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Recommendations of the Second Punjab Governance Reforms Commission

Eighth Status Report

Eighth PGRC Report on Improving Standards of Public Health Facilities and Medical Education in Punjab

Punjab Governance Reforms Commission
July 2013

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Eighth PGRC Report on Improving Standards of Public Health Facilities and Medical Education in Punjab

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Preface

Compelling challenges like absence of a state health policy, mismatch between centre sponsored disease control programmess in operation and morbidities in the state and the need to put in place process for ensuring availability of essential drugs, requires the Government of Punjab to refocus on structural determinants and policy direction of the Health sector. With increase in life style diseases communicable health problems still are significant. The culture of medical practice needs to be shifted towards social context of health and ill health. When people fall ill their social position should not determine their access to health services and quality of treatment; health services are one of the channels for reducing inequalities. The report deals with recommendations for improving standards of Public health facilities and seeks state intervention to reorient public health education /curricula and pedagogy in order to strengthen social determinants and health. It also addresses some of the major challenges facing the health administration such as shortfall of core specialties as well as other staff, recognising limitations of Contractual professionals to meet this shortfall, special incentives for Rural Service and bring back health management and accountability to health professionals.

Pramod Kumar

Chairman, PGRC

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Section I

Improving the Standards of Public Health Facilities

Perspective

Punjab, home to the Green Revolution, is striving hard to achieve the Millennium Development Goals. It is at a more advanced stage of human development than many other states of India. In terms of the Human Development Index, it ranks 5th among Indian states. Education and health are important areas focus in the state. During the 1970s and 1980s, reasonable funds were allocated to develop public health services. Since the mid-1980s, growth slowed and the state got pushed into a financial crisis. Since then, several Indian States have achieved GDP growth rates higher than Punjab. It now ranks 8th in terms of per capita GDP (Rs 91,575)**.** Punjab is among the three major debt-stressed states in India. Consequently, state allocation of funds to the social sector, especially the public health sector, has stagnated. The implementation of the National Rural Health Mission, a flagship programme of the Government of India, has given a fresh impetus to health sector activities in Punjab as has also happened in other states.

Structure and Functions

Punjab's Department of Health and Family Welfare is responsible for providing public healthcare services in the state. In 1973, the Department of Medical Education and Research was separated and DoHFW, through the Directorate of Health Services, is now responsible for primary and secondary healthcare. In the year 1995 the Punjab Health Systems Corporation (PHSC) was set up through a special Act. At present, PHSC provides healthcare in over 176 Health Institutions which include 19 District Hospitals, 2 Special Hospitals, 43 Sub-divisional Hospitals and 123 Community Health Centres. The Directorate of Health Services continues to manage Primary Health Centres (PHCs) and Sub-Health Centres (SCs). It is also responsible for the administration of centrally funded health and family welfare programmes. Since 2005, Punjab is also implementing the National Rural Health Mission funded by the Union Ministry of Health and Family Welfare. Mission Director NRHM is responsible for administration of the Mission, which is implemented largely

through the health institutions of PHSC and DHS with some involvement of subsidiary health centers/rural dispensaries. Industrial workers are served by the ESI Corporation through a separate directorate in DoHFW with fund sharing between Ministry of Labor, GOI and State Govt.

The State of Punjab has also devised an additional healthcare delivery system in the rural areas wherein since 2006 health care in 1310 Subsidiary Health Centres (SHCs) is provided by the Rural Development Department through Zila Parishads by engaging doctors and paramedics on a 'service contract' basis. In urban areas, Municipal Committees/Corporations have a rudimentary public health service. Several thousand private medical practitioners in the formal and informal sector (including quacks) provide medical care for a fee in urban and rural areas.

In all, four government departments are involved in the delivery of public health and medical care in Punjab namely, the Department of Health and Family Welfare, Department of Medical Education and Research, Department of Rural Development and Panchayats and Department of Local Bodies. The Health Department has a separate administration for Directorate of Health Services, PHSC, and NRHM. Coordination for strategic planning, monitoring and evaluation of the health system in terms of infrastructure, human resources, logistics, governance, service provision and quality of care is vital for the smooth functioning of the health system. Hence, a coordination mechanism needs to be set up in the state for the development of a responsive health system that can meet the needs of public health and healthcare in the foreseeable future.

Current Health Scenario

Health indicators in Punjab are better than many other states. It ranks third in the country in terms of birth rate (16.2 per 1000 population) (Sample Registration System Bulletin 2012). The infant mortality rate of 30 per 1000 live births places it at fifth rank (Sample Registration System Bulletin 2012). It has a maternal mortality ratio of 172 per 100,000 live births (Sample Registration System MMR Bulletin 2007-09). The percentage of fully immunised children is 83% (Coverage Evaluation Survey 2009). Around 61% of deliveries are conducted

in health institutions; the share of government and private institutions stands at 22% and 39% respectively (Coverage Evaluation Survey 2009). On the other hand, only 52% children under the age of five years with diarrhea receive oral rehydration therapy (ORT) (Coverage Evaluation Survey 2009) and only a few receive zinc (National Family Health Survey-3). Only 13% of under-five children with acute respiratory infections receive antibiotics (National Family Health Survey-3) (Annexure 1).

A major concern is the rising cost of medical care. Average expenditure for hospitalization in Punjab is Rs. 15,431 which is one among the highest across the country (Prinja S et al. Indian J Med Res 2012;136(3):421-31). Even in government health institutions, average out-of-pocket expenditure is Rs. 270/- per OPD consultation and Rs. 7,700/- per hospitalization (Prinja S et al. Indian J Med Res 2012;136(3):421-31) (Annexure 1). User charges, inadequate supply of medicines and other surgical supplies and lab reagents has led to escalation in the cost of medical care in government health institutions. The state does not allocate adequate budget for medicines and supplies. User fees collected by Rogi Kalyan Samitis and NRHM funds allocated by the Government of India are used to partially meet expenses related to medical and surgical supplies. At least 20% of the health budget should be allocated for medical and surgical supplies. Clearly, declining outlay on social sectors is responsible for a cut on soft items in budget such as medicines.

The public health share out of the total budgetary expenditure has plummeted from around 9% during 1980-81 to 6.97 per cent during the 1989-90, 5.46 per cent during 1992-93, falling to 4.35 per cent during 2004-05. Within the health sector, the share of medical education, research and training has consistently gone down. This has adversely affected teaching and training of medical personnel and the development of clinical skills leading to deterioration in tertiary, secondary and primary health care. The population served per bed in rural areas has increased from 1276 during the early 1980s to 1555 during the last decade. In this scenario, an overwhelming majority of services are sought from private health care practitioners at high cost leading to catastrophic health expenditure which pushes many families to live below the poverty line. Allocation of Rs 1700 per capita per year is needed to provide basic health care to every citizen of Punjab.

A. Status of Health Facilities

Methods

Two teams were constituted for visiting a sample of health facilities in Fatehgarh Sahib, Mansa and Tarn Taran District (Annexure 2). The teams were comprised of faculty, resident doctors and other public health workforce from the School of Public Health, PGIMER Chandigarh. A list of health facilities in Fatehgarh Sahib, Mansa and Tarn Taran District was obtained. Ten health facilities were visited initially to cover all the blocks in the Fatehgarh Sahib District as well as different levels of health facilities. However, three more health facilities were later also visited, making total of 13 health facilities covered. In Mansa District, 12 health facilities were visited to cover all the blocks as well as different levels of health facilities. In Tarn Taran District, seven health facilities were visited to cover all the blocks as well as different levels of health facilities (Annexure 3). The teams visited the selected health facilities and review the functioning of the facility in terms of its service provision, human resources, logistics, supplies, infrastructure etc. The teams also visited few households to look into the utilization of health services and quality of care. Following methods were used to review the health facility functioning.

1. Record reviews
2. Interviews with the service providers
3. Exit interviews with the patients coming to the health facility
4. Interviews with the community members

A rapid review of a sample of health facilities revealed that the capacity of health services is low, the administration and supervision mechanism is weak, human resources are inadequate, medical and surgical supplies are irregular and inadequate, as are laboratory and investigation facilities. However, the status of buildings and equipment is at a satisfactory level. The Information system is also functioning well. The Free Emergency Response Service has made its presence felt contributing to trauma care, maternal and neo-natal services and overall accessibility of healthcare facilities. Health services are serving large number of people despite constraints (Annexure 4a-d). NRHM has activated most of the peripheral health institutions such as Sub-centres and Primary Health Centres. With

right direction and support, health services can perform better. The salient features of key elements of health services are described below.

1. **Physical Infrastructure**

Most of the health facilities are easily accessible thanks to motorable roads. The building and general infrastructure at most health care facilities are reasonably well constructed but need proper annual maintenance. Residential quarters, in particular, need major overhaul.
The number of functional beds in a health facility is below the standard for that set up. Arrangements for continuous electricity and water supply are in place at most of the health care facilities. However, at some facilities, power cuts are a major worry. Despite having inverters or generators, the problem persists because the use of generators is a costly affair due to consumption of diesel. There is proper signage in most health institutions; list of health services are available; notice boards on duty days and timings; doctors on duty are available. Health education material in the local language is also on display.

2. **Human Resources**

Most of the hospitals are plagued with the problem of vacant posts of medical, paramedical and support staff. There is an acute shortage of specialists, in particular, Gynaecologists, Paediatricians, Radiologists, and Anaesthetists (Annexure 4a). The vacancy position ranges from 26% (general doctors) to 38% (specialists), and 31% posts were lying vacant for nurses. Twelve percent posts for paramedics involving pharmacists, lab technicians, radiographers and operation theatre technician were also vacant. A separate cadre for General Medical Officers and Specialists does not exist; as a result, OPD services suffer since specialist doctors have to handle emergency duties and administrative duties as well. Frequent transfers of doctors are a cause for concern in most health facilities. Also, recruitment and appointment of specialists takes a while and it is a long time before a specialist can actually be appointed at the health facility. This forces patients to look towards private health institutions.
Due to acute shortage of paramedical staff, particularly staff nurses, laboratory technicians and support staff, all beds available in an institution are not utilised. To overcome the shortage of specialist doctors in the State, a new recruitment policy has been initiated in which monthly walk-in interviews are held and campus placement is being done. The

recruitment of medical, paramedical, technical and other support staff also needs to be fast-tracked.

3. Medicines and surgical supplies

In most of the health facilities, less than half the quantity of medicines required is available. The supply of drugs from DHS and PHSC is irregular. Most of the health facilities have to buy medicines from user charges or *Rogi Kalyan Samiti* funds. Despite this most patients are required to purchase the medicines from outside. Non-availability of drugs at the health facility promotes dissatisfaction within the health services staff and among patients.

In the Budget for 2012-13, Government has announced that essential generic drugs will be provided free of cost at all public health facilities. A list of 277 medicines and consumables has been finalized. It has been decided to follow a single rate contract for the procurement of medicines, consumables and material at the State Head Quarter which can be used for purchases at the hospital level. Rate contracts for 159 essential drugs, 24 consumables, X-ray films, etc, have been finalized and flow of medicines started with effect from Jan 1, 2013. Sufficient funds have been provided in the Programme Implementation Plan of the NRHM for the year 2012-13 for providing essential drugs free of cost to all patients visiting Public Health Facilities in the State. However, sustained and adequate provisions need to be made in the state budget each year to ensure the sustenance of this excellent endeavour.

4. Equipment

Most equipment is available, but inadequate supply of reagents affects the performance of laboratory services at most of the health facilities. X-ray facility is available at most places, whereas in some places X-ray machines are not fully utilized due to the absence of X-ray technicians. Ultrasound facilities are not available in many centres due to non-availability of radiologists. Due to the shortage of surgical specialist/anaesthesiologist, equipment in operation theatres remains unused at certain centres.

5. Ambulance Service

The Emergency Response Service ambulance network (Dial 108) is operational. Medical, para-medical staff and beneficiaries have confidence in this service. The catchment area for referral institutions needs to be worked out so as to ensure optimum utilisation of all kinds

of government health facilities. However, the ambulances need to be equipped with trained staff to take care of emergency during transportation.

6. Health Management Information System

Most of the registers/records are updated regularly**.** All reporting formats are being maintained properly and are sent to higher institutions on time. HMIS initiated by NRHM is also operational. Pooling of all types of information into a repository could be helpful in streamlining planning.

7. Financing

Funds made available under *Rogi Kalyan Samiti* are insufficient and were provided very late to the institutions. Funds are utilized for improving health services e.g., for maintenance of infrastructure, purchase of drugs and surgical materials, purchase of inverter, maintenance of generator etc. Delay or non-availability of funds hampers routine service delivery. A large proportion (45%) of user-charges is spent on drugs and other consumables due to their short supply.

8. Governance

Monitoring and evaluation is also weak since Medical Officers do not get time to supervise the work of their subordinates and field staff. Paramedical supervisors are not available in the system. Keeping in view the above mentioned observations, the following steps need to be taken by the Government of Punjab so as to prepare itself to deliver universal health care.

A. Recommendations

a. Health Financing

i. **Increased budget allocation to health sector:** Presently state is spending about Rs. 1200 crores (0.46% of GDP) as compared to 0.9-1.2% of GDP at National level. We may require raising health sector budget to national level and then progressively increase to achieve a target as suggested for provision of health to all (Annexure 5). State budget should be increased to provide health care initially to women, girls and the elderly and in due course, to all. In particular, the state non-plan budget on

drugs, consumables and equipments should be raised. This will certainly reduce household out-of-pocket expenditure and provide relief to poor households

ii. Effort should be made to identify unproductive expenditure and idle resources eg some of equipments were observed to be not in use. There is need for optimal utilization of existing resources.

iii. A rapid review of the Rashtriya Swasthya Bima Yojana that was implemented a year ago, should be carried out so as to assess the poteintial for scaling up universal health care.

b. Governance

iv. There is urgent need to regulate private clinics, nursing homes and laboratories. A Committee has been constituted to give recommendations for the draft of a Punjab Clinical Establishment Act. This effort should be taken forward on priority.

v. State Health Authorities/ Municipal Committees/ Panchayati Raj Institutions should be empowered with a Public Health Act for preventing the spread of diseases and protection, promotion and maintenance of public health. Although there are a number of legal mechanisms to support public health measures in an epidemic situation, they are not being addressed under a single legislation. There is an urgent need to assemble all the provisions in one over-arching public health legislation, so that the implementation of the responses to an epidemic can be effectively monitored. A sound Public Health Act infrastructure is important because it establishes the powers and duties of government to prevent injury and disease and promote the population's health. It empowers the government to take special measures and prescribe regulations that are to be observed by the public to contain the spread of the disease. It ensures broad legal framework for providing essential public health services and functions and powers to respond to public health emergencies through effective collaboration. The act will cover environmental health hazards, health promotion and behavior change, housing, food hygiene, communicable disease control, water safety and sanitation, vector control, measures during fairs and festivals, waste management etc.

c. Human Resources

vi. Urgent efforts should be made to fill up all the vacant positions as per State norms initially and should be increased as per Indian Public Health Standards in phased

manner. Rational human resource deployment policy should be adopted. Specialists should be paid more than the general doctors and rural medical officers. This will attract more specialists to serve on public health institutions.

vii. The sanctioned staff strength is inadequate to provide the requisite service level. An assessment should be done for the State to find out how many staff positions need to be created for all categories of health personnel including doctors for up-gradation of health facilities to the IPHS. This will help in planning and recruitment of the required specialists and Medical Officers in future.

viii. Separate administrative cadre/ public health cadre may be developed for administrative posts at State, District, Sub-division and Block level.

ix. Proper and well maintained residential accommodation for doctors and other staff may be provided at all levels of health centres as per requirement.

x. To overcome the shortage of Radiologists and Anaesthetists, efforts should be made to involve Radiologists and Anaesthetists in private sector by giving appropriate financial incentives, so as to ensure uninterrupted service delivery at public health institutions.

d. Health Care Delivery

xi. The District Hospital should be adequately suitably staffed with specialists in Obstt & Gynae, Medicine, Surgery, Paediatrics and Anaesthesia, and equipped with laboratory and radiology facilities to provide comprehensive health care services.

xii. Rationalisation of emergency services in select predesignated institutions so that say in a radius of 30 km one institution is fully equipped to handle 24x7 emergencies and there is no overlapping.

xiii. Community Health Centres should be strengthened as per IPHS standards. Anesthetist should be posted at a CHC.

xiv. Networking of district level health care facilities with the Medical Colleges in the State

xv. Citizens' participation in healthcare is desirable and must be encouraged to attract donations/resources from philanthropic groups. Maintenance is a problem with hospitals and they must be encouraged to look for local partnerships in the maintenance of supportive services so that funds being spent on them currently can be used for patient care. Similarly efforts can be made to attract donor interest in

hospitals through imaginative techniques that may appeal to NRIs, local industry and so on.

e. Drugs & Technology

xvi. Ensure continued supply of essential drugs and other consumables, lab reagents etc. at all public health institutions. A framework for monitoring and supervision should be set up to resolve the procurement and supply issues that may arise from time to time. There should be a regular practice of prescription audit to discourage doctors from overprescribing or prescribing drugs from outside. An online system of inventory control and monitoring of the procurement and supply chain should be developed to know the lead time status and to keep an eye on the entire mechanism.

xvii. With the current trend of rising incidence of non-communicable diseases, the list of common ailments, essential drug list and drug dispensing policy should be modified if the budget permits. The drugs for monthly supply should be provided to patients with chronic diseases like hypertension, diabetes etc..

xviii. Efforts should be made to ensure that all the required reagents and equipment in the laboratories are available in functional condition. For those special investigations, which cannot be carried out at the public health facilities due to various reasons, the authorities should tie up with private laboratories at pre-negotiated consessional rates so that patients can be referred to these laboratories and they do not end up paying a higher price for investigations.

xix. The facilities of MRI, CT scan, Mammography and other advanced investigations are under consideration to be provided at District Hospitals in Public-Private Partnership mode. The same should be extended for provision at Sub-divisional Hospitals.

f. Information System and Monitoring:

xx. Pooling of all health related information into a repository.

xxi. External monitoring and evaluation of service/performance of the Public Health Institutions in the State of Punjab should be done by an independent agency like School of Public Health, PGIMER Chandigarh. This will provide inputs for better performance of health services.

xxii. State Bureau of Health Intelligence(SBHI) on the pattern of CBHI

- Will produce health intelligence for policy and planning

- Think tank for strategic initiatives
- Monitoring of health indicators and recommendations
- Publication of annual Health Profile of Punjab

xxiii. A system of showcasing good practices may be set up so that hospitals and individuals who perform better on monitorable indicators are rewarded with more facilities and incentives to boost morale.

Annexure 1

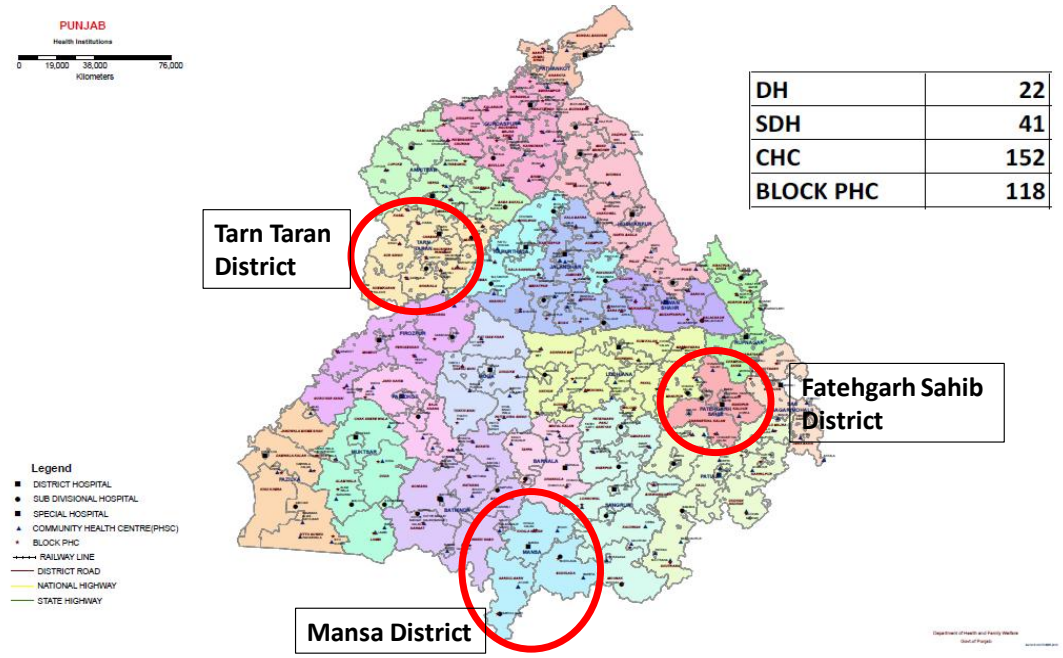
Comparison of Health Indicators

Health indicators	India	Punjab	Source
Birth rate	21.8 per 1000 population	16.2 per 1000 population	SRS Bulletin (2012)
Death rate	7.1 per 1000 population	6.8 per 1000 population	SRS Bulletin (2012)
IMR	44/1000 live births	30/1000 live births	SRS Bulletin (2012)
MMR	212/100000 live births	172/100000 live births	SRS Bulletin (MMR)(2007-09)
Full Immunization %	61%	83%	CES 2009
Child under 2, with Diarrohea , received ORT	43%	52%	CES 2009
% of Institutional deliveries	73 %(Public=47%, Private=26%)	61% (Public=22%, Private=39%)	CES 2009
OPD public sector	20%	16%	NSSO (60th round) Prinja S. Health care inequities in North India: role of public sector in universalizing health care. IJMR 2012
IPD public sector	40%	30%	
Out of Pocket Expenditure	OPD-Rs 201, IPD-Rs 5695	OPD-Rs 348, IPD-Rs 9000	

Annexure 2

Health Facility Review

Fatehgarh Sahib, Mansa & Tarn Taran Districts



DH	22
SDH	41
CHC	152
BLOCK PHC	118

Annexure 3

Health Facilities: Sample

Type of Health Facility (Population)	Fatehgarh Sahib (6 Lakh)		Mansa (8 Lakh)		Tarn Taran (11 Lakh)		All (25 Lakh)	
	Number	Sample	Number	Sample	Number	Sample	Number	Sample
District Hospital	1	1	1	1	1	1	3	3
Sub-Division Hospital	1	1	1	1	1	1	3	3
ESI Hospital	1	0	0	0	0	0	1	0
CHC	4	2	4	2	9	1	17	5
PHC*	14	4	17	4	28	2	59	10
Rural Dispensary	23	3	37	2	59	1	119	6
Urban Dispensary	6	0	1	0	0	0	7	0
Sub centre	73	2	101	2	153	1	327	5
Total	123	13	162	12	251	7	536	32

*PHC include Rural Hospital, Block PHC and Mini-PHC

No. of functional beds: 678
(203 in Fatehgarh Sahib , 192 in Mansa & 283 in Tarn Taran District)
(includes beds at District Hospital, Sub divisional Hospital and CHCs)

Annexure 4a

Staff

Staff categories	Fatehgarh Sahib	Mansa	Tarn Taran	Total	Vacancy (%)
	Posted (Sanctioned)	Posted (Sanctioned)	Posted (Sanctioned)	Posted (Sanctioned)	
Specialist doctors	37 (52)	27 (50)	36 (60)	100 (162)	38
General doctors	33 (38)	27 (55)	63 (74)	123 (167)	26
Nurses	53 (61)	39 (57)	67 (112)	159 (230)	31
Paramedics*	52 (64)	63 (73)	150 (164)	265 (301)	12
Supervisors**	28 (31)	29 (51)	86 (93)	143 (175)	18
Health Workers (F)	92 (96)	102 (106)	252 (281)	446 (483)	8
Health Workers (M)	28 (73)	50 (103)	113 (147)	191 (323)	41

*Pharmacist, Lab technicians, Radiographer, OT technician
**LHV, Sanitary Inspector, Food Inspector, Drug Inspector, Block Extension Educator

Resources in District Fatehgarh Sahib, Mansa & Tarn Taran

Health personnel	Norms	Fatehgarh Sahib	Mansa	Tarn Taran	Total
Doctor : Nurse	1 : 3	1.3	1.4	1.5	1.3
Doctor : Population	1 : 3500	8,569	14,237	11,773	11,364
Nurse : Population	1 : 5000	11,317	19,713	17,396	15,938
Pharmacist : Population	1 : 10000	16,662	15,376	14,389	15.175
Lab technician : Population	1 : 10000	1,19,963	85,423	24,799	41,544
ANM : Population	1 : 5000	6,520	7,537	4,625	5,682
Bed : Population	1 : 3333	2,955	4,004	4,118	3,738

Annexure 4b

Services in Fatehgarh Sahib & Mansa District

Service output	Fatehgarh Sahib	Mansa	Tarn Taran	Total
OPD patients	4,09,183	4,49,572	7,40,650	15,99,405
IPD patients	17,499	25,288	23,914	66,701
Surgeries	18,836	12,694	16,814	48,344
Deliveries	2,723	4,854	5,260	12,837
Lab tests	1,93,176	2,27,106	3,32,861	7,53,143
X-Rays	20,151	34,777	29,701	84,629
Bed Occupancy (%)*	75.1	69.1	51.9	65.3

*Bed occupancy= [In-patient Days/(No. of **functional** beds*365)]*100

Service output/staff/day
Fatehgarh Sahib, Mansa & Tarn Taran Districts

Output indicators	Average Number/day
OPD patients/Doctor	39
Caesareans/OBG doctor	1
Surgeries/Surgeon*	6
Deliveries/Nurse	1
Lab tests/technician	74
X-rays/Radiographer	20

*Includes Departments of Surgery, Orthopedics, Eye, ENT

Utilization of Health Services for Illness Treatments & Hospitalizations

Parameter	Fatehgarh Sahib	Mansa	Tarn Taran	Total
Population	5,99,814	7,68,808	11,65,535	25,34,157
Estimated No. of ailments*	16,68,443	21,38,516	32,42,052	70,49,011
No. of ailments attended by Health Service	3,16,832 (-81%)	3,58,920 (-83%)	7,40,650 (-77%)	14,16,402 (-80%)
Estimated No. of hospitalizations/ year*	17,994	23,064	34,966	76,025
No. of hospitalizations/year by health services	17,499 (-3%)	25,288 (+1%)	23,914 (-32%)	66,701 (-13%)

*As per NSSO 60th round, figures in parenthesis are estimated gap in service utilizations

Status of Health facilities: Fatehgarh Sahib District

5=Very good, 4=Good, 3=Satisfactory, 2=Poor, 1=Very poor

Health facility Blocks of Health System	District hospital	Sub divisional hospital	CHC	Block PHC	Mini-PHC	SHC	Sub centre	OVER ALL
Building	3	3	3	2	3	3	4	3
Human resources								
•Specialist	3	3	2	2	2	-	-	2
•Medical personnel	3	3	4	4	2	3	-	4
•Para medical personnel	2	2	2	2	2	3	3	3
•Support staff	2	2	2	3	-	-	-	2
Drugs	2	2	2	3	2	2	3	2
Equipments	3	3	3	3	3	2	4	3
HMIS	3	3	3	3	3	3	4	3
Financing	3	3	2	3	3	2	4	3
Governance	3	3	3	2	2	2	3	2
OVERALL	3	3	3	2	2	2	4	3

Annexure 4d

Status of Health facilities: Mansa District

5=Very good, 4=Good, 3=Satisfactory, 2=Poor, 1=Very poor

Health facility Blocks of Health System	District hospital	Sub divisional hospital	CHC	Block PHC	Mini-PHC	SHC	Sub centre	OVER ALL
Building	3	3	4	4	4	3	4	3
Human resources								
•Specialist	2	1	1	3	1	-	-	2
•Medical personnel	3	1	2	3	1	1	-	2
•Para medical personnel	2	2	3	3	1	3	4	3
•Support Staff	2	3	3	3	-	-	-	2
Drugs	3	2	2	3	2	4	4	3
Equipments	3	3	3	3	3	2	4	3
HMIS	3	3	4	3	3	3	4	3
Financing	3	3	3	3	3	3	4	3
Governance	3	2	3	3	3	2	3	3
OVERALL	3	2	3	3	2	3	4	3

Status of Health facilities: Tarn Taran District

5=Very good, 4=Good, 3=Satisfactory, 2=Poor, 1=Very poor

Health facility Blocks of Health System	District hospital	Sub divisional hospital	CHC	Block PHC	Mini-PHC	SHC	Sub centre	OVER ALL
Building	3	3	3	3	3	2	3	3
Human resources								
•Specialist	3	3	2	2	-	-	-	2
•Medical personnel	3	3	4	2	3	3	-	3
•Para medical personnel	3	2	3	2	3	3	4	3
•Support staff	2	2	2	2	1	-	-	2
Drugs	3	3	3	3	3	3	2	3
Equipments	3	3	3	3	2	3	4	3
HMIS	4	4	3	3	3	3	4	4
Financing	3	3	3	3	3	3	4	3
Governance	4	3	3	2	2	2	3	3
OVERALL	**3**	**3**	**3**	**2**	**2**	**3**	**3**	**3**

Annexure 5

Financial Estimations for Punjab

Health Budget	Current Allocation	Proposed Allocation		
		Scenario 1	Scenario 2	Scenario 3
Percent GDP (%)	0.46	1.50	2.50	3.80
Per Capita (Rs)	433	1404	2341	3558
Overall Allocation (Crore Rs.)	1200	3891	6485	9858

Section II

Improving the Standards of Medical Education

Perspective

Punjab is among prosperous states in India with its health indicators better than many other states and the national average. It ranks as third state in birth rate (16.2 per 1000 population) and ninth in death rate (6.8 per 1000 population). The infant mortality rate is 30 per 1000 live births which places it at fifth rank. It has maternal mortality rate of 172 per 100000 live births. However, there is a lot which still needs to be improved and this can be achieved through a multipronged strategy which should include building-up the capacity and competence of health care professionals. Medical Colleges play an important role in the training and development of health care professionals, besides providing the much needed tertiary level medical care. The Government Medical Colleges in the State have been the major tertiary level medical care providers and have produced highly competent doctors and medical scientists. However, a need has been felt to maintain the high standards set in the past and to further improve the quality of medical education and patient care in the government run medical institutions of the State.

Government Medical Colleges in Punjab work under the administrative control of the Department of Medical Education & Research, Government of Punjab. Headed by a Minister of cabinet rank, the Department has an Administrative Secretary and subordinate functionaries. The Directorate of Research & Medical Education was established in the Year 1973 by bi-furcating the Directorate of Health Services. The main function of this Directorate is to facilitate development of quality medical facilities in Government and Private medical institutions and to provide for high quality medical and paramedical manpower in the region.

Hospitals attached to the Medical colleges cater not only to the health and family welfare needs of the adjoining areas but also cater to the specialized services and as referral hospitals providing secondary and tertiary health care facilities. Special clinics like Diabetic, STD, Leprosy, Antenatal, Family Planning and Well Baby Clinic have also been established in

these hospitals for the benefit of the patients. De-addiction Centers have been started in all the State Medical Colleges.

To give impetus to the development of quality medical education, Baba Farid University of Health Sciences was established under B.F.U.H.S. Act 1998. At present, there are 10 medical colleges affiliated to Baba Farid University of Health Sciences. These are Guru Gobind Singh Medical College, Faridkot; Govt. Medical College Amritsar; Govt. Medical College Patiala; Christian Medical College Ludhiana; Dayanand Medical College Ludhiana; Sri Guru Ram Das Institute of Medical Sciences & Research, Amritsar; Adesh Institute of Medical Sciences & Research, Bathinda; Gian Sagar Medical College & Hospital, Patiala; Punjab Institute of Medical Sciences, Jalandhar; and Chintpurni Medical College & Hospital, Pathankot.

Government Medical College at Amritsar is the oldest medical college of the State and among the oldest medical institutions of the northern India. The college is training 150 MBBS graduates every year. Government Medical College at Patiala is the second oldest medical college of the State. It was started in 1953 with the intake of 50 students for MBBS and at present 150 students are admitted every year for the MBBS course. Guru Gobind Singh Medical College, Faridkot was established in 1973. Since then the college has trained over 50 MBBS doctors every year. Besides MBBS graduates, these institutions train postgraduates (MD/MS) in various disciplines. These Institutions have provided brilliant doctors and medical scientists not only to prestigious institution of India like Postgraduate Institute of Medical Education & Research, Chandigarh and All India Institute of Medical Sciences, New Delhi but also to many other prestigious medical institutes in the world.

In order to keep pace with the advances in medical care and education that is taking place elsewhere and to improve the academic environment of these medical colleges, the Task Group concerned itself with the up-gradation of standards of patient care services and medical education in these institutions. Two sub-groups were constituted for visiting Govt. Medical Colleges at Amritsar and Patiala for taking stock of the condition in these medical colleges in terms of the personnel and facilities etc.

Situational Analysis

1. Faculty at Government Medical Colleges

(i) In the recent past, some senior level faculty members have left government medical colleges and joined private medical colleges. Higher financial remuneration offered by these private sector medical colleges could be a major reason for this attrition. However, working conditions and environment conducive for growth and development can reverse this trend. The faculty at present in government medical colleges felt a need for professional development programmes to improve their skills in the research methodology, writing research papers, teaching skills, etc. The agencies like Indian Council of Medical Research, Department of Science and Technology; and institutes like PGIMER Chandigarh and AIIMS, New Delhi could be requested to conduct professional development programs for the Faculty.

(ii) Most of the power centered around the Heads of Departments. Other faculty members in the Departments were not consulted sufficient enough to improve training of graduate and postgraduate students; or to improve working conditions of the Departments. A need was felt to hold regular faculty meetings in the Departments for appraisal of needs and development of the Departments.

(iii) Medical colleges were found facing shortage of Senior Residents. One of the main reasons was considered to be the current practice to recruit Senior Residents from the Punjab Civil Medical Services (PCMS) cadre and that has created its own set of difficulties. After completion of MD/MS, a PCMS doctor is needed to serve for one year in the parent department before becoming eligible to join Senior Residency. This time gap of one year de-motivates many to pursue Senior Residency. In super-speciality departments, candidates with only post-graduate qualifications (MD/MS) were appointed at some time as faculty members and they have not received till date three-year training in super-specialty. This has created quite an anomalous situation. Medical Council of India has formulated a plan to designate the faculty in medical colleges as per three tier system. However, the faculty positions are placed in multiple tiers in these medical colleges. This affects their relative position vis-à-vis faculty members in

medical colleges elsewhere and also affects their promotional and financial prospects.

2. Teaching and Training of Students at Government Medical Colleges

(i) The information presented during lectures in classes often contains the central concepts of the course. Traditionally, transfer of knowledge via handwritten lecture notes or didactic lectures was an essential element of academic life. Modern learning methods generally incorporate additional activities, e.g. group exercises, group discussions and even student presentations etc. The use of audio-visual aids has changed the format and content of learning sessions. The lectures delivered during theory classes in these medical colleges of the State were didactic, boring and continuous without any break. In addition to regular theory classes, students also need evening bed-side classes/rounds to improve knowledge which is not done at present. The exposure to community-based teaching was also deficient. The medical college requires urban and rural field centers under their administrative control for smoothly conducting community-based training of students and interns.

(ii) For postgraduate students, the rotation in various departments is required not only to enhance but also to enrich their knowledge and practical skills in various disciplines related to their area of specialization. However, such practice is not followed in these medical colleges. There is an urgent need to appoint Faculty Coordinators for undergraduate and postgraduate studies. A plan of teaching activities and methods for every six months must be prepared in advance for each discipline. Inter departmental collaborations are woefully lacking.

3. Infrastructure at Government Medical Colleges

(i) Library provides physical or digital access to study material for references or borrowing. It should contain catalogue, books, periodicals, newspapers, journals, computer with internet facility, thesis database etc. In government medical colleges of Punjab, the library infrastructure and facility was found inadequate e.g. the books were old, only limited journals were available, 24 hours services were lacking. The lack of provision of separate annual funds for library is the main reason for such appalling conditions..

(ii) The infrastructure particularly of hostels and dissection halls also requires attention. The hostel buildings are very old and students often face problems of water and sanitation facilities. The limited number of cadavers force many students to work on single cadaver only which hinders their learning. Alternative methods like computer simulations are very much needed to overcome such shortages. There was lack of critical facilities like clinical photography department, medical education and research cells and even the provision of MRI facility in one of the medical colleges.

(iii) Telemedicine uses information technology and telecommunication in order to provide clinical health care at a distance. It permits communications between medical personnel and experts with convenience and fidelity, as well as transmission of medical, imaging and health informatics data from one site to another. Telemedicine can be used as a teaching tool by which experienced medical staff can observe, show and instruct medical staff in another location, more effective or faster examination techniques. The medical colleges in Punjab are linked with district hospitals and PGIMER, Chandigarh via telemedicine. But telemedicine link with PGIMER Chandigarh is underutilized. All the medical colleges have been provided with connectivity through National Knowledge Network which should be used for transmission of teaching sessions and case discussions.

4. Administration at Government Medical Colleges

(i) The local administration of medical colleges is carried out by the Principals of respective colleges. The administration of the hospitals attached to medical colleges is under the control of Medical Superintendents. However, for a long time there is no appointment of the regular Principal and Medical Superintendent in these Colleges. There is no sanctioned substantive post of Principal and Vice-Principal. Principals have very limited financial powers. It was told to be pathetically low as Rs. 500/- . The user charges generated in hospitals are sent to State Treasury rather than being utilized for the improvement of facilities and services at medical colleges.

Recommendations

The availability of talented medical faculty and bright students in the Government Medical Colleges of Punjab is a cherished desire. Appropriate attention is required to be paid to enhance their knowledge and skills. Administrative support and access to latest technology and gadgetry for optimal patient care is critically needed. In addition effective governance and accountability is also desired to revamp the medical education and services in these medical colleges. There are actions which can be taken at the local level i.e at the level of Medical College Administration itself. However, there are actions which are required at the level of higher State administration. Accordingly, following recommendations are being made to improve the standards and conditions of medical education and patient care at the Government Medical Colleges of the State of Punjab.

I. At the level of Medical Colleges:

1. To constitute a College Council comprising HODs and 10 senior most Professors of the medical college and this should meet every two months.
2. To constitute Academic Committees and Hospital Management Committees at respective Government Medical Colleges.
3. To take steps to document department wise staff shortages, faculty vacancies and the need to create new posts. The medical college administrations should apprise higher authorities of the need to bridge the gap.
4. To submit proposals for creation of super-specialities with adequate justification for the man power and the equipment.
5. To hold regular faculty meetings in the Departments.
6. To prepare a list of facilities/equipment that is critically required for the optimal functioning of respective Departments and for academic training.
7. To appoint Faculty In-charge/Faculty Coordinator for UG and PG studies and to establish/energize Medical Education Cell at each college.
8. To prepare a plan of teaching activities and methods for six months including schedule for evening teaching and rotation in superspeciality departments and this needs to be appraised at three months interval.
9. To improve medical record keeping for educational and research purposes

10. To constitute Research Cell for facilitating extra mural research, to facilitate inter departmental research collaborations and to provide fora for sharing of research activities of the departments.
11. To hold Annual Convocations of the College for symbolism and identity.
12. Each college should make a mission statement on its vision and core values.

II. At State level:

A. Short term:

1. To have regular appointments for the posts of Principal and Medical Superintendent; and to revive the posts of Vice Principal and Deputy Medical Superintendent.
2. Strengthening/initializing various super-specialities in the medical colleges to meet the demands for specialized medical care and improve the standards.
3. Anomaly created because of appointing MD/MS candidates in super-specialty departments needs to be corrected.
4. To resolve the issue of shortage of Senior Residents by streamlining appointment of fresh eligible candidates and change in quota for PCMS candidates in MD/MS courses and Senior Residency positions.
5. To plan professional development programs for the Faculty emphasizing teaching skills, research methodology etc.
6. To increase the working hours of Govt. Medical Colleges in State after having consultation with faculty.
7. To provide latest technology like MRI/CT scan and other necessary facilities, to ensure effective patient care, and training and research activities.
8. Medical record section should be strengthened.
9. Telemedicine and Tele-education link with PGIMER, Chandigarh (and similar other institutions) should be strengthened for improving patient services and education and training of residents.
10. Library facility should be modernised.
11. User charges should be spent for improving facilities in the college instead of being transferred to central treasury.
12. The financial powers of the Principals and the Medical Superintendents must be enhanced for their optimal functioning of day to day need of the institution.

13. The faculty of medical colleges should be entitled to fellowships, academic allowance, and academic leave for attending conferences etc.
14. There should be a separate provision annually for research funding and attending conferences (one National conference every year and one International conference every two years with active participation such as presenting a paper being the basic requirement).
15. Visiting faculty from other institutions such as institutes of national importance and ICMR institutions should be invited to medical colleges at regular intervals to share their knowledge and experience and mentor the local faculty.

B. Long term:

1. To have urban and rural field centers under the administrative control of medical colleges for training of students in preventive medicine.
2. Improvements in conditions of hostels for UG and PG students, dissection hall facility, lecture theatres etc.
3. Expansion of UG seats should only be done after adequate infrastructure has been created to meet the demands.
4. In order to improve engineering services in medical colleges and to professionalize procurement, greater synergies should be built with Health department, especially Punjab Health Systems Corporation.
5. It should be strictly enforced that faculty and the staff working in medical colleges do not indulge in private practice.

Conclusion

Implementation of the above recommendations will definitely improve the standards of medical education, research and patient care at the level of Govt. Medical Colleges of Punjab.

This will help not only to create competent health professionals but also provide for State of the Art health care facilities and services for the people of Punjab.