Public Hospital Reforms in Madhya Pradesh (India): Perceptions and Trends

Paper prepared for the 18th European Conference on
Modern South Asian Studies
Lund University, Sweden
6-9 July, 2004

http://www.csh-delhi.com

Girish Kumar
Fellow, Centre de Sciences Humaines
New Delhi (India)
Tel. : (91 11) 2301 62 59/ 2301 4682
Fax: (91 11) 2301 84 80
e-mail: girish@csh-delhi.com

Public Hospital Reforms in Madhya Pradesh (India): Perceptions and Trends

Girish Kumar

I

The Context

The last decade of the last century heralded a new dawn in the country. First and foremost, the unfolding of economic policy reforms initiated in early 1991. Although the reforms were targeted mainly at the core sectors of commerce, finance and industry, the policy measures triggered a chain of actions leading to privatisation and deregulation in other areas. This inter *alia* assured a recognized space for private sector to operate in the areas till then considered to be exclusive preserve of the public sector. Second, the 73rd and 74th Constitutional Amendments (1992) brought a comprehensive decentralisation package, paving way for community initiatives at the local level. Although the political regimes both in the centre and the provinces/states have been criticized for the sluggish pace of reforms, the post-liberalization phase has offered ample scope for restructuring the pattern of governance. This entails creating democratic space and laying enabling conditions by the state for participation of the people in managing their affairs at the local level. Steps taken in that direction, it is assumed, will lead to community initiatives in the public domain, largely monopolized by the ineffective state institutions.

In the realm of health services, for quite long, people had suffered on account of various factors. Notable among these were: absence or near-absence of medico and para-medico personnel in remote areas, negligence on the part of health bureaucracy and medico personnel alike, lack of infrastructure including unavailability of primary health centres (PHCs) and sub-health centres (SHCs) in required numbers in the rural areas etc.

To improve the situation in rural areas there was a massive expansion of rural health infrastructure[1] during the period of sixth (1982-87) and seventh five-year (1987-92) plans

[1]In order to cater to the health needs of the rural populace, a three tiered health infrastructure was laid down during the sixth & seventh five year plan in the 1980s. Accordingly, for a cluster of 5,000 population a sub-centre was created. Similarly, at every 30,000 population a Primary Health Centre (PHC) was set up and, likewise, a Community Health Centre (CHC) for every 100,000 population. As per their organizational structure, a sub-centre is the 'peripheral contact point between the primary health care system and the community.' The PHC, in continuation, is considered to be the 'first contact point between the village community and the medical officer' but it runs out-patient care only with minimum facilities for in-patient care. Indeed, the in-patient care and treatment of specialists are available at the level of CHCs only. In plain terms, the sub-centres are run not by qualified doctors but by para-medicos. One can consult a doctor at a PHC but if a patient's condition demands continuous observation and hence admittance in the public health centre, s/he will have to go to a CHC. The available figure shows that by November 1999 a total number of 137,271 such sub-centres (60 % of which was financed by the federal government), 22, 975 PHCs, and 2935 CHCs were operating through out the country. All these confirm huge investments in health infrastructure. But do they really provide services to the patient's satisfaction? We do not have data to confirm this point. But, it is well known, "many institutions are not fully functional due to staff shortage and non-availability of drugs and consumables…Posts sanctioned in excess of norms are generally in well located PHCs to give doctors credit for rural service, aggravating the shortage in under-served areas. The problem is more serious than the vacant position indicates: the data does not capture the large scale absenteeism of doctors in rural areas. Government doctors practice privately with or without permission, and this means inadequate attention for patients in government institutions. The overall result is the poor utilization and near collapse of the rural health infrastructure, particularly the PHCs and CHCs in most

but studies conducted during the second half of the seventh plan and also during the initial years of the eighth plan period revealed that PHCs were "grossly underutilized" largely due to inadequate "staff, medicine, equipment, transport, etc." and also because the PHCs were mainly engaged in "completing family planning[2] targets"(Duggal, Nandraj &Vadir 1995).

Under the given circumstances the rural populace was left with no other option except turn to private practitioners, quite often trained in non-allopathic systems, or flock to already crowded *taluka* (sub-district) or district level hospitals. What aggravated the matter further was the progressive reduction in budgetary allocations in the health sector[3]. This was in conformity with the World Bank's agenda for the health sector. It needs mentioning that with the eighth five-year plan, the union government had already agreed to accept the major recommendations of the World Bank. This included budgetary cuts in public spending on health services, introduction of 'user fee' and privatization of medical care[4] (Qadeer 1999, Rao 1999, Krishnan 1999, World Bank 1993). To cap it all, it is

---

states". See, National Sample Survey 42nd and 52nd round, Household Surveys (1991-92) of the National Council of Applied Economic Research, Delhi, cited in Misra et al (2003:25)

[2] The Federal Ministry of Health & Family Welfare comprises three independent departments: Health, Family Welfare, and Indian Systems of Medicine (ISM). The ISM constitutes six different systems-Ayurveda, Sidha, Yoga, Unani, Naturopathy and Homeopathy. Of these only first three could be claimed as entirely indigenous. Moreover, notwithstanding a parallel infrastructure, including hospitals and teaching institutions as well as over 6 lakh registered practitioners under different streams of ISM, an overwhelming 90 percent of incidence of illness is treated in allopathic mode. Even registered ISM practitioners treat their patients with allopathic medicines, though they are not authorized to do so. It should be also noted that "even though public health & family planning (FP) services had to be delivered through the common rural health infrastructure, the emphasis on FP targets have virtually "transferred the entire rural health portfolio to that department , divorcing it from other health programmes". Not surprisingly, the PHCs in many states are perceived as FP centres. (Misra opcit;).

[3] Following the initiation of economic reforms in 1991, it was envisaged that the gradual withdrawl of the federal government from public sectors (read industry mainly and to some extent infrastructure, too) would enable it to hike its spending in the social sector. Contrary to this perceived wisdom, the fiscal situation deteriorated, "following a temporary stabilization in the early 1990s, eroding the government's ability to step up investments in health". This is not to deny, however, the increasing allocation for centrally sponsored health programmes, which went up from Rs.208.17 crore in 1992-3 to Rs 489.71crore in 1996-7, thanks to external assistance from both bilateral and multilateral sources. Another point to be considered, which is rather more significant, is that the share of the state governments account for 75 per cent of total public health expenditure. Therefore, what matters more is the financial health of states than the centre. And most of the state governments suffer from acute fiscal deficits. The stated reasons are many including their inability to cut subsidies, privatize loss-making public undertakings, curtail the oversized bureaucracy etc. In short, the lack of reforms which is adding to their combined gross fiscal deficits: starting from the range of 2.4 to 2.9 percent in 1993-94, the combined fiscal deficit of states has gone up to 4.9 per cent in 1999-2000 (Budget speech of the Finance Minister, February 28, 2001). It deserves mentioning here that the fiscal crisis faced by the states was further aggravated by a sharp increase in the salary and pension bills in the wake of the Fifth Pay Commission's recommendations.

[4]There was substantial investment in the social sector in the 1950s and 1960s, the first two decades after India's independence. The tempo could not be maintained in the 1970s in the wake of the oil crisis which triggered a worldwide recession. In fact, "the late seventies saw a cut-back of investments in the social sectors and the debate on privatization gained importance" in the developed world primarily, though it had wider ramifications for the developing countries, including India. For a detailed discussion on provisions of

estimated that nearly three-fourths (about 70 percent) of the total health budget in most of the states are spent on meeting recurring expenditure on salaries and establishment alone. Put simply, the reduction in health allocations has greatly affected the non-salary components of the health expenditure.

Caught into the quagmire of shrinking budget on the one hand and growing demands for catering to the health need of the ever-increasing number of people on the other, most state governments have resorted to alternative options. These options are largely based on the concept of public-private partnership (PPP). The nature and extent of partnership may differ, but it is rooted in three fundamental assumptions: one, it will reduce the financial burden of the government; two, strengthen the capacity of the private sector to cater to the health need of people; and three, improve the quality of health care through new management structures. The well-known models of PPP (Bhat, 2000, Savas[5], 2000) as practiced in most of the states (provinces) are given under:

(I)Offering subsidized land and certain exemption on excise duty on import of machinery as well as other fiscal incentives to private sector to set up super-specialized hospitals. This model is seen practically in the major 18 states of the country. But they are mostly concentrated in state capitals and in a few important cities[6].

(II) Handing over management of primary health centres (PHCs) to NGOs (e.g. Gujarat) but PHCs would continue to be wholly financed by the state government; and

(III) Involving industries in managing health centres as in Tamil Nadu. Under this scheme an industry will adopt a local primary or sub-health centre (SHC) and would be responsible for building, maintaining and equipping the facility while the state government would continue providing staff and medicine. Apart from these models of structured partnership, there is yet another model of NGOs and PHCs working in tandem to provide health care to the community.

Rogi Kalyan Samiti: On a different track has come yet another innovative scheme of PPP in Madhya Pradesh. This calls for the formation of 'Rogi Kalyan Samiti'(RKS), loosely translated as Patients Welfare Society. The RKS seeks partnership of all concerned actors at the local level to raise funds for the upkeep of the public hospitals

---

health care as well as the social origins of private health care in India in historical perspectives see, Baru, 1998; also Nandraj, Muraleedharan et al. (2001).

[5] The study of Savas (2000) is more comprehensive but he has discussed PPP in the context of privatization alone.

[6] Again among the states, concentration of such hospitals are heaviest in four mega-polis (more in Mumbai, Chennai & Delhi but less in Kolkata) and in key cities like Bangalore, Hyderabad, Chandigarh, Ahemadabad, Surat, Vadodara, etc. In other words, these hospitals are concentrated more in relatively developed southern and western parts of the country. “Those states, where private healthcare is prominent, have experienced either higher growth rates in agricultural incomes, as in Punjab, Haryana and Andhra Pradesh, or very high growth in demand for health care, as in Kerala”, notes a data-rich study. The reverse is true in case of economically backward, poor states, such as Bihar, Uttar Pradesh , Madhya Pradesh, and Orissa where “high levels of poverty and low incomes presumably restrict the demand for private health care” (Krishnan 1999:210). It may also be noted that during the previous two decades, cities like Patna, Bhubaneshwar (the capital city of Bihar and Orissa respectively) have witnessed a mushrooming growth of a large number of small and medium sized private nursing homes, signifying the near defunct status of public health institutions.

and, in turn, ensures their participation in the management of health services. This includes, administration at the local level, charitable organizations, donors, leading citizens of the area, people's elected representatives as well as hospital staff. The Madhya Pradesh scheme of PPP is all the more unique in the sense that unlike in other states, where partnership has been sought from market forces (excepting the areas where NGOs are being involved), the RKS seeks direct involvement of the users (people) and service providers (doctors, para-medicos) in running the public hospitals. Thus if the motivational factor in the case of former is profit, the latter instance is of meeting the social goal and, by extension, raising the social capital.

II

The conceptual frame, methodology and sampling

A study of public-private partnership (PPP) in managing the government hospitals and health centres involves a close scrutiny of a complex system at work. It encompasses a large number of variables. This includes the rationale and extent of partnership, stakes of the key players involved, willingness of the state to allow the utilization of public institution and its infrastructure under new management system, acceptance of the new set of rules by the users and above all, their (users) willingness to pay for the services available under the changed set-up, etc. It can even be tempting to assess the effectiveness of the new system by making a comparative analysis "of the costs and effects of clinical and public health" under both the previous and present institutional management practices but "availability of such highly intensive data is rather difficult"[7] (Sankar & Kathuria 2004). The paucity of relevant empirical data, i.e. the effective performance of the new system could, however, be overcome with the field observations and interviews of the patients, their attendants and local people of the town concerned. Besides, anybody who is a little familiar with the (mal) functioning of government hospitals and dispensaries in economically and socially backward states of the country can easily understand the import of the new system, even without visiting the hospitals where such changes have occurred.

Situated against this conceptual frame and the context, the basic objective of this study is to document an innovative reform package involving public hospitals and present it before a wider audience. Apart from taking stock of the ongoing reforms in selected hospitals in Madhya Pradesh, the paper seeks to critically examine the decision-making process as well as sharing of responsibilities by different stakeholders under the aegis of RKS. It also aims at assessing the strength of institutional arrangements developed for ensuring transparency and accountability of the new management structure. And above all, its reach and impact in terms of catering to the healthcare needs of the primary stakeholders, more specifically of the patients in general and poor in particular and their level of satisfaction.

The study is based on the data collected from 9 hospitals (case study method) located at

[7] For a number of reasons including the conceptual problem, the use of different determinants-whether to "use the monetary expenditure on health" only or consider also "non-health-system determinants such as income and education levels" as well as the extent of public hygiene or even access to safe drinking water and nutrition level etc. See, Sankar and Kathuria (2004).

different levels in five selected districts of Madhya Pradesh. The sampling was purposive[8] and hospitals were selected following discussions with the concerned officials, including the director, health services and a senior officer belonging to elite central administrative services (of MP cadre) who happens to be progenitor of this reform package. All the 9 hospitals were visited during the last six months beginning from September 2003. At each hospital, apart from interviewing doctors including the chief medical officers, support staff, patients and their attendants, discussions were also held with elected representatives as well as government officials. Informal talks with common people and key informants in most of the district towns helped clear many doubts. The relevant facts and figures, for instance details of earning and expenditure of the RKS resources were collected from these hospitals.

The paper is organized into six sections. The first section, as given above, provides the backdrop, context and the rationale of 'partnership' as well as its varying models evolved so far and put to work in different states of the country. The second section elucidates the conceptual frame of the study, its methodology and sampling as well as structural design of the paper. A brief overview of the state of Madhya Pradesh highlighting its recent reform oriented initiatives is presented in the third section. This section also gives a brief profile of the district/ study areas covered in the study. The process of unfolding of the new system under the aegis of *Rogi Kalyan Samiti* in two hospitals under entirely different circumstances is documented in the fourth section. The major findings of the study, based on a comparative assessment of the functioning of the selected hospitals are discussed in the fifth section. Put simply, this section aims at assessing the impact of the public-private partnership on the functioning of government hospitals by highlighting the relative strength and weaknesses of the new management system at work. The conclusions drawn are given in the last section.

III

A profile of the state

In the wake of reorgainsation of Indian provinces in late1950s, the state of Madhya Pradesh[9] was created in 1956. Spread in 4.43 lakh (1 million = 10 lakh) sq. km. and covering about 14 percent of the country's geographical area, this centrally located

[8] For the simple reason that like all reform oriented process, the progress is slow and tardy too in case of translating the ideals of RKS into practices. After discussions with the concerned officials and other knowledgeable sources, the impression I had gained was that practically in all the district level hospitals something or other had been added to their physical infrastructure (new equipments, renovations of old buildings etc.), thanks to the additional resources now available under RKS, but its underlying assumptions in its letter and spirit was yet to be internalized in most of the hospitals. Therefore, it was decided to select any 10 from a dozen or so hospitals identified as those where visible changes had occurred. Then, restricting the sample size to 10 was also a logical outcome of time and budgetary constraints.

[9] The geographical boundaries of this state have undergone changes many times. In 1956, it was created by merging the areas falling under two states, namely, the Central provinces (CP) and Vindhya Pradesh. Altogether, the new state had five distinct regions, and prior to independence, some of its constituent units were governed under the provisions of the British-India acts while the rest were under the control of hereditary rulers (princely states) and were essentially politically backward. In fact, the level of political and economic developments, including their exposure to the functioning of local level institutions in the constituent units of the state were at variance among its constituent units.

province was the biggest [10] in India and naturally, far more heterogeneous (Purohit, 1971) as compared to any other state in India. Nearly two-fifth of the area of the state was under the forest cover and then it had largest contingent of Scheduled Tribes, comprising 26 percent (as against 7 percent national average) of the total population. Until early 1990s, the state had hardly witnessed any organised or protest movement; even lacked a distinct cultural and political identity. In terms of all development indices, it had always been clubbed with the BIMARU[11] states. It is still largely rural, dependent on subsistence agricultural farming with very low level of farm productivity. Land reforms were never on its agenda. Cooperatives and other village level institutions such as panchayats (a three-tier institution of rural governance) never gained roots in its political soil. Green revolution bypassed it; it did not witness the mobilization and consequent political empowerment of backward castes either. Neither could it create a sound industrial base for itself, despite huge mineral deposits. No wonder, it has the largest number of poor (people below poverty line in official parlance) 42.52 in 1993-94 as against the national average 35.97 (Planning Commission 2002); it held 30th rank among all 35 states and union territories. Madhya Pradesh was and is essentially a feudal state which has retained its feudal moorings in many ways.

Given its rigid social frame, relative backward political consciousness enforced with widespread poverty and deprivation, it is hardly surprising that Madhya Pradesh also faltered on the track of democratic decentralization (the first politico-administrative reform introduced in the country) during its two earlier phases in the early 1960s and in the early 1980s (Kumar 2002). In fact, earlier this state has rarely earned appreciation in any field, including health sector.

In 1971, for instance, the number of doctors per 100,000 population in India was 27.57 and after two decades, in 1991 it could reach up to 47.19. The corresponding figures for Madhya Pradesh, 11.53 and 16.92 respectively were far below the all-India average. On the other hand, with 1.28 PHCs per 100,000 population, Madhya Pradesh had a better record as compared to all-India average of 1.17 in 1971. But by 1991, the all-India average rose to 3.55, where as the corresponding state figure remained stagnating at 2.33. If one goes by this criterion alone, that is, the number of PHCs at one lakh population, it could be seen that Maghya Pradesh was ranking sixth among sixteen major states in the country in 1971 but by 1991, the state had slipped down to the thirteenth position. Measured in terms of other health indicators, the performance of this state has been far behind the national average (Table -1).

---

[10] In 2001, it was divided into two states. By carving out pre-dominantly tribal areas, spread over in 16 districts in eastern and south-eastern part of Madhya Pradesh, a new state called Chattisgarh was created. The state still has a substantial tribal population.

[11] Loosely translated as 'perpetually sick', the term BIMARU is used both as an abbreviation and also as a connotation in Hindi. Literally it refers to an individual or an organization which is unable to compete with the healthy ones owing to its continued sickness. As an abbreviation, it stands for Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan. Together they represent the Hindi heartland of the country and in terms of all possible social and economic development indicator, they stand far below as compared to relatively developed states in the southern and western part of the country. Due to their continued backwardness, they are referred to as perpetually sick states.

Table 1: Health Indicators (Varying Years)

	LEB	IMR	MMR	BAHP
M.P.	55.1	131	498	30.1
India	60.7	77	407	43.3

Source: National family Health Survey (1998-99) and Ministry of Health and Family Welfare, GOI (Annual Report, 2000-1)

(Legend: LEB- Life expectancy at Birth (1992-96); IMR- Infant Mortality Rate (1991); MMR- Maternal Mortality Rate(1998); BAHP- Birth attended by Health professionals (1998-99)

The 1993 turned out to be a watershed in the history of Madhya Pradesh when Chief minister Digvijay Singh took charge of this beleaguered state. Perhaps for the first time, Madhya Pradesh earned kudos for becoming the first state to hold elections for the institutions of third-tier of governance following a major constitutional amendment to this effect. Subsequently, during his decade long tenure, a series of innovative initiatives including rural livelihood programmes, delivery of services and women's empowerment in particular were launched (Kumar 2004). Well acknowledged by the UNDP, even some of these initiatives including the RKS received international (Global Development Network) awards too (Hindu, 26|12|2002).

Study areas

The nine selected hospitals were taken from five districts, namely, Bhopal, Devas, Khandwa (Esat Nimar), Indore and Ujjain. Of these, Dewas, Indore and Ujjain are contiguous; rather Dewas is at the equidistance from both Indore and Ujjain city. All the five cities have more than one million population, the biggest, however, is Indore (see Table 2) which also happens to be the commercial capital of the state. Bhopal, the capital city is well endowed with several management and technical institutions, including a medical college and a prestigious cultural centre. It is also known for its commercial activities besides having a sprawling industrial township. Altogether, it has 10 big public hospitals[12] and as many as 36 big, medium and small size nursing homes and hospitals, including a trauma centre, an eye and a heart hospital.

Devas is a district town, located at a distance of 160 kms from the state capital. It has a fairly large tribal population. It used to be a sleepy, non-descript town with a solitary signpost of development- a federal government organization for printing (Indian) currency notes. Lately, during the last decade, it emerged a new hub of a large number of industries in the private sector. The number of hospitals and nursing homes are modest as compared to big cities like Indore or Ujjain. The latter is one of the ancient cities, a religious place dotted with several temples; it has an ancient observatory too. With a

[12] Included among these hospitals, six belong to specialized category : two Unani and Ayurvedic hospitals, one for TB patients, yet another exclusively for women (Sultania Lady Hospital), and one for the victims of Bhopal Gas disaster 1983 (Bhopal Memorial Hospital & Research Centre). There is yet another associate hospital of the Bhopal medical college (Hamidia Hospital). Besides these there are four hospitals in the general category. Of these, two, viz, JP hospital and a small size Katju hospitals were studied.

fairly large Scheduled caste population, Ujjain parliamentary seat is reserved for this community.

Table – 2: Profile of the Study Area

Districts	Area (in sq.km.)	Total Population	Sex Ratio	Population Density	% Literates	% Urban Population
Ujjain	6,085	1,709,885	940	281	71.18	38.74
Dewas	7,025	1,306,617	932	186	61.04	27.35
Indore	3,899	2,585,321	911	663	74.82	71.57
East Nimar	10,743	1,708,170	936	159	61.71	26.95
Bhopal	2,770	1,836,784	896	663	75.08	80.53
Madhya Pradesh		60,385,118	920	196	64.08	26.67

Source : Census of India, 2001

The city of Indore, as mentioned above, is the biggest in our sample. It has more than five dozen hospitals, including 21 Ayurvedic, unani and Homeopathic hospitals. Among all the three neighbouring district towns/ cities, there is one thing in common: the presence of Jains, a community of merchants essentially, who control the commerce and trade in all these three cities, though numerically they are small, comprising not more than 3-4 per cent of total population. Their trading practices may not be different than those of other business communities, they are well-known for their philanthropic activities. The same is true of Badnagar[13], a tehsil level small town, located at a distance of 50 kms. from Ujjain city. Several charitable educational and health institutions are run by this community in Indore city which is also known for the publication of a fairly influential and widely read Hindi newspaper (*Nai Duniya)*.

Table 3: District-wise No. Of Allopathic Institutions & Beds (1998-99)

Districts	Distt. Hospital		Urban CH		CHC		PHC		Total	
	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds
Bhopal	1	210	2	125	2	30	10	12	15	377
Devas	1	270	2	30	2	60	25	55	30	415
Indore	1	100	4	242	3	96	26	48	34	486
Khandawa	1	290	1	111	7	210	46	46	55	657
Ujjain	1	57	5	161	2	60	20	34	28	826
M.P.	42	9148	74	3609	342	10338	1690	2069	2305	27347

Source: www.mp.nic.in/des/scmp2000/scmpT113.htm

[13] It should be noted that the total population of Badnagar town, the headquarters of the tehsil having the same name, is approximately 35 thousand. Being numerically large and having big stake in the land and the state politics, the Brahmins and Rajputs dominate the area. Together, they constitute about 25-30 percent of the total population. The Jains, the business/ trading community, comprise about 3-4 per cent of the total.

Khandawa, the headquarters of East Nimar, is situated in south-western part of the state in the range of satpura hills. In fact Khandwa is only railway station which falls on all the northern, southern, eastern and western routes. Put simply, it has direct rail links with the all four metropolises in the country. Yet devoid of any major industrial activity, the district is known for its subsistence agriculture. The landholdings of the majority of peasants are small and agricultural labourers are in sizeable number. Among its pride of place is Lady Butler hospital[14], one of the oldest in the region. A PHC at Pandhana tehsil, located at a distance of 20 kms. from Khandwa was also covered in this study.

IV

The RKS: Genesis and Evolution

The decision to form ' Rogi Kalyan Samiti' (RKS) was, however, a bureaucratic intervention made amidst the scare of plague looming large over the western part of Madhya Pradesh following its outbreak in Surat, a major commercial city in neighbouring Gujarat, in 1994. Then, the Maharaja Yashwant Rao (popularly known as MY) Hospital, the 750-bed district hospital of Indore, the biggest industrial city in Madhya Pradesh, was in throes of an unprecedented crisis. It was infested with thousands of rats, the carriers of plague virus. The fear of plague had necessitated a thorough clean-up operation involving a major task- trap the rats and kill. The district treasury did not have the money for this operation. Frustrated with the lack of resources, the then district collector of Indore decided to make use of an obscure official directive, permitting the collector to set up RKS. Put simply, it meant involving people[15] in running the hospital as also for the welfare of patients. The RKS was formed; an appeal was made to people and charitable organizations for donating money for the purpose. The response was quick as soon the money started flowing. Within a month Rs. 48 lakhs (4.8 million rupees) was collected. That was enough not only to tide over the immediate crisis but also to refurbish

[14] Named after the wife of the then British governor, the Lady Butler hospital is relevant for us in more than one way. In first place, it is the product of a classic instance of public –private partnership. Secondly, it is a major sign-post of RKS sponsored success. This hospital was established way back in 1929, largely with the initiative of Sir Arthur Butler, the British governor of Central Provinces and Berar. Having moved by the plight of women, dying in a large number while delivering child since there was no hospital around, he decided to set up a hospital. For the stated purpose, however, he urged the local notables to contribute resources to which he added government grants. The donors' names are inscribed on a plaque at the entrance of the hospital (See, East Nimar District Gazetteer, 1969).
This old hospital, later became gyaeneacology department of the Khandwa district hospital. It was lying almost defunct for almost fifteen years when the reform package started unfolding. Thanks to the resources raised through RKS, this hospital was thoroughly renovated and its past physical glory was restored.

[15] It was a massive exercise by all means. In order to kill the rats and clean the hospital, it was decided to close the hospital for over a month period. It necessitated, in first place, evacuation and shifting of hundreds of patients to several hospitals, both in government and private sector which was swiftly done. All the exit routes were sealed and then poisonous gas was used to kill the rats, thousands in number. There were tones of garbage in the hospital including old, rusted or broken furniture, beds –all the rejected and discarded items which were lying for there for years together. In the past, perhaps the hospital was never cleaned thoroughly. It took 40 trucks to remove the garbage from the compound, the then district collector revealed. Subsequently, it was refurbished. Earlier its lay out was chaotic; for instance, the mortuary was next to the drug store. Therefore, as per the requirement and convenience of the patients suffering from different ailments, or for that matter, staff room for nurses etc. everything was relocated. The MY hospital got a new look and new lease of life (Interview with S.R. Mohanty, Bhopal, September 11, 2003)

the old hospital and put it under a different management system. The district administration, doctors, nurses, para-medicos, donors, people's elected representatives and the press- all the possible local level actors decided to join hands together to keep the momentum on for the upkeep of the hospital and improve upon its existing services. And thus, RKS was given a formal shape and authority.

Highly impressed with this novel programme, Chief Minister Digvijay Singh issued directive for the implementation of this programme in all district level public hospitals in the state. The RKS was reportedly formed in "more than half of the nearly 1,200 public hospitals in the state" and "an estimated Rs.37- 40 crore"(1 crore = 10 million) was "raised across undivided Madhya Pradesh in the five years and spent on the improvement of the hospital" (India Today, January 8,2001). Under the new management system, the patients are charged user's fee for the health care services they avail of. However, the poor patients, those who cannot afford to pay this fee are exempted and treated free of cost. To cap it all, they do not have to bring any testimony to support their poor state of being, their self-certification is taken as a valid proof of their poverty. The success of RKS triggered further innovative steps such as allowing commercial use of hospital land.

The "system works", observed an Unicef team which assessed the impact of RKS towards the end of 2000. The system, however, is not without any lacunae. For, it was pointed out that "overall control of the local RKS bodies remain in the hands of the collector and if he is not interested in health care then the whole thing might just drift"[16] (Ibid;).

[16] Any body who is a little familiar with the institution of the district collector would testify to this fact. As the fountainhead of the district administration, the collector directly or indirectly controls most of the district level bodies. But it is nearly impossible for a collector to pay special attention to a particular committee on regular basis. Yet if a collector has concern for the health sector, s/he is in a position to mobilize funds and reduce dependency over the government. At any rate, the rider remains, that is, if the collector is interested and on his agenda health remains a high priority programme. The reverse is equally true. That once the progenitor is gone, the programme, howsoever innovative, might collapse sooner or later. In any case, the very dependence on an individual is an antithesis to the process of institutionalization.

In contrast to Indore, the RKS at Badnagar *tehsil* (a sub-division, an administrative unit below the district) hospital began on a different note. Interestingly, it all started with what is described as a clear miss-match between the training of personnel and the jobs they handle. Trained basically as a surgeon, Dr. L. A. Kapadia, the medical officer in charge of Badnagar hospital was at pains when he found himself posted at this hospital which did not have even a sanctioned post for a resident surgeon. That was Badnagar hospital in 1979. As a physician, Dr Kapadia began his innings. Obviously, he was unhappy for not getting opportunity to apply his surgical skills in use. Although there was nothing to prevent him from practicing surgery, the biggest handicap was the unavailability of basic infrastructural facilities. Therefore, Dr. Kapadia had to wait for a decade to get 'operation table' and 'suction pump' - two essential components of a surgeon's workplace. It should be noted however, these instruments had not come from the state health establishment, but were provided by a few philanthropically-tuned young Jain businessmen of the area.

As mentioned above, its seedlings had been planted much before the Indore initiative[17], and accordingly, it has moved on a different track. Earlier, the partnership was forged (for the welfare of patients) unofficially and without any organisational frame. Therefore, the RKS at Badnagar could take a proper shape only after the official pronouncement to this effect. On June 1, 1996, almost two years after the success of Indore experiment, the state government instructed to form RKS at '*tehsil*' level. Within a month it was formed and four months later the RKS Badnagar was officially registered.

The user's fee was introduced but it was kept deliberately low. For, unlike private hospitals, the motive was not to make profit. The registration fee, for instance, was fixed at Rs.2 in case of OPD (out patient department who came for consultation only) and Rs.5 in case of indoor patients who were admitted. Likewise, the bed charge was Rs. 5 per day, Rs. 30 for x-ray (of all type) and for surgical operation it was Rs. 150 (raised to Rs. 250 in February 2001). Similarly, there were varying charges for different type of laboratory/ pathological tests. On this account alone the RKS earned Rs. 7.51 lakhs[18]

[17] Raising some additional resources from the donors and users was not something novel that had occurred at Badnagar sadar or MY hospital alone. In bits and pieces, it had earlier been attempted elsewhere too. A nominal user's fee (rupee one for OPD and rupees 5 for IPD) way introduced at the Chacha Nehru Children hospital (CNCH), Indore way back in 1985 with the due approval of the then chief minister (Interview with Dr. B.C. Chapparwal, a former medical superintendent of CNCH,Indore, September 23, 2003) . In 1992-93 under a 'Child survival and Safe Motherhood Programme' (sponsored by the Global Task Force in which the UNICEF was also involved) staff members of Dhar (adjacent to Indore district) hospital had collected funds to set up a dignified women and Child department (WCD) as a part of the hospital. At that time, from the collected funds, even the Dhar hospital was given a face lift. Even WCD, to some extent, was operating like RKS. What was the motivational factor? I asked. "They were expecting incentives and appreciation too from the sponsoring agency", a key official of the directorate of health, Bhopal explained (Discussion at Bhopal, September 10, 2003).

[18] The average number of patients handled by the RKS Badnagar is over 100 per day. In 1996, the total number of patients was 41,039. Among them 34,822 had come to OPD (that is, those who came for consultation only); 4,537 were admitted, including 1,230 cases of child delivery. The total number of patients went up to 42,291 in 1998 but last year it came down to 41,224. Thus from the registration fee alone the hospital gets, on an average, Rs. one lakh annually. Considering the annual budget of this hospital, which is said to be approximately Rs.30 lakh, it is nothing. Of this, it should be noted, not even two percent is provided for the patient's care.

during the last seven years ending March 2002. With this amount, hospital was renovated, essential medical equipment were procured; next year a pathological block, x-ray block and two special wards were also constructed. Over and above, the RKS was also instrumental in getting a medicine shop constructed inside the hospital campus. By auctioning it, the RKS raised 7.21 lakh rupees. At the same time it ensured the availability of essential drugs in the campus and that too round the clock. Similarly, by auctioning a canteen inside the hospital campus RKS received 3.32 lakh rupees.

Associated Facilities: In April 1997 a 'Sulabh Complex' was constructed to extend bathroom facility to a surging crowd of patients and their attendants. Subsequently, under the auspices of *Annapurna Seva Samiti*[19], mess facility was also launched for the patients and their attendants. This shows the evolving characteristic of RKS. Everything was not planned in the beginning. On the contrary, it started on a modest scale to provide relief to poor patients. Gradually, it went on expanding, adding necessary structures as per the felt need of the patients.

V

The RKS at Work: Trends and Perceptions

Earlier the public hospitals were plagued by many problems: for instance, posts lying vacant for quite long; inadequate supply of essential materials, such as x-ray films or essential chemicals to run pathological laboratories etc. Still they had everything required to run curative services: staff, infrastructure, annual budget, supply of medicines and other sundry materials from the government depots. Undoubtedly, there were shortcomings in every sphere. But a feeling of demoralization had gripped the doctors in general, more particularly at the level of chief medical officers (CMOs). “There was a crisis of confidence”, to quote a relatively young doctor serving at Bhopal based JP

---

[19] *'Annapurna Seva Samiti'* is perhaps the latest addition to the hospital campus. This too has an interesting background. It is well known that people (patients and their attendants) mostly coming from the villages either happen to be poor or men of modest means. They normally cook their meal on earthen *chullah* (oven). This not only creates unhygienic condition but also adds to the environment pollution (imagine the black smoke and left over littered around the hospital campus). To overcome this problem, again a few enthusiastic philanthropists raised money and set up a mess in August 2000, three and half years after the RKS became operational at Badnagar. Annapurna is managed by a retired schoolteacher, with the help of five full time employees, including cook, cashier etc. Practically, every day a vegetarian meal for 50-60 people is cooked which is provided on a token rate of five rupees per person. People have donated money and they continue to do so. To provide food to the needy ones is considered to be a noble, pious act in oriental societies. Driven by this feeling, individuals sponsor either lunch/ dinner or both a day by paying Rs. 750 (in case of lunch alone it is 500 rupees and likewise, Rs. 350 for dinner only) on special occasions, such as birth-day of their children or on wedding anniversary. It needs mentioning that though 'Annapurna' is very much a part of the RKS, on day-to-day basis, it operates under the control and supervision of its manager who reports to the executive committee monthly meetings of RKS. “Providing subsidized food to patients and attendants”, the official guidelines for RKS reads, also happen to be one of the stated objectives of the RKS, therefore, mess facility has come up practically everywhere, as an associated accessory of the RKS. But nowhere else did we find the mess facilities equal to what we observed at Badnagar,and to a large extent at Devas, too. In fact, it was worst at Ujjain (see, *Nai Duniya,*January 23, 29 and 30, 2004) and to a lesser degree at Indore. It was just so at rest of the hospitals covered in this study.

hospital. “It was really embarrassing when as the CMO, I would not be able to sort out even sundry grievances that would cost not even 20 rupees. It is not a big amount. But can a CMO go on spending, howsoever little amount it is, practically every day from his own pocket? It was a helpless situation. For everything you had to report to the directorate of health services and wait endlessly for their response. Meanwhile not only would the patient suffer but the staff would also be sitting idle[20]. For he would not have the wherewithal to attend to his/her work”, elaborating the manifestations of crisis, a CMO of one of the sample hospitals commented.

Decentralisation of authority and responsibility sharing

Now they do not have to wait. They have sufficient funds at their disposal. For petty expenses they do not have to take prior permission. In fact, in some hospitals (JP for instance) enlightened CMOs have decentralized the system of responsibility sharing and decision-making as well. Accordingly, all the departmental heads have petty cash to take care of their day-to-day expenses, including minor repair works or for buying, for instance, a bulb or tube (for lighting). They can decide what else their priorities are and if it does not involve substantial expenditure, they need not rush to the CMO. Likewise, the CMO is also authorized to spend within a prescribed limit without seeking prior approval of the district collector, chairman of the RKS executive committee at the district hospitals. “It is this sense of empowerment which in turn has helped me instilling discipline among the support staff and doctors alike. All the services have been streamlined. Everybody has some work to do. And I do not have to run after them. Of course, I go on my rounds, twice a day which in a way help build pressure on those who still are lagging behind”, the JP hospital (Bhopal) CMO explained us.

Decentralisation has worked as the functioning of departments has improved, commented the Dean of MGM medical college, Indore. The MY hospital is an associate hospital of this medical college. To a large extent, it has helped to overcome day-to-day hassles[21]. Regrettably, this assertion of the Dean was not shared by others. In fact, discussions with a few departmental heads and medical superintendents of other associate hospitals in the sprawling campus of this medical college revealed that they were hardly consulted by the former. “They do not have a voice in the RKS of MY hospital. There is a lack of an integrated approach; the Dean’s attention is focussed on his own (orthopaedics)

[20] “Earlier, the x-ray films allocated to the hospital would be exhausted in three-four months. Then in the rest of eight-nine months, I would be sitting idle. In the absence of x-ray films, I would not have any work to do. The patients would suffer and I would feel bad. I would have resigned had there been better working conditions in the private sector at my level. Besides, the fear of losing a government job with residential accommodation always loomed large in my mind since the stepping out of the hospital. Above all, I was getting my salary regularly. Yet, honestly speaking, it was a real pain. Quite often I felt sick. Now, my hands are full round the year, thanks to the RKS. And, patients are equally happy,” a radiologist posted in one of the hospitals in the capital city told us the dramatic effect RKS has brought on his own life and work in a government hospital.

[21]Initially, the head of departments at MY hospital were given Rs. 1000 as contingency amount; it was subsequently raised to Rs. 2000 and finally, Rs. 5000. They are also authorized to call tender and buy equipment essential for their respective departments without prior permission and of course, within a prescribed limit. This has instilled a sense of trust among colleagues (Interview with the CMO, MY hospital Indore, September 25, 2003.

department", rued a retired chief of one of the associated hospitals. A visit to the orthopaedics department confirmed this allegation. The cleanliness, the number of equipments, in general upkeep- by all means, this department wore a different look as compared to any other department of MY hospital. The lack of team spirit in the functioning of the present dean was pointed out by other doctors, too. "Lack of promotional avenues for doctors including middle level supervisory staff as well as complete absence of a mechanism for reward and punishment (read incentives for best performing doctors and staff and in reverse case disciplinary, if not punitive, action against the erring or negligent staff, including doctors) has added to the maladies of hospitals functioning", to quote a group of doctors at Khandwa[22]. In continuation, they also dismissed the notion of decentralization at work in their hospital. Paradoxically, the 'team spirit' was noticeable among the doctors but they seemed aloof, cut-off from the RKS driven reforms. Rather, a few of them contemptuously called the RKS a big hoax. A lack of team spirit was also noticeable at the Bhopal based another (Katju) hospital, at Ujjain and Badnagar[23] too, though the latter has earned kudos for taking several other RKS linked successful initiatives.

The expenditure and earning patterns of RKS

On an average, there is five to ten percent increase in the annual income of the hospital, thanks to the collection of the RKS induced user's fee. A look at the balance sheet of the district hospital, Khandwa reveals that its overall earning has gradually gone up and on. For instance, during the financial year1995-96, its total earning from all sources[24] was 116, 452 rupees but by 2002-03, it registered five times growth, notching a figure of 615,007 rupees. This is true of practically all hospitals observed. Clearly, there was willingness on the part of the patients to pay for the services they were availing of.[25] And

[22] There is a 'tea club' within the premises of the Khandwa sadar hospital where the serving doctors meet every evening. Not only the club offers them an opportunity to enjoy a little break over a cup of tea, it also serves as a forum of free exchange of opinion and sharing information among the doctors who regularly discuss the administrative, professional as well as personal matters. Most importantly, this forum is also open to the local private practitioners. Over the years, the club has matured as an institution, promoting trust and fraternal relations among its members. The acting CMO was kind enough to permit me to use the occasion to have a group discussion with the doctors available on January 25, 2004, the day I visited the hospital. The impression I gained from the discussions with them was that the RKS had simply touched upon just one of the maladies, that is, lack of resources. But it has failed to address other equally important problems.

[23] For a detailed case study of the Badnagar hospital, see, Kumar 2003.

[24] This means earning from the following services: donations, OPD, IPD (admission fee from those who were admitted in the hospital), private ward, operation theatre/ labour (child delivery), x-ray, pathological laboratory, ECG (electro-cardiogram), ICCU, blood bank etc. By and large, the heads were the same in case of other hospitals, though some had a few more sources such as rents from shops constructed in the campus, ambulance services, parking lot /cycle stands, sale of tender forms & bidding contracts, interest on savings, and if there were some more technical services available like sonography (in Ujjain).

[25] On an average, 2-2.5 lakh rupees are collected monthly at the JP hospital (Bhopal) as user's fee alone, Mushtaq Ali told us. The daily collection is deposited in the local branch of the State Bank of India, Indore (one of the 14 scheduled banks in India) after 12 am. Ali was appointed on an ad hoc basis in 1999 to take care of day-to-day accounts, correspondence and also to feed in the computer the details of RKS related activities. He also prepares agenda of executive and general body meetings of RKS and writes the minutes of these meetings later.

decidedly, the service delivery mechanism must have improved; otherwise people would not have paid. The pattern was by and large the same in practically all of the selected hospitals.

What use they were making of these additional resources, collected in the form of service charges? Again at Khandwa hospital, the total expenditure was a paltry 30, 341 rupees in 1995-96; 133, 588 rupees next year to 516,918 rupees in 2002- 03 on half a dozen heads, including miscellaneous expenses.[26] Incidentally, the last item i.e. miscellaneous expenses seem to be heavy, followed by medicine purchase and the cost of repair and construction. There are, of course, variations in income and expenditure pattern across the hospitals studied. For instance, the inventory of expenditure procured from Ujjain district hospital is too big to compare with Khandwa. For instance at Ujjain, the balance sheet shows huge expenses on account of staff salary, their travelling and conveyance allowances as well as remuneration allowances, totaling over 5.62 lakhs rupees in 2001-2. Likewise, in the same period, three items - building maintenance, sanitary material as well as repair and maintenance- a total of more than 10 lakh rupees was spent from the RKS fund. Incidentally, there has been a recurring expense on the building repair and maintenance, year after year starting from 1997. Although we did not get satisfactory explanation[27] to this end, they went on happily pointing out that the annual earnings have increased and correspondingly, the expenses too, but the latter never exceeding the former. To illustrate this point, it should be noted that in the financial year 1996-97 the total income from various sources was in tune of 14 lakh rupees whereas the corresponding expenditure figure was its nearly half. On the other hand in Dewas, the expenses incurred during 2000-1 was equal precisely to the dot to its earning, at least this is what its audit report reveals. This *inter alia* shows that of the total of nearly 2 million rupees spent on various items, a little less than 3 lakh rupees was spent on civil work (repair and maintenance of the building and hospital premises), painting, furniture and

[26] The six expenditure heads were; stationary, machinery, medicine, repair & construction, return of fare (collected earlier in excess, hence returned in two financial years) and a broad miscellaneous expenditure.

[27] The working environment at this hospital was different largely because of an enthusiastic medical superintendent. When I first visited the Ujjain district hospital in January 2002, the RKS of this hospital was earning nearly Rs. 2.50 lakh per month from user's fee alone. The charges were almost in the same order as in Badnagar. With the user's fee and donations raised under the auspices of the RKS, the hospital had added a burn unit, costing Rs. 7.8 lakh. It had enhanced the services rendered by x-ray, and pathological units. And people were gladly paying since charges were almost three to four times lower than the prevailing market rates. "For an electro-cardio-gram one has to pay just Rs. 15 while the private nursing homes charge Rs. 50-60 for the same. For blood sugar test in the hospital it is Rs. 8, the corresponding market rate is Rs. 30. With these facilities assured in the hospital, thanks to RKS, the business of private nursing homes have gone down", the medical superintendent underlined the comparative advantage of the RKS at Ujjain. It should be noted there are about two dozen nursing homes in Ujjain city, including half a dozen big ones with each having 50-bed capacity. We also learnt that the local chemist association has donated medicines worth thousands of rupees. Similarly, a big textile industry donated 100 blankets worth over 70 thousand rupees. To cap it all, recently, the governing body of the RKS sanctioned 8 air-conditioners for the hospital in just three days. "It would have taken several months to get the sanction from the health department", a beaming medical superintendent told us and added, "getting as many as 8 air-conditions sanctioned at a stretch from the government department was simply unthinkable" (Interview with Dr. D. K. Sen , Ujjain, January 8, 2002)

electrical appliances. Incidentally, just a year after (i.e. during 2002-3), again on these four items alone, over 12 lakh rupees (of the total 32.22 lakh rupees) was spent. It is also not clear as to what stands for 'contingency' on which a huge amount (8.23 lakh rupees) was found incurred during the same financial year.

However, a retired superintendent of MY hospital expressed serious concern over the misuse or wanton use of resources[28] without any qualm as such by the current dean. Several such instances were brought to our notice, attesting to the fact that the 'felt needs' are underlined by the man at the helm of affairs. And this was not a problem specific to MY hospital alone. Expenditure on unnecessary items, or wrong priorities fixed by the influential doctors, (i.e. head of the institution or their hangers on) or simple wasteful expenditures- all these were noticed in most of the hospitals. That the head of the institution might go wrong in the exercise of its authority; such probability exists in any management structure. This is true of RKS too. For, the new management structure either lacks check and balance provision in-built in the system or they have been rendered useless. In either case, it is regrettable. But, barring a few exceptions, the fee or donations collected are not being properly utilized in most of the hospitals covered in the study. It all depends upon the perception of the head of the institutions. Although it is not a discovery per se, it belies the conception that if there were additional sources of income and the management was broad based, the situation would automatically improve.

Patient's satisfaction

The public hospitals are flush with resources, thanks to the willingness of patients to share the cost of treatment by paying the service charges, that is, user's fee. They are paying for the simple reason that services are available now. In the pre-reform period, a visit to the hospital was meant for free consultation only. And only the poor would seek admittance or avail a modicum of IPD facilities[29]. Earlier, in any case, patients had to buy all the essential items required for surgical operations[30]. Over 200 patients and their

[28] For instance, an intensive surgical care unit (ICCU) worth a little over three million rupees was constructed and was lying unused for the last eight months since its operational details were not worked out. At the same time, the diagnostic lab was privatized on the plea was that an auto analyzer (for testing blood sample on a large scale at a time) would cost one million rupees. To the present dispensation, either it was a useless investment or there were lack of resources. At any rate, it was a wrong assessment. The lab has an important place in medical education since the students acquire hands on practice but this fact was simply ignored, without caring for the future of the medical students (Interview with a former CMO, MY hospital, Indore, September 24, 2003).

[29]The budgetary provisions for the patients' care was half a rupee per out-patient per day (i.e. the patients who come for consultation only) and two and half rupees for in patients (those who are admitted and occupy beds) and add to it a rupee more in case of bigger hospitals. "These rates were fixed up almost a quarter of century earlier and were never revised", the CMO of Ujjain hospital told us (January 8, 2002).

[30]This includes even items like gloves, catgut (surgical sutures), naso-gastric tube, catheter, even cleaning material like liquid iodine. Some of these items are quite expensive. For instance, a small bottle containing 100 ml of liquid iodine costs Rs. 40. Now the attendants of patients do not have to run from a chemist's shop to another since everything is provided by the RKS. And since purchasing is done in bulk, the relative cost of these materials goes down and quality is ensured. People gladly pay this amount for the very simple reason that it is nominal as compared to the operation fee charged by nursing homes. Besides, those who are unable to afford it, they are treated free of cost. At least, half a dozen poor patients testified to this fact

attendants across all the sampled hospitals were interviewed and a great majority of them expressed satisfaction with the functioning of the hospitals. Narrated variously, the substance of their response was that the quality of services had gone up and several facilities had been added; the doctors and nurses were more attentive. This was, however, not true of the patients at Ujjain and My hospital, Indore. Paradoxically, the MY hospital which witnessed the birth of the RKS was in a bad shape. In fact, it was passing through a series of crises, one after another, so much so that even the then medical superintendent voiced his unhappiness with the state of affairs, putting accusing fingers on the lower level staff. "There is too much insubordination but one cannot take any action either against junior doctors or support staff, more particularly sweepers", he added. The lower level staff on the other hand blamed the administration for privatization of services. It was indeed chaotic. It may also be mentioned that the affairs of the MY hospital had already received a lot of negative media coverage (charges of corruption included). Therefore, the hospital administration had instructed its staff to not to speak to outsiders on hospital affairs. The superintendent and the dean spoke of 'political interference' too. This point was also raised at a few more hospitals, including Badnagar and JP hospital where RKS led reforms have paid great dividends.

Transparency and Accountability

The dissatisfaction among the lower and middle level staff, including junior doctors was to a large extent, a function of their perception of the RKS. The RKS was formed following a government fiat without taking hospital staff in general into confidence. They were neither directly involved in the day-to-day management of RKS nor did they gain the opportunity to attend RKS meetings. Thus, remaining devoid of any insights into the nature of changes that began surfacing, they developed suspicion, even mistrust for this otherwise innovative step. Privatization of certain services, appointment of a few staff and collection of user's fee further confused them. Indeed, some of them began apprehending retrenchment- fear of losing employment. Although none of the permanent staff have lost their jobs, nor was it the stated objective of the RKS, their collective fear has not completely been allayed. As a matter of fact, the lack of transparency (regarding the purchase of equipments or contracts awarded to private parties) and accountability on the part of the new management structure towards the hospital staff has reinforced their suspicion. The tall claim of introducing change in the overall management of hospital rings hollow to their ears when they find the doctors, as usual, attaching more priority to their private practice than spending the required numbers of hours in attending to patients in the wards or in the OPD section.

Is it any wonder that the hospital staves, in general, seem to be alienated from what is going on under the auspices of the RKS? Notable exceptions apart, practically in most of the sample hospitals the lower and even middle level staff appeared totally oblivious of

---

(Interview with Dr. Kapadia and scores of patients at Badnagar, during my visits in January 2002 and September 2004).

the objective of the on-going reform process in their respective work place. If the degree of mistrust or disliking, as we noticed, was the greatest among the staff of the MY hospital, followed by Ujjain, the alienation was also noticeable in the response and attitude of the staff even in those hospitals like Bhopal (JP) or Khandwa where RKS induced changes are more conspicuous. Badnagar was an unusual exception where doctors, not support staff or nurses, sounded unconcerned. Over and above, the peculiar mind-set of the pampered government employees at the lower level particularly causes conflicts and tensions. As the superintendent of the MY hospital pointed out: they do not realise that the additional staff (sweeper for instance) is hired for the better upkeep of the hospital. Therefore, instead of cooperating with them, they either abdicate their responsibilities, passing buck on them or create mischief. In either case, the regular employees of the government hospitals prefer to keep the RKS recruited staff at an arm's length.

Leadership and change

The effectiveness of any institutional structure depends, to a large extent, upon the perception, motivation and vision of its head. And the RKS is no exception. Rather, these characteristics (of leadership) become all the more crucial since the chief medical officer of the traditional health administrative set-up also happens to be the secretary of the (modern management structure) RKS. Taking a cue from the old adage that the leadership attributes varies from one person to another, an attempt was made to quantify these qualities with reference to the following points: Have they succeeded in transforming 'I' into 'We', combining self interest and common good while striking a balance between immediate and long term goals? Do they listen to their subordinates and are they open to criticisms and suggestions? What is the extent of authority and responsibility sharing? Are they making judicious use of the resources generated through the user's fee? If the performance of the sample hospitals is measured on a ten-point scale in the light of specific questions raised above, supplemented with the general observations, the JP hospital with 8 point would score the first position, quickly followed by Badnagar sadar hospital. At the bottom of the list would be the Ujjain, MY hospital and Katju hospital, scoring 2-3 point. The grading for the rest would be in the average range of 4-5 points. Among them, however, Devas and Khandwa hospital, I found, slightly better despite the absence of a dynamic leadership. However, both these hospitals have committed staff, particularly lab technicians and nurses as well as a couple of doctors.

VI

Summing-up

The RKS heralded a major initiative to reform the near-defunct government hospitals in Madhya Pradesh. As a result, new structures have been created, additional resources have been mobilised, more facilities have been assured to patients and additional hands are available to serve them without putting financial burden on the state exchequer. Steps have been taken to enforce the accountability of the staff, including doctors as well as the transparency in the use of available resources, though on both these counts there is much

to be desired. Above all, the patients appear to be by and large satisfied, though we came across a large number of dissatisfied patients, and for obvious reasons, at Ujjain and MY hospital, Indore. The monitoring is limited as it is more attuned to observing procedures than an exercise in ushering dynamism in the functioning of the RKS. The proceedings of the RKS executive committee meetings would testify to this fact. Indeed, the main actors of the RKS, noble souls apart, seem to be complacent, happy, satisfied, even saturated with their performance, as if they have reached the end of the journey; there is nothing beyond. This does not mean that the reforms have failed to motivate staff, fired by the zeal and sense of duty. They are there and so are the leaders: visionary, disciplinarian, industrious and trustworthy who inspire confidence among the team members. But they are a very thin minority. Thus there is hardly any organised effort to bring about a change in the behavioural pattern, work ethics; inject the sense of duty and mould the traditional mindset of the health functionaries in order to make them the *de facto* agents of change. Admittedly, the task is far from being completed. Yet, the fact remains that a period of less than a decade is too short to internalize the essence of the reform by all the stakeholders.

Notwithstanding such shortcomings, the RKS has been able to change the mindset of the people that the state is all doer and service provider and also that these services could be availed of without paying or sharing the cost. At the same time, it has an in-built safety net for the poor patients too. Most importantly, the RKS has demonstrated that the huge health infrastructure created in 1970s and 1980s could be saved from going waste in the face of ever-shrinking budgetary allocations, if reforms on these lines, with little innovations here and there, are introduced in other provinces. The bottom line is: reform the old administrative structures, make it broad based and encourage experiments, create space for the community-centred actions, and engage people in meaningful participation by laying the enabling conditions. To cap it all, ensure follow-up actions since one time intervention would fail to yield the desired results.

References

Baru, Rama V. (1998), *Private Health Care in India: Social Characteristics and Trends,* Sage, Delhi.

Bhat, Ramesh (2000), "Issues in Health: Public-Private Partnership", *Economic and Political Weekly (henceforth EPW),* December 30, pp 4706-16.

Duggal R, S. Nandraj and A.Vadir (1995), "Health Expenditure across States-Part I", *EPW,* April 15, pp 834-44.

Kumar,Girish (2002),*Constitutionalising Panchayats: The Response of State Legislatures* Occasional Paper, No. 4, Centre de Sciences Humaines, Delhi.

---------- (2003), "Promoting Public-Private Partnership in Health Services", *EPW*, July 19, pp 3041-45.

---------- (2004), *Desires Without Matching Deeds: Democratic Decentralisation in India* (forthcoming).

Krishnan, T.N. (1999), "Access to Health and Burden of Treatment in India: An Inter-state Comparison" in Rao (ed. 1999), pp 212-230.

Misra, Rajiv, et al.(2003), *India Health Report*, OUP, Delhi.

Nandraj, S., V.R. Muraleedharan et al. (ed.1999), Private Health Sector in India: Review and Annotated Bibliography, CEHAT, Mumbai.

Planning Commission (2002), National Human Development Report, OUP, Delhi

Qadeer, Imrana (1999), "The World Development Report 1993: The Brave New World of Primary Health care" in Rao (ed. 1999).

Rao, Mohan (ed.1999), *Disinvesting in Health: The World Bank's Presription for Health,* Sage, Delhi.

Sankar, Deepa, Vanish Kathuria (2004), "Health System Performance in Rural India: Efficiency Estimates across States", *EPW,* March 27, pp 1427-33.

Savas,E.S.(2000), *Privatization and Public- Private Partnerships,* Affiliated East-West Press, Delhi.

Shrivastav, P.N.(1969), *Madhya Pradesh District gazetteers, East Nimar*

World Bank (1993), *World Development Report1993*, OUP, Delhi.