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Prof. J.S. Bajaj
Vice Chairman, Punjab State Planning Board, Punjab

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Former Director AIIMS, New Delhi

Dr. Deoki Nandan
Director National Institute of Health
& Family Welfare, New Delhi

Dr. Shakti Gupta
Medical Superintendent, AIIMS, New Delhi

Dr. Sukhdev Singh
Director, Family Welfare Punjab
From: 24.9.2007 to 16.4.2008

Dr. SPS Sohal
Director, Family Welfare Punjab
From:

SPECIAL CONTRIBUTOR

Satish Chandra, IAS,
Principal Secretary Planning and Health

CONVENOR MEMBER

Dr. Roshan Sunkaria, IAS,
Managing Director, PHSC
From: 24.9.2007 to 16.4.2008

T.R. Sarangal, IAS,
Managing Director, PHSC
From: 16.4.2008 to 15.9.2008

M.S. Sandhu, IAS,
Managing Director, PHSC
From: 16.9.2008 to 7.7.2009

Raji P. Shrivastava, IAS,
Managing Director, PHSC
From: 7.7.2009 till date.

COORDINATOR

Tejveer Singh, IAS,
Special Secretary to the Government of
Punjab, Department of Planning
From:

SECRETARY

Vipin Sharma
General Manager (F&A)
Punjab Health Systems Corporation.

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ON LETTERHEAD

FOREWORD

As a result of intensive deliberations between the World Bank, Union Ministry of Health and Family Welfare and the Planning Commission, Government of India, the States of Karnataka, Punjab, and West Bengal were identified for financial support aimed at strengthening secondary level health care infrastructure and services. The main objective was to enhance the quality of health care at the secondary level so as to provide effective referral and linkage with primary health care institutions and service providers. As Member (Health), Planning Commission, my personal commitment towards a successful outcome of the project continued beyond the phases of planning and implementation.

The Punjab Health Systems Corporation was established through an Act of Legislation in April, 1996, with a view to providing, expanding, improving and administering medical care in the State of Punjab. The facilities established or strengthened as a result of World Bank assistance were entrusted to the newly established Corporation. It was therefore timely that the Hon'ble Chief Minister, Punjab in 2007 constituted the Review Committee to undertake an extensive appraisal of the structural organization and operational framework of the health care institutions established or strengthened as a result of the World Bank Project and presently functioning under Punjab Health Systems Corporation.

As per internationally accepted norms, the Review Committee considered health systems as comprising all organizations, institutions and resources devoted to generate health actions for both the individual health care as well as for the public health services, either through direct intervention or through intersectoral activities. The primary aim of health systems is therefore to restore, promote, or maintain individual and public health taking a holistic view of health as well as the determinants of health.

An optimally functional health system must ensure social equity in service delivery logistics, must be accountable to the people, and should provide health services that are affordable by the State as well as the public. Finally, effectiveness and efficiency

of the health system must be measurable through careful monitoring of optimal utilization of human, material and financial resources. The Review Committee had amongst its members health planners, health managers, public health experts as well as those well conversant with institutional and hospital management. Through a most purposeful collaboration of its members, the Review Committee has endeavoured to measure and evaluate the performance of Punjab Health Systems Corporation. The Committee has commended its strengths, identified its weaknesses, and made recommendations to chart the future course of action. The report that follows is an outcome of the collective efforts. The support provided by the Director, National Institute of Health and Family Welfare, New Delhi in designing, organizing and conducting field studies is acknowledged.

As Chairman, I wish to take this opportunity to convey my profound gratitude to the Members of the Review Committee for offering close cooperation extended so willingly and so unhesitatingly. My colleagues in the State Planning Board, Sh. Satish Chandra, IAS, Principal Secretary Planning & Health, Sh. Tejveer Singh, IAS, Special Secretary Planning (presently on deputation outside the State), were most helpful and offered valuable assistance. Smt. Raji P. Shrivastava, IAS and Sh. Vipin Sharma of the Punjab Health Systems Corporation effectively participated in the deliberations, provided the requisite data and offered secretarial assistance. To all of them, my special thanks.

Our policies and programmes must reflect our concerted efforts for developing, validating, and delivering health practices and procedures which are professionally sound, socially equitable, and managerially efficient. It is our fervent hope and wish that this report will facilitate such development.

Sd/-
Prof. J.S. Bajaj
Chairman, Review Committee &
Vice Chairman, Punjab State Planning Board
Chandigarh.

CHAPTER - I

EXECUTIVE SUMMARY

1.1 The State of Punjab has been a frontrunner in economic growth and development having scripted for itself a place of pride in the history of the country's economic development after Independence. However, having passed through various political vicissitudes and an era of strife and turmoil, its performance on many social indicators has raised serious concern among political leaders and health administrators alike. The Government of Punjab under the leadership of the Hon'ble Chief Minister Sardar Parkash Singh Badal, constituted the State Review Committee to review the working of the Punjab Health Systems Corporation and assess the current scenario with reference to the capacity-building that occurred with the assistance of the World Bank-aided Health Systems Project.

1.2 The Report begins by examining the formation of the Punjab Health Systems Corporation (PHSC) and sanction of the World Bank Project to the State. The Report then proceeds to analyze how the Corporation has functioned in its over-a-decade long existence. Certain institutional issues and shortcomings that emerged during the course of the study have been delineated.

1.3 The Committee felt the need to carry out an empirical assessment of PHSC's healthcare facilities and identified one of the members of the Review Committee (RC), the Director of the National Institute of Health and Family Welfare (NIHFW), New Delhi for undertaking a study. The study design and outline were prepared in consultation with the Committee with the Chairman providing appropriate guidance in preparing the study proformae. In a subsequent meeting of the RC, members made suggestions which were incorporated into the study design/ proformae. The expenses incurred by the NIHFW in the conduct of the study were defrayed through a grant by the State Planning Board. The findings of this exhaustive study, which was spread across 10 districts of the State's three distinct geographical regions, viz. Malwa, Doaba and Majha, have been encapsulated in the next chapter.

1.4 The Committee, in addition to the survey of the working of the three (now two) teaching facilities under the charge of PHSC, also carried out a first-hand assessment of these institutions. The findings are presented in the report in the chapter on Review of Teaching Facilities.

1.5 The Committee has presented its recommendations which form the body of the Report's sixth chapter. The Committee has focused on issues related to manpower and human resource development; issues related to infrastructure, management and support facilities, ways and means to improve emergency care in hospitals and CHCs as well as made certain recommendations on systemic improvements using a well designed Health Information Systems.

1.6 The Report has based its findings and recommendations on the inference and outcomes of the empirical study carried out by NIHFW under the guidance of the Chairman as well as the considered views of eminent health professionals on the Committee. The Punjab Health Systems Corporation Act, 1996, in its

preamble, emphasizes the need “to provide for the constitution of a Corporation for establishing, expanding, improving and administering medical care in Punjab”. Within this overarching mandate, the Report should be useful to administrators by providing a contemporary external assessment of the status of delivery of healthcare services in the State of Punjab. The Report should be seen as a critique of the strengths and shortcomings of the past but should also help the Department and the PHSC in orienting itself to a conceptual framework of health systems, and in scripting a brighter future.

CHAPTER – II

BACKGROUND, FORMULATION OF THE PHSC AND THE WORLD BANK PROJECT

2.1 Hospital Services at the Secondary level play a vital and complementary role to primary health care. The Government sector is engaged both in preventive and curative aspects of health care though only an insignificant sum of the total is being spent on the curative part. It was realized that District Hospitals, Sub-Divisional Hospitals and Community Health Centres lack basic medical equipment and diagnostic services and have critical gaps in infrastructure. To revamp the whole system, a proposal was drafted to seek assistance from the World Bank. The WB Team visited Punjab in March, 1995, held discussions with His Excellency the Governor, the Chief Minister, the Health Minister, the Chief Secretary and the Secretaries of Line Departments. It also visited a number of medical institutions. As per their recommendations, a workshop was held to ascertain the kinds of improvement required for providing better health care facilities to the people of the State.

2.2 THE WORKSHOP AND THE RESOLUTION

The Department of Health and Family Welfare, Punjab, organized a Workshop from 27th to 29th April, 1995 at Kharar in which 33 Senior Doctors including the Director Health Services, all Civil Surgeons, the Deputy Directors and Senior Medical Officers and senior Administrators/ Managers participated. Different groups deliberated on policy issues, surgical, medical and laboratory services and identified the categories of services to be provided at CHC, Sub-Divisional and District Hospitals including requirements in terms of staff, space, instruments and equipment. The Workshop adopted the following resolution:

> "The group is of the considered and genuine opinion that there should be a fully autonomous and self-sufficient Corporation named Punjab Health Systems Corporation. This Corporation should be headed by a Chairman, who shall be the Secretary, Health and Family Welfare, Punjab."

As per the outcome of the workshop, the Project for revamping the Secondary Level Health Care Services was proposed to assist in:

(a) Adding and renovating hospital buildings at the block, sub-divisional and district headquarters;
(b) Supplementation of accommodation for essential staff;
(c) Provision of more ambulances and better machinery and equipment;
(d) Increase in body strength at some places;
(e) Additional hospital linen and accessories; and
(f) Maintenance funds for buildings, vehicles, machinery and equipments.
(g) Strengthening management and implementation capacity by introducing a Hospital Management Information System (HMIS) to evaluate and monitor capacities and performance of hospitals by establishing connectivity for quick flow of data. Strengthening

of Human Resource Deployment, Implementation of Quality Assurance Programme, Referral Systems, Information Education & Communication (IEC); and

(h) Implementation of the Health Sector Development Programme, which includes enhancing the role of the private health sector in the delivery and management of health services, implementation of user charges policy, tackling of gender issues and enhancing financing and resource allocation for the health sector.

2.3 THE PROJECT

The Punjab Health Systems Corporation was enacted through a special Act of Legislation to provide for the constitution of a Corporation for establishing, expanding, improving and administering medical care in the State of Punjab.

The World Bank sanctioned the Second State Health Systems Development Project of US$ 106.10 million to upgrade the envisaged areas of upgradation.

Loan	Rs.252.00 crore
Grant	Rs.127.00 crore
Share of the State Govt.	Rs. 43.00 crore
Total :	**Rs. 422.00 crore**

The approved heads of expenditure were:

i.	Civil works for renovation, new construction & extensions	Rs.174.00 crore
ii.	Major/Minor equipment, surgical packs & Furniture	Rs. 66.00 crore
iii.	Vehicles & Ambulances	Rs. 9.00 crore*
iv.	Medicines, Medical Lab. supplies	Rs. 26.00 crore*
v.	Information Systems & Computers	Rs. 11.00 crore
vi.	Training & Workshops	Rs. 13.00 crore
vii.	Salaries & Office Expenses	Rs. 50.00crore
viii.	Price Contingencies	Rs. 73.00 crore
	Total :	**Rs. 422.00 crore**

*Rs.15.00 crore was additionally agreed.

2.4 LEGISLATIVE MEASURES AND SIGNING OF THE AGREEMENTS

The World Bank procedures for release of soft term loans are stringent and inflexible. As the stipulated conditions for negotiating the loan in Washington, the World Bank desired that an Ordinance be passed whereby the detailed structure of the Corporation should be enacted. After approval of the World Bank Attorneys, Ordinance No. 4 of 1995 was passed on 20th October, 1995. It was approved in a tripartite meeting of the World Bank, Government of India and the State Government. The World Bank, in its Board of Directors meeting, approved the Project on 24th March, 1996. As per the assurances given by the State Government from time to time to the World Bank, the State Government passed an Act No. 6 of 1996 in April 1996 establishing the Punjab Health Systems Corporation and brought 150 non-teaching hospitals (included in the proposed Project) under the purview

of the Punjab Health Systems Corporation with some changes in the Ordinance which were agreed upon in Washington during negotiations. A copy of the Punjab Health Systems Corporation Act, 1996 (Punjab Act No. 6 of 1996) is enclosed as **ANNEXURE-I** along with amendments done through the Punjab Health Systems Corporation (Amendment) Act, 2004 (Punjab Act No. 14 of 2004) is enclosed as **ANNEXURE-II**. Specifically, the Article regarding privatization was deleted as also the Chairman could be a Doctor of eminence. Subsequently, the Government of India, on behalf of the State Government signed the Project Agreement on 18th April, 1996 and also directly signed the Credit Agreement on even date with the World Bank. On the basis of the legal opinion of the Advocate-General, Punjab dated 10th June, 1996 (regarding execution of Agreements on behalf of the State of Punjab/ PHSC), a valid and legally binding obligation on the part of the State of Punjab, the World Bank opened the credit for the Project on 29th June, 1996.

2.5 CHANGES IN THE STRUCTURE OF THE CORPORATION

The PCMS Association, from the outset, had a recalcitrant stance on the formation of the Corporation. Though earnest efforts were made by Departmental heads to allay their apprehensions, initially little headway could be made in this regard. On the basis of deliberations which took place in the series of the meetings held at various levels with the PCMS Association, the Association was assured that the State Government would redress their grievances by incorporating the necessary changes in the functioning of the Corporation. The Minister for Health and Family Welfare on 31.3.97 held a meeting to resolve various pressing issues and to invite suggestions to improve medi-care in the State. This meeting was attended by the Principal Secretary Health and Special Secretary Health along with representatives of the PCMS Association. In that meeting, the following changes in the functioning of the Health Corporation were agreed upon:

- The title of property of 150 health institutions would not be transferred to the Corporation. The User Charges of these institutions would also remain the same as in other Government hospitals and dispensaries.

- The Government directed the Corporation to withdraw its notification dated 25.10.96 seeking options of employees for their willingness to work under the Corporation.

- The powers in respect of recruitment, postings, transfers and punishments of doctors and health employees, would remain with the Government as was the case before setting up the Corporation. Civil Surgeons would continue to remain overall in-charges in the district including of the hospitals under Corporation control.

In order to formalize the above-mentioned decisions the State Government issued a notification on 20.5.97 (enclosed as **ANNEXURE-III**), which was placed before the Board for their consideration, so that if required, the representation could be made to the State Government for reconsideration of its decisions. The original suggested policy level changes and the amendments made thereafter are placed in an annotated form as **ANNEXURE-IV**.

The categories of Health Professionals which were available in the PHSC in the year 1997 were as under:

SPECIALITY	POSITION IN 1997			
	Norms	Available	Short	Surplus
SENIOR MEDICAL OFFICER (SMO)	169	107	62	0
MEDICINE	176	135	41	0
SURGERY	176	148	28	0
GYNAECOLOGY	176	105	71	0
PAEDIATRICS	175	86	89	0
ORTHOPAEDICS	64	60	4	0
ANAESTHESIOLOGY	64	51	13	0
PATHOLOGY	59	38	21	0
OPHTHALMOLOGY	59	69	0	10
RADIOLOGY	59	23	36	0
PSYCHIATRY	28	16	12	0
BLOOD TRANSFUSION OFFICER (BTO)	28	15	13	0
MEDICAL OFFICER (MBBS)	405	203	202	0
DENTAL	175	141	34	0
SKIN & VD	28	34	0	6
EAR, NOSE AND THROAT (ENT)	28	51	0	23
MICROBIOLOGY	6	10	0	4
TOTAL =	**1875**	**1292**	**626**	**43**

CHAPTER – III

ORGANIZATIONAL STRUCTURE

3.1 CONSTITUTION OF THE BOARD

As per Section 2 read with Section 3 of the PHSC Act, the Corporation consists of:

(a) *The Chairman of the Corporation who shall be an eminent public person or a distinguished and eminent medical person;
(aa) *"The Vice Chairman" of the Corporation, who shall be the Secretary to Government of Punjab, Department of Health and Family Welfare.
(b) The Managing Director, who shall be an officer of the Indian Administrative Service;
(c) A Board of Directors; and
(d) Such other employees, as may be determined by the Board of Directors.

* As after The Punjab Health Systems Corporation (Amendment) Act, 2004 (Punjab Act No. 14 of 2004)

As per Sub Section (i) of Section 5 of the PHSC Act, the Managing Director is an Executive Officer of the Corporation and shall implement the decision of the Board of Directors and shall exercise such other powers and perform such other functions as may be delegated to him from time to time by the Board of Directors. Further, sub section (2) of Section 5 of the PHSC Act enables the Managing Director to exercise general control and supervision over the dispensaries and hospitals in the effective performance of their functions under this Act or the Regulations made there under.

As per Section 6, there shall be a Board of Directors consisting of the following members, namely;

(a) *The Chairman of the Corporation, who shall be an eminent public person or a distinguished and eminent medical person.
(aa) *The Vice Chairman of the Corporation, who shall be the Secretary to Government of Punjab, Department of Health & Family Welfare.
(b) The Managing Director ;
(c) The Secretary to Government of Punjab in the Department of Finance;
(d) The Secretary to the Government of Punjab in the Department of Rural Development and Panchayats;
(e) The Secretary to the Government of Punjab in the Department of Local Government;
(f) A representative of the Government of India in the Ministry of Health;
(g) The Director of Health Services, Punjab; and
(h) Six eminent persons as given below, nominated by the Government for a period of three years :
Provided that no nominee shall be a member of the Board of Directors for more than two terms or six years whichever is less;

(i) a representative of a Medical Institution of excellence in the country;

(ii) two distinguished experts in professions related to Medicine and Health ;

(iii) an experienced professional in Systems Management or Telecommunications;

(iv) the Director of the National Institute of Pharmaceutical Education and Research (NIPER); and

(v) a representative of a reputed industrial house manufacturing pharmaceuticals.

* As after The Punjab Health Systems Corporation (Amendment) Act, 2004 (Punjab Act No. 14 of 2004)

3.2 CHAIRMAN & VICE CHAIRMAN

Originally, as per the Ordinance, the Secretary to the Government of Punjab, Department of Health and Family Welfare was designated as the Chairman of the Corporation. While passing the Act of the PHSC, the Government incorporated a conscious change wherein in addition to the Secretary to the Government of Punjab, Department of Health, a distinguished and eminent medical person was enabled to be appointed as Chairman. In the year 2004, another amendment was made paving the way for an eminent pubic person to be also appointed as Chairman of the Corporation. An amendment was also made to create the post of Vice Chairman of the Corporation who shall be the Secretary to the Government of Punjab, Department of Health and Family Welfare.

As per Section 3 (a) of the principal Act, the Chairman of the Corporation shall be the Secretary to the Government of Punjab in the Department of Health & Family Welfare or a distinguished or eminent medical person. Further, in accordance with the amendments which were carried it was substituted that the Chairman of the Corporation shall be an eminent public person or a distinguished and eminent medical person. Following is the incumbency chart for the post of Chairman.

Name	Period during which he or she remained Chairman / Chairperson
Sh. G.P.S Sahi, IAS	20.10.95 to 20.6.96
Dr. B.N.S. Walia (Ex-Director, PGIMER)	21.06.96 to 13.12.96
Mrs. Poonam Khetarpal, IAS	13.12.96 to 18.02.97
Sh. Rajesh Chhabra, IAS	19.09.97 to 2.11.99
Sh. P.K.Verma, IAS	3.11.99 to 9.10.01
Sh. Rajan Kashyap, IAS	10.10.01 to 9.10.02
Mrs. Rupan Deol Bajaj, IAS	9.11.02 to 8.5.03

Name	Period during which he or she remained Chairman
	9.5.03 to 26.6.03 FN
Lt. Col. C.D.S. Kamboj	26.6.03 (AN) to 22.1.07
Sh. D.S. Guru, IAS	23.1.07 to 23.4.07
Sh. A.R. Talwar, IAS **	16.3.07 to 2.4.07
Sh. Vi in, IAS	23.4.07 to 30.11.08
Sh. A.R. Talwar, IAS **	1.12.08 to 7.7.09
Sh. Satish Chandra, IAS,	17.7.09 till date

As per the amendments made in the principal Act, as per Section 3 (aa) the Vice Chairman of the Corporation shall be the Secretary to Government of Punjab, Department of Health & Family Welfare. Following are the incumbency details for the post of Vice-Chairman.

Name	Period during which he or she remained Vice Chairman
Sh. D. S Jaspal, IAS *	26.6.03 (AN) to 12.10.03
Sh. D.S. Guru, IAS **	13.10.03 to 20.4.07
Sh. Vijay Kain, IAS **	20.4.07 to 30.11.08
Sh. A.R. Talwar, IAS **	1.12.08 to 7.7.09
Sh. Satish Chandra, IAS **	17.7.09 to till date

* Due to an amendment in the Act, Shri D.S. Jaspal, IAS, became Vice-Chairman of the PHSC upon the joining of Lt. Col. CDS Kamboj, who was appointed by State Government as the Chairman of PHSC.

** The incumbents were having dual charge of Chairman as well as Vice- Chairman.

No administrative and financial powers vest with the Chairman or Vice Chairman. The role of the Chairman has been specified in the Regulations followed by the PHSC for Conduct of Business by the Board of Directors. (enclosed as **ANNEXURE-V**).

3.3 MANAGING DIRECTOR

As per Sub Section (b) of Section 3 of the PHSC Act, the Managing Director shall be an officer of the Indian Administrative Service. Following are the incumbency details for the post of Managing Director.

Name	Period
. .	. . . .
Shri. S.S. Channy, IAS	14.12.96 to 29.10.99
.	. . . .
Ms. Kusumjit Sidhu, IAS	7.3.02 to 11.10.02
r . . . ,	. . . .
Mrs. Anjali Bhawra, IAS	**21.5.03 to 3.7.04**
. . .	. . . .
Shri. Roshan Sunkaria, IAS	10.9.07 to 16.4.08
. . .	. . . .
Shri. Mandeep Singh Sandhu, IAS	16.9.08 to 7.7.09.
. i P. Shrivastava, IAS,	From 7.7.09 till date

The longest tenure as a Managing Director was that of Sh. T.R. Sarangal who remained Managing Director from 4.8.04 to 10.9.07 and again from 16.4.08 to 15.9.08. The shortest tenure as a Managing Director was of that Ms. Kusumjit Sidhu, who remained Managing Director from 7.3.02 to 11.10.02.

3.4 NOMINATED MEMBERS

As per Sub Section (h) of Section 6, six eminent persons can be nominated on the Board. The position right from the very beginning is as under:

i) Right from its inception, Director PGIMER is on the Board as a representative of a Medical Institution of excellence in the country.

ii) Against the posts of two distinguished experts in the professions related to Medicine and Health, following is the position:

Name of the expert	Period
Dr. P.N. Chuttani ,	Jan, 1996 to 19.7.1996
Dr. Narinder N. Wig, Retired Professor of Psychiatry, PGIMER	20.3.96 to 19.3.02.
Dr. Kuldip Singh Professor, Dayanand Medical College Ludhiana.	28.10.98 to 31.10.04
Dr. Kuldip Singh Khera, Retd. Professor, Government Medical College Patiala.	22.7.03 to 22.7.06

Name of the expert	Period

Dr. B.D. Gupta MD FRCR (London) Retd. Professor, Deptt. of Radiotherapy, PGIMER.	18.6.07 to 17.6.2010
Dr. Radha Krishan Kumra, MBBS, MD (Medicine), Retd. Prof. & Head of the Dept. of Medicine, Medical College, Amritsar.	18.6.07 to 17.6.2010

It is pertinent to note that the post vacated by Dr. P.N. Chuttani on account of his sudden death was filled by the appointment of Dr. Kuldip Singh. This post remained vacant from 20.7.96 to 27.10.98 and again from 1.11.04 to 17.6.07. The post vacated by Dr. N.N. Wig on 19.3.02 remained vacant from 20.3.02 to 21.7.03 and was filled by the appointment of Dr. Kuldip Singh Khera on 22.7.03.

Again this post remained vacant from 23.7.03 to 17.6.07. From the above, it may be seen that both the posts of the health experts remained vacant from 23.7.03 to 17.6.07.

iii) Against the post of experienced professional in Systems Management or Telecommunications, following is the position.

Name of the expert	Period during which he remained on the Board
Mr. Vijay Kumar Director, Case Computer, Ex-IBM.	1996 to 31.12.2002.
Dr. Rajneesh Arora, Dean Alumni Placement & Research Outreach Guru Nanak Dev University, Amritsar.	22.11.07 to 21.11.08 and 23.11.09 to 22.11.2012

It is pertinent to note that though Mr. Vijay Kumar's term had expired in December, 2002, he was called as a special invitee up to 31.12.2006. From 1.1.2003 to 21.11.07 this post remained vacant. Dr. Rajneesh Arora, after serving for one year, left upon appointment as Vice-Chancellor of Punjab Technical University, Jalandhar.

iv) The Director NIPER Mohali, is on the Board right from the inception of the Corporation.

v) Against the post of representative of a reputed industrial house manufacturing pharmaceuticals, Sh. Malvinder Mohan Singh, CEO & Managing Director, Ranbaxy Laboratories remained on the Board for the period from 17.9.07 to 16.9.08. Now, Sh. Atul Sobti MD Ranbaxy Laboratories is on the Board for the period from 23.11.2009 to 22.11.2012.

3.5 BOARD MEETINGS

Since its inception, the Board of PHSC has conducted twenty seven meetings. Agenda Items which were placed before the Board for consideration are enclosed as **ANNEXURE-VI**.

3.6 REGULATIONS

As per Section 25 of the PHSC Act, the Corporation can make regulations consistent with the Act to provide for all or for any on the following matters namely;

(a) The duties of the members, officers and employees of the Corporation and their salaries, allowances and other terms and conditions of services;

(b) The procedure to be followed at the meetings of the Corporation and the manner in which the corporation shall conduct its meetings;

(c) The administration of the funds and other properties of the Corporation and the maintenance of its accounts;

(d) The procedure to be followed by the Corporation in inviting, considering and accepting tenders ; and

(e) Any other matter arising out of the functions of the Corporation under this Act in which it is required, necessary or expedient to make regulations.

The Board of the PHSC in its first meeting held on 6th January, 1996, approved the following regulations;

i) Regulations for the conduct of business by the Board of Directors

ii) Regulations to govern the terms and conditions of the employees of the Corporation.

iii) The manual for accounts and audit.

The Board of Directors in its 2nd Emergent Meeting held on 14.2.1996 approved the procurement procedures to be followed by the Punjab Health Systems Corporation which included the accepting of tenders, etc. These were based on the procurement arrangement as per the guidelines issued by the World Bank. After the completion of the World Bank Project the Board amended these procurement procedures to some extent in its 20th meeting held on 3.6.2005.

3.7 FUNCTIONING OF THE CORPORATION

3.7.1 COMPARATIVE POSITION OF THE HEALTH INSTITUTIONS AND BED STRENGTHS

Following are the comparative tables for 1996 and 2008 concerning health institutions and bed strength.

Tier	1996		2008	
	No. of Health Institutions	**Bed Strength**	**No. of Health Institutions**	**Bed Strength**
District Hospitals	17	1639	21	2243
Sub Divisional Hospitals	43	1640	39	2089
Community Health Centres	89	1878	107	2217
TOTAL	**149**	**5157**	**167**	**6549**
str ct w osp ta w se comparative information is enclosed as **ANNEXURE-VII**.				

3.7.2 HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

The following are the comparative tables for 1996 and 2008 concerning health manpower:

Particulars	Norms	Availability		Short	
		1996	**2008**	**1996**	**2008**
Senior Medical Officer	169	107	142	62	27
Specialist doctors	1301	982	1007	319	294
MBBS	405	203	279	202	126
TOTAL	**1875**	**1292**	**1428**	**583**	**447**

Specialty wise and category wise comparative position of availability of manpower in the year 1996 as compared to 2008 is elaborated in the following Table. It can be seen that the position of specialist doctors and general duty doctors has marginally improved though the number of specialists were made available in the PHSC hospitals from the Subsidiary Health Centres handed over to the Zila Parishads in the year 2006. In some categories of specialist doctors, there is a shortage, while in others, the specialists are surplus. The surplus position in the category of specialist doctors specifically in Ophthalmology, ENT, and Skin has further increased whereas shortage in critical specialties like Paediatrics has increased. Likewise the position of para-medical staff has improved marginally.

AVAILABILITY OF MEDICAL STAFF

SPECIALITY	POSITION AS ON 1997 AND 2008

	Norms	Available		Short		Surplus	
		1997	2008	1997	2008	1997	2008
SENIOR MEDICAL OFFICER (SMO)	169	107	142	62	27	0	0
MEDICINE	176	135	142	41	34	0	0
SURGERY	176	148	151	28	25	0	0
GYNAECOLOGY	176	105	121	71	55	0	0
PAEDIATRICS	175	86	90	89	85	0	0
ORTHOPAEDICS	64	60	63	4	1	0	0
ANAESTHESIOLOGY	64	51	54	13	10	0	0
PATHOLOGY	59	38	47	21	12	0	0
OPHTHALMOLOGY	59	69	74	0	0	10	15
RADIOLOGY	59	23	27	36	32	0	0
PSYCHIATRY	28	16	17	12	11	0	0
BLOOD TRANSFUSION OFFICER	28	15	17	13	11	0	0
MEDICAL OFFICER (MBBS)	405	203	279	202	126	0	0
DENTAL	175	141	93	34	82	0	0
SKIN & VD	28	34	39	0	0	6	11
EAR, NOSE AND THROAT (ENT)	28	51	59	0	0	23	31
MICROBIOLOGY	6	10	13	0	0	4	7
TOTAL	**1875**	**1292**	**1428**	**626**	**511**	**43**	**64**

AVAILABILITY OF PARAMEDICAL STAFF

PARTICULARS	NORMS	AVAILABILITY		SHORT	
		1997	2008	1997	2008
Matron	22	12	14	10	8
Nursing Sister / Staff Nurse	1797	972	1568	825	229
Lab. Technician	418	253	360	165	58
Radiographer	186	113	159	73	27
Pharmacist	513	482	575	31	-

PARTICULARS	NORMS	AVAILABILITY		SHORT	
		1997	2008	1997	2008
O.T. Attendant	187	72	31	115	156
Ambulance Driver	349	242	216	107	133

Administrative Staff SA/CO/Accountants/Steno/ Store Keepers/Electrician etc.	669	515	468	154	201
Ward	3175	3045	2719	130	456
TOTAL	**7316**	**5706**	**6110**	**1610**	**1268**

TRAINING: Under the World Bank Project, a Training Needs Assessment was got done through the Administrative Staff College of India to identify the nature of training to be imparted at different levels. Based on the assessment, training curricula were finalized.

23396 training sessions were organized as against a target of 10000;

Category	Clinical/Managerial/ Hands on Equipment	Referral	Waste Management	Surveillance	Total
Doctors	2080	2997	955	780	6812
Nurses	1560	1699	2032	7460	1560
Paramedics	1691				12882
Class IV			2142		2142
Total	**5331**	**4696**	**5129**	**8240**	**23396**

Training sessions have been organized in prestigious institutions like PGIMER Chandigarh, CMC Ludhiana, GMCH Chandigarh, AIIMS New Delhi, LBSNAA Mussoorie, NICD New Delhi, MGSIPA Chandigarh, C-DAC Mohali, ASCI Hyderabad, Institute of Health and Management Research, Jaipur. Training has been given in the area of clinical skills, managerial skills, hands-on equipment, HMIS, Surveillance, Referrals, Waste Management, Procurement, Computers and Finance. Two State level training centres have been set up to impart on-the-job training to doctors and paramedics.

Various foreign visits were funded which include the Project Negotiation, Study Tours and the Procurement Training (Equipment and Works) in the ILO Training Centre at Turin Italy. Apart from this, participation was also sponsored for the Quality Healthcare and Certification Programme in International Health in Boston USA. A total amount of Rs. 86 lakh was spent. Most of the doctors who have attended the Procurement Training and Certification Courses have submitted their reports and feedback to the PHSC on return. The group which was sent for negotiation of the Project has submitted a report to the Board vide Agenda Item No. 2.1 in its meeting held on 14.2.1996. However, these reports were neither discussed in the Board nor

any remedial action taken on the recommendations. Apart from this, no feedback in respect of the various ideas imbibed there was placed before the Board. The services of doctors who were trained were utilized in the PHSC. At present, two doctors and one engineer who were imparted procurement training are still working in the PHSC in the same field. Rest of the doctors/other officers either have retired or have been transferred to some other places. A copy of the list of Foreign Tours by Ministers/Officers is enclosed as **ANNEXURE – VIII**.

3.7.3. INFRASTRUCTURE

Civil Works:-Under the World Bank project, 15 District Hospitals, 2 Special Hospitals, 38 Sub Divisional Hospitals and 100 Area/Community hospitals along with 2 training centres have been renovated /extended. In 34 hospitals additional facilities for patients' attendants have been augmented. Additional 2.40 lac sq. mtrs. covered area of the existing hospitals was increased by way of extension. Out of a total of 157 institutions renovated / extended under the project, 14 institutions have been constructed at new sites due to inadequate expansion provisions and improper locations for emergency (situated in crowded places). The building condition in most of the hospitals is adequate. There is a need for continuous maintenance of these hospitals.

Procurement Of Equipment:- At the start of the World Bank Project, an equipment status survey was got done to identify the availability of the equipment (repairable and non-repairable) against the norms. 105 types of different major/minor equipment was purchased and installed. The present status of the equipment available in the PHSC hospitals include equipment already available before the start of the project, equipment purchased under the World Bank project and equipment purchased after the closure of the project from the Plan Side and other sources of funding.

The present status of major equipment costing more than Rs. 45000/- (US $ 1000) was reviewed and a summary of the status of equipment is enclosed as **ANNEXURE-IX**. Out of the total equipment available, 2.63% of the equipment requires condemnation being non serviceable. Out of the workable equipment, 3.23% equipment is under repair, 80.55% of the equipment is being utilized and 13.59% equipment is lying in the hospitals unutilized. An analysis is offered as under:-

STATUS OF EQUIPMENT

{Figures in %age}

Type of Equipment	Non repairable	Under repair	Utilized	Unutilized
Imaging Equipment	3.25	3.25	85.70	7.80
Electromagnetic Equipment	3.44	2.68	78.08	15.80
Pneumatic and Hydraulic Instruments	1.77	1.15	85.23	11.85
Laboratory Equipment	2.39	4.31	81.34	11.96

Type of Equipment	Non repairable	Under repair	Utilized	Unutilized
Refrigerators /Mortuary	0	1.89	98.11	0
Waste management Equipment	0	0	0	100

Generator Sets	0	17.47	82.53	0
TOTAL	**2.63**	**3.23**	**80.55**	**13.59**

The main reasons for non utilization of usable equipment can be attributed to the following -

i) The percentage of unutilized equipment is quite high in the categories of Imaging Equipment and Electromagnetic Equipment, Pneumatic, Hydraulic and Sterilization Equipment. This is largely because of anomalies deployment caused by acute shortage of manpower. Staff requires training in many instances.

ii) Waste management equipment is lying unutilized. One of the reasons cited is change in planning for handling waste management. However, the matter was never taken up to the Board.

iii) Old equipment at some stations is awaiting disposal.

iv) Some equipment is lying unutilized due to higher cost of reagents and consumables.

3.7.4 REPAYMENT OF LOANS

On March 21st, 1996, the International Development Association (IDA) approved credit of SDR 235.5 million (US$ 350 million equivalent) under the multi-states Health Systems Development Project for implementation in the States of Karnataka, Punjab and West Bengal. The Development Credit Agreement and the Project Agreements were signed on April 18, 1996 on behalf of the Government of India and the respective States. The credit became effective on June 27th, 1996 covering the expenditure relating to project preparation activities after 1st May, 1995 under retroactive financing. The project cost in Punjab was estimated at about US$ 106.1 million involving IDA finance about US$ 89.7 million and Government of Punjab US$ 16.4 million. Out of the total credit the base line allocation for the Punjab was SDR 55.60 million (US$ 89.7 million equivalent) and SDR 60.40 million (US$ 79.91 million equivalent) including unallocated share which was revised to the tune of SDR 61.07 (US$ 81.14 million). As per the standard arrangements approved under the social sector projects, the Government of India is provided interest free loan from the World Bank. Only commitment charges are being levied in case of non-drawl of the amounts. The Government of India passes the loan portion amount to the State under the standard arrangements as an Additional Central Assistance (30% Grant and 70% Loan). The GoI bears the exchange risks and the State Government has to pay interest on the applicable rate of interest on ACA. The State Government also repays the loan to the GoI received as ACA as per the standard arrangements. The State Government passes the World Bank assistance received through GoI as ACA and its own share to the implementing agency as a grant-in-aid. The implementing agency (PHSC) and the Department of Health and Family Welfare do not have to repay any loan either to the State Government or the GoI.

3.7.5. STATE OF FINANCES

Up to July, 2004, the World Bank funding was open. All the funds up to this date were being drawn from Plan side. Before the closure of World Bank funding, the matter was placed before the Board of the PHSC in its 19th meeting held on 15.3.2004. The Board unanimously approved that the matter may be taken up with the State Government for providing recurrent cost from the Non-Plan side which was earlier being provided by the World Bank. Accordingly, the matter was taken up with the State Government and the State Government issued a notification vide memo No. 1/51/04-1HBIV/690609, dated 5.4.04 that PHSC may continue beyond 31.3.2004. In view of this notification, the State Government in the Finance Department agreed to provide Rs. 15.40 crore to the PHSC annually to meet its recurrent cost expenditure as per the following details.

ANNUAL GRANT RECEIVED FROM THE GOVERNMENT

Particulars of Expenditure	Amount In Lakh Rupees
Personnel Expenses - a ary & o er a m n s ra ve expenses	699.35
Office Expenses - Electricity, Water, POL, Postage, Telephone, Legal Expenses, etc.	88.15
Training, Library & Consultancy	5.50
Hospital Expenses - Biomedical waste disposal, equipment maintenance, sanitation expenses, vehicles, ambulances etc.	300.00
Hospital Consumables & Medicines including maintenance of hospitals	447.00
TOTAL	**1540.00**
Note: Statement indicating approved outlay for FY 08-09, Grant-in-Aid received, Expenditure for FY 08-09 and Proposed Outlay for FY 09-10 is enclosed as **ANNEXURE-X**	

These funds are being drawn by the PHSC from the State Government to meet its recurrent expenditure.

Apart from this, from time to time, the PHSC has been drawing funds from the Plan side. Allocations made during the FY 2008-09 and 2009-10 under the schemes of the PHSC are as under:-

ASSISTANCE TO THE CORPORATION FROM PLAN SIDE

	ANNUAL PLAN	ANNUAL PLAN

DHS 3/PH 738 Punjab Nirogi Yojna (33:66)	100.00	100.00	200.00	-
	150.00	150.00	0.00	-
DHS 11/PH 742 Extension and Upgradation of Existing Health Institutions.	250.00	0.00	2500.00	-
	210.00	198.09	100.00	-
DHS-15 Setting up of Urban Health Care Centres in Municipal Corporation Town Bathinda (ACA 2008-09)	1000.00	0.00	500.00	-
	100.00	100.00	200.00	-
DHS 23 Providing Hotline Facilities in the District as well as Sub Divisional Hospital (more than 100 beds) for maintaining emergency services	0.00	0.00	0.00	0.00
CENTRALLY SPONSORED SCHEMES				
CS 6/CS XXV(i) Institute of Mental Health at Amritsar	0.00	0.00	200.00	0.00

FUNDING THROUGH USER CHARGES

The thrust on implementation of the User Charges at nominal rates adopted by the State Government from time to time has been given during the implementation of the World Bank project. It has been emphasized that the principle of implementing user charges should be made more rigorous for both inpatient and outpatient diagnostic and treatment services in hospitals. The PHSC is charging user charges as adopted by the Punjab Government from time to time.

Retention & utilization of user charges at the point of collection:

The State Government has allowed the PHSC vide memo No. 16/144/96-1HB-4/4291, dt. 12.2.97 to retain the user charges collected from patients at the point of collection and use it for non-salary, non-recurring cost purposes to bring improvement in the working of the hospitals. Further, in order to utilize these charges for improvement in the hospital, PHSC has issued detailed guidelines to all the Civil Surgeons, Deputy Medical Commissioners vide which

it has been allowed that retained revenue by the higher priority should be used as under;

1	Drugs (45%)	Vital drugs, all types of expenditure incurred during natural calamities and unaccompanied accident cases, I.V. fluids, X-ray films, Purchase of Lab. Reagents, Bandages, Gauges, Surgical packs etc.
2	Improving facilities for patients (25%)	Washing or replacing Bed sheets, Purchase of Mattresses etc. Repair/Painting of Hospital Furniture, and repair of Laboratory equipment, cleaning of wards, laboratory, Toilets etc. POL and minor repair to ambulances for patients.
3	Maintenance of Building (15%)	Emergency repairs of Building, electrical items, Public Health Fittings, Maintenance of lawns etc.
4	Maintenance of equipment (15%)	Minor maintenance of medical or non-medical equipments.

Presently, the PHSC hospitals are collecting around Rs. 23 crore annually as compared to Rs. 41 lakh in the year 1996. Following are the comparative figures of collection and utilization.

(Rs. In Lacs)

PARTICULARS		**FINANCIAL YEAR**	
		1996-97	**2008-09**
RECEIPTS		**40.80**	**2346.62**
UTILIZATION		**10.11**	**2190.60**
Drugs	45%	3.99	935.78
Improving Facilities to Patients	25%	4.02	808.46
Maintenance of Building	15%	0.74	237.48
Maintenance of Equipment	15%	1.36	208.88

Further, year-wise collection and utilization from 1996-97 to 2008-09 are enclosed as **ANNEXURE-XI.**

3.7.6 ANNUAL REPORTS

As per Section 16 of the PHSC Act, the Corporation has to prepare an Annual Financial Statement and the Government is to lay this statement on the table of the State Legislature. The Corporation is to take into consideration any comments on the said statement on the table of State Legislature. The Corporation prepares two types of financial statements. One, regarding the statutory accounts of the Corporation in connection with the receipt and payments of various grants and its utilization and other related statutory

accounts and, two, accounts relating to the receipts and utilization of the user
charges retained at facility level. The Corporation has already finalized both its accounts up to Financial Year (FY) 2007-08. Both statements of Annual Accounts up to FY 2006-07 have been laid on the table of the Punjab Vidhan Sabha. No comments are reported to have been received in this regard. The Annual Accounts for the Financial Year 2007-08 are being placed before the Board, after that the same will be sent to Punjab Vidhan Sabha as per the laid down procedure.

The Committee notes that the process of compilation of accounts and their mandatory approval by the BOD must be made regular and expeditious and the report must be placed before the House in the ensuing year itself. The Committee also observes that the Annual Report (as being prepared presently) only incorporates the Annual Accounts and the financial estimates. The Annual Report should provide a comprehensive overview of the activities of the Corporation highlighting the performance and advancements made by the Corporation during the Financial Year under report.

3.7.7 HEALTH MANAGEMENT INFORMATION SYSTEM

The HMIS is a mechanism for collecting and monitoring information which assists in organizational needs, program implementation and monitoring, problem solving and system integration. Under the World Bank Project, under various components, physical as well as capacity building inputs were provided. In the year 1999 Health Management Information System was introduced to measure the efficiency and effectiveness of the inputs provided under the project. The strengthening of the Health Management Information System has been done by ensuring regular inflow of data from all districts as the Health Management Information System data plays a vital role in formulation of health policies and development plans.

In 1997, the PHSC initiated the process for development of a computer based HMIS system. M/s Tata Consultancy Services was engaged. The company was to develop 9 Modules i.e. (i) OPD System (ii) Inpatient System (iii) Diagnostic Centre Management System (iv) Equipment Maintenance System (v) Blood bank Management System (vi) MIS for Disease Surveillance (vii) Personnel Data Base System (viii) Drug Procurement and Disbursement and (ix) Integrated Finance Management System. It has been reported that during the course of implementation, TCS took an inordinately long time in the development of certain modules. In the year 2001, it was decided at the level of the then Managing Director (based on the recommendations of a Committee) to implement computer based HMIS system in a limited number of 50 hospitals (all District Hospitals/Special Hospitals, selected Sub Divisional Hospitals and very few Community Health Centres) by dropping four modules keeping in view the following factors;

i) There would be an additional requirement of manpower i.e. computer operators and maintenance strength. Though support could be given during the implementation of World Bank project, later on salaries of computer operators and other staff would have to be sourced from the user charges. So, the implementation of HMIS

was done in limited hospitals where adequate generation of user charges was.

ii) There is limited patient traffic in some CHCs. Also, due to power cuts, it would not be viable to install computerized systems in CHCs with power back-up.

iii) The Accounts and Finance Section had already started working on TALLY and major procurement activities had come to a close due to limited time remaining for the closure of the World Bank Project, which was closing by March-2002.

Only five modules were taken up i.e. (i) OPD System (ii) Inpatient System (iii) Diagnostic Centre Management System (iv) Blood Bank Management System and(v) Management Information System (MIS) instead of MIS for Disease Surveillance. Year wise reports as well as six monthly reports are available on HMIS. Brief comparative highlights on a year-wise basis may be perused from the table given below.

Indicator	Comparative Position						
	CY 1996	**CY 1999**	**CY 2004**	**CY 2007**	**CY 2008**	**%age Increase/ Decrease**	
						(96-08)	**(07-08)**
Functional Bed Strength	5157	4551	6401	6259	6649	28.93	6.23
Admission (In Lacs)	2.43	2.55	3.65	4.42	4.68	92.00	5.75
Out Patient (In Lacs)	51.98	53.39	87.11	99.90	104.49	101.04	4.59
Bed Occupancy Rate (BOR) %age							
➢ DH	68.52	82.05	76.96	84.59	82.50	13.98	-2.09
➢ SDH	64.49	80.73	61.12	75.14	70.75	6.26	-4.39
➢ CHC	17.86	45.41	26.49	30.91	33.17	15.31	2.26
Surgeries (In Lacs)	0.40	0.62	3.19	4.19	4.63	1061.06	10.58
Deliveries (In Lacs)	0.18	0.20	0.31	0.40	0.46	157.36	15.04
X-ray and Scanning Tests (In Lacs)	0.80	1.67	6.33	7.47	8.03	897.71	7.50
Lab. Tests (In Lacs)	2.78	13.39	35.62	51.22	56.67	1937.96	10.66

This table shows the overall picture of the hospitals under PHSC. More elaborate hospital-wise indicators are available in the six-monthly and yearly reports. A comparative study is being done to judge the performance of an individual hospital. The efficiency of the hospital is being measured by looking into the increase in the number of out-patients, and in-patients. Likewise the performance of the hospital is being judged by looking into the BOR i.e. bed occupancy rate, average length of stay and bed turnover rate. Also very important efficiency indicators are the number of surgeries, deliveries, and lab tests and diagnostic tests. During the World Bank project, various inputs were provided in terms of civil infrastructure, equipment, manpower and other software activities. With the result, the hospitals under the PHSC have

continuously established increase in their vital performance indicators. Effectiveness of hospitals is judged against a set of core indicators as elaborated above for the hospitals. These core indicators include other important components like; cleanliness, waste management, collection of user charges, availability of life-saving drugs. In the past, regular patient satisfaction surveys were carried out to ascertain the levels of efficiency in the functioning of various hospitals.

Every hospital has a system of monitoring through six-monthly reports and annual reports. A system was introduced to review the functioning of all the hospitals brought under the ambit of the World Bank Project through the monthly review meetings of respective Civil Surgeon and DMCs. The monthly report contains data relating to activity indicators clinical indicators and diagnostic indicators which are as under:

Activity Indicators	Clinical Indicators	Diagnostic Indicators
Admissions	Surgeries	Lab. Tests
Out Patients	Deliveries	X-ray / Ultrasound
Bed Occupancy Rate		
Turn Over Rate		
Average Length of Stay		
Out patient / In patient Ratio		

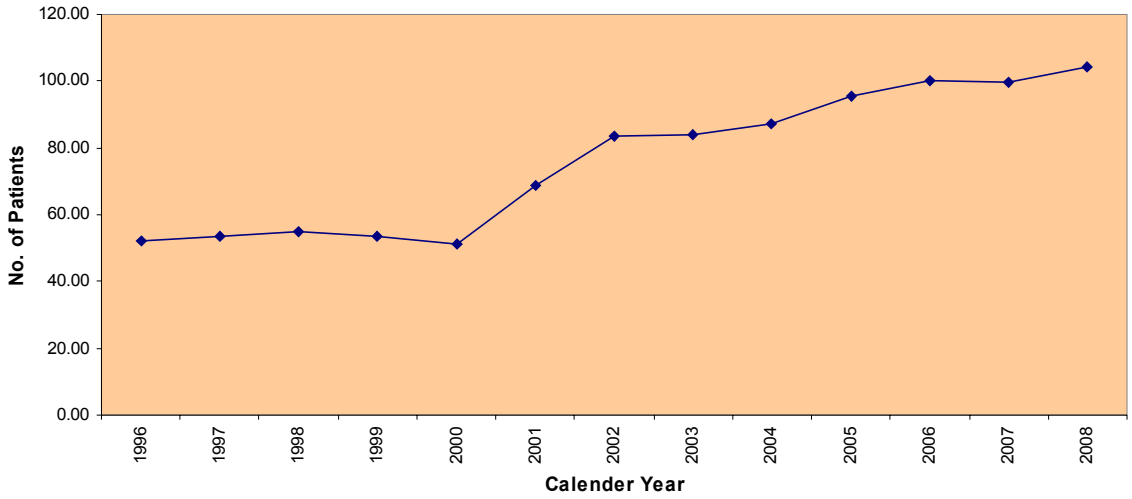
Monthly meetings with the Dy. Medical Commissioners have been conducted to review the performance of each districts. Each DMC reviews the overall performance of the hospitals in the district and SMO In-charge reviews the performance of each specialist doctor in his hospitals against fixed benchmarks.

There is a decrease noted in functional bed strength from the year 2004 to 2007 in some hospitals due to non availability of requisite staff as per norms and civil infrastructure. These hospitals are; Chak Sherewala (22 to 12) Doda (24 to 12) Khanna (100 to 50)

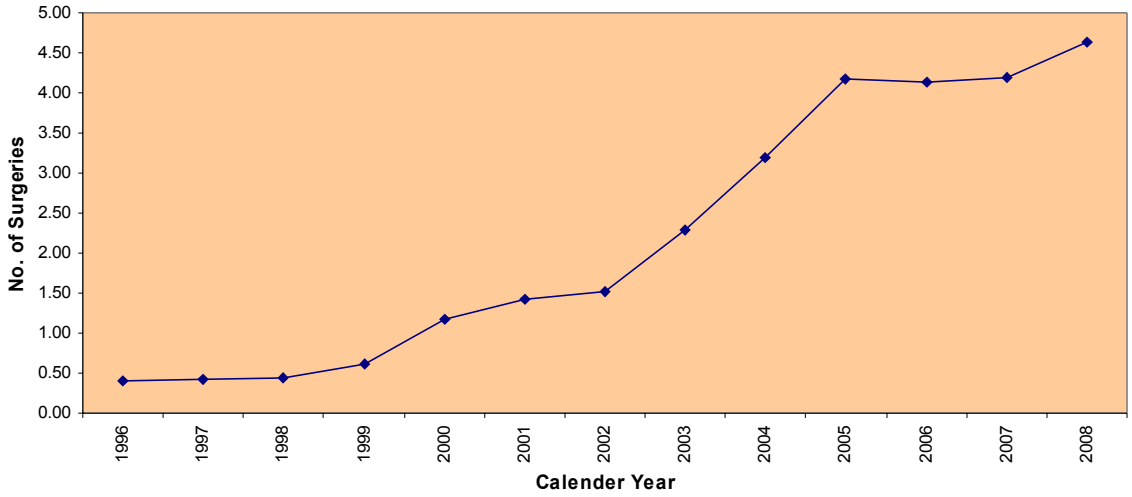
Budhlada (47 to 30) Nabha (150 to 90) Kalo Majra (15 to 6) and Daroli Bhai (30 to 10). Likewise, there is increase in functional bed strength in the year 2008 as compared to 2007 due to increase in the functional bed capacity of the some hospitals i.e. DH Amritsar (50 to 75), Baba Bakala (30 to 50) Talwandi Sabo (30 to 50) Dasuya (50 to 100), Samana (25 to 100) and Bhikhi (0 to 12).

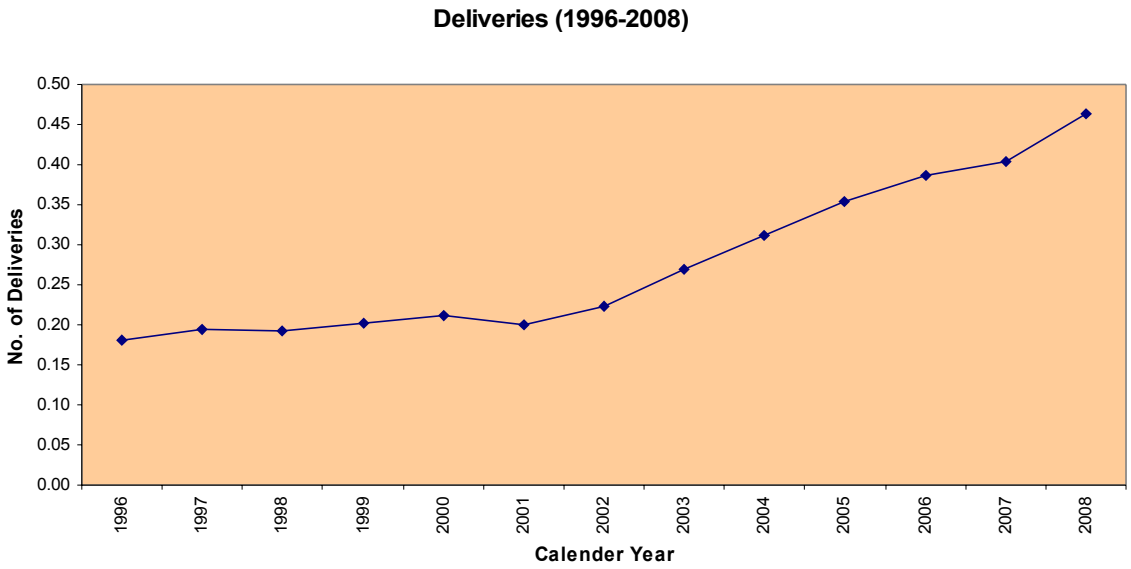
The Committee notes with concern the decrease in the functional bed strength and advocates that the matter should be placed before the Board from time to time. The Committee is also of the view that though there are no performance indicators for tracking emergency services, these should also be included. Details of Emergency Services i.e. Road Accidents, Suicides, Farm Accidents, Burns, etc. should be captured.

OPD Cases (1996-2008)



Surgeries (1996-2008)





3.7.8 GRADING OF HOSPITALS

To compare overall quality of services being provided by hospitals at various levels, a grading mechanism was introduced in the year 2001. The performance of the hospitals is being graded on the basis of a core set of performance and quality indicators. Out of a total 100 marks, 60 marks are for performance indicators and 40 marks for quality indicators. Details are as under:-

i) **Performance Indicators (60)** -- Out patients (5) In patients (10) Minor surgeries (5), Major surgeries (10), Deliveries (10), Radiological Investigations (10) and Lab. Tests (10)

ii) **Quality Indicators (40)** -- Waste Management Handling (5), Availability of vital drugs (5), Cleanliness & Swab Test (10), Availability of doctors & patient satisfaction (10) and User Charges (10).

Initially, six monthly grading was done but from August, 2002, grading has been introduced on monthly basis. The hospitals are being graded and awarded as **A+** (>90%), **A** (75-89%), **B** (60-74%), **C** (40-59%) and **D** (<40%). However, from the data provided by the Corporation it is apparent that the ongoing grading reflects only quantitative aspects.

POSITION AS IN FEBRUARY 2009

GRADING	DH/SH	SDH	CHC	Total
	15	21	23	
A	6	14	50	70
	0	1	26	
C	0	3	6	9
	0	0	1	1

3.7.9 BENCHMARKING OF SPECIALIST DOCTORS

In the year 2002, basic benchmarks for specialist doctors were introduced and are assessed on quarterly basis. This was in keeping with the realization that specialist doctors must perform certain minimum procedures keeping in view the infrastructure made available. These benchmarks were fixed on the basis of the functional bed strength of a particular hospital. For example; it is expected from a general surgeon to perform 25 minor surgeries (excluding vasectomies) and 15 major surgeries (excluding tubectomy) in hospitals with bed strength in excess of 200, 16/12 minor / major surgeries in the hospital more than 100 but less than 200 beds, 14/10 minor / major surgeries in the hospital having bed capacity 70-100 beds, 10 / 6 minor/major surgeries in the hospital having bed strength of 50-69, 6 / 4 minor/major surgeries in the hospital having bed strength of 15-49 beds and 6 minor surgeries in the hospital having less than 15 beds. The benchmarks have been fixed for Medical Specialists, Gynaecologists, Paediatricians, Orthopaedists, ENT specialists, Dermatologists, TB Specialists, Blood Bank In-charges, Radiologists, Pathologists, Anesthesiologists, Psychiatrists and Dentists. Details are placed as **ANNEXURE-XII**. On review of the benchmarks report, it is found that 4-5% specialist doctors have not been achieving their defined benchmarks. Specialist doctors who achieve more than 500% benchmarks are being given appreciation letters. Explanation is sought in of specialist doctors who are not achieving the prescribed benchmarks.

3.7.10 PATIENT SATISFACTION SURVEYS

The first patient satisfaction survey was conducted in the year 1999. Patients visiting the health institutions were given a questionnaire along with a self addressed envelope with prepaid postage to be mailed to PHSC. However, the programme did not succeed because of low response.

On a pilot basis, the first survey was conducted in the year 2000 in 6 District Hospitals by interviewing only IPD patients. This survey was conducted internally by PHSC staff. In Phase–II (in Nov 2000), again a survey was got done through college students in which 17 District Hospitals were taken involving only the IPD patients. In Phase-III (in 2001), formats were revised taking into consideration formats devised under the Karnataka Health Project (KHSDP). 17 District Hospitals, 68 Sub Divisional Hospitals & Community Health Centres were covered.

In the year 2001, a third party survey was carried out to assess patient satisfaction. IIHMR, Jaipur did the survey covering 48 PHSC institutions with a sample size of 2522 OPD patients, 516 IPD patients, 139 Discharged patients, 325 Attendants of patients and 390 Staff members. It may, however be noted that these surveys were neither comprehensive nor representative of all health institutions under the charge of PHSC.

In October 2003 and May 2004, M/s Price Waterhouse Coopers, Kolkata conducted two surveys at a cost of Rs. 22.22 lakhs in all the 154 hospitals, which included 19 District Hospitals, 42 Sub Divisional Hospitals and 93 Community Health Centres. This fairly comprehensive study encompassed a sample size of 5604 OPD and 405 IPD patients during the first survey and a sample size 5150 OPD and 777 IPD patients for the second survey. In these

surveys, satisfaction levels of majority of patients ranged from dissatisfied to somewhat dissatisfied.

	VD	SwD	SwS	VS	Total
	1.27	7.89	66.39	24.45	
	1.82	10.07	80.25	7.86	100

VD –Very Dissatisfied; SwD-Somewhat Dissatisfied; SwS-Somewhat Satisfied; VS – Very Satisfied

The levels of satisfaction/dis-satisfaction varied from District Hospitals to Sub Divisional Hospitals and CHCs on different indicators. In most cases, the satisfaction levels in CHCs and SDHs were found to be below par. Paradoxically, most IPD and OPD respondents reported that they had selected the PHSC hospitals due to skilled doctors, low cost of treatment, good infrastructure and patients expected good behaviour and courtesy from the doctors and nursing staff. Based on the feedback given by respondents during the course of the study, there were various recommendations made by the Consultants for remedial further action by the Corporation. *Ironically, little effort appears to have been made towards implementation of these recommendations. The findings/ recommendations of the PWC survey were not placed before the Board though these were sent to the World Bank*.

In the year 2007, by using the formats finalized during the survey conducted in October 2003 and May 2004 PHSC got the survey done from M/s CRRID, Chandigarh at a cost of Rs. 2.08 lakh. 134 IPD and 363 OPD patients were surveyed in 21 District Hospitals/ Special Hospitals and 41 Sub Divisional Hospitals. *Though the performance of Community Health Centres in the earlier surveys was found least satisfactory, strangely these were not taken into consideration due to constraints on budget.* On analysis of the feedback given by the patients who have also visited private institutions, it was analyzed that 68% patients visiting PHSC hospitals were satisfied as compared to 33% in private hospitals, 24% were neither satisfied nor dissatisfied in PHSC hospitals as compared to 22% in the private hospitals and 8% were dissatisfied in PHSC hospitals as compared to 45% in private hospitals. *The sample size taken was too small and was not covering adequate number of rural institutions where generally the services suffer. Moreover, community-based surveys should be taken for juxtaposing the functioning of PHSC vis-à-vis Private Hospitals by analyzing the perspective of the community rather than interviewing the patients who have come to PHSC hospitals. It needs little reiteration that continuous patients' satisfaction surveys should be conducted on standardized formats to analyze the improvements. Adequate budget allocation should be arranged from the State Government. for conducting patients' satisfaction survey on a regular basis..*

3.7.11 EXTERNAL REVIEWS OF THE WORLD BANK

Twenty World Bank missions visited the State during the identification, preparation, appraisal and implementation of the project activities. The Bank's input right from the beginning remained noteworthy. Step-wise fixation of benchmarks played a crucial role. Benchmarking was done not only as per the Project Implementation Plan but also keeping in view the capacity and

perceived weak areas. A significant role was played by the Bank missions through timely intervention to address the constraints of inadequate and untimely flow of funds at the highest level for corrective measures to ensure timely and effective implementation of the project. A summary of the World Bank Health Mission which visited the State since March-97 to March-04 is enclosed as **ANNEXURE-XIII.**

CHAPTER – IV

REVIEW COMMITTEE STUDY AND FINDINGS

4.1 STUDY

The State Government constituted a Review Committee (RC) vide its notification No. 16/26/96-1HBIV/49, dated 24.9.07 (**ANNEXURE-XIV)** to conduct in-depth review of the PHSC in order to assess the efficiency and an effectiveness of the system. The RC decided to entrust the study to one of its members, the Director of the National Institute of Health and Family Welfare (NIHFW), New Delhi. It was asked to conduct an empirical study based on the protocols finalized by the RC. The expenses incurred by the NIHFW in the conduct of the study were defrayed through a grant from the State Planning Board. The teams of NIHFW selected (using a population proportionate sampling technique) 10 District Hospitals, 10 Sub Divisional Hospitals and 10 CHCs in the 10 districts falling in Punjab's distinct geographical regions i.e. Doaba, Majha and Malwa. Key quantitative information was collected using Facility Survey Checklist, Interview Schedules (for health staff), Exit Interviews of clients and Interviews with other stakeholders. The information obtained was further triangulated with qualitative observations by conducting Focus Group Discussions (FGDs) with the community. Fieldwork for the study was conducted between 15th January 2008 and 5th March 2008. A copy of the study report conduced by NIHFW is enclosed as **ANNEXURE-XV.**

During the study, a survey was conducted to assess the existing facilities with respect to various indicators at each health institution. Also, in order to assess the quality of services, views of beneficiaries as well as other stakeholders like civil servants, elected representatives of that area and health/ hospital administrators were taken. Views of the community residing near the sample health institutions were also taken. Based on the analysis of quantitative and qualitative data, the observations drawn forth are as follows:

4.2 FACILITY SURVEY

INFRASTRUCTURE - Infrastructure wise almost all the hospitals/ health centres under study were easily accessible from the Bus Stop and nearest Railway Station and easily approachable by a motorable road. The building and general infrastructure for all the health care facilities were found to be reasonably well constructed. However, most of the hospitals were not found to be equipped with the required equipment. In some hospitals, equipment existed but there was a mismatch as some were found to be either not in use and some were reported to be out of order. The surrounding of these health care facilities and the cleanliness of the premises, specifically the toilets and general landscape, were not up to the mark. Almost every health facility required serious attention towards this aspect.

MANPOWER - As regards human resources, almost all the hospitals under the study had vacant posts, including posts of doctors and support staff. The doctors posted in these hospitals were from one single cadre. There was no separate cadre for GDMO and Specialists. As a result, particularly in CHCs and Sub Divisional Hospitals, the Specialists were also doing night/ emergency duties and hence were not available for regular OPDs. Doctors, including

specialists, in the hospitals under study were supposed to perform other duties like VIP duties, attend court cases and remain involved in various public health activities and health *melas*. If regular GDMO would have been available, these duties could well be undertaken by them. There was acute shortage of Radiologists, Anaesthetists, Paediatricians and Gynaecologists in almost all the hospitals, particularly in Sub Divisional Hospitals and CHCs. There was also acute shortage of support staff, particularly technical staff in Sub Divisional Hospitals and CHCs. Frequent transfers of doctors without any laid down policy guideline has also been reflected as a cause of concern in these hospitals. For example, in case where a doctor of one specialty is transferred, he/ she was most likely to be replaced by a doctor of another specialty. This disrupts the services for that particular specialty and ultimately patients suffer.

MEDICINE - Regarding availability of medicines, it was observed in all the hospitals and reported by almost everybody that most of the medicines were not available. The patients were found to be purchasing medicines from outside. Though there was a provision of supply from the State and District level, in practice most of these centres reported that they are asked to buy medicines from the User Charges Fund. It was also observed that purchasing medicines from User Charges Fund had become a routine practice in almost every hospital/ health centre under study.

DIAGNOSTIC SERVICES - Though the laboratory and diagnostic services were available in all the hospitals assessed, the functioning of labs was not reported to be up to the mark. Many a times, patients were forced to get the tests done from outside due to lack of reagents and equipment. Regarding radiological services, X-ray Units were found to be non-functional due to erratic electric supply and non-availability of films. Moreover, Radiologists were also not available in all the hospitals.

ROUND THE CLOCK SERVICES - Emergency and Maternity services found to be worst affected mainly in Sub Divisional Hospitals and CHCs. The main reason for this was non-availability of doctors round-the-clock for Emergency and Maternity services. Even Nursing staff was not found willing to perform duties in the night/ odd hours due to security reasons, as other staff and people were not available during night hours. It was revealed that due to non-availability of the staff and other facilities, the patients had to return back from the facility. As a result, the community is gradually losing confidence in the hospitals. This may be one of the most crucial reasons for low utilization of health facilities.

ICUs - Five district hospitals out of ten were reported to be possessing an Intensive Care Unit, while none of the two special hospitals assessed were having this facility. ICU was available at only four SDHs with the bed strength ranging from 2 to 6 beds. None of these ICUs were found to be air-conditioned and were also not having any back up generator support. None of the CHCs had an ICU.

PREPAREDNESS FOR DISASTERS - None of the hospitals, including District Hospitals were found to be properly prepared to deal with any disaster situation. Though almost all the health set ups maintain a cupboard for disaster medicines and consumables none of the hospitals including District Hospitals were having any well-prepared Disaster Action Plan. Nor were they found to be possessing any disaster manual or found to have carried out a mock drill.

REFERRAL SYSTEM - Though on paper all these hospitals are having a well laid down referral system in practice this is not very meticulously followed. Mostly the patients are transferred from the lower health centre to the higher centre without any feedback loop. No guidelines are available at the facilities for "whom to refer", "how to refer" "when to refer" and "where to refer".

DENTAL SERVICES - All the ten district hospitals and two special hospitals covered under the study were having dental services, except the special hospital at Bathinda, where no Dental Department exists. All the sub-divisional hospitals and CHCs were found providing dental services except in two sub-divisional hospitals and four CHCs respectively. It emerges that dental services appear to have received less attention as compared to other medical services.

MEDICAL RECORDS - Seven district hospitals and one special hospital were having a medical record room with enough number of racks. The medical record room was found to be managed by a trained medical record officer or technician in 50% of thedistrict hospitals and both the special hospitals. But none of these Medical Records Departments were properly planned and organized. Most of the data and statistics from Medical Records were found to be maintained manually. None of the Medical Record Departments were found to be fully computerized. Most of the case-sheets kept in the Medical Record Departments were found to be incomplete and mostly not maintained as per any definite standard indexing procedure.

STORES - The Medical Store management was not found to be well organized in keeping with the modern techniques of store management. In almost all the hospitals, only a few medicines could be found in the medical stores of health facilities. The record maintenance of the stores was not found to be in proper order and they were not maintaining any "Buffer Stock" or calculating the "Reorder Level". The scientific 'Inventory Control Techniques' were not practiced in any of the stores visited and the staff was also not having much knowledge about this technique.

OTHER FACILITIES - None of the hospitals were providing regular diet to their in-patients, except in one Subdivisional hospital (Malerkotla). It has been suggested that if the patients are provided diet from the hospitals, this would be highly appreciated. The relatives of the patients, particularly those who are coming from distant places, were not having any proper place to stay (*dharamshala*) and were having no access to other facilities like toilets, kitchen, etc. As a result they were found loitering all over the place in and around the hospital. Similarly, basic facilities like toilets, particularly separate toilets for ladies, were not available in every OPD. The health facilities must also have other services like STD booths, canteen and subsidized chemist shop.

Residential accommodation available to the doctors and staff was not found to be fully utilized, mostly due to poor maintenance of residential accommodation.

RKS- Rogi Kalyan Samitis were reported to have been set up in all the hospitals, but due to their internal administrative problems and non-fulfillment of the required pre-requisites, these Samitis were found to be non-functional or yet to be made functional in almost all the hospitals. Funds under these Samitis were found to be un-utilized in all these hospitals.

4.3 VIEWS OF THE BENEFICIARIES

A total of 580 respondents were interviewed in the Out Patient Department and 224 respondents from In-Patient Departments of various health institutions like CHCs, Sub-Divisional Hospitals, District Hospitals and two Special Hospitals of the Punjab Health System Corporation to obtain their opinion about the available health services.

Majority of respondents utilizing PHSC were females (56.3%) as compared to males (43.7%). Mostly these female patients were having poor education, low income and in the age group of 15-30 years.

More than 3/4th of the respondents were paying user charges for obtaining an OPD card and for getting investigations done. 77.7% of the respondents were not satisfied with the admission procedures and 86.2% of respondents at CHCs and 81% at SDHs rated it poor. Only half of the respondents were aware of the rules and regulation of these health facilities regarding admission procedures.

Overall ratings of general cleanliness of the OPD along with basic facilities were found to be better in the Special Hospitals and the same was comparatively lower in the CHCs. According to the findings, 66.5% rated general cleanliness of wards and beds as good whereas 44.2% respondents rated it average. 66.5% respondents had perceived the cleanliness of bed linen as good, while 30.8% respondents perceived it average. There is a need to *improve the general cleanliness and cleanliness of linen in Sub-divisional hospitals and District hospitals.* Out of various health institutions, 74.1% respondents perceived that the level of comfort in the wards was good but 30% perceived comfort as average, with somewhat better comfort in CHCs and Special Hospitals. Only 47.3% respondents perceived that toilets were clean. This was further low in case of District Hospitals and Sub-Divisional Hospitals.

Facilities like fan and lights were found to be good according to 75.7% of respondents in OPD and 79.5% for in-patients. These facilities were not up to the mark in the OPDs of CHCs, although it was good in the wards of the CHCs. District Hospitals were found requiring improvement for both outpatients and inpatients services. STD/ PCO booths were not present in 57% of health institutions and only 16.7% of CHCs were having STD/ PCO booths out of these health institutions. 14% of health institutions were not having a separate toilet facility which was 23.7% in case of CHCs. 11% of health institutions were lacking in drinking water facilities and again CHCs were found lacking more in context of this facility also. *Separate toilet facilities need to be made available to*

the female respondents, particularly when more number of females is utilizing the services of the OPD of various institutions. 16.7% of CHCs did not have screens in the examination room.

Among OPD patients, 81.4% said that adequacy of information given to them about their disease and treatment by the doctor was good. 69.2% inpatients reported the adequacy of information as good. In the case of OPD, information given was least in CHCs as compared to other institutions, but on the contrary CHCs were found to be better in case of inpatient services.

Only 10.3% respondents stated that all medicines are available in the OPD and 26.4% stated that none of the medicines are available in the OPD. When the percentage was seen separately in the various health institutions, the availability of medicines was reported to be more in Sub-divisional hospitals and the least in District hospitals. In case of In-Patient Department, only 13.4% respondents stated that all the medicines were available and 29% respondents stated that none of the medicines were available in the wards. When the percentage was seen separately in the various health setups, the availability of medicines was found to be more in Special hospitals and least in the Sub-divisional hospitals. Among the in-patients, 91.1% respondents were found to have spent money on medicines and in case of different health institutions, the percentage of respondents who spent money on medicines was as high as 100% at Sub-Divisional Hospitals and up to 69% at CHCs.

Out of all respondents interviewed in OPD, 50.7% stated that the facilities like laboratory and radiological investigations were good. In case of in-patients, 65.6% stated that the facilities such as laboratory and radiological investigations were good.

Overall availability of doctors as stated by the respondents at the health institutions was 94.8%. When respondents were asked about doctor's behavior towards them, 91.4% respondents from OPD and 93.3% from IPD reported that the doctor's behaviour was good. Availability and behaviour of staff were found to be similar in case of specialists. When percentage availability of doctors and specialists were seen separately then it was found lower in case of CHCs and district hospitals among all the institutions. Availability and behavior of nurses was not found to be as good as in the case of doctors. Availability of nurses was found to be 79% and good behavior of nurses in OPD was reported at 64.5%. On the other hand, 80.4% nurses behaviour was reported as good in the in-patient department of various health institutions with lowest in sub-divisional hospitals (67%). Overall, 56.9% staff members' behaviour was perceived as good by the respondents in the OPD of various institutions, which was 74% in case of in-patient services. Behaviour of staff was rated lowest in CHCs as compared to other health institutions. In case of OPD, 2.9% respondents were found to have paid staff members of the hospitals other than user fees for obtaining desired healthcare services.

Time spent in waiting for specialist consultation in the OPD was less than 15 minutes for 63.4% respondents and more than 30 minutes for other 13.9%. In case of investigations, 83.6% respondents were found to have waited for 15

minutes and 6.5% for more than 30 minutes. Waiting time for getting medicines in the OPD was up to 10 minutes for 80.8% respondents. Patients at district hospitals and special hospitals were found to have waited for a longer time period.

Only 46.4% respondents in all the health institutions perceived that the security at these facilities was good, whereas 17% respondents perceived it as poor. It means that more than half of the respondents did not feel adequately secure in the inpatient department. *It underscores the need to augment security in the health institutions with more focus on CHCs and Sub Divisional Hospitals.*

Overall, 75.9% of OPD and 79% of in-patient respondents rated the quality of treatment in the hospitals as good. CHCs and Sub-Divisional Hospitals were rated lower in quality in comparison to the other institutions. Overall, 77.9% respondents in OPD were satisfied with the services of various health institutions. However, only 2.3% respondents were fully satisfied with the services of the OPDs. 22.1% respondents were not satisfied with the services available at the health institutions. 94.2% respondents of the in-patient department were satisfied and only 5.8% were not satisfied with the services of the health institutions. *Overall rating about the cooperation at the reception counter of the various institutions was found to be good but CHCs need to undertake improvements in this regard.* 70% respondents rated their experience at OPD as good while this proportion is only 57% at CHCs. This indicates that services at CHCs need overall improvement.

To sum up, overall experience of respondents at OPDs of the various health institutions under study was not found to be very satisfactory. This observation holds true in particular for CHCs and District Hospitals and merits further attention. A good percentage of respondents felt that the quality of treatment in the hospitals needs to be improved, mainly in the CHCs, as these were in the rural areas and mostly the community was not having any other alternatives for health care.

4.4 VIEWS OF THE COMMUNITY (BASED ON FOCUSED GROUP DISCUSSIONS)

One of the clear responses was that the general administration of the hospital needed rectification. This included cleanliness, recruitment of staff, doctors with specialties, drinking water arrangement, toilets on all the floors and wards, electricity (lightening arrangement), generator, water tank, timely repair of accessories and machines, etc. All necessary medicines should be provided by the hospital. If not possible, at least the BPL families should get this facility. For other patients, subsidized medicines may be a good option. At least in the emergency situation, hospitals should provide every facility like diagnostic services or medicines. It emerged that Surgeons must be made available for emergencies. For strengthening emergency services, ambulances need to be arranged at very minimum rates. Doctors on emergency duty should be available 24 hours. Other responses included that provision for laboratory and ultrasound should be there in every health setup and fees for the diagnostic tests should also be subsidized. It was the strong opinion of the community that private practice of the Government doctors should be stopped.

Among other suggestions that were received was that local community participation should be enhanced for utilization of health services. There was a great need in the community to organize health camps, health *melas*, various health educational activities, etc especially, in far-flung areas. Every village should have a trained *dai* (midwife) and a lady doctor. It was desired that at least delivery facility for pregnant women should be provided by the Government free of cost. If all the facilities with the good doctors were available, people would prefer to utilize these health facilities.

4.5 VIEWS OF THE STAKEHOLDERS

Other stakeholders reported that infrastructure facilities needed to be strengthened and required equipment needs to be provided. Cleanliness in all healthcare institutions should be emphasized. Additional water facilities with clean, treated water should be provided. Plantation in and around the hospital complex should be increased. More equipment for diagnostic facility (i.e. CT scan, MRI) should be made available for poor patients. Technician for Ultrasound must be recruited. Costly equipment should have AMCs. Generators with more power and capacity should be made available to improve functioning, as frequent power failure is a perpetual problem in many areas.

The respondents averred that as salaries of doctors are not very lucrative they go in for private practice. They proposed that more contractual employees are required – especially class IV and lab technicians. Public Private Partnership model needs to be introduced in such facilities. Vacant staff positions should be filled up forthwith. Regular training should be provided to the staff. Manpower shortage, especially that of radiologists, anaesthetists, paediatricians, gynaecologist and obstetricians, along with class IV employees, must be seriously looked into for improving healthcare delivery in Government institutions. Repair and maintenance of staff quarters should be done. Performance linked appraisal should be adopted.

Night and emergency services should be improved and more doctors should be made available. Security guards must be recruited to improve security of in patients. Security services might be provided on contract. Facility in-charge should be given authority to cut down on non-performing staff. Fully equipped ambulance and CT scan should be provided. The 50 bedded hospitals need to be upgraded to 100 beds to meet the community needs. There should be provision of a seminar room in all institutions.

Among their other suggestions were - supply (both quantitatively and qualitatively) of essential drugs needs to be increased and improved for increasing acceptance of the services. Paid wards should be started. Transport services should be improved. More number of ambulances should be made available. A separate vehicle should be made available for SMO for field visits. Telemedicine should be promoted. Health insurance should be made available for poor patients. Awareness of services should be done through media.

4.6 CONCLUSION

In summary, it emerged from interaction with the community, clients and other stakeholders that the HS project has succeeded in building the infrastructure. But its further maintenance, its capacity to address the community needs and satisfaction and provision of quality health care services through public health facilities still needs to be addressed for better utilization of the available resources.

CHAPTER – V

REVIEW OF TEACHING FACILITIES

1.1 The PHSC has under its charge the following teaching facilities:

(a) The State Institute of Health & Family Welfare (SIHFW), SAS Nagar (Mohali).
(b) The Institute of Mental Health (Government Mental Hospital), Amritsar

The State Institute of Nursing and Paramedical Sciences (SINPS) at Badal (Muktsar) was originally set up by the PHSC in 2001. However, in 2008 it was formally transferred to the Baba Farid University of Health & Medical Sciences, Faridkot under the directions of the State Government.

5.2 The Committee visited the SIHFW at SAS Nagar (Mohali) in February 2009. The Institute was set up in 1992 and was upgraded to its present location as part of the WB-assisted project from its earlier premises at Kharar (near Mohali). Since 1st April 2004, the Institute has been functional from its present location. The Committee was led by Chairman Prof. JS Bajaj and included its members Sh. MS Sandhu, MD PHSC, Sh. Tejveer Singh, Special Secretary, Planning and Sh. Satish Chandra, Secretary Planning & Mission Director NRHM (as special invitee). The purpose of the visit was to empirically assess the infrastructure created and appraise the methodology and quality of instruction being imparted there. It is pertinent to mention that NIHFW has done a detailed appraisal of the functioning of the Institute as part of its empirical study.

5.3 The general observations of the Committee on the working of the Institute are summarized as follows:

- Good physical infrastructure has been created at the Institute though the general upkeep deserves to be improved upon. This is especially significant as the headquarters of the PHSC are also housed in the same premises.

- The number and duration of Courses being run at the Institute was found to be satisfactory. However, the methodology of instruction (pedagogy) leaves room for significant improvement. In one class on Vector Borne Disease Surveillance which was visited by the Committee members, participants (doctors) were made to read out the GoI guidelines. Little effort appeared to be made by the instructors to prepare good presentations using different learning aids for better internalization of course curricula.

- The instructors do not appear to have been selected based upon their pedagogical skills. Availability of instructors seems to be the predominant factor in their selection. It is suggested that the Institute must maintain a data bank of the lecturers as well as the feedback received by various in-house or external Faculty.

- The in-house Faculty posted at the Institute must attempt to develop their teaching skills through participating in various Training Development Programmes being run by the Department of Personnel, GoI. The present

capacity of the in-house Faculty was not found up to the mark. For starters,

it is proposed that the Institute may attempt to benchmark itself on the lines of NIHFW as well as imbibe some of the best practices being followed in SIHFWs in other States as well as training institutes of the GoI across the country.

- There does not appear to be any scientific approach to training being followed at the Institute. The Institute must conduct a proper Training Needs Analysis (TNA) of potential participants as well as from their supervisory officers. Likewise, feedback must be obtained both during and at the end-of-the-course for making suitable corrections in the training programmes.

- Special thought needs to be given to undertake training needs assessment of different categories of health professionals and thereafter devise suitable training programmes to address those needs. Presently, training at the Institute is largely supply-driven. For instance, training is being organized as part of GoI sponsored initiatives under various schemes and programmes. The role of the Institute must not be limited to being a crucible for conducting the said programmes. Rather, it must conduct its independent research based upon the courses held and the felt needs of the health sector and thereafter provide independent inputs to the State Government.

- The Institute must pursue with the required seriousness its plans of awarding Certificates and Diplomas for courses run by it in collaboration with the NIHFW. It must also follow to logical fruition its proposal for developing the Institute as a Regional Institute of Public Health for the North Zone.

- Given its favorable location (close to Chandigarh), the Institute must collaborate more closely with the School of Public Health in PGI, Chandigarh and NIHFW to undertake capacity building and have a clear vision to establish itself as the foremost SIHFW in the country within the next 3-5 years.

5.4 The Committee broadly endorses the findings of the RC study team regarding the assessment of the Mental Hospital at Amritsar. The Institute has a long history and has developed a reputation at the all-India level in psychiatry related issues. However, the Hospital has lacked strong political and Government support and its infrastructure is also in dire need of upgradation. It is understood that efforts are afoot to address some of these issues by the State Government.

5.5 The Committee did not conduct any independent appraisal of the functioning of the SINPS, Badal as the same has since been transferred from the charge of PHSC to the Baba Farid University of Health & Medical Sciences. However, the NIHFW report has undertaken a critical appraisal of the working of the Institute as well as a SWOT Analysis. The Committee endorses the findings of the NIHFW team in the matter.

CHAPTER – VI

RECOMMENDATIONS

After examining the backdrop and circumstances that led to the formation of the Corporation, its organizational structure and performance over the years and the empirical study carried out to assess the functioning of the healthcare and teaching facilities under its charge, the Committee makes the following recommendations:

6.1 ORGANIZATIONAL STRUCTURE:

The Committee observed that though the organizational structure and the regulatory structure of the Corporation is good, the operational framework requires substantial improvement. Its observations are as follows:

(a) In order to provide greater focus to the general working of the Corporation, a distinguished medical personality of national repute having vast experience in the management of the health institutions should be appointed Chairperson of the Corporation. This should be legally incorporated for adherence in future.

(b) The posts of all nominated members should be filled on a regular basis. The Corporation must initiate the process of nomination by Government well in time. Further, the Corporation must seek and utilize the expertise of Technical members on issues like Health Management Information Systems. No post on the Board of the PHSC should be left unfilled for a more than one month.

(c) Board meetings should be held regularly, at least once every quarter. The Board must play a proactive role in the affairs of the Corporation and guide its working while allowing sufficient autonomy to facilitate its day-to-day functioning.

(d) An independent Annual Performance Report should be prepared and should be placed before the Board within three months from the close of the financial year. The Report must be comprehensive and give an objective account of all activities undertaken by the Corporation in pursuance of its functions laid down under the Act and its performance in terms of achievements against the targets.

(e) There is a need to enlarge the role of the Board in the functioning of the Corporation. The Committee noted that in the year 2003-04, the Corporation commissioned a patient satisfaction survey by PriceWaterhouseCooper, Kolkata. *The recommendations which emerged from the survey were not placed before the Board nor was any action initiated for further improvement. The Committee observed that all such surveys and their recommendations should be placed before the Board in future.*

6.2 FUNCTIONING OF THE CORPORATION:

HUMAN RESOURCES FOR HEALTH – CONCERNS AND CONSTRAINTS

i) The Health Department and PHSC must evolve a proper and rational HR policy for proper manpower development. This must focus on recruitment, induction training, regular in-service training through short and medium term refresher courses, CMEs, timely promotions and a transparent policy for transfers. Presently, the Health Department is largely engaged in resolving establishment-related problems of its staff leaving little time and energy to focus on improving the delivery of healthcare services in the State. However, it is also well nigh true that these issues have proved to be fairly intractable and various State Governments have attempted to evolve their home-grown solutions for these problems. It is, therefore, proposed that we may examine the initiatives taken by various State Governments and attempt to evolve a comprehensive HRH policy best suited to the State's needs in a time-bound manner.

ii) There is a need to define the role of the Deputy Medical Commissioners who have been positioned at the district level to coordinate the activities of the PHSC. Also there is a need to strengthen the role of the Deputy Medical Commissioners for effective monitoring of secondary level institutions.

iii) The Committee observed that there is a dire need to foster integration between primary and secondary levels in the delivery of health services. The PHSC needs to strengthen its activities and role in the implementation of various National and State Disease Control Programmes, strengthening of Referral Systems and Disease Surveillance. The Committee is of the view that referral transport at block level should be strengthened to handle emergencies in rural areas.

iv) It is important to focus on the importance of re-training of staff at all levels. Issues such as professionalism in doctors' dealing with patients, para-medical staff, clerks or attendants, must be instilled as part of the work ethic in all PHSC hospitals and CHCs. These shortcomings appear as a common strand running across the two studies conducted by PWC in 2003-04 and by the present Committee in 2008-09.

v) The Committee observed that there is an inadequate focus on the training for hospital management and clinical services. Training Needs Assessment should be carried out in order to identify and prioritize the training requirements in the hospitals. Also there is a need for effective coordination with the Medical Colleges for training. A comprehensive policy should be designed to strengthen training capacity in the Medical Colleges.

vi) The Committee observed that under the Telemedicine project, linkages have been established with the Medical Colleges and PGIMER,

Chandigarh. The Committee is of the opinion that under this project, in order to provide continuing medical education (CME), steps should be taken such that CME is extended to district level hospitals. The efforts should also be made to strengthen the libraries at District and Sub-Divisional Levels. Doctors should have the facility of access to medical journals through E-Libraries.

vii) An assessment should be done for the State of Punjab to find out the staff position for all categories of health workers, including doctors. Moreover, based on IPHS norms, posts for GDMOs and other essential categories of specialists may be created and filled up. Availability of basic specialists in the respective health centres would help develop confidence in the community and result in increased utilization of services. Urgent efforts may be made to fill up all vacant positions.

viii) The Committee is conscious of the fact that it may not be possible to create separate cadres for administrative posts at district, sub-division and CHC levels. Yet there is a need to ensure that specialists (when scarce in number) are not assigned these responsibilities, thereby compromising their clinical work in hospitals.

ix) As reported, salaries of the doctors under PHSC were not at par with the private sector and this could be one of the reasons for the high attrition rate among doctors. Performance-based incentives may be considered for retaining existing specialists. The State Government may also explore the possibility of enlisting the services of private practicing specialists/ consultants in disciplines where specialists in Government are fewer (such as anaesthesia) through a workable public-private partnership set up. This exercise can be done under human resource innovation which is one of the components in the NRHM. A similar performance assessment system was already in practice i.e. 'Bench Marking'. Also by this method, it may be easier to retain specialists in disciplines like radiology, anaesthesia, paediatrics, gynaecology, etc.

x) To increase the utilization of facilities, the Government may consider starting evening OPDs on a pilot basis. On an experimental basis, these may be started as Pay Clinics. A substantial share of the earning from these Pay Clinics may be apportioned to the clinicians while the rest could be divided as honorarium for support staff as well as contribution to the Rogi Kalyan Samiti funds. It would also help partly defray overhead costs. The amount paid to the doctors as honorarium may be in proportion to the number of patients they are attending.

(The Hon'ble Chairman has observed that in the past, the Government had started such pay clinics but due to certain administrative problems, this scheme was discontinued in Medical Colleges).

EQUIPMENT AND SUPPLY ISSUES

xi) Regarding availability of drugs at all health care institutions, the beneficiary had basic expectations that medicines, particularly essential

ones should be provided by the health facility. Moreover, it is a moral obligation on the authorities to supply at least life-saving and essential medicines. Therefore, it is recommended that every health centre should prepare a list of medicines (drug formulary) to be used at that centre and send it to the concerned authorities for procurement/ indent. At the State level, these lists of drugs, coming from various types of health facilities through their respective district headquarters should be compiled and a common list prepared. Applying scientific Inventory Control Techniques of ABC and VED analysis, a list of all life-saving and essential drugs as well as more expensive ones (which shall not be more than 20% of the total procured drugs) can be drawn up for purchase and supply. These medicines should be procured at the state level and distributed to the districts for onwards supply.

Alternatively, the state may fix up the rate contract for each item after following the laid down procurement procedures for drug items and supply this information with the required authority letter to the respective districts so that they can directly procure these medicines from the suppliers at rates fixed by the Department using Rogi Kalyan Samiti funds (as and where they have become optimally functional) or user charges. By this partially decentralized procurement, the availability of medicines will definitely improve the quality of the medicines can also be ensured. This will also involve the local community in the affairs of the hospital.

Every hospital/ health centre should have a proper antibiotic policy and standard treatment protocol along with a regular prescription audit. There is a need for strengthening of Rogi Kalyan Samitis at hospital levels.

The Committee advises the Corporation to examine the feasibility of adapting the Tamil Nadu Government model which has come to be recognized at the national level as a successful and sustainable model. Tamil Nadu Medical Services Corporation Limited (TNMSCL) supports the Government by arranging timely high quality drugs, medicines, surgical and suture items for around 11000 institutions, which include all Medical Teaching Intuitions, Secondary Level Hospitals, Primary Health Institutions, ESI Hospitals, Panchayat Union Dispensaries, Prisons, Maternity Institutions and Local Body Medical Facilities.

xii) The committee was of the view that the Corporation may like to consider the need to provide essential medicines free of cost to all BPL patients. Similarly, it may also be examined whether delivery facility can be provided free of charge by the Government. This is especially relevant given the Government's mission under NRHM to increase institutionalized deliveries to lower MMR and IMR.
Taking cognizance of these deliberations, the Government has started giving free delivery services to all pregnant women in its hospitals w.e.f. 1.11.2008

Apart from this, a concept for creating requisite infrastructure within the hospitals for providing generic medicines at reasonable prices round the clock to public should be promoted. Though PHSC has taken initiatives for opening of Jan Aushadhi Stores in the premises of the

District Hospitals (already opened in 13 districts and in 7 districts, they are likely to be opened by December, 2009). This initiative should be extended to Sub Divisional Hospitals and Community Health Centres. Also, doctors should be encouraged to prescribe generic drugs to the public.

xiii) In respect of Diagnostic Facilities, efforts must be undertaken to ensure that all the required reagents and equipment in the laboratories are made available at any given time. However, this must be followed by systemic improvements to ensure sustainability and there must be a proper appreciation of these issues at the State level. For special investigations that are not carried out in the respective centres, the authorities may consider a tie-up with private laboratories at pre-negotiated, fixed rates and ensure quality control norms. With these arrangements, beneficiaries can be referred to these laboratories at negotiated Government rates and would be saved of exhorbitant costs. For poor patients, health facilities may offset these charges from the funds available under user charges/ Rogi Kalyan Samitis.

UPKEEP AND MAINTENANCE OF INFRASTRUCTURE

xiv) The Committee observed that there is a need for monitoring the up-keep of equipment and its utilization and the following immediate steps should be taken.

i) Efforts should be made to condemn non serviceable equipment.
ii) The categorization of equipment should be made based on their value and importance.
iii) Log books for each vital and important equipment should be maintained.
iv) Continuous hands-on training should be given to the staff using the equipment.
v) The Committee also observed that there is a mismatch between the equipment and manpower. In order to improve utilization, mismatches should be removed.
vi) A comprehensive policy should be prepared to ensure the proper upkeep and utilization of the equipment.

xv) There is a need for concerted effort to improve the general upkeep, cleanliness and landscaping of these institutions. The element of supervision needs to be introduced at multiple levels with the final responsibility being that of the head of the facility. The findings of the Review Committee's empirical study have elucidated these shortcomings quite succinctly. A training capsule focusing on roles and responsibilities of various levels of administrative staff could be developed by the SIHFW and rolled out to cover the concerned doctors and staff over one/ two years. For house-keeping and sanitation, PHSC could consider outsourcing some of its services to professional organizations of repute with experience of working in health facilities. Fire-safety norms need to be complied with meticulously along with

carrying out of mock-drills for proper emergency response to meet with any eventuality.

xvi) Satisfaction levels have been found to be lowest in Sub Divisional Hospitals and Community Health Centres. Basic infrastructure like lights, fans, STD PCO booths, drinking water facilities, toilets, etc need to be urgently brought at par with the best in the country given the fact that there has been a substantially higher outgo on maintenance in the past few years. The Committee would like the PHSC to specifically address certain gender concerns by way of ladies' toilets, screens in examination rooms, etc. given the increasing number of women availing services.

xvii) Proper and well-maintained residential accommodation for doctors and other staff may be provided at all levels of health centres. Security in the health institutions needs to be improved with more focus on CHCs and sub divisional hospitals.

xviii) Every Hospital should have a Hospital Infection Control Committee. There should be regular and focused clinical rounds in all the health centres i.e. CHCs and above. This should be attended by all doctors.

MEDICAL RECORDS AND HMIS

xix) There is an urgent need to improve the working of the Medical Records Department in these institutions. The information in medical records helps the hospital administrator monitor the utilization pattern in his institution and take corrective action for optimizing performance. All PHSC facilities must adopt and implement standard IPHS protocols following standard indexing systems to make future retrieval of records easy. In addition, every hospital should come out with a statistical bulletin, which should include some of the important hospital utilization indices such as bed occupancy rate, average length of stay, bed turnover interval, gross and net death rate, etc.

xx) Admission procedures need to be improved and made more transparent with greater focus on CHC and Sub Divisional Hospitals. The entire gamut of issues related to needs of patients and their attendants, highlighted in NIHFW's report, should be carefully examined and implemented in a time-bound manner.

xxi) The HMIS implementation needs to be made more broad-based to be able to capture the qualitative aspects of hospital functioning, besides the quantitative assessment on select indicators being carried out currently. PHSC would be well advised to review the original plan suggested by TCS in 1997 (which was only partially implemented) given the technological advances in the field of ICT in the intervening decade. Secondly, the need for a dedicated and committed systems expert on the BoD cannot be over-emphasized. The Corporation must mainstream this concern in order to ensure sustained improvement in its performance.

EMERGENCY SERVICES

xxii) The need for improving round-the-clock emergency services cannot be over-emphasized. These must be equipped with required strength of doctors and support staff and doctors may be posted in these hospitals particularly at sub divisional hospital and CHC exclusively to run emergency services. These emergency services must be equipped with round-the-clock doctors as well as essential diagnostic services and life-saving medicines. Related issues pertaining to providing adequate security at night also deserve careful consideration.

xxiii) Similarly, emergency obstetric services need to be made available at every level. Hence efforts should be made to ensure that every hospital, atleast upto the CHC level, should have one gynaecologist with all ancillary support facilities. A model of public private partnership like the one followed in Gujarat (Chiranjeevi scheme) may be looked into for strengthening maternity services.

EMPOWERING CITIZENS

xxiv) There is a strong need to empower citizens through community education. Every hospital/ health centre should clearly display the Citizens' Charter and the name, designation and telephone numbers of the concerned officers whom a complainant can approach with a dispute or complaint. The beneficiaries should also be informed about the routine procedures they are expected to follow in that health centre as also their rights, through low cost brochures/ hand bills.

6.3 CONVERGENCE OF FLAGSHIP PROGRAMMES

xxv) Both national missions, viz. the NRHM and the proposed NUHM, aim to address the health concerns of the poor by facilitating equitable access to available health facilities and strengthening of existing capacities. The NUHM will rely on institutional structure of NRHM for administration and operationalization of its activities.

PHSC can play a vital role in empanelment of secondary level and tertiary level private hospitals. Further, the PHSC's secondary level hospitals can be an effective tool for community outreach services in urban areas i.e. implementation of various National and State Disease Control Programmes supporting referral from the first referral urban institution. This activity can be made more effective by establishing outreach points.. Already, Punjab has tested a successful model at Amritsar which has received appreciation at the national level.

Here, the Committee would like to draw the attention of the Corporation towards the present dichotomy between the working of the institutions under its charge and the implementation of major National Programmes. Effectively, all secondary health care (from CHCs to District Hospitals) has been placed under the Corporation's charge which forms the bulk of the healthcare delivery system in the State. However, implementation continues to be the responsibility of the Civil Surgeon at the district level and Director Health Services at the State level. It is high time that a closer integration is achieved between

primary healthcare and secondary healthcare systems to implement National Health Programmes and help Punjab attain its desired goals.

6.4. NEED FOR PROMOTION OF PUBLIC PRIVATE PARTNERSHIPS

The State Governments do not have adequate funds to invest in infrastructure development of more secondary or tertiary level hospitals. Even if states have made investments in health infrastructure through externally aided projects, such improved facilities also tend to run down rapidly in the absence of adequately funded maintenance systems. Public awareness and expectations from health services provided by the Government are rising rapidly making the management of public health systems and programmes more challenging than it was earlier. Public-private partnerships in the health sector can supplement the Government's efforts in several ways enumerated below:

- Increasing the number of people receiving health services
- Conservation of scarce public resources and targeting them for the poor
- Source of revenue for the private and public sector partners
- Ensuring regular supply of medicines
- Improved infrastructure and facilities
- Easing the pressure on the public sector

There is a need for identification of available surplus land in the existing hospitals and utilizing it for more and more public private partnerships.

6.5. REDUCTION IN HEALTHCARE EXPENDITURE OF CITIZEN

The PHSC can play a vital role by promoting community health risk pooling and health insurance as a measure for protecting the poor from the impoverishing effect of illness. This can be done by introducing Community Health Insurance. In the State, there are two health insurance schemes under implementation i.e. Bhai Ghanaya Scheme meant for cooperative sector members, and, another Rashtriya Swasthya Bima Yojana meant for the BPL population. Both the schemes have their own merits and reservations. There is a need for development of a new scheme having benefits of both the schemes and the funds being received by the State Government from public private partnerships arrangements can be used for cross subsidizing the funding of the premium of the scheme to be framed.

To sum up, the Project has succeeded in building healthcare infrastructure. However, the test now lies in sustained use of the created capacity while addressing community needs and providing quality healthcare services through optimal utilization of the available resources. The empirical study carried out by the Committee has highlighted the deficiencies in the delivery system which need immediate attention and sustained corrective action.

CHAPTER – VII

CONCLUSION

"It is better to light a candle than to curse the darkness" - Old Chinese Proverb.

7.1 The Review Committee has attempted to conduct an objective critique of the working of the Punjab State Health Systems Corporation. The present Report comes almost a decade-and-a-half after the launch of an ambitious World Bank-assisted project to upgrade and improve the delivery of secondary healthcare services in Punjab. The present exercise is, therefore, most timely and hopefully, an accurate and unbiased assessment of the relative success and failures of the project.

7.2 The Committee felt it imperative to undertake a meaningful study at an empirical level of the functioning of hospitals and other health institutions under the charge of the PHSC. Of course, there were earlier evaluation studies carried out by various institutions that could have formed the basis of the present report. However, it was the considered view of the members of the Committee that in view of the mandate given by the Government, it was essential to have contemporary data with a substantial sample size in order to base findings that could be considered truly representative for the State of Punjab. Hence, it was decided to entrust one of the members of the Committee, viz. the National Institute of Health & Family Welfare, New Delhi to carry out the study. The findings of the study have provided reliable primary data for the Committee to undertake an objective analysis.

7.3 The performance of the PHSC is a story of both notable successes and lost opportunities – the tale runs almost as parallel strands when one analyses the realization of the aims and objectives of the project. To use the popular IT idiom, successes have been registered on the "hardware front" whereas on the "software front" the picture is not so heartening. There has been marked improvement in the physical infrastructure of the secondary-level healthcare institutions entrusted under the charge of the specially-created Corporation. However, operational issues still continue to retard the effective working of these institutions. The general upkeep, cleanliness and house-keeping of these hospitals have not attained the levels of excellence expected after infusion of major capital to each of these entities.

7.4 On the other hand, while examining manpower issues, procurement of essential medicines, incremental additions of specialized medical and diagnostic equipment and most importantly, monitoring and automation, the Committee could not find the commensurate improvement. The empirical study, referred to earlier, provides a detailed mirror image of the current performance on each of these aspects of the working of the Corporation. It is pertinent to add that most issues highlighted in an earlier study conducted by Price Waterhouse Coopers in 2003-04 still continue to be major areas of concern half-a-decade later. Professionalism, which the project aimed to infuse over time through capacity-building of existing manpower, does not seem to have penetrated to the desired levels. Of course, it would be unfair to lay the blame entirely at the door of the Corporation as many of the problems it is beset with are related to larger concerns that have now bothered the

successive Governments in the State – depleted manpower, lack of sound human resource development policy for health professionals and the like.

7.5 The Committee would like to suggest for the consideration of the State Government that greater thought must be given to issues related to capacity building of the employees, both doctors and para-medic staff. It has been also proposed that the Corporation must be headed, as its Chairperson, by a health professional of national repute, as had been originally envisaged by the legislature. The Managing Director, who is expected to be an IAS officer, must be carefully selected based upon the officer's aptitude and domain knowledge of the health sector. These senior leaders are expected to impart the necessary dynamism to the working of the Corporation, each complementing the other. A progressive reform in the way manpower issues are handled by the State Government would surely help launch the State into a higher orbit of achievement. In our opinion, the current mismatch between Punjab's economic development and its performance on health and related indicators can effectively be corrected over the next decade or so.

7.6 The Committee would like to place on record its sincere appreciation of the Hon'ble Chief Minister of Punjab who displayed the resolve and foresight to have the present study undertaken in order to prepare a road map for future and take remedial measures. While, on the one hand, it needs to be underscored that the concern of the State Government to improve the state of healthcare is indeed transparent, on the other, the need for dedicated and coordinated action cannot be over-emphasized today as the health sector across the country is the recipient of major funds under national flagship programmes. From the on-going National Rural Health Mission to the ensuing National Urban Health Mission, the health sector is today poised for a quality push forward. PHSC, with the gains accumulated over the past decade, must consolidate and emerge as the country's foremost achiever in the healthcare sector and help Punjab attains its rightful position of pre-eminence in the country.

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