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THE HINDU

Hospital or hell hole?

Padmini Sitaraman takes a look at the conditions in the burns centre of the Victoria Hospital

It was nearly midnight on May 30 this year. Sudhadevi, a middle-aged woman living in Koramangala, suffered burns all over her body. Moaning and writhing in agony, she was rushed to St. John's Hospital where she was given emergency treatment. But she was refused admission on the ground that no bed was available. The desperate relatives went from one hospital to another seeking further treatment for Sudhadevi, but in vain.

Finally, around 3 a.m., they brought her to the burns centre of the Victoria Hospital. They were aghast to find that not one doctor was on duty. By the time the junior doctor arrived and gave her a pain killer, it was 8.30 a.m. He told the family that the senior doctor would attend on her, that he was participating in a meeting right then. It was noon when the senior doctor arrived and began treatment. But he need not have bothered: a few minutes later, she breathed her last.

This is an account given by Vimochana, a forum for women's rights that is making efforts to draw attention to what it says the poor conditions in the only State-run burns centre in the city, which is the only refuge for people who cannot afford private medical care. "Not only is the environs detrimental to the recovery of the patient, being situated in the midst of noise and squalor, absolute apathy, callousness, but the indifference of all the staff is distressing," says Vimochana.

To highlight the problem, members of Vimochana staged a silent demonstration on September 8 in front of the centre, carrying placards that perhaps expressed the feelings of many of the relatives of the burns victims who are brought to the centre. Two among the placards said: "Doctors, where have all your ethics gone?" and "Victoria Hospital burns centre is a dark hole of despair and death". The stir was called off only after the Minister of State for Medical Education, Dr. M.Shankar Naik, arrived and assured them that the Government was keen to improve the burns centre.

The Victoria Hospital is the biggest Government hospital in the city. At least five women with 35 to 100 per cent burns are brought to the hospital every day. Often, all of them would be in their early Twenties. At an average, two to three of them do not survive. As per the hospital figures, 61 persons died of burns in January this year, 65 in February, 73 in March, 66 in April, 60 in May and 70 in June. In 1995, 1,314 persons including 972 women died of burns. Of the women, 795 were married. In 1996, 677 persons including 519 women (460 of them were married) died of burns.

The hospital records relating to Sudhadevi's case say that she was brought with 100 per cent burns suffered in an accident and that treatment began "immediately" after she was admitted. The records have it that IV fluids, antibiotics, pain killers and sedatives were given to Sudhadevi and that she died at 12.30 p.m. on May 31.

Says Dr. H.D.Ballal, Medical Superintendent: "There is a doctor on call all 24 hours in the casualty." In his view, the higher the percentage of burns, the less the chances of survival. "If the person has suffered more than 40 per cent burns, it is a touch-and-go situation because secondary infection will set in. Besides, there is the possibility of cross infection too." However, according to sources, negligence on the part of some doctors is one of the factors causing death due to burns.

There are innumerable complaints about the hospital and the burns centre. Relatives of patients at the centre say that seldom is treatment given immediately and that only money can get things moving. Some persons allege that even the doctors demand money.

"The patients' families have to buy everything," says Ms. Donna Fernandes of Vimochana. One would expect doctors and the staff of a hospital to be considerate persons. But at the Victoria Hospital, one cannot, it seems. This has been the experience of the relatives of persons admitted to the burns centre. There is no urgency in trying to save lives and every patient is given up for lost, says Ms. Fernandes with emotion.

The centre has come under fire for its unhygienic conditions. Visitors say there is dirt and filth everywhere. "The toilets are in a bad condition," says Mr. Navin Challam, a social worker. Moreover, people are freely allowed to enter the burns centre and this increases the danger of infection to the patients.

It is said that there are only 25 beds in the centre and that there is also shortage of medicines. Dr. Ballal dismisses the charge saying there are 42 beds, including two each in the special and emergency wards. Drugs are given free to poor patients, he says.

Dr. Ballal feels that the uncontrolled entry of people into the burns ward can be checked only if the hospital hires security personnel. "We have sent a proposal to the Government seeking its permission to entrust cleaning and security to private agencies," he says. Visitors seem to be unaware that infection has to be prevented. The distraught among them rough up the attendant if he tries to stop them from entering the centre, Dr. Ballal adds.

According to him, the death rate in the centre is high as often patients with a high percentage of burns are brought to the centre only after they are refused admission in other hospitals. "Many hospitals turn away patients who have suffered more than 40 per cent burns. But we have never sent them back," notes Dr. Ballal.

In his opinion, the conditions at the burns centre are not bad. "I visit the centre every day and have pulled up employ es for not doing their work. I have suspended some of them following complaints."

However, a visit to the centre showed that it is not spotlessly clean. But many beds were vacant. Burns victims, some of them groaning with pain, and anguished relatives were seen crowding the area.

The hospital authorities, in a bid to improve service, have suggested that patients with less than 30 per cent burns and those needing

Members of Vimochana staging a demonstration demanding better care and facilities at the burns centre. — Picture by K. Bhagya Prakash

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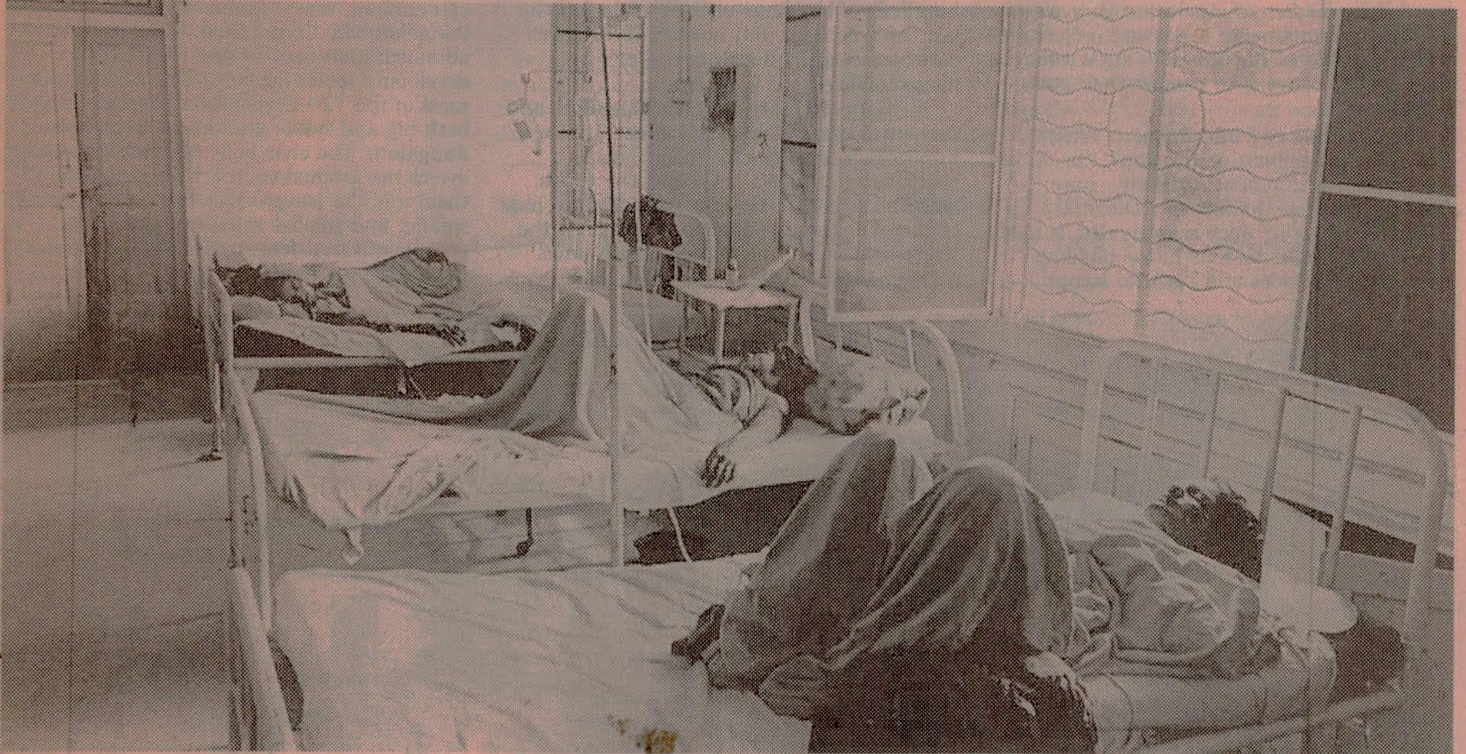
Bangalore



A view of the burns ward in the Victoria Hospital. — Picture by K. Bhagya Prakash

intensive care should be kept in separate wards. Patients with infections should be isolated. "This can be done provided we are given men, material and space. There is no Intensive Care Unit in this hospital although a proposal was made five years ago and the space earmarked," says Dr. Ballal, adding that six ventilators will be installed at the Victoria Hospital soon.

The Minister, Dr. Naik, admits that there may be one or two black sheep among the hospital staff. The charges against the hospital are vague, according to him. "I have asked Vimochana to give me in writing specific complaints about the staff and also about corruption in the hospital." He says it is planned to shift the burns ward to the building that will be vacated when the Jayadeva Institute of Cardiology is moved to its new building in Bannerghatta.

Vimochana has made suggestions for the better functioning of the burns centre. It has suggested that an ambulance with facility for providing first aid should be kept ready; that a classification of burn be made; that burn centres be set up in different parts of the city; and that higher salaries be given to the doctors and staff considering that their jobs are highly stressful and emotionally exhausting. Vimochana feels that better pay will help end corruption.

Some private hospitals do extend medicare to burns victims but the cost of treatment is high. The Mallya Hospital, which has been given an ISO 9002 certificate, opened a burns centre earlier this year with plastic surgeons offering specialised care. Says Dr. Nandakumar Jairam, Medical Director of the Hospital: "We have two beds. The unit was set up as we felt the need to provide better facilities." No patient is turned away whatever the percentage of burns. Emergency treatment begins as soon as the burns victim is admitted. It is up to the patient's relatives to decide whether treatment should be continued at the hospital or the patient taken to another hospital, he says.

"The cost depends on the extent of burns, the degree of burns, the complications and plastic surgery. We try to give the maximum possible concessions. It is not only treatment of burns. Skin grafting has to be done later," observes Dr. Jairam. Among the hospitals that treat burns victims are the M. S.Ramaiah and St. John's Hospitals. The Manipal Hospital has so far treated one victim of burns, it is learnt.

What prompted Vimochana to take up the issue of burns victims? "In the process of following up cases of dowry death, our attention was drawn to the medicare available for the women who manage to survive — particularly those who suffer burns. We found that even if they survive the torture inflicted on them by their own people, the callousness of the State medical establishment, which is the only hope of the majority of those who cannot afford private medical care, drives the women to painful death," says Vimochana. "As it is, women are suffering. And when they come to the burns centre, the staff treat them cruelly. Why should they come there to die?" asks Ms. Fernandes.

For the last 18 years, Vimochana has been working on issues relating to domestic violence. A study of cases of unnatural deaths of married women in the city was taken up by the team consisting of Ms. Fernandes, Ms. A. Ragini, Ms. N.Shanti, Ms. K.Satya and Ms. Gouramma.

Many of these are not accidental deaths: they are cases of murder, feels Vimochana. "We want a special cell for such cases set up as the guilty are not being charged. Such a cell should investigate cases of burns sustained accidentally and prove that these are not cases of murder," says Ms. Fernandes. The study has found that many of the burns victims were from the Tannery Road and Magadi Road areas, D.J.Halli and Mahalakshmi Layout.

Dowry deaths are investigated by the Anti-Dowry Cell (ADC) in the CoD located in Cauvery Bhavan. The Cell probes death of women occurring within seven years of marriage following harassment for dowry. It takes over the investigation only after a case is registered. In a year, 230 to 240 cases are investigated of which between 20 and 25 per cent are from the city and a majority from the economically weaker sections of society. After investigation, the ADC gives the final report. "The chargesheet is filed if there is enough evidence against the alleged party. A 'B 'report is prepared if it is found during investigation that death was accidental. A 'C' report is filed if we cannot detect a case," says Mr. A.R.Infant, DIG (CID).

Mr. Infant says that this year, the ADC has filed chargesheets in 27 dowry death cases out of the 39 cases reported. In 1996, 61 dowry deaths were reported in the city and 58 persons chargesheeted.

There are allegations that policemen have been found to take the thumb impression of the burns victim on a blank paper, for preparing the statement. Mr. Infant denies the charges against policemen including that they demand money during investigations. "These (the allegations) are vague. I am ready to take action provided I get specific petitions. A written complaint was handed over recently and it is being investigated." In his view, the statement of the police officers should be given credence and summary trials made in some cases.

M 5.2d

HEALTH CARE WASTE DISPOSAL

- An exploration
: Problem definition & Probable Solutions

(Extract from the executive summary)

Department of Community Medicine

M S Ramaiah Medical College
Bangalore - 560 054 INDIA

PROBLEM DEFINITION :

Health Care Waste is casually dealt with both by Health Care settings and the Civic bodies. This is dangerous to Health care Personnel, Waste handlers and the Community. Reasons for this appears to be :

1 Lack of awareness among doctors, nurses, administrators about hazards of improper Health Care Waste management; options available for its proper management; lack of awareness among Waste handlers (Ayahs, personnel near incinerator and land filling sites, rag pickers) regarding hazards of Health Care Waste.

2 Lack of Information support for doctors, administrators, nurses, Waste handlers

3 Lack of practices like

- segregation of infected Waste and sharps
- disinfection of infected waste
- Sanitary landfilling
- Recycling of recyclable items
- use of protective devices
- periodic medical examination
- Immunisation of Personnel
- Precautions for prevention of HIV-AIDS
- Incineration facilities meeting Central Pollution Control Standards.

4 Lack of effective organisational bodies of Health Care settings and Lack of coordination between civic bodies and Health Care settings.

PROBABLE SOLUTIONS

CAPACITY BUILDING

of Doctors, Administrators, Nurses, Waste handlers on hazards of Health Care Waste; available options for its management; available cooperation from the civic body - through training and information support. Segregation of Infected Waste promoted as a culture in Health Care settings.

STRENGTHENING FACILITIES FOR FINAL DISPOSAL OF HEALTH CARE WASTE

a) It is suggested that 500 acres of land outside the city limits be earmarked, developed and managed for Solid Waste disposal - of which a portion be earmarked for Health Care Waste disposal.

b) Sanitary Landfilling taken up

c) Cooperative common incinerators meeting central Pollution Control Standards for Health Care Waste which is infected are commissioned and their function is supervised and monitored.

d) Small industries are set up for recycling plastic items, metal sharps (and ? Bandage cloth after decontamination)

e) Better transportation vehicles - covered and automatic are procured and a parallel system is practiced for the transportation of General Solid Wastes and Health Care Waste separately by the civic bodies.

f) All Health Care settings - big and small are registered at the 12 Sub-health Offices of the city. The Sub-health Offices can be focal points of support to respective Health Care settings located in their jurisdictional areas. Periodic returns related to Waste generation to be submitted to Sub-health Offices by the respective Health Care settings. Based on these calculations, logistics of transportation is jointly arranged and managed by joint contributions and participation by both the management of Health Care settings and Civic bodies.

AWARENESS ACTIVITIES

a) Health education materials like posters, pamphlets, booklets, flip charts on Health Care Waste management in local language is developed and consciousness is created among Waste handlers and the community

b) Community's involvement is to be sought in identifying areas for Sanitary land fill and hygienic practices of Waste collection and transport - of both General Waste and Health Care Waste.

c) There is a need to start a resource centre in the City which can provide information support in the form of periodic news letters and other means to all Health Care settings, NGO's, etc. An NGO can be supported to take up this role with the back up of a Medical college resource.

INFECTION CONTROL COMMITTEES

It is suggested that infection control committees be established in all Health Care settings where bed strength is more than 100 ; and the committee to supervise Health Care Waste Management, Hospital Acquired Infections and General Infection Control.

RESEARCH ACTIVITIES

- The investigators suggest that the State Government shall encourage the Civic bodies to take up the following research activities in collaboration with Medical Colleges and Engineering Colleges on priority;

a) developing curriculum for training doctors, nurses, administrators, waste handlers in the area of health care waste management

b) Feasibility studies to recycle metal sharps , plastic items in safe ways

c) techno-economic assessments of solid waste/health care waste in different cities, towns, etc.

d) conducting waste surveys in different Health Care settings including measurement of quantity of such generated waste

e) feasibility studies for efficient establishment and running of common incinerators/ sanitary land filling/ composting etc.

f) sentinel surveillance of hazards due to Health Care Waste management in selected ranges of the City

g) studying sickness absenteeism and causes for the same among waste handlers

h) maintenance and periodi[illegible]w of morbidity registers of health care personnel

RECORDING AND REPORTING

The investigators suggest that systems of recording and reporting of the following events are developed and submitted periodically to the infection control committee of the city/ civic body by health care settings:

- Quantity and type of waste generated
- Illness/ injuries noted among waste handlers
- Difficulties faced and solutions adopted to solve the same by Health Care settings in Health Care Waste management
- Immunization status of staff regarding tetanus, typhoid and hepatitis B
- Training status of staff on Health Care Waste management.

The investigators feel that legislative control is to be exercised only after capacity building and strenghtening of facilities is taken up for two to three years

Till sanitary land filling/ common incineration facilities/ individual incineration facilities/ safe recycling methods of some of the items of Health Care Wastes become available or other methods of treatment and disposal are accessible and adopted the following appear to be the options available for immediate action;

1) Disinfection of waste before disposal
2) Segregation of infected waste and metal sharps
3) Safe practices within Health Care settings
4) Practice of universal precautions for preventing HIV-AIDS
5) Capacity building of Health Care personnel and waste handlers
6) Document quantity of waste generated
7) Document hazards due to Health Care Waste

The investigators have made an attempt to draft a manual for training doctors, nurses, house keeping officers, administrators and educational material for waste handlers (ayahs, pourakaarmikas etc.,) It is being planned to field test and subject it for wider consultation before being put for practical use.

MS.2e

BURNS CARE IN INDIA:

For professionals dealing with burns care in India, the high mortality, morbidity, unknown epidemiology and socio-economic problems remain areas of great concern.

HOW DO WE COMPARE WITH DEVELOPED COUNTRIES?

1. We do not have a single centre dedicated to burns care.
2. Our 50% mortality is in the 30-40% BSA Burn group. In the west and east this is in the 60-80% range depending on age.
3. The morbidity is very high.

THE CHANGES THAT NEED TO BE MADE:

1. We need to start burns centres dedicated to the care of burns, at least one in each State.
2. The prevailing centres and District hospitals need upgrading.
3. Intensive care facilities should be provided.
4. Well trained & motivated multidisciplinary burns teams should be introduced and the number of Staff should be adequate.
5. Barrier nursing and rigid environmental bacterial control are absolutely essential.

WHY IS IT SO DIFFICULT TO CHANGE?

1. LACK OF AWARENESS:

   The majority of Policy makers, administrators, doctors and the public are probably unaware of how an ideal burns centre should run?

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2. FINANCES:

The inability to mobilise funds to upgrade these units appears to be a major deterrent to change.

3. LACK OF MOTIVATED PERSONNEL:

As of now, very few professionals take up burns care exclusively. It is essential to have full time, motivated personnel for any long term improvements to be felt.

THE SOCIO ECONOMIC PROBLEM:

A large percentage of major burns occurs in the lower socio-economic group. Illiteracy, over-crowding, marital disharmony and poverty all contribute to the etiology, morbidity and mortality of burns.

HOW CAN CHANGES COME ABOUT?

The existing system needs complete overhauling if we are to make any major impact. This can only come about if the Government, Policy makers, Administrators, Doctors, Industry, previous patients and concerned Social groups all put their heads together to solve the issues previously mentioned. One start would be to bring together all concerned persons in A BURNS FOUNDATION.

A more detailed report is available with:

DR.RAVI NARAYAN,
Society For Community Health Awareness, Research & Action,
326, 5th Main, 1st Block,
Koramangala, Bangalore.95.

Ph: 553 1518.

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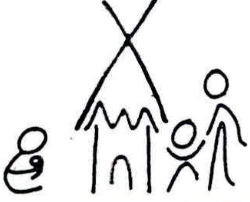


ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೋಶ
COMMUNITY HEALTH CELL

Phone : 5531518
Fax : (080) 55 333 58
Attn. CHC

No. 367, 'Srinivasa Nilaya', Jakkasandra, 1st Main, 1st Block, Koramangala, BANGALORE - 560 034.

Workshop : "Citizens Participation in the management of Public Hospitals"

Venue : Victoria Hospital, Bangalore (New Kitchen near Reception).

Date : 1st September, 1997 **Time : 9 a.m - 4.30 p.m.**

Organised by : CAG / PAC / Victoria Hospital / Bowring Hospital / CHC

BACKGROUND / OBJECTIVES

* A Workshop on the theme "Citizens Participation in the Management of Public Hospitals" is being organised by Citizens Action Group, Public Affairs Centre, Victoria Hospital, Bowring Hospital, and Community Health Cell, on 1st September 1997 from 9 a.m. to 4.30 p.m. at Victoria Hospital.

* The objectives of the Workshop are to explore some practical ways and means by which citizens groups can support the management and improvement of services / facilities in Public Hospitals in the city.

* The Workshop will consider a Citizen Action Group study on Public Hospitals and case studies on Public hospital experiences and will reflect on some broad principles and framework to enhance citizen participation in responding to the situation.

* Two specific areas of need will be focussed upon in depth through group discussions as specific examples in which some focussed action can be initiated after the Workshop. These are: (a) Waste Management practices in Hospitals (b) Burns Care - Problems & Solutions.

* The Workshop will be an initiative primarily to enhance the interactive dialogue between citizens groups, public hospitals and health training and policy research centres in the city.

* The workshop is being hosted by the Medical Superintendent of Victoria Hospital (Dr. Ballal) and his team. Participants will be primarily staff from both Victoria and Bowring hospitals but a representative team from all the public and private hospitals in the city will also be invited to participate.

26th August, 1997

Dr. Ravi Narayan,
Coordinator, CHC

Society for Community Health Awareness, Research and Action
Registered under the Karnataka Societies Registration Act 17 of 1960, S. No. 44/91-92
Registered Office: No. 326, 5th Main, 1st Block, Koramangala, Bangalore - 560 034.

Workshop : "Citizens Participation in the Management of Public Hospitals"

Time	Tentative Programme	Resource persons
9.00 am - 9.30 am	**Breakfast**	
	9.30 am - 11.00 am **Session I**	
9.30 am - 9.50 am	Welcome Introduction by participants	Dr. Ballal (Victoria Hospital)
9.50 am - 10.00 am	Background and Objectives of Workshop	Ms. Nomita Chandy (CAG)
10.00 am - 10.15 a.m.	Public Hospitals and Citizens participation - An overview	RN (CHC)
10.15 am - 11.00 a.m.	CAG Report on Public Hospitals incorporating case studies	Ms. Anjana Iyer (PAC) Dr. S. Ganapathi (CAG)
11.00 am - 11.15 am	TEA	
	11.15 a.m. - 1.15 p.m. **Session II**	Moderator: Dr. Saraswathy Ganapathy
11.15 am- 11.45 am	Reflections on CAG Report	Dr. Ballal (Victoria Hospital) Dr. Chandramma (Bowring Hospital)
11.45 am - 12.30 pm	Questions / Answers Experiences / Suggestions	Participants
12.30 pm - 1.00 p.m.	Insight into waste management practices in Hospitals	M.S. Ramaiah Medical College team
1.00 pm - 1.15 p.m.	Burns Ward Management (Presentations)	St.John's Medical College team
1.15 - 2.00 p..m.	LUNCH	
	2.00 p.m. - 3.00 p.m. **Session III**	
2.00 p.m - 3.00 p.m	Group discussions: Themes I - Hospital Waste Management ii. Burns Ward Management (Number of groups discussing themes will depend on number of participants opting for the specific theme)	Chairperson: Rapporteurs and resource persons. (separate list)
	3.00 p.m. - 4.00 p.m. **Session IV**	Chairperson: Ms. Pramila Nesargi
3.00 - 3.45 p.m.	Plenary: Reports of Group Discussions - Suggestions	
3.45 - 4.00 p.m.	TEA	
4.00 - 4.30 p.m.	Plan of Action and Key Recommendations of Workshop; Summing up.	

Background Papers

1) Summary of CAG Report; 2) Public Hospitals and Citizens' Participation ;
3) Rogi Kalyan Samiti - A Report ; 4) Health Care Waste management - A Report;
5) Burns Care - The problems - some solutions

Special Guests

1. Minister of Health ; 2. Minister of Medical Education ; 3. Bangalore City Corporation Commissioner ;
4. Director of Health Services ; 5. Ms. Pramila Nesargi, Chairman, Visitors' Board, Victoria Hospital ;
6. Sri Rajanna, Chairman, Visitors' Board, Bowring Hospital.

H 5-2a

Bangalore Hospitals and the Urban Poor

A Report Card

- Anjana Iyer & Suresh Balakrishnan
(PUBLIC AFFAIRS CENTRE, Bangalore).

A Summary

The quality of hospital services is an important element in the package of services that citizens rely on, during periods of physical disorder and trauma. While medical services have seen many a technical advance, it has been accompanied by increases in costs and complexity. there has been a growing concern over the deteriorating quality of health care provided by public hospitals. These problems become more visible when it comes to the question of health services to the poor.

How do citizens, especially the poor experience these services? What is their feedback to the health care system? where are the improvements required? In order to examine these issues, the Public Affairs Centre, Bangalore, recently designed and carried out a study. The study assesses difficulties encountered by the poor while making use of hospitals, the quality of specific components of service, and the different types of action for improving services. the findings of this study are expected to provide a framework for public interest groups and administrators of health care design systems for improving access to health care for the poor and the quality of service that they receive.

The study of hospital services in Bangalore was conducted by the Public Affairs Centre, a non-profit organisation based in Bangalore, in collaboration with the Citizens' Action Group. This study attempted to generate feedback from the urban poor on the quality of hospital services they receive. Three categories of hospitals were surveyed - Government or "Public" hospitals, hospitals run by the Bangalore City Corporation (BCC) and missionary / charitable trust hospitals.

The study was carried out in three parts;

* Forty one case studies on the experiences of the poor with hospital services

* A field survey using a structured questionnaire on different aspects of feedback from sections of the urban poor on hospital services, and

* A series of interviews with hospital administrators on their perceptions of problems that affect the quality of hospital services.

Conclusions

- The urban poor in Bangalore have been using a variety of options for health care. While Government hospitals play a major role, other hospitals, including Mission and Private hospitals contribute to health care for the poor. Any strategy for health care for the poor has to envisage appropriate inputs for all the institutions involved in this sector.
-
- In terms of costs, Government hospitals come out as the cheapest source of health care for the poor. This is not only in terms of percentage of patients enjoying free treatment, but also of total costs incurred by an overwhelming majority of the patients. The unfortunate part of this otherwise positive phenomenon is that a major part of the costs incurred by the poor are towards illegitimate side-payments often extorted by different participants in the health care system.
-
- But the most significant problems seem to be in the quality of medical care that the poor receive. To start with, the waiting time they have to go through before receiving medical attention and treatment seems to be quite high. Second, injections and medicines, presumably free or subsidised, are often not available at Government hospitals. But the more important problem seems to be the total absence of standards or the lack of awareness among patients about what they can expect at hospitals. It is form this point of view that Mission and Private hospitals seem to be serving the poor in a much better manner.
-
- The manner in which activities are managed in the Government hospitals also merit attention. The seriousness of this problem can be seen from a simple area like cleanliness of hospitals. although there was no major difference in the frequency with which cleaning was carried out across different types of hospitals, the level of cleanliness at Government hospitals were rated in much poorer terms. Similarly, the poor need to run form pillar to post, to find medicines, sometimes in life and death situations, while being treated in Government hospitals - whereas, dispensaries of Mission hospitals are rated to be far more efficient in this regard.
-
- One approach to seeking better quality of medical services and facilities that the poor are compelled to seek, is by resorting to speed money payment. This approach seems to apply to all levels of medical personnel (from doctors to sweepers), and for all types of services (from operations to entry into wards without authorisation). Although there is wide variation in the quantum of payments, the problem seems to be most acute in Corporation Maternity Hospitals, which are used primarily by the poor. Designing interventions to reduce the instances of extortion could certainly begin there.

(In collaboration with CITIZENS' ACTION GROUP, Bangalore).

M S.26

Efficacy in Administration of Hospitals

A Case Study of Private & Government Hospitals in Bangalore

Piush Anthony
Doctoral Fellow
ISEC, Bangalore

Suggestions/Recommendations

1. Hospital management and organisational structure needs a complete overhaul in the case of government hospitals. The work load of doctors and other staff is an area of concern which needs attention. The first step can be filling the vacant posts and deleting/reshuffling the posts that non-functioning and unspecified.

2. The practise of doctors being appointed as administrators in government hospitals seems to be a problem as far as the poor management of human as well as other resources are concerned, since they are not trained in administrative/management skills. The relatively superior management systems observed in private hospitals can be attributed to the fact that these are managed by 'administrators', trained or experienced.

3. The efficiency of the hospital lies in the nursing care provided. Better nursing care is assured through division of labour and continuous monitoring created through different categories of nursing staff. For example, supervisory level staff at ward/floor levels, who ensure efficient management in private hospitals. This is one area government hospitals need to reform their organizational structure.

4. Greater devolution of power to the senior officials is necessary in the case of government hospitals which ensures effective handling of complaints from patients thereby ensuring efficient management and customer satisfaction.

5. It is clear from the analysis that government hospitals has high occupancy rate. This can be translated into efficient income improving mechanisms if there are systems introduced, which will ensure identification of income levels of patients without giving way for leakages. This will to some extent arrest corruption in government hospitals.

6. There is a need to ensure provision of medical social workers in government hospitals to support and help poor patients. They can provide guidelines and information to patients in meeting their demands as rights and also can act as a mediator between the administration and the patients.

7. There is a need to develop systems of supervision and vigilance in government hospitals to ensure that corruption is arrested, which will help a long way in building the image of government hospitals. This is very important as it can initiate positive changes in the work culture/environment of the government hospitals.

8. It is also essential to build systematic awareness among the people on the role of efficient public health care system, which ensures demand for public health services as it is obligatory on the part of the government to provide health services to the people and the poor cannot be in a position to access private services. The present day duality in health care access is denying the opportunity of improving government hospital management as only the poor are accessing it, who tend to be less articulate about the problems and who will have limited access or information about the redressal machineries.

9. A greater role for medical professionals and their associations have to be recognised in this regard to influence the authorities in revamping the hospitals with better facilities and more human resources. The medical fraternity has to take a pro-active role in ensuring that poor people get their due share of efficient health care from the public system.

10. For the implementation of any of the above suggestions, it is imperative to build vigilant citizens' action on this front. Herein emerges the role of NGOs in initiating and campaigning for such a move. It should be in the direction of creating awareness among the people about health care as their right, through various mechanisms which are effective in reaching the lower rungs of the economic ladder. they can also take initiative in campaigning for incorporating minimum health care as fundamental right in the constitution as such, perhaps as part of the 'right to Life (Article 21). This will provide the people a legal mechanism to seek redressal when this right is denied. also, bringing the medical profession under the CPA should also be taken up, for it would confer certain beneficial results such as: medical records will be maintained more rigorously, the patient's right to information will be respected, greater standardization will become necessary, standards of nursing homes will have to improve and corruptive practices will be checked. To begin with, they can even sponsor medical social workers to government hospitals. Implementation of health tax for certain categories of income should also be put forward as outlay for health expenditure tend to decrease. Any effort for greater privatization of health care should be prevented on the grounds that poor will dispossessed and discriminated.

M 5.2c

INITIATIVES

This section introduces creative and innovative experiments that reflect proactive efforts of administrators, citizens and NGOs in producing models that needs to be disseminated and shared. The initiatives covered in this would attempt to highlight the need for creating mechanisms for people's participation that hinges around replicability and adaptability. We welcome contributions to this section.

Rogi Kalyan Samiti, Indore : People's Participation in Managing Public Hospitals

Maharaja Yashwantrao Hospital in Indore, Madhya Pradesh is today operationalising a unique and innovative programme which is fast setting new standards in hospital management. For people who are familiar to the hospital, the turnaround is nothing short of a miracle! The hospital, which at one point of time was considered to be a premier institution for providing medical services in the country, had over the years deteriorated to abysmal levels. Newspaper reports carried horror stories on the appalling conditions, especially the existence of thousands of rats and rodents!

It was the plague scare in 1994 that catalysed the district administration to clean up the hospital by embarking on a Programme called Kayakalp Abhiyan - or operation metamorphosis/rejuvenation. The District Red Cross Society was identified to undertake this task. The mammoth 730 beds hospital along with five other supporting hospitals were evacuated and all the patients shifted to 12 hospitals situated in different parts of the town. The entire complex was cleaned and disinfected; some 150 truck loads of garbage and junk was removed from the hospital.

The whole exercise was participatory in nature and involved the people of the town in drawing up the policy framework for every stage of the operation. Further to this, it was decided to put in place a committee to act as a group of Trustees for the hospital, called the Rogi Kalyan Samiti or the Patient Welfare Committee and another executive committee to manage the day to day functions of the hospital. The Rogi Kalyan Samiti, registered as an NGO, was given complete control over the functioning of the hospital. The Executive Committee meets every week and deliberates on changes and improvements that could be affected on a continuous basis.

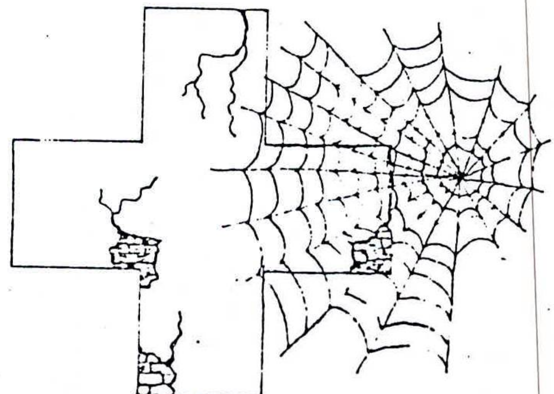
To improve the financial position of the hospital, it was decided to introduce user charges subject to certain criteria; funds received are deposited with the Rogi Kalyan Samiti. Apart from funds received from imposition of user charges, the Samiti is also empowered to receive donations in cash or kind from the public. These funds can be used for improving hospital administration, upgradation of facilities and to provide medical care to the poor and needy, free of cost or at extremely subsidised rates as compared to private hospitals.

Today, Rogi Kalyan Samitis have been set up in all the 45 districts of the State. Though most of the innovations like systemic improvements and introduction of user charges are confined to district hospitals, similar efforts are seeping to the sub-district level hospitals also. Perhaps, the most heartening experience has been the highly interactive role played by people's representatives, local body officials and citizens in bringing about this change. This innovative experiment has brought about many tangible and indirect benefits. A total of Rs. 8 crores has been collected by the Samitis in various districts; daily collections range between Rs. 1,000 and Rs. 15,000 in each hospital depending on the location. The scheme also attracts considerable allocation from the MP's and MLA's discretionary funds. The District Red Cross Societies which are working in tandem with Rogi Kalyan Samitis have become quite active.

The experience of the Rogi Kalyan Samitis highlights certain valuable 'learnings':

- For one, it is important not only to create institutions for the public welfare but equally so or more to ensure regular maintenance and upkeep, provision for improved facilities, regular review of performance and also to ensure that the morale of the work force remains at optimum level of motivation.
- It is essential to involve citizens to fund and manage various projects taken up to improve civic life; this would force the system to be more accountable to the general public.
- The idea to introduce some amount of user charges in public institutions generates a demand from the beneficiaries to be given better services and professional attention. This also prevents any misuse of the highly subsidised government facilities by people who have easy access to them.

Source : Rogi Kalyan Samiti : People's Participation in the Management of Public Health Institutions by S.R. Mohanty, Rajiv Gandhi Missions Occasional Papers - Document 002/96



WORLD HEALTH ORGANIZATION
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FACSIMILE Message No. 32015 Page 1 of 9 pages

From: Director, ARA

To: Dr R. Narayan, CHC, Society for Community Health and Awareness, Research & Action, No. 326, 5th Main, 1st Block, Koramangala, Bangalore 560 034, India

Your ref.:

Fax No.: 80 5533358 Date: 20 August 1997

Our ref.: P9/181/113

Subject: MEETING ON POLICY-ORIENTED MONITORING OF EQUITY IN HEALTH AND HEALTH CARE - Geneva, 29 September - 3 October 1997

I am delighted that you will be able to participate in the above meeting and am pleased to advise you that WHO will cover your costs.

In view of your extensive experience in India in the use of existing data sources and your concern for objective analysis of the health inequities at community level, I am pleased to invite you to serve as Moderator of Panel #2. The subject for this panel is "Using existing data sources to assess equity in health and health care at the national, provincial, and district levels in developing countries. Please see the attached draft Programme for details of the issues to be covered by panellists. In order to prepare for this task I would be grateful if you would familiarize yourself with these issues. Your own comments and observations during the session will be a welcome addition to the proceedings.

For the duration of the meeting you will serve as a WHO Temporary Adviser and I am attaching a note containing information about financial and travel arrangements as well as on insurance, visas and vaccinations. Please read this note carefully. A travel authorization has been prepared for you and you will shortly receive instructions from The World Health Organization, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110002, telephone: 11 331 78 04 or fax 11 331 86 07. In the meantime, you may make your reservations through WHO.

Hotel accommodation has been reserved for you at the Hotel Moderne, rue de Berne, Telephone 732 81 00 or Fax 738 26 58. Should you be arriving after 18.00 hours on 28 September please advise the hotel direct.

We are very much looking forward to your participation in this meeting and should you require any further information you can either contact me or Ms Marianne Jensen who is the focal point for Equity in this Division and is also coordinating the meeting.

E. Tarimo, M.D.

cc: SEARO Fax 91 11 331 8607

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PUBLIC HOSPITALS AND CITIZENS PARTICIPATION

Some Reflections

I. Citizens participation in the Management of Public Hospitals

- ◊ Public Hospital Management and staff - Victoria / Bowring
- ◊ Government Health Policy makers - DHS/KHSDP/IMA
- ◊ Technical Resource Groups - CHC, MSRMC, SJMC, etc.
- ◊ Citizens Groups
- ◊ Others

II. Citizens Participation : The potential

- ◊ Feedback to improve services
- ◊ Watchdog Role - Surveys/reviews
- ◊ Financial support to improve services
- ◊ Complimentary/supplementary/facilitatory services
- ◊ Representative participation in Management

III. Citizens participation : some Models.

- ◊ Hospital Volunteers / Auxiliaries
- ◊ Visitors / Boards / committees
- ◊ Rogi Kalyan Samitis
- ◊ Citizens/NGOs providing complementary services on contract
- ◊ Others???

IV. Case Studies

1. Hospital Auxiliary

- ◊ Visiting patients
- ◊ providing food and medicine and reading material
- ◊ facilitating use/access of facilities at OPD

2. Rogi Kalyan Samitis (M.P.)

A. Cleanliness
B. User charges
C. Collect Donations - used for
- improving Hospital administration;
- upgradation of facilities
- provide medical care to poor (free or extremely subsidised)

V. Citizens Participation : Some issues

- Need for change in Management / professional attitudes
  (Patient as Beneficiary - - to Patient as participant)
- Opportunities for feedback / interactive dialogue to be created
- Focus on what is wrong? and not who is to blame?
  (fault finding - - to problem solving)
- Focus on the poor and marginalised
  (the most dispossessed / discriminated)

VI. The Future of 'Participation'

1. Can we manage cleanliness and Hospital waste management?
2. Can we improve specific services
   - ⇒ Burns Ward
   - ⇒ Mortuary
   - ⇒ Canteen
   - ⇒ Others
3. Can we provide 'social workers/volunteers' to facilitate access and use of OPD services?
4. Can we be watchdog to check unhealthy and corrupt practices?

VII. Workshop Framework:

1. Watchdog Role : CAG / PAC Studies
2. Complementary Strategies
3. Improving Waste Management Hospital {Public Health}
4. Improving Burns Care {Clinical}
5. Interactive Dialogue
6. Any other Action?

Dr. Ravi Narayan, Community Health Cell, Bangalore.

For further details or follow-up please contact:

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Bangalore - 560 034.

Phone : 553 15 18 Fax : 080 - 553 33 58.

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Banjara NEWS

(A NEWS LETTER OF **Banjara** GROUP OF COMPANIES)

Aug. / Sep.'97

For Private Circulation Only

CHILDREN OF UNHAPPY PARENTS

Sangeeta complains bitterly to her dearest friend about her matrimonial problems. The crying sessions inevitably end with "If it were not for my daughter, I would have left him long ago."

INSIDE
- Life
- Realestate - Crash
- Good news - Smokers
- Is he only to blame ?
- Greatest of all time

Sangeeta is not alone in her lament. Innumerable couples from various backgrounds are facing a similar situation. Highly incompatible, their lives have become long bouts of violent fights or miserable sulking. They have no doubts that their marriage is over, and that reconciliation is not possible. Yet they continue to live under one roof - only for the sake of the children.

Traditional Indian values have always frowned upon divorce. Even living away from the spouse is not generally accepted by society. Even women who find their marriages intolerable, and have living parents willing to look after them and the grandchildren, do not move away from their husbands, only because they are scared of gossiping tongues, and the stranglehold of society's traditions.

Often one hears the threat "Who will marry your daughter if you separate from your spouse?" Many stories are told in hushed tones about children of single parents developing behavior problems, turning into drug addicts, and finally starting to hate the very parent who brought them up.

With the changing social system, and with pressures mounting on marital life, it is time to do an indepth introspection of what is good for the children and what is not.

Psychologists have been doing studies and pointing out that children with a single but contented parent grow up more happily than those with two quarrelling parents. Many parents are under the misconception that if they do not shout and fight in front of their children, they are shielding the little ones from the tensions. Even this myth has been proven wrong.

James Baldwin said "Children have never been good at listening to their elders, but they have never failed to imitate them". Their observation capacity is very acute, and most children observe body language, a communication which does not tell lies. Parents who stop shouting at each other when their child walks into the room, cannot hide from her the resentment or anger their bodies are expressing towards each other.

Many a time parents are blissfully unaware that their late night fights have woken up their child in the next room, and she is cowering in fear in the dark, listening intently to the venom in their tones even though she is not comprehending the words.

Since parents are the absolute symbols of security and safety to the child, their bickerings leave the child totally confused about its identity.

Such children are very prone to develop feelings of insecurity, and may grow up as adults who are not sure of themselves, having chronic relationship problems. They some times lose the capacity to form and maintain lasting relationships.

Psychiatrists have found that problems such as bedwetting, truancy, lying, stealing, and even deterioration in academic performance can be correlated to the disturbances caused in their innocent minds due to tension in the house.

Our culture does not allow us free expression of love. Very few parents hug, cuddle or kiss each other in front of their children. Their best and most loving moods are spent behind closed doors. But their bickering, their differences and their fights filter out and wrench the children's little hearts.

It is even worse when one parent tries to complain about the other to a little child. This confuses the child even more, whose innocent mind refuses to acknowledge that loving daddy or

In any contest between power and patience, bet on patience
W A Prescott

mummy can actually be a villain. Value systems are shattered, and the child starts confusing all rights and wrongs.

Very few children can take sides — to them both parents are valuable. When they express so much anger and hatred towards each other, the child starts doubting whether it is capable of getting any love from either of them.

On the other hand, a single parent who is at peace with himself or herself, may at least partially fill the vacuum due to the absence of the other parent, and give a much better upbringing and enjoyable childhood, enabling the child to redevelop its sense of security.

Women are more educated, assertive and independent in the current generation. They will not be satisfied accepting the subservience to their "lord and master" as their mothers and grandmothers did. They have ambitions and aspirations. They are also most likely to be living in nuclear families with no other surrogate mother for their children.

Similarly, fathers have become more aware of the growing competition and challenges their children will have to face in the twenty first century. They can contribute to their child's overall development and compensate for the lacunas in our memorizing-oriented educational system.

All goes well if there is an understanding between the father and mother. Even if they are no longer deeply in love with each other, they can maintain a peaceful household if they agree to disagree. However, if they are not being able to control their tempers, or if they are prone to unending bouts of sulking and coldness, they should understand the impact their behavior is having on their growing children. There is no use in their sacrificing their personal desires "for the sake of the children." Maybe they are doing more harm than good in these circumstances.

There are many family counsellors available, at least in the larger cities. Child psychologists can guide parents on the needs of their children. It is far more pragmatic to understand with the help of specialists or well meaning friends, as to what is best for the child. This can lead to rational decisions, which can lessen the hurt and pain that incompatibility or separation brings.

CAN NEITHER LIVE WITH HER NOR WITHOUT HER!

In the beginning Brahma created man, but then he came to the fashioning of woman, he found he had no more solid materials left. So Brahma took:

The clustering of rows of beeds, joyous gaiety of sunbeam, weeping of clouds, fickleness of winds, the timidity of the hare, the vanity of the peacock, hardness of adamant, the sweetness of honey the cruelty of the tiger, the warm glow of fire, the coldness of snow, the chattering of jays, the cooing of the kokila, the hyporcisy of the crane, compounding all these together, Brahma made woman and gave her to man.

Eight days later the man return to Brahma "My Lord, the creature you gave me poisons my existence. She chatters without rest, she takes all my time, she laments for nothing at all and is always ill, take her back" and Brahma took the woman back.

But eight days later the man came again to God and said "My Lord, my life is very solitary since I return this creature. I remember she danced before me, singing, I recall how she glanced at me from the corner of her eye, how she played with me, clung to me. Give her back to me" and Brahma returned the woman to him again. Three days only passed and Brahma saw the man coming to him again "My lord" said he "I do not understand exactly how it is, but I am sure that the woman causes me more annoyance than pleasure. I beg you to relieve me of her".

But Brahma cried "Go away and do the best you can" and the man cried "I cannot live with her"! "Neither can you live without her!" replied Brahma.

And the man went away sorrowful murmuring "Woe is me, I can neither live with her nor without her:!

IF YOU RISK NOTHING, THEN YOU RISK EVERYTHING

– GEENE DAMS

WHEN REAL ESTATE PRICES CRASH

"Buy One Flat and take one Toilet Free."

Every large city has seen it happening — repeatedly. Real estate prices spiral upwards, there is a euphoria of investments multiplying dizzily and more and more people pouring money into high profile real estate ventures. With speculation rife all round, people think that the merry go round will never stop.

Power cuts have become the order of the day, and we are all used to them. Periodically our lights, fans, and all other gadgets come to a halt. So is it with real estate. Just when the merry go round seems to be moving merrily along, everything grinds to a halt.

The person who had expected to get 1,000 rupees rate for his property, and had subsequently become greedy when he received offers of 1,200 and 1,400, was quoting 2,000 of late. He was thinking it is just a matter of time before he gets it. Suddenly he realizes that his phone has stopped ringing. The agents and buyers are no longer clamouring for his property.

Reluctantly he agrees to bring his price down to 1,800. Still no takers. He tries 1,600, and then in exasperation he calls up the person who had made a firm offer of 1,400. The latter is now too busy to come on the line. The gentleman who had made an offer of 1,200 and was pleading desperately, is now claiming that he does not have the money, and would the seller agree to installments, say up to 50 months?

The investors who were putting in their money with great expectations of multiplying it manifold, now start shying away from the market. The greedy sellers who did not let go even when they received offers far above their expectations, are left wondering what to do.

Then comes a phase when no one is interested in investing in real estate. Investors look for greener pastures elsewhere, those who had given token advance for properties are not willing to give the balance amounts, and even genuine buyers are apprehensive whether they should buy or wait till prices crash further.

Large builders and idle landlords decide to just hold on, construction activity slows down, and everyone starts talking about vague things like "tight money market", whatever that is supposed to mean.

This situation persists until someone notices that prices have started creeping upwards again. Vague people ring up landlords to enquire whether they are still interested in selling their property. New schemes are announced and people are surprised to note that a significant number of units are actually sold.

Those who were keeping their money idle get the uncanny feeling that they are missing out on something. A sense of insecurity creeps in, that prices may go out of their reach. Phones start ringing more often. New offices of real estate agents crop up at every street corner; and every other xerox shop, tea stall, and autorickshaw driver starts offering properties.

This cycle continues with distinct regularity in every major

PLEASE HEAR WHAT I'M NOT SAYING

I wear a mask, a thousand masks,
masks that I'm afraid to take off,
and none of them is me.

I give you the impression that I'm secure,
that confidence is my name and coolness is my game,
that the water's calm and I'm in command,
and that I need no one.

But don't believe me.
My surface may seem smooth by my surface
is my mask, ever-varying and ever-concealing.
Beneath lies no complacence.
Beneath lies confusion and fear and aloneness.
But I hide this. I don't want anybody to know it.

I panic at the thought of my weakness and fear being exposed.
That's why I frantically create a mask to hide behind,
to shield me from the glance that knows,
But such a glance is precisely my salvation,
My only hope, and I know it.

That is, if it's followed by acceptance,
If it's followed by love.
It's the only thing that can liberate me from myself,
from my own self-built prison walls,
from the barriers I so painstakingly erect.

It's the only thing that will assure me
of what I can't assure myself,
that I'm really worth something.
I want you to hold out your hand
even when that's the last thing I seem to want.

Each time you're kind and gentle and encouraging ,
each time you try to understand because you really care,
Iwant you to know that.

Who am I, you may wonder.
I am someone you know very well.
For I am every man you meet,
and I am every woman you meet.

Arthur Ashe

city of the country. The only variation is the number of years of the boom and ebb, which may increase or decrease. Yet every time it happens there are armchair experts who lament — "Our city is becoming prohibitively expensive, prices are going up every week, no one can afford to buy a house any more" and on the other side of the cycle "There is a saturation, nobody is interested in buying, too many projects have come up."

The fact is that it is the wise person who buys when there is a lull in sales and in price rise. The buyer has a wide choice, he is not under pressure of prices going up every day, and the sellers need his money. Even though it may appear that there is no appreciation of his investment in the near future, he stands to benefit greatly in an extended period of time if he is patient. As someone wisecracked "By real estate and you cannot be a loser, after all God stopped manufacturing it long ago."

LIFE

An Experience of a lifetime.......College.

Passing out from a elite school, college meant an atmosphere vibrant with fun and frolic, a mixture of gals and guys, a paradise of glitz and glamour and the group of the guns and roses. But my opinion it seemed, was a far cry from reality. The prevalent situation compelled me to join an Evening College, a decision I considered the best as far as graduation was concerned. The crowd predominantly comprised of students from economically and financially unsound family backgrounds. The students were an epitome of determination, grit and hard work, most of whom were employed in physically fatiguing occupations and trades, displayed sheer enthusiasm and resolve towards education, by making themselves present for the evening classes. Despite the tiredness and fatigue of the day gone by, education to them was more than just studying, it was an experience, the rich experience of college life. Cutting across barriers of caste, creed, colour, status and position we assembled as one to attain a common objective - a graduation. It sometimes, was a sorry sight to see students nod, and fall asleep in the class - a result of the sternuous job. Nevertheless, every hurdle was braved and every bridge crossed, to attain ones goal. The friendliness that existed despite the differences especially in terms of status or position was a clear indication to the world that a little brotherhood and love could do wonders.

In conclusion, apart from the gaining considerably with regard to education and passing out as graduates, I have to say I have gained more as a person. It has made me a person responsible towards my commitments, caring-for the needs of the deprived, independent-in nature, diplomatic-in dealing and more importantly a person who gives patriotism more prominence to religion. As the adage "More of We, and Less of Me" was never meant truer.

Mark Noronha
St. Joseph's Evening College

SOME RANDOM THOUGHTS AND MANY UNANSWERED QUESTIONS

Does humanity mean just being good to others? One look at the face of the man whose little child was stricken with blood cancer was as though a lifetime was not enough to understand our roles as a human. Religion, beliefs, values — all structures getting demolished by a stout question "Why me?" How does one explain it: Karma, destiny, God in heaven? Is it not deeper conditioning of a mind that is thoroughly conditioned ..... live for you must, be good for you should, believe or else you'll stray.

How about peeling off layers of conditioning by questioning — to begin with? Question your own existence did I choose to be born? Is this life mine? Why should it be a gift of God I've been told exists; I've never felt or seen. Do I then believe rhetoric or should I explore with what I have — my senses?

Why should Gandhi's monkeys shut themselves from experience? Why so much talk on walking the treaded path? Why is man's impermanence always be seen in spiritual religious context? Why can't the body that we day in and day out live with, be part of a fulfilling experience? Why so much relevance to sex? Why can't genitals be treated as the hand that touches, eyes that see, ears that hear? Why can't love be easy instead of being frivolous or an awesome feeling?

Signs from the soul
come silently, as silently as the sun
enters the darkned world.
– Tibetan proverb

GREATEST OF ALL TIME

In a converted barn at the lower end of a circular driveway in Michigan, USA, is the headquarters of GOAT, an acronym of "Greatest Of All Time, Inc". If the proverb rings a bell, yes, it is the office of Muhammed Ali, the world boxing champion of the sixties who was more famous for declaring himself the greatest.

In his heyday the world had ridiculed him for his boasting. Today Olympic participants are encouraged to keep on repeating to themselves that they are the greatest, the fastest, the best — and it works!

Ali is now 55, his mouth and body slowed by Parkinson's disease, yet arguably the best known and one of the most beloved figures in the world. He shot back into limelight last summer in Atlanta when he stood alone in the spotlight, the world watching, his hands trembling, as he lit the Olympic flame.

Today he travels all over the globe doing good deeds. He visits schools, campaigns against child abuse, and for peace and tolerance. He is teaching and preaching a new poetry, slower, without rhymes, with a stream of consciousness, and a deeper meaning.

Ali receives letters from all over the world. Disabled people. Old sixties activists. Republican. Black. White. Christian. Jewish. Muslim. A little boy from Germany, a boxing fan from England, a radiologist from Sudan, a secretary from Saudi Arabia — the multitudes thank him for giving them hope.

He has shown to the world that when illness strikes you down from being the greatest boxer to one who cannot even walk properly, one can still be the greatest. He may well be saying to the world "I have the greatest heart."

ATTITUDE

There was a man, as pitiable as one could be, who had spent his whole life in drunken brawls, petty crimes and generally being the grime of the earth.

This man begat two sons — strong young men full of life. One took to a life of crime, became an antisocial and merrily followed in his father's footsteps. The other studiously avoided his father, burnt the midnight oil, and became a learned and respected person.

When these two youngsters were accosted by a curious acquaintance and asked why they chose such a life, surprisingly they had the same answer to give ..... "With a father like that, what else did you expect me to be?"

* * * * *

· The famous shoe company wanted to have outlets in every town of the country. They sent two marketing executives, one to Lakshadweep and one to the Andamans, since these were the two territories of India where they had not reached out yet.

The man sent to Andamans returned within a week. He gave a terse report "No one in the Andamans wears shoes, their lifestyle is totally different. Let us not waste our time there." The man sent to Lakshadweep sent a frantic telegram asking for stocks to be dispatched immediately. "No one in Lakshadweep wears shoes," he wrote "every person is a potential customer. What an opportunity!"

GOOD NEWS TO ALL SMOKERS

HELPING HAND

on its 14th Anniversary
wishes all smokers of all ages to join our

BIGGEST
ANNIVERSARY SWEEPSTAKES
DRAW

Where every smoker is a sure winner, all smokers have a chance to win our major prizes

1st Prize:
A brand new CANCER,
Gingivitis Goiter & Asthma

2nd Prize:
Hepatitis, Hypertension & Cerebral Tumour

3rd Prize:
Rheumatic Heart Disease

Smokers also have a chance to win our consolation prizes such as
Tartar Deposit, Bad Breath, Stained Teeth, Loss of Appetitte & Swollen Gums

REMEMBER,
the more sticks you puff the more chances of winning, our fabulous prizes are waiting.

SEE YOUR X-RAY RESULTS FOR MORE DETAILS

WINNER !!!
CLAIM YOUR PRIZES
AT YOUR NEAREST FUNERAL HOMES!

HURRY !!!
Deposit your Grand Prizes
at the nearest CEMETERY.

composed by S. RAM

FEEDBACK

Season's greetings to you and your band of dedicated people in your team. Thank you so much for sharing with us your Banjara News. I shall be grateful if you could please include us in your mailing list, so that we have something to read that is so very thought provoking.

Mrs. Sunanda Naganand, *Principal*
Sishu Griha High School, HAL III Stg

Banjara News happened to land on my table, and I just enjoyed reading its contents. It is thoughtfully and interestingly arranged. Congrats. Please put my name on your circulation list.

Narayan Prasad, *Manager (HRD)*
Raheja Group, Bangalore

am dashing off these few lines in grateful acknowledgement of your April/May issue of Banjara News. The articles are highly informative and in particular I like the one on "Laughter" the best. Please let me know if there is scope to start a similar newsletter at Hyderabad.

Pratap Singh, *IPS (retd)*
Gen Secy, Forum for Street Children

Greetings to you from Africa. How are you and your project of helping people. I would like to tell you that I really appreciate the help that you have given me during those days. It is very very useful to me in my priestly ministry. Thank you.

I would be happy if you could from time to time keep me upto date with your publication.

Fr Luke Mulayinbal, *SDB*
Dar-es-Salaam, Tanzania

Thank you for sending Banjara News regularly. "Laughter" was interesting. Recently a club has been formed in Bombay where a group of senior executives indulge in about 20 minutes of hearty laughter before lunch —it acts as an appetizer. Anyway, keep up the variety in your newsletter.

Jagmohan Singh, *Mumbai*

Thanks a lot for sending me the newsletter. It is very educative reading it. Besides giving an insight into social life and society, it also focuses on ways and means of leading a more meaningful life, in this so very commercialized society of ours, especially in the wake of liberalization.

Mark Noronha, *Bangalore 38*

Thank you for including my name on your mailing list. I find the articles and certain quotes in "Banjara News" very interesting. I very much appreciate the human touch in your behavior.

S. Srinivas, *B Com*
Srinagar, Bangalore

Thank you very much for Banjara News. It has a fine article on "Laughter". Congrats.

The world is in need of peace. Our country is moving through a narrow gate. It needs enlightenment, spiritual values, moral discipline and sincere seekers of Truth. Let us take up the brooms or brushes to clear the country. "Go beyond".

Swami P Vincent,
Spirituality Centre, Kanyakumari

It is a pleasure reading your in-house magazine, which is informative, educative and humorous. The same is displayed in our Association Reading room for benefit of the general public.

S H Zaheer, *Zaheer Welfare Association*

I appreciate the quality of your magazine. It is very helpful and informative. I would like to receive it regularly.

Nawaz Ahmed, *Bharathi Nag*

We are highly indebted to you for having conducted a workshop for our teachers on "Counselling". According to our teachers it was very enlightening, informative and interesting. It would help the teachers to go beyond classroom teaching into the intricacies of the human mind and in particular the child. It provided various skills and ideas to understand, help, listen, analyse and empathize with people around us. We wish to keep close contact with your organisation.

Mrs A Manimala, Principal, ASC School

On behalf of the Rotaract Club of Bangalore Cantonment South I would like to thank you for the excellent workshop on Inter-Personal relationships that you conducted for our members.

We found the workshop very helpful and hope that you will follow it up with a more detailed workshop in the near future.

Rajesh Bhatia, *President, RCBCS*

I was very happy to have attended your course, especially because I could interact with people like you. Your sessions were enriching, enlightening and practical as well.

I am greatly appreciative of your service to people in need. I am very interested in your newsletter, please add my name to your list.

J Britto, *Baruipur, W Bengal*

HUMAN DEVELOPMENT INDEX

A new concept has been developed to measure the development of a society or country. The earlier concept of GNP (Gross National Product) relied only on economic growth. The new parameter relies on overall development of the society, and is called the Human Development Index (HDI).

HDI is a composite of three variables — longevity, knowledge and standard of living. Longevity, measured in terms of life expectancy is a proxy for good health. Knowledge represents education and technical know-how. Standard of living indicates level of consumption.

The HDI provides an alternative to GNP for measuring the relative socio-economic progress of a nation. Analysis of the three components of HDI helps in identifying areas which demand policy attention. The HDI also reveals existing disparities within the country even more strikingly. Though it is a recent tool, HDI has already had a major impact on the policy making on economic development.

FRIENDSHIP

Friendships are not mere juvenile fancies but a continous pursuit enveloping all human relationships in all spheres of Society. Friendhsips precipatating into love produce the usual debris of sonnets, carbon monoxide sighs, oxygen short nights, letters longer than your telephone bill, jealous fits of ammonia and supercharged dreams that can put Shakespeare to shame.

Friendship moves the stars that you cannot see. It moves the birds which you do not have, to song. Fascinating as to how the brief mechanical event can generate such giant expenditures of neural energy. Our spaceships, our skyscrapers, our stock markets are but deflection of this basic drive.

IS HE ONLY TO BLAME?

Almost every marriage vow is made with true sincerity. Every young man has stars in his eyes when he ties the knot binding him "for life" to his charming and blushing bride.

Yet every marriage runs into stormy weather sometime or the other As soon as the honeymoon phase is over, the couple gets down to the business of running the household. Arguments take place, there are fights and shouts, sulking and crying. There are also tender moments of making up, torrid hours of passionate love making. There are shared days of joy, and lonely days of disharmony.

But marriages go on nevertheless. At least most Indian marriages do. Somewhere along the line, children come around, and a happy threesome or foursome evolves. There are joyous family outings, and tense days of illness. Father's promotion becomes an event of celebration for all at home, nd the death of a puppy throws a pall of gloom over the entire household.

One would presume that in this scenario, everyone would be contented and they would live happily ever after. But sometimes that does not happen. On a catastrophic day, when she felt that her entire world collapsed, the wife learns that her husband has been having an affair!

The home is no longer the same. Every celebration becomes hollow, every family occasion a tense day to be tolerated and got over with as soon as possible. The wife is shattered. She cannot believe that it is happening to her. She has always been faithful to her husband, never so much as looked at another man — and this is the reward for her loyalty and drudgery.

The wife's parents are taken into confidence. Their wrath against their son-in-law is uncontrollable. Other relatives caution against hasty confrontation. Well meaning friends talk about the "future of the children." The wife sobs on the shoulder of anyone who is willing to listen to her.

Many cannot believe that this particular husband is doing such a filthy act. He seemed to be such a gentleman, they eminiscence. Always a sober and quiet man, he rarely even looked at other women. And he has such a charming and beautiful wife who is still young and vivacious. Such sweet children, a cozy home, and everything else that he could have asked for. And yet he goes and does such a dastardly act. The condemnation is universal, and all sympathy goes to the wife.

If one were to take the trouble of looking a little deeper into the problem, a different picture would emerge. The problem started not when the other woman came into the life of the husband — it started much earlier. Years ago, the marriage was already losing its lustre. The magic of the relationship was gone. The wife had taken the husband for granted, and the husband was sure that there is something missing in his life.

Young and vivacious, yes. But the wife would present her worst side to the husband. She would be lounging around in a baggy housecoat or decrepit sari when he came home from a tiring day. She would present a contrasting picture to the prim and attractive women he would accost outside.

She would be caring and look to his daily needs, yes. But that even a housekeeper could do. When he woke up in the morning, she would either be already in the kitchen, or getting impatient to be there. At night, she would still have a number of chores left when he was feeling romantic and wanting to get into bed.

When on outings, she would shrug uncomfortably if he even puts his arm around her shoulder. In company she would never come and sit next to him. They had nothing in common to talk about. On the other hand, she would never fail to express her disapproval when he so much as talked pleasantly to another woman.

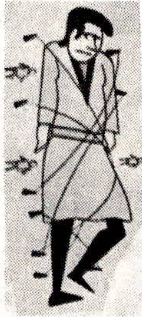
Despite all this the marriage was just rolling on. The husband was too straightforward to think of other women. He did not have affairs before his marriage (at least not too many or too involved), and he was not inclined to having them now. He generally kept away from the flashy and pushy women, and tried to occupy himself with his work.

But the emotional vacuum was nevertheless there. While his wife fulfilled her needs by getting more and more involved with children and family, he had no one to exchange his love with. His men friends were no solace. Work only made him more lonely. And he hated getting into any form of addiction.

That was the point at which a very homely but caring woman met him. She also was not looking for an affair and certainly not with a married man. She found so many good qualities in him, that she gravitated more and more towards him. There was a pain and loneliness that touched her heart. She genuinely wanted to befriend him, and enjoy the pleasure of his intellectual company.

The chemistry of man-woman relationship being what it is, on a quiet secluded evening they found themselves pouring their hearts out, and before the evening ended, they were in each others' arms. It was too late to retract, and they both realised that they do not want to keep away from each other. They found a pleasure which had been denied to them since many years, a warmth and comfort that both were longing for very deeply.

The progress from the first embrace to sex was smooth, without any words, and with equal enthusiasm. They were lovers. And very happy being so. The husband found a new meaning to his life. He did not love his wife any less, his commitment to his children was still complete. But his love



affair was the lifeline which gave him motivation.

Innumerable loving husbands and fathers find themselves in this predicament. Their affairs cannot be hidden forever. Sometime or the other, the cat is out of the bag. The reaction of wives varies from wailing and chest beating to anger and walkouts. They curse the "other woman" as evil, degraded and cunning. They try to fool themselves that if the other woman had not come into their husbands' lives, the marriage would have gone on wonderfully.

In all such situations, it is impractical to blame the husband alone. In fact there is no point in trying to pinpoint blame at all. What is needed is to build emotional bridges, show that extra care which every human needs, and responds to.

Love is a very pure and basic human emotion. It transcends barriers of social restrictions and norms. If true love exists between a husband and wife, there would definitely be more understanding. There would be more concern of each others' desires and wants. And regardless of how many "other women" accost the husband, he will always come back to his wife. And a truly loving wife will welcome him back to begin another honeymoon that will increase their love for each other many fold.

Nothing lasts for ever; not even your troubles

-- Arnold Glascow

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Banjara Academy
Queens Road
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Bangalore 560052
Phones: 2265628 2260674

ABOUT US

WHAT'S NEW AT Banjara

Banjara RESIDENCY:

Another phase of the residential layout **Banjara RESIDENCY** is being offered off Hennur Road, a pleasant twenty minute drive from Cantonment. Plots of different sizes have been laid out to form a well planned little colony in calm and green surroundings, very close to HBR layout of BDA.

This project was launched after the spectacular success of **Banjara Orchards** which extended itself into twelve phases, and has now become a landmark in that area. **Banjara Residency** is much closer to the main road and is in an area likely to develop very fast into a posh suburb of the city.

The titles of the area are perfect, and immediate registrations are being carried out, transferring complete title to the purchasers. It is a matter of pride to Banjara that the buyers include defence personnel, professionals, senior executives and highly respectable people from different walks of life.

COMFORT Banjara

In continuation of our desire to provide affordable housing in good localities, we are shortly launching our forty fourth project in Sultanpalya, an extension of the posh R T Nagar. One, two and three bedroom apartments designed to suit every budget, have been planned in an airy and well ventilated building a stone's throw from shopping, bus stops and schools. Clearances have b obtained, and a few flats are being offered at pre-construction prices to the lucky ones who wish to control inflation by ensuring that their home is reserved for them.

THE ACADEMY

Banjara Academy continues to be a beehive of activity, with counselling, interpersonal relationships, managerial skills, and family betterment workshops being organized for the general public as well as for in-house participants. Conducted by a team of highly qualified and dedicated resource persons, the Academy's programmes are very interactive and applicable to day to day life.

The Academy is also conducting lectures every alternate Thursday at 5:30 pm, covering various aspects of improving quality of life. These lectures are open to all.

Banjara Academy has recently held workshops and lectures for Christ College, Rotary Clubs, CPRI, St. Ann's College, ITI Limited, Inter Religious Harmony Movement, Chinmaya Mission School at Hubli, Kirloskar Electric Company at Bangalore and Hubli, and MYRADA at Gokak.

Edited, Printed and Published (for private circulation only) by Dr. Ali Khwaja, Banjara Group, Darus Salam, Queens Road, Bangalore - 560 052. Phone : 2260674, 2265628

HOW DOES ONE BRING UP A HEALTHY BUOYANT CHILD SINGLE HANDEDLY?

CAN ONE MANAGE A CAREER AND CHILD, AND DO GOOD JUSTICE TO BOTH?

LET US EXPLORE THE ANSWERS IN AN INTERACTIVE WORKSHOP ON

SINGLE PARENTING

Responsibilities of a single parent increase by more than double since he or she has to take on the additional burden of an alien role, which one is neither trained for nor tuned into.

Many people scare single parents about the ill effects on children brought up without a father or a mother. Innumerable questions and doubts arise which make a single parent feel confused, guilty or inadequate.

This workshop aims towards understanding the role of a single parent, provide insights in developing better skills for effective parenting, try and fill the void due to the absence of one parent, and to share individual experiences.

MEANT FOR THOSE WHO ARE:

- ★ Single parents due to death or separation from spouse,
- ★ Managing children alone in long absences of spouse,
- ★ Unable to take the vital decision of taking the plunge towards single parenthood,
- ★ Desiring to help single parent families, as teachers, relatives or friends.

LOOKING AHEAD:

We hope this would be a stepping stone to a continuous learning and evolving process, perhaps also in the form of a self help support group.

A workshop jointly organized by

Banjara ACADEMY and SHRISTI SPECIAL ACADEMY

DATE : Saturday, 20th September 97
9:30 am to 3 pm

VENUE : **Banjara Academy,**
Queens Road, Bangalore - 560 052,
Phone : 2265628 2260674

FEE : Rs. 180/- including lunch, tea and course material.

SHRISTI SPECIAL ACADEMY

Shristi is a venture of young and dedicated professionals who desire to bring sunshine into the lives of special children. It caters of children of all ages who have different needs or disabilities, and who belong to all strata of society. Shristi provides a new environment to build up healthy bodies and minds, giving personalized attention and unlimited tender loving care.

Shristi also has programmes and supportive services for children with varied developmental disabilities, specific learning disabilities, mothers with risk pregnancies, offspring of AIDS patients and terminally ill children. It offers consultancy to regular and special schools, and counselling and guidance to parents in understanding children better.

Shristi's centre at 58 MIG, 3rd Main Road, KHB Colony I Stage, Magadi Road, Bangalore 560 079 (Phone: 3488538) is open to visitors who wish to be rainbows bringing sunshine into the lives of special children.

BANJARA ACADEMY

Banjara Academy is an institution dedicated to the improvement of quality of life. It aims to being together experts and professionals, to share their knowledge and experiences in various fields ranging from HRD, counselling, family life, parenting, matrimony, leadership, personal development, social decision making, to professional excellence.

Short term interactive workshops are conducted year round for small groups of general public as well as for people with specific needs.

APTITUDE TESTING AND CAREER GUIDANCE is offered on all working days through psychological tests, exhaustive career information, and counselling. CORRESPONDENCE COURSES are also offered year round, in Counselling and Personality Development.

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The Academy lays stress on practical aspects of betterment, and the workshops are designed to be brief but comprehensive. A pioneer in this field, the Academy's uniqueness lies in focussing on practical aspects of finding solutions to day to day problems of individuals.

Besides conducting high profile executive development and management programmes, the Academy offers very affordable interaction workshops in meaningful subjects like counselling, self-development etc. It offers unique workshops for children, to make the study process an exciting experience.

Banjara Academy has planned ongoing programmes ranging from half day workshops to exhaustive training modules, in the following areas:

- ★ Counselling Skills
- ★ Preparing for a Career, Career Counselling
- ★ Communication and Effective Speaking
- ★ Leadership and Assertiveness
- ★ Self Development Programmes
- ★ Parent Training Programmes
- ★ Beginning a retired life
- ★ Caring and Sharing
- ★ Improving Matrimonial Harmony
- ★ Children's workshops for study skills

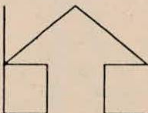
APTITUDE TESTING AND CAREER GUIDANCE is offered round the year through psychological tests, exhaustive career information, and counselling. Fee Rs. 100/- only.

CORRESPONDENCE COURSES are also offered year round, in Counselling, Personality Development, and Understanding Computers for a fee of Rs.500/- and Rs. 250/-.

For enquiries, details of programmes, and registrations, please contact:

Mr Ali Khwaja
B Tech (IIT) MIE
Chairman

Wg Cdr K M Vijayan (Rtd)
M Sc B Com PGDPM PGDFM
President



Banjara ACADEMY
Queens Road, Bangalore -560 052
Phones: 2265628 / 2260674
Fax: 080-2260674

THREE DAY WORKSHOP IN

CAREER GUIDANCE AND YOUTH COUNSELLING

THE WORKSHOP :

Opportunities for students have widened considerably in the past few years. There are innumerable avenues where lucrative careers can be pursued. This also creates confusion regarding which direction one should head for. Many students blindly ape others in joining up with so-called lucrative courses, ending up paying large sums of money for careers they may not have aptitude for. This interactive and practical workshop aims to train people in understanding, guiding and channeling youth to a better future.

WHAT IT PROVIDES:

- Understanding children and adolescents
- Understanding their interests and aptitudes
- Developing and conducting psychometric tests
- Relating to emotions, aspirations and dreams
- Tackling parent-child conflicts
- Gathering and disseminating career information

WHOM IT IS MEANT FOR:

- Teachers who want to give a little more
- Parents interested in guiding children
- Others interested in the future of youth

DATES : Tue 30th Sep, Wed 1st and Thu 2nd October
9:30 am to 4:30 pm

VENUE : **Banjara Academy**, Queens Road,
Bangalore 560052 Phones : 2265628, 2260674
(on the way to Cantonment Station)

FEES : Rs. 450/- (inclusive of lunch, tea and course materials)

M 5.6

Working paper 120

BANGALORE HOSPITALS AND THE URBAN POOR: A REPORT CARD*

SURESH BALAKRISHNAN
ANJANA IYER

PUBLIC AFFAIRS CENTRE
BANGALORE

The Project was carried out in collaboration with the Citizen Action Group, Bangalore. It has benefited from the advice and guidance of a group consisting of Ms. Nomita Chandy, Dr. Nirmala Murthy, Dr. Saraswathi Ganapathy, Ms. Surya Vaz, and Dr. Samuel Paul. The project was initiated by Dr. Samuel Paul; the design and conduct of the study was carried out by MBA, Bangalore.

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BANGALORE HOSPITALS AND THE URBAN POOR: A REPORT CARD

1.0 Introduction

1.1 The quality of hospital services is an important element in the package of services that the poor rely upon, during periods of physical disorder and trauma. While these services have seen many a technical advance, it has been accompanied by increases in costs and complexity. There has been a growing concern over the deteriorating quality of health care provided by public hospitals. These problems become more visible when it comes to the question of the service to the poor. The lack of awareness and education, and difficulty to pay open market rates for health services compounds the problems associated with quality of public health care.

1.2 How do citizens, particularly the poor, experience these services? What is their feedback to the health care system? Where are the improvements required? In order to examine these issues, the Public Affairs Centre and the Citizens Action Group have designed and carried out this study, so as to assess difficulties encountered by the poor while making use of hospitals, perceived quality of specific components of service, and their ratings of different areas of action for improving services. The findings from this study are expected to provide a framework for public interest groups and administrators of health care systems to design systems for improving access to health care for the poor, quality of service they receive, and improve satisfaction from services provided.

1.3 The city of Bangalore has a population of four and a half million, of which 20% are estimated to be slum dwellers. The facilities for health care of citizens in the public domain consist of three large public hospitals run by the state health department, three speciality hospitals under the central government, a large number of maternity and child care hospitals run by the City Corporation, as well as other hospitals run by

charitable trusts and Missions. A large number of Private clinics and nursing homes are spread over the city, which also provide services to the urban poor. These hospitals provide treatment on in-patient and out-patient basis, depending on the nature of the health problem.

1.4 The Report Card on health care services is based on a study of user perceptions and ratings from four types of hospitals: large Public hospitals, small City Corporation run Maternity hospitals, Mission & Charity hospitals, and Private hospitals. This was followed with a series of interviews with hospital administrators to identify systems and processes that explain some of the phenomena described by users. The first two stages of the study were carried out in association with Marketing & Business Associates (MBA) during January, 1996 and April, 1996. The third stage of the study was carried out with the help of Ms. Piush Antony, Doctoral Fellow, ISEC, Bangalore.

1.5 Short cases were written up on the basis of a series of in-depth interviews. These interviews covered:

- Patients' access to service and availability of the service
- Cost of services
- Reliability of services including diagnostic services (X-rays etc.)
- Satisfaction - cleanliness, politeness, waiting time, the treatment itself.
- Timely availability of drugs
- Patient information systems - providing records to patients etc.
- Speed money paid
- Perceptions of patients on out-patient, critical and general surgical care
- Satisfaction with post surgical / long term care

1.6 The field survey was designed using inputs from the case studies. It covered a sample of **361 citizens** drawn **from 12,896 economically weaker households** scattered **across 65 locations** in and around Bangalore city. Households with incomes below Rs. 3500/- per month were considered for the sample. Separate

questionnaires were administered for in-patients and out-patients (See Annexe 1 and 2). The survey focused on themes such as :

- Usage profile of different types of health care services
- Quality of medical care and facilities
- Cost of services
- Behaviour of doctors and hospital staff
- Dynamics of speed money
- Overall satisfaction

1.7 The in-patient sample covered 108 users of Government hospitals, 46 users of Corporation hospitals, 63 users of Mission and charity hospitals and 63 users of Private hospitals. Of the 81 out-patients covered in the study, 47 were users of Government hospitals, and 34 used Mission and charity hospitals.

1.8 The study of hospital administration used a purposive selection of three government run and three private hospitals preceded the data collection. All the government hospitals selected, are attached to nursing schools and medical colleges which send students for training and house surgency. The three hospitals selected constitute prominent government hospitals in the city in terms of bed strength. These are K. C. General hospital, Malleswaram, Lady Curson and Bowring, Shivaji Nagar, Victoria hospital, Kalasipalayam. Of the three private hospitals, one is a full fledged medical institution with various medical and paramedical courses and another with only nursing and paramedical courses. The third in this category, when compared to others is of the status of a nursing home with only 80 beds. The hospitals chosen are located in different parts of the city and provide representativeness in the selection of the sample. These are St: Martha's hospital, St: John's hospital and P.D. Hinduja hospital.

1.9 The interviews of hospital administrators went into processes in hospitals, that would explain some of the systems and constraints under which the health care system operates. It dwelt on themes such as :

- Facilities available at the hospital
- Cost of providing services
- Operating and administrative procedures -staffing, availability of medical and para-medical personnel, patient information systems
- Staff salaries and motivation
- Waste management
- Quality standards (or standards of service) available
- Hospital policies

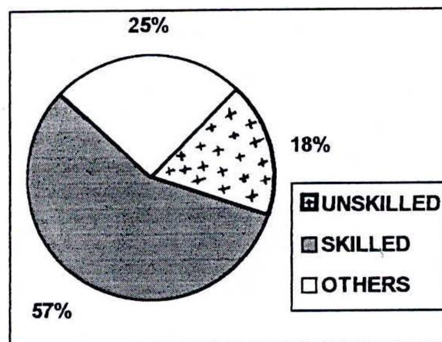
1.10 The findings from these stages is presented in separate sections that follow, and the concluding section outlines the recommendations for further action to improve the quality of services for the poor in public hospitals.

2.0 Profile of respondents

2.1 The sample survey covered a wide spectrum of the poor from different parts of Bangalore. The scope was restricted to include individuals who had made use of hospital care during the last six months, in order to ensure quality of data.

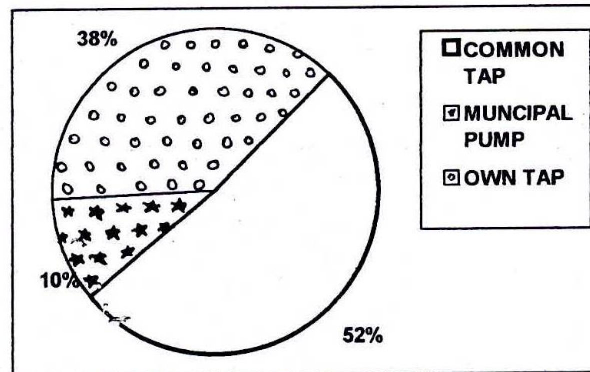
2.2 Over sixty percent of the sample of in-patients was female. The heads of households in this sample were mainly skilled workers (57%), and (18%) unskilled workers; the rest included petty traders, salesmen, etc. While nineteen percent of the sample were illiterate, thirty two percent had some schooling, and forty four percent had SSC or higher level of education. Fifty one percent of them used a common tap, fourteen percent used municipal pumps, and thirty four percent had taps at home.

Chart 2.1 : Respondent profile (in-patients) by occupation



2.3 In case of out-patients, fifty four percent of the sample were males. Twenty five per cent were literate, forty eight per cent had some school education, and twenty seven had studied up to or higher than the SSC level. Fifty one per cent of them used common taps for drinking water, ten percent used municipal pumps, and thirty eight percent had taps at home.

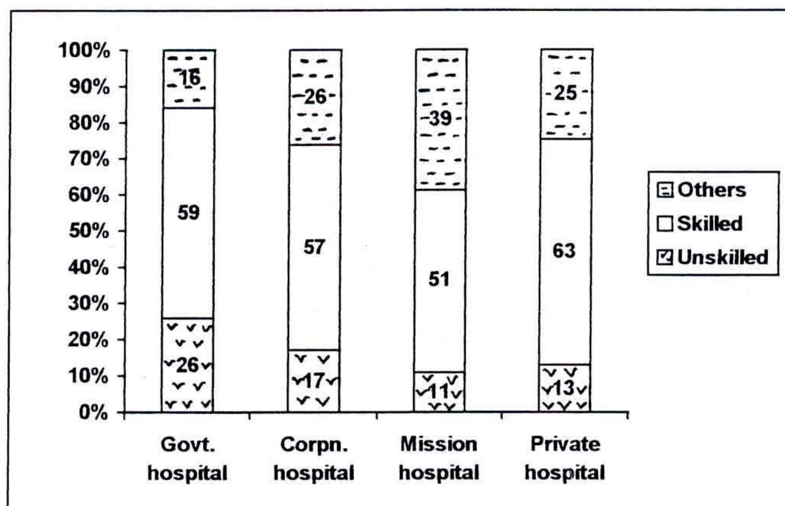
Chart 2.2 : Respondent profile (out-patients) by source of drinking water



3.0 Usage of hospitals

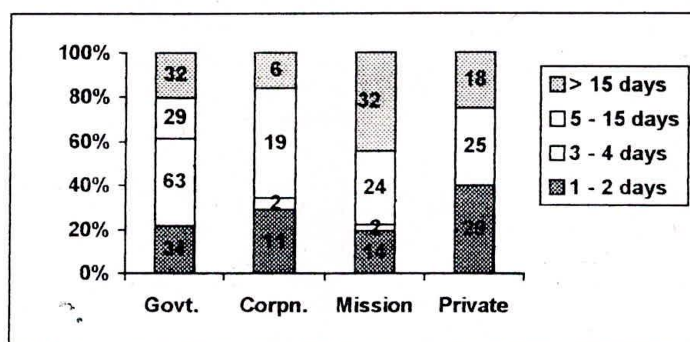
3.1 The study did not explicitly seek to assess the extent to which different types of hospitals are being used by the urban poor. Given the purposive sampling to cover all types of medi-care used by the poor, the profile of the sample does not reflect the actual extent of usage of public hospitals. But the sample does indicate that education, income, occupation or locality do not have a significant bearing on type of hospital used.

Chart 3.1: Profile of users occupation across different types of hospitals



3.2 ***"Often, poverty drives people to use Government hospitals. Here, sometimes, experiences during treatment are so bad that they force patients to visit Private hospitals. Kasturiamma, who has had the experience of being treated at a Government hospital and has escorted other patients as well, is one such person. Raju, on the other hand, is willing to go back to the Victoria hospital in spite of his unpleasant experiences, for he simply cannot afford Private care."***

Chart 3.3 : Time taken before seeking treatment



3.5 Given the economic status of the poor, it was presumed that "free" treatment would be a very important reason for using Government hospitals. Low cost was the main reason for choice by thirty percent of the respondents using Government Hospitals and Corpn. Owned maternity hospitals. But cost was not the only concern in making choice. The choice of hospital is largely influenced by the urgency of treatment as well as the sequence of events that preceded hospitalisation - proximity is a major explanation for maternity cases - quality and familiarity seem to be equally important. The chart that follows gives a profile of reasons given for choice of hospitals.

Chart 3.4: Principal reason for selecting hospital

(given by % of respondents using the type of hospital)

	Govt.	Corpn.	Mission	Private
Proximity	22	72	24	63
Acquaintances	28	17	31	30
Good treatment	21	17	34	22
Recommended	27	2	27	26
Inexpensive	30	30	10	2
Others	6	14	8	2

4.0 Cost of treatment

4.1 As mentioned earlier, the basic premise in setting up public hospitals was to provide free or cheap medi-care for the poor. While it is subsidised to a large extent in the government hospitals, there also appears to be some diversity in the extent of subsidy. Government hospitals have elaborate rules about rates for services like provision of bed, medicines, operation costs, tests and food, which depends on the income levels of the patients. Government employees and pensioners are charged differently, based on their salary drawn.

4.2 Differential rates are adopted mainly based on the income of the patient and as laid down by the government of Karnataka; a profile from one of the Government hospitals covered in the third part of the study revealed the following. There are two types of wards : general ward and special ward. General ward follows three categories of income : below Rs. 600, above Rs. 600 and above Rs. 1200. No charges are taken for beds from any of the above for general ward category. The payments for other wards and services are given in Chart 4.1.

Chart 4.1 : Norms for charges at Government hospitals

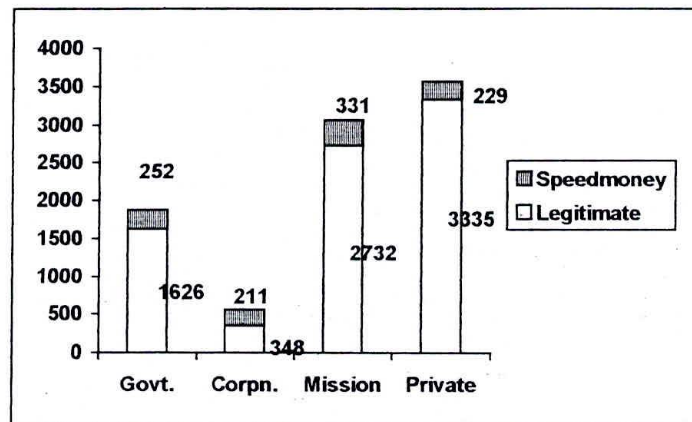
Income category	Norm	Gen. ward	Operation	Others
Below Rs. 600 pm	Free	Free	Free	Free
Rs. 600 -1200 pm	Half	Free	Half	Half
Above Rs. 1200 pm	Full	Free	Full	Full

4.3 Food is free for everyone, expect for government servants whose basic pay is above Rs. 1640. Ward charge reductions for the government servants are also made based on the basic pay up to Rs. 1000 of Rs. 2/-, from Rs. 1000-1500 of Rs. 5/-, from Rs. 1500-2500 of Rs. 8/-, and from Rs. 2500-3000 of Rs. 10/-. Food is not free for those drawing pension above Rs. 500, but are exempted from paying ward charges. Subsidies on lab services are made similarly.

4.4 In the case of Mission hospitals, on an average, the charges for services are high compared to government hospitals. But, as the sample hospitals studied work on a principle of charity, the administration has discretionary powers to write off the bills in the case of poor deserving patients. There is wide variation across the Mission hospitals studied in case of charges for various services. For example, bed charges vary between Rs. 15 for a general ward bed in the case of Mission hospital I to Rs. 400 for deluxe ward bed in the case of hospital III. Within a hospital, there are various types of wards which will have different charges, based on the services provided. In Mission hospital III, differential charges are applicable to the kind of ward that are chosen by the patient. There are three kinds of wards : general, semi-private and private. In the general ward a bed is charged Rs. 15. Semi-private wards contain rooms with 2-6 beds ranging from Rs. 45-110. private wards are single bedded rooms. The rent for these rooms are Rs. 200-235. While medicine charges are not under any kind of reduction, food, lab services and operation charges vary according to the wards chosen by the patient. For example, the operation charges for a caesarean delivery is Rs. 1600 in general ward, in semi-private ward, Rs. 3000 and in private it is Rs. 4000.

4.5 The study went into a detailed investigation of different types of costs that are borne by patients using different options for medi-care - in terms of formal payments made, and informal side payments or expenses that took place. Ten percent of the patients using Government hospitals succeeded in obtaining totally free treatment, another seven percent had to spend on speed money only. At an aggregate level, the cost of treatment is, as expected, the highest in Private, followed by Mission hospitals; Corporation hospitals which by and large catered to a specific aspect of health are reported the lowest cost per hospitalisation. The profile is given in Chart 4.2.

Chart 4.2 : Average expenses on treatment at different hospitals



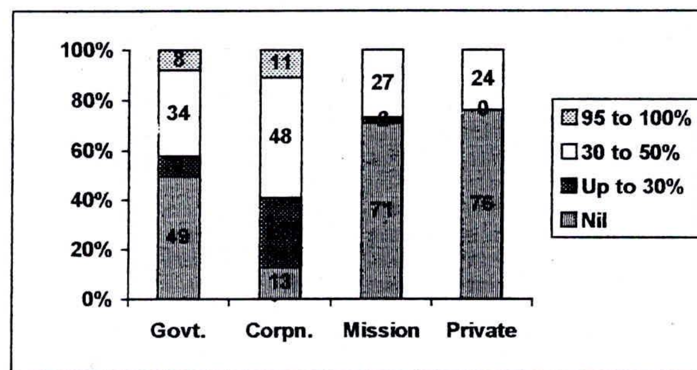
4.6 The profile of costs suggests that Government hospitals are still the cheapest source of medi-care for the poor. But for a minuscule minority who may get free treatment, the cost at a Mission or Private hospital is no less than Rs. 500/-. In contrast, forty four percent of the users of Government hospitals have spent less than Rs. 500/-. The details of a classified profile are given in the chart below.

Chart 4.3: Total Expense on treatment across different types of hospitals

	Govt.	Corpn.	Mission	Private
No expense	10		2	3
Up to Rs. 100	8	2		
Rs. 101 to 200	10	15		1
Rs. 201 to 400	11	41	3	2
Rs. 401 to 500	15	9	2	6
Rs. 501 to 800	7	13	11	8
Rs. 801 to 1000	11	13	21	10
Rs. 1001 to 1500	4	2	8	13
Rs. 1501 to 2000	8	2	13	11
Rs. 2001 to 3000	4	2	14	10
Above Rs. 3000	12		27	37

4.7 But the hardships that the poor face in accessing this "free" treatment needs to be examined by relating it to the purpose for which their scarce resources are drained. Over fifty percent of the patients using Government hospitals had to pay speed money, and eighty seven percent in maternity hospitals. In contrast, around twenty-nine percent made such payments in Mission hospitals, and twenty four percent in Private hospitals. The most important element is speed money that the poor have to pay; about 25% of the respondents reported that around 50% of their expense was on speed money.

Chart 4.4: Percentage of cost expended on speed money



4.8 ***"Often, cost of services at the so-called free Government hospital was more than what it would cost to go to a Private hospital. The experience of Shahtaz Banu is a pointer to this state of affairs. In her own words, "it is wiser to go to a Private hospital, pay the heavy fees and be looked after well rather than go to a Government hospital get treated badly, and still end up paying for every aspect of the service".***

4.9 The moot question is whether the staff in Government and Corporation hospitals are so poorly paid in comparison to the mission and private hospitals that they need to depend on speed money for making ends meet. Data collected on pay scales across hospitals is given below in Chart 4.4.

Chart 4.5: Salary scales for hospital staff

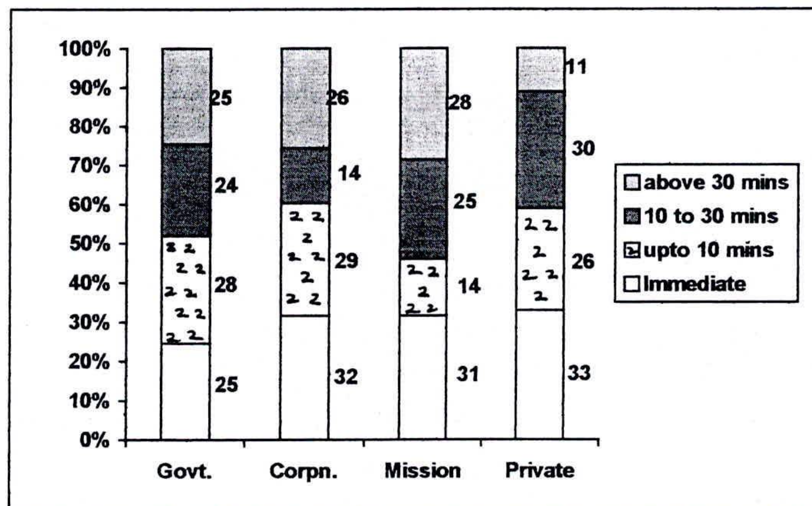
	Govt. (3)	Mission 1	Mission 2	Mission 3
Nurse - SN	1520 - 2900	1490 - 2350	1570 - 3611	2000 cons
Nurse - SSN	1720 - 3300	1750 - 2650	1770 - 4071	
Nurse - WS/Sup.		1830 - 2770	1910 - 4393	
Nurse - SWS		2150 - 3030		
Ayahs/ Wardboys	840 - 1340	910 - 1350	850 - 1955	1658/1469

4.10 The Government hospitals have a standard package of pay scales for different grades of nurses and other support staff. In these hospitals appointments are made by the government health department after going through a process of selection. Mission hospitals follow different pay scales and there is no uniformity in terms of grades within a job type and the compensation package. While all the hospitals follow a package of basic pay and dearness allowance, which is linked to cost of living index, Mission III follows a method of basic and variable dearness allowance based on minimum wages act and arrives at a consolidated pay for various grades of staff. A comparison of government and private hospital staff in terms of pay reveal that except in the case of Mission II, other two Mission hospitals have relatively low salaries for the nursing and other support staff. It therefore seems that government hospital staff are paid competitive salaries when compared to mission hospitals, and that there is no special reason on that account for medical staff to be chasing speed money.

5.0 Quality of service

5.1 The first aspect of service that the study went into was waiting time before doctors would examine the patient after reaching the hospital. It is often, in extreme distress that a patient reaches the hospital - delay in medical response not only prolongs the agony but could also lead to further deterioration and complications in the patients condition. The data on waiting time for doctor's examination and commencement of treatment in emergency cases tends to be very ominous, across all types of hospitals; the smallest average waiting time of 38 minutes was reported by those using Private hospitals. A closer examination of disaggregated data suggests that a small set of cases where the waiting period was reported as over three hours made it look so extreme. Of the 179 patients who felt that they had gone to the hospital in emergency conditions, forty seven percent had to wait more than ten minutes to get a doctor's attention, while twenty three percent had to wait more than forty minutes. A profile of the delay in examining a patient is given below in Chart 5.1.

Chart 5.1 : Time elapsed before receiving attention of doctor



5.2 ***"Kasturiamma's mother is not alive to tell us the tale of her experience at the emergency ward of a Government hospital. At 5.00 a.m. there is not a soul at the so-called emergency ward who is awake to provide the assistance. After much cajoling, a doctor is summoned by a reluctant nurse and ward boy. There is no sense of urgency in the trainee doctor's movements. The patient continues to be critical. Medicines are prescribed, but the pharmacy is shut. The patient, a victim of apathy, finally succumbs to her illness."***

5.3 Private hospitals tend to be much better in starting treatment once the examination has been completed - forty nine percent report that treatment commenced within ten minutes of reaching the hospital. The Mission & Charity hospitals seem to fare relatively badly in this critical area, with only thirty percent reporting that treatment commenced within ten minutes - perhaps they are overstretched for doctors, or their para-medics do so good a job that doctors can take their time. But the situation is much worse in Government hospitals, where over fifty percent of the patients report having to wait fifteen minutes to three hours for treatment to commence. Details are given below in the chart below.

Chart 5.2 : Time before treatment commenced for emergency patients

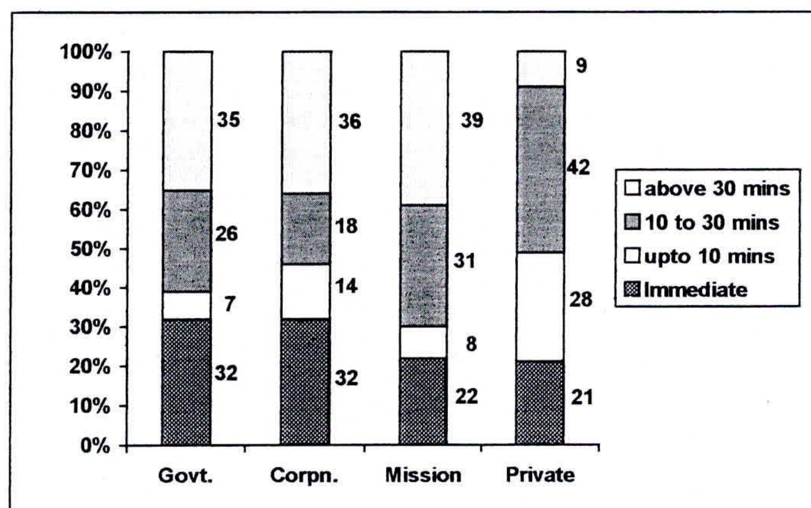
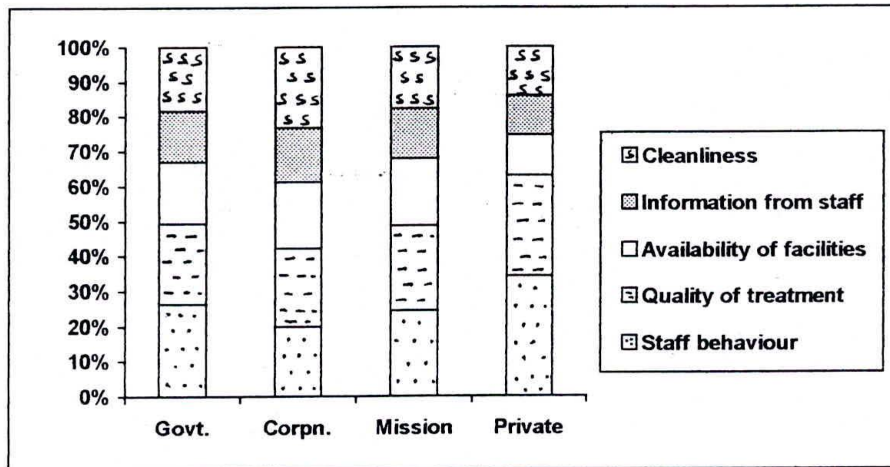


Chart 6.5: Areas calling for improvement

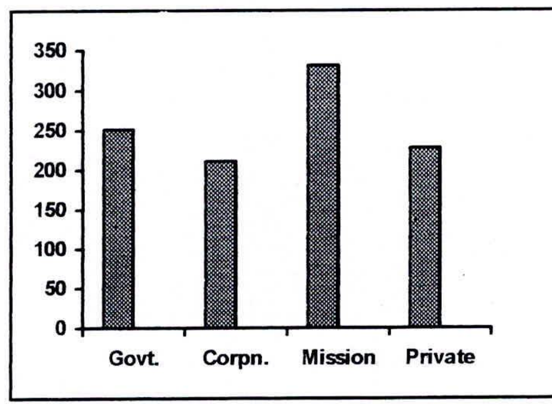


7.0 Speed money

7.1 The non-formal payments for hospital services have been clubbed under the label "speed money". There seems to be little difference across different hospitals, when one looks at the average amount paid. The profile is given in Chart 7.1.

Chart 7.1: Quantum of speed money payments by in-patients

(in Rs.)



7.2 A closer look at the quantity of payment made by different patients indicate that the phenomenon is at its peak in Corporation hospitals, even though it is the smallest in terms of the average amount. Almost 87% of patients using Corporation hospitals are paying speed money. The case studies suggest that maternity cases have, traditionally, evoked a sort of celebration rather than pathos of illness - yet, it does not explain why speed money had to be paid to get hot water, or to get the baby examined. The study also indicates that Mission and Private hospitals are not free of this malaise. Since less than 30% of users of Mission and Private hospitals pay speed money, it could be assumed that the problem is limited to Government hospitals.

7.3 ***"Many mothers like Sushilakumari, face the problem of having to cough up money to see their new-born babies. Rates - 150 rupees for a female baby and 200 rupees for a male baby. To add insult to injury, it is clearly a perverse form of gender discrimination. And the peculiar market forces that seem to have pegged the rates uniformly all over Bangalore. Sometimes, fact can be stranger than fiction."***

Chart 7.2 : Profile of speed money payments in different hospitals

(given by % of respondents using the type of hospital)

	Govt.	Corpn.	Mission	Private
No money paid	49	11	71	76
Up to Rs. 100	14	29	19	7
Rs 100 to Rs. 400	23	50	5	5
Above Rs. 400	13	11	5	13

7.4 Many of the reasons for payment have something to do with particular services which may have been part of the package of services to be provided free of cost in Government and corporation hospitals. But a sizeable amount seems to be paid as a token of appreciation or consideration for services/flexibility in these hospitals - to what extent they are extorted is a question.

Chart 7.3 : Purpose of speed money payment

(given by % of respondents using the type of hospital)

	Govt.	Corpn.	Mission	Private
To ensure good treatment	25	12	6	80
Pay for services	19	19	17	0
Have patient cleaned	8	12	28	20
Flexibility of watchmen	4	2	6	7
Ayahs/nurses etc. demanded money	21	17	22	0
Token of gratitude	10	17	33	7
On discharge	8	29	0	0
Others	36	26	6	0

7.5 ***"Staff rarely made a move unless money was paid for every chore. Be it a case of providing a wheel- chair or of giving the daily dose of medicines. Many patients, who had visited Bowring hospital had this story to tell. What is more horrifying is the fact the even surgeries would be scheduled only when the doctors were "taken care of". Even a leg that would have to be amputated if immediate treatment was not given did not merit the due care."***

7.6 A closer analysis of whether patients who paid speed money experienced positive results suggests that they were perhaps cheated in the bargain. A scrutiny of waiting periods, availability of medicines, etc., when related to speed money paid, did not indicate any definite pattern. In other words, many of the patients who reported "not having paid speed money" also indicated that treatment time was low or that medicines and injections were available to them at Government hospitals. While it is heartening to see such instances of positive behaviour in hospitals, it also reflects the agony that many would have gone

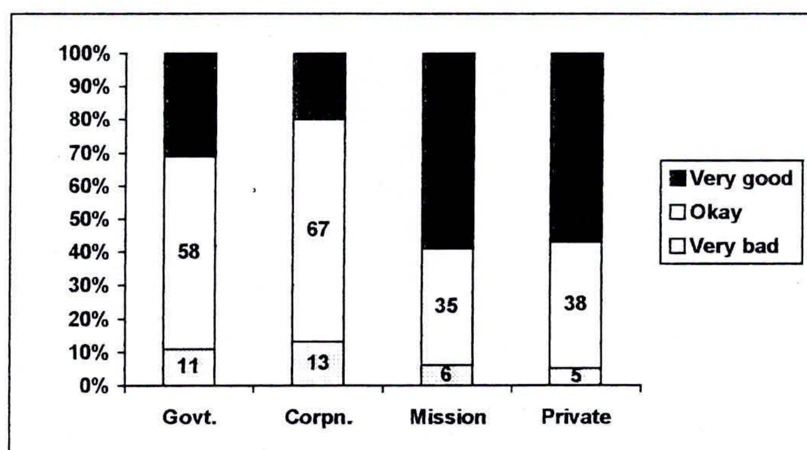
through after paying through their nose for services that were supposed to theirs for the asking.

7.7 ***"Basha, a 30 year old, was told at the Bowring hospital that he needed to undergo surgery for his ulcer condition. He waited patiently for almost a month for his operation to be scheduled. Not being able to take the wait any longer, he paid Rs. 500 to the doctors. His operation was scheduled within two days. His post-operative experiences were far from pleasant. In his own words - "only a wretched person should step inside these hospitals."***

8.0 Overall impressions that patients hold about hospitals

8.1 The most important factor in creating an impression on the patient is the perception about the extent to which cure was achieved through the treatment. Around 83% of patients overall, reported successful treatment, of which 40% visited the same hospital again after discharge. The overall ratings that patients gave different types of hospitals, presented below in Chart 8.1 suggests that treatment at Mission and Private hospitals is seen in more positive light.

Chart 8.1: Overall ratings of hospitals by patients



8.2 The analysis of reasons advanced for overall rating clearly highlights the importance attached to perceived quality of treatment over aspects such as cost and staff behaviour. While poor quality of treatment explains over half the ratings of Government and Corporation hospitals as very bad, around 80% of the ratings of Mission and Private hospitals as Very Good come from patients who felt that the treatment was very good. On the contrary, Very Good ratings on account of Less expensive/Free treatment was highlighted by 21% of the in-patients who rated the Government hospitals positively.

8.3 The case studies on hospital administration indicated that there are variations across hospitals in terms of attending to complaints from patients and public. While all hospitals have a complaint book/box, most grievances are conveyed orally to doctors/RMO during their daily rounds in the case of government hospitals and to the ward supervisor/nursing superintendent in the case of private hospitals. The usual complaints in government hospitals are with regard to cleanliness of the wards and against individual members of the staff.

8.4 In government hospitals there seems to be no mechanism to attend to the complaints as action on erring nurses or ward staff due to strong political affiliations of the respective unions. In the case of senior officials, most often informal channels are used to address any complaints, as senior medical officers do not exercise their powers to take action on any complaint against doctors/senior staff. A related difficulty faced by the senior officials is that, certain complaints like water shortage etc. often falls beyond their capacity to address, which makes the services short of satisfaction.

8.5 At the same time, another official revealed that they usually get fewer complaints when compared to private hospitals mainly due to three reasons. First, the kind of patients they have are from the low income group and tend to be less demanding - they are less articulate about the extent to which they are eligible for 'free' services, and are often 'private patients' of a government doctor. In such cases, they manage to get the same services by bribing the concerned personnel. Third, the expectations of patients on services and their demanding capacity are low, since they do not pay for it.

8.6 In the case of private hospitals, complaints are often related to maintenance, which tend to be addressed immediately by the concerned senior officials and the redressal mechanisms are in place and work effectively to the satisfaction of the patients. This stems from the fact that in private hospitals management bestows greater degree of autonomy to the senior officials who take decisions as and when the need arises.

8.7 There is no record of patient satisfaction surveys in the hospitals studied, except in case of two Mission hospitals, conducted two years ago. Of these, two hospitals are planning to have a survey in the coming year. In these two hospitals, based on the previous survey findings, improvements were made as per the demands of the patients. Issues like timings of diet, visitors, and ingredients of the diet were attended to based on the patient satisfaction surveys.

9.0 Conclusions

9.1 The urban poor in Bangalore have been using a variety of options for health care. While Government hospitals play a major role, other hospitals, including Mission and Private hospitals contribute to health care for the poor. Any strategy for health care for the poor has to envisage appropriate inputs for all the institutions involved in this sector.

9.2 In terms of costs, Government hospitals come out as the cheapest source of health care for the poor. This is not only in terms of percentage of patients enjoying free treatment, but also of total costs incurred by an overwhelming majority of the patients. The unfortunate part of this otherwise positive phenomenon is that a major part of the costs incurred by the poor are towards illegitimate side-payments, often extorted by different participants in the health care system.

9.3 But the most significant problems seem to be in the quality of medical care that the poor receive. To start with, the waiting time they have to go through before receiving medical attention and treatment seems to be quite high. Second, injections and medicines, presumably free or subsidised, are often not available at Government hospitals. But the more important problem seems to be the total absence of standards or the lack of awareness among patients about what they can expect at hospitals. It is from this point of view that Mission and Private hospitals seem to be serving the poor in a much better manner.

9.4 The manner in which activities are managed in the Government hospitals also merit attention. The seriousness of this problem can be seen from a simple area like cleanliness of hospitals. Although there was no major difference in the frequency with which cleaning was carried out across different types of hospitals, the level of cleanliness at Government hospitals were rated in much poorer terms. Similarly, the poor need to run from pillar to post, to find medicines,

sometimes in life and death situations, while being treated in Government hospitals - whereas, dispensaries of Mission hospitals are rated to be far more efficient in this regard.

9.5 One approach to seeking better quality of medical services and facilities that the poor are compelled to seek, is by resorting to speed money payment. This approach seems to apply to all levels of medical personnel (from doctors to sweepers), and for all types of services (from operations to entry into wards without authorisation). Although there is wide variation in the quantum of payments, the problem seems to be most acute in Corporation Maternity Hospitals, which are used primarily by the poor. Designing interventions to reduce the instances of extortion could certainly begin there.

9.6 Patients who have been in-patients at Government hospitals seem to be less likely to follow up their treatment with subsequent visits. While part of this phenomenon can be explained in terms of the tendency to avoid hospitals as far as possible, the poor quality of instructions that patients receive is also an important factor. This is a major area of concern, since improper follow up may not only lead to poor recovery and dissatisfaction, but also to a waste of all the efforts that have already been put in.

9.7 The feedback from patients have also highlighted the serious misgivings they have on the quality of treatment. Notwithstanding the poor ratings for helpfulness and courtesy from nursing and other hospital staff, and the speed money paid, they have highlighted quality of treatment as the major issue. This feedback highlights the distress that the poor encounter in hospitals, and the urgent need to create mechanisms for improving quality and creating confidence.

9.8 The willingness of a large sample from the poor to make use of Private and Mission hospitals, and the average cost of treatment they have reported, suggest that "free" treatment is not always preferred at the cost of quality. It is true that this does not explain the situation of the destitute and the absolute poor

- but it forcefully presents the fact that "reasonably" priced services which guarantee quality are the need of the day. The cost profile also suggests that many of the hidden or illegitimate costs can be recovered as legitimate fees, provided hospitals can specify them as services to be paid for - implicit in this sort of situation is the pressure to bring quality into these services.

P 5.7

BANGALORE HOSPITALS AND THE URBAN POOR:

A REPORT CARD

- EXTRACT OF THE SUMMARY AND CONCLUSIONS

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Send to CHC

Bangalore Hospitals and the Urban Poor
A Report Card

A Summary

The quality of hospital services is an important element in the package of services that citizens rely on, during periods of physical disorder and trauma. While medical services have seen many a technical advance, it has been accompanied by increases in costs and complexity. There has been a growing concern over the deteriorating quality of health care provided by public hospitals. These problems become more visible when it comes to the question of health services to the poor.

How do citizens, especially the poor experience these services ? What is their feedback to the health care system ? Where are the improvements required ? In order to examine these issues, the Public Affairs Centre, Bangalore, recently designed and carried out a study. The study assesses difficulties encountered by the poor while making use of hospitals, the quality of specific components of service, and the different types of action for improving services. The findings of this study are expected to provide a framework for public interest groups and administrators of health care to design systems for improving access to health care for the poor and the quality of service that they receive.

The study of hospital services in Bangalore was conducted by the Public Affairs Centre, a non-profit organisation based in Bangalore, in collaboration with the Citizens Action Group. This study attempted to generate feedback from the urban poor on the quality of hospital services they receive. Three categories of hospitals were surveyed - Government or "Public" hospitals, hospitals run by

the Bangalore City Corporation (BCC), and missionary /charitable trust hospitals.

The study was carried out in three parts:

- Forty one case studies on the experiences of the poor with hospital services
- A field survey using a structured questionnaire on different aspects of feedback from sections of the urban poor on hospital services, and
- A series of interviews with hospital administrators on their perceptions of problems that affect the quality of hospital services.

M 5.8

Efficacy in Administration of Hospitals: A Case Study of Private and Government Hospitals in Bangalore

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Introduction

Like any other areas of socio-economic reality ideological underpinnings influence our understanding of matters related to health. The concept of health care has changed over time and space and these changes have occured, mostly regarding the relative efficiency of the state versus market in the production and distribution of health care services. The market versus state debate focuses on the nature of the commodity 'health care' and not good health. To put it in other words, is the responsibility of distribution of health care social rather than individual? The system of health care existing in a country evolves from the definition of health care as social or individual. Accordingly there are two dominant patterns of health care. One envisages an equitable system where health is seen as an item of social consumption and good health as not only a basic right in itself but also as a basic precondition for enjoying social and economic equality. The other concieves health as a commodity to be purchased and hence privatisation is encouraged. At the level of political discourse, this gets transferred as three schools of thought: conservatives for whom health care is a private good and is best left to the market to be distributed and priced according to supply and demand; liberals hold the view that health care is both a private and a social good and therefore there is a role for the government to play, which is akin to the concept of welfare state; and the marxist recognise health care as a social good and as a right which should be controlled by the state and demands an understanding of class relations in society to analyse the diversity and disparity of health care.

The neo-classical school of economics is divided over the relative merits of market and state in achieving the objectives of efficiency in the allocation of health care services. But due to the experience of Great Depression of 1930s and the influence of keynesian economics, many capitalist countries made large scale government investments in the post-war period in the provision of social services. State intervention was advocated to complement the market forces in achieving a high level of economic activity with full employment by making liberal markets more productive. However, with the arrival of stagflation all over the western capitalist world in 1970s Kesnesian economics and welfare state lost its ideological as well as material basis. Recession and concommitant decrease in the government revenues resulted in mounting budgetary deficits forcing the state to reduce public expenditure on the welfare activities. The revival of neo-classical monetarism accounted the growth in public spending responsible for all adverse economic developments, insisted on privatisation and made a cut into the provision of social services including health care in the capitalist countries. Thus, the debate over the state intervention in health care is not merely based on the nature of the commodity health care, but it emanates from the very foundations of capitalist economies.

In India, health planning was declared an integral part of socio-economic planning before independence, and after independence, the blue print for national health policy proivded by the Bhore committee had recommended the free provision of health care services. The successive five year plans also followed the recommendations of the report.

But there are some inherent problems regarding our health expenditure pattern and utilisation. This is crucial in understanding the present state of our public health system and the increasing trend towards privatisation. The sectoral prioties implemented in the national health policies were skewed towards curative medicine and certain categories of health personnel and towards certain regions. About 55 per cent of public expenditure is spent on curative health care and medical education while majority of the population continue to suffer from a host of infectious and communicable diseases and the share of public health services, which are more relevant to the health needs is just one third of total expenditure. In medical education also, the actual emphasis has been on producing the well trained but highly specialised man power in curative services while the health policy documents kept on repeating the need for creating physicians in social and preventive medicines and para medical personnel. As a result we have more than one doctor per nurse instead of having serveal nurses per doctor. Similarly we have one doctor for about every 3381 population, while there is only on mid-wife or health visitor per 13977 population.

The emphasis on the production of well trained doctors who are largely concentrated in the urban areas has deprived the rural poor of having basic health facilities. This is evident from the fact that in rural areas where more than 70 per cent of population live, only about 30 per cent of doctors and 17 per cent of beds are located. The problem of rural urban disparities in health care services is further aggrevated by the disparities in the regional distribution. If we super impose regional and rural-urban disparities, there emerges the real extent of inequalities in the distribution of health care between various parts of the study. The gross disparities in the distribution of health care with no relevance to the health needs of people, has taken place in spite of the fact that government owns about 75 per cent of total hospitals and dispanceray beds.

Moreover, most policy initiatives concentrate on the instrumental role of health, rather than on its intrinsic importance. Health has been looked upon as a means to increase productivity and not on its own sake. As a result the national health policy (1983) is basically concerned with demographic details to be achieved by the year 2000 AD and issues such as net productive rate. It does not deal with broader philosophical questions such as equitable provision of health services and on the current deprivation of certain sections.

So we see the genesis of the crisis as the paucity of public funds, low priority given to health budget and the demand for health care do not match and this has given rise to financial crisis in the system. The latest available data show that only 75 per cent of population has access to health care. The ratio of population per hospital bed is 1371 which is lower than the ratio for South Asia but high when compared to other low income countries and middle

income countries. The per capita health expenditure by the govenment is a dismal amount of Rs.40 per man,woman,and children per year.'Of this Rs. 24 is spent for the urban areas and the remaining Rs.16 in the rural areas. On the other hand, studies show that in 20001 AD, government will have to spend about Rs.77 to 81. Hence, there is an increasing demand to raise the plan out lay for public health expenditure.

Also, there are studies to prove that the problem of the health sector in India is non-fulfilment of the targets especially in PHC for which 3.7 per cent is provided. Because, by and large, they argue that the existing patten of expenditure still follows the colonial pattern. Literature health economics also reveals that the economic constraints of present day hospitals in India are the product of their past legacy. Many of the hospitals were set up by foreign missionaries who provided all financial assistance. As a result, they did not find reason to mobilise the financial resources on their own. Even today, hospitals are not run on economic principles. At the same time hospital industry operates in an oligopolistic market. Therefore, the industry has many sick units.

Inspite of these short comings India fares well in health services compared to most other low income countries. Within India the southern states record a better health status than rest of the country. Among the four southern states, Andhra Pradesh spends least on health and next to it is Karnataka.

Privatisition of health care

In India, till the 1980s, largely government controlled the health care system. Due to the factors discussed above,which happened at the macro level, India also opened up its health sector slowly for privatisation.

Privatisation of health care is based on the following assumptions.

1. helath care is an economic commodity and can be purchased like any other good.
2.
health care providers have profit seeking and maximising concerns
3. If health care is purely on market mechanism, then prices will be reasonable and

4.Government intervention should be limited to correct market failures and accomplishing social goals outside the ambit of market forces.

Each of these can be debated and are linked to the basic question of whether health is seen as a social or private good. Supporters of privatisation are of the view that it widens choices to the consumers and it takes the pressure off the government health care system and offers an alternative. It is argued that economic efficiency gains are likely to occur if governments of the third world begin to cooperate with the private sector.

Critics of privatisation are of the view that, luxury hospitals in the third world will widen disparities in health care and they claim that improvements in health indicates the benefits of a

strong public helath care system. Another assumption that market based health care is more efficient than non market is also dismissed by comparing the National Health Service with the American private health care.

A significant development in this regard, that happend in India was the first medical industrial complex which was set up in 1983, with Apollo hospital in Madras. This followed a radical transformation in urban health care system with corporate secotr making inroads into provision of health care by setting up big hospitals with latest equipment and technology. This was possible because of government support in the form of subsidies and its policies towards private hospitals and drug industry.

Back ground to the study

In the wake of liberalization there is an increasing demand for privatisation for better services and efficiency. In the case of health care also, the trend is not different and this is more noticeable in the urban centres of India. There are various factors responsible for this, of which the important ones are an overloaded public health care system, technological developments of expensive diagnostic and medical equipment and the growing standard of living found in these large metropolis. Moreover, demand for private health care is most often artificially created by posing it against the relative inefficiency in terms of the quality and quantum of services in public health care system; to be precise, the services rendered by the government hospitals. The main accusations raised against the government hospitals are corruption, lack of facilities, lack of experts, inhuman nursing care and unhygenic environment. Thus, Indian health care system, at least in the urban areas are slowly changing in favour of private capital accumulation and high technology medicare for a few at the cost of the health needs of majority of the population. At the same time, the cost of medical care has outgrown the average Indian's capacity and this makes it imperative to have state sponsored health care. Therefore it is necessary to find a way out for the disillusionment with the existing public health delivery systems and ensure that it should not lead to a two tier health care system where a minority is privileged with access to extensive high technology and specialised care merely due to their high purchasing capacity and governmental care which is often posed as inferior, for the rest of the population. With this in view, the present study attempts a comparison of the public and private health care systems in Bangalore to raise some pertinent issues of concern to them

The study probes into both public and private health care in the city of Bangalore and examine the performance of each sector. Private in this study refers to hospitals owned by individuals and institutions and government and public are used interchangeably.

Objectives

Methodology and Sample Selection

The study followed case study method. This included un structured questionnaire schedule, in depth interviews with the key administrative officials and perusal of operational manuals and documentation procedures of each hospital.

Some of the main issues addressed in the study included staffs; strength, training and motivation, customer service, standards and procedures of service, hyiegene and waste management and hospital policies.

A purposive selection of three government run and three private hospitals preceeded the data collection. All the government hospitals selected, are attached to nursing schools and medical colleges which send students for training and house surgency. The three hospitals selected constitute prominent government hospitals in the city in terms of bed strength. These are K.C.General hospital,Malleswaram (case I), Lady Curson and Bowring,Shivaji Nagar (caseII), Victoria hospital, Kalasippalayam (case III).

Of the three private hospitals, one is a full fledged medical institution with various medical and paramedical courses and another with only nursing and paramedical courses. The third in this category, when compared to others is of the status of a nursing home with only 80 beds. The hospitals chosen are located in different parts of the city thus providing a representativeness to the selection of the sample. These are St:Martha's hospital (caseIV), St:John's hospital (caseV) and P.D.Hinduja hospital (case VI)

Analysis and findings

This section covers analysis related to various parameters that determine efficiency and effectiveness of health care across government and private hospitals.

Staff and Capacity Utilisation

Tables 1&2 provide the data related to number of beds available, doctors, paramedical and other support staff, average Out Patients (per day) and average bed occupancy rate (per month).

Table No.1 Profile of Hospitals Studied

	Bed Strength	Avg.Occc. /Month.	Avg. OP/Day.
Government			
Case I	453	340 (75)	700
Case II	686	480 (70)	1000
Case III	764	691 (91)	1240
Private			
Case IV	575	402 (70)	764
Case V	800	750 (94)	772
Case VI	80	46 (65)	50

Note: Avg.Occ: Average Occupancy , OP:Out Patients
Figures in bracketts are per cent

Table No:2 Details of Staff

	Doctors				Nurses			Others		
	Per.	Con.	Std.	Tot.	Per.	Std.	Tot.	N.Aid	Help.	Para.
Govt.										
Case I	30	40	-	70	79	800	879	45	125	20
Case II	65	-	62	127	123	140	263	29	90	27
Case III	32	-	75	107	181	180	361	40	115	35
Private										
Case IV	58	6	5	69	176	240	416	50	90	45
Case V	146	-	173	319	408	299	707	191	175	331
Case VI	14	43	-	54	25	-	25	18	4	28

Note: Per : permanant,Con:Consultants, Tot:Total,Std:Students, N.Aid:Nursing aids/Ayahs,Help:Helpers/ward boys/sanitary workers Para:Paramedical staffs

From the above two tables it is evident that there is no substantial difference in occupancy rate across hospitals. On an average, government hospitals tend to get more out patients per day compared to private hospitals. In terms of number of doctors and nurses there is no discernable trend in government and private hospitals, though there is variation in their numbers. Trainee staff (medical & nursing students) also varied across the hospitals studied as per the bed strength of the hospital. Since there are no norms available to comment on absolute numbers, we need to resort to comparisons across the hospitals in terms of certain ratios like bed strength to personnel and occupancy rate to personnel (Tables 3,4 & 5).

Table No.3 Comparison of Personnel & Occupancy against Bed Stength of Hospitals

	Avg.Oc.Rate	Bed Strength to Doctors		Nurses		N.Aids	Hel.	P.Med
		Per.	Tot.	Per.	Tot			
Govt.								
Case I	.75	.07	.15	.17	1.95*	.10	.28	.04
Case II	.70	.10	.19	.18	.40	.04	.13	.04
Case III	.90	.04	.14	.24	.50	.05	.15	.05
Private								
Case IV	.70	.10	.12	.31	.80	.09	.16	.08
Case V	.94	.18	.40	.51	.90	.24	.22	.41
Case VI	.65	.18	.80	.31	.31	.23	.05	.35

Note:Per : permanant,Tot:Total, N.Aid:Nursing aid ,Help:Helpers, P.Med:Para Medical staff.
* 800 nursing students get apprenticeship in this hospital.

The ratio of bed strength to occupancy rate does not vary substantially across private and government hospitals. In both the cases it is well above 70 per cent except case IV, which shows a relatively high capacity utilisation in terms of beds. In terms of personnel to bed strength, there is a clear case of private hospitals ahead of government hospitals. This essentially means that personnel in government hospitals have to provide services to more number of patients on the average, when compared to private hospitals. Does this mean workload in the case of government hospital personnel is relatively high ? In order to answer this, we need to look at personnel against average occupancy rate.

Table No.4 Comparison of Average Bed Occupancy Rate to Personnel

	Avg.Occ.Rate to Doctors		Nurses		N.Aids	Hel.	P.Med
	Per.	Tot.	Per.	Tot			
Govt.							
Case I	.09	.20	.23	2.6	.13	.37	.06
Case II	.14	.30	.30	.55	.06	.19	.06
Case III	.05	.20	.30	.52	.06	.17	.06
Private							
Case IV	.14	.20	.43	1.03	.12	.22	.11
Case V	.19	.40	.54	.90	.25	.23	.44
Case VI	.30	.17	.50	.54	.40	.09	.60

Note:Per : permanant,Tot:Total, N.Aid:Nursing aid ,Help:Helpers, P.Med:Para Medical staff.

Taking occupancy rate for comparison, we can see that private hospitals have higher permanant doctors per occupancy compared to government hospitals. This ratio narrows down to a limited extent, if we add consultants and house surgeons to this categroy. Still one can safely conclude that on an average, government hospital doctors service more number of patients compared to private hospital doctors. Coming to other staffs, there is clear evidence that the staff work load in terms of occupancy rate is high in government hospitals compared to private hospitals. Glaring differences can be seen in the case of para medical staff and

nursing aids.

Table No.5 Comparison of Personnel Against Out Patients

	Out Patients to					
	Doctors		Nurses		N.Aids	P.Med
	Per.	Tot.	Per.	Tot		
Govt.						
Case I	.04	.10	.11	1.3	.06	.03
Case II	.07	.13	.12	.30	.03	.03
Case III	.03	.09	.15	.30	.03	.03
Private						
Case IV	.08	.08	.23	.50	.07	.06
Case V	.19	.40	.53	.90	.25	.43
Case VI	.30	1.08	.50	.50	.36	.60

Note:Per : permanant,Tot:Total, N.Aid:Nursing aid ,Help:Helpers, P.Med:Para Medical staff.

As these hospitals need to cater to out patients, it is pertinent to look at the work load with respect to out patients as well in order to get a complete picture. It can be seen from table 5 that government hospitals has high work load in this case as well. The number of doctors attending per out patient is high in the case of private hospitals compared to government hospitals. A uniformly high ratios with respect to other personnel reveal that private hospital staff has less work load of out patients compared to their counterparts in government service.

As the above analysis indicates, there is high level of work load in the case of government hospital personnel compared to the same in private hospitals with respect to bed strength, occupancy and out patients. Besides this, it has to be recognised that, in all the government hospitals there exists more beds than what is actually sanctioned. For example, in case III, while the sanctioned bed strength is 764, there exists 961 beds. To this extent the recorded workload of government hospital staff is an under estimate.

It can aslo be seen that in the case of government hospitals, the number of permanant nurses per patient is below the standard norm of 1:3. Private hospitals seem to be following this norm. It can also be seen that this ratio is maintained in the case of government hospitals with the help of nursing students from government as well as private nursing schools.

Coming to support staff like nursing aids and helpers/ward boys, we see that there is no substantial disparity across government and private hospitals. Excepting Case I, in the case of other two government hospitals, the ratio of nursing aids and helpers against bed strength and occupancy rate is very low. The two hospitals viz., Case II & III, are the prominent ones in the city, located at the most populous areas of the city. The fact that there are less nursing aids and helpers reflect in the general maintanance of cleanliness and hygiene of the hsopitals as we shall see in subsequent analysis.

It was revealed in our discussions with the officials that, in the case of Case II, against the sanctioned 251 positions of group D/

class IV (Nursing aids & helpers), the effective strength is only 209, which leaves a gap of 42 positions to be filled in. Similarly in Case III, of the 343 sanctioned positions, there are only 301 group D working staff, which leaves again a gap of 42 positions. It was mentioned by the officials that, for the past three years, appointments for group D positions were freezed by the government for lack of funds. It is to be noticed that these these posts were fixed 40 years back. Besides this vacant positions, those staffs whose transfers and postings are done against their choices/priorities tend to go on long leaves.

Analysis of Pay Scales

As we are aware that in any professional service, monetory compensation becomes a crucial incentive for the personnel to deliver services efficiently. This is the case with health sector as well. A comparison of pay scales of different grades of staff is attempted below in order to see whether any disparities exist between government and private hospitals and any linkages of that to the performance and work load of the staff. Table 6 provides data on compensation package for each grade of staff in the hospitals studied.

Table No.6 Pay Scales of Nurses, Ward Boys and Ayahs (in Rs.)

Cases I,II & III	Nurses: SN	Nurses: SSN			Ayahs/Wardboys
Pay Scale	1520-2900	1720-3300			840-1340

Case IV	Nurses: SN	Nurses: SSN	Nurses: WS	Nurses: SWS	Ayahs/Wardboys
Scale	1490-2350	1750-2650	1830-2770	2150-3030	910-1350

Case V	Nurses: SN	Nurses: SSN	Nurses: Sup.Nurse	Ayahs/Wardboys
Scale	1570-3611	1770-4071	1910-4393	850-1955

	Nurses	Ayahs	Wardboys
Case VI	2000 Consolidated (821 basic + 900 VDA)	1658 (758 basic+900 VDA)	1469 (569basic+ 900 VDA)

Government hospitals have a standard package of pay scales for different grades of nurses and other support staff. In these hospitals appointments are made by the government health department after going through a process of selection.

Private hospitals follow different pay scales and there is no uniformity in terms of grades within a job type and the compensation package. While all the hospitals follow a package of basic pay and dearness allowance, which is linked to cost of living index, Case VI, follows a method of basic and variable dearness allowance based on minimum wages act and arrives at a consolidated pay for various grades of staff. A comparision of government and private hospital staff in terms of pay reveal that except in the case of Case V, other two private hospitals have relatively low salaries for the nursing and other support staff.
It can be inferred from the data that government hospital staff are paid competetive salaries when compared to private hospitals.

Along with monetary compensation, training and motivation of staff plays a crucial role in determining the efficiencey of the service delivery. Table 7 provides data on availability of such incentives in the hospitals studied.

Table No.7 Training and Motivation for Nurses, Ayahs & Ward Boys

	Training	Evaluation	Motivation/Reward
Case I	Nil	Nil	Nil
Case II	Nil	Nil	Nil
Case III	Nil	Nil	Nil
Case IV	Probation	Nil	Nil
Case V	Probation	Yes	Yes
Case VI	Nil	Yes	Nil

It can be seen that government hospitals are completely devoid of any training, motivation and evaluation schemes operational.

In government hospitals doctors and nurses appointed will have training prior to their appointment, and no such training is available for rest of the staff. It was revealed during our discussions that these trainings for doctors and nurses are irregularly held, which according to some officials amount to non existence of any such training. There is no system of evaluation, incentives for motivation for the staff in government hospitals. Promotions are given based on the seniority following state government rules.

This is not the case with private hospitals. Some of them have training in the form of probation and evaluation systems, informal as well as formal are in place. Incentives are also operational in the case of Case V, which also has an excellent system of training, and evaluation systems for group D staff. In Case V hospital, a process of four evaluations during the probationary period preceede confirmation of a temporary staff nurse who has to under go similar evaluation process to reach the confirmed staff nurse stage. Similarly there is a training programme for ward boys which is of one year duration. This hospital has a reward system which operates through 'best wad' and 'best department' awards.

Customer Service:

On this front, there are variations across hospitals in terms of attending to complaints from the patients and public. All the hospitals have reported having complaint book/box which are supposed to be checked every day. But most often, complaints are conveyed orally to doctors/RMO during their daily rounds in the case of government hospitals and to the ward supervisor/nursing superintendent in the case of private hospitals. The ususal complaints in government hospitals are related to cleanliness of the wards and against individuals.

In government hospitals there seems to be no mechanism to attend to the complaints as many officials reported that they will not be able to take any action on erring nurses or ward staff due to strong political affliations of the respective unions. In the case of senior officials, most often informal channels are used to address any complaints, as senior medical officers do not exercise

their powers to take action on any complaint against doctors/senior staff. A related difficulty faced by the senior officers is that, certain complaints like water shortage etc often falls beyond their capacity to address, which makes the services short of satisfaction.

At the same time, another official revealed that they usually get fewer complaints when compared to private hospitals mainly due to three reasons. One, the kind of patients they get are usually from the low income group and tend to be less demanding and less articulative about the 'free' treatment they recieve, second, those from other income groups, most often government servants, who also recieve it almost free, will either be a 'private patient' of a doctor in which case he/she sees to that the patient recieves better care, or manage to get the same services by bribing the concerned personnel, and the third, the expectations of patients on services and their demanding capacity are low, since they do not pay for it.

In the case of private hospitals, complaints are often related to maintenance, which will be addressed immeaditely by the concerned senior officials and the redressal mechanisms are in place and work effectively to the satisfaction of the patients. This stems from the fact that in private hospitals management bestows greater degree of autonomy to the senior officials who take decisions as and when the need arises.

There is no record of patient satisfaction surveys in the three government hospitals studied. Except in case VI, other two private hospitals had conducted patient satisfaction surveys two years ago. These two hospitals are planning to have one more survey in the coming year. In these two hospitals, based on the previous survey findings, improvements were made as per the demands of the patients. Issues like timings of diet, visitors, and ingredients of the diet were attended to based on the patient satisfaction surveys.

Standards of service/Operational Procedures

All the three government hospitals follow an administrative manual which is published by the directorate of health services. This manual provides rules to be followed by the officials in relation to management of the staff and considerations and categories that are applicable to patients. These hospitals have to produce monthly financial reports along with basic statistics of admissions, discharges, operations and out patients (department wise) to the directorate of health services.

In the case of private hospitals, respective managements set the rules and regulations. In this sense there is no standard operational manuals for private hospitals. But they follow service manuals prepared by their managements in the case of human resource management.

All the hospitals studied have expressed strongly for the need for a standard operational manual for different categories of hospitals irrespective of the type of management viz.,private or government. They support this for the following expectations.

1. It ensures basic necessities, relevant upgradation and

maintanance of machinaries and facilities.
2. It is seen as a first step in curtailing the commercial attitude and corruption which has crept into the medical field.
3. Ensures good quality of health service to the poorest
4. Ensures that health care is a service and not a profit making industry.

On implementation of such standards, some officials interviewed have opined that it will not come about by building more number of big hospitals in the urban areas but by upgrading the existing ones with more specialisations and facilities and by building small hospitals with primary health care so that population in a particular geographical area can be serviced. Some other officials were sceptic about the implementation of such standards and opine that such an action needs tremendous political will.

Similarly, their opinion regarding arriving at and adopting a system of health care services such as the one in U.K (NHS), were divided. Some officials welcomed such a proposal but were very pessimistic. According to them, we have to go a long way in overcoming the hindrances for such an implementation and in creating awareness among the people. Issues like un affordability of primary, secondary and teritory services, varying education levels, lack of transport facilities were seen as areas of concern by many in adopting a national health service system.

Hospital Policies:

All the hospitals have elaborate systems of documentations as far as the admisisons, treatment, discharge and other records of the patients. There are prescribed, printed formats (in some cases files) for admission record, doctor's note, nurse's note, billing, progress record, medication record, daily record, lab report, graphic charts and discharge summary (See the enclosed file for a sample of forms prescribed). In this case, government and private hospitals exhibit no disparity. But in government hospitals there is no mechanism to check whether these records are maintained or not.

Rates of Services Provided:

This differs between type of hospitals. Government hospitals have elaborate rules which govern the rates charged for various services like provision of bed, medicines, operation costs, tests and food. It mainly depends on the income levels of the patients. Government employees and pensioners are charged differently, based on their salary drawn. For example, in Case I, the following are the charges for various services.

Differential rates are adopted mainly based on the income of the patient and as laid down by the government of Karnataka. There are two types of wards: general ward and special ward. General ward follows three categoriesof income: below 600, above 600 and above 1200. No charges are taken for beds from any of the general ward category. For the first category all the services and other things are absolutely free. This includes food and operations. Second category has to pay half the charges and the third category full charges. In the special ward, three types of beds are there: beds which costs Rs.7.50 (40 in number), Rs.12 (10) and Rs.15 (2). Food is free for everyone, except for government servants whose basic

wards twice a day also becomes problematic at times due to water scarcity. A major complaint from the officials in this regard is lack of sufficient number of staff. This seems to be the case, as government hospitals on an average has less helpers and many posts of that grade have not been filled for a long time. At the sametime, there exists certain types of group IV jobs in government hsopitals which seems to be un necessisary in the day to day functioning of the hospital. Lack of relevance and proper job description for many group IV jobs makes the whole system in efficient. Officials could not explain the utility of certain staff who are recruited against group IV vacancies. For example there are no clear job descriptions for jobs like seargent, cycle orderly, Motchi (cobbler), street bearer, kit boy, literate attendant etc. Officers tend to give them some work on an adhoc manner.

Table No.8 System of Management of Waste

Cases --->	I	II	III	IV	V	VI
Hygeine						
Cleanining (No.times a day)	2	2	2	2	3	2
Water Scarcity	Yes	No	Yes	No	No	No
Power Shortage	Yes	Yes	Yes	No	No	No
Supervision	Yes	Yes	Yes	Yes	Yes	Yes
Waste Management						
Incinerator	No	No	Yes	Yes	Yes	No
Pit	Yes	Yes	Yes	Yes	Yes	Yes
Collection of waste (intervals- months)	2	on demand	on demand	1	1	1
Waste Collection agents	private	private	private	BCC	BCC	BCC

Note: BCC; Bangalore City Coroporation staff

Private hospitals seems to have better record in waste management. They also have better hygiene facilities as they do not face problems of water scarcity and power shortage.

In government hospitals, only one of them have functional incinerator. In the case of Case II, the incinerator which is installed is not functioning, due to the lack of 50 KV power supply. Two out of the three private hospitals have incinerator. The third hospital under study, being small in size, manages waste disposal by resorting to the services of city corporation staff.

pay is above Rs.1640. Ward charge reductions for the government servants are also made based on the basic pay. These reductions are as follows: basic pay upto Rs.1000-2/-, Rs.1000-1500-5/-, Rs.1500-2500-8/-,Rs.2500-3000-10/-. For government pensioners, food is not free for those whose pension exceeds Rs.500, but ward charges are free. For Rs.500-750 category, ward reduction is Rs.5, for Rs.750-1250-8/- and for Rs.1250-1500-10/-. Reductions in the lab services are also done in the same way.

In the case of CASE II and III hospitals, categories of beds differ while the rest remain the same. For example, in Case II, in the special ward, there are five types of beds. The cost varies from Rs.7.50 (20 in number), Rs 15 (10), Rs.30 (6), Rs.100 (6) and Rs.225 (VVIP rooms 2 in number).

In the case of private hospitals, on an average, the charges for services are high compared to government hospitals. But, as the sample hospitals studied work on a principle of charity, the administration have discretionary powers to write off the bills in the case of poor and deserving patients.

There is wide variation across the private hospitals studied in case of charges for various services. For example, bed charges vary between Rs.15 for a general ward bed in the case of hospital IV to to Rs.400 for deluxe ward bed in the case of hospital VI. Within a hospital, there are various types of wards which will have different charges, based on the services provided.

In Case IV, differential charges are applicable to the kind of ward that are chosen by the patient. There are three kinds of wards: general, semi-private and private. In the general ward a bed is charged Rs.15. Semi-private wards contain rooms with 2-6 beds ranging from Rs.45-110. Private wards are single bedded rooms. The rent for these rooms are Rs.200-235. Whille medicine charges are not under any kind of reduction, food, lab services and operation charges vary according to the wards chosen by the patient. For example, the operation charges for a ceaserian delivery is Rs.1600 in general ward, in semi-private ward, Rs.3000 and in private it is Rs.4000.

In the case of CASE V & VI hospitals the charges are of similar nature with minor variations, based on the services provided. In the case of hospital V, a medical social worker intervenes in matters of rates which are not affordable to the patients.

Hygiene and Waste Management

The efficiency with which a hospital provides services is reflected in their systems of hygiene and waste management. On this front, there is a marked difference between government and private hospitals (Table 8). While certain operations like cleaning the premises and wards is mandatory in all hospitals ,certain difficulties faced by the government hospitals result in sub optimum performance by the hospital management in maintaining hygiene. For example, water scarcity, irregular power supply lack of incinerator to burn the waste - absense of which leads to dumping of all the wastes into a pit in the hospital premises- and are collected by the private agents at irregular intervals- lead to poor hygiene management in government hospitals. Cleaning of the

It is reported by the government hospital officials that, waste collection is given to private agents because corporation endeavours in this regard turned out to be unreliable in the past. But as seen in the table above, private hospitals get the same work done by the corporation staff effectively and at regular intervals. This needs attention and clarification. It is not clear, why the government hospitals are unable to get the services of the corporation ? or do we have to see it as a deliberate attempt on the part of hospital administration to give waste disposal contracts to private agents.

Most of the officials hold the view that 50 per cent of complaints regarding the hygiene and cleanliness of government hospitals are 'imaginary'. They account for the rest as, the kind of patients they get come from low income categories with unhygienic practices,and additional beds they provide on obligatory basis on emergencies make the existing system iinefficient. In this regard, an official used the analogy of the claims of convent/public schools on their better results when compared to government hospitals. The same is true regarding the performance of hospitals on records,like mortality rate. For a private hospital, there is no obligation to attend to all the cases they recieve where as this is not the case with government hospitals.

There is no infection control audit in none of the government hospitals. According to them, 'every thing is made infection free' and claim to have been using disposable syringes alone. In stark contrast, private hospitals have infection audit committees. In cases of IV & VI, the committee meets occasionally and in Case V, it meets once in three months or more frequently as the case may be.

On Corruption in Health Care Services

As part of the survey, we attempted to address this issue through informal interviews with some officials of the hospitals.

It is popularly assumed by many that there is wide spread demand for speed money (bribe) in government hospitals at almost all levels. This was answered affirmatively by both government and private hospital officials. At the lower levels bribe is so rampant that, in one of the government hospitals, as reported by the officials themselves, to reveal the sex of the new born baby, the attendants demand bribe from the patient's relatives. It was reported by the officials that they can do very little to stop such happenings due to the presence of strong unions of staff. Besides this, it is felt by the authorities that patients take initiative in giving tips to get the services done instead of complaining.

At the higher levels, patients are favoured with specialised care, once the doctors are 'met at their private clinics for consultation'.

But as already mentioned,many government hospital officials opine that about 50 per cent of the complaints on government hospitals are imaginary. And they strongly feel that ' anything that is given free is not valued' and recommend a nominal admission fee and some mechanisms by which income levels (of the patients) can be checked, which will improve income of the hospitals and arrest

corruption to some extent. In the present system, anybody who is not in government sector can claim to have income below 600 or 1000 to avail of the facilities given to these income categories. Many officials account for corruption as "corruption breeds corrpution". For example, according to some officials, bribing concerned officials to obtain tranfers and postings in government hospitals is a common feature.

Summary and suggestions

This study attempted to understand various dimensions of urban health care in terms of the nuances in the performance of private and government hospitals. The study looked at indicators related to occupancy, professional personnel, support staff, their management, patient satisfaction, hospital policies (including personnel policies) to understand the linkages between quality of service provision and management.

It is argued that there is increasing demand for private health care for its efficient delivery system. This argument is often posed against the inefficiency of government hospitals. Our study reveals that the occupancy rate in government hospitals is as high as that of private ones. This indicates that, there is greater demand for public health care system which needs to be revamped to meet the demand. This also indicates that privatisation is not the alternative but, improving the delivery of public helath care is the need of the hour.

It can be seen from the data that there is substantial difference in the work load for doctors, nurses and paramedical staff in terms of bed strength, occupancy rate and out-patients. There is a clear evidence that government hospitals have to attend to far more number of patients compared to private hospitals.

While there is higher work load, it is also observed that in government hospitals, the number of nurses employed are far below the norms set for serving the patients. It is also observed that at group D level, there are quite a few vacant posts (staff like nursing aids/ayahs and ward boys/ helpers) which would have increased the work load of these sections who are responsible for maintaining the hygiene of hospitals. In contrast we see that private hospitals have sufficient number of staff to attend to hygiene and waste management.

Corruption practices and work load seem to have high correlation: when there are more work to be attended, they try to be choosy based on the monetary tips that is offered. The popular notion about the services of government hospitals are supportive of this, as patients offer money as though it is mandatory.

Coming to monetary compensation to the staff, there is no appreciable difference between government and private hospitals, especially related to jobs like nurses, nursing aids and helpers. But there are differences in various categories within a position. For example, in private hospitals, there are various positions within a job type of 'nurse' where promotions in terms of

responsibilities and pay scale are more easy (ward supervisor, floor supervisor, ward in charge etc.).

While all the hospitals have complaint redressal mechanisms, there is a clear disparity on actions taken on complaints. Private hospitals are far ahead on this front, as the decision making power is completely left to the senior officials and there is certain amount of decentralisation. In contrast government hospital officials seem to be hesitant to exercise the powers bestowed on them for they encounter the following situations.

a. On colleagues of equal rank, they cannot take any action but refer the complaints to higher ups
b. On group D staff, they would not like to take action as that would create unrest due to the interference of unions which got strong political affiliations.
c.On some occassions complaints would be beyond their administrative powers to handle.

Private hospitals seems to have better hygiene and waste management. This stems from the fact that there are clear division of labour among the staff and the line of command is clearly spelt out. The same was not the case with government hsopitals. Added to this, government hospitals have less person power and lack facilites like adequate water supply. In some cases power shortages often result in lack of cleanliness. Absence of supervisory positions with adequate power of management make it even more difficult to manage with the existing staffs.

The most important differnce in terms of the quality of services rendered by private and government hospitals stems from the work environment and the work culture existing in both the cases. There is no continuous monitoring or ocassional evaluation and a sense of commitment is totally lacking in government hospitals as they do not share the ownership. This is equally applicable to the patients also. For the staffs, salary is assured irrespective of the quality and amount of services they attend to and for the patients, it is the cheapest service available than a basic right. In private hospitals this is maintained through 'role models.'

Suggestions/Recommendations:

1. Hospital management and organisational structure needs a complete overhaul in the case of government hospitals. The work load of doctors and other staffs is an area of concern which needs attention. The first step can be filling the vacant posts and deleting/reshuffling the posts that non-functioning and unspecified.

2. The practise of doctors being appointed as administrators in government hospitals seems to be a problem as far as the poor management of human as well as other resources are concerned, since they are not trained in administrative/management skills. The relatively superior management systems observed in private hospitals can be attributed to the fact that these are managed by 'administrators,'trained or experienced.

3. The efficiency of the hospital lies in the nursing care provided. Better nursing care is assured through divison of labour and continuous monitoring created through different categories of

nursing staff. For example, superviory level staff at ward/floor levels, who ensure efficient management in private hospitals. This is one area government hospitals need to reform their organisational structure.

4. Greater devolution of power to the senior officials is necessary in the case of government hospitals which ensures effective handling of complaints from patients thereby ensuring efficient management and customer satisfaction.

5. It is clear from the analysis that government hospitals has high occupancy rate. This can be translated into efficient income improving mechanisms if there are systems introduced, which will ensure identification of income levels of patients without giving way for leakages. This will to some extent arrest corruption in government hospitals.

6. There is a need to ensure provision of medical social workers in government hospitals to support and help poor patients. They can provide guidelines and informations to patients in meeting their demands as rights and also can act as a mediator between the administration and the patients.

7. There is a need to develop systems of supervision and vigilence in government hospitals to ensure that corruption is arrested, which will help a long way in building the image of government hospitals. This is very important as it can initiate positive changes in the work culture/environment of the government hospitals.

8. It is also essential to build systematic awareness among the people on the role of efficient public helath care system, which ensures demand for public helath services as it is obligatory on the part of the government to provide health services to the people and the poor cannot be in a position to access private services. The presnent day duality in health care access is denying the oppurtunity of improving government hospital management as only the poor are accessing it, who tend to be less articulative about the problems and who will have limited access or information about the redressal machienaries.

A greater role for medical professionals and their associations have to be recognised in this regard to influence the authorties in revamping the hospitals with better facilities and more human resources. The medical fraternity has to take a pro active role in ensuring that poor people get their due share of efficient health care from the public system.

9. For the implementation of any of the above suggestions, it is imperative to build vigilant citizens action on this front. Herein emerges the role of NGOs in initiating and campaigning for such a move. It should be in the direction of creating awareness among the people about health care as their right, through various mechanisms which are effective in reaching the lower rungs of the economic ladder. They can also take initiative in campaigning for incorporating minimum health care as fundamental right in the constitution as such, perhaps as part of the Right to Life (Article 21). This will provide the people a legal mechanism to seek redressal when this right is denied. Also, bringing the medical profession under the CPA should also be taken up, for it would

confer certain beneficial results such as: medical records will be maintained more rigorously, the patient's right to information will be respected, greater standardisation will become necessary, standards of nursing homes will have to improve and corruptive practices will be checked. To begin with they can even sponsor medical social workers to government hospitals. Implementation of health tax for certain categories of income should also be put forward as outlay for health expediture tend to decrease. Any effort for greater privatisation of health care should be prevented on the grounds that poor will be dispossessed and discriminated.

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M 5.9

ROGI KALYAN SAMITI: PEOPLE'S PARTICIPATION IN THE MANAGEMENT OF PUBLIC HEALTH INSTITUTIONS

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RAJIV GANDHI MISSIONS
OCCASIONAL PAPERS
DOCUMENT - 002/ 96

PREFACE

In a recent report of the World Bank the dilemma of developing countries in the field of public health has been expressed in the following manner :-

"Most developing countries have achieved remarkable gains in the field of public health in the last few decades. However, to reinforce this, the delivery system must ensure provision of basic services to households that are often poor and dispersed. Along with rising incomes, aging population and increasing urbanisation, the demand for better hospitals and improved health services are rising at a time when public spending in general cannot be increased and in many cases it is being reduced. While financing increasing expectations for health care facilities is certainly a concern for the policy makers, it is becoming increasingly clear that people's participation in maintenance of institutions in the field of public health is absolutely imperative in order to ensure their smooth functioning"

It was ironically the plague epidemic towards the end of 1994 in the town of Surat that provided the impetus for an experiment to improve the public health delivery system in Indore district situated on the Western part of Madhya Pradesh. The steps taken by the District administration with the help of the people of Indore to clean up the mammoth Maharaja Yeswantrao hospital which was not only infested with thousands of rodents but whose level of hygiene, maintenance and patient care was appalling, provided the starting point of a project to completely revamp the public health care machinery by bringing in public participation. The Chief Minister of Madhya Pradesh Shri Digvijay Singh after personally reviewing the project, directed that the system be replicated in all the hospitals of the State of Madhya Pradesh. As a result substantial improvements in the institutions and improved efficiency in patient care in the public health delivery system is being effected in many parts of the state underscoring the need for greater community control of our public health institutons.

Chapter-I

THE BEGINNING : THE INDORE EXPERIMENT

Maharaja Yashwantrao Hospital which is attached to the Mahatma Gandhi Memorial Medical College at Indore is an institution which at one point of time was considered to be a premier institution for providing medical services in the country. Ever since it was established in its present form in the year 1955, while there have been occasional moments of glory, the deterioration in the standard and condition of the hospital had been gradual but definite. It was the plague scare in Surat in the month of 1994 that attracted the attention of a terrified city to the need to clean-up the M.Y. Hospital. In response to the plague scare a meeting was organised by the District Administration with important opinion leaders of the town to discuss the strategy to fight the crisis. While most people stressed the need to improve the cleanliness/civic amenities of the town, several persons drew attention to the appaling conditions of hygiene in the M.Y. Hospital. The fact that the hospital has become home to thousands of rats, many of whom had become enormous in size, added a degree of urgency to the need to eradicate the rodents and clean-up M.Y. Hospital; repair the building; carry out scientific allotment of space and to improve the over-all administration of the hospital as part of a comprehensive package to ensure a kind of metamorphosis to this premier institution of the State. The district administration took up the task. It was called - KAYAKALP ABHIYAN - or operation metamorphosis/ rejuvenation. For doing the job quickly while maintaining people's participation and a kind of social audit, it was decided to do it through the District Red Cross Society. In response to an appeal made to the people of Indore. donations started pouring in. In the first week itself. more than Rs. Ten Lacs were collected.

The mammoth 730 beds hospital alongwith five other supporting hospitals was stripped bare and all of its patients were shifted to 12 hospitals situated all over the town. The entire complex was cleaned, thus removing hundred of tons of rubbish and killing thousands of rodents; pests and insects. Some 150 truck loads of garbage and junk was removed from the hospital which covered a mini stadium.

After this, all the physical facilities were restored and the hospital renovated to a state better than ever before. Throughout the entire process, the team persisted with the system of involving the people of the town in drawing up the policy frame-work for every stage of the operation. A group of citizens numbering over 100 persons and including members of the press, M.Ps, M.L.As, representatives of political parties, office bearers of several associations, medical community, district officials etc. met regularly to give appropriate advice at every stage . In one meeting, there was a general apprehension that unless a system was evolved for ensuring a degree of permanency to these changes then despite our best efforts the hospital may lapse back into its old state of decadence in no time. As a fallout of these discussions it was decided to take the following measures at the earliest

1. Carry out a scientific reallocation of available space

2. Introduce user charges in the hospital

3. Initiate redefinition of administrative responsibilities.

The following chapter deals at length with the introduction of user charges redefinition of administrative responsibilities as well as the emergence of the concept of the Rogi Kalyan Samiti .

As is the case with most major institutions. scientific reallocation of space was vital to ensure smooth functioning of the hospital . As expected , this also was the task which proved the most difficult and required immense amount of coordination and several days of discussions . The following were some of the important results of the reallocation :

1. All the OPDs of the various departments were to be put in a single wing of the hospital ,

2. The operation theatre complexes were cleared of offices,

3. An emergency ward of 100 beds was created and set aside for unexpected accidents/calamities.

4. All the private wards being used as Doctor's consultation rooms were cleared.

5. Some 40 old rooms reclaimed after the cleaning process were used as specialist clinics.

6. Doctors, specialists, wards, and rooms of para-medical staff every department were restricted to the wing earmarked for that department only.

7. Pathological tests of the various departments was centralised .

All the above and several other measures to rationalise the use of the available space not only improved hygiene and effciency of the hospital but also immensely enhanced the user's convenience.

CHAPTER-II

ROGI KALYAN SAMITI - THE CONCEPT

In most government hospitals, not enough attention is paid towards the problems of General Administration, Co-ordination, Problem solving and day-to-day management. As a result, it is left to a handful of officials headed by a Superintendent and constrained by stringent regulations to manage the hospitals. After effecting extensive physical improvements, on the basis of considerable discussions it was decided to put in place a committee to act as a group of Trustees for the hospital and another executive committee to manage the day to day running of the hospital. The former group was called the ROGI KALYAN SAMITI or the patient welfare committee. This was to be registered as an NGO. and given complete control over the functioning of the hospital. The executive committee was to meet every week and go into every aspect of the running of the hospital, deliberate on changes and improvements that could be effected on a continuous basis. While the Rogi Kalyan Samiti had over-all control over the finances available with it, the executive committee was to use the finances made available to it by the Rogi Kalyan Samiti. Extensive duties and responsibilities were chalked-out for each member of the executive committee and this was reviewed in the weekly meetings as well as in the sittings of the Rogi Kalyan Samiti.

In an effort to improve the financial strength of the institution, it was decided to introduce user charges in the hospital as it was believed that excellent health care on a continuous basis cannot be ensured without adequate financial provision. At the same time it was also felt that free health care was not perceived as the best kind of health care by the patients themselves. A committee was set up to determine the modalities for introduction of user charges.

The following broad guidelines were drawn up for the system of levying user charges :

1. Charges must be levied for all facilities provided in the hospital including the outdoor patient ticket, pathological tests, indoor beds, specialised treatment, operation etc.

2. The poor section of the society and other groups as determined by the government (for example persons below the poverty lines, freedom fighters etc.) would be exempted from the levy.

3. The charges for the general wards would be nominal, while those for patients in the private wards could be higher. However, in no case should be charges in the private wards be higher than 50% of the charges for similar services in the private sector.

4. Funds received from this would be deposited with the "Rogi Kalyan Samiti" (patient welfare committee).

User charges were introduced in December 1994 for the first time in the M.Y. hospital. The charges were extremely nominal and were restricted to a few items initially. They were expanded and made more comprehensive after two months. The progress of the project was reviewed on a regular basis by the State Govt. In one such review at Bhopal, under the express directive of the Chief Minister, the State Government took a policy decision to ensure that Rogi Kalyan Samitis be set up all over the State of Madhya Pradesh. The basic characteristic of the Rogi Kalyan Samitis would be as follows :

1. Rogi Kalyan Samitis (RKS) would be set up in all medical colleges, district hospitals, community health centre levels.

2. The RKS would have people's representative, health officials, local district officials. Panchayat Raj representative as well as leading donors as their members.

3 The RKS for its functioning shall be deemed not as a government agency but almost as an N.G.O.

4. The RKS could utilise all government assets and services to impose the charges. It would be free to determine the quantum of charges on the basis of the local circumstances.

5. The funds thus received will not be deposited in the state exchequer but will be available to be spent by the executive committee constituted by the R.K.S.

Apart from funds received from imposition of user charges, the RKS has been empowered to receive donations in cash or kind from the public at large. The RKS. can use these funds for

1. Ensuring cleaning, security and other services of the hospital through private agencies.

2. Providing improved facilities by addition or upgradation of O.T. complexes; burn unit; ICCU; paediatric (ICU); CAT-scan units; centralised pathological set up etc.

3. Purchase of equipment, chemicals, furniture and other necessities for efficient running of the hospitals.

4. Providing improved medical facilities through purchase of modern equipment through the donation received and if required through loans from financial institutions.

5. Providing a better atmosphere, providing facilities for attendants and ensuring improved medical facilities in general

6. Endeavour to provide medical care to the poor and needy free of cost or extremely subsidised rates as compared to private hospitals.

CHAPTER - III

ROGI KALYAN SAMITI - THE RESULTS

In the last year or so Rogi Kalyan Samitis have been set-up in all the 45 districts of the State. While in some districts the registration has been done of the committee at all the three levels, in a handful of districts the process is being completed. Most of the district hospitals have introduced user charges and most improvements have been concentrated in these hospitals, but several enterprising officers posted at subdivisional levels have also carried out similar exercises at sub district level hospitals..

One of the most heartening experience has been that MP's, MLA's, Office Bearers of Panchayati Raj institutions as well as people at large have been enthused into taking active part in this process. The following have been some of the highlights of this experiment in the past two years:-

1. A total of over Rs 8.00 Crores has been collected by the various districts through donations and introduction of user charges.

2. MP's and MLA's have earmarked funds out of their discretionary MP and MLA funds for improvements of health institutions.

3. The District Red Cross Society have been functioning in tandem with Rogi Kalyan Samiti and they have in turn become more active of late.

4. In most hospitals after the introduction of user charges, privatisation of various ancillary services viz maintaining cleanliness, security and canteen services etc. are being introduced in phased manner.

5. Daily collection by the Rogi Kalyan Samiti range between Rs 1,000 to Rs 15,000 in each hospital depending on location. A conservative estimate would put the monthly collection at around Rs 50.00 Lacs.

In most hospitals the initial improvement effected includes improvements in the building, furniture, upgradation of equipment, electrical fittings, toilets and drainage systems and introduction of privatisation. In districts where ambitious plans have been put into effect such steps as

construction of burn units, ICCU, Operation Theatres, hi tech equipment like MRI's and CAT Scans, centralised pathological units paediatric ICU's sonography and endoscopy facilities have been provided or are in the process of being implemented.

While there has been wide spread appreciation in the improvement in most of the hospitals the number of patients has increased after the introduction of user charges. The availability of a large amount of untied funds brought about the following visible/invisible benefits as delineated below :

1. Introduction of a certain amount of privatisation reduced the pressure on the existing staff and also improved efficiency.

2. As the RKS was free to function as an NGO it could make Funds available to the heads of the department to carry out maintenance and improvements in their departments without being constrained by stringent Govt. regulations.

3. Availability of funds on a day to-day contingent expenditure and regular maintenance ensured better working conditions for the doctors & staff.

4. Payment of a certain charges by the patient established the patient's right to better professional medical attention and therefore he insisted on proper service from the officials concerned.

5. The Doctor and the para-medical staff also felt a sense of responsibility and moral pressure to improve their performance and we believe that we have witnessed a definite and positive improvement in the work ethics in the Govt. Hospitals in the last year & half.

CHAPTER - IV

CONCLUSIONS

In a welfare State like ours, while several institutions have been created to provide facilities and services to the people at large, very often adequate planning and care has not gone into maintaining these institutions. As a result of inadequate funding, lack of proper administration and even a certin degree of callousness on the part of the authorities concerned, the deterioration in the condition of these institutions and the services they provide is so marked that it often raises fundamental questions about the abilities, bonafides and sincerity of the administrators concerned.

Over the past few decades the surge in population, rising expectations and cost of health care along with a chronic shortage of vital resources has unfortunately resulted in a decline of hygiene, cleanliness and patient care in most of our public health institutions. Added to this has been the allurement of handsome income in the private sector also resulting in decline in the sincerity, motivation and dedication of doctors and para-medic staff in the public health institutions. From the experience of Indore and subsequent experience from other districts of Madhya Pradesh where this institutional arrangement was replicated, the following conclusions can be made :-

1. It is important not only to create institutions for the public welfare but it is also essential to ensure regular maintenance and up-keep, provision for improved facilities, regular review of their performance and ensuring that the morale of the work force remains at optimum level of motivation.

2. It is essential to involve members of the society to fund and manage various projects taken up to improve civic life and provide for better civic facilities. While this facilitates easy availability of scarce resources on the one hand, it also guarantees the participation of the society at large in the functioning of public institutions on the other. This forces the Government officials managing these institutions to be more accountable to the people at large.

3. It become clear that it is a good idea to introduce some amount of user charges in public institutions like hospitals, schools, etc. as this generates a demand from the beneficiaries to be given their due right-thus preventing callous or irresponsible behaviour by the Government servants in discharge of their duties. At the same time, this also prevents unnecessary use/misuse of the highly subsidised government facilities by people who have easy access to them.

As expected the experiment outlined in this report had a few detractors and some critics but reports of unceased confidence and satisfaction of patients coming to the government hospital after these improvements, vastly improved the working conditions, improved hygiene and cleanliness, upgradation of equipments, involvement of the society and increased overall efficiency that is being institutionalised throughout State provides the inspiration to continue with the system, streamline it and improve it even further.

There has been an effort to create a system which shall be self-sustaining, where motivation of the staff and the involvement of the public would be part of a system designed to guarantee functioning of the hospitals better than ever before. These are early days yet. How the new institutional mechanism of Rogi Kalyam Samitis shape up to take greater control of the health needs of the community will depend on how much confidence is reposed by the decision makers in area of public health.

M 5.10

Health Care Waste Disposal

- An exploration

EXECUTIVE SUMMARY

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* 1997 *

ACKNOWLEDGMENT

Bangalore Mahanagara Palike; Centre for Environment Education, Bangalore; Department of Ecology, Environment and Forests, Government of Karnataka; All the experts consulted, All Health Care Settings; Departments of Community Medicine of BMC - Bangalore, MMC - Mysore, KMC - Mangalore, JJMC - Davanagere; Staff of Bangalore Mahanagara Palike; Rag pickers; are greatly acknowledged for their Co-operation, and inputs for this endeavour.

The investigators specially acknowledge the help and co-operation received from the different Departments of M S Ramaiah Medical College; The Dean, Nursing Superintendent and Personnel Officer of M S Ramaiah Medical Teaching Hospital; and their colleagues in the Department of Community Medicine, M S Ramaiah Medical College.

Interested readers are referred to the complete document for details.

HOSPITAL WASTE MANAGEMENT IS AN IMPORTANT SUBJECT THAT NEEDS URGENT ATTENTION. IN MOST CIRCUMSTANCES IT IS APPROPRIATE TO CONSIDER AN INCREMENTAL APPROACH REALISING THAT AN IMPROVEMENT IS OF GREAT VALUE EVEN IF RESOURCES DO NOT ALLOW ACHIEVEMENT OF HIGHEST STANDARDS IMMEDIATELY

- REPORT OF A CONSULTATION ON MEDICAL WASTES MANAGEMENT IN DEVELOPING COUNTRIES, WHO, GENEVA, 1992.

Health Care Waste, if not handled properly, has the potential to be hazardous - Hazards may be because of Soil/ Water Pollution to the community or to the Health Care Personnel like the doctor, Nurses, Nursing aides, Helpers, Ayahs, within the health Care Settings. It can also be hazardous to the Pourakarmikas, personnel of Private contractors, Lorry drivers, personnel at incineration/ land filling sites, Rag pickers.

Hepatitis B, Hepatitis C (not in our country), HIV, Tetanus and Staphylococcal infections appear to be the diseases that may be transmitted. Enteric related infections can affect large communities.

Health Care Waste is being handled very casually in the Developing Countries. Clear delineation of the problem and measures and methods to solve the same needs to be modified and adapted to our needs and situations in Developing Countries.

This was discussed by all the Medical Colleges and Health Officers of the Bangalore Mahanagara Palike (BMP) in an endeavour organised by the Centre for Environment Education and Bangalore Mahanagara Palike under the Chairmanship of Mr. Yelappa Reddy, Retired Secretary II, Government of Karnataka. Formation of an Infection Control Committee for the City and Development of a Training/ Reference Manual to meet the requirements of information support were the two important recommendations, which were presented to the then Administrator of Bangalore Mahanagara Palike, Dr. A Ravindra. Both the recommendations were accepted and M S Ramaiah Medical College was entrusted with the task of supporting the endeavour by developing the manual.

Department of Ecology, Environment and Forests of Government of Karnataka came forward to support the endeavour in entirety. Following is a brief report of the exploration done to facilitate the development of the manual.

As the literature available which is useful to the Developing Countries is meager, informal Consultations were held in different Health Care settings. It was thought that with insights gained from this, one can proceed further in developing the Manual.

OBJECTIVES

1 To develop a practical working manual for Health Care Waste disposal and General infection Control in different Health Care settings.

2 To develop such a manual by a process of continued consultation and interaction with people of different categories who are involved in Waste Disposal and Infection Control.

This report is a documentation of efforts put in to achieve Objective number 2

Methodology

Apart from literature search and discussion within the Department of Community Medicine, M S Ramaiah Medical College (MSRMC), two specific activities were undertaken :

I Visit to different Health Care settings and Informal Consultation with the Personnel - 10 dispensaries, 8 Maternity Homes, 10 Private Hospitals and Nursing Homes and 31 General Practitioners - were held.

Also, information was collected from 4 Medical College Hospitals and 5 Primary Health Centres by Correspondence. [Total 68 Health Care Settings covered]

II Interaction and Consultation with a) Experts in Community Health and Environmental Engineering b) Junior and Senior Health Inspectors of Bangalore Mahanagara Palike c) Pourakarmikas d) Rag pickers.

Information for the first activity was collected by using a Predesigned Open ended Questionnaire developed for the purpose in consultation with M S Ramaiah Teaching Hospital; finalised in consultation with Centre for Environment Education, CEE, Bangalore Mahanagara Palike, BMP; after field testing at M S Ramaiah Hospital.

The team which consisted of members from MSRMC, Bangalore Mahanagara Palike and CEE collected the information.

IMPRESSIONS AND MAJOR FINDINGS :-

I OUTCOME OF INTERACTIONS WITH PERSONNEL OUTSIDE THE HEALTH CARE SETTING

Six thousand seven hundred Pourakarmikas and four thousand four hundred labourers of Private Contractors take the responsibility of Solid Waste Disposal at grass root level in Bangalore City.

Pourakarmikas find the following Health Care Waste mixed with solid waste : syringes, needles, cotton, bandage cloth, drip sets, packing materials, ampoules, vials, glass bottles.

Pourakarmikas appear to be unaware of the diseases transmitted by the improper management of Health Care Waste.

Pourakarmikas like to use Gloves, masks, boots, if supplied to them.

About 10,000 rag pickers are at work in the City of Bangalore.

Pourakarmikas, labourers of Private contractors and Rag pickers are exposed to the risk of Health Care Waste apart from personnel like Ayahs, Helpers, Nurses, Nursing aides, Laboratory Technicians and Doctors within the Health are setting.

Preplacement/ Periodic Medical Examination; Immunisation against Typhoid, Tetanus and Hepatitis B does not exist as a system.

On an average, one Junior Health Inspector supervises the work of 75 Pourakarmikas in one ward. Each ward, in residential area covers 10 sq. Km; About 50,000 population live in each ward.

Approximately 250 Kg of Solid Waste is collected by one Pourakarmika per day through street scavenging. Approximately 45 street bins will be there in each ward.

Health education materials on safe methods of handling and disposal of Solid/ Health Care Waste is scarcely available and used.

About 2100 metric tonnes of Solid Waste is generated in Bangalore City every day.

HEALTH CARE WASTE DISPOSAL - AN EXPLORATION

Health Care Waste is likely to be 5 kg per day for a hospital with 15 beds according to Junior and Senior Health Inspectors of Bangalore Mahanagara Palike.

Health Care Waste generated in Hospitals is about 600 gm per bed per day. In Clinics/ Dispensaries, waste generated is about 200 gm per day if 30-40 persons are seen on outpatient basis. (These are based on observations and eye estimates during the informal consultations)

One hundred lorries belonging to Bangalore Mahanagara Palike and One hundred and twenty lorries belonging to private contractors carry 6-7 tonnes of general solid waste twice a day to the outskirts of the city. The lorries are open and spillage of Waste on the roads is a common feature.

Health Care Waste is casually managed and thrown to the dustbins in the streets often. Health Care Waste, this way gets mixed with general waste and is collected together

Gloves and masks were not found to be used by the Pourakarmikas. Many were found using chappals.

Disposable syringes are sold at rate of Rs. 10 per Kg and Glass bottles are sold at the rate of Re. 1 to Rs. 2 per bottle depending on the size of the bottle.

A large amount (major portion) of general Solid Waste generated in the City is simply dumped insanitarily a few kilometers away from the city. A large amount of Health Care Waste finds its way out getting mixed with this solid waste.

II OUTCOME OF INTERACTIONS WITH PERSONNEL WITHIN THE HEALTH CARE SETTING

Segregation of Health Care Waste into Infected Waste and Domestic Waste is rarely done in the different Health Care settings. Among the 14 Hospitals visited, in 7 segregation of one or the other item was noticed. In one hospital, a specific attempt was found to have been made to segregate infected waste.

Plastic dustbins in private Health Care settings and Galvanised Iron bins in government Health Care settings are the common type of Dustbins found.

Only 22 (32.33%) health Care settings had bins with lids. And only 4 (5.88%) Health Care settings had bins with foot operated lids.

Frequency of emptying the bins was done once daily in 43 (63.23%) and twice daily in 14(20.58%) Health Care settings.

Using trolley was noticed in 2 (2.94) Health Care settings for the transportation of Health Care Waste.

In 54 (79.41%) Health Care settings visited, waste sharps are casually thrown in the dust bins along with other solid waste.

Common method of disposal of Laboratory specimens - Urine/ stools and Blood was into the underground drainage system. Only in 3 (4.41%) Health Care settings visited, blood remains were decontaminated before disposal.

Gloves and Aprons were used by Laboratory technicians in 11 (16.17%) Health Care settings.

Bombay broom in 36 (52.94%) and native broom in 30 (44.11%) Health Care settings constituted the type of brooms used in Health Care settings for sweepings.

Mopping with a Mop cloth was the method of mopping the floor in 55 (80.88%) Health Care settings, whereas Sofa stick with a cloth was used in 6 (8.82%) institutions.

In 52 (76.47%) Health Care settings, no protective devices were used by the waste handlers.

In 26 (38.23%) Health Care settings, in house laundry was the rule. In 14 (45.16%) of the General Practitioner's clinics visited, it was reported that linen was washed in the Ayah's or the Doctor's house. In 19 (27.94%) Health Care settings, services of outside laundry was utilised.

In 25 (36.76%) Health care settings, contaminated linen was washed separately and disinfected before sending to the laundry.

In 57 (83.82%) of the Health Care settings, no facility was available for waste disposal.

In 26 (38.23%) Health Care settings, contaminated linen was washed separately.

Out of the 68 Health Care settings visited, 51 (75.00%) felt that it is good to have a common incinerator.

No Medical examination - Preplacement or Periodic, was in vogue in 60 (88.23%) Health Care settings visited.

Practice of Immunisation against Hepatitis was noticed in only 6 (8.82%) Health Care settings.

In 40 (61.76%) Health Care settings, attitude of the respondents towards this informal consultation was encouraging.

In 42 (61.76%) Health Care settings, willingness was forthcoming for quantification of Health Care Waste and in 44 (64.70%) willingness was forthcoming to take up field testing of the manual.

PROBLEM DEFINITION :

Health Care Waste is casually dealt with both by Health Care settings and the Civic bodies. This is dangerous to Health care Personnel, Waste handlers and the Community. Reasons for this appears to be :

1 Lack of awareness — among doctors, nurses, administrators about hazards of improper Health Care Waste management; options available for its proper management; lack of awareness among Waste handlers (Ayahs, personnel near incinerator and land filling sites, rag pickers) regarding hazards of Health Care Waste.

2 Lack of Information support — for doctors, administrators, nurses, Waste handlers

3 Lack of practices like

- segregation of infected Waste and sharps
- disinfection of infected waste
- Sanitary landfilling
- Recycling of recyclable items
- use of protective devices
- periodic medical examination
- Immunisation of Personnel
- Precautions for prevention of HIV-AIDS
- Incineration facilities meeting Central Pollution Control Standards.

4 Lack of effective organisational bodies of Health Care settings and Lack of coordination between civic bodies and Health Care settings.

PROBABLE SOLUTIONS

CAPACITY BUILDING

of Doctors, Administrators, Nurses, Waste handlers on hazards of Health Care Waste; available options for its management; available cooperation from the civic body - through training and information support. Segregation of Infected Waste promoted as a culture in Health Care settings.

STRENGTHENING FACILITIES FOR FINAL DISPOSAL OF HEALTH CARE WASTE

a) It is suggested that 500 acres of land outside the city limits be earmarked, developed and managed for Solid Waste disposal - of which a portion be earmarked for Health Care Waste disposal.

b) Sanitary Landfilling taken up

c) Cooperative common incinerators meeting central Pollution Control Standards for Health Care Waste which is infected are commissioned and their function is supervised and monitored.

d) Small industries are set up for recycling plastic items, metal sharps (and ? Bandage cloth after decontamination)

e) Better transportation vehicles - covered and automatic are procured and a parallel system is practiced for the transportation of General Solid Wastes and Health Care Waste separately by the civic bodies.

f) All Health Care settings - big and small are registered at the 12 Sub-health Offices of the city. The Sub-health Offices can be focal points of support to respective Health Care settings located in their jurisdictional areas. Periodic returns related to Waste generation to be submitted to Sub-health Offices by the respective Health Care settings. Based on these calculations, logistics of transportation is jointly arranged and managed by joint contributions and participation by both the management of Health Care settings and Civic bodies.

AWARENESS ACTIVITIES

a) Health education materials like posters, pamphlets, booklets, flip charts on Health Care Waste management in local language is developed and consciousness is created among Waste handlers and the community

b) Community's involvement is to be sought in identifying areas for Sanitary land fill and hygienic practices of Waste collection and transport - of both General Waste and Health Care Waste.

c) There is a need to start a resource centre in the City which can provide information support in the form of periodic news letters and other means to all Health Care settings, NGO's, etc. An NGO can be supported to take up this role with the back up of a Medical college resource.

INFECTION CONTROL COMMITTEES

It is suggested that infection control committees be established in all Health Care settings where bed strength is more than 100 ; and the committee to supervise Health Care Waste Management, Hospital Acquired Infections and General Infection Control.

RESEARCH ACTIVITIES

The investigators suggest that the State Government shall encourage the Civic bodies to take up the following research activities in collaboration with Medical Colleges and Engineering Colleges on priority;

a) developing curriculum for training doctors, nurses, administrators, waste handlers in the area of health care waste management

b) Feasibility studies to recycle metal sharps , plastic items in safe ways

c) techno-economic assessments of solid waste/health care waste in different cities, towns, etc.

d) conducting waste surveys in different Health Care settings including measurement of quantity of such generated waste

e) feasibility studies for efficient establishment and running of common incinerators/ sanitary land filling/ composting etc.

f) sentinel surveillance of hazards due to Health Care Waste management in selected ranges of the City

g) studying sickness absenteeism and causes for the same among waste handlers

h) maintenance and periodic review of morbidity registers of health care personnel

RECORDING AND REPORTING

The investigators suggest that systems of recording and reporting of the following events are developed and submitted periodically to the infection control committee of the city/ civic body by health care settings:

- Quantity and type of waste generated
- Illness/ injuries noted among waste handlers
- Difficulties faced and solutions adopted to solve the same by Health Care settings in Health Care Waste management
- Immunization status of staff regarding tetanus, typhoid and hepatitis B
- Training status of staff on Health Care Waste management.

The investigators feel that legislative control is to be exercised only after capacity building and strenghtening of facilities is taken up for two to three years

Till sanitary land filling/ common incineration facilities/ individual incineration facilities/ safe recycling methods of some of the items of Health Care Wastes become available or other methods of treatment and disposal are accessible and adopted the following appear to be the options available for immediate action;

1) Disinfection of waste before disposal
2) Segregation of infected waste and metal sharps
3) Safe practices within Health Care settings
4) Practice of universal precautions for preventing HIV-AIDS
5) Capacity building of Health Care personnel and waste handlers
6) Document quantity of waste generated
7) Document hazards due to Health Care Waste

The investigators have made an attempt to draft a manual for training doctors, nurses, house keeping officers, administrators and educational material for waste handlers (ayahs, pourakaarmikas etc.,) It is being planned to field test and subject it for wider consultation before being put for practical use.

M 5.11

BURNS CARE

THE PROBLEM

SOME SOLUTIONS

FEW THOUGHTS

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-oOo-

Organising burns care continues to be a major problem in our country with the large numbers of burns and few centres working in this field. A rough estimate is that there are approximately 6 million cases of which $\frac{1}{2}$ million require admission every year. Most minor burns over 15 to 20% of body surface area or with other associated problems need hospitalisation. Our centre alone admits approximately 100 to 150 patients every year.

So the major areas of concern would be to identify the actual epidemiology of burns in our country and to work towards preventing them and simultaneously create more specialised centres, fully equipped and staffed to give adequate care.

PREVIOUS MORTALITY:

A few years ago, when we reviewed our statistics, we were alarmed to find a fairly high mortality rate. Most of our patients succumbed to infections, some due to respiratory burns and occasionally early acute renal failures. In the 30-40% burns group, we had a 50% mortality rate which meant that of every 100 admitted in that group only 50 would survive.

At that time, we had a separate ward but two patients to a room, with nurses common to the entire ward and no isolation of instruments or waste of each patient.

Cotd..2

CHANGES MADE:

In consultation with our administrators & microbiologists, we brought about the following changes:

1. A separate batch of sisters were posted to the burns ward, who were to wear gowns, caps & masks at all times and not to move to other wards, in a ratio of 1 nurse:3 patients.
2. The entry of visitors was restricted preferably to one or two care-givers who are instructed on basic hygiene and provided with gowns, caps & masks.
3. Each patient was given a single room.
4. Each patient was given a separate BP apparatus, thermometer, stethescope, bed pan & waste bucket,etc.
5. Fumigation and cleaning techniques were reviewed.
6. Dressings were shifted from a common area to individual rooms and separate sterile packs were introduced for each dressing. However, bins continue to be used, as well.

   At this point, we noticed that frequent change of Senior Staff Nurses was continuing to be a major handicap in improving our quality of care.

7. A Senior Staff Nurse, motivated to care for burns was identified and sent for training and has since been working in the burns unit. This has helped considerably to improve the quality of care.
8. At this point, our medical colleagues agreed to provide us a cubicle in the Medical Intensive Care and any patient requiring either ventilatory care or intensive care could be treated here. This has helped to save a few very sick patients.

Cotd..3

9. When possible, in situations hither to unsalvageable, we started excising the burns early and grafting.

PRESENT SITUATION:

A review of our last year's work shows;

a. Our mortality rate has come down from 50% to 20%.

b. The 50% mortality had shifted from 30-40% to 50-60%. In the 40-50%, we had almost 70% survival but this drastically come down above 50% burns.

c. The few who survived deep burns above 50% underwent excision of the burns and some had relation homograft.

d. Early excisions helped considerably even in the 30-50% group.

e. Above 50% deep burns the mortality and morbidity is still very high.

f. Sepsis accounted for more than 60% of the deaths while respiratory burns was the other major killer.

FUTURE POSSIBILITIES:

It appears at this point that if we need to further improve the mortality and morbidity of major burns, as well as the care, we would have to consider major changes in the organisation and management protocols:

1. Starting a burns centre dedicated to the treatment of burns. This means full time staff and a ward only for burns.

2. A burns centre would include intensive care for acute and sick patients, graded care as well as general care with all the necessary equipment.

Cotd..4

3. Methods of keeping environmental bacterial count very low like laminar air flow, air curtains, air conditioning, etc., will have to be incorporated.

4. Periodic surveillance protocols and rigid isolation techniques must be practiced.

5. Early excision and grafting of the burn wound is likely to contribute significantly to reducing hospitalisation, costs, mortality and morbidity.

   This however will entail

   a. More early operating time on an emergency rather than scheduled basis.

   b. Very good blood bank facilities.

   c. Intensive care facilities.

   d. More manpower.

6. All the above will require a large team including intensivists, plastic surgeons, nurses, residents, microbiologists, nutritionists, nephrologists, physiotherapists and social workers.

MOTIVATING PERSONNEL:

It is no easy task to find personnel to work whole time in burns. It is labour intensive, involves long hours and the big dressings can be exhausting. The poor pain control, high mortality and morbidity and inadequate monitoring and resusciation equipment probably contribute to affecting the morale of burn care-givers. Some ways of overcoming this would include

1. Adequate monitoring facilities including cardiac monitors, pulse oximeters, etc.

Cotd..5

2. Intensive care facilities including ventilators.

3. Adequate staff including dressers, physiotherapists, social workers, clinical physiologists.

4. Shorter shifts probably six to eight hours.

5. Very good pain control preferably a full time anaesthetist.

6. Adequate remuneration.

CHOOSING THE DIRECTOR:

A major question at this point is who should head a burns unit? The acute phase and the numerous medical complications associated with burns are best managed by an intensive care specialist with a special interest in burns. A surgeon really comes into the picture for excisions and resurfacing and later reconstructions.

TRAINING THE BURNS SURGEON:

After training in Craniofacial Surgery, Microvascular Surgery, Hand Surgery and General Reconstructive Surgery, it would be a retrogressive step to limit onceself entirely to burns. But the only way the burns care can change dramatically is if we have full time doctors working only in burns. Improving working conditions would definitely help to draw manpower into burns. The Shriners Burns Centres and Army Burns Centres in America are standing examples of this. The other option is to introduce a new speciality of burns with a different curriculum.

DECENTRALISATION OF CARE:

Another thought is the decentralisation of burns care. All minor and most moderate burns upto 25-30% can be treated at the periphery. A burns network can be formed.

Cotd..6

Centres identified. Personnel could periodically be trained and basic facilities to care for moderate burns could be improved at these centres.

EDUCATION & PREVENTION:

Scalds in the kitchen, floor level cooking, the pump stove appear to be major contributors to burns. We probably do not have correct statistics regarding suicidal & homicidal burns related to marital disharmony. Identifying the exact etiology, educating through the media, bringing in legislations and trying to diffuse marital disharmony, alcoholism and dowry harassment would be relevant social areas of work to prevent & reduce the incidence of burns.

THE BOTTOM LINE:

Finances remain a major constraint in establishing modern centres & running them.

1. To upgrade the major centres to include intensive care units, good bacterial control, adequate operating facilities.
2. To upgrade peripheral centres to treat moderate burns.
3. To employ adequate staff and pay them well.
4. To provide for care of poorer patients including
    a. Medicines
    b. Blood
    c. Food
    d. Rehabiliation.
5. To provide for regular training facilities at different levels of burns care-givers both in India and abroad and to have exchange programmes.

Cotd..7

A POSSIBLE START:

One thought is the establishment of a Burns Foundation which could identify local & international donors and help with the upgrading of facilities and sponsoring of individual patients, burn units or beds in a unit, as well as work towards social change. It could act as a necleus to bring together people from different walks of society,concernedabout the problems and keen on caring for these unfortunate victims. The problems are multidimensional and it is only by concentrated and unselfish efforts that we can make any impact. The quality of burns care in a country is a good reflection of society's concern for human life and suffering and I sincerely wish we could start somewhere to upgrade our care.

रोगी कल्याण समिति

नियमावली

संचालनालय स्वास्थ्य सेवायें मध्यप्रदेश

प्रारूप क्रमांक-1
समितियों के पंजीयन हेतु ज्ञापन-पत्र
(देखिए नियम 3)

1. समिति का नाम **सामुदायिक स्वास्थ्य केंद्र /विकास खंड स्तरीय प्राथमिक स्वास्थ्य केंन्द्र रोगी कल्याण समिति**

2. समिति का कार्यालय .... तहसील .... जिला .... में स्थित होगा।

3. समिति के उद्देश्य निम्नलिखित होंगे :–

1. ग्रामीण क्षेत्र के भूमिहीन परिवारों की महिलाओं/लड़कियों को चिकित्सा लाभ।
2. रोगी के संबंधियों को अस्पताल परिसर में ठहरने की व्यवस्था।
3. रोगी के एक परिचारक की निःशुल्क भोजन व्यवस्था।
4. अस्पताल प्रबंधन में सुधार।
5. चिकित्सा से संबंधित अन्य कार्य।

4. समिति के प्रबंध विनियमों द्वारा समिति के कार्यों का ~~प्रबंध शासन परिषद संचालकों, सभा या~~ प्रबन्धन शासी-निकाय को सौंपा गया है जिनके सदस्यों के नाम, पते तथा धन्धों का उल्लेख निम्नांकित है :–

क्रमांक 1	नाम 2	पद 3	पता 4	धन्धा 5
1.	अनुविभागीय अधिकारी राजस्व	कार्यकारी निदेशक तथा अध्यक्ष		
2.	अनुविभागीय अधिकारी, लोक निर्माण विभाग	सदस्य		
3.	अनुविभागीय अधिकारी राजस्व द्वारा मनोनीत दानदाताओं के एक या दो प्रतिनिधि		सदस्य	
4.	शासी निकाय द्वारा सहयोजित अधिकारी/व्यक्ति	सदस्य		
5.	खण्ड चिकित्सा अधिकारी	सदस्य सचिव		
6.	महिला बाल विकास परियोजना अधिकारी	सदस्य-उपसचिव		

5. समिति के इस ज्ञापन-पत्र के साथ समिति के विनियमों की एक प्रमाणित प्रति जैसा कि म.प्र. सोसायटी रजिस्ट्रीकरण अधिनियम 1973 (1973.का 44 की धारा 5 की उपधारा-1) के अधीन अपेक्षित है, संलग्न है।
हम अनेक व्यक्ति जिनके नाम और पते नीचे लिखे हैं समिति का निर्माण उपरोक्त ज्ञापन-पत्र के अनुसार करने के इच्छुक हैं तथा ज्ञापन-पत्र पर निम्नांकित साक्षियों की उपस्थिति में हस्ताक्षर किए हैं।

क्रमांक	निर्माणकर्त्ताओं के नाम-पते	हस्ताक्षर
1	2	3
1.		
2.		
3.		
4.		
5.		
6.		
7.		

साक्षी

हस्ताक्षर ....

नाम ....

पता ....

सामु. स्व. केन्द्र/विकास खंड स्तरीय प्राथमिक स्वास्थ्य केन्द्र
रोगी कल्याण समिति की नियमावली

1. संस्था का नाम ....

2. संस्था का कार्यालय .... म. नं. ....
   मोहल्ले का नाम .... तहसील .... जिला .... (म.प्र.)

3. संस्था का कार्यक्षेत्र .... मध्यप्रदेश होगा।

4. संस्था का उद्देश्य (जो ज्ञापन पत्र में अंकित है वही लिखो)
   1. ग्रामीण क्षेत्र के भूमिहीन परिवारों की महिलाओं/लड़कियों को चिकित्सा लाभ।
   2. रोगी के सम्बन्धियों को अस्पताल परिसर में ठहरने की व्यवस्था।
   3. रोगी के एक परिचारक की निःशुल्क भोजन व्यवस्था।
   4. अस्पताल प्रबंधन में सुधार।
   5. चिकित्सा से संबंधित अन्य कार्य।

5. सदस्यता – संस्था के निम्नलिखित श्रेणी के सदस्य होंगे :–

क्र.	सदस्य	पद
1.	संबंधित जनपद पंचायत अध्यक्ष	अध्यक्ष
2.	उस क्षेत्र से निर्वाचित लोक सभा सदस्य	सदस्य
3.	उस क्षेत्र से निर्वाचित विधायक	सदस्य
4.	संबंधित नगर पालिका अध्यक्ष	सदस्य
5.	संबंधित अनुविभागीय अधिकारी	कार्यकारी निदेशक तथा मुख्य कार्यपालन अधिकारी
6.	महिला बाल विकास परियोजना अधिकारी	सदस्य-उपसचिव
7.	अस्पताल को रुपये 25,000/ से अधिक देने वाले सामान्य जाति के व्यक्ति	सदस्य
8.	अस्पताल को 1,000 रु. से अधिक दान देने वाले अनुसूचित जनजाति के व्यक्ति	सदस्य
9.	अनुविभागीय अधिकारी,लोक निर्माण विभाग	सदस्य
10.	खण्ड चिकित्सा अधिकारी	सदस्य

6. सदस्यता की प्राप्ति — उपरोक्तानुसार

7. सदस्यों की योग्यता :
   1. आयु 18 वर्ष से कम न हो।
   2. भारतीय नागरिक हो।
   3. समिति के नियमों के पालन की प्रतिज्ञा की हो।
   4. सद्चरित्र हो तथा मद्यपान न करता हो।

8. सदस्यता की समाप्ति : संस्था की सदस्यता निम्नलिखित स्थिति में समाप्त हो जावेगी :–
   1. मृत्यु हो जाने पर।
   2. पागल हो जाने पर।

3. संस्था की देय चंदे की रकम नियम 5 में बताये अनुसार जमा न करने पर।

9. संस्था कार्यालय में सदस्य पंजी रखी जावेगी जिसमें निम्न ब्योरे दर्ज किए जायेंगे :–

1. प्रत्येक सदस्य का नाम-पता तथा व्यवसाय
2. वह तारीख जिसमें सदस्यों को प्रवेश दिया गया हो।
3. वह तारीख जिससे सदस्यता समाप्ति हुई हो।

10. **(अ) साधारण सभा**–साधारण सभा में नियम 5 में दर्शाये श्रेणी के सदस्य समावेशित होंगे। साधारण सभा की बैठक आवश्यकतानुसार हुआ करेगी परन्तु वर्ष में एक बार बैठक अनिवार्य होगी। बैठक का माह तथा बैठक का स्थान व समय की सूचना कार्यकारिणी समिति द्वारा निश्चित कर 15 दिवस पूर्व प्रत्येक सदस्य को दी जावेगी। बैठक का कोरम 1/3 सदस्यों का होगा। संस्था की प्रथम आमसभा पंजीयन दिनांक से तीन माह के भीतर बुलाई जावेगी। उसमें संस्था के पदाधिकारियों का विधिवत् निर्वाचन किया जावेगा। यादे संबंधित आमसभा का आयोजन किसी समय नहीं किया जाता तो पंजीयक को अधिकार होगा कि वह संस्था की आमसभा का आयोजन किसी जिम्मेदार कर्मचारी के मार्गदर्शन में एवं पदाधिकारियों का विधिवत् चुनाव कराया जावेगा।

(ब) शासी निकाय की सभा–शास. निकाय की बैठक प्रत्येक माह होगी तथा बैठक का एजेन्डा तथा सूचना बैठक दिनांक से सात दिन पूर्व शासी निकाय के प्रत्येक सदस्य को भेजी जाना आवश्यक होगी। बैठक में कोरम 1/2 सदस्यों का होगा। यदि बैठक का कोरम पूर्ण नहीं होता है तो बैठक एक घण्टे के लिये स्थगित की जाकर उसी स्थान पर उसी दिन पुनः की जा सकेगी जिसके लिये कोरम की कोई शर्त न होगी।

(स) विशेष–यदि कम से कम कुल संख्या (कुल सदस्यों की पंजी का) के 2/3 सदस्यों द्वारा लिखित रूप से बैठक बुलाने हेतु आवेदन किया जाये तो उनके दर्शाये विषय पर विचार करने के लिये साधारण सभा की बैठक बुलाई जावेगी। विशेष संकल्प पारित हो जाने पर संकल्प की प्रति पंजीयक को संकल्प पारित हो जाने के दिनाँक से 14 दिन के भीतर भेजी जावेगी। पंजीयक को इस संबंध में आवश्यक निर्देश जारी करने तथा समिति को परामर्श देने का अधिकार होगा।

11. साधारण सभा के अधिकार व कर्त्तव्य–(क) संस्था के पिछले वर्ष का वार्षिक विवरण प्रगति प्रतिवेदन स्वीकृत करना (ख) संस्था की स्थाई निधि व संपत्ति की ठीक व्यवस्था करना (ग) आगामी वर्ष के लिए लेखा परीक्षकों की नियुक्ति करना (घ) अन्य ऐसे विषयों पर विचार करना जो शासी निकाय द्वारा प्रस्तुत हो (च) संस्था द्वारा संचालित संस्थाओं के आय-व्यय पत्रकों को स्वीकृत करना (छ) बजट का अनुमोदन करना।

12. दिन प्रतिदिन का कार्य देखने के लिए समिति का शासी निकाय होगा, जिसके निम्नलिखित सदस्य होंगे:–

1.	अनुविभागीय अधिकारी	कार्यकारी निदेशक तथा अध्यक्ष
2.	अनुविभागीय अधिकारी, लोक निर्माण विभाग	सदस्य
3.	अनुविभागीय अधिकारी द्वारा मनोनीत दानदाताओं के एक या दो अधिकारी	सदस्य
4.	शासी निकाय द्वारा सहयोजित अधिकारी/व्यक्ति	सदस्य
5.	खण्ड चिकित्सा अधिकारी	सदस्य सचिव
6.	महिला बाल विकास परियोजना अधिकारी	सदस्य - उपसचिव

के लिये लोक निर्माण विभाग को हस्तांतरित कर दिया जाय। इससे निर्माण कार्य का स्तर भी ठीक बना रहेगा और सधारण की व्यवस्था भी ठीक हो जायेगी। लोक निर्माण विभाग को निवेदन किया जायेगा कि वे समिति के लिये बनाये जाने वाले भवनों पर सुपरविजन चार्ज न लें।

(ड) रोगी कल्याण समिति का अपना बैंक खाता समिति के मुख्यालय पर होगा जिसमें निम्नानुसार धनराशियां जमा होंगी :-

(1) दानदाताओं से प्राप्त धनराशि।

(2) शासन द्वारा अस्पताल में उपलब्ध कराई गई सुविधाओं पर लगाई गई फीस ।

इस बैंक खाते का संचालन समिति की नीतियों के अनुसार समिति के शासी निकाय द्वारा नामांकित अधिकारियों द्वारा किया जायेगा।

(ण) रोगी कल्याण समिति को आयुष्मति योजना के अन्तर्गत समय-समय पर धनराशि महिला एवं बाल विकास कल्याण विभाग द्वारा दी जाती है। यह धनराशि समिति के अलग खाते में रखी जायेगी। इस धनराशि का व्यय उसी विभाग के निर्देशों के अन्तर्गत किया जायेगा। इस धनराशि की प्राप्ति तथा व्यय का लेखा इत्यादि भी उन्हीं के निर्देशों के अनुसार रखा जायेगा।

(त) सामान्यतया जिस अस्पताल के लिए जो धनराशि प्राप्त होगी उसी अस्पताल के लिये उसका उपयोग होगा। किन्तु रोगी कल्याण समिति जिला मुख्यालय के खाते से उतनी धनराशि जिले के अन्य सिवि अस्पतालों को दे सकेगी जितनी कि वह उचित समझे। यह व्यवस्था इसलिये की जा रही है कि यदि संभव हो तो छोटे सिविल अस्पतालों को जिला स्तर से सहायता मिल सके।

(थ) सिविल अस्पतालों की समितियां सामान्यतया जिला रोगी कल्याण समिति से समन्वय स्थापित रखेंगी। किन्तु ऐसे नीति निर्देशों के अंतर्गत जो सामान्य सहमति से निर्धारित हो, स्थानीय स्तर पर स्थानीय कार्यों के संबंध में स्वतंत्र रूप से निर्णय ले सकेंगी।

14. **वित्तीय व्यवस्था :-**

(1) जो भी संस्थाएं या व्यक्ति अस्पताल को कुछ भी धनराशि अथवा अन्य वस्तुयें दान में देना चाहे तो उसे स्वीकार करने का अधिकार समिति को होगा। ये सभी दान स्वेच्छा से दिया दान होगा। क्योंकि दानदाता को समिति की सदस्यता देने का प्रस्ताव है, अतः दान स्वीकार करने से पहले दानदाता के चाल-चलन आदि की जानकारी प्राप्त कर ली जाये। संदेहजनक चरित्र के व्यक्तियों से दान न लिया जाये।

(2) जो व्यक्ति अथवा संस्था सिविल अस्पताल को रु. पचीस हजार, जिला अस्पताल को रु. एक ल तथा चिकित्सा महाविद्यालय से सम्बद्ध अस्पताल को रु. दो लाख से अधिक दान दे उन्हें समिति की सदस्यता दी जावेगी। व्यक्तिगत दान देने वाला स्वयं सदस्य होगा और दानदाता संस्था को एक प्रतिनिधि नामांकित करने का अधिकार होगा।

(3) अस्पताल में प्रदाय की जाने वाली सुविधायें – जैसे लेबोरेट्री टेस्ट, एक्स-रे इत्यादि पर समिति द्वारा फीस लगाई जा सकेगी। शासकीय रोजगार योजनाओं के अन्तर्गत ऐसे व्यक्तियों की सूचियां बनाई गई हैं जो गरीबी रेखा से नीचे हैं। ऐसी सूचियां ग्रामीण और शहरी दोनों प्रकार के क्षेत्रों में बनाई गई है। सूची में सम्मिलित व्यक्तियों को कार्ड भी वितरित किये जा रहे हैं। इन कार्डधारी व्यक्तियों से अस्पताल की सुविधाओं के लिये कोई फीस नहीं ली जायेगी। शेष व्यक्ति रोगी कल्याण समिति द्वारा निर्धारित फीस देंगे।

13. **शासी निकाय के अधिकार व कर्त्तव्य :–**

(अ) जिन उद्देश्यों की प्राप्ति हेतु समिति का गठन हुआ है उसकी पूर्ति करना और इस आशय की पूर्ति हेतु व्यवस्था करना।

(ब) पिछले वर्ष का आय-व्यय का लेखा (पूर्णतः परीक्षित किया हुआ) प्रगति प्रतिवेदन के साथ प्रतिवर्ष साधारण सभा की बैठक में प्रस्तुत करना।

(स) समिति एवं उसके अधीन संचालित संस्थाओं के कर्मचारियों के वेतन तथा भत्ते आदि का भुगतान करना। संस्था की चल-अचल संपत्ति पर लगने वाले कर आदि का भुगतान करना।

(द)अन्य आवश्यक कार्य करना, जो साधारण सभा द्वारा समय-समय पर सौंपे जायें।

(च)~~संस्था की समस्त चल अचल संपत्ति शासी निकाय के नाम से रहेगी।~~

(छ) संस्था द्वारा कोई भी स्थावर संपत्ति रजिस्ट्रार की लिखित अनुज्ञा के बिना विक्रय द्वारा या अन्यथा अर्जित या अन्तरित नहीं की जायेगी।

(ज) विशेष बैठक आमंत्रित कर संस्था के विधान में संशोधन किये जाने के प्रस्ताव पर विचार-विमर्श कर साधारण सभा की बैठक में उसको स्वीकृति हेतु प्रस्तुत करेगी। साधारण सभा में कुल सदस्यों के 2/3 मत से संशोधन पारित होने पर उक्त प्रस्ताव पारित कर पंजीयक को अनुमोदन हेतु भेजा जावेगा।

(झ) शासन से अन्य स्वीकृतियां प्राप्त करने के बाद समिति के द्वारा उपरोक्तानुसार जो धनराशि एकत्र की जाएगी उसका व्यय करने का अधिकार समिति को होगा। समिति की सामान्य सभा वर्ष में एक बार बजट स्वीकृत कर यह निर्णय करेगी कि किस कार्य के लिये कितनी धनराशि उपलब्ध कराई जावे। अन्य आवश्यक कार्य निपटाने के लिये समिति की बैठक 3 माह में कम से कम एक बार होगी। आवश्यकता पड़ने पर कभी भी बैठक बुलाई जा सकती है। नीतिगत निर्णय समिति की सामान्य सभा में लिये जायेंगे। समिति द्वारा लिये गये निर्णयों के क्रियान्वयन तथा उन पर हुए व्यय की पूर्ण जानकारी सामान्य सभा को प्रस्तुत की जायेगी।

(ट)सामान्य सभा द्वारा स्वीकृत बजट के अंतर्गत तथा अन्य नीतिगत निर्णयों के अनुसार व्यय करने का अधिकार शासी निकाय को होगा जो कुछ हद तक इन अधिकारों को कार्यकारी निदेशक अथवा सचिव अथवा अन्य अधिकारी को डेलीगेट कर सकेगी। इस धनराशि से समिति अस्पताल के रख-रखाव पर भी व्यय कर सकेगी और नये उपकरण क्रय करने, उपकरणों की मरम्मत, दवायें तथा अन्य आवश्यक वस्तुओं के क्रय पर भी व्यय कर सकेगी। किन्तु समिति को किसी भी स्थिति में अस्थाई अथवा स्थाई पद स्वीकृत करने का अथवा आवर्ती व्यय स्वीकृत करने का अधिकार नहीं होगा।

(ठ)समिति द्वारा यदि अस्पताल प्रांगण में कोई निर्माण कराया जाना हो तो उसके लिये शासन की पूर्व स्वीकृति आवश्यक होगी। अस्पताल प्रांगण में कोई दुकाने अथवा व्यावसायिक संस्थायें स्थापित नहीं की जायेंगी और न ही किसी निजी व्यक्ति को दुकान आदि चलाने की अनुमति दी जायेगी। अस्पताल के उपयोग के लिये निर्माण शासन की अनुमति से किया जा सकेगा, क्योंकि समिति द्वारा बनाये गये भवन आदि भी अन्ततोगत्वा लोक निर्माण विभाग द्वारा संधारित किये जायेंगे। अतः उचित यही होगा कि सामान्यतः निर्माण कार्य लोक निर्माण विभाग से कराया जाये और कार्य पूर्ण होने पर निर्मित भवन संधारण

15. **समिति का कार्य संचालन तथा लेखा संधारण :–**

समिति को अपने कार्य संचालन के लिए कोई नवीन पद स्वीकृत करने अथवा नवीन आवर्ती व्यय स्वीकृत करने का अधिकार नहीं होगा। समिति का संपूर्ण कार्य संचालन स्वास्थ्य विभाग के वर्तमान अमले के माध्यम से किया जायेगा। लेखा संधारण का कार्य भी स्वास्थ्य विभाग के लेखा अधिकारी द्वारा निर्धारित प्रपत्रों में किया जायेगा। लेखा सदैव अद्यतन रखा जायेगा और मांग करने पर जिलाध्यक्ष द्वारा अधिकृत अधिकारियों, स्वास्थ्य विभाग के अधिकारियों तथा आडीटर्स को उपलब्ध कराया जायेगा। यह अतिरिक्त कार्य करने वाले कर्मचारियों को समिति द्वारा कुछ मानदेय अपने कोष से दिया जा सकेगा। मानदेय कितना हो इसका निर्णय शासी निकाय द्वारा किया जायेगा। मानदेय की राशि शासन द्वारा नहीं दी जावेगी। समिति को प्राप्त राशि के लेखा का आडिट स्थानीय निधि संपरीक्षा द्वारा किया जावेगा। आडिट फीस समिति को स्वयं के श्रोतों से वहन करनी होगी।

16. **अध्यक्ष के अधिकार :–**

अध्यक्ष साधारण सभा की समस्त बैठकों की अध्यक्षता करेगा तथा सदस्य सचिव द्वारा साधारण सभा की बैठकों का आयोजन करवायेगा। अध्यक्ष का मत विचारार्थ विषयों में निर्णयात्मक होगा।

17. **सचिव के अधिकार :–**

(1) साधारण सभा एवं शासी निकाय की बैठक समय-समय पर बुलाना और समस्त आवेदन-पत्र तथा सुझाव जो प्राप्त हों, प्रस्तुत करना।

(2) समिति का आय-व्यय का लेखा परीक्षण प्रतिवेदन तैयार करके साधारण सभा के सम्मुख प्रस्तुत करना।

(3) समिति के सारे कागजातों को तैयार करना तथा करवाना। उनका निरीक्षण करना व अनियमितता पाये जाने पर उसकी सूचना शासी निकाय को देना।

(4) समिति की धनराशि का पूर्ण हिसाब रखना तथा कार्यकारी निदेशक द्वारा स्वीकृत व्यय करना।

18. **कार्यकारी निदेशक के अधिकार :–**

(1) कार्यकारी निदेशक शासी निकाय की बैठकों की अध्यक्षता करेगा।

(2) किसी कार्य के लिये एक समय में रुपये 20000 तक व्यय की स्वीकृति देने का अधिकार कार्यकारी निदेशक को होगा। इससे अधिक राशि के व्यय की स्वीकृति शासी निकाय द्वारा दी जायेगी

(3) शासी निकाय की बैठकों में कार्यकारी निदेशक का मत विचारार्थ विषयों में निर्णयात्मक होगा।

19. **बैंक खाता :–**

संस्था की समस्त निधि किसी अनुसूचित बैंक या पोस्ट आफिस में रहेगी। धन का आहरण कार्यकारी निदेशक तथा सचिव के संयुक्त हस्ताक्षरों से होगा। दैनिक व्यय हेतु सचिव के पास अधिकतम रु 20,000 रहेंगे।

20. पंजीयक को भेजी जाने वाली जानकारी :–

अधिनियम की धारा 27 के अन्तर्गत संस्था की वार्षिक आमसभा होने के दिनांक से 14 दिन के भीतर निर्धारित प्रारूप पर शासी निकाय की सूची फाइल की जावेगी तथा धारा 28 के अन्तर्गत संस्था का परीक्षित लेखा भेजा जाएगा ।

21. संशोधन :–

संस्था के विधान में संशोधन साधारण सभा की बैठक में कुल सदस्यों के 2/3 मतों से पारित होगा। यदि आवश्यक हुआ तो संस्था के हित में उसके पंजीकृत विधान में संशोधन करने का अधिकार पंजीयक फर्म्स एवं संस्थाएं को होगा जो प्रत्येक सदस्य को मान्य होगा।

22. विघटन :–

संस्था का विघटन साधारण सभा में कुल सदस्यों के 3/5 मत से पारित किया जावेगा। विघटन के पश्चात संस्था की चल तथा अचल संपत्ति किसी समान उद्देश्यों वाली संस्था को सौंप दी जावेगी। उक्त समस्त कार्यवाही अधिनियम के प्रावधानों के अनुसार की जावेगी।

23. संपत्ति :–

संस्था की समस्त चल तथा अचल संपत्ति संस्था के नाम से रहेगी। संस्था की अचल संपत्ति (स्थावर) रजिस्ट्रार फर्म्स एवं संस्थाएं की लिखित अनुज्ञा के बिना विक्रय द्वारा, दान द्वारा या अन्यथा प्रकार से अर्जित या अन्तरित नहीं की जा सकेगी।

24. **बैंक खाता :–**

संस्था की समस्त निधि किसी अनुसूचित बैंक या पोस्ट आफिस में रहेगी। समय-समय पर धन जमा करने व निकालने की प्रक्रिया जारी रहेगी।

25. **पंजीयक द्वारा बैठक बुलाना :–**

संस्था की पंजीयत नियमावली के अनुसार पदाधिकारियों द्वारा वार्षिक बैठक न बुलाये जाने पर या अन्य प्रकार से आवश्यक होने पर पंजीयक फर्म्स एवं संस्थाएं को बैठक बुलाने का अधिकार होगा। साथ ही वह बैठक में विचारार्थ विषय निश्चित कर सकेगा।

26. **विवाद :–**

संस्था में किसी प्रकार का विवाद उत्पन्न होने पर अध्यक्ष को साधारण सभा की अनुमति से सुलझाने का अधिकार होगा। यदि इस निश्चय या निर्णय से पक्षों को संतोष न हो, तो वह रजिस्ट्रार की ओर विवाद के निर्णय के लिये भेज सकेंगे। रजिस्ट्रार का निर्णय अंतिम व सर्वमान्य होगा। संचालित सभाओं के विवाद अथवा प्रबंध समिति के विवाद उत्पन्न होने पर अंतिम निर्णय देने का अधिकार रजिस्ट्रार को होगा।

प्रारुप -१

मेटरनिटी बेनीफिट हेतु आवेदन पत्र

प्रति,

१. मुख्य कार्यपालीन अधिकारी
जनपद पंचायत
द्वारा ग्राम पंचायत

२. आयुक्त/मुख्य नगरपालिका अधिकारी,
नगर निगम/नगरपालिका/नगर पंचायत

कृपया मुझे राष्ट्रीय मेटरनिटी बेनीफिट योजना के अन्तर्गत ३००/- रुपये सहायता राशि स्वीकृत करने का कष्ट करें।

१. आवेदिका का नाम ....

२. पति का नाम ....

३. आयु ....

४. जाति ....

५. पूर्ण पता ....

६. जीवित बच्चो की संख्या ....

७. परिवार की वार्षिक आय रु. .... मेरा परिवार गरीबी रेखा के नीचे है.

८. प्रसव का संभावित दिनांक ....

आवेदिका के हस्ताक्षर

घोषणा - पत्र

(प्रारूप-१ का भाग)

मैं, श्रीमती .... पति ....

निवासी .... सत्यनिष्ठा

से यह घोषणा करती हूँ कि ऊपर बताई गई जानकारी मेरे ज्ञान के अनुसार सही है .

आवेदिका के हस्ताक्षर

प्रमाण - पत्र

(प्रारूप-१ का भाग)

प्रमाणित किया जाता है कि आवेदिका श्रीमती ....

पति .... पता ....

की आयु .... वर्ष है। उनका परिवार गरीबी रेखा के नीचे जीवनयापन करता है। तत्सबंधित सर्वेक्षण सूची

में उनका नाम क्रमांक .... पर है। उनके .... जीवित बच्चे हैं। इनके प्रसव का

संभावित दिनांक .... हैं।

हस्ता. ....

सरपंच ग्राम पंचायत ....

मुख्य कार्यपालीन अधिकारी ....

नगरीय स्थानीय ....

अरूणिमा योजना

अरूणिमा योजना का उद्देश्य शाला मे पढने वाले समस्त छात्रो का वर्ष मे एक बार स्वास्थ्य परीक्षण कर उपचार करना।

बिलासपुर जिले के अर्न्तगत समस्त शालाओ का स्वस्थ्य परीक्षण हेतु वार्षिक कलेण्डर बनाया जाता हैं तथा निर्धारित तिथीयों में चिकित्सकों के द्वारा छात्रों का स्वस्थ्य परीक्षण किया जाता है। प्रत्येक विकास खण्ड के अर्न्तगत आने वाले समस्त शालाओ के छात्रों का स्वस्थ्य परीक्षण उस विकास खण्ड के चिकित्सकों द्वारा किया जाता है तथा रोग ग्रस्त पाये जाने पर पर उनका उपचार किया जाता है जटिल रोग होने पर उसके उपचार के लिये जिला चिकित्सालय/मेडिकल कालेज मे भेजने की व्यवस्था की जाती हैं।

बिलासपुर जिले में यदि बच्चों को नेत्र संबन्धी तकलीफ या दृष्टी दोष है तो उसे निशुल्क चश्मे की भी व्यवस्था स्थानीय सहयोग से की जाती है।

वर्तमान मे आंगनबाड़ी, छात्रावास मे बच्चो का भी स्वस्थ्य परीक्षण किया जाता है।

हाईस्कूल मे छात्रो का रक्त परीक्षण कर रक्त समूह की भी जानकारी दी जाती है।

ANNEXURE - II

Questionnaire for Outdoor Patients:

Name of Patient :

Address :

Diagnosis :

1. What are the common problems faced by you in the OPD ? :

2. Do you have to wait for a long time ? : Yes/No

3. How is the behaviour of doctors ? : Good/Bad

4. How is the behaviour of staff nurses, ward boys, doctors, etc.? : Good/Bad

5. Are the prescribed medicines easily available ? : Yes/No

6. Do the doctors on duty ask you to come to their private clinics ? : Yes/No

7. Have you suffered due to wrong diagnosis by the doctor ? : Yes/No

8. Have you noticed favouritism, or pro-relative jumping in the queue ? : Yes/No

ANNEXURE - III

Questionnaire for Doctors (Senior, Junior & Residents)

Name of the Hospital :

Address :

Category of Hospital : Gen. Maternity Eye TB Others

Please give the following details pertaining to your Dept. only:

1. Name of your unit :

2. Years of service in this hospital :

3. Your designation (full-time, part-time/honorary) :

4. Total number of beds attached to your unit :

   i) Are the number of beds sufficient ? : Yes/No

   ii) If no, then how many do you suggest ? :

   iii) How many beds were full on last OPD/Emergency day ? Any patient on floor ? :

5. (a) Total number of actual hours spent by you per day in treating patients

On OPD day :
On ward day :
On operation day :

(b) Average number of patients treated in OPD per day in your unit (new + old cases) :

(c) How many doctors are there in your unit?

Senior :
Junior :

6. (a) Are you satisfied with the competence of your nursing staff? : To a large extent/somewhat/ not at all

(b) Are you satisfied with the competence of your resident doctors? : To a large extent/somewhat/ not at all

7. Whether the staff is sufficient for your unit : Yes/No

If no, what type of staff is not sufficient ? :

For what functions ? :

Give details of posts lying vacant in your Dept. :

Name of Post Lying Vacant	Why ?	For How Long ?

8. The five most common diseases seen by you during the last two years in your unit ?

: OPD
1)
2)
3)
4)
5)

: In-patients
1)
2)
3)
4)
5)

9. Which are the five most common diseases responsible for death in your Dept. ? :
1)
2)
3)
4)
5)

10. Are all essential medicines available in your hospital for indoor and OPD patients ? : Yes/No

List seven essential drugs which are most commonly prescribed but are not available in the hospital ?

1)
2)
3)
4)
5)
6)
7)

11. What problems do you face in the operation room with reference to the availability of equipment, power, staff support ? Please elaborate. :

12. Give frequency of breakdowns of essential equipment used by you

Name	No. of breakdowns per month

Reasons for breakdown (Please tick)

Unknown ( )
Mechanical ( )
Negligence ( )
Careless operation ( )
Lack of maintenance ( )
Long use ( )

13. Please give list of important (must) equipment which you feel that your Department should have.

Name of equipment	No. required	Function of equipment

14. Please give details of machines lying unused

Name of machine lying unused	No. of machines lying unused	Since when ?

Reason for machines lying unused (Please tick)

Uninstalled ( )
Obsolete ( )
Malfunctioning constantly ( )

15. Please give details of machines installed but lying unused due to lack of trained operators

Name of machine	Its use	Since when ?

16. What is the frequency of power failure in your Dept. per month ?

17. (a) Are you satisfied with the reports available from other Depts. ? : Yes/No

(b) If no, then :

Name of Dept.	Reason

18. Under what circumstances do you refer the patient to other institutions ? :

19. (a) What are cleanliness standards in your wards, operation theatre, OPD ?

	O P D	Ward	Operation theatre	Sanitary facilities
1) Excellent				
2) Good				
3) Acceptable				
4) Quite dirty				
5) Extremely dirty				

(b) What can be done to improve this ?

20. Are you satisfied with the facilities available in your unit? Please give rating to the following:

	Very satisfactory	Moderately	Low	Not
1) Staff				
2) Equipment				
3) Medicine, dressing				
4) Support service				
5) Ward service				
6) Operation theatre				

21. What are the phenomena endangering patient care ? :

22. Are you satisfied with the equipment sterilisation facility of the hospital ? : Yes/No

    If no, please explain

23. Do you see hospital-acquired infection ? : Yes/No

    How common is it?

Very Common	(>50% of patients)	Frequent	(30-50%)
Uncommon	(10-29%)	Rare	(2-9%)
Very rare	(<2%)		

24. Are you facing any difficulties in the Casualty Dept./Emergency Ward/ Intensive Care ? : Yes/No

    If yes, specify :

25. Are you satisfied with the quality of drugs, dressings etc. supplied by the hospitals ? :

    If not, specify for example:

    1) Drugs are substandard
    2) Irregular supply
    3) Quota insufficient
    4) Any other

26. What steps do you take to overcome non-availability of drugs/ medical instruments, etc. ?

    Please tick:

    (a) You report to authorities — Action is taken
    (b) You feel there is no use of reporting — No action is taken
    (c) Any other, please specify

27. Do you think of late patient care has improved or deteriorated ? Please give reasons for your opinion.

28. Do you think there is interference from politicians ? Yes/No

    Does it affect health services to patients ? Yes/No

    Please elaborate

29. On an average what proportion of your time in the hospital do you devote to :

    Patient care
    Teaching
    Administrative work
    Other work

    Total 100 %

30. Does adequate academic interaction with other doctors take place ? Give rating to the following:

    Regularly Occasionally Never

31. Have you any comments on inter-departmental co-operation ?

32. Is immediate action taken on your complaints by the Administration ? Yes/ No

33. What administrative steps do you suggest so that no patient becomes a victim of negligence ?

34. What kind of statistical information is maintained and available with regard to your department ?

    Satisfactory Unsatisfactory

35. How satisfied are you with other supporting departments ?

    Satisfied
    Not satisfied
    X-ray, pathology, anasthesiology

    (only for clinical dept. which use these services)

36. Any other instructions/suggestions you would like to give :

Community Health Centre / Block level PHC

Pts welfare committee Rules

1. Name of organization ---------

2. Organization office --------- House No. ----- Mohalla

Taluka ------ Distt ----

3. Working Area of organization

4. Objective of the organization (

1. Medical benefits ~~to rural areas~~ landless families & women / Girls in Rural area
2. Arrangements of stay of Pts Relatives in Hospital campus.
3. Arrangements of free food for ~~opp~~ Pts attendent.
4. Improvement in Hospital management.
5. Other works related to Medicals.

5. Members: organization will have following members

1.	Janpad Panchayat President ~~of~~ Janpad	President
2.	M.P. from that area	Member
3.	MLA " "	"
4.	Municipality chairman of that area	"
5.		
6.	CMO DPO -- ----	Memb & Vice Presd
7.	Any person donating more than Rs 25,000/.	Member
8.	Any ~~person~~ SC/ST donating more than Rs 1000/-	Member
9.	PWD officer	Member
10	Block Medical officer.	"

6. List of members : as above

7. Qualification of Members.

1. Age: more than 18 yrs
2. Indian Citizen
3. taken oath to to follow the committee rule
4. Sound character and non Alcoholic.

8. Membership will be ~~ceased of~~ ceased after

- Death of person
- If member become Insane

8. ~~3~~. Not depositing the Donation amount payable to organization. as per rule No 5

9. Registration ~~certificate~~ should be kept in organization office. with following information

1. Name, address and occupation of every Member
2. Date of Members entry
3. Date ~~of~~ on which Membership has been seized.

10.

BURNS CARE IN INDIA:

For professionals dealing with burns care in India, the high mortality, morbidity, unknown epidemiology and socio-economic problems remain areas of great concern.

HOW DO WE COMPARE WITH DEVELOPED COUNTRIES?

1. We do not have a single centre dedicated to burns care.
2. Our 50% mortality is in the 30-40% BSA Burn group. In the west and east this is in the 60-80% range depending on age.
3. The morbidity is very high.

THE CHANGES THAT NEED TO BE MADE:

1. We need to start burns centres dedicated to the care of burns, at least one in each State.
2. The prevailing centres and District hospitals need upgrading.
3. Intensive care facilities should be provided.
4. Well trained & motivated multidisciplinary burns teams should be introduced and the number of Staff should be adequate.
5. Barrier nursing and rigid environmental bacterial control are absolutely essential.

WHY IS IT SO DIFFICULT TO CHANGE?

1. LACK OF AWARENESS:

   The majority of Policy makers, administrators, doctors and the public are probably unaware of how an ideal burns centre should run?

Cotd..2

2. **FINANCES:**

The inability to mobilise funds to upgrade these units appears to be a major deterrent to change.

3. **LACK OF MOTIVATED PERSONNEL:**

As of now, very few professionals take up burns care exclusively. It is essential to have full time, motivated personnel for any long term improvements to be felt.

THE SOCIO ECONOMIC PROBLEM:

A large percentage of major burns occurs in the lower socio-economic group. Illiteracy, over-crowding, marital disharmony and poverty all contribute to the etiology, morbidity and mortality of burns.

HOW CAN CHANGES COME ABOUT?

The existing system needs complete overhauling if we are to make any major impact. This can only come about if the Government, Policy makers, Administrators, Doctors, Industry, previous patients and concerned Social groups all put their heads together to solve the issues previously mentioned. One start would be to bring together all concerned persons in A BURNS FOUNDATION.

A more detailed report is available with:

DR.RAVI NARAYAN,
Society For Community Health Awareness, Research & Action,
326, 5th Main, 1st Block,
Koramangala, Bangalore.95.

Ph: 553 1518.

Efficacy in Administration of Hospitals

A Case Study of Private & Government Hospitals in Bangalore

Piush Anthony
Doctoral Fellow
ISEC, Bangalore

Suggestions/Recommendations

1. Hospital management and organisational structure needs a complete overhaul in the case of government hospitals. The work load of doctors and other staff is an area of concern which needs attention. The first step can be filling the vacant posts and deleting/reshuffling the posts that non-functioning and unspecified.

2. The practise of doctors being appointed as administrators in government hospitals seems to be a problem as far as the poor management of human as well as other resources are concerned, since they are not trained in administrative/management skills. The relatively superior management systems observed in private hospitals can be attributed to the fact that these are managed by 'administrators', trained or experienced.

3. The efficiency of the hospital lies in the nursing care provided. Better nursing care is assured through division of labour and continuous monitoring created through different categories of nursing staff. For example, supervisory level staff at ward/floor levels, who ensure efficient management in private hospitals. This is one area government hospitals need to reform their organizational structure.

4. Greater devolution of power to the senior officials is necessary in the case of government hospitals which ensures effective handling of complaints from patients thereby ensuring efficient management and customer satisfaction.

5. It is clear from the analysis that government hospitals has high occupancy rate. This can be translated into efficient income improving mechanisms if there are systems introduced, which will ensure identification of income levels of patients without giving way for leakages. This will to some extent arrest corruption in government hospitals.

6. There is a need to ensure provision of medical social workers in government hospitals to support and help poor patients. They can provide guidelines and information to patients in meeting their demands as rights and also can act as a mediator between the administration and the patients.

7. There is a need to develop systems of supervision and vigilance in government hospitals to ensure that corruption is arrested, which will help a long way in building the image of government hospitals. This is very important as it can initiate positive changes in the work culture/environment of the government hospitals.

8. It is also essential to build systematic awareness among the people on the role of efficient public health care system, which ensures demand for public health services as it is obligatory on the part of the government to provide health services to the people and the poor cannot be in a position to access private services. The present day duality in health care access is denying the opportunity of improving government hospital management as only the poor are accessing it, who tend to be less articulate about the problems and who will have limited access or information about the redressal machineries.

9. A greater role for medical professionals and their associations have to be recognised in this regard to influence the authorities in revamping the hospitals with better facilities and more human resources. The medical fraternity has to take a pro-active role in ensuring that poor people get their due share of efficient health care from the public system.

10. For the implementation of any of the above suggestions, it is imperative to build vigilant citizens' action on this front. Herein emerges the role of NGOs in initiating and campaigning for such a move. It should be in the direction of creating awareness among the people about health care as their right, through various mechanisms which are effective in reaching the lower rungs of the economic ladder. they can also take initiative in campaigning for incorporating minimum health care as fundamental right in the constitution as such, perhaps as part of the 'right to Life (Article 21). This will provide the people a legal mechanism to seek redressal when this right is denied. also, bringing the medical profession under the CPA should also be taken up, for it would confer certain beneficial results such as: medical records will be maintained more rigorously, the patient's right to information will be respected, greater standardization will become necessary, standards of nursing homes will have to improve and corruptive practices will be checked. To begin with, they can even sponsor medical social workers to government hospitals. Implementation of health tax for certain categories of income should also be put forward as outlay for health expenditure tend to decrease. Any effort for greater privatization of health care should be prevented on the grounds that poor will dispossessed and discriminated.

Bangalore Hospitals and the Urban Poor

- Anjana Iyer & Suresh Balakrishnan
(PUBLIC AFFAIRS CENTRE, Bangalore).

A Report Card

A Summary

The quality of hospital services is an important element in the package of services that citizens rely on, during periods of physical disorder and trauma. While medical services have seen many a technical advance, it has been accompanied by increases in costs and complexity. there has been a growing concern over the deteriorating quality of health care provided by public hospitals. These problems become more visible when it comes to the question of health services to the poor.

How do citizens, especially the poor experience these services? What is their feedback to the health care system? where are the improvements required? In order to examine these issues, the Public Affairs Centre, Bangalore, recently designed and carried out a study. The study assesses difficulties encountered by the poor while making use of hospitals, the quality of specific components of service, and the different types of action for improving services. the findings of this study are expected to provide a framework for public interest groups and administrators of health care design systems for improving access to health care for the poor and the quality of service that they receive.

The study of hospital services in Bangalore was conducted by the Public Affairs Centre, a non-profit organisation based in Bangalore, in collaboration with the Citizens' Action Group. This study attempted to generate feedback from the urban poor on the quality of hospital services they receive. Three categories of hospitals were surveyed - Government or "Public" hospitals, hospitals run by the Bangalore City Corporation (BCC) and missionary / charitable trust hospitals.

The study was carried out in three parts;

- Forty one case studies on the experiences of the poor with hospital services

- A field survey using a structured questionnaire on different aspects of feedback from sections of the urban poor on hospital services, and

- A series of interviews with hospital administrators on their perceptions of problems that affect the quality of hospital services.

Conclusions

- The urban poor in Bangalore have been using a variety of options for health care. While Government hospitals play a major role, other hospitals, including Mission and Private hospitals contribute to health care for the poor. Any strategy for health care for the poor has to envisage appropriate inputs for all the institutions involved in this sector.
-
- In terms of costs, Government hospitals come out as the cheapest source of health care for the poor. This is not only in terms of percentage of patients enjoying free treatment, but also of total costs incurred by an overwhelming majority of the patients. The unfortunate part of this otherwise positive phenomenon is that a major part of the costs incurred by the poor are towards illegitimate side-payments often extorted by different participants in the health care system.
-
- But the most significant problems seem to be in the quality of medical care that the poor receive. To start with, the waiting time they have to go through before receiving medical attention and treatment seems to be quite high. Second, injections and medicines, presumably free or subsidised, are often not available at Government hospitals. But the more important problem seems to be the total absence of standards or the lack of awareness among patients about what they can expect at hospitals. It is form this point of view that Mission and Private hospitals seem to be serving the poor in a much better manner.
-
- The manner in which activities are managed in the Government hospitals also merit attention. The seriousness of this problem can be seen from a simple area like cleanliness of hospitals. although there was no major difference in the frequency with which cleaning was carried out across different types of hospitals, the level of cleanliness at Government hospitals were rated in much poorer terms. Similarly, the poor need to run form pillar to post, to find medicines, sometimes in life and death situations, while being treated in Government hospitals - whereas, dispensaries of Mission hospitals are rated to be far more efficient in this regard.
-
- One approach to seeking better quality of medical services and facilities that the poor are compelled to seek, is by resorting to speed money payment. This approach seems to apply to all levels of medical personnel (from doctors to sweepers), and for all types of services (from operations to entry into wards without authorisation). Although there is wide variation in the quantum of payments, the problem seems to be most acute in Corporation Maternity Hospitals, which are used primarily by the poor. Designing interventions to reduce the instances of extortion could certainly begin there.

(In collaboration with CITIZENS' ACTION GROUP, Bangalore).

INFECTION CONTROL COMMITTEES

It is suggested that infection control committees be established in all Health Care settings where bed strength is more than 100 ; and the committee to supervise Health Care Waste Management, Hospital Acquired Infections and General Infection Control.

RESEARCH ACTIVITIES

The investigators suggest that the State Government shall encourage the Civic bodies to take up the following research activities in collaboration with Medical Colleges and Engineering Colleges on priority;

a) developing curriculum for training doctors, nurses, administrators, waste handlers in the area of health care waste management

b) Feasibility studies to recycle metal sharps , plastic items in safe ways

c) techno-economic assessments of solid waste/health care waste in different cities, towns, etc.

d) conducting waste surveys in different Health Care settings including measurement of quantity of such generated waste

e) feasibility studies for efficient establishment and running of common incinerators/ sanitary land filling/ composting etc.

f) sentinel surveillance of hazards due to Health Care Waste management in selected ranges of the City

g) studying sickness absenteeism and causes for the same among waste handlers

h) maintenance and periodic review of morbidity registers of health care personnel