adjustment (see discussion in the text). The plan is to reduce the fiscal deficit to 2 percent of NSDP, and eliminate the revenue deficit by 2005-06.

Source: IFEP, 2003

components, such as drugs (from 6 to 10 percent of the total budget¹⁹), as a means to achieve better health outputs within the given resource envelope.

¹⁹ The IFEP makes the hypothesis that salaries will grow nominally at 2 percent per annum, while the non-pay revenue expenditure increases according to a rate of inflation of 5 percent per year.

Table 2.4: Integrated Financial and Economic Plan-proposed evolution of budget aggregates

Impact indicators (percent)	Base year	Scenario A	Scenario B
Share of health budget	4.2	4.9	5.5
Per capita spending	178	255	286
Share of primary care services	35	44	49
Share of secondary +tertiary care services	44	41	36
Share of pay-component	74	68	63
Share of drugs	6	10	17
Share of non-pay expenditure	20	22	21

IFEP, 2003

60. In conclusion, the fiscal constraint in West Bengal, as in most other Indian states, is particularly troubling. If so, financial support to sustain and scale up provision of essential services to achieve the state priorities in health will come mainly from four sources:

- a. external resources (which may include both international and some increased central resources),
 - b. expenditure reallocations within the health sector and from other sectors,
 - c. efficiency gains, and
 - d. leveraging private sector provision.
- a. Central government support to the state of West Bengal has been lower in proportion to SGHE relative to most other states, and there is scope for improvement. As for international assistance, the recent commitment by DFID to a ten-years support program for the state is an important development (see Chapter 5). However, additional external resources are still needed, even if these cannot and should not substitute for a strong government commitment to support priority programs.
 - b. We have discussed already the potential benefits from resource reallocations within the health sector and from efficiency gains. Reallocations from other sectors, such as from the current high subsidies granted to poorly performing Public Sector Undertakings (PSUs), would potentially free up significant additional funds for priority programs in health and education. By international comparison West Bengal, as the rest of India, invests relatively less on health and education, and spends much more on subsidies. However, there are complex, difficult to change political economic equilibria which explain the current situation. In order to progressively reallocate government funding away from wasteful and potentially regressive activities towards more equitable and potentially more productive investments, such as those in basic health and education programmes, the government would need to grapple with difficult choices. There is clearly a trade-off and a choice to be made between short-term political gains, and more

long-term, diffuse benefits, which greater investments in basic health and education services for the poor would bring about.

- d. Finally, more leveraging of private sector provision can potentially lead to significant gains in terms of quality and efficiency. In Chapter 6 we propose activities which would lead to a more effective utilization of the potential of the private sector in improving health outcomes.

III. Delivery system and health seeking behavior

3.1 Public Sector Delivery system

61. **The public sector has a large number of health facilities at all levels.** The government of West Bengal runs 18 District hospitals, 65 sub-district/state general hospitals (SDH/SGH), 95 Rural Hospitals (RH²⁰), 252 Block Primary Health Centres (BPHC), 922 Primary Health Centres (PHC), and 8,126 small sub-centres at the village level staffed by Multi-purpose Workers (MPWs). In addition, there are few urban tertiary hospitals attached to the Medical Colleges²¹. The total number of beds in the public sector is estimated to be equal to 71,074, (58,721, excluding those at the primary care level²²). The existing capacity is the result of investments implemented in the more remote past, while physical capacity building over the last two decades has been slow.²³
62. **The current GoWB's strategy is to consolidate and upgrade existing infrastructure, rather than further expanding it²⁴.** While the government would increase the number of sub-centres, it does not intend to add new PHCs/BPHCs. Instead, the plan is to upgrade about one-third of the existing PHCs into BPHCs, and converting all BPHCs into Rural Hospitals.
63. **Most public hospitals are in urban areas.** Although the rural population accounts for 72 percent of the total population, only one-fourth of the public hospitals, and 11 percent of the beds are located in rural areas (IFEP, 2003).
64. **Primary care sector institutions lack basic inputs.** The results from a recent inventory of services in three districts of West Bengal (Hooghly, Purulia, and Kochbihar)²⁵ shows that lower level facilities lack critical inputs. For example, about half of the PHCs and one-fifth of the First Referral Units (FRUs) do not have a continuous supply of water, 19 percent of PHCs do not have electricity, in 84 percent a telephone is missing, and in 92 percent a vehicle for emergencies is missing.

ISM&H Institutions and Facilities

65. "Ayurvedic institutions include 189 dispensaries, 107 Block Primary Health Centres/Primary Health Centres units, one pharmacy and garden, one testing laboratory (plus one more is in the process of getting established during 2003-04), and 3 hospitals with educational facilities. The facilities under homoeopathic system of medicines include 13 colleges and hospitals (5 government and 8 private) with 500 beds, and 545 dispensaries of which 240 being attached

20 They are equivalent to the Community Health Centres in other states.

21 The state has 7 medical colleges with 1,003 seats for MBBS students, and one dental college with 50 seats. There are also a few institutions delivering post-graduate and post-doctoral courses in modern medicine as well as ayurvedic/homoeopathic colleges.

22 The state also has 1,269 primary health centres (RH/BPHC/PHC), with 12,353 beds, mainly used for observation, or for one-day cases.

23 The state added only 31 hospitals taking the total from 398 in 1980 to 429 by the end of 2001-02. Similarly, population served per bed increased from 936 in 1987 to 1,136 in 2001-02.

24 See Health Sector Reforms (2nd Edition), DHFW.

25 Economic Information Technology, 1999. *Facility survey (1999) under RCH project*, West Bengal.

with BPHC/PHC. Under urani system of medicines the state has only two hospitals with 110 beds²⁶ (IFEP, 2003, p. 3)”.

Human resources

66. As at the end of calendar year 2001, the state’s total human resources in the health sector included: 32,296 allopathic medical practitioners; 3,014 ayurvedic practitioners; 37,401 homoeopathic practitioners; 46,167 nursing personnel (general nurses, public health nurses, assistant nurse-cum-midwives, and lady visitors); and 21,729 pharmacists.
67. The population served per doctor has remained approximately constant over the period 1981-2001. It is estimated that in 2001 the population served per doctor was equal to 2,500. However, during the same period, the position in respect of nursing personnel has improved significantly. The population served per nurse has decreased from 2,613 in 1981 to 1,749 in 2001, reflecting an improvement by 33.5 percent (IFEP, 2003, p. 5).
68. **In terms of human resources, wide gap exist between sanctioned posts and personnel in position, particularly in rural areas.** In rural areas the government is estimated to have one doctor per 4,727 population, while in Kolkata it has one per 830 population. In the case of PHCs, out of a total number of sanctioned posts for doctors equal to 1,841, 294 are vacant (16 percent of the total)²⁷. Critical resource gaps, in staff, equipment and drugs, persist at the peripheral level, even if availability of doctors to the rural population has improved significantly compared to the position in 1983, when there was one doctor per 5,386 population²⁸.
69. **Absenteeism appears to be quite high particularly in primary care institutions.** A recent study commissioned as part of the World Bank World Development Report 2003 (Chaudhury et al, 2003, Habyarimana et al., 2003, and NRI and World Bank, 2003) found absenteeism rates equal to 43 percent in primary care centres²⁹.

Medical Education

70. The State also produces 905 MBBS doctors, nearly 200 paraprofessionals (pharmacy, radiography, pathology, etc.) and about 1,200 nurses (ANM/GNM/diploma-holder/etc) every year. After a gap of a decade, the government has again started training programmes for Auxiliary Nurse Midwives in all the districts (IFEP, p. 6).

3.2 Private or non-government sector delivery system

71. There is a broad range of private providers, including private (for-profit and charitable) hospitals, modern solo private practitioners, qualified providers of Indian System of Medicine (ISM), operators of small nursing homes (polyclinics) and medical diagnostic centers, traditional birth attendants, known as dais, and unqualified or not-fully qualified providers (e.g. rural medical practitioners, or RMPs, quacks). We don’t have any information on the

²⁶ Source of data: *State Bureau of Health Intelligence Directorate of Health Services, 2001-02, GoWB.*

²⁷ Source of data: *Tenth Five Year Plan, Planning Commission, GOI.*

²⁸ Source of manpower data: *State Bureau of Health Intelligence Directorate of Health Services, op. cit.*

²⁹ Absenteeism is measured as the percentage of staff who are supposed to be present but are not on the day of an unannounced visit. It includes staff whose absence is “excused” and “not excused”.

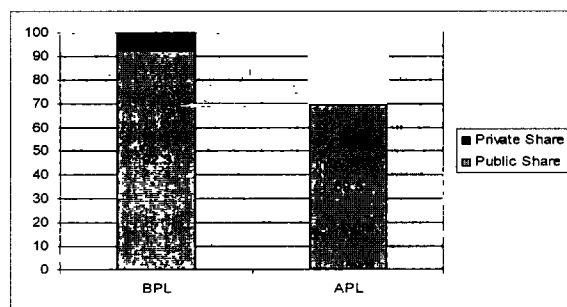
total size of the private sector delivery system, nor on its break-down among different types of providers. According to government sources of information, the private sector has only 20 percent of the total bed-power in the sector.

72. In addition, many government practitioners seem to have a dual job holding, and they spend a significant portion of their time in private practice (although there is hardly any documented evidence of this phenomenon).

3.3 Health seeking behavior

73. **The majority of people in West Bengal seek care from the private for profit sector for outpatient care (OPD), but utilize public hospitals for inpatient care (IP).**
- According to NSS data (1995-96)³⁰, about 86 percent of OPD patients are catered for in the private sector. A further 9 percent attend public as well as private health care facilities.
 - A different pattern emerges with respect to inpatient care where the public sector still dominates the private sector. According to NSS data (1995-96), about 81 percent of IP episodes are catered for in the public sector. Among those above the poverty line, 69 percent utilized public facilities for IP care (among the wealthiest 20 percent of the population, approximately 55 percent). For those below the poverty line, the percentage is as high as 92 percent (see Figure 3.1). However, if West Bengal followed the same pattern as other states, it is likely that the private share of inpatient cases will have grown substantially over the last decade.

Figure 3.1: Distribution of Utilization of inpatient care services between the Public and Private Sector, 1995-96



Source: Mahal et al., 2001

74. Table 3.1 below indicates that there are stark differences in utilization patterns between rural and urban populations. The rural population tends to use less formal allopathic services from private providers relative to the urban population.

³⁰ See also: "Health Financing in West Bengal", Nov. 2002, Indian Institute for Health Management Research (IIHMR) & Institute for Health Sector Development (IHSD), DFID Health Systems Resource Centre.

Table 3.1 : Source Of Health Care – Rural and Urban (1998) –
Percent distribution of households by main source of health care when household members fall sick (IP + OPD), according to region

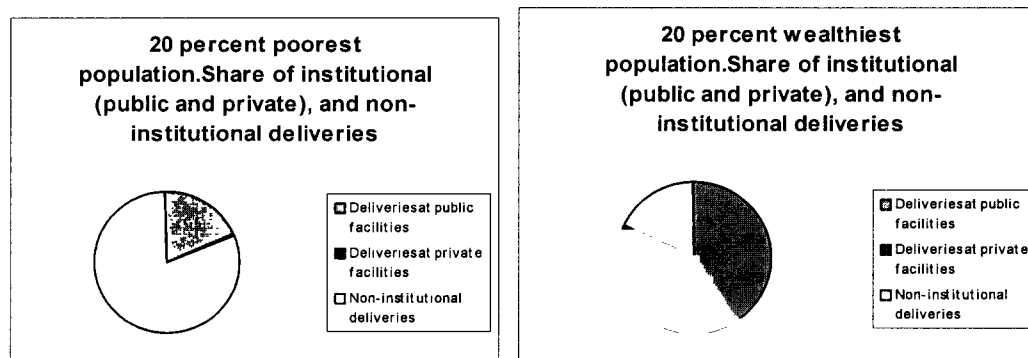
Source of care	Rural	Urban	Total
Public medical sector	27.4	15.4	24.2
Govt./municipal Hospital	7.1	11.9	8.4
NGO or trust	0.3	0.8	0.5
Pvt. Medical sector	52.7	81.2	60.3
Pvt. Hospital/clinic	2.3	3.7	2.7
Private doctor	33.7	67.7	43.2
Other source	19.4	2.4	14.9
Number of Households	3,466	1,259	4,725

*Missing observations on caste excluded from the analysis

Source: NFHS-II, 1998/99

75. The same patterns is observed for deliveries. The poor and those residing in rural areas tend to deliver more at home, and not to use formal private institutions. Overall, among those who deliver in institutions (40.1 percent of the total), about $\frac{3}{4}$ chose public facilities and only $\frac{1}{4}$ private ones in 1995-96. It is likely that the share of the private sector has increased over the last decade.

Figure 3.2: Institutional deliveries as a proportion of total deliveries by type of facility, Category: Rural & Urban



Source: National Sample Survey 1995-96, 52nd Round

76. It is unclear what attributes make private providers to thrive, particularly in the provision of outpatient ambulatory services. There is no clear evidence showing that clinical quality in the private sector is unequivocally better or worse than in the public sector.
77. However, there is evidence showing that prices in the informal private sector are lower than all payment associated with seeking care from public providers (which includes price of drugs, transportation, and sometimes informal payments to doctors). Note from the table

below that for major ailments, public facilities' prices are 72 percent of formal private sector prices, and more than twice the prices for "other" providers. In addition, private providers respect more confidentiality, are available at convenient hours, and are more likely to be present than public providers (see subsection on Quality of care, next Chapter).

Table 3:2 Mean out-of-pocket expenditures for health services: public and private sector³¹ in three districts of West Bengal

Service type	Public Sector		Private (qualified) sector		Other	
	percent who paid	Mean payment* (Rs)	percent who paid	Mean payment* (Rs)	percent who paid	Mean payment* (Rs)
Major ailments	94.9	1897.6	99.8	2649.5	97.3	720.3
Minor ailments	69.2	309.2	99.3	845.2	97.4	222.4
Birth delivery – institution	99.4	636.6	100	3450.6	-	-
Birth delivery – home	-	-	-	-	81.4	115.60

* Payment includes consultations, hospital costs, drugs, tests, transport and lodging.

Source: HFWB, 2002, originally from *Studies on Health Financing in West Bengal (Chapter 3)*, IIMMR, 2002

78. The evidence also shows that users of public facilities need to buy medicines and do tests in the private sector: in public facilities for major ailments medicines account for 64 percent while tests account for another 11 percent of total OOP expenditure, for minor ailments medicines account for 84 percent of the total, by far the greatest proportion.
79. Finally, the evidence indicates that private sector providers are intensely utilized also by the poor. Formal sector providers are utilized more for major ailments, and informal private providers for minor ailments. According to the study in three districts cited before (reported in HFWB, 2002), among the poorest 25 percent of the population 38.6 percent used private providers for major ailments (both inpatient and outpatient care), while 57.7 percent used informal providers (RMPs and quacks) for minor ailments. This implies that any intervention which improves quality of services in the private sector would not be a subsidy for the rich, but it would benefit the poor.

³¹ Indian Institute of Health Management Research (IIHMR). 2002. *Studies on Health Financing in West Bengal*. Draft. Jaipur, India, Chap-3.

IV. Health system performance

80. In general, the health system in West Bengal performs slightly better than the Indian average. However, the state's performance is much lower than that of the most advanced states in the South and West, and there are striking inequalities across geographical areas and socio-economic groups.

Table 4.1: Comparative Health Service Coverage and Access Indicators

	percent Children Receiving All vaccinations (1-3y) ³²	percent of Pregnant Women Receiving at least 1 Ante- Natal Check Up	percent of Pregnant Women Receiving at least 2 Tetanus Toxoid Injections	percent Pregnant Women Receiving Folic Acid	percent Instit. Deliveries	percent of Births Attended by Health Profession- al	percent Married Women Using any Contracepti ve Method
All India	42.0	65.4	66.8	57.6	33.6	42.3	48.2
Punjab	72.1	74.0	89.9	79.6	37.5	62.6	66.7
Kerala	79.7	98.8	86.4	95.2	93.0	94.0	63.7
Tamil Nadu	88.8	98.5	95.4	93.2	79.3	83.8	52.1
Maharashtra	78.4	90.4	74.9	84.8	52.6	59.4	60.9
Karnataka	60.0	86.3	74.9	78.0	51.1	59.1	58.3
West Bengal	43.8	90.0	82.4	71.6	40.1	44.2	66.6
Andhra Pradesh	58.7	92.7	81.5	81.2	49.8	65.2	59.6

Source: NFHS-II, 1998/99

81. The evidence also indicates that West Bengal has achieved mixed results during the '90s: some indicators, such as immunization and antenatal care coverage have improved, but others, such as early recognition and prompt and effective treatment of life threatening illnesses (especially ARI, and diarrhea) have worsened.

³² Other studies on vaccinations found much higher coverage rates. A survey study by UNICEF in 2001-2002 found that the percentage of fully immunized infants was equal to 78.5%.

Table 4.2: Evolution in Maternal and Child Health Service Performance Indicators³³

	WB 1992-93	WB 1998-99	India 1998
No antenatal check-up (percent)	24.6	9.5	34.0
Institutional deliveries (percent)	31.5	40.1	33.6
Children 12-23 months fully immunized (percent)	34.2	43.8	42.0
Children with ARI to health care provider (percent)	61.7	52.4	64.0
Children with diarrhoea to health care provider (percent)	82.1	54.2	63.4
Malnutrition (<- 2sd) (percent)	56.8	48.7	47.0
TFR (15-49y)	2.92	2.29	2.85
IMR	75.3	48.7	67.6

Source: NFHS-I, 1992-93, and NFHS-II, 1998-99

Equity

82. Wide disparities in coverage persist:

- **across districts and between rural and urban areas.** For example, the average across the state for institutional deliveries is 40.1 percent, and for full immunization 43.8 percent. However, in the worst performing districts only 20 percent deliver in institutions, and only 29 percent of children are fully immunized. By contrast, in the best performing districts, the shares are respectively 91 and 83 percent (source: Peters et al, 2002). While only 31.4 of the rural women delivery in facilities, 79.7 of women living in urban areas do. While 41.4 percent of the children in rural areas receive full-vaccination, 58.6 of those living in urban areas do;
- **across different socio-economic groups.** For example, while among those who belong to the 20 percent wealthiest segment of the population 76.6 percent of children with Acute Respiratory Infection are taken to a health provider, only 43.6 among those who belong to the poorest 20 percent. The following table summarizes some of the evidence available on the system inequalities in terms of services' coverage.

Table 4.3: Health system performance indicators by socio-economic status and by region

Performance indicator	Wealth Quintile		Region		Total
	Lowest	Highest	Rural	Urban	
No antenatal check-up (percent)	15.7	0.1	10.8	3.6	9.5
Institutional deliveries (percent)	21.5	86.3	31.4	79.7	40.2
Children 12-23 months fully immunized(percent)	31.7	70.0	41.4	58.6	44.5

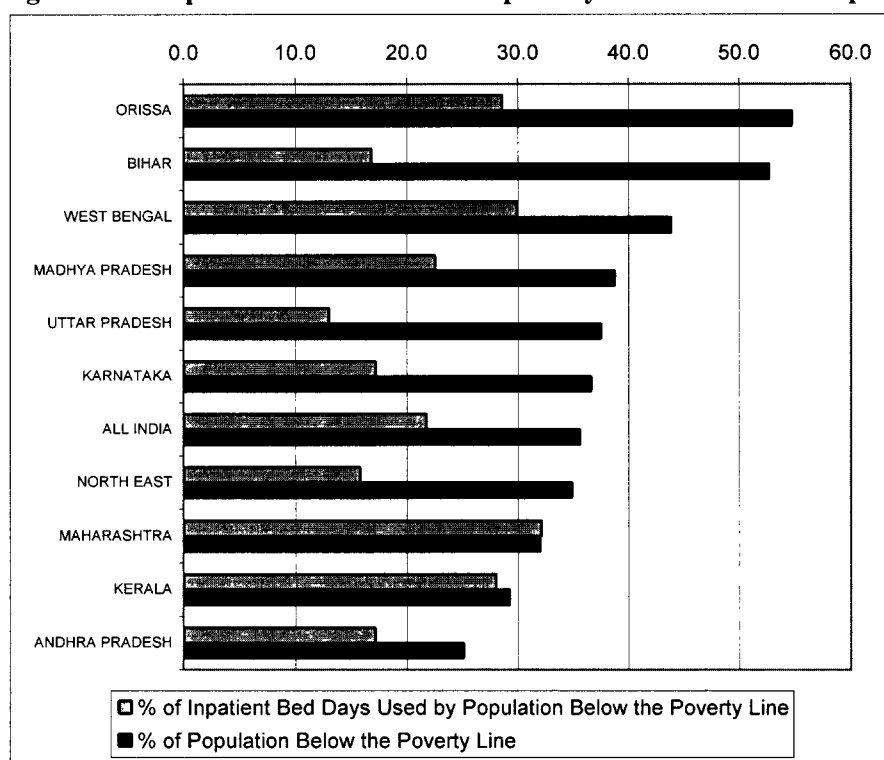
³³ NFHS-I (1992-93) indicators are for children under 4 years of age while the indicators from NFHS 2 (1998) are for children under 3 years of age.

Children with ARI to health care provider (percent)	Wealth Quintile		Region		
	43.6	76.6	52.2	51.7	52.4

Source: NFHS-II (1998-99)

83. **Public expenditure disproportionately benefit the rich.** The ratio of subsidy to richest versus poorest 20 percent of the population is 2.73 (Mahal et al. 2001), **mainly because expenditure on public hospitals is pro-rich.** For inpatient care, while 43.9 percent of the population is estimated to be below the poverty line, they utilize only 29.9 percent of inpatient bed-days. The location of most public facilities in urban areas contributes to make them less accessible to the poor. Note that in terms of equity, West Bengal shows average results in India, worse than most Southern and Western Indian states, but better than most Northern and Eastern states.

Figure 4.1: Population share below the poverty line and share of inpatient bad days, 1995-96



Source: Mahal, Yazbeck, Peters and Ramana, 2001

84. Hospital care is pro-rich also considering the outpatient component (OPD). NSS-based (1995-96) evidence shows that hospital-based OPD favor those above the poverty line, while PHC based outpatient care favors those below the poverty line (Mahal, Yazbeck, Peters and Ramana, 2001).
85. **West Bengal does not perform well in terms of financial protection.** OOP expenditure poses a severe barrier to access health services. According to the NSS data 1995-96, 30 to 40 percent of potential users could not seek care because of financial reasons. The same source

indicates that over a third of the hospitalized people below the poverty line (BPL), both in public and private hospitals, had to borrow or sell assets to finance their care. The majority of these fell into poverty as a result. According to the findings of a survey covering Hooghly, Coochbihar and Purulia districts³⁴, 7 percent of the persons surveyed had to sell or mortgage their property to meet the costs associated with a major ailment (HFWB, 2002)³⁵. The percentage is higher in rural than in urban areas.

Efficiency

86. This section, which draws entirely upon the HFWB, 2002 document, presents the only available information on the level of efficiency in the public sector. No information is available on the level of efficiency in the private sector.
87. We have little information on activity levels in the public sector, and on costs and activity levels in the private sector. Thus, it is extremely difficult to draw any firm conclusion on the level of technical efficiency in service provision. However, the symptoms of low technical efficiency in government health services manifest themselves in levels of various output or performance indicators. These include facility based efficiency indicators (such as bed occupancy rate and average length of stay, the proportion of patients being referred and so on), and the availability of critical inputs. Table 4.4 shows the average level of performance in the state's secondary level institutions. More information is presented in Chapter 5, discussing the achievements of the World Bank supported project.

Table 4.4: Performance indicators at different levels of facilities in West Bengal, 2001

Types of Hospital	Bed Occupancy rate percent	Average length of stay	percent of patients referred out to discharged	percent of patients referred in to total in-patients	percent of major surgeries to admissions	percent of deliveries to admissions	percent of imaging tests to OPD+IPD	percent of lab tests to total OPD+IPD	percent of post operative fatalities
District Hospital	87.69	4.79	3.19	8.03	9.76	19.81	4.41	13.74	0.06
Sub-district /Sub-general hospital	76.70	4.01	8.03	4.28	7.69	20.34	3.44	8.78	0.09
Rural hospital	62.70	2.55	16.63	3.92	-	25.64	1.19	5.44	-
Block PHC	52.12	2.12	13.88	-	-	22.68	-	3.76	-

Source: Health Financing in West Bengal: Structures, Challenges, and Options, 2002, originally taken from Hospital activity and efficiency indicators (Jan – Dec, 2001), State Bureau of Health Intelligence, West Bengal

88. A few points deserve attention, as indicated by the HFWB, 2002 (HFWB, 2002, p. 16):

³⁴ IIHMR survey in Hooghly, Kochbihar and Purulia

³⁵ See for further details *Health financing in West Bengal*, Nov.2002, *op. cit.*

- The lower level hospitals are technically less efficient. For example, while the bed occupancy rate at district hospitals is pretty high, the same at referral levels (BPHC or RH) is significantly low.
 - The referral system appears to be very weak. Among all in-patients in the District Hospitals, only 8 percent were referred. This clearly indicates that a large section of population suffering with major illnesses bypass the middle level facilities (BPHC or RH) and seek treatment directly at the DH level. Most people buy and consume drugs over-the counter for minor ailments, or directly seek care from higher level facilities in urban areas for major ailments or emergencies.
 - Low utilisation of diagnostics services at the public hospitals, which probably indicates low maintenance of equipment, lack of specialized staff, and shortages of consumable supplies (however, these have improved recently, look at Chapter 5).
89. Analysis of activity data in the three districts also showed that there is a high variability in performance, and that lower level institutions are performing worse than higher level institutions. The inventory of facilities found that PHCs lack basic inputs, such as water (missing in 50 percent of them), and that specialist are often missing also from first referral institutions. The situation is decisively better in District Hospitals.

Quality of care

90. Information on the quality of care in the private and public sector comes from a variety of mainly qualitative studies, with different methodologies, and of widely varying reliability and accuracy. Overall, we still have little rigorous and reliable information on the quality of services in the private and public sector.
91. Despite lack of systematic knowledge, the state has indicated concern for quality of care in the private sector. The West Bengal Clinical Establishment Rules 1951, as amended up to January 2001, have been notified and put into effect from 30 May 2001 to regulate quality and impose respect of minimum standards. No information is available on the enforcement of these rules.
92. From the NFHS-2 1998-99 it appears that quality of care is higher in urban areas. In particular, in the rural areas patients find facilities not as clean, and the attitude of staff not as respectful and responsive (“staff talk to them nicely” and “respected their need for privacy” had the lowest scores).
93. The results from a community survey undertaken as part of the World Bank project (HSDP-II) indicates that in most cases patients of the poorer segments of the population, SC/ST, or living in rural areas rely on non-fully qualified practitioners (RMPs), and other non-allopathic forms of medicine, particularly for minor illnesses. By contrast, more educated and wealthy people rely on private fully trained (MBBS) doctors. Qualified private providers and nursing homes are almost universally considered better than public ones, but often patients cannot afford them.
94. By contrast, people tend to go to the public hospital for more serious health concerns. The study highlighted several obstacles to the use of public hospitals by SC/ST people. Quoting from the Health Systems Development Project Status Report, May 20003, p. 70: “Their (ST patients’) experiences at the hospital ranges from bad to worse. When they take the pains of hiring a mode of transport and reaching the hospital, very often they are left unattended for

hours. The doctor does not even listen to symptoms and writes down the medicine, which they are expected to purchase. Some doctors are good and give them sound advice, but it always helps to carry a letter from the Panchayat. The nurses and the other staff are very rude and the only way they behave properly is if they have some recommendations....A number of patients thus die more out of negligence than ignorance”.

95. From the patient satisfaction surveys, two key issues stand out as obstacles in the government sector: (i) lack of attention from unwelcoming staff, and (ii) lack of medicines especially in the rural areas.
96. As for the problem of lack of medicines, a study by Blackstone showed that in hospitals there is no rigorous estimate of drug requirements, no basic store management principle in place, and that most of the personnel responsible for drug management have no formal training.

V. Externally supported projects and recent innovations in the health sector

5.1 Externally Aided Projects

97. In recent years the state has introduced some health improvements through projects with various donors. These have led to renovation and upgrading of selected hospitals and health centers, introduction of quality improvement programs for hospitals, some improvements in the efficiency of hospital management, and introduction of certain reforms in governance at the district level. There has been an increase in utilization of secondary and tertiary public facilities, and some perceived enhancement in quality of care. However, the evidence shows that, despite progress, much remains to be done to improve the performance of the public institutions. The situation is more problematic in the rural areas. Moreover, new infrastructure investments and increased staff numbers have led to increases in recurrent costs by as much as 8 percent.

The State Health Systems Development Project (SHSDP II)

98. The World Bank funded a State Health Systems Development Project (SHSDP II), from June 1996 to March 2004. The revised project cost stands at Rs. 7,832.9 million³⁶. The project strengthened the secondary care sector and introduced a series of significant managerial innovations.

Achievements

I. Civil Works:

99. The World Bank supported project contributed to up gradation and capacity building of secondary health care facilities (total budget, Rs.3,600 million, plus 2,500 million in equipment and other supplies). Its scope included 214 hospitals (18 district hospitals, 61 sub-divisional/ state general hospitals, and 95 rural hospitals) and 36 health centres (8 BPHCs and 28 PHCs) in the remote areas of Sunderbans.

II. Reforms and innovations:

a. Improved Management

100. **Health management information system (HMIS).** The project introduced significant change in HMIS. A HMIS manual was developed, and a system of *monthly report* of performance indicators for all hospitals in the state and *quarterly report* of performance and efficiency for district/state government/sub-divisional/rural hospitals and BPHCs was introduced. Prior to the project's establishment, there was no performance culture in the ministry. Without computerization of records and a strong MIS system, records were irregular and erratic. The new HMIS has made possible a better record-keeping of inputs and outputs, and could help managers set basic targets for their facilities. Unfortunately, the lack of initiative and the lack of managerial capacity have so far hindered the full utilization of the HMIS analysis to improve accountability and hospital management.

³⁶ A total of Rs. 6,096 million has been spent till 2002-03

101. **Establishment of Quality Assurance Programme in Secondary and Tertiary Hospitals.** Establishing the HMIS system together with evidence from patient/customer satisfaction surveys have contributed to assess the quality of service delivery. To grade hospitals, 12 quality indicators have been selected, later extended to 14³⁷, and each hospital has been graded between A+ to E according to its performance on those 14 quality indicators. This has created a positive peer pressure and increased awareness among service providers. Measuring performance, and creating a healthy competition among hospitals based on mutually agreed benchmarks provides an incentive to improve performance.
102. **The DHFW has also initiated some reforms in human resource management, although the changes have not been yet sufficient and need consolidation.** First, greater autonomy has been introduced at the facility level, with delegation of administrative and financial powers to Principals of medical Colleges, Chief medical Officers, Superintendents of hospitals and Assistant Chief Medical officer for health. Second, the DHFW committed to introduce a more rational and transparent transfer policy for medical staff. Third, doctors have been hired on a contract basis. Fourth, non-clinical services, such as scavenging, security, diet, and cleaning, have been contracted out to the private sector. Progress is also been made in establishment of diagnostic facilities in hospital premises in joint venture with the private sector.
103. **Introduction of bio-waste management techniques.** The DHFW also introduced improved bio waste management techniques separating hospital waste into three categories of (i) hazardous materials, (ii) infectious waste and (iii) generic waste. This system is working fairly well, with the exceptions of a few facilities that were identified in a recent health audit. Constraining factors to have been the lukewarm response by Municipalities, non availability of recycling/reprocessing industries, and non-involvement of doctors. A waste autoclave installed in Govt. hospital has also utilised as CTF for private units.
104. **The DHFW has created a Strategic Planning Cell,** later renamed Strategic Planning and Sector Reform Cell, under whose supervision a number of strategic studies have been undertaken. These studies will provide government with a rich information base on which to design and implement future reforms. They include a study on the rational use of drugs and reasons hindering drug availability, one on follow-up of pregnancy related complications, and one on health financing. The DHFW has also initiated strengthening of the disease surveillance system, to improve the information base on the burden of disease.
105. Finally, in order o strengthen managerial capacity, the DHFW has developed a State Institute for Health and Family Welfare, as the Apex Institution for training of paramedical staff, in-service training of medical staff in public health management and operation research in the state.

b. Innovative health financing initiatives

106. **Augmentation of user-charges in secondary and tertiary hospitals.** The fees were first introduced in the late '80s. The fees were revised in March 2002, and then more recently

³⁷ These include: emergency admission rate, use and content of display board at entrance, bed turn-over rate, filling of Bed Head Tickets, referred patients (in and out), new-born death rate, segregation of waste, number of major and minor surgeries, testing of drinking water quality, cleanliness of hospital, doctor's attention to patients' queries.

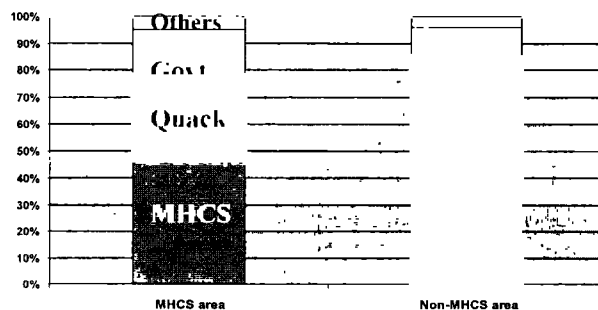
they were raised by 30percent, but revenue has not increased as a result. The government took two other innovative decisions: 1. Introduction of afternoon Pay Clinics in secondary and tertiary facilities; 2. Introduction of diet charges for patients.

107. Despite the above innovations, the revenue form user-fees has so far been extremely low (1.38 percent of total costs for District Hospitals, or 8 percent of its non-salary recurrent costs, according to the IIMR 2002 study.). Several reasons contribute to this poor results. First, there are no real incentives for the administration to collect the fees, because funds cannot be retained at the facility level. DHFW was eager to allow facilities to retain charges. However, the Finance Department argued that there were legal obstacles to retention of user charges. Thus, doctors and other staff prefer to continue collecting informally, or to “integrate” their salary by working privately, while nobody has a real interest in making payments more transparent. Second, the exemption policy is extremely loose: there is no control over the indigent certificates required for exemption.
108. **For motivating facilities to collect fees, it is necessary that revenues generated are retained, controlled, and utilized at the collection point.** International evidence shows that if the revenue from the fees can be used to motivate staff, to procure essential drugs, to keep facilities clean and to maintain basic equipment, the user charges can produce a limited negative impact on the poor, and a positive impact overall, because people are willing to pay something more in order to have better quality services.
109. The government has recently proposed to introduce new pre-payment and insurance schemes, inspired by the Karnataka experience with the Yashismini scheme promoted through the farmers’ cooperatives. To our knowledge the scheme has not yet been initiated.

c. Pilot projects to test new models for increasing access to health services for vulnerable groups with the highest disease burden

110. **Involvement of NGOs in service provision.** Another interesting experience is the involvement of NGOs in the provision of medical services by organizing **mobile clinics** in 382 remote villages of the Sunderbans region. This has lead to radical improvements in service delivery in one of poorest and underserved areas of the state, as the following figure shows:

Figure 5.1 Percentage distribution of patients in the Sunderbans, by source of treatment



*MHCS= Mobile Health Clinics

Source: Government of West Bengal

111. In general, in West Bengal, NGOs are actively involved in many health and family welfare services. For instance, in public health programmes like blindness control, NGOs undertake more than 80 percent of the cataract operations.

Outputs

112. The World Bank supported project led to some positive developments in the management of the secondary and tertiary care institutions, indicated in the increased volume of their activities. Table 5.1 indicates the increases in key performance indicators during the first seven years of the project. The improvement in performance is higher in Rural Hospitals, and for lab tests and other diagnostic tests.

Table 5.1 Key performance indicators 1997 – 2003

Performance Indicators	Type of facility	1997 (baseline)	2003	Rate of Increase 2003 over 1997
OPD per month per hospital	DH ³⁸	15,348	19,632	27.9%
	SDH/SGH ³⁹	7,998	10,967	37.1%
	RH ⁴⁰	6,081	9,113	49.9%
IP per month per hospital	DH	2,338	3,045	30.2%
	SDH/SGH	1,104	1,243	12.6%
	RH	257	402	56.4%
Bed occupancy rate (%)	DH	81.2	90.1	11.0%
	SDH/SGH	74.2	85.0	14.6%
	RH	47.9	82.3	71.8%
Average length of stay	DH	5.30	4.22	-20.4%
	SDH/SGH	4.10	4.06	-1.0%
	RH	3.30	2.91	-11.8%
Average monthly X-rays done	DH	779	1273	63.4%
	SDH/SGH	321	473	47.4%
	RH	40	129	222.5%
Percentage of inpatients and outpatients receiving laboratory tests	DH	10.50	15.09	43.7%
	SDH/SGH	5.65	9.67	71.2%
	RH	3.54	5.64	59.3%
Percentage of major surgeries to admissions	DH	7.81	10.27	31.5%
	SDH/SGH	6.78	7.98	17.7%
Percentage of deliveries to admissions	DH	17.20	18.09	5.2%
	SDH/SGH	18.68	18.66	-0.1%
	RH	22.29	19.7	-11.6%

Source: DHFW, Government of West Bengal

³⁸ District Hospitals

³⁹ Sub-Divisional Hospitals/State General Hospitals

⁴⁰ Rural Hospitals. Rural hospitals correspond to Community health Centres of other states in India

113. The number of deliveries performed by public hospitals has also increased (more in DH and RH than in SDH/SGH hospitals). However, these hospitals seem not to have been able to take on the lead role of providers of emergency obstetric care, which is one of the most important functions they were meant to fulfil. Presently, only about one fourth of the total number of deliveries is estimated to take place in the facilities rehabilitated by the project. Lack of key specialist staff, such as anaesthesiologists and gynaecologists, lack of support staff, lack of key medicines and other supplies, dual-job holding by most doctors, all these factors hamper the full utilization of the secondary care facilities for obstetric cases.
114. According to the patient satisfaction surveys (which were repeated three times over the period 2000-02), significant improvements have also been achieved in availability and courteousness of doctors and nurses. For inpatient care, nursing care was reported as the most important contributing factor to patient's satisfaction/dissatisfaction in 30 percent of the cases; second factor was doctors' attention (26 percent of cases). The latter was by far the most important factor for OPD (80 percent of cases). Some of the more problematic indicators at the time of the first survey have shown improvements in subsequent surveys. Over 83 percent of the patients reported to be satisfied of the services received.
115. The surveys also show that outsourcing sanitation and other non-clinical services has led to significant improvements in facilities' cleanliness and appearance. The more recent patient survey indicated 76 percent of patients were satisfied with the cleanliness of the facilities, compared to 61 percent two years before.
116. Finally, the surveys show that the hospitals have been able to attract an increasing number of people belonging to the poorest 20 percent of the population (an estimated additional 0.2 million).

Outstanding issues

a. Lack of broad ownership of the reforms

117. The project has been less effective in promoting change and in being a spearhead for systemic/structural reforms. For example, the project intended to promote innovations in health financing, protect and increase the share of the state public expenditure for health or reallocate resources in favour of non-salary expenditures. By and large, these objectives were not achieved. The project has hardly had any influence at the level (mostly in the Department of Finance) where decisions concerning the size and composition of health expenditure are taken. Also, its influence on the Department of Health and Family Welfare as a whole has not been decisive. Managerial improvements have been largely limited to the secondary and tertiary sector and in the facilities supported by the project, and so to some extent controlled by the Project Management Unit. The rest of the system does not seem to have been improved. For example, the primary sector, where the problems of absenteeism, lack of medicines, etc are more severe, does not seem to have been influenced by the changes occurring in hospitals.

118. The ownership of reform programs has remained weak and their implementation has lacked vigour. The existing style of governance and the overall culture in which the bureaucracy operates does not provide strong incentives for creative thinking or innovation. The general tendency among many is to protect the status quo, and top level bureaucrats do not have interest in addressing sector policy or strategic issues, also because of short tenures. There is a very limited scope for mutual learning or for taking decisions which may be politically risky. In this context, the reforms and the managerial improvements implemented in the state in the last few years have been achieved mainly thanks to the extensively hard work of few key but isolated individuals.

b. Improper and under utilization of facilities

119. **Under utilization of the secondary care facilities.** Although the secondary sector oversaw a tremendous increase in the number of in-patient and outpatient cases, there are signs that capacity is still not being fully utilized, particularly in rural hospitals. The overall impression is that the new facilities are being run as successful OPD centers that also cater for minor surgeries such as tubectomy, appendectomy, vasectomy etc. whereas due to lack of specialists and other support staff they are not fully utilized for more complicated treatment, or utilized after-hour. The facilities which are functional are well utilized between 9.00am and 3.00pm. In the late afternoon, patients disperse as all but one doctor leaves the building and a skeleton staff is left to run the facility.

120. **Increased capacity has not yet led to a sufficient increase in institutional deliveries.** Partly due to the problems outlined above, the secondary and tertiary hospitals currently attend roughly 23-24 percent of the total births in the state⁴¹. The secondary facilities have not yet been able to take on the role of main providers of emergency obstetric care, which they were meant to assume. The district and sub-district hospitals are doing better than the sub-division and rural hospitals.

c. Other issues

121. In conclusion, the experience of the State Health Systems' project shows that progress in performance is directly linked not only to capital investment, but to better human resource management, and to increased recurrent inputs (maintenance security, drugs, skilled manpower, etc.).

122. **Primary sector needs to be pulled up to provide appropriate support and to sustain the benefits of the project.** Improving primary care is essential to create a well-functioning referral system which could lead to a better utilization of secondary and tertiary care facilities.

123. **The qualitative aspects of working force, especially motivation and attitude, still remain an area of concern.** Thirdly, the experience of the WBHSDP indicates that participation of medical providers (in sustaining the project) based on complete ownership is a serious challenge, and that the process of improving management is extremely difficult.

⁴¹ Hospitals, Sub Divisional Hospitals, State General Hospitals and Rural Hospitals in the State attended 391,097 deliveries in 2003, 24% of estimated annual total no. of births (1,666,139) in West Bengal.

Monitoring of various norms and procedures at the hospital level needs to be further strengthened.

d. Financial impact on recurrent costs

124. The overall financial impact of externally supported health projects in the 1990s, which concentrated on capital expenditure, was to increase recurrent costs, including for salaries, by approximately 8percent. Thus, the projects may in the long term further squeeze expenditure on other essential services, such as primary and public health activities, which are likely to produce a stronger impact on priority health outcomes.

Other externally supported projects

125. The World Bank also supported the Family Welfare Urban Slum IIP-VIII project. Its budget was equal to Rs. million 984.7. It covered a population of 3.8 million in 3 municipal corporations and 38 municipalities. The project has brought about significant improvements in the health system coverage of slum populations, and has produced important innovations in the engagement of NGOs in service provision, as documented by Economic Review, GoWB, 2002-03. **The successful grass-root service delivery model initiate during IPP-VIII could be used as an example to be replicated to the rest of the state** (see Duza et al. 2003).
126. Other externally aided activities already ongoing or in preparation include:
- a. in April 2001 DFID approved a Project Concept Note to support the DHFW in a Health Systems Development Initiative, with a planned grant of 200 million GB pounds over a period of 10 years. To guide the release of the grant, the Strategic Planning and Sector Reform Cell, DHFW, has been tasked to develop a Strategic Framework and an Integrated Financial and Economic Plan with external technical assistance (see next Chapter).
 - b. The European Commission (EC) is supporting a Sector Investment Programme (SIP), which is meant to supplement and strengthen the health reform and decentralization processes. The SIP activities (budget equal to Rs. 452 million) include a school health programme, a survey of selected tribal districts and a tribal project, a urban health improvement (building upon activities initiated under IPP-VIII project), ANM training, support to state thalassemia control programme, MIS development, IMR and MMR survey in six selected districts, and activities to strengthen rural hospitals.
 - c. The state is also implementing a Basic Health Programme, with a “software” component” (technical support to develop the primary care sector) supported by GTZ, and a “hardware” component supported by KfW in 8 districts. GTZ started working in September 1999. The first phase of their programme is closing in June 2004 (total planned cost equal to EURO 4.8 million, or Rs. 2,600 million). The second phase will end in June 2007, having a budget of EURO 2.5 million (approx. Rs. 1,350 million). The KfW funded Basic Health Project has an estimated cost of Rs. 1,920 million commenced in May 2001 and it will be completed by April 2006. Phase I of the project (expected to be completed by

April 2004) involves renovation of 113 BPHCs and 92 PHCs, and construction of 308 new sub-centres. Under Phase II, 113 BPHCs would be renovated and 213 new sub-centres constructed. Project funds would be spent on civil works and supply of essential drugs, equipments and furniture. The project also incorporates supply of 226 ambulances, to be operated by NGOs.

- d. Other agencies such as UNICEF, ICFE and NACO are also active in various areas of health improvement.

5.2 Recent Developments

Decentralization process

127. The GoWB decided to create a unique *District Health and Family Welfare Society*, bringing under it all the health care activities/programmes in the district, while at the same time abolishing all the other committees and societies. The district Society has an executive committee chaired by the Sabhadhipati of Zilla Parishad and has District Magistrate as Executive Vice Chairman⁴². The Chief Medical Officer of Health (CMOH) of the district is the Member Secretary of the district Society⁴³. NGO and other stakeholders also participate in the meetings of the Society. To enable the field functionaries to discharge their duties efficiently and effectively, the district Societies are vested with wide administrative and financial powers. For instance, the CMOH is now competent to sanction leave for all medical officers and paramedical and support staff. They can also manage routine maintenance of equipment and procurement of medical stores.
128. These developments will hopefully eliminate the confusion stemming from the multiplicity and fragmentation of funding channels at the district level, make more clear the lines of accountability, and at the same time increase flexibility and community participation in the use of funds. The current changes are being reported to show positive effect in the management related issues⁴⁴.

Enhanced community involvement in the delivery of services

129. In addition to district level Societies, the GoWB has constituted *Block Health and Family Welfare Societies*. The constitution of these follows the same pattern as district Societies, with the only variation that they involve the members and functionaries of *gram panchayat* (GP) and *gram sansads* (GS). The services of all the sub-centre workers are being placed under the GPs, and the borders of the subcentres are being redefined to coincide with the GP borders. The new organization structure at the grass-root level is explained in detail in Annex one.
130. The above process is part of a larger plan to enhance community participation in the management of health services. There are moves afoot to augment the capacity of NGOs and

⁴² All political parties have the privilege to nominate one of the MLAs elected from the district as member of the society.

⁴³ To ensure overall control and supervision of various programmes of basic health care, the offices of the CMOH, Dy. CMOH II, Dy. CMOH III and Zonal Leprosy Officer have been amalgamated into one office, i.e., the office of the CMOH. All public health functions and funds are now controlled by the CMOH.

⁴⁴ Source: West Bengal Health Systems Development Project, Status Report, Nov. 2003

Community Based Organizations (CBOs), particularly the woman self-help groups (SHGs). The members of the woman self-help groups will be trained by NGOs. Besides, both NGOs and CBOs have been allowed access to facilities at government hospitals. In collaboration with NGOs, the government has also decided to set up eye banks and a mechanism for collection of eyes.

Public Private Partnership

131. The Department of Health and Family Welfare is committed to establishment of Public Private Partnerships (PPP). This would involve engagement with Private Sector, both profit and not for profit (NGOs and CBOs). To translate the commitment of the Government into reality a new and separate branch under the title of "Public Private Partnership" was established in the Department in October 2002.
132. The process started with contracting out of non-medical activities of the hospitals. Subsequently, establishment of diagnostic facilities by private sector in tertiary care hospitals was identified as priority area and several units for MRI and CT Scan were established. For primary health care the following four priority areas have been selected:
 - Establishment of diagnostic facilities by private parties in Rural Hospitals.
 - Management of ambulances purchased and provided by the Government by NGOs, community based organizations, etc.
 - Establishment of drug shops in BPHCs and Rural Hospitals by Private Partners.
 - Outsourcing of non-functioning PHCs.
133. Schemes for first two areas have already been developed and approved. The scheme for drug shops is under discussion with Finance Department. The scheme for handing over of PHCs to Private Parties for management is under preparation. Approvals have already been given for establishment of diagnostic facilities in different Rural Hospitals.
134. Several proposals for collaboration with Private Sector in Secondary and Tertiary Health Care Sector have also been received. Some examples of such proposals which are under examination and discussion are: a. establishment of dialysis unit; b. geriatric clinic; c. super specialty Cancer Hospital, d. college of Pharmaceutical Science for Aurvedic drugs, and others.

VI. The way forward: what needs to be strengthened and what needs to be done differently

135. The Department of Health and Family Welfare (DHFV) is developing a new strategic approach to policy development, has undertaken certain important reform initiatives, and has recently formulated a new State Health Sector Strategy 2003-2012. As part of this effort, since March 2002 the government has constituted a state level apex committee chaired by the Principal Secretary, DHFW. This Committee has taken the lead for policymaking, monitoring the development and implementation of the Strategic Framework⁴⁵, and coordinating the activities of donor-partner assisted programmes. A Mission Statement for the DHFW, in line with the National Health Policy of India (NHP-2002) has been articulated, which reads as follows: *“The mission of the Department of Health and Family Welfare Department of the Government of West Bengal is to improve the health status of all the people of West Bengal, especially the poorest and those in greatest need.”*
136. The priority health outcomes set for the state are to: a) decrease infant and child mortality and improve nutritional status, b) improving reproductive health; c) decrease maternal mortality, and d) control infectious diseases. Acknowledging that several of the priority health indicators are better in West Bengal than their national equivalents, the DHFW has posed for itself more ambitious goals than those included in the Government of India National Health and Population Plans and the tenth Five Year Plan. These goals are outlined in Table 6.1.

Table 6.1 Health Outcome Goals

Health Outcome Indicators	Current situation	RCH II 2004-9	National Population Policy 2010	West Bengal 2010
Neonatal mortality	26/1000	20/1000		15/1000*
Infant Mortality Rate	47/1000	35/1000	30/1000	30/1000*
Maternal Mortality Ratio	200/100,000	150/100,000	100/100,000	Below 100/100,000*
Birth rate	20.6/1,000			14/1,000
Under-weight birth rate	25%			10%
Deliveries by skilled attendant (not TBA)	55.6%		100%	100%
Institutional deliveries	47%		80%	80%
% of mothers receiving antenatal care	64%			100%
HIV/AIDS**	?		“Contain the spread of HIV/AIDS”	“achieve zero level growth HIV/AIDS”
Total Fertility Rate	2.3	2.2	2.1	2.1
Couple Protection rate (modern methods)	47%	65%	Meet 100% needs	90%*
% children fully immunised	56%	100%		100%

* Where West Bengal’s performance is significantly better than the national average for these indicators, they have been proportionately adjusted.

** The State’s HIV/AIDS Prevention and Control Action Plan is specified in the Annex XX of the Health Strategy

⁴⁵ The Strategic Framework defines health outcome goals and identify the strategies and operational initiatives necessary to realize the DHFW’s Mission Statement. From the budget speech of DHFW, 2002: “...the Strategic Framework will allow The GoWB to lead the development of a process whereby the donor community and other partners, including the Government of India, plan their support in a coordinated and targeted manner. This will in turn facilitate prioritization of service provision, improved management systems and better resource allocation.”

137. Looking at the evidence from the '90s, so far West Bengal seems to have been on target in reducing infant mortality, but not in improving its major health systems' performance indicators⁴⁶. If the same rates of change recorded during the '90s continue, in 2010 children immunized will be 64.6 percent⁴⁷ and institutional deliveries 58.6 percent of the total, and not 100 percent as stated in the Health Strategy. In addition, the trend for coverage of children with diarrhea and ARI has been negative over the '90s. Thus, it is clear that to achieve the above ambitious targets the DHFW there is a need to introduce courageous and quite radical reforms, which represent a challenging agenda of reorientation of the public sector. They require changing the way many staff within the public health sector function and address their roles and responsibilities. Reforms must represent the recognition that government has a stewardship role to play for ensuring both the public and the private health systems operate and interact in such a way that all parts of society and particularly the most vulnerable parts of society have access to affordable good-quality essential services.
138. In developing a new strategy, the GoWB should try to replicate and scale up successful service delivery experiences such as those initiated during the IPP-VIII project in the poor areas of Kolkata, characterized by community participation and ownership, flexible delivery systems, and focus on results (outputs and outcomes).
139. In the new strategy it is also important to distinguish more clearly between problems which have efficacious interventions exclusively as part of ambulatory care services – such as the life-threatening illnesses and communicable diseases – and those which do not, such as reducing maternal and neonatal mortality. The former can be addressed exclusively by actions to affect services at or near community level. The latter typically require also higher level services, usually beyond those that can be adequately financed or provided at the primary health center level.
140. To improve **post neonatal and child mortality indicators**, control communicable diseases, and prevent non-communicable diseases, the focus needs to be **on ambulatory care, nutrition, and on diseases prevention and health promotion activities**. The targets must include interventions which will: increase coverage of immunization; prevent those diseases for which there are already good preventive interventions; recognize at an early stage and promptly and effectively treat life threatening illnesses (especially ARI, diarrhea and malaria); and improve child feeding practices to prevent malnutrition⁴⁸. How to do this at a time of severe fiscal constraints is the challenge of course.
141. For **maternal and neonatal mortality reduction**, improved antenatal care, increase coverage of supervised deliveries, and improved postnatal care are essential. First referral units need to play a critical role by providing 24/24 access to emergency obstetric care services.
142. The challenge needs to be addressed from several points of view: in secondary care, further improving performance of public facilities, and make a better use of the growing capacity of private facilities, in primary care, strengthening the coverage/quality of public

⁴⁶ Evidence on maternal mortality is too poor, and the different sources are too discordant to be able to put a precise number on its rate of change over the '90s.

⁴⁷ As mentioned before the NFHS estimate of immunization coverage is challenged by a UNICEF survey finding coverage greater than 75 percent in 2001-02.

⁴⁸ Even though malnutrition is the underlying cause of up to sixty percent of all infant and child deaths, only limited progress has been made in improving the nutrition situation (children malnourished decrease from 56.8 to 48.7 of the total between 1992 and 1998).

providers (mainly ANMs and PHC staff, but also including nutritional programs such as ICDS), engaging formal and informal non-government providers (which account for more than 80 percent of first-contact services), experimenting innovative delivery systems characterized by outreach activities, team-work, greater community participation and new accountability mechanisms based on results.

143. In the remaining part of this concluding chapter, we will explore more in depth a few of these directions of reform. Further definition of these options and of the way forward will be articulated in partnership and dialogue with the Government of West Bengal.

Engaging private providers in the delivery of essential services

144. Many of the goals will involve the private sector, a topic which the Strategy has not yet sufficiently confronted, and that can potentially lead to step up the rate of progress in health, building on the experience being cumulated in the national TB and other programs (such as IPP-VIII), and on the other initiatives more recently proposed by the Public-Private Partnership wing of the Department established in October 2002 (see Chapter 5).
145. The market share of the private sector in both rural and urban areas and for both inpatients and even more outpatients is large and increasing. For ambulatory care, the first healthcare provider consulted, especially by the poor, is most frequently a Rural Medical Practitioner. Qualified private providers are also important, especially for those with higher incomes but also for the poor in some more developed areas. In some locations and for specific services NGOs are the most important providers.
146. However, quality of care in the private sector is a serious issue, which needs to be addressed, particularly quality of care provided by not-fully qualified providers. There are several types of not-fully qualified providers, including practitioners of traditional forms of medicine who also administer allopathic treatment, faith healers, assistant pharmacists and drug sellers, etc. The anecdotal evidence available suggests that informal providers continue to practice irrational medicine, and can endanger their patients health by unnecessary and often unsanitary treatments, such as harmful injections, and over-prescription or under-prescription of antibiotics. For qualified providers, anecdotal evidence indicates that: a) their services are too costly and not accessible to the majority of the population: prices are not posted publicly, and they tend to be well beyond poor people's ability to pay, and at times patients belonging to lower casts and minority groups are openly refused treatment; b) they tend to over-prescribe and provide unnecessary treatment, particularly to better-off patients (supply-induced demand).
147. **The private sector has enormous unexploited potential to help deliver information and services that would address the priority health goals, but in order to exploit such potential a completely new strategy of engagement must be articulated by the government.**
148. Three strategic priority areas for public-private partnership (PPP)/collaboration can already be identified: a) engagement of private providers in National programs, building upon what has been achieved particularly in the TB control program; b) Service Agreements with private providers for the management of Primary Health Centres and other provider units; c) social franchising schemes and other mechanisms to engage RMPs and other grass-root providers, particularly in the poorer districts of the state.

149. Another area where the private sector could play a potentially important role is in improving maternal health, both by providing antenatal and postnatal care services, as well by contributing to step up coverage of emergency obstetric care services. For the latter, secondary care facilities both in the public and private sector must play a critical role.
150. Although it is common to see the provision of supervised deliveries as the responsibility of the state, this need not be the case. For example, in Andhra Pradesh supervised deliveries increased from 25percent to 50percent between 1992 and 1998 – almost all of this increase was in the private sector. It is important that West Bengal looks at all the options as it plans for the next 10 years.
151. Finally, for other secondary care and tertiary services, whose impact on priority health outcomes is more limited, a much increased emphasis on private sector investment in hospitals will help to create fiscal space for reallocation of funds to activities in support of essential services. This will also help create bed space for the poor in public hospitals. It is important that agreements between government and private sector in tertiary care result in net savings for government, and not additional expenditure, so that more resources can be devoted to essential public health and primary care services.
152. A gradual and planned increase in involvement of the private sector in provision of hospital beds, together with greater autonomy and a strengthening of the current system of user fees at public hospitals is recommended. But first, the GoWB needs to develop an institutional framework for enhancing the quality of care in the private sector, which would include licensing, an accreditation system, and a continuous programme of quality monitoring and evaluation.
153. It is important that a new Public Private Partnership strategy, outlining the various ways in which the diverse segments of the private sector will be incorporated, is defined in the next few months, in collaboration with key voluntary sector organizations and with the key representative groups for the for-profit sector. The strategy should include initial plans for pilots on a significant scale which can then be supported and rigorously evaluated.

Reorienting the public sector, in order to improve its performance in achieving priority health outcomes

154. **Revise and expand proposed public health activities.** The public sector in West Bengal has focused largely on providing curative and family planning services to individuals, with less emphasis on population-based services that seek to reduce the exposure to disease of the population as a whole, for example health promotion and education campaigns. As a result, levels of morbidity and mortality remain high. The Department of Health and Family Welfare has expressed strong interest in redressing this imbalance in the orientation of public sector health services and improving quality of existing services and responsiveness. The development of disease prevention activities is of particular importance at this moment not only for achieving the priority health outcomes set in the Health Strategy, but also to face the emerging burden from Non Communicable Diseases.
155. **Revise personnel policies, and propose innovations to the current work organization in the public sector.** The objectives are to reduce bias in HR deployment, enhance incentives for good practice, increase accountability, increase coverage in rural areas, and reduce corruption.

156. **Improving Stewardship and Management.** This would include:

a. **Strengthening Government's Oversight Role.** There is a need to establish an organizational locus for continuous monitoring and evaluation of health system development, and use of that information in policy design. This role can be taken up by the Strategic Planning and Reform Cell created within the DHFW. The planning cell can lead the development of an evidence-based approach to the definition and implementation of new policies.

- There is also a need to strengthen technical capacity amongst senior and mid-level officers in the DHFW to design, plan, and implement major health system innovations such as health financing reform, or engagement of private providers in the provision of essential services. Presently, there is little expertise in accounting, economics, and management in the Department, as most senior positions are given to clinicians. Good doctors do not necessarily make for good managers, and the skills required to be an eye surgeon are entirely different from those required to manage public health care. The government should review its structure, and consider what organizational and capacity building strategies could be proposed to address the above deficiencies. Possible actions to be considered include: strengthening the planning cell within the Department of Health, revise requirements/qualifications for senior officials, establish collaboration with leading health policy institutes to guarantee continuous training for senior officials, revising Medical education present syllabus with addition of some new subjects like economics, and management. Improving planning, management and oversight capacity will require a 10 year program of phased training and specific technical assistance.

b. **Improving management.** Management in the public sector is extremely weak also at the decentralized level. Government officials are given little leeway for improving the existing system and there are few incentives for reform minded officials to push for improvements. In this situation it is suggested that government: (i) **Re-orient the public sector towards a results-based system:** drawing on its recent experience in secondary health reforms, government needs to strengthen its planning and performance management system, and to develop service delivery indicators for monitoring impact. (ii) The ongoing **decentralization process needs to be accompanied by improved capacity at the local level, and stronger and more transparent accountability mechanisms.** The process of decentralization and greater community participation can potentially lead to significant improvements in performance. However, it needs to be accompanied by strengthened capacity at the local level, and by the introduction of clear lines of accountability. Emphasis should be on flexibility in the use of resources, but at the same time stronger control on performance. (iii) **Experiment new models for organizing service delivery at the grass-root level.** The government needs to develop strategies for establishing PHC teams, promoting teamwork, and implement individual and team incentives linked to performance. Also, alternative delivery models such as those based on mobile clinics and outreach activities (eg, mobile clinics in Sundarbans region) are potentially a more effective means to cover underserved areas, and should be scaled up. Third, the GoWB should experiment new approaches to drug procurement, and for capital maintenance, building on the positive experiences of other Indian states (for example, Tamil Nadu experience in drug procurement). (iv) **Eliminate the split in activities between different government departments working in health and health related activities.** There is a need for greater intersectoral collaboration to improve the

effectiveness of nutrition, disease prevention and control interventions, education and environment programs.

157. **Strengthen health financing.** The DHFW needs to develop a health financing strategy, which addresses the governments overall goals of improving health outcomes, is logically consistent, and fiscally and administratively sustainable. This document fully endorses the approach and analysis contained the HFWB document (HFWB, 2002, p. 30 and subsequent pages).
158. One key objective is to address the current low levels of allocative and technical efficiency in the delivery of public health services, by improving the efficiency of financial management especially at the district level. Initial steps to achieve such allocative and technical efficiency include:
 - a. Reviewing budgets, generate more information on financial flows, and increase transparency and accountability in the use of funds. This study recommends that a Health Public Expenditure Review (HPER) is conducted: a HPER is meant to improve our evidence basis on the flow of funds with the public system, and should include a public expenditure management review, to understand at which levels and according to which criteria decisions concerning allocation of public resources for health are taken. The analysis of the flow of funds within the health sector should also include private sources of financing and private providers.
 - b. Analysis of existing risk-pooling/health insurance schemes. As we saw in Chapter 2, OOP are estimated to finance almost 70 percent of total health expenditures in the state, and health insurance is still in its infancy. This analysis should form the basis for a new strategy aimed at mobilizing more resources for health on a prepaid basis, pooling them, allocating them effectively, and using payment and purchasing methods to achieve priority health goals.
 - c. Improving the coordination of all external funds, ultimately leading to the pooling of all external funds to the sector. Ad-hoc planning and the poor coordination of multiple initiatives and agencies (including GoI, and development partners) had proved to be an inefficient way of bringing about real improvements in the system.
159. The Department of Health and Family Welfare should also agree with the Department of Finance on a financing plan for the health sector through 2012 linked to the priority health outcomes. An important step will be the definition of a Medium Term Fiscal Plan, building upon the existing IFEP document. The long term financial plan for the sector will:
 - a. Recognize that there are real fiscal constraints.
 - b. Set priorities for public expenditure on health based on priority outcomes.
 - c. Emphasize that achieving the priority health outcomes requires that more resources be allocated to them.

- d. Identify where the funds for these high priority activities will come from and ensure that they are protected over the next decade.

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Annex 1: Restructuring of Sub-Centers and Consequential Changes in the Organizational Setup

Multipurpose Health Program in rural areas was introduced under GO No: Health/FW/1563/35-22/85 dated 26.07.85, by integrating different Public Health Programs under Health & Family Welfare, Maternity & Child Health, and Nutrition. In order to ensure focused supervision and effective implementation of the program, it was necessary to bring about some restructuring of the existing organizational framework at the sub-centre and sector levels, along with some changes in the block level staff set up.

The changes ordered are as follows:

1. There shall be one sub-centre, designated as the 'Headquarters Sub-Centre', at the Gram Panchayat Headquarters of every district. If the existing sub-centre of the GP Headquarters is located in a rented building, it should preferably be shifted to the GP building. If the GP Headquarters does not have a sub-centre, the sub-centre situated at the nearest village may be considered for relocation at the GP Headquarters.
This structure will be maintained in all GPs of the district. However, existing sub-centers at the BPHCs and PHCs will not be disturbed.
2. At each GP Headquarters, there will be one Health Supervisor (Male or Female) from either the second or the third tier, who will supervise the functions of the Health Assistants of the sub-centers located within a particular GP. The existing second and third tier of supervisors will not be required.
The vacancies in the positions of supervisors will be filled up by upliftment from amongst the eligible Health Assistants, male and female, as per norms and existing orders.
3. The components of the first tier of supervisors will remain undisturbed.
4. Each sub-centre shall have one Health Assistant (F). The Headquarters Sub-Center at GP shall have one Health Assistant (M). If additional HA (M) is available, they will be allotted to other non-Headquarters Sub-Center, depending on the requirements. The female HA will be in charge of the sub-centre but this will not in any way affect the seniority and status of the male HA, if any, of the sub-centre.
In case of emergency, the services of the HA(M) at the area of the Headquarters Sub-Center, may be utilized at the non-Headquarters Sub-Center located within the GP. One female voluntary attendant in each sub-centre will remain as usual. Headquarters of Health Supervisors will be their GP Headquarters Sub-centre as usual.
5. In the absence of HA (M) in non-Headquarters Sub-Center, there will be one Honorary Male Volunteer in each of these centres. Guidelines for raising these male volunteers and payment of performance-based honorarium will be issued separately in consultation with the Panchayat & Rural Development Department.
6. To ensure adequate participation of the community for better implementation of the National and State Health Programs, Self Help Groups (SHGs) working in the concerned Gram Sansads are required to be associated with the activities of the sub-centers by the concerned GP. They will act as a link between the sub-centres and the community. It is felt that this process will enable the GP to have active female volunteers at each Gram Sansad. The SHGs will initiate the process of collection of contribution of Rs.2/- per month from each household for the services rendered. The detailed guidelines in these respects including payment of performance-based honorarium and collection of contribution will be issued by the Department of Health & Family Welfare in consultation with the Panchayat & Rural Development Department.

7. The Health Assistant (Male & Female) and Health Supervisor will be included as members of the "Siksha O Swasthya Upa-Samity" of the GP.
8. The District Health & Family Welfare Samities and the Block Health & Family Welfare Samities which have been entrusted with the responsibility of co-ordination, supervision and implementation of all Health related activities including National and State Health Programs, shall act as apex body of the existing district level and block level set ups respectively of all Health & Family Welfare Programs.
9. Instructions for engagement of HA(F) for the newly allotted sub-centres to be set up under the 10th Plan period will be issued separately.
10. BMOH will be assisted in the implementation of the scheme by MOs of the PHCs, BPHCs, and Rural Hospitals. BMOH will allot sub-centers of one or two GP to each MO for monitoring and supervising of MPH activities, depending on number of GPs within the block and availability of MOs.

