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EXTERNAL ASSISTANCE FOR HEALTH SECTOR: TRENDS AND IMPACT DURING ECONOMIC REFORMS, WITH A SPECIAL REFERENCE TO ORISSA

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1. Introduction

External assistance to the Indian health sector is not new. Considering the under-developed nature of health services in many parts of the country, major external donor agencies with a strong health sector commitment have been assisting in areas that range from systemic processes/institutions (like increasing infrastructure for primary health care, improvement of second-tier health system, etc.) to specific disease-oriented interventions (like eradication of leprosy and tuberculosis, blindness control, HIV/AIDS control, etc.).

1.1 Statement of the Research Theme and Its Relevance to Economic Reforms

From the discussions that follow, it will come to one's knowledge that during 1990s, the number of external agencies making health sector intervention in India, at both the national and state levels, steadily increased. Correspondingly, the volume of funds from these external sources has grown substantially. Immediately, the question that comes to one's mind is that why this has happened and whether there a link between the economic reforms process in the country and the increase in external assistance for the social sector. Going further, one would be interested to know whether there has occurred any perceptible improvement in the performance of the sectors that have been externally assisted in a major way during the reforms period? In case of the social sectors, where it is hard to evaluate performance in quantitative terms, has there been any change in service quality or delivery mechanism because of externally assisted projects? Has this led to any improvement in crucial process-related and performance indicators? Do the external donor agencies set any priorities before giving funds to the state governments? How the funds from the donor agencies flow to the states? Considering the focus of the present study, the above concerns translate themselves to the basic research theme of **an analysis of the trends and impacts of external assistance to the health sector during the economic reforms period,** i.e. the post 1991 scenario. The analysis is almost exclusively based on the experiences of the health sector in Orissa. *Besides being one of the least developed states in the country, the experience of Orissa is unique in the sense that it has received a lot of attention from a major donor agency and that this involvement on the part of the donor so far covers a period of over 20 years and it will continue at least for another 7 years.*

1.2 Methodology, Objectives and Outline of the Study

The data and information for this study has been generated from secondary sources, interviews and discussions. Secondary sources include Annual Reports of the Union Ministry of Health and Family Welfare, Evaluation Reports of Various Health Sector Projects in Orissa, External Assistance Brochure of the Department of Economic Affairs, Family Welfare Yearbook of the Union Ministry of Health and Family Welfare, etc. A number of health sector professionals – medical and non-medical – were contacted to gather a lot of unwritten/ unrecorded information. With Orissa as the state under reference, the specific objectives of the study are:

i. To identify the sources of external assistance to Orissa's health sector and the procedure and steps involved with obtaining external assistance;
ii. To analyse the trends in the flow of external funds during the reforms period as compared to that during pre-reforms period;
iii. To highlight reforms period 'shifts', if any, in approaches of donor agencies for assisting the health sector of Orissa;
iv. To profile linkages between economic reforms, external assistance and health sector reform initiatives, if any, during the last decade at the state level; and
v. To evaluate the impact of external assistance on the health sector of the state in terms of selected input and output indicators.

It is very important to mention here that detailed information pertaining to externally assisted projects/programmes is hard to obtain, particularly at the state level. There is one External Assistance Brochure (2000-2001) prepared by the Department of Economic Affairs (DEA), Ministry of Finance, which claims to have given the information pertaining to all the projects supported by external assistance source-wise since the first Five Year Plan. But the difficulty is, the amount of grant/loan given by each agency/country has been reflected in terms of its own currency (say, Dollar or Yen or Franc). Thus, for any year, a comparison of the levels of assistance from different countries/agencies requires a conversion of the stated amounts to rupee terms, which in turn, needs the data relating to the exchange rates of rupee in terms of different currencies for that particular year. Moreover, though this Brochure claims that data pertaining to all externally assisted projects has been profiled, it is actually not so. The researchers have found out at least a couple of cases where particular externally assisted projects have not been mentioned in the document.

One would usually expect that each year's Annual Report of the Union Ministry of Health and Family Welfare would profile the amount of external assistance given to various States for different projects during that particular year. But there has been no attempt by the Ministry to give data in a coherent form. Although some data is given,

the presentation is very confusing. In fact, when one of the researchers approached one 'Section Officer' (International Health Division) of the Ministry to obtain some data, the 'Section Officer' advised the researcher to approach the DEA and confided that in order to answer a relevant Parliament Question, they themselves had to approach the DEA. Although the 'Officer' showed some data on external assistance obtained from the DEA, he refused to part with it citing breach of secrecy. Actually, many officials sitting at various ministries show a very difficult attitude in sharing information that should by all accounts be in the public domain. But there are a few who offered ready help.

Collecting data on Orissa's health sector initiatives was a very difficult affair. Maintenance of records or documenting information is a great problem in the State and even if some information is available, the custodians of such information struggle to share it. But some good people in the Government set up gave very encouraging response and shared some of the available information.

2. Economic Reforms and External Assistance: General Trends in the Indian Context

If one glances through the External Assistance records of the Department of Economic Affairs, Ministry of Finance and Annual Reports of the Ministry of Health and Family Welfare, one would come to know that prior to the launching of the economic reforms programme in India[1], only a few countries provided financial assistance for health sector projects in the country. Notable among them are, Denmark (DANIDA), United Kingdom (ODA/DFID) and the United States of America (USAID). But the number of countries investing in the health sector of India has increased after the economic reforms programme in India took off in a big way in the early part of the 1990s. Now, countries like Canada, Germany, Japan, Netherlands, and the European Union have come forward to fund health sector programmes in our country. International agencies, especially those belonging to the UN System, like the WHO and the UNICEF always invested in the health sector of India as they are doing now. However, WHO operates only through the Ministry of Health & Family Welfare, Government of India, while UNICEF operates through the Ministry of Health & Family Welfare of the Centre and the States, Department of Women and Child Development of the Centre as well as of the States and also through NGOs at the national and state levels.

2.1 Trends in the Flow of External Assistance

Table-1 presents a summary picture

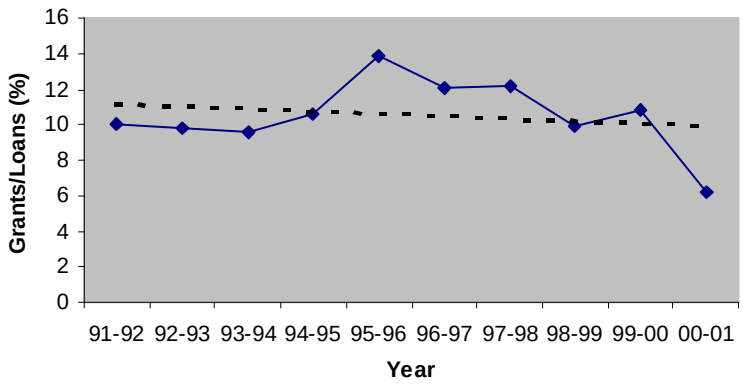
[1] The present study takes 1991 as the dividing year to distinguish between the pre-reforms and reforms periods. Though the roots of the reforms process in India can be traced way back to the 1970s, it is generally accepted that comprehensive and large-scale structural adjustment measures were introduced in 1991.

relating to the loan component of the year-wise external assistance flows to the account of the Central government from all sources for the period 1991-92 to 2000-2001. While the summary table does not provide any sector-specific particulars, still there is enough information to draw some important insights on the general trends in the flow of external assistance to the country. First, it is important to note that, for the period 1991 to 2001, the grants component of external assistance relative to the loan part shows a slowly declining trend in the country (Figure-1). This may be representative of the donor agencies' attempts to apply a squeeze on the softer side of their assistance to the country during the reforms period. An issue that emerges out of this for further research is that whether the external donors have followed a pattern in this regard, and if so, which are the sectors that have been favoured or discriminated against.

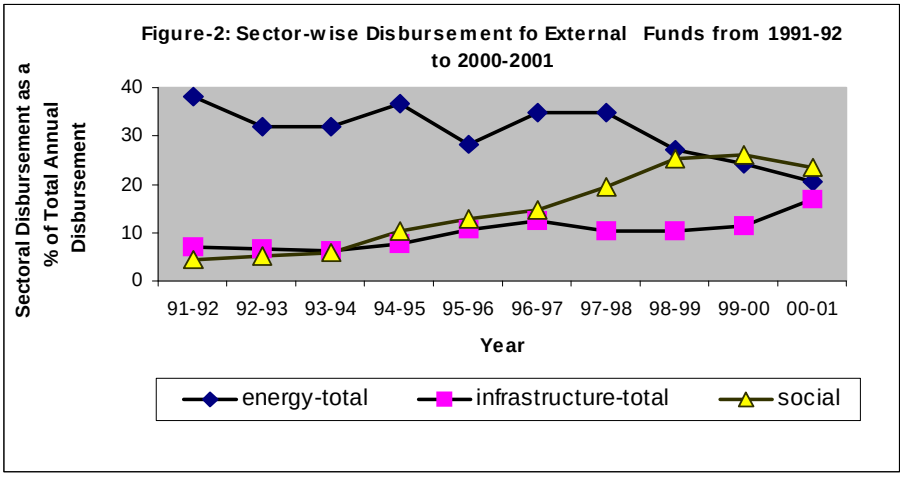
The second insight that one may draw from Table-1 relates to the trend in the average interest rate in the last decade. From a level of 4.17 in 1991-92, the average interest rate on the external loan assistance to the Government of India is seen to have experienced an almost continuous decline to the level of 2.53 in 2000-2001. While this may have acted as an incentive for the central government to give the go-ahead signal to the state governments or central-line ministries in their quest to try for more and more external assistance over the years, one should also take note of the simultaneous decline in the average maturity (in terms of years) on new loan commitments by the donors (Table-1).

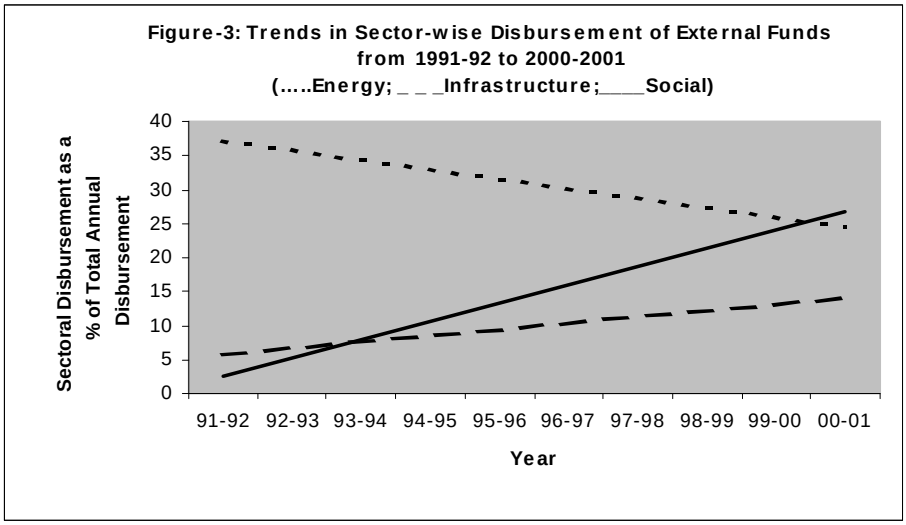
Sector-specific data on the central government's disbursement of loans and grants obtained from external sources are presented in Table-2. Unfortunately, for the

Figure-1: Trend in the Grants/Loans (%) Indicator of External Assistance to India from 1991-92 to 2000-2001



social sector, the data is available for all the services taken together and hence, there is no way to analyse the trends in the flow of external funds to the health sector in particular. Still, it is interesting to note that during the reforms period, external assistance to the social sector as a whole has increased sharply, particularly in the later half of the 1990s. In Figure-2, the annual disbursement of external assistance to social sector (as % of the total annual disbursement of external funds) for the period 1991-92 to 2000-2001 is compared with similar percentage figures derived for the energy and infrastructure – two major non-social sectors to have benefited from external assistance. As the trend lines corresponding to the three sectors reveal in Figure-3, during the reforms period, the social sector has experienced a dramatic increase in the external funds disbursed to it as against the declining trend in case of the energy sector and relatively slowly increasing trend for the infrastructure sector.





2.2 External Assistance to the Health Sector in India

Besides the increase in the number of external donors providing assistance to the health sector in the country, there has also occurred a significant increase in the range of their activities within the sector itself. This is illustrated with reference to one major donor agency – the World Bank. Prior to the 1990s, the World Bank had provided health related assistance to only one project (which was implemented in several phases) in India in the name of India Population Project (IPP). The Bank's assistance under this programme is still continuing and so far 9 such projects have been completed in various states and cities like West Bengal, Delhi, Karnataka, Maharashtra and Tamil Nadu. However, it is very interesting to note from the available records (Table-3) that after the launching of the economic reforms process in India, the Bank (through its human development wing – IDA) has started financing a number of national level projects like Child Survival and Safe Motherhood Programme, AIDS Control Programme, Family Welfare (Urban Slum) Project, Cataract Blindness Control Project, Leprosy Elimination Project, Secondary Level Health Systems Development Project (in 8 States), Malaria Control Project, Reproductive and Child Health Project and Woman and Child Development Project.

Table–3: World Bank Aided Health Sector Projects in India over the Years

Sl. No.	Name of Project	Year
1	IPP-I	1972
2	IPP-II	1980
3	IPP-III	1984
4	IPP-IV	1985
5	IPP-V	1988
6	IPP-VI	1989
7	IPP-VII	1990
8	Integrated Child Development-I	1990
9	Child Survival & Safe Motherhood	1992
10	National AIDs Control-I	1992
11	Integrated Child Development-II	1993
12	IPP-VIII	1993
13	IPP-IX	1994
14	Family Welfare (Urban Slum)	1994
15	National Leprosy Elimination	1994
16	Cataract Blindness Control	1994
17	AP Health System Development	1994
18	Karnataka Health Systems Development	1996
19	National Malaria Control	1997
20	Reproductive & Child Health	1997
21	Orissa Health Systems Development	1998
22	National AIDS Control-II	1999
23	Women & Child Development	1999
24	Maharashtra Health Systems Development	1999

Source: Brochure on 'External Assistance' 2000-2001, Ministry of Finance, GoI.

The flows of external assistance to the health sectors in different states of the country differ in terms of (i) the number and profiles of the donor agencies involved; (ii) the magnitude of assistance; and (iii) the range of activities/systems assisted within the sector. It would be enlightening to know the specific influences working on a donor agency's decision to invest in the health sector of a particular state/region. In the absence of any specific information on this, the next best thing would be to study the patterns of external assistance at the state level over a period of time by a particular donor and from it to draw certain pertinent insights. In this context, it is thought useful to present a comparative picture of the trends in external assistance to the health sectors of three states of the country – Maharashtra, Karnataka and Orissa – which differ significantly from each other in terms of the level of economic development. While Maharashtra ranks among the most developed states in the country in terms of its per capita State Domestic Product (SDP), Orissa comes across as one of the least developed and Karnataka in the middle category on the basis of the same development indicator. It is thought relevant to examine the possible links between external assistance to a social sector such as health and the level of development of a state.

Table-4 gives the details of health sector projects implemented with external assistance in the three states, i.e. Orissa, Karnataka and Maharashtra. It is very important to mention here that the projects given in Tables-4 & 5 have been carried out with the help of the respective sponsoring agencies directly in the three states. However, external assistance routed through the Ministry of Health & Family Welfare, Government of India in the form of Central Assistance are also provided to the states through normal budgetary support. This kind of support has especially been provided in case of National Programmes like Pulse Polio, TB Control, Leprosy Control, Blindness Control, etc. However, it was very difficult to track the external assistance data for individual states with respect to the National Programmes, because it has not been reflected in any relevant government document.

Table–4: Details of Externally Aided Health Sector Projects (completed and on-going) in Orissa, Karnataka, and Maharashtra

Sl. No.	Name of Donor Agency	Name of Project	State	No. of Districts	Project Cost (in Rs. Crores)	Period of Operation
Completed Projects						
1	World Bank	IPP – I	Karnataka	5	9.83	1973-80
2	USAID	-	Maharashtra	3	15.83	1980-86
3	ODA (UK)	OHFWP – I	Orissa	5	33.67	1980-87
4	World Bank	IPP – V	Maharashtra	Mumbai	71.45	1988-96
5	ODA (UK)	OHFWP – II	Orissa	5	77.25	1989-96
6	World Bank	IPP – VIII	Karnataka	Bangalore	39.23	1993-98
7	World Bank	IPP – IX	Karnataka	State-wide	114.75	1994-2001
8	UNFPA	-	Maharashtra	5	38.36	1989-96
9	KFW & GTZ (Germany)	-	Maharashtra	4	47.9	1996-2001
10	DFID	OHFWP – III	Orissa	2	23.3	1997-2002
11	World Bank	Secondary Health System Programme	Karnataka	State-wide	546	1996-2001
Ongoing Projects						
12	UNFPA	IPD	Maharashtra	-	33.67	21-12-98 Onwards
13	UNFPA	IPD	Orissa	-	25.2	04-06-99 Onwards
14	World Bank	RCH	Orissa	1	15	-
15	World Bank	RCH	Karnataka	1	15.05	-
16	World Bank	RCH	Maharashtra	1	13.78	-
17	KFW (Germany)	Sec. Hosp. Programme	Karnataka	4	45	1997-2002
18	DANIDA (Denmark)	T. B. Programme	Orissa	-	31.95	-
19	World Bank	Secondary Health System Programme	Orissa	State-wide	41.6	1998-2003
20	World Bank	Secondary Health System Programme	Maharashtra	State-wide	72.7	1999-2004

Source: Annual Reports of 1996-97 & 2000-01, Ministry of Health & Family Welfare, GoI.

Table – 5: Donor-wise Break-up of Externally Aided Health Sector Projects in the 3 States (completed and on-going)

Sl. No.	Name of Donor	State	No. of Projects
1	World Bank	Karnataka	5
		Orissa	2
		Maharashtra	3
2	USAID	Maharashtra	1
3	ODA/DFID	Orissa	3
4	UNFPA	Maharashtra	2
		Orissa	1
5	KFW & GTZ	Karnataka	1
		Maharashtra	1
6	DANIDA	Orissa	1
7	**6 Donors**	**3 States**	**20 Projects**

2.3 Procedure and Guiding Principles for Getting External Aid and Role of Centre & States

The procedure for getting external assistance has remained the same over all these years. For availing external assistance, the procedure is the same irrespective of the nature of assistance (loan or grant) or the nature of the recipient organization (State/ Central Government Ministry or PSU). The project proposal has to be initiated by the recipient organization. After necessary clearances from the Planning Commission regarding inclusion of the project/scheme in the Plan, the proposal is sent to DEA with recommendations of the Central Line Ministry for taking up with the external agency.

In case of a scheme or project of the State Government, the Government of India (GOI) takes the loan or the grant and passes it on to the State Government in the form of Additional Central Assistance (ACA) for Externally Aided Projects. The repayment liability to the external agency is that of the GOI which bears the entire foreign exchange risk. For normal category states, the ACA is given in the form of 30% grant and 70% loan. The loan part of ACA at present carries interest rate of around 11–12 % and is repayable over 20 years by the State Govt. For special category states (N-E states, J&K, etc.), ACA consists of 90% grant and 10% loan. For the schemes of Central Line Ministries, the funds are released in the form of grants only and the repayment to the external agency is done by the Ministry of Finance.

The Central Health Ministry implements programmes like Malaria Control Programme, National Aids Programme, etc. as national programmes and the funds in this regard flow to the State Governments in the form of grant. However, the implementation of these schemes generally involves a state government's share. There is no difference on the terms and conditions of ACA being given to the state governments for externally aided projects in different sectors.

3. Orissa's Health Sector at a Glance

3.1 Development of the Public Health Services System in Orissa

Prior to the establishment of allopathic hospitals in Orissa in the early 19th century, people generally had either no access or were reluctant to accept modern medical systems due to educational backwardness and blind beliefs regarding infectious diseases. Witchcraft and sorcery were rampant. However, *Ayurveda* played a vital role in more systematic treatment at that time. A network of hospitals and dispensaries doing primarily curative work using modern medicine existed before independence. The hospitals were under the district boards. The growth of modern medical institutions in a more widespread manner and the increasing faith of the people in modern systems happened after independence.

The State of Orissa was formed on 1st April 1936 and had only 6 Districts at that time. The Public Health Act and Rules of Madras Presidency were in force till 1939 in the southern part of Orissa. The major milestones in the development of health services in Orissa from 1939 onwards are presented in Table-6 below

Table– 6: Milestones in the Development of Health Services in Orissa

YEAR	EVENT
1939	Orissa Service Code in force. Post of Director, Health Services and cadre of Civil Surgeons established.
1944	Cuttack Medical College established.
1959-60	Burla Medical College came into being.
1962-63	Establishment of Berhampur Medical College.
1964	State Family Planning Officer post created; basic health services scheme introduced.
1970	Registration of Birth and Death Rules came into force. It became the responsibility of the Health and Family Welfare Department.
1977	1/3 of PHCs converted to upgraded PHCs. Ayurvedic and Homeopathic Doctors attached to the upgraded PHCs.
1981	Phase – I of External Assistance by Overseas Development Assistance (ODA), United Kingdom.
1985	Dispensaries converted to single doctor PHCs.
1989-90	Phase - II of External Assistance by Overseas Development Assistance (ODA), United Kingdom.
1997	Phase – III of External Assistance by Overseas Development Assistance (ODA), United Kingdom.

The total number of health institutions (allopathic) is 1702 which includes 3 Medical College Hospitals, 31 District headquarter hospitals, 157 Community Health Centres, 1351 Primary Health Centres (old & new) – as per 1997 data. The Doctor (in government service) to population ratio is 1:7440 and the population served per medical institution is 21,600.

Public sector expenditure on health is about 1.2% of the Gross State Domestic Product and about 3% of the annual budget. A large proportion of the funds is spent on the tertiary sector. The sustained increase in the wage and salary component in the health budget has made the non-salary portion shrink over the years.

3.2 Health Performance of the State

Orissa's population (provisional) according to the 2001 census is 36,706,920, which is 3.57% of the country's population. The state appears to be close to achieving population stabilization with an annual growth rate of 1.59% (2001 Census), as against the all-India growth rate of 2.13%. The Crude Birth Rate (CBR) has declined substantially from 34.6 per 1000 population in 1971 to 33.1 in 1981 and 24.1 in 1999 (rural: 24.6, urban: 20.3 and all-India: 26.5). The gender ratio (females per 1000 males) of 972 (in 1991 and 2001) compares favourably with the national level figure of 933. Life expectancy at birth for 1996-2001 is projected as 58.30 years (58.5 years for males and 58.1 years for females), which is below the national figure of 62.90 years, but still marks an improvement for the state from the 1981-86 figures of 54.1 and 51.9 years for males and females, respectively. The Maternal Mortality Rate (MMR) is 367 in the State whereas the corresponding national figure stands at 407 (SRS, 1999). The percentage of children fully vaccinated is 63.4 as against the national figure of 63.3 (ICMR, 1999).

As against the above achievements, issues of concern still persist. While the Infant Mortality Rate (IMR) in the state has declined from 135 in 1981 to 97 in 1999, it is still the highest in the country, much above the national average of 70. Infant mortality accounts for nearly one-third of the total deaths during a year. The major causes of infant mortality are associated with prematurity, birth injuries, diarrhoea and congenital malfunctions. In the case of maternal mortality, the most important cause is identified to be delivery related complications.

The disease burden in the State is high, but when considered along with indicators of nutritional status among women and children, there is reason to believe that a substantial proportion of morbidity and mortality is *preventable*. Communicable, pregnancy related and childhood ailments account for about 65% of the diseases. Rural-Urban differences remain in the state with respect to many of the health indicators (for instance, in 1999, rural IMR was 100

as against the urban IMR of 65; similarly, while the rural CDR is 11.1, the urban CDR stands at 7.1).

3.3 State Health Administration: Existing Structure

The Minister, Health and Family Welfare, is in overall charge of the State's health administration. The Secretary, Health and Family Welfare, is the Chief Executive of the Department. The Secretary advises and guides the Minister in all major policy and administrative decisions.

The Department is divided into six separate Directorates, each headed by a Director. The Directorates are Directorate of Health Services (DHS), Directorate of Family Welfare (DFW), the Directorate of Medical Education and Training, the State Institute of Health and Family Welfare (SIHFW), the Directorate of Indian Systems of Medicine and Homeopathy (ISMH), and the Office of the Drug Controller (DC). At present, medical professionals head all the Directorates, except the last two. The Director, ISMH, is a person with administrative background and the DC is a trained professional in Pharmacy.

The DHS is the 'Chief Technical Advisor' to the State government on matters relating to preventive and curative health services at the primary and secondary levels and is responsible for supervision, monitoring and implementation of all health activities in the State. The SIHFW imparts health education to all kinds of professionals and in-service training to paramedics.

At the District level, the Chief District Medical Officer (CDMO) is the head of the District health administration and is assisted by 3 Assistant District Medical Officers (ADMOs) and occasionally, by other Programme Officers.

At the Block level, the health care activities are looked after by the Community Health Centre (CHC) Medical Officer or the Medical Officer of the Block Primary Health Centre (PHC). She/he is assisted by a team of doctors, paramedical and ancillary staff. The CHC or the Block PHC is usually set up for a population of approximately 80,000 to 1,20,000. Below the CHC or Block PHC is the single doctor institution known as the Primary Health Centre (New). This is meant to cater to a population of 30,000 in plain areas and 20,000 in tribal and hilly areas. Below the PHC (New) are several Sub-centres. Each Sub-centre, which is set up for a population of 5000 in plain areas and 3,000 in tribal and hilly areas, is staffed by paramedical professionals, viz. a female Multipurpose Health Worker (MHW) or Auxiliary Nurse Midwife (ANM) and a male MHW.

4. Flow of External Assistance to Orissa

Funds from foreign donor agencies are routed to the state government through the Govt. of India in the form of Additional

Central Assistance (ACA)[2] and constitute an important segment of the State Plan. Like normal State Plan Assistance, ACA consists of 70% loan and 30% grant. Irrespective of the rate of interest charged by the donor agencies to Govt. of India, the loan component of the ACA carries the same rate of interest as the loan component of the normal State Plan Assistance (which, at present, carries the rate of interest of 12.5% per annum). Some of the external assistance is on nominal interest ranging from 0.5 – 4%, but the state government has no way of benefiting since the central government charges the same rate of interest on all types of assistance.

4.1 External Aid Flow to the Health Sector of Orissa in the Pre-reforms Period

The Ministry of Health and Family Welfare, Orissa prepared a plan in 1980 to increase and strengthen facilities for the delivery of Health and Family Welfare Services in an integrated manner in accordance with the approach outlined in the Sixth Plan (1980–85). According to the Sixth Plan, the strengthening of infrastructure was perceived as the main key to achievement of various health goals in the country. Accordingly, a plan was made to achieve the goal of better infrastructure in some selected districts of major States within a period of five years. These selected interventions came to be known as 'Area Projects'. For achieving this, partial assistance from International/Bilateral donor agencies was sought.

The ultimate objectives of these projects were to improve Health and Family Welfare infrastructure in these areas, which was thought to contribute to reduction in fertility, maternal and child mortality and morbidity. In Orissa, the project was operated in the name of Orissa Health and Family Welfare Project (OHFWP) and was assisted by the Overseas Development Assistance (ODA) of the United Kingdom, which has now become the Department for International Development (DFID).

4.1.1 Phase I of ODA Assistance (1981-88)

The first donor agency to come to Orissa for providing assistance for improvement of infrastructure was the ODA. In the first phase of the 'Area Project' plan, five districts of Orissa out of a total of 13 districts were selected. These districts were: Cuttack, Ganjam, Kalahandi, Phulbani and Puri.

[2] Important projects assisted by major donor agencies (such as, the World Bank, Japan Bank for International Cooperation, Kreditanstalt fun Wiederaufbau of Germany, etc.) are usually financed by the state government initially, and on the basis of eligible expenditure, reimbursement is claimed from the Govt. of India. The amount so reimbursed is called Additional Central Assistance.

In this project, infrastructure was given the major thrust[3] although some resources were devoted to training of personnel, strengthening of referral system at the primary level, i.e. from PHCs to CHCs, and putting a Management Information System (MIS) in place.

For building of infrastructure at the PHC and Sub-centre level (1,400 buildings were built or upgraded during this phase), the State's Public Works Department (PWD) was given the responsibility. Most of the construction took place in 1986-87, almost coinciding with the end of Phase I[4]. But due to lack of supervision and monitoring of the work done by the PWD, the buildings were of very poor quality and there was rampant pilferage of resources at the local level. Another disturbing feature of the buildings was their location. The Health Department decided that the buildings are to be built on available government land or by purchasing land from the private parties. Ultimately, when the buildings were constructed there were no takers for the infrastructure because they were located at places, which the users did not like. At the PHC level, wherever the staff quarters were not built around the PHC, the staff of the PHC faced difficulty in attending the centres because of lack of convenient transport or distance from their place of residence. At the Sub-centre level, the ANMs found it very difficult to come to the centre especially if their places of residence were located at a distance from the Sub-centre. People also found it difficult to attend to the Sub-centre because of the distance factor or its inconvenient location. The buildings were lying unused for long and many of them collapsed because of lack of care and maintenance. There was almost no community involvement in the entire process of infrastructure building.

Vehicles were also purchased during the project. But these vehicles were soon rendered useless due to lack of provision for their maintenance. Many hospital equipment were also purchased for providing better service to the public. However, due to lack of proper maintenance and timely repair, they were also rendered dysfunctional. The State government washed off its hands by citing the strong reason of

[3] The proposed pattern of expenditure was (in terms of percentages of the total proposed budget):

(i) Construction	: 43.1
(ii) Staff Salaries	: 29.2
(iii) Drugs, Equipment & Furniture	: 16.2
(iv) Transportation	: 6.6
(v) Training and making of Teaching Aids	: 4.9

[4] In fact, the slow pace of construction activities during Phase I of the OHFWP is symptomatic of the confrontationist interface between different state departments, in this case the Dept. of Health and Family Welfare and the Orissa Public Works Dept. The 1994 Strategic Review Report makes a brief mention of "the difficulties to make the OPWD implement the plan for construction" (p-69).

lack of adequate resources for the maintenance of vehicles and equipment.

In many cases, drivers and technicians were recruited with investment from the project resources. But it became very difficult for the State Government to support these additional staff beyond a point. Therefore, due to lack of personnel to handle the vehicles and equipment, these became redundant.

Training was also imparted to the paramedics, field health workers, Traditional Birth Attendants (TBAs) and doctors in this programme. One Information, Education and Communication (IEC) Unit was established at Bhubaneswar for facilitating capacity building. Training programmes were organized within the State, outside the State and outside the country as well. But all these capacity building exercises were not used optimally because the concerned personnel did not undertake enough outreach services. A large number of people also could not get the information due to inadequate IEC activities regarding the improved capacity of the health personnel. Therefore, the benefit of all the training and capacity building exercises could not reach the majority of the population in the targeted districts.

For building an effective Management Information System (MIS), efforts were also made. A lot of information was generated from the lowest level, i.e. the ANM. The ANMs were asked to give detailed information on the progress of various health programmes. But due to difficulties in travelling to various places in the Sub-centre area and due to lack of provision of adequate travelling allowance to the ANMs, they usually cooked up data in the reports submitted to the upper levels. Even if the information was correct, the MIS was never made a two-way process for facilitating better functioning of the system.

However, since infrastructure was the dominant feature of the project it was primarily favoured by the politicians because of the visibility of such infrastructure. Even if 'hardware' was poorer in quality, the politicians could claim that they have ensured progress by building PHC or Sub-centre buildings for the people of the area. But the problem of the people remained unsolved to a large extent[5].

According to some health professionals who were associated with the project, there was large-scale discontentment among the health sector professionals regarding the whole issue of infrastructure building because their opinion was never taken into consideration while the work was being undertaken even though they were ultimately to use such infrastructure.

[5] Strangely enough, the 1988 official evaluation (by the state government and the ODA Final Review Team) of the Project was quite favourable and the conclusion made was that the Project had been generally successful in meeting its objectives. This was in conflict with the evaluation findings reached by a number of independent consultants during the same time.

4.2 External Aid Flow to the Health Sector of Orissa During the Reforms Period

In spite of the obvious lacunae of an infrastructure dominated 'Area Project' scheme, it was a favourite among many vested interests because of its visibility and the scope it offered to ensure 'leakage' of resources. Therefore, the second phase of the project was introduced in the State in another 5 districts of the still uncovered 8 districts (the State had a total number of 13 districts). These districts were Dhenkanal, Sambalpur, Sundargarh, Mayurbhanj and Keonjhar. For better management of the project a 'Project Management Unit' (PMU) was created with one 'Engineering Unit' and one 'Finance Unit' inside the PMU. This was done to ensure better degree of efficiency and effectiveness.

4.2.1 Phase II of ODA Assistance (1989-96)

Though the predominance of infrastructure creation remained intact in the second phase of the OHFW Project, the infrastructure creation process witnessed some major changes that were meant for the better. One, the PWD was not given the contract of building infrastructure. Instead, a more professionally managed agency, the Infrastructure Development Corporation of Orissa (IDCO) was given the responsibility. Two, the monitoring of the infrastructure building process was made rigorous because of the presence of engineering people in the PMU itself to oversee the progress of the work. Three, this time around, local people were involved in site selection and construction. This brought in a lot of innovation in the process of construction and ensured community contribution in terms of labour and resources. The famous environment friendly and cost effective 'Lauri Baker'[6] style of infrastructure was built at many places. All these factors combined together contributed to the building of comparatively better quality infrastructure.

As far as training was concerned, this phase came up with some bold outcomes. It contributed to the strengthening of Rural Health Centres at Atabira, Digapahandi and Jagatsinghpur. These three centres were the rural training and exposure centres meant for Doctors passing out from the Burla (Sambalpur), Berhampur and Cuttack Medical Colleges, respectively. However, these centres did not have any interactive programmes among the Medical Colleges nor the State Health and Family Welfare Department ever thought of utilizing their infrastructure for in-service training. There was also the problem of reporting. The Principals of the respective Medical Colleges had absolute control over them and it was difficult for the other health officials of the State government to pass orders to these centres for undertaking various training activities. However, the IEC Centre set up

[6] Lauri Baker is a famous architect of Kerala and his style of buildings are becoming very famous in many areas of the country for its simple, environmentally suitable and low-cost approach.

during the earlier phase of the project was upgraded to the State Institute for Health and Family Welfare (SIHFW). Some suitable administrative decisions were taken as a result of which, SIHFW became the apex training institution in the State and other training units were directed to schedule various training programmes in consultation with the SIHFW. Besides, Health and Family Welfare training centres also came up at Cuttack and Sambalpur during this period. Apart from this District Training Units (DTUs) also came up for facilitating training of the ANMs at the district level.

Various training programmes were organized for clinical, managerial and nursing staff inside and outside the State as well as outside the country. Thousands of staff were trained for improved service delivery to the people. The training component was extended to all over the State for better coverage.

One Health Equipment Maintenance Unit at Bhubaneswar was established during this period for ensuring one-time repair of all the equipment that were lying unused due to lack of funds in the State government for their repair.

A Family Health Card maintenance system was also introduced in the project districts to facilitate better monitoring of critical areas in mother and child health.

But after the end of the project cycle around 1996, many serious loopholes were identified in the implementation of the programmes. Maintenance of infrastructure was a big problem during this period also because the State government did not have enough funds. The State government was also not prepared to bear additional burden of maintaining the SIHFW, although it was important for training and re-training of health personnel. MIS was again functioning as mostly a one-way process and was ANM centred. At one point of time it was discovered that one ANM had to maintain 37 registers for generating required data. So, where was the time and energy left for her to undertake outreach services?[7]

The Family Health Card system was discontinued because of problems of maintenance by the ANMs. The District Training Units specifically established for training the ANMs also became non-functional in due course of time.

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[7] The supply-driven (rather than user-driven) nature of health sector information systems has been commented upon in a number of studies (ASCIH, 1989; Martinez et al, 1994). The reason attributed to the increased burden of data collection on the primary level health staff is the 'verticalisation' of many health programmes over the years and the creation of new divisions. The new proformas and other data collection devices have tended to add to, rather than replace, the existing ones.

4.2.2 Phase III of ODA Assistance (1997-2002)

The OHFWP has been in operation in Orissa since 1981. But it was realized after the end of the two phases of the programme that the inputs of infrastructure and training have not ensured the expected increase in quality of services made available to the people[8] . Some of the buildings produced by the project were already falling down due to lack of maintenance, outreach services suffered due to lack of support for transport of personnel and drugs were often in short supply. Systems failure was widely seen to be the underlying cause (for instance, failure of the system to allocate funds for maintenance, drugs and transport). A number of obstacles were identified for the delivery of quality services[9] . These obstacles included:

- Lack of resources in three vital areas: maintenance of buildings and equipment; supply of medicine and reimbursement of mobility (travel) allowance.
- Lack of local planning and management.
- Lack of quality training and uneven work distribution.

Lack of Resources

Only 10-20% of expenditure at the PHC and Sub-centre level was spent on non-salary costs such as drugs, travel and repair of buildings and equipment. This was inadequate and created a number of problems.

- Centre's infrastructure and accommodation was poorly maintained and dirty.
- Equipment was either missing or was dysfunctional because of poor repair.
- Essential drugs were not available in sufficient quantity.
- Travel allowances were not always paid in full or in time.

Without proper accommodation and facilities to carry out their work, the staff become demotivated and were less willing to stay in their place of posting. Dirty facilities in poor condition discouraged people from using them. Non-provisioning for travel costs led to discontinuance of outreach programmes and supervising tours. The 1996 Impact Assessment Study estimated that, in order to deliver effective services, the state government would need to more than double its budget for non-salary costs

[8] The 1994 Strategic Review and the 1996 Impact Assessment study acknowledge that though Phase I and II contributed substantially to the provisioning of buildings, equipment and training at the primary health care level, their impact in terms of increased use or improved quality of health services has not been significantly felt.

[9] The 1996 Impact Assessment study indicates that the users of sub-centres, PHCs and CHCs perceive quality to consist, in part, of buildings in good repair and the availability of drugs and health workers, especially doctors. Further, 'quality of health services' includes other factors such as the inter-personal relations between providers and patients, health workers' clinical skills, clinic opening hours, and the availability of services that meet people's priority needs.

at Sub-centres. Similar or even greater gaps are likely to exist at other levels of the primary health system coming under the public sector[10].

Lack of Local Planning and Management

The 1994 Strategic Review Report identified the lack of policy and planning capacity in the state as a major constraint in developing a health service that is responsive to local needs. Within the districts there was little opportunity for health staff to alter services in response to the local needs. Indeed a lot of priority was given to target driven and centrally sponsored services, such as family welfare and immunization and this may not be locally appropriate. For example, if respiratory infections and malaria kill many children in a district, health workers promoting sterilization and immunization will seem irrelevant. Therefore, the public will not automatically value the services provided at the primary level and will go to the secondary level. As a result the secondary systems will be overcrowded and the primary system will be under-utilized and opportunities are lost for health education and preventive practices.

Lack of Quality Training

Doctors and health workers complained that the training they received was not adequate for the tasks they were expected to do and there are few opportunities for further in-service training. Many doctors having post-graduate training in a clinical specialization that was suitable for secondary level services were working in primary services without receiving training in public health or management. Practical skills' training for health workers was of low quality both in clinical and communication skills.

Systems Failure: The Underlying Causes

The underlying causes of the obstacles discussed above are often due to systems failure. This means that the mechanisms by which the government brought personnel and resources together to get things done were inefficient. For instance, while discussing its attempts to obtain a comprehensive staffing profile of the health sector in the state, the 1994 Strategic Review Report records the lack of information with the finance department of the state and comments that "… it is significant that the agency responsible for the allocation of recurrent budgets to health facilities *has no information on staffing patterns on which to base such decisions*" (p-18; emphasis added). Without reform of inefficient and poorly funded systems, further investment in such things as new buildings was unlikely to benefit the general people. An example of how systemic obstacles affected conditions in a clinic is given in the box below.

[10] The Project Memorandum of Phase III of the OHFW Project (1997) gives an estimate of the additional non-salary resources required for the whole state to the extent of Rs.390 million per year, equivalent to 15% of the total health budget of the state or 0.7% of the total state expenditure of Rs.55 billion.

A PROBLEM WITH THE MAINTENANCE SYSTEM

A leaking roof had damaged the wall of a PHC and short-circuited the electrical wiring.

Indents were submitted requesting repair and after 3 weeks someone arrived to fix the wiring. The roof was still leaking, however, so electrical work cannot be done and the electrician returned to the HQ. Five days later the rural works department fixed the roof and plasters the wall.

The electrician is recalled and he replaced the old wiring. Unfortunately, the new plaster is damaged by the work so another indent was sent to the rural works department to repair the plaster. The Medical Officer was told that there was no money left in the budget for further repairs and he should send another request next April.

Shortly after the electrician finished his work, the Medical Officer entered his room to begin the clinic. He tried to switch on the light, but the bulb was fused. He was annoyed to find out that there was no more petty cash to buy a new one. So once more he held the clinic in the dim twilight of the unlit room.

4.2.3 Involvement of other Donor Agencies with Orissa's Health Sector in the Reforms Period

It would be pertinent here to mention that the ODA/DFID project is the only externally aided project implemented in the State of Orissa that has cut across the pre-91 and post-91 periods, the dividing line being introduction of large-scale economic reform measures in the country in the year 1991. A number of external agencies came to the state to invest in its health sector in the post-1995 period. These agencies have played their own part in introducing and accelerating the reform process in the health sector of the state. They have been successful in persuading the state government that initiating reform measures would usher in more public satisfaction and better resource mobilization. The names of these agencies and the areas of their intervention are given below in Table-8.

Table-8: Externally Aided Health Sector Projects In Orissa at Present

AGENCY	PROGRAMME/PROJECT
World Bank	Orissa Health Systems Development Project (OHSDP) – development of district level hospitals
World Bank	RCH Programme, Malaria Programme, HIV/AIDS Programme and Blindness Control Programme
DFID	Primary Health Sector Reform Programme
DANIDA	Leprosy Programme, TB Programme
Lepra India (UK)	Leprosy Programme
UNFPA	IPD Programme
UNICEF	Immunization Programme, Sanitation Programme
European Commission	Sector Investment & Reform Programme
CARE India (USA)	Specific Area Intervention in Nutrition & Health

5. Health Sector Reforms in Orissa and Role of External Assistance

The role of external assistance in determining the pace and content of health sector reforms in Orissa has been crucial. The DFID, in particular, has had a significant influence in shaping the reforms agenda of the state, obviously owing to its long presence and the magnitude of its commitments in the region's health sector. In fact, as will be discussed below, Stage 1 of Phase III of the OHFW Project was designed to dovetail into a comprehensive reforms programme at the state level.

5.1 DFID-Sponsored Initiatives in Orissa's Health Sector: Phase III of ODA Assistance (1997-2002) and the three Ms

In Phase III of the OHFW Project, the ODA (by now it had become DFID) decided not to fund any more the construction of buildings without bringing about some systemic changes in the health sector of the state[11]. Therefore, it was communicated by the DFID to the Government of Orissa that it would provide resources for introducing reforms in three areas of concern: Medicines, Maintenance and Mobility (known as 3 M's). Phase 3 of the OHFWP was to have two stages: stage 1 and stage 2. In stage 1, the 3 systems to be given emphasis were:

- System of supply of **medicines**.
- System for supply of travelling allowance for ensuring **mobility**.
- System for **maintenance** of buildings and equipment.

The DFID decided not to support reform in these systems in the remaining 3 uncovered districts of Bolangir, Balasore and

[11] This policy shift on the part of the DFID may be linked to a series of evaluative studies on the functioning of OHFWP and investigations on the constraints hindering the development of Orissa's health sector. The two most influential investigations have been the Strategic Review Report of the health sector carried out in 1994 by the Liverpool Associates in Tropical Health, and the Impact Assessment Study carried out in 1996 by the Institute for Health Service Development.

Koraput of the earlier ODA projects. However, by this time the districts had been reorganized in Orissa in 1993 and the previous 13 districts had become 30 districts. Because of the reorganization, the uncovered 3 districts of the ODA's project (OHFWP) became 8. The DFID decided to experiment the reform process of 3 M's in two selected districts of Bhadrak (newly created) and Keonjhar.

In addition to the main three activities of reform, the project also aimed at considering as to how to improve community participation and suggest how services might be made more responsive to local needs by altering the service mix. Attempts were also to be made by the health sector staff to work more closely with other social sector organizations and institutions such as the Panchayati Raj Institutions (PRIs).

At the State level it was also thought to undertake some intense research to find the best ways to successful initiatives within the two experimental districts, i.e. Bhadrak and Keonjhar. It was envisaged that, using the results of the DFID-sponsored initiatives in these two districts and policy research, the State would draw up a programme of policy reform to be incorporated into the project plan for stage 2 (for the remaining old 3 districts which had then reorganized into 8 districts). During stage 1, management and training skills were to be strengthened with the initiatives to be undertaken by the SIHFW.

It was made very clear by the DFID that stage 1 would be counted a success only if the following two conditions were met:

- There was demonstrable improvement in quality and utilization of health services as a result of increased funding and local management.
- The State has put in place feasible programmes of policy reform, which is likely to succeed in introducing changes to all districts in sustainable manner.

With these future programmes in mind, the experimentation in 3 M's (medicine, mobility and maintenance) in the two experimental districts of Bhadrak and Keonjhar started. But soon after, the experimental steps taken in the two districts ushered in reforms in the entire state.

5.1.1 Changes in Medicine Procurement

The objective of this initiative was to make sufficient and good quality drugs available to patients in all public health institutions. Prior to the DFID-sponsored experiment under Phase III of the OHFW Project, the procedure relating to purchase of drugs for the State health institutions involved a mechanism for finalizing the list of drugs, prices and suppliers *at the State level*, allotting funds to the districts and thereafter allowing the CDMOs to manage the procurement and distribution. The system was time taking and cumbersome, the medicines were costly, there was no essential drug list, medicines were ordered by brand

name, there was no quality test and there were many irregularities in purchases. Some irregularities observed by one of the medical professionals associated with the DFID are presented in the box below.

IRREGULARITIES IN THE MEDICINE PROCUREMENT SYSTEM

The CDMOs of the districts were allocated funds to purchase medicines. They were supplied with an approved list of medicine suppliers and they could choose any of them for supply of specific medicines.

The CDMOs used to purchase medicines not as per the needs of individual PHCs in their districts. More often than not, this led to a mismatch between the demand for and supply of medicines. For example, the medicine for a particular disease was supplied to a PHC that had no need for the same. The medicine supplied will not be used and this will be a dead-weight wastage. Moreover, this will result in corruption in the sense that the unrequired medicine will be sold in the market and the money will be pocketed by the hospital staff.

The CDMOs usually entered into unholy alliances with the medicine suppliers. They will ask the medicine suppliers to quote higher prices and give false bills for medicines not purchased at all. This benefited the CDMOs, local politicians and the medicine suppliers. But this resulted in lesser supply of drugs to the people.

In order to do away with the irregularities and ensure more and quality supply of drugs, a new **centralized procurement system** largely borrowed from Tamil Nadu was introduced and it brought in several welcome changes.

An essential drug list was drawn up listing drugs in generic names. This was further classified into three categories for the primary, secondary and tertiary level institutions. Thereafter, orders for the drugs were placed and while payments were made centrally, the supplies were delivered at the district level with the cost of supply incurred by the suppliers. Before the orders were finally placed, a secret quality check from well-known laboratories of the country was made at the expense of the suppliers. Each institution was informed of its entitlement of drugs (by value) and was given a passbook. It can make its own selection, constrained only by the essential drug list and the overall entitlement. Quality was insisted upon with proper packing, logos and quality testing. For emergency purchases, only 20% of the drug budget was paid to the CDMOs.

5.1.2 Improvements in Mobility

Earlier the health personnel did not have adequate petty cash at their disposal to meet the necessary travel expenses to carry out outreach activities. In the two

DFID-sponsored project districts, sufficient provisions were made to meet this need. Further, to ensure better mobility, emphasis was laid on **efficiency savings** and **rationalization** of vehicle use.

Vehicles were available with many block level PHCs or CHCs. The Medical Officers of the concerned PHCs/CHCs were asked to declare their tour plan in the area much in advance so that other personnel in need of travelling to those specified places could travel by the same vehicle. This not only resulted in rationalization of vehicle use but also saved money and time.

In some other cases, vehicles were used when special camps were organized at remote areas. The vehicles that carried equipment and personnel to the camp site stood unutilised at the site for many hours. In such cases it was decided that other personnel would plan their schedule in such a way so that the vehicles could be used for outreach programmes in and around the campsite during the time they were lying idle. This is another small but significant instance of optimising use of available vehicles for ensuring better 'mobility'.

The provisioning for travel expenses in the two project districts led to a feeling of inequality among the staff of other non-project districts. Therefore, the State government decided to do something at the State level to meet this problem. However, the State government did not have adequate funds to meet the travel needs of all the health personnel. *Therefore, a policy decision was made to provide travelling allowance/ mobility support to the most important staff in the entire set up, i.e. the ANM*. It is the ANM who always remains in touch with the people and works at the grassroots level. Therefore, the ANM's requirement was considered paramount.

5.1.3 Improvements in the Maintenance System

All building maintenance work, including petty and annual maintenance, as well as special repairs had been the responsibility of three government engineering departments, the Works Department (for urban areas), the Urban Development Department (for urban water supply and sanitation) and the Rural Development Department (for rural areas). Since these departments have personnel only at the district or at best block headquarters level, and since health department buildings were scattered far and wide, most of the institutions did not get attended to at the time dire requirement. Petty repairs, which may cost a few hundred and few thousand rupees, were almost never taken up in time. The matter therefore needed to be addressed.

Under the DFID-sponsored initiative, the project districts were given the necessary assistance. But, very soon, realizing the importance of the matter, the State government decided to identify hundred block CHCs / PHCs and the in-

charge Medical Officers were given Rs. 10,000 each annually to take up petty repairs. They were asked to undertake urgent minor repair works following simple procedures. The impact of this programme was immensely beneficial for the concerned CHCs/PHCs. This initiative is being extended to the whole state shortly, remarked some top government officials.

5.2 Health Sector Reform Initiatives Undertaken in Orissa by the Government

Interest in health sector reform at the government level began to gather strength in Orissa in the mid-1990s. **Two events heralded the beginning of this process. First, the formation of a Committee of the Orissa Legislature chaired by the Health Minister (called the House Committee) which looked into three important aspects of health care**, and advised on (i) raising additional resources for health care activities by introduction and retention of user charges in the medical colleges and district hospitals; (ii) granting greater autonomy to the major hospitals; and (iii) the abolition of private practice by government doctors. **The second event was the evaluation done by the DFID (earlier ODA) of its two health and family welfare projects in Orissa which concluded that further capital investment in the health sector of the state would be inadvisable unless certain systemic changes were undertaken**.

In the 5 years or so following these two events, a number of reforms, both large and small have been introduced in the health sector in Orissa. Some of them relate to changes in administrative and operational systems, some to changes in personnel policies including skill development for better service delivery and some are aimed at giving a minimum health guarantee to the people. The reforms have had varying degrees of success. The DFID-sponsored reform initiatives relating to drug procurement, mobility of medical personnel and maintenance of buildings in the project districts and the subsequent adoption of these steps by the state government have been already discussed. The salient features of some of the other principal reform measures are described briefly below in tabular form.

Sl.no.	Nature of Reforms in the	Introduced	Objective	Applicability	Expected and Realized Impact
1	**User Charges**	*1997*	*To raise resources for the health institutions from people*	*All tertiary, district and block level government hospitals in the State*	*By making funds available at the hospital level for day-to-day working capital and emergency needs, the*
2	**Privatization of Cleaning in**	*1998*	*To ensure cleanliness in public hospitals.*	*Undertaken as a pilot project in a few district level and tertiary*	*An indication of the felt need for, and popularity of cleanliness. Some district hospitals have contracted out*
3	**Mandatory Pre-PG Rural Service**	*1999*	*To ensure the presence of doctors in remote and difficult areas and also to provide better rural orientation to young doctors.*	*To the whole State.*	*For the doctors, this scheme has its plus points in that the assignment is for a limited period only and is linked to something that is highly desired (a PG degree). Since the scheme involves young doctors who have freshly qualified, greater acceptance of the rural assignments among them is obviously expected. Senior doctors are supposed to be spared from such assignments. However, as per newspaper reports, there appears to have been no improvement in the ground situation in remote and difficult areas as far as the presence of doctor is concerned.*
4	**Pancha Byadhi Chikitsa (5 Diseases' Treatment Scheme)**	*1999*	*To ensure that every patient who goes to a public hospital is guaranteed treatment at government cost for 5 major diseases (malaria, leprosy, diarrhoea, acute respiratory disorders, and scabies). It is estimated that 70% of the patients who attended public health institutions came for treatment of one or the other of these diseases. Two more diseases, TB and Helminthiasis (parasitic infestation) are soon to be added to this list.*	*The whole State – a pilot project*	*The scheme has created a health entitlement and risk protection guarantee for the poor, because it has been kept out of the user fee collection system.*

Sl.no.	Nature of Reforms in the Health Sector	Introduced	Objective	Applicability	Expected and Realized Impact
5	**State Health and Family Welfare Society**	*1998*	*To create a simple, problem free method for making funds available for health care activities, as and when required, for specific programmes.*	*The whole State*	*Easy access to funds, flexibility of use and better adaptability to crises and contingencies are the expected benefits of this reform measure. It is to lead to less dependence on the State's finance department which had control over funds (that was given by the Centre for specific programmes) amalgamated in the State budgetary resources.*
6	**Amalgamation of District Health Societies**	*1999*	*To have a composite district health society for better management instead of having separate societies for central or donor funded programmes on blindness, leprosy, TB, malaria, etc. but with separate earmarked funds for each programme.*	*The whole State*	*The setting up of Zilla Swasthya Samiti – ZSS (District Health Society) is aimed at facilitating better management and systematic functioning. It has also paved the way for shifting the responsibility of ZSS to the Zilla Parishads from the over-burdened hands of Collectors. But the total transfer of such responsibility has not been possible so far.*
7	**Formation of District Cadres for Paramedics**	*1998*	*To create smaller and more manageable cadres for lower level functionaries.*	*The whole State.*	*This scheme is expected to lead to better availability of paramedics in difficult areas, less hardship for personnel due to long-distance inter-district transfers and consequently better service to the public. However, there is no evidence to suggest that it has achieved the desired impact.*
8	**Handing over of PHCs to NGOs**	*1997*	*To allow remote PHCs to be better managed, give better health care to the public.*	*A pilot project in 2 districts.*	*The experiment did not run for very long, as the NGOs did not have the resources and ability to run the institutions. However, fresh attempts are in the offing in this direction.*

5.2.1 Analysis of the Impact of Two Selected Reform Measures

Although the state government in the past decade has undertaken many reform initiatives, this paper tries to evaluate the effects of two selected reform initiatives related to (a) user charges and (b) drug management system.

a. User Fee Collection

Even before 1997, the user fee collection from patients was in existence in government hospitals of Orissa but it was restricted to certain items such as accommodation in air-conditioned cabins, use of ambulance, x-ray and few other medical investigations. The House Committee constituted by the Orissa Legislative Assembly to review the health care system recommended collection of 'user charges' in all district headquarters hospitals, all three medical colleges of the state and a few other hospitals. This was done with effect from 01/07/1997 (vide a government order dated 24/06/1997) "in order to generate additional resources to supplement the budgetary allocation with a view to improve and extend the medical facilities". The government order revised the existing rates and covered new areas for levy of fees/charges in respect of accommodation, transportation, radio-diagnosis, and medical investigation. **However, the order exempted patients from poor families living below poverty line from any such fees/charges, with the condition that there must be a recommendation of the treating physician and the CDMO/ Superintendent of the concerned hospital.** To make the system easier for the poor people, the order made it clear that the authorities should not insist on production of records and documents as a matter of proof that the user household resides below the poverty line. At the same time, the number of exemption cases should not exceed 40% of the total patients from whom charges are collected.

The government order provided for the formation of a society at the level of each hospital so that the funds collected could be utilized for the "maintenance and improvement of the respective hospitals and for ensuring qualitative health care facilities without being deposited in the concerned treasuries".

A 1999 study on 'user charges in Orissa' reports that that the user charge collection system introduced in the government hospitals in Orissa has substantially benefited both the hospitals and the patients. The hospital authorities were able to mobilise resources at their disposal for otherwise neglected activities of the hospitals thereby improving the health service delivery system. Many hospital authorities were able to feel a sense of belongingness to the institution and motivated to take up initiatives for improving the service performance. The patients in general accepted the system. Those who had to pay

user fees were of the opinion that it is affordable and associated it with improvements in the quality of health care services.

However, the study does report isolated incidents of non-cooperation and sabotage by health personnel and professionals. There were also problems like collecting fees from poor patients, over charging and non-payment of balance, delayed bank remittance, utilization of collection without depositing in the bank, not giving proper receipt, delaying results etc. These are problems specific to the individuals and can be controlled. A more damaging revelation by the study relates to the tendency on the part of some Medical Officers to prescribe and direct patients to use the diagnostic services located outside even when such facilities are available in the hospital. The reason usually cited is that the privately maintained facilities are better in terms of quality and reliability. However, how this quality of private facilities could be guaranteed by the Medical Officers, when they themselves were given the opportunity to improve the quality of the services provided by them (using the user fees), is a nexus not fully explored.

According to available figures, the fee collection from 1/7/97 to 31/3/99 was Rs. 2.98 Crores, which amounted to roughly 1% of the then total government expenditure on health in the state. Out of this amount, a major portion (Rs. 1.13 Crores) was collected from the SCB Medical College, Cuttack. Though these figures reveal the potential of user fee collection as one of the major areas for resource mobilization, some serious information gaps exist with regards to who is paying for what, the economic impact of the charges on the users, and the extent to which such charges have affected quality and accessibility of public health care services/facilities.

b. Drug Inventory Management System (DIMS)

A change in the pharmaceutical policy was effected by the Orissa Health & Family Welfare Department from early 1998. The changes were intended to restructure drug procurement and distribution system. The underlining principle of the reform measure was to make available and accessible the maximum possible types of quality drugs, optimizing the existing financial resources, rational drug management and improved prescribing practices.

The major features of this policy comprised:

- A rational drug list containing essential items of drugs in generic names only.
- Freedom of institutions to choose any drug in any quantity, constrained only by a given budget and essential drug list.
- Centralized drug procurement from manufacturers only, to ensure best competitive prices.

- Twenty percent of the drug budget made available to the district and peripheral institutions for emergency purchase and meeting expenditure towards transport.
- Online inventory control system that connects 33 warehouses and one central drug store attached to the main office to the central office.

The benefits of the new system were many. The essential drug list in generic names cut down the purchase of many unnecessary drugs and resulted in rational drug prescription. Bulk purchase, central payment and adherence to a strict schedule of payment resulted in economies of scale and greater value for money (for example, IV fluids earlier supplied at the district level at Rs. 16 per bottle came down to Rs. 6). This may have contributed to the decrease in the annual drug budget of the State in recent years (Table-9). Strip packing increased the acceptability of drugs by the public. Quality testing and blacklisting of sub-standard drug suppliers resulted in good quality drugs being supplied. The institutions had the freedom to select their own drugs and, most important of all, drugs were available in plenty in all institutions. Because of introduction of a centralized drug procurement and supply mechanism, a computerized on-line inventory control system could be put in place. This resulted in improved monitoring of drug availability at the district level at any point of time and better transparency and accountability.

Table – 9: Budget of Allopathic Medicine in Orissa

(Rs. in Lakhs)

Year	**Sector**		
	Non-Plan	*State Plan*	**Total**
1997 - 98	787.17	333.11	1120.28
1998 – 99	813.64	617.53	1431.17
1999 – 2000	813.79	287.55	1101.34
2000 – 2001	761.3	109.09	870.39
2001 – 2002 (Provisional)	760.25	297.42	1057.67
2002 – 2003 (Provisional)	760.75	408.8	1169.55

It is likely that because of competition and maintenance of transparency in the drug procurement system, drug prices have remained more or less unchanged over the years. A comparison of the cost of various drugs and the stock position of drugs at various hospitals before and after the DIMS was introduced gives the following figures. The comparison by and large shows that the newly introduced system has produced positive results as far as costs and stock positions of various drugs are concerned.

Figure 4: Comparision of Cost Before & After DIMS

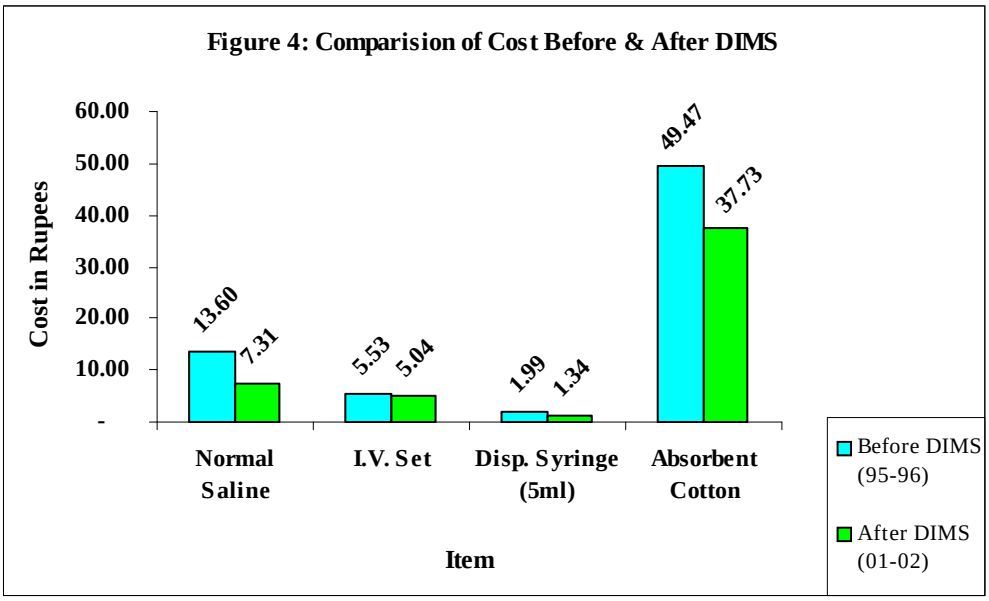


Figure 5: Comparision of Stock Position Before & After DIMS
Inj. Anti Snake Venum

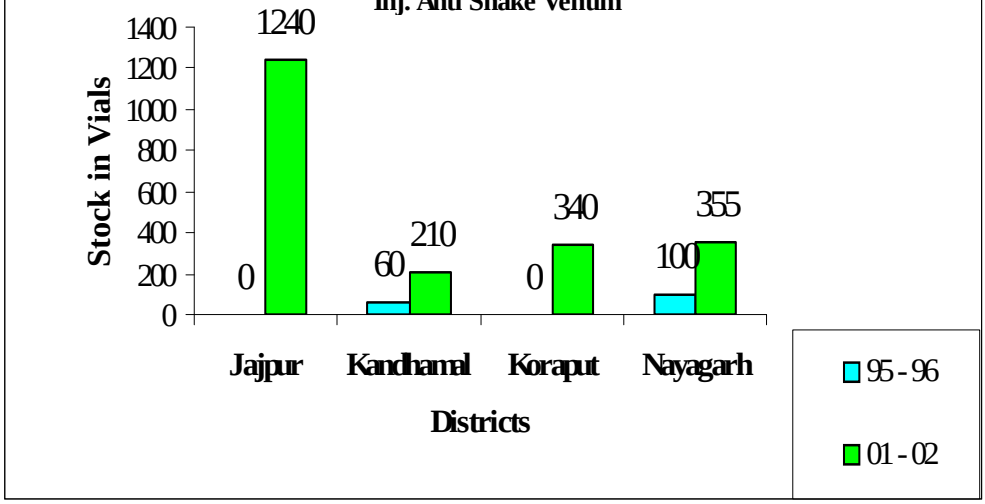


Figure 6: Compa

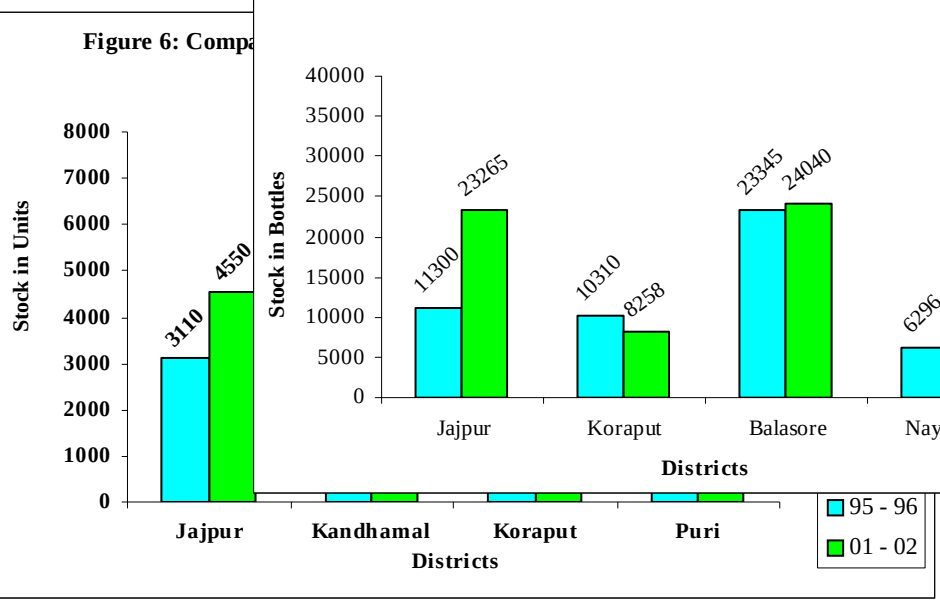
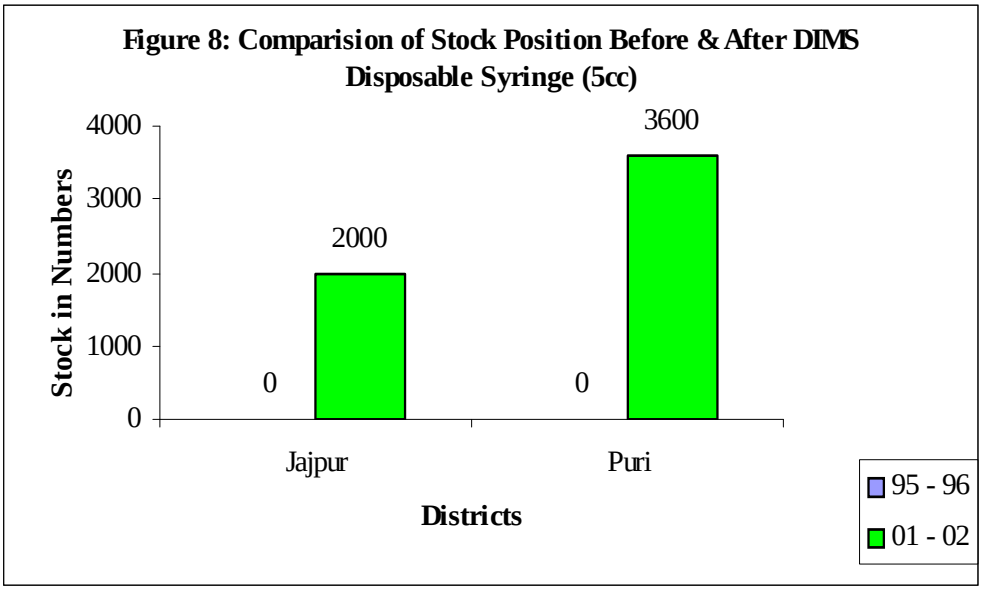


Figure 7: Comparision of Stock Position Before & After DIMS
I.V. FLUIDS



6. Other Impacts of External Assistance on Health Sector of Orissa

Apart from the reform measures mentioned above, some other effects of external assistance to the health sector of Orissa is also witnessed. These are summarized below.

6.1 Community Participation

In the OHFWP (Phase – III) Project, the project memorandum clearly indicates the options for: (i) increasing the involvement of communities in health services management and delivery; (ii) ensuring equity for disadvantaged groups in consultation with those groups; and (iii) consulting with service users, their representatives and other stakeholders for greater community involvement. There is no mention of seeking or prompting initial investments by the communities for provision/delivery of health services.

But in the "Norm-based guidelines for the preparation of district plan of operation", or in the document "An outline of procedure for undertaking activities contained in the district plan of operation", nothing has been mentioned as to how the objectives for community involvement will be achieved.

Expectedly, no attempt has been made in any of the above directions and there is no evidence to suggest that a participatory approach has ever been adopted either to address the problems specific to the disadvantaged groups (women, children, scheduled castes, scheduled tribes, etc.) or to take their opinion for making suitable changes in the service delivery mechanism.

As far as accepting community contribution as a norm for future health service activities, nothing has been initiated and the issue remains as sensitive and touchy as ever and the politicians are afraid of making any move in this direction.

6.2 Preventive, Curative & Promotive Aspects of Health Care

There are three aspects of the health service delivery scenario: preventive, curative and the promotive. There are three tiers in the health system: primary, secondary and tertiary. The primary health care (consisting of PHCs, CHCs and Sub-centres) tier is more preventive and promotive in nature in Orissa than curative. It is largely oriented towards MCH and in particular to meet physical targets. Although, the strongly felt need of the people is for curative care, it is not met to a satisfactory extent at the primary level. The ODA project in its initial two phases played a vital role in creating infrastructure and provided physical accessibility to the unreached. **Physical accessibility was assumed to be the most important factor determining provision of health services**. But it is now being increasingly recognized that simply providing a facility is not enough and that demand generation is also required, particularly for promotive and preventive services as those provided by the government.

The first curative facility in the government structure is the single-doctor PHC covering a population of 25–30,000 population. It is common knowledge that most of these doctors do not reside near the PHCs and rather they prefer to stay in nearby towns. They commute to the PHC and are not able to give the full time of the day to attend to the patients who come for getting curative care. They also remain absent in spite of several measures taken by the government in the recent years. At the sub-centre level, very little is provided by the ANMs in the way of curative services. ANMs have a very limited selection of drugs available and are rarely present at the sub-centre since they are supposed to spend most days in visiting nearby villages.

Since the people are not very sure that they will receive the desired curative treatment at the PHC level, they prefer to travel to the CHC in the nearby town or to district hospitals, i.e. the secondary tier. Realizing that people are more dependent upon these hospitals for curative purposes, the Government of Orissa has started an ambitious Secondary Health System Development Project in the State with the help of World Bank. This is also aimed at lessening the excessive pressure on the tertiary level hospitals, i.e. Medical College Hospitals. It is needless to mention here that the tertiary tier mostly provides curative services and also creates trained manpower for providing these services.

In the recent years, the World Bank has provided financial support to the Government of India to launch many National Programmes, which has reinforced the importance of the preventive mechanism

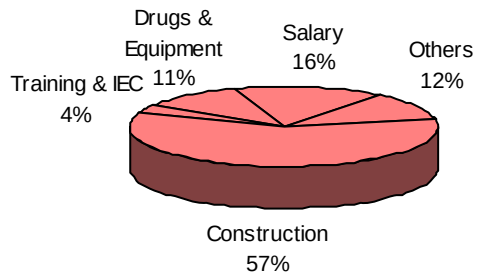
in health services. For meeting the needs of the National Programmes, the vast physical network of PHCs and Sub-centres have been helpful to a great extent.

Whilst the main causes of health problems in India indicate a clear need for a major investment in health education and health promotion, not enough was done in the past to boost the promotive aspect. However, in the recent years IEC activities have been given importance by the government as well as by the Non Government Organizations being supported by the National and International Agencies such as the UNICEF, Plan International, Family Planning Association of India, National AIDS Control Organization, Parivaar Seva Sanstha, Voluntary Health Association of India, CARE, etc. One can now-a-days see the practical outcome of such efforts in the form of billboards, posters, awareness campaigns, and advertisements in newspapers, radio programmes and the television. Over the recent years the role of promotive campaigns has increased. Moreover, the independently run National Programmes on TB, Malaria, Leprosy, HIV/AIDS, etc. have greatly contributed to the promotive aspect.

Therefore, there is no evidence in general to suggest that any of the three aspects of health services – preventive, promotive and curative – has got special attention or received more importance in relation to the other aspects.

One project, i.e. the ODA supported OHFWP programme ran both in the period before the economic reforms programme in India started and also after it. If one looks at the available project documents to know which of the activities dominated the project cost estimates, then the following picture emerges.

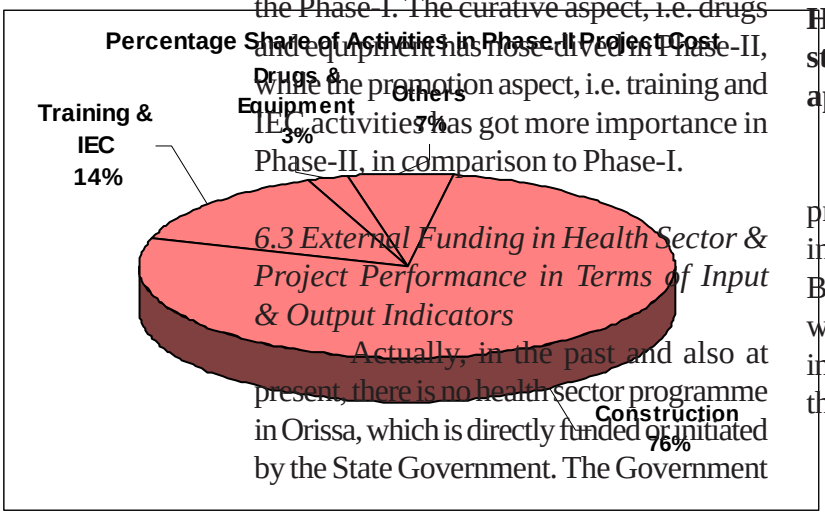
Percentage Share of Activties in Phase-I Project Cost



Note: Phase-I of the ODA Project was implemented in the pre-reform period.

Note: Phase-II of the ODA Project was implemented in the pre-reform period as well as after the reforms started.

The above two pictures give an idea that the preventive aspect, i.e. through the construction of new PHC, CHC and Sub-centre buildings has got a boost in the concerned project in the Phase-II than in the Phase-I. The curative aspect, i.e. drugs and equipment has lose-dived in Phase-II, while the promotion aspect, i.e. training and IEC activities has got more importance in Phase-II, in comparison to Phase-I.



6.3 External Funding in Health Sector & Project Performance in Terms of Input & Output Indicators

Actually, in the past and also at present, there is no health sector programme in Orissa, which is directly funded or initiated by the State Government. The Government of Orissa always implemented the programmes initiated by the Union Health Ministry and followed the National Health Policy guidelines. **Until recently (September 2000) it did not have a Health Policy of its own, although it is still in a draft stage and is awaiting the approval of the State legislature**.

The first two phases of the ODA project did not have any reference to the input and output indicators of the projects. But the Phase-III of the project reflects a well-defined input and output indicators' list in the form of a logical framework. Some of them are reflected in the table below.

Table – 9: Input And Output Indicators Of Phase-III ODA (DFID) Project			
Sl. No.	**Input Indicators**	**Output Indicators**	**How Far Realized**
1	Govt. of Orissa (GoO) continues to support sector-reform programme politically and financially.	Government orders or legislation issued for continued implementation of sector reform by August 2000.	The Draft Health Policy document was ready by September 2002. But it still awaits approval by legislature.
2	District managers have necessary levels of delegated authority for personnel, decision-making and budgets and expenditure.	Health Worker absenteeism reduced to agreed target level. IEC activities and products meet health sector needs.	No available data to suggest that health worker absenteeism has reduced.
3	GoO generates support for and contains opposition to reform, e.g. from health workers, professional organizations, unions and politicians.	Significant increase in user satisfaction. Physical environment meets defined standards of cleanliness and repair.	No satisfactory advancement has been made in all the tiers of health delivery system in the State.
4	Users have influence in priority setting and in the accountability of local health service providers.	SC/ST and women are significantly higher in proportion of people served.	Increase in user numbers. But no certainty regarding the proportion of SC/ST & women.
5	No significant delay in passing orders or legislation for health sector reform.	Directorates of Health & Family Welfare contribute to policy analyses.	Delay in passing orders is the norm in Government sector.
6	Current working practices will not constrain officials' ability to introduce change.	Improvements in indicators of quality, equity and priority setting as a result of maintenance systems and health worker availability.	Management manpower is not in response to the needs of the people. No marked improvement in maintenance systems.

The Secondary Health System Development Project supported by the World Bank and being implemented at present in the State has also very clearly mentioned input and output indicators in the project document. Now it becomes quite evident that the projects that are initiated of late by external agencies always insist on a clear mention of input and output indicators and working on those lines.

As far as centrally sponsored programmes, there is no evidence to suggest that the input and output indicators are taken as the guiding lights for project implementation. But the World Bank and other agencies now-a-days finance most of the nationally implemented programmes. One only hopes that due to insistence of external donors such indicators are accepted as guidelines for implementation of such projects.

6.4 Effects on Health Financing

Over the years the percentage of the expenditure on commodities fell from 27% to around 14%. When translated in

Table – 10: Health Budget as a Percentage of State Budget

Year	Health Budget as %age of state Budget
1990-91	3.61
1991-92	2.92
1992-93	2.98
1993-94	2.96
1994-95	2.74
1995-96	2.86
1996-97	3
1997-98	2.67
1999-2000	3
2000-2001	2.98
2001-2002	3.05

health budget in relation to the total budget of the State has declined. Although, ascertaining the reasons of this decline needs a deeper analysis, one of the reasons could be the flow of external assistance to the State. If this is indeed one of the reasons then the State authorities must formulate long term plans from now to keep the budget increasing even after the external assistance in various activities are withdrawn in future. A glance at the following table will make the picture of the declining health budget clear.

As in the case in many other states of India, a major problem in the health budget of the state is the growing mis-match between salary-related expenditures and expenditures on commodities. The health sector salary-related expenditures increased from 71% of total expenditure in 1974-78 to 81% in 1985-88. Over the same periods, terms of the ratio of salary-related expenditures to commodity-related expenditures, the lopsided growth of the budget is strikingly evident – from 2.6:1 in 1974-78 to 5.6:1 in 1985-88. This trend in the health sector expenditure pattern continues in the present period also. Very serious thought on finding sustainable sources of finance for health services delivery must be made in order to avoid difficult situations in future.

7. Tracking the Flow of Funds at the District, Block and PHC Levels

One of the researchers went on a field trip to the Keonjhar District of Orissa, i.e. one of the districts where health reforms started for the first time in Orissa with the financial assistance of DFID. The researcher interviewed the Chief District Medical Officer (CDMO) regarding the subjects

whether they are able to know what fund comes from which source and whether they maintain separate accounts for each separate source of funds differentiated by the purpose of such funds. The facts that emerged from the interview are the following:

a. At least little more than a decade back, the funds which came from the State Government for different purposes like, building PHCs, Sub-centres, residential quarters for Medical Officers and health personnel, malaria eradication programme, leprosy eradication programme, etc. were not being kept separately for each purpose. This used to create difficulties for the district administration to spend the money rationally and for the purpose it was allocated. When everything was kept together, certain issues used to suffer. This also used to lead to unnecessary expenditure on not-so-important heads. For example, certain amount has been provided for new construction, repair and maintenance. If the amounts are not kept separately, this would invariably lead to over expenditure on construction and as a result, crucial needs for petty maintenance and repair would suffer.

b. Further, for example, the allocation for leprosy programme was overspent because the funds for many programmes were kept together. This would mean less expenditure for malaria programme or TB programme. When funds are earmarked for separate programmes in separate accounts, the usual tendency is to rationalize and economize expenditure and to manage within the given limits. But when funds for various purposes are kept together, usually one purpose is served at the cost of another.

c. However, for the last 6/7 years, with the formation of Zilla Swasthya Samiti (ZSS) – district health committee – the funds for various purposes are being kept separately. The donors also make it a point to ensure that the purpose for which their fund is given is not diluted and the entire allotment is exclusively spent on the specific programme.

d. At least in case of the DFID funded reform package in the Orissa Health & Family Welfare (Phase-III) Programme - OHFWP - the funding agency always insisted for separate accounts at the Block level, i.e. Community Health Centre. But this did not pave the way for maintenance of separate accounts for other programmes/activities.

e. At the PHC level, one can see the trace of the investments made by the ODA, during the OHFWP Phase – I and Phase – II for construction of PHC buildings, expansion of the existing structure or construction of new ones for providing additional beds, construction of residential quarters, etc. even if in most cases the buildings have deteriorated due to low quality of material used during the construction process.

8. Concluding Remarks and Policy Implications

Health sector reforms in Orissa represents a classic case of external assistance propelled initiative, with DFID playing the role of a catalyst. ***Although the researchers have not yet found any document establishing concretely as to why DFID (the erstwhile ODA) chose Orissa as its destination, it can be safely guessed that the relative backwardness of Orissa's economy and the large scale underdeveloped nature of Orissa's health service delivery mechanism must have prompted the external donor agency to invest in creating health infrastructure in the state*** more than two decades back. Accessibility of people in general to some kind of a system at a reachable distance where a doctor and other paramedics are available was seen as a key determinant for delivering health services.

It became a different story altogether when the Orissa government approached the DFID (new *avatar* of ODA) to give funds for Phase III of the predominantly infrastructure-oriented project to cover the remaining 3 districts of Orissa (uncovered by earlier ODA projects). Infrastructure creation was the best option for the political bosses to show tangible results to their constituency. ***The DFID on its own made certain conditions to be realized before it made any commitments for the development of the health sector in the state. This opened the gates for reform initiatives.*** The Government of Orissa (GoO) also went beyond the 3M's and initiated many other measures for ensuring a better health delivery mechanism in the state.

But when we measure the success of such initiatives, there seems to be little reason for celebration. ***The number of externally assisted projects in Orissa has increased. It has certainly created a better impact in terms of removing the immediate worry of the GoO to search for sources of funds to address the health of the people of the state. But this opportunity has not been utilized to find out alternative and sustainable sources of finance for financing the health sector needs in future.***

It has certainly created more buildings, equipment, beds, medical and paramedical staff, vehicles, volume of drugs, etc. But putting these hardware to good use and thereby meeting peoples' needs in this poor state has remained far from satisfactory. Here a clear distinction between 'process' and 'performance' indicators has become glaring vis-à-vis reform outcomes. ***The process outputs have been encouraging. But there seems to be no trace of a perceptible increase in the performance of the health sector.***

The 'hardware' in any given situation will show good results only when it is put to rigorous use. But the persons

responsible to put them into good use must be adaptable to the changed scenario and the new demands. There is in fact a lack of internalization of the reform measures by the health sector personnel themselves. A retired health sector professional remarked very aptly during an interview that ***'although the wherewithal to ensure better health service delivery has been by and large put in place through external support, the persons suitable to implement the same cannot unfortunately be supplied by the external agencies. They have to be our local people or those who are already inside the system. Unless they internalize the prerequisites of a broad based reformed structure, how can we expect better results from them in the field?'***

Realizing this need, a sectoral investment programme (by EC) specially designed for reforming people who are manning the state's health sector has already begun. A case in point is the initiative of the Orissa government to send young doctors pursuing their P.G. courses in the 3 Medical Colleges of the state to remote areas for serving the people in the remote/rural areas. This was mooted as a solution to the perpetual problem of large-scale absence of doctors in those areas. Doctors who have a family or children never wanted to be posted in rural areas because of the fear of their family being left out of the modern facilities that are available in the towns or their children lagging behind others for want of good educational institutions in a rural set up. To overcome this problem it was thought that if young people were posted in rural areas then a long-term solution could be effected to this complex problem. Even to encourage such people and also to have a safeguard, it was decided to award some marks to such people in their P.G. Degree examination in lieu of their service in the rural areas. But this also has not resulted in any good result. Numerous newspaper reports suggest that this system has not worked and the people at the helm of affairs in the Directorate of Health Services also admit that this system has been a great failure and the doctors posted in rural areas find out their ways to remain absent for a large part of the month.

In order to effectively check this large scale absence of doctors in rural areas the State Health Department decided in January 2003 that the doctors cannot go on leave unless they take permission from the concerned Panchayat Samiti. ***This decision was reported to have been taken after much insistence of the external donors like the DFID***. But as soon as this news was out, the doctors started giving warnings to the state government for 'mass leave' or 'mass resignation' if they were asked to report to such people as the Chairperson of the concerned Panchayat Samiti. It shows very firm reluctance on the part of health professionals when community control over health issues is put in the agenda. This raises a larger question in the health service delivery

system. What is the way to ensure community participation when community based institutions like the *Panchayats* are prevented from having a say in the health issues? ***The most crucial factor in ensuring proper health service inside the government system to the poor who cannot afford 'private health service systems' is the doctor's ready availability at the health centre for consultation. If the doctor is missing or is unwilling to cooperate with the community evolved mechanism, then what is the way out? Is there any other mechanism that can work satisfactorily to ensure the doctor's presence in rural areas?*** This remains one of the points in the unfinished agenda of the reform process.

There are reports regarding satisfaction of people with the 'user charges' collection system. ***Some places like 'Jeypore' in Koraput District have become the ideal cases for emulation in user fee collection, their proper utilization and delivering expected services to the people.*** However, in most of the cases this option has not been tried out with commitment by the health professionals in spite of the fact that it has great potential for raising crucial resources for the health sector. With a little more commitment the facility user can go back being more satisfied and that will eventually increase the chances of more user fee collection. ***Some health administrators sitting at the headquarters also express their unhappiness with the system simply because they have lost control over some finances. They are skeptical of the proper utilization of resources that are raised at the hospital level because they think that they are always the better managers of public funds. Their 'heartburn' can be understood from the fact that even for petty expenditure the district health administrator used to come to them asking for allocations. They are obviously annoyed because their role in control over resources has more or less decreased.*** They spare no opportunity to dub the new system as people's welfare retarding. This is another crucial point to cite the unpreparedness of health sector personnel to accept the newer nuances of reforms.

The ordinary health service user somehow has not been put high on the agenda during this period although clear indications are there on behalf of the donor agencies asking the government to introduce systems for such changes. ***The health system has somehow become a hostage to the needs and aspirations of the personnel who are getting paid for their work. There is more concern among these people when attempts are made to make them more accountable or to deliver the goods properly. Their voices get shriller whenever they think that their interests are going to suffer on account of attempts for bettering the system in favour of the rural people.*** The

political class has never been able to convince them to do the needful or accept the change. How after all the people are to be given better service if their voices are not heard or they are not made party to decisions that ultimately affect their future? What kind of reform measure needs to be taken to ensure a people-centric approach? The answer is not unavailable. There are instances in our own country in states like Kerala and Andhra Pradesh where the rural health service delivery mechanism has been linked with the P*anchayat* systems of governance. The time has now come for taking the right initiatives for achieving desired changes that percolate to the lowest level.

Somehow or the other, the finer messages of economic reforms have not percolated well in the health sector. The efforts for systemic changes, less government intervention, facilitating community involvement in deciding the nature of primary health service delivery mechanism, searching for alternative and viable sources of resources within the system, raising performance levels of the health sector professionals have not been made at all.

The 'Vision Document – 2010' recently developed by the GoO and the 'Draft Health Policy' document reflect a very tall order for the achievements to be made in the future as a part of the overall reforms initiatives. Obviously, there has been enough indication in the document regarding the crucial role of external assistance for achieving a 'reformed health sector'. The following are some of the key highlights of the future agenda of action in the health sector of Orissa.

i. Substantial reduction in IMR, MMR, communicable disease burden and effective check on non-communicable diseases.
ii. Better distribution of public provided services in terms of equity and geographic access.
iii. Partnership with private providers in comprehensive health care.
iv. Professionally managed hospitals with personnel skill upgradation and staff motivation.
v. Differential charging of health services.
vi. A mix of financing options including community financing, health insurance and government financing keeping in view the increasing fiscal constraints.
vii. Health and Family Welfare services to be charged at cost for people above a particular income level.

Some of these long-term objectives can only be achieved through a broad-based reform initiatives and the key to the successful achievement of these is a larger role for the people's participation. These objectives also reflect user cost collection as a crucial input for financing the health sector needs. ***Wide***

ranging partnerships with a variety of stake holders, differential charging of health services, full cost recovery from some targeted population, equity and geographic access are very crucial elements for any health sector initiatives and these action points are very well in tandem with the overall reform process of the economy as a whole. The future of health service and achieving the ultimate goal of 'health for all' will only be a reality if strong and determined steps are taken by all the key players in the health sector.

In order to achieve these, it is recommended that a serious attempt for fusion of initiatives by the health providers, community leaders, health administrators, health sector researchers and non-government organizations should be made to achieve the long-term goals. For this a further identification of research goals in the areas of user fee collection, networking for public-private domain partnerships, scope, feasibility and methodology of differential fee collection and areas for greater community involvement is necessary to give further impetus to policy making and targeting of achievable and deliverable goals within a reasonable span of time.

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Persons Interviewed

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2. Dr. Suresh Mishra, Consultant, OHSDP (World Bank Project) & Former Project Officer, OHFWP (ODA Project).
3. Dr. Jyotsna Pattnaik, Project Officer, OHFWP (ODA/DFID Project).
4. Dr. Anusuya Das, Consultant, European Commission's Sector Investment Project & Former Project Officer, OHFWP (ODA/DFID Project)
5. Dr. Vijay Pillai, Consultant, DFID, Orissa
6. Ms. Supriya Pattnaik, Head of Orissa State DFID, Bhubaneswar.
7. Dr. Siba Kumar Rath, Consultant, European Commission's Sector Investment Project & Former CDMO of Cuttack and Bolangir Districts.
8. Dr. P. K. Acharya, Former Director, Health Services, Government of Orissa.
9. Dr. Ranjana Kar, Assistant Director, SIHFW and Former Statistician, OHFWP (ODA/DFID Project).
10. Mr. N. G. Bal, Statistical Advisor, OHSDP (World Bank Project) & Former Assistant Director, Statistics, Government of Orissa.
11. Mr. Ajay Seth, Director, DEA, Government of India.
12. Dr. Seba Mahapatra, Director, Health Services, Government of Orissa.
13. Mr. S. K. Naik, Secretary, Health, Government of India.
14. Dr. B. P. Mahapatra, Head, Orissa State Unit, UNFPA.
15. Dr. A.C. Dey, CDMO, Keonjhar District, Orissa.
16. Dr. R. K. Paty, Deputy Director, Orissa Drug Management Unit, Bhubaneswar.