

19. Functional Review of Department of Health and Family Welfare in Karnataka

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Introduction

In recent years, there has been growing disappointment and dissatisfaction among the public with the performance of various government departments responsible for provision of basic and essential public services. Despite the economic reform measures that have been introduced, efficiency in public service provision remains neglected. Performance of the public service system, in general, depends on many factors. These include organizational structures, financial resources, transparency and accountability, attitudes and perceptions of people towards service delivery, interaction between service providers and clients, and above all, the functioning of government machinery and its linkages with other departments including local self-governments.

The Government of Karnataka has initiated several innovative measures to improve the performance of government departments and local bodies. Setting up of the Karnataka Administrative Reforms Commission (KARC) is one such initiative, intended to provide necessary inputs to streamline the administrative machinery and service delivery system. To fulfil its mandate, KARC has decided to undertake functional reviews of various departments in the state. At the instance of KARC, ISEC undertook the functional review of the Department of Health and Family Welfare during May to September 2001, sponsored by the Ford Foundation, New Delhi. This review pertains to the specific issues of policy making and operational aspects of the Department, keeping in view the overall objective of improving efficiency in service delivery, transparency in administration, and people's participation with devolution of powers.

Objectives of the Review

1. To conduct an objective assessment of the functioning of the state health department at policy making and implementation levels;
2. To study the organizational structure of the department and its effectiveness including manpower planning.
3. To study the functioning of the health department at the district level and below under the decentralized set-up.
4. To understand the availability and utilization of public health services at various levels.
5. To examine the clients' perceptions and suggest measures to improve interaction between service providers and beneficiaries for provision and accessing of quality health care services.
6. To make specific recommendations to the state government for improving efficiency and accountability in service delivery at all levels in the health department to promote a responsive administration through civil service reforms.

Methodology

A review of this nature and magnitude demands not only information and inputs from macro levels but also insights from the grass-roots level. Accordingly, a two-pronged approach was adopted for the study. First, discussions were carried out with health functionaries at all levels, starting from Principal Secretary and Commissioner of State Health Department to ANMs and male health workers in the villages. Officials at the State Secretariat, Directorate, Divisional, district and taluk levels were interviewed for this purpose. Institutions such as district and taluk hospitals, community health centres, primary health centres and sub-centres were visited and their functioning examined. Functionaries of Panchayati Raj Institutions at district, taluk and gram panchayat levels were interviewed to seek their views and concerns. Detailed discussions were held with Deputy Commissioners and Chief Executive Officers (CEOs) of Zilla Panchayats to assess the performance of the department and the existing inter-sectoral and inter-departmental co-ordination. Data were also obtained from Training Institutions of the Department at various levels. Second, to understand the effectiveness of service delivery from clientele perspective, a sample survey was conducted among 454 service seekers of public health facilities. In addition to this information, the findings and recommendations of major surveys, reports and research studies were reviewed for this purpose.

Five districts in the state — Kolar, Uttara Kannada, Gulbarga, Chamarajanagar and Bijapur — were selected for a detailed investigation. It was considered that these districts broadly represent all the administrative divisions and geographical regions of Karnataka. From each district, three taluks were identified to undertake sample survey, focus group discussions (FGDs) and in-depth interviews.

Major Findings and Recommendations

In the light of the above review, the following recommendations have been made:

1. In the state as a whole, out of 63,963 sanctioned posts, around 24 per cent of the posts are vacant, considering all categories. However, in certain critical cadres, the vacancy position is alarming. Nearly 50 per cent of the pharmacist posts and 39 per cent of the lab-technician posts are lying vacant. Even in the case of Medical Officers, the vacancy level is around 17 per cent.
2. But what is shocking is the regional disparities in the staff position at different centres. In Gulbarga district, nearly 42 per cent of the posts of Medical Officers are vacant even after the appointment of contract doctors. 74 per cent of pharmacists are not in a position in Chamarajnagar district. The vacancy level of Lab Technician is as high as 37 per cent both in Uttara Kannada and Chamarajnagar districts. In the category of male health workers, 67 per cent of the posts are not filled in Kolar, whereas the critical category of ANMs — the real link between the health department and the public — about 36 per cent of the posts are vacant in Gulbarga district. All existing vacancies, particularly in the categories of PHC Medical Officer, pharmacist, lab-technician, staff nurse and ANMs, must be filled at the earliest. A special recruitment drive to fill these crucial posts must be undertaken with all seriousness.
3. The health infrastructure in the state, in terms of number of institutions, is quite

satisfactory. The average area and population covered by a PHC or sub-centre is well within the prescribed national norm. However, many new PHCs have been started in certain locations based on political considerations, rather than established criteria. Attention should be paid to the location of primary health centres and sub-centres with the view to greater integration of the staff with the local population. Instead of sanctioning new health institutions, Government should focus on strengthening the existing institutions in terms of infrastructure and manpower, to make it really functional.

4. The mere existence of a health institution does not ensure its satisfactory functioning and utility to the common man. Many of them lack basic facilities like electricity, water, telephone and a vehicle. Some of them are located in rented buildings. Measures should be initiated to improve the infrastructure and its proper maintenance.
5. The main reason cited during the study for the poor functioning and low utilization of PHC facilities is the absence of the Medical Officer / Lady Medical Officer at the headquarters. Facilities should be made available for the stay of crucial medical staff at the PHC compound itself.
6. Soft loans should be provided to ANMs and Medical Officers to purchase two-wheelers. This will facilitate field visits and supervision in the villages as well as their availability in PHCs and sub-centres.
7. Though attempts were made at district levels to recruit doctors on contract basis, in many areas it is not very successful. Their salary should be raised on par with regular Medical Officers. There is no systematic attempt to regularise the services of these doctors working in difficult situations even after many years, which in a way affects their morale.
8. In a service department like health, abolition of existing posts must be done with extreme caution. The blanket decision of abolishing a certain percentage of posts with immediate effect may not be feasible, even in spite of the mounting financial burden. However, we need to differentiate between the posts 'providing health care services' and posts of purely 'administrative' nature in the Health Department.
9. Regarding the appointment of Medical Officers, tenure-specific posting should be given and rural service should be made compulsory in the initial years. Those doctors/paramedical staff working in the remote and backward areas of the state must be encouraged with substantial incentives, both in terms of cash, PG education and promotions.
10. A highly responsible post like District Health and Family Welfare Officer (DHO) should have tenure-specific appointments. Most of the newly appointed DHOs have only a few months of service before their retirement and have no interest in initiating any improvement.
11. To ensure proper supervision of the functioning of PHCs, the position of the Taluk Health Officer (THO) should be strengthened. In most of the taluks, the THO is the chief Medical Officer in-charge of taluk hospitals / CHCs, and he/she has very little time to monitor the functioning of PHCs. It is recommended that THO should be given full administrative powers and time to discharge duties as a supervisory officer, rather than as a mere 'manager' of a particular hospital in the taluk.
12. The administrative structure of the department at state and district levels, as proposed by the Task Force on Health and Family Welfare, is appropriate in terms of

improving efficiency and responsive administration. However, at the district level the two posts of the District Medical Officer (DMO) and District Health Officer (DHO), may lead to dual centres of authority and lack of co-ordination and a huge financial burden. Necessary administrative procedures must be evolved to avoid this.

13. Though the government has provided a large network of health facilities throughout the state, their utilisation by the public is considerably low. There are many factors such as distance, lack of health personnel, non-availability of medicines, hostile behaviour of health staff, absence of doctors, etc., which determine the utilisation of services. It is a well-known fact that people have a very poor image of government health facilities. It is the responsibility of the government to ensure that quality health care is available and accessible to the needy at an affordable price.
14. A review of training programmes of the department reveals that it is more 'project-driven activity' rather than a regular responsibility of the department, based on any need-based appraisals. It was also found that the four Regional Health and Family Welfare Training Centres (RHFUTC) are mostly inactive. At least once in five years, every staff member of the department should receive refresher training. The Department should chalk out an action plan for future training programmes, in accordance with a need-based appraisal.
15. The State Institute of Health and Family Welfare (SIHFW) should be strengthened with capable faculty and facilities to discharge its responsibility as an apex training institute in the State.
16. Decentralisation of health services through intervention of Panchayati Raj Institutions is expected to provide better service delivery and make health personnel accountable to the public. To some extent this is true in Karnataka. It has resulted in better functioning of PHCs and improved attendance of doctors and paramedical staff. But in many instances, this study observed lack of faith and respect between health functionaries and panchayat leaders, which has adversely affected the services.
17. Though at the district level, there is frequent interaction and supervision between ZP and district health office, it is practically non-existent at the taluk and village levels. The health committees rarely meet and even in taluk and gram panchayat meetings, health issues were seldom discussed. There is an urgent need to activate the health committees for the benefit of the community.
18. Training and orientation programme on health and related issues should be given to all panchayat members at the beginning of their tenure. This will help them to realise their responsibilities and the need for co-operating with health functionaries at all levels.
19. Regarding drug management, certain new procedures need to be adopted. In many instances, the drugs purchased are not utilised in time. There were frequent delays in supply of medicines from the General Medical Stores. Irrespective of the coverage of the population and staff strength of PHCs, medicines were supplied to all PHCs in similar quantities. This has resulted in an acute shortage of drugs in some places and wastage of medicines in some other places. Distribution of medicines should be based on the criteria of demand.
20. A corporation may be set up to take care of procurement, storage and distribution of drugs, equipment and ancillary items.

21. The department should seriously consider 'privatising' the non-clinical services in hospitals /CHCs / PHCs. The experience of a few hospitals under KHSDP, where the non-clinical services have been contracted out, is encouraging.
22. The user charges are expected to provide additional revenue for maintaining hospitals. Recognising the patients' ability to pay, certain sections of the people can be targeted for levying user charges. While doing so, the poor must be protected, since most of the people availing of government health facilities are from the poorer segments of society.
23. Private practice by government doctors can be allowed under certain conditions. However, their presence in the PHCs/hospitals during working hours must be made compulsory and strict action initiated against those who violate the rules.
24. The per capita expenditure on health in Karnataka, which includes public health, medical and family welfare, in 1999-00 was Rs.185.10 and compares favourably with those in the neighbouring states. The comparatively larger figures in Karnataka in some years are related to injection of funds through Externally Aided Projects (EAPs). The overall expenditure on health and family welfare is in the range of 1.1 and 1.4 of net state domestic product, but the reliance on EAPs is increasing. Considering that EAPs are more of loans rather than grants, utilisation of these funds demands utmost care and efficiency.
25. Appreciation and recognition of individual contributions are motivational factors for committed personnel. However, outstanding contributions of our health administrators, specialists and health personnel have never been recognised by the state government. Awards should be instituted for noteworthy performance of doctors and field workers, which will boost morale and instil pride in undertaking certain tasks.
26. Many states have formulated their own population policies, which gave an impetus to their efforts to address state-specific problems. The results of 2001 Census indicate that Karnataka is lagging behind all other South Indian states in demographic transition. The state should formulate a population and health policy within the broad framework of National Population Policy (2000) and National Health Policy (2002) and implement it sincerely.