

## RAJASTHAN

Rajasthan evokes multihued images of a land of gallant rulers and bedecked camels dotting the desert landscape. In the last fifty years, it has emerged as a major tourist destination in India, both for the domestic and foreign tourists. Rajasthan has a total geographical area of 3,42,239 sq. km. The state was formed in March 1949, by a merger of 19 principalities and 2 chief ships, with Ajmer-Merwara being added in 1956, as recommended by the States' Reorganization Commission. Administratively, it is divided into 32 districts, which are further sub-divided into 241 tehsils and 237 development blocks. The State is characterized by a dispersed pattern of settlement, with diverse physiography ranging from desert and semi-arid regions of Western Rajasthan to the greener belt east of the Aravallis, and the hilly tribal tracts in the Southeast. More than 60 percent of the State's total area is desert, with sparsely distributed population. Agriculture continues to be dependent on rainfall, the failure of which causes severe drought and scarcity conditions. The decadal growth of population is high in Rajasthan, while the literacy level, especially for girls, is among the lowest in the country. At the same time, Rajasthan has witnessed several important initiatives involving voluntary groups, issue-based citizens' action, and democratic decentralisation. There have been efforts by citizens to organise themselves to fight perceived injustice and specific causes. Some notable examples of public action include the movement for right to information.

### Organization of Health Services and Programmes

During the last few decades, the medical and health infrastructure has expanded considerably in Rajasthan,

<sup>1</sup> The Integrated Population and Development (IPD) project is being implemented in seven districts of Rajasthan through UNFPA assistance since February, 1999.

particularly in the rural areas. As in other states, Rajasthan too is involved in implementation of various national health programmes. The UNFPA supported IPD<sup>1</sup> project is also under implementation while the Secondary Health System Project supported by the World Bank is also underway. Some of the challenges facing the health sector include provision of healthcare for infants and children; reproductive health and antenatal and postnatal care of the mother; diseases associated with poverty; and poor sanitation. The burden of disease imposed upon women by patriarchal culture the stark regional and social disparities, increasing signs of discrimination against women, and the poor condition of health services needs to be addressed on a priority basis.<sup>2</sup>

In an attempt to improve access to health care, the State has been investing over 50% of the plan funds for primary health care for the last decade. At the same time, in order to ensure sufficient funds for development of secondary and tertiary levels of care, the State Government has attempted certain reforms and innovations.<sup>3</sup>

Reforms initiatives in Rajasthan include:

### (I) Public Private Partnership

#### A. **Participation of the private sector in health**

With a view to participation of the private sector in health, the Government of Rajasthan has initiated a series of policy measures. These include formulation of a policy

<sup>2</sup>Govt. of Rajasthan (2002), "Rajasthan Human Development Report 2002", Government of Rajasthan.

<sup>3</sup>Govt. of Rajasthan (2003), Power-point presentation on 'Rajasthan Health System Reforms: A Perspective' at the workshop on India's Health System: Role of Health Sector, September 4-5, 2003, New Delhi, organized by GOI in collaboration with the WHO.

on private sector participation for installation of sophisticated medical technology in public sector hospitals, policy of medical colleges / dental colleges in private sector, formation of guidelines for setting up nursing institutions in the private sector and rules regarding acceptance of donation and charities from private individuals or public bodies for medical purposes.

**(i) Policy on private sector participation for installation of sophisticated medical technology in public sector hospitals<sup>4</sup>**

With a view to equip the government hospitals with latest diagnostic and treatment machines/equipment, the GoR decided to involve the private sector to install these diagnostic/treatment machines/equipment in hospitals. The Medicare Relief Society has the authority to decide the number and type of diagnostic/treatment machines required for efficient functioning of the hospital. The broad criteria for deciding the number and type of machines is based on patient load and capacity of the machines already installed in the hospital. The machines/equipment would be divided in two categories: (a) Investigative/diagnostic Machines<sup>ii</sup> and Equipment and (b) Treatment machines<sup>iii</sup> (e.g. Lithotripsy). While fixing rates for procedures, the element of cross subsidization for exempted categories like BPL families/ widows/ destitute and others is also kept in view.

Following the implementation of this policy, no new diagnostic machines/equipment and sophisticated treatment machines would be purchased either from Government budget or from RMRS funds. Thereafter, only in cases where private investment might not be feasible, cases for prior permission of the Government

<sup>4</sup> Department of Medical, Health & Family Welfare Services, GoR (2000), Policy on private sector participation for installation of sophisticated medical technology in public sector hospitals, Govt. of Rajasthan & GO No. F.15 (5)MPH/Gr.-2/99.

would be moved for such purchases. Existing machines would continue to be operated by the hospitals till they became obsolete or beyond economical repair/ replacement. If a machine/equipment is under utilized, the Government would consider transferring it to the private sector, to avoid uneconomical operation and unnecessary burden on state exchequer. For ensuring quality of tests, quality protocols would be developed and circulated for implementation. This policy is expected to benefit the patients as availability of ensured clientele in public hospitals would bring down the rates of various tests/procedures considerably as compared to the market rates. Once the machines are installed, the doctors would not be allowed to refer patients to other private centers for tests in the areas for which facilities are available in hospitals.

**(ii) Policy for medical colleges / dental colleges in private sector<sup>5</sup>**

To involve the private sector in augmenting the availability of doctors and medical facilities in the state, a policy for private sector participation in Medical and Dental education was announced. This policy seeks to attract investors to set up Medical and Dental Colleges in the private sector in the State. As per the Cabinet decision on the subject<sup>6</sup> and recommendations of the Empowered Committee for Establishment of Medical and Dental Colleges in private sector, the essentiality certificate cum NOC for establishment of Medical College/Dental College in private sector in the State will be issued by the Sub Committee of the administrative department subject to certain conditions.

<sup>5</sup> Department of Medical, Health & Family Welfare Services, GoR (2000), Policy for medical colleges / dental colleges in private sector, Govt. of Rajasthan

<sup>6</sup>No.67/97 dated 7.8.1997

These conditions include undertaking by the applicant organization to follow norms and directives of the MCI/DCI and the Supreme Court regarding fee and other aspects of admissions; to establish College & Hospital in a given time frame; agreement to abide by the selection/admission criteria laid down by State Govt. MCI and DCI and availability of sufficient funds for development and guarantees. Thereafter, only eligible applications are forwarded to MCI/DCI/MOHFW. It is further stipulated that the applicant organization needs to have sufficient land for establishment; development and expansion of College and Hospital, under its ownership.

The final decision is based on availability of land with the organization, availability of hospital having minimum 300 beds for Medical College / 100 beds for Dental College with scope for expansion, involvement of associates from the field of Medical Sciences, Administration/ Management and Financial Management amongst other criteria.

### **(iii) Guidelines for setting up nursing colleges<sup>7</sup>**

With the purpose of augmenting availability of trained para medical/ nursing personnel in the State, guidelines have been issued for setting nursing colleges in the private sector. It is stipulated these schools follow the curriculum prescribed by the Indian Nursing Council/Rajasthan Nursing Council. The school is required to fulfill prescribed standards/requirements set by Indian Nursing Council/Rajasthan Nursing Council with regard to teaching staff; physical facilities; clinical facilities including hospital and field practice area; hospital beds etc; admission criteria and process. Further, they must

be registered under Societies Registration Act 1860,  
<sup>7</sup>Department Of Medical, Health & Family Welfare Services, GoR (2000), "Guidelines for setting up of nursing institutions in private sector", Govt. of Rajasthan

Trust Act 1882, Wakf Act 1954, or under similar legal provisions applicable in the State.

Procedurally, the recommendation for granting permission to establish nursing training institution is forwarded to Indian Nursing Council. Priority is given to organizations having their own hospital with 150 beds. Those not having their own hospital are required to submit an agreement letter from the Superintendent of the hospital, that such facilities will be made available for a minimum, period of three years. It is also required that such hospitals are located within a radius of 10 km from the training school. Attachment with any government hospital is not permitted. Stipulations are made about the proportion of male and female students to be admitted, proportion of NRI candidates who can be admitted, and reservation rules. A committee comprising of Secretary, Medical & Health & FW, Director, Medical & Health Services and others is the final decision making authority.

### **(iv) Rules for acceptance of donations and charities<sup>8</sup>**

The Government of Rajasthan has formulated rules, called the Rajasthan Medical Institution (Contribution) Rules, 1980 for acceptance of donations and charities from private individuals or public bodies for medical purposes. As per provisions of these rules, any contribution, subject to its acceptance by the Government would consist of cash or be in kind for equipment, drugs, food materials or any property moveable or immovable, legally transferable for the purpose of Medical

<sup>8</sup>Department of Medical, Health & Family Welfare Services, GoR (2000), "Rules regarding acceptance of Donations & Charities from Private Individuals or Public Bodies for Medical purposes", Govt. of Rajasthan

Institutions & Services. Every contribution made under these rules can only be utilized for the specific object or purpose for which it has been made. Any person/s or public body desirous of making a contribution is required to apply in writing to the Government, offering the same and also stating the purpose for which the offer may be utilized. In cases where the government accepts a contribution for the purpose of construction works, it may if required, allot land free of charge. It is stipulated that in such cases, the land shall remain the property of the government, its construction and furnishing shall be in accordance with the plan prepared or concurred by the State Public Works Department and that the building so constructed shall vest with the State Medical & Public Health Department.

The amount of contribution which can be accepted by the authority or authorities at various levels has been laid down. For instance, the Director of Medical & Health Services can accept a donation upto Rs. 10 lakhs. These donations are meant for betterment of the existing facilities and should not impose any additional financial liability on the State. Further, any contribution received under these rules, is required to be notified in the Rajasthan Gazette. A gift deed appropriately modified and approved by the competent authority, is required to be executed for all items of donations accepted under these rules.

**(v) Policy to encourage private investment in hospitals, diagnostic centres & nursing homes**

In order to encourage the private investment in hospitals, diagnostic centres and nursing homes,

Medical and Health Department of Government of Rajasthan (GoR) developed a detailed policy in 1996.<sup>iv</sup>

Since then, the GoR has developed a policy for attracting private investors including Non Resident Indians to set up their projects in the health sector. This policy encourages the establishment of hospitals (having atleast 50 beds along with OPD facilities), diagnostic centres, charitable medical institutions and nursing homes (having atleast 10 beds along with OPD facilities). As an incentive, land is allotted for setting up various categories of medical institutions in the private sector, at 25 percent of the market price of agricultural land in rural area for upto 10,000 sq. meters and at 50 percent of market price for more than 10,000 sq. meters. In urban areas, the land is sold at the reserve price for residential purposes.

The policy accords concessions to poor patients. Medical institutions that have been allotted land on concessional rates are required to provide at least 10 percent of beds free to BPL card holders. They would be charged only 25% of the cost of medicines, diagnostic tests and other expenditure. Furthermore, such institutions are required to provide OPD facility for one hour daily, twice a day for BPL card holders, economically weaker sections and to poor patients. They are also required to maintain separate records of poor patients given free service.

In case, the land allotted is not utilized for setting up various categories of institutions within a period of three years from the date of allotment, the same would revert back to Government and any structure erected

on it, would become the property of the State Government.

A State level Empowered Committee under the chairmanship of Chief Secretary set up under a single window system would consider the proposals referred to the Government for providing facilities and incentives under the policy.

### **B. Outsourcing of services**

In the State of Rajasthan, contracting out has been undertaken for the cleaning services in hospitals, management of the cycle stand as well as the canteen. Details of the same are being ascertained.

## **(II) Decentralization**

### **A. Initiatives in Decentralization**

The Government of Rajasthan has embarked on a programme of strengthening panchayats and granting them a greater role in governance and public affairs. The linkage between decentralisation strategies and health care has become an important thrust area. Following the 73<sup>rd</sup> and 74<sup>th</sup> Constitutional Amendments, the Rajasthan Panchayati Raj (Modification of provision in their application to the Scheduled Areas) Act 1999 has been enacted in order to provide wide ranging powers to the village committees in the predominantly tribal areas. By way of legislation, all sarpanchas have been made members of respective Panchayat Samitis and similarly all pradhans have been made members of Zila Parishads. Furthermore, 29 subjects have been identified for transfer to panchayats under section 243 G of the 11<sup>th</sup> schedule of the Constitution. Out of these, in 16 subjects viz. Medical and Health, Family Welfare,

Ayurveda, Renewable Energy, Forests, Animal Husbandry, Fisheries, Rural Development, Agriculture, Food & Civil Supplies, Social Welfare, ICDS, Irrigation, PHED, Primary Education & Literacy, the local level institutions have been transferred to PRIs in Rajasthan.

The other developments include decentralization of planning to the district level through District Planning Committees which is headed by Zila Pramukh. The planning and execution of local level schemes is being increasingly done through a three-tier Panchayati Raj structure. The Chief Planning Officers posted in the districts serve as Member-Secretaries of these committees with the overall function being overseen by the Panchayati Raj Department at State Level. Procedures have been evolved in order to ensure effective social audit of all developmental programmes through the meetings of Gram and Ward Sabhas.

However, there are some inherent problems in the interface between panchayats and the health system. These relate to the disjunction in jurisdiction between panchayats and the tiers of the health system. Further, the technical character of delivery of curative health services does not conform to the current cultural and capacity mode of panchayats. Therefore, investment in building capacity of local bodies for better health planning and management is seen as essential.

### **(i) District Reproductive & Child Health (RCH) Society & Decentralized Programme Management**

The Government of Rajasthan constituted District Health Societies (DHS) in all districts<sup>9</sup> thereby merging four

<sup>9</sup> GO dated 15<sup>th</sup> July 1999

societies – Malaria, Tuberculosis, Leprosy and Blindness into a District Health Society. Through this initiative, it sought to ensure extensive decentralization of powers and responsibilities to the district level. Guidelines were laid down pertaining to registration, membership criteria, roles and responsibilities of members, meetings, etc. It was envisaged that the DHS would be responsible for approval of annual plans and budgets. The Health and Family Welfare Department officials were empowered to implement the plans, once approved without any need for subsequent approvals on files.<sup>10</sup>

The District RCH societies were registered in 1999 to facilitate implementation of World Bank funded RCH project. Thereafter, in the UNFPA supported seven IPD<sup>11</sup> districts, these societies were extended to include IPD project objectives. A major shift in the implementation strategy of the IPD Project is the decentralization of programme planning, implementation and evaluation through District RCH Society (DRCHS). The DRCHS has the authority and accountability for project implementation. It has full powers to make financial and administrative decisions subject to the overall guidelines and directions issued by the GoR.

In the year 1999-2000, the UNFPA-IPD project<sup>12</sup> implementation started through the extended District RCH societies. As a first step, the members of the Societies were oriented about the objective and functioning of society. Thereafter, the financial and budgetary rules for the functioning of societies were

<sup>10</sup> Department Letter dated, 12<sup>th</sup> August 1999

<sup>11</sup> The project aims to improve access and quality of reproductive health services, contribute to promotion of gender equity and equality, introduce missing RH services, address the needs of sub-population, enhance availability and utilization of emergency obstetric care and enhance management capabilities at state and district level through promotion of decentralized programme planning and management.

developed and shared with district societies; the details of recruitment process for the staff of District Project Management Cell (PMC) were developed by State Project Management Unit (PMU) in consultation with office bearer of district societies. The staff of newly established District Project Management Cell (PMC) and District RCH officers were oriented about the functioning of District society mechanism in a state level workshop and efforts were made to provide support in terms of technical inputs and guidelines required to enhance capacity for decentralised management.

In the initial stage, it was felt that decentralisation of project management at district level created several layers of bureaucracy resulting into lengthy procedures of decision making. One of the most difficult tasks faced by state PMU was to bring about changes in the functioning style of district officers. In the month of August 1999, a meeting of all Chief Medical and Health officers was organized wherein the Chief Medical & Health Officers expressed that the working of societies had been centralised by Collectors resulting into delay in decision making. The secretary (FW) issued a circular to clarify the role of chairman and other issues related to functioning of district societies. This helped to an extent to systematize functioning of district societies. In the second year of project implementation, functioning of district societies were analyzed at the state level. It was observed that though the society mechanism brought about structural, functional and operational changes into functioning of government system at district level, the results were not reaching upto the expected levels. Some of the issues identified included, the manner in which the meetings were organized, systems for programme

<sup>12</sup> Kumar Abhay & Jain M.L (2003), “Decentralized Program Management: An IPD Experience”, IPD Project Review Workshop, jointly organized by GOR and UNFPA, 15 Feb 2003

monitoring and financial control. Hence, an attempt was made to streamline functioning of district societies, so that expected project objectives could be achieved in the project period.

The District Society has a Governing Board (GB) chaired by District Collector. The Chief Medical & Health Officer / District RCH Officer (RCHO) is the Member Secretary of the GB<sup>v</sup>. The Executive Committee (EC) of the DRCHS is chaired by the CM&HO and has to meet every month to develop operational plans, review progress and ensure project implementation on the laid down procedures and on the guidelines issued by GoR<sup>vi</sup>. The RCHO is the member Secretary of the Executive Committee.

In terms of programme implementation, at the National level, the Department of Family Welfare under the Ministry of Health and Family Welfare, GOI is executing the project. At the state level, this is managed and implemented by Department of Health and Family Welfare. The other project partners include, Department of Women, Child Development, Education, Panchyati Raj, the Women's Resource Centre (WRC) and non-governmental agencies involved in the implementation of IPD activities at the state level. The Dy. Secretary (Medical Group V) is the Project Director of IPD project while at the district level, the programme is implemented through the DRCHS under the Chairpersonship of the District Collector. It provides for active participation of elected public representatives and NGOs in the planning and implementation of the activities, close coordination among the on-going health and FW projects and partner departments.

The challenges faced in establishing a society mechanism for decentralized program management brings out the important role played by individuals as well as the adverse impact of the frequent turnover of officials on systematization of the society. It is apparent that time needs to be invested in ensuring that district officers initiate appropriate decision making processes especially since, at times the delegation of authority to district society is perceived as a redistribution of the existing decision making authority and resisted by those who fear the potential loss of power. At such a juncture, State government needs to create an environment so that the people particularly at the state level accept change. This clearly brings out the necessity to develop clear understanding among the key officers about their role and responsibilities to make decentralization process functional. Furthermore, the involvement and commitment of members of society from other government department, NGOs and PRI representatives is essential for ensuring the success of this effort.

### (III) Reforms related to Human Resources

#### **A. Appointments on contractual basis**

With a view to fill in the large number of posts of Medical Doctors lying vacant in districts, and thereby having an impact on the care and treatment of patients, the State government decided to hire the services of Medical Officers (MBBS degree holders), either by way of hiring retired doctors or appointing doctors on an ad-hoc basis.<sup>13</sup> The state government decided to hire services of retired doctors in 10 districts. A committee comprising of the concerned District Collector and Chief Medical

<sup>13</sup> GO No. F (33) MPH/Gr.II/94 dated 26.10.1994

& Health Officer appoints these Medical Officers, subject to certain terms and conditions. The terms and conditions stipulated that these contractual appointments would be made for a period of one year, and would be subject to extension, if required; the doctor should not have crossed 65 years of age and should be in good physical health. The remuneration is fixed at Rs. 150 per day. These appointments were made as against sanctioned posts only and the Chief Medical Officer is responsible for issuing the appointment orders, based on the recommendations of the above mentioned committee.

In case of ad-hoc appointments of doctors, the Chief Medical Officer is authorized to appoint doctors against sanctioned vacant posts, based on recommendations of the committee, which comprises of the District Collector, Joint / Deputy Director posted at respective divisional headquarter, the concerned Treasury Officer and the CMO himself/herself. The presence of the District Collector is essential at the time of the committee arriving at any decision pertaining to these appointments. These ad-hoc appointments are made as per the usual terms and conditions. Similarly, contractual appointments are being given to Auxiliary Nurse Midwives (ANMs), Laboratory technicians, Staff nurses and medical officers at the district level.

Since the implementation of this scheme, certain modifications have been affected. The details of the same are being ascertained.

## **B. Initiation of three month anaesthesia training**

In order to address the shortfall of anaesthetists and bring about rational allocation of resources, a three month training in anaesthesia has been initiated. This initiative aims to address the design problem, wherein at the CHC level, provisions were made for appointment of surgeons. However, no stipulations were made to ensure that supportive services of anaesthetists too are available to the surgeons. Hence, a short term training course of three months was started wherein the Medical Officers were trained as anaesthetists. As a response to this, cases were registered in the High Court against these doctors, thereby leading to lack of interest in this initiative. In order to address these problems, a blueprint for ensuring availability of anaesthetists at all CHCs was developed. The interventions planned, included, identification of anaesthetists who have already undergone the three month training and their re-deployment; creating an inventory of those already trained and working as anaesthetist and seeking certification, launching a five and half month training programme supported by the Govt. of India in anaesthesia; increasing the number of post-graduate and diploma seats in anaesthesia, re-designating MOs at CHC as MO-Anaesthesia and retaining the option to train surgeons and gynaecologists in local anaesthesia.

### **(IV) Changes in Financing Methods**

<sup>14</sup> Mangal D.K, (2004) Institutionalization of user charges in government hospitals in Rajasthan, Indian Journal of Health Management, Sage Publications, 6 (1), pp. 1-22.

<sup>15</sup> Mangal D. K, (2004), Power-point presentation on "User fees in Rajasthan" at workshop, 'Strategies for Health Financing in India' January 14, 2004, New Delhi

<sup>16</sup> Lubhaya Ram (2000) Health Financing: Cost Recovery Policies in Rajasthan in 'Financing Reproductive & Child Health Care in Rajasthan', IIMR – The Policy Project, pp- 85-91

### A. Formation of Medical Relief Society<sup>14-15-16</sup>

The first attempts at cost recovery and cost sharing in the early 1980s, took the form of 'pay clinics' and 'auto finance schemes'. In the pay clinics, specialists were permitted to offer consultation services in hospitals on specified days and time, usually immediately before or after the hospitals hours, for a fixed fee. The patients were charged consultation fees by the hospitals, a part of which was distributed to the specialist doctors and the rest was deposited in the government exchequer. An Auto Finance Scheme (AFS) was introduced in 1982, wherein nominal charges were introduced for diagnostic tests, mainly for X-rays. The revenue was to be deposited in the exchequer and the institution was then allotted additional budget for consumables based on its earnings. These schemes became dysfunctional over a period of time and proved to be unsuccessful. The probable reasons for that include, lack of interest on part of the participating specialist doctors and institutions, lack of any incentives to generate revenue, and the fact that the revenue generated was deposited in the State Treasury.

In the face of problems like dwindling public resources in real terms, shortage of diagnostic facilities and laboratory equipment, a general deterioration in physical infrastructure, a need was felt to mobilize resources from the community. Hence, the Medical and Health Department decided to create an autonomous society with a view to introduce collection of user charges vide a government order<sup>17</sup> to create Medicare Relief Society (MRS) in medical college hospitals and all district hospitals under section 20 of the Rajasthan Societies

Act, 1958. A draft constitution and rules were enclosed for reference and adaptation. The societies are registered at hospital level, district level and sub district level and have now been expanded up-to community health centre (CHC) level. In all 304 Medical relief Societies are currently functional in Rajasthan.

Numerous guidelines and orders were issued to ensure effective functioning of these societies. In 1996, the MRS was scaled up to cover all hospitals having upto 100 beds. By way of an order<sup>18</sup>, the control of all equipment, earlier used under the auto finance scheme was transferred to the societies, along with the responsibility for maintenance of the same. Thereafter, purchase of hospital equipment was permitted<sup>19</sup> under the Sahbhagi Nagar Vikas Yojana, wherein if half of the cost of the equipment was obtained through public contribution, the State government contributed the remaining half. Amendments were also made to the Rajasthan Civil Service (Medical Attendance) Rules, 1970 so as to allow reimbursement of the charges paid by the government employees to the MRS for diagnostic tests and investigations. Thereafter, it was decided that the Governing body (GB) of the MRS should include a public representative. Hence, all societies passed a resolution to this effect and MLAs could then be nominated by the government as members in MRS. Another development was the setting up of Life Line Fluid Stores in August 1996 in the SMS Hospital. This was followed by all the societies being advised to start similar outlets in their respective hospitals.<sup>20</sup> Given the positive experience of running MRS, a decision was taken to start such societies at all hospitals having 100 beds and a circular

<sup>17</sup> GO issued on 29<sup>th</sup> September 1995

<sup>18</sup> GO dated 1 February 1996

<sup>19</sup> Department letter dated 11 April 1996

<sup>20</sup> Departmental letter dated 3 September 1996

<sup>21</sup> Circular dated 17 September 1996

<sup>22</sup> Circular dated 23 January 1998

<sup>23</sup> Dated 27 February 1997

to this effect was issued.<sup>21</sup> Thereafter, MRS was started in all hospitals having less than 100 beds through another circular.<sup>22</sup>

In the interim period, various other orders were passed. These included retaining income from cottage wards / private wards and auditorium<sup>23</sup>; provision of free services to poor, freedom fighters, pensioners, retired army men, accident cases, destitute, senior citizens and free investigations under the various national health programmes.<sup>24</sup> In the same year, guidelines were issued for fixing user charges, regular audit of accounts of the society by a Chartered Account and usage of excess revenue in the same calendar year<sup>25</sup> and exemption of donations received from income tax under section 80G of the IT act.<sup>26</sup> In 1998,<sup>27</sup> guidelines were issued for utilization of revenue generated by the societies. These guidelines stipulated that up to 50 percent of the revenue could be spent on purchase of new equipment while the other half had to be spent on provision of facilities to patients, cleanliness, maintenance and purchase of items. Detailed guidelines for purchase, maintenance and repair works were also issued.<sup>28</sup>

The MRS is registered separately for each hospital, based on a model constitution and rules provided by the State government. The management structure of MRS consists of an autonomous management committee comprising of 9-11 official and non-official members at State, Regional and District levels. The Executive Committee takes day to day decisions<sup>vii</sup>.

Essentially the MRS seeks to compliment and supplement the health facility through generation of additional revenue; retain and use the resources generated in the

hospital through decentralized decision-making. The MRS provides low cost diagnostic and treatment services, free medical services to poor and disadvantaged, obtains donations from financial institutions, conserves resources through adopting wards and opening of life line fluid stores, arranges facilities such as the Sulabh complex, maintains buildings, equipment and contracts out services amongst others. It is also authorized to introduce user charges on diagnostics and treatment services. The Society is permitted to retain the revenue generated and to utilize it for improvement of health care services in the respective hospitals. The Society functions outside the purview of the State and the General Financial Rules (GFR) do not apply and it can purchase equipment according to its own requirements. Mainly, the funds in MRS are used for maintenance and renovation of building, maintenance and repair of equipment, purchase of new equipment, improving sanitation and cleanliness, improving other facilities for patients and attendants, computerization of various systems and provision of free medicines for BPL families. The source of funds for the Society includes seed money by State Government and transfer of operational control of diagnostic machines to the societies. As mentioned above, free services are provided to certain sections of the population as stipulated in the order. These include, families living below the poverty line, widows, freedom fighters, destitute, citizens over 70 years and retired government servants.

Cost recovery in Rajasthan averages 10-15% of the hospital budget, although it ranges from 4 to 25% in some institutions. While no systematic costing exercise has been carried out, the rates levied are 50% of the

<sup>24</sup> Order dated 17 October 1997

<sup>25</sup> Letter dated 29 August 1997

<sup>26</sup> Dated 29 September 1997

<sup>27</sup> Order dated 28 January 1998 and 2 June 1998

<sup>28</sup> Dated 15 May 1999

prevailing market rate. Since, the institution of user fees in 1995, the same has been revised thrice. For instance, on an average, the OPD charges are Rs. 2, the inpatient charges being Rs. 5, in-patient referral by private practitioner costs Rs. 10, while the bed charges for the private cabins, cubicles or cottage wards range between Rs. 100-600.

It has been seen that MRS has resulted in improved quality and utilization of services. However, some challenges remain. Some of these include, rational use of surplus funds, ensuring free services to exempted categories, ensuring 25 % of surplus funds are utilized for BPL persons for providing free drugs, ensuring use of funds in the same financial year, developing systems for setting user fee, expanding the scope for levying user fee and ensuring proper systems for perspective planning and accounting.

Regular monitoring of the MRS is undertaken at the level of Director, Health Services and Secretary, Medical & Health Department. The Medical and Health Department provides support to the MRS, monitors the revenue and expenditure on a monthly basis. In August 2000, the state government constituted a state level committee under the chairmanship of the Health Minister to review the working of the MRS.<sup>viii</sup>

At the same time, there continue to remain some policy issues for consideration. Some of the challenges and areas which require more inputs include enhancing management capabilities of the hospital administrators, systems and procedures of procurement, maintenance of equipment and hospital building, contracting and

<sup>29</sup> Chaudhary Ranjit Roy & Gurbani Nirmal Kumar (2004), 'Life Line Fluid and Drug Stores: State Sponsored Cost-Sharing Medical care through autonomous societies' in 'Enhancing Access to Quality Medicines for the Underserved', pp. 10-33, Anamaya Publishers, New Delhi.

outsourcing, ensuring that the state does not reduce current level of funding, issuing clear guidelines and principles, ensuring adequate representation of public representatives, ensuring that the hospital administrators are oriented and trained well, creating transparent, efficient and accountable systems for collection, retention, and use of excess funds generated, designing intervention in consultation with key stake holders and extending support to the initiative.

#### **B. Establishment of Life Line Fluid Stores<sup>29</sup>**

Based on the success achieved in implementing the Medical Relief Society (MRS) in the SMS Hospital Jaipur, another innovative source of finance, the Life Line Fluid Store (LLFS) was established in August 1996 to provide high quality drugs and surgical items to patients at affordable prices. The LLFS is a pharmacy store that functions within the public hospital.

It was seen that I.V fluids and drips, for which there was a big demand, were being sold by the retailers at the printed maximum retail price (MRP) of Rs. 30-35/- (including Local Tax), while the real cost to the wholesaler was in the range of Rs. 6-7. Hence, there was a huge margin, which was passed on to the patient. Given the success of implementing the MRS, it was felt that the MRS could act as an outlet for selling of essential and emergency drugs wherein the drugs would be sold to the patients at a marginal profit and at almost 40 to 50 percent of the market cost. This was the genesis of the LLFS.

As a first step, a dedicated and efficient manager with experience in business was identified, followed by

identification of space within the hospital for storage and selling of the drugs. An arrangement was worked out, wherein products of interested manufacturers were kept on a consignment basis. Based on the sales, payments were made, after a period of 15 days. A committee of doctors was authorized to select the pharmaceutical products that were to be sold and to fix their sale prices. To prevent the monopoly of any one manufacturer, to safeguard against stock out situations and to ensure uninterrupted and regular availability of products, the price of the lowest bidder of repute was fixed as the standard price of the drug. The quality aspect was assured by selecting only reputed manufacturers approved by the committee of doctors. The suppliers in turn were informed that the LLFS was under no obligation to sell their products and in case of any doubt about the quality, the stock would be returned. Hence, selection decisions are based on information regarding the quality of the products, the market price, the price offered by the supplier and demand, without a tender process by taking a 'lowest price certificate' from the supplier. Branded products of reputed companies are also approved. The benefits of sales from the promotional schemes offered by the manufacturer/supplier in turn are passed on to the consumers.

The contract for each LLFS is awarded by the MRS to a pharmacist as a contractor for a period of 1-2 years by inviting applications. Guidelines for selection of contractor have been issued.<sup>30</sup> The contractor is provided a fixed salary plus 1% commission on the sale and has to manage the supporting staff from the receipts. The contractor manages the sale, procurement of approved ~~items and maintenance of~~ necessary stock and sale

<sup>30</sup> GO No. F.14(1) M&H/1/97/2 dated 21.10.2000

<sup>31</sup> Vide a Department letter dated 3 September 1996.

<sup>32</sup> GO No. F.22(15) Med./74 Pt. dated 6.3.2000 and GO F.22(15) Med.2/74 Pt. dated 27.3.2000

accounts. The suppliers maintain the supplies at their stores, through a 'challan' (a credit note issued by the seller), and receive payment on sale. A separate account is maintained for the LLFS, which is incorporated into the MRS account at the close of the financial year.

As a response to the establishment of the LLFS at SMS hospital, the Chemists and Druggists Association (CDA) started lobbying against it. A resolution was passed, that no supplier would supply drugs to LLFS on a consignment basis. However, this decision was defied by the suppliers, who continued to provide drugs to the LLFS. Presently, I.V. fluids, surgical items and injectable antibiotics are also sold through the LLFS. Following the success of LLFS at the SMS hospital, all the MRS were directed to start LLFS.<sup>31</sup> The LLFS functions in all hospitals with 100 or more beds and the services are available for 24 hours.

(V) Re-organization and re-structuring of existing system

**A. Drug Policy & Procurement system**

Drug policy and procurement reforms consist of formulation of an Essential Drug List (EDL) and directions for implementation. The genesis of drug policy and related reforms in Rajasthan can broadly be traced to the organization of a workshop on rational use of drugs in 1998. Based on the recommendations of this workshop, a committee was formed to develop an EDL. The EDL was then finalized and began to be used for procurement<sup>32</sup>. The EDL, first developed in 2000 is presently being revised. The standard treatment

guidelines (STGs) have also been developed and are currently under notification. In terms of procurement, centralized approval is sought and procurement is undertaken at the districts. Available drugs are purchased from Rajasthan Drugs & Pharmaceuticals Limited at an institutional price while for the remaining, tenders are invited from other PSUs and decision is made through a two-bid system.

### **B. Creation of Rajiv Gandhi Population Mission<sup>33</sup>**

The Rajiv Gandhi Population Mission was created in 2001 under the chairmanship of the Chief Minister, in compliance of the Cabinet decision 68/2001, dated 20-21 June 2001. The Mission seeks to enhance the effective implementation of the Rajasthan State Population Policy-2000. It also seeks to optimally utilize the opportunities created through Panchayati Raj, enhance public-private partnership for improving the availability and accessibility of health services to the people. The strategies to be utilized include increasing access to reproductive health and family planning services through social marketing, creating demand for reproductive health and family planning services, ensuring effective inter-sectoral collaboration, effective implementation of legislation; concentrating on the unmet need for reproductive and child health and family planning and improving quality of care. The Mission is headed by a full time Mission Director and Secretary to the Chief Minister is the Mission Co-ordinator. An Empowered Committee supports the Mission while a Technical Support Group assists the Mission Director.

In order to ensure need based, area specific interventions, decentralized programme management forms the cornerstone of the Mission. The health and population programme management has been decentralized to the PRIs. Annual plans at the village, sub-centre, PHC and district levels are being prepared with the active participation of the community and functionaries of related departments at the respective levels. Local capacity building for decentralized participatory planning has also been created. The PRIs are responsible for approval, implementation and monitoring of the performance of the programme.

### **(VI) Innovative Schemes & Programmes**

#### **A. Jan Mangal Programme<sup>34</sup>**

The Jan Mangal Programme was started to promote the health of the mother and child through proper spacing between births. The programme first began in 1992-93 in Udaipur and Alwar districts of Rajasthan. Based on the spirit of volunteerism, the programme is routed by a husband-wife couple at the village level. These couple volunteers are identified as Jan Mangal Couples (JMC). One JMC is selected for every village having a population of 500 to 1,000 while two JMCs are selected for villages having population between 1,000 – 2,000. The selection of JMC is undertaken by ANMs by contacting opinion leaders, elected representatives, ICDS worker, Nehru Yuva Kendra (NYK) members and adult education teachers. Based on the list provided by the ANMs, the final selection is done by Deputy Chief Medical and Health Officer (Family Welfare) at the district level. The stipulated criteria is that the couple resides in the village, enjoys credibility in the community,

<sup>33</sup> Govt. of Rajasthan (2001), Mission Document: Rajiv Gandhi Population Mission, Medical, Health & Family Welfare Dept.

<sup>34</sup> UNFPA (2003), Community based programme for improving health of mothers & children: Jan Mangal Programme in Rajasthan.

is willing to work as volunteers, fall into the age group of 25 to 35 years, is functionally literate and are preferably users of any contraceptive method.

With a view to capacity building, a three-tier training design of three days duration at every level has been adopted for the JMC.<sup>ix</sup> The Block level trainers (BTTs) conduct the trainings of JM volunteers at the PHC level. All the selected JMCs are trained for three days on issues related to maternal morbidity and mortality due to frequent pregnancies, its ill effects on child health, the need and benefits of using spacing methods, knowledge on use of method and their likely side effects. They were also briefed on the objectives of the JM Project, implementation and monitoring mechanisms to be adopted and to address problems faced by JM couples in their course of work.

A simple reporting format has been developed for the JMCs, wherein emphasis is laid on initial use of pills and condoms, continuation, side effects and dropouts. At sector PHC level, a bi-monthly meeting called 'milan baithak' is held wherein the JMCs share reports, replenish supplies and seek information on specific problems of users. The meeting is also used for continuing education sessions, distribution of communication material, information about health/RCH camps and disbursement of wage loss and travel expense. These meetings are addressed by Medical Officers of concerned PHCs, JM Coordinator, LHV and ANMs also participate in the meeting. JMCs bring their reports to the bi-monthly meetings, which are then compiled first at the PHC level, and then at block PHC level for onward transmission to the district. At the district level, JM Coordinator prepares

a consolidated report which is sent to the state level. Information regarding attendance in these meetings and number of JMC dropping out of the programme is also compiled in these meetings. As most of the JMCs are daily wage labourers, they are paid an amount of Rs 100 per volunteer to compensate for their wage loss and travel expenses to participate in the bi-monthly 'milan baithak'.

The Jan Mangal programme is managed through an autonomous body - the State Health and Family Welfare Society for Voluntary Sector, Registered under the Societies Registration Act, under the chairpersonship of Secretary (Family Welfare), Govt. of Rajasthan. The Director Medical, Health & Family Welfare Services is the Member Secretary. Considering the scale and intensity of operations, a coordination unit (CU), headed by a NGO person, designated as State Coordinator, was set up at the state level in February 1997. The unit was responsible for development of comprehensive action plan, implementation, initial training, material development, budget finalisation & guidelines for its utilisation, carrying out base line and monitoring of district Jan Mangal activities. However, contractual positions in the state PMU have been discontinued since 2001 and the project is being managed by the Demography Cell, DoFW. District level Jan Mangal coordinators have been placed in all the districts. It was also thought that the district level co-ordinators should not work as separate identity but be made part of the larger delivery system. Such integration could have, in case of dearth of time and resources among the district officers, ensured utilizing the district coordinators for monitoring the quality of project activities.

The Jan Mangal Programme has ensured ready availability and accessibility of OCPs and condoms in remote villages and also facilitated the creation of a large community based volunteer cadre. The total number of JMCs in all 32 districts, as of March'03, was 28,303. As per the report of GoR, upto March'03, the JMCs were catering to total 2,41,817 users of condoms and oral pills. In spite of such successes, there have also been some constraints in programme implementation.

It has been seen that the ANMs perceived the JMCs, as competitors rather than facilitators, and hence did not supply contraceptives to them on field visits. The mid-course assessment undertaken, studied the conduct of the *Milan Baithaks*. The interest shown by the doctor and supervisor in holding *Milan Baithaks* was found to be poor. They also did not encourage the JM couples to pose questions, clear doubts and reinforce knowledge. The role of the supervisors in this regard was perceived to be better. The JM couples complained that time spent in *Milan Baithaks* was long. The project suffers from some of the usual constraints within the system such as lack of timely provision of funds, ensuring proper conduct of *Milan Baithaks*, inculcate interest among the doctors and district level officials in supporting and monitoring the project activities. Some of the lessons learnt, include need to improve the management of the programme, the need for reorientation of JMCs; identification of JMCs by giving them a bag and recognition of JMCs by organising district level programme. The JM project was initiated for a period for two years after which an assessment was undertaken. This was in addition to the monitoring visits undertaken at periodic intervals, review

of receipt of MIS reports and discussions with district officers. The UNFPA also sponsored an evaluation study at the end of 1995. This study was carried out by the independent agency Media Research Group with a view to ascertain the overall effectiveness of Jan Mangal programme in Alwar and Udaipur districts. The results of the study revealed that Jan Mangal volunteers motivated a significant number of couples. Some of the problems discovered were maintaining volunteer's continuity in *milan baithaks*, tie up with gram panchayats, maintenance and dispatch of records/report. The evaluating agency recommended more intensive training of Jan Mangal volunteers, ensuring well designed *milan baithaks*, regular supply of contraceptives and timely payment of wage loss. It also recommended publishing a newsletter on Jan Mangal issues.

#### **B. Equity Enablers**

Equity Enablers includes the BPL Medicare Card Scheme being implemented by the State. About 23 lakh cards have been distributed. 25 percent of funds raised under the MRS are utilized for purchase of drugs for BPL patients. This is in addition to the drug budget of the health institutions.

#### **C. Mukhya Mantri Jeevan Raksha Kosh**

Given the high cost medical facilities, their inaccessibility to persons living below the poverty line, the Mukhya Mantri Jeevan Raksha Kosh, was started to provide cent percent financial assistance to the poor for diagnosis and treatment of serious ailments including cancer, heart disease, kidney and thalesammia. Upto June 2004, 3613

persons had benefited with a financial assistance of Rs. 1678 crore under this initiative.

## (VII) Other Policy Initiatives

In the arena of policy reforms, the following policies have been framed. These are Population Policy & RG Population Mission, training policy, essential drug policy, policy to promote private sector and transfer policy amongst others. Health Vision 2025 is being worked upon. Some of the other policies under consideration are formulation of a State health policy, anti quackery bill, clinical establishment Act and regulatory authority for health care and medical education.

### <sup>i</sup> Regulation of the private sector-

Attempts have been made towards the enactment of the Rajasthan Clinical Establishment Regulation Bill, 2001/ 2002

<sup>ii</sup> For investigative/diagnostic machines, licensee can avail of space in the hospital building to install the machine, provided that s/he maintains and operates the equipment as per conditions laid out in the license. The MRS invites open tenders, with the tenderer being required to quote annual license fees and rates per tests separately in the bid. The licensee is required to pay a monthly rent of Rs. 5000 per month to RMRS, provide upto 20% of the tests free of cost for categories specified by the Govt and bear all expenses on account of electricity, water, maintenance, etc. The offers received are then evaluated by the Secretary of the MRS and placed before the Governing Body for final decision.

<sup>iii</sup> For treatment machines like lithotripsy, cath lab, etc which are to be operated by the doctor themselves would be purchased by RMRS through bank loan for which necessary bank guarantee would be made available by the Finance Department. These machines would be operated on self financing basis by RMRS and the rates for procedure would be fixed in a manner that payment of load is made in time.

<sup>iv</sup> In the policy statement, the government specified the need for development of effective secondary and tertiary care system. It acknowledged the financial crunch faced by the government and the need for efficiency and better clientele servicing. These were specified as reasons for involving the private sector in health care. In order to attract investment from private providers in speciality services and curative care, the GoR has categorized bidding institutions into four categories. These are:

- *Category A:* Charitable medical institutions (non-profit organisation) willing to set-up at least one advanced diagnostic or curative services by acquiring medical equipment from the approved list of state government or offering speciality services as per the plan approved by the state government.
- *Category B:* Charitable medical institutions having their own plan to set-up health facilities.
- *Category C:* Institutions (registered firms, societies, trusts) interested in setting-up speciality hospital in specialities approved by the state government and in particular geographic region.
- *Category D:* For-profit organisations (nursing homes providing maternity and child care facilities having at least 10 beds and OPD facilities, hospitals having at least 50 beds and OPD facilities, diagnostic centres).

The policy instrument of the GoR includes providing land at subsidised rates and provision of other fiscal benefits to institutions interested in setting-up health facility. The subsidy varied according to categorisation defined above and depended on whether the facility was to be set-up in rural or urban area. Further to this, GoR also provided fiscal incentives on all purchases of medical equipment, plant and machinery provided they are from approved list of DoHFW and facilities set-up before 31 March 1999. These incentives were as follows:

- Exemption from payment of sales tax on purchases of medical equipment, plant and machinery;
- Exemption from payment of octroi on medical equipment, plant and machinery, whether imported or got from other states.
- Other fiscal benefits from state level and other financial institutions as per the provisions of those institutions.

A specific time frame of two years from the date of allotment was laid for the use of allotted land. The Government constituted a broad-based empowered committee to screen all bidding proposals and for short-listing and final selection of institutions. Most of the related department secretaries, including inter-alia, Secretaries from Departments of Finance, Health, Industry, Revenue, Urban Development and Housing were members of this committee. The response to the policy initiative of GoR was reasonable. In all 14 proposals were received. Each bidding institution was required to submit an application along with project feasibility report and proof for the sources of funding to set-up the project.

In terms of implementation, despite having a comprehensive policy on private participation, the final clearances and allotment decisions faced number of procedural difficulties. Since no locations were identified before the start of the process, the implementation of policy had to work out the details of available locations. For this purpose, the preferences from each bidding institution were collated first. The Committee forwarded this information to respective development authority or to the Municipal Corporation. Since the number of development authorities and municipalities involved were too many, it became difficult to co-ordinate the whole process. Each agency was required to come up with detailed information about the possible sites of the required sizes. This process resulted in applicant getting number of options of land locations for his proposed project. This created a bit of confusion and led to delays in decision making. The government also experienced time delays in implementing the policy due to the problems faced in getting number of clearances from various departments. Authorities were not prepared to implement and give clearances as there was no agreement on how the losses will be shared across the departments. It also created procedural difficulties in implementing the policy because most of the developmental authorities were selling these properties through auction. This was seen as major departure from set procedures and there was reluctance to depart from existing practices.

Source: Bhat Ramesh (1999), "Public-private partnerships in health sector: issues and prospects", Second revised draft, IIM-A

<sup>v</sup>The Society includes representatives from the district level heads of Education, WCD, NGOs, 2-3 eminent citizens, Pradhans of Panchayat Samiti, 3-4 members of Women

's Forum, State PMU Representative, Dy. Project Coordinator and UNFPA representative. The GB is scheduled to meet at least once each quarter and is responsible for annual plan finalization, activity monitoring and inter institutional coordination.

<sup>vi</sup> The EC has district level heads of Health, Education, WCD, representatives of the Collector, elected representatives comprising of at least 50% women representatives, 2-3 NGOs, 2-3 eminent persons (who may be familiar with the district), members of women 's forum, State PMU representative, Dy. Project Coordinator and UNFPA Representative.

<sup>vii</sup> The Management structure at Jaipur comprises of the Secretary, Medical and Health as the Chairman, the Divisional Commissioner as Vice Chairman, the Superintendent Medical College as Member Secretary amongst others. The structure is replicated similarly at the regional and district level.

<sup>viii</sup> It also commissioned two studies in the year 1997-98 and 2002-03, to assess the impact of MRS on quality of health services. The details of the same are being ascertained.

<sup>ix</sup> The state level team has trained district level resource persons known as District Training Team (DTT), which comprises of 12 resource persons ( six men and six women) - Dy CMHO (FW), DMCHO/DRCHO, EPO, two MOs, two LHVs, Project Director-District Women Development Agency/Block Extension Educator, four NGO representatives. The DTTs then organised training of block level trainers (BTT) who were sector PHC MO, LHV and NGO representative. DTT and BTT were developed to eventually train the JM Volunteers. DTTs and BTTs were equipped with necessary training and communication skills, supervisory and monitoring procedures to train the JM couples in-turn and to manage the programme.