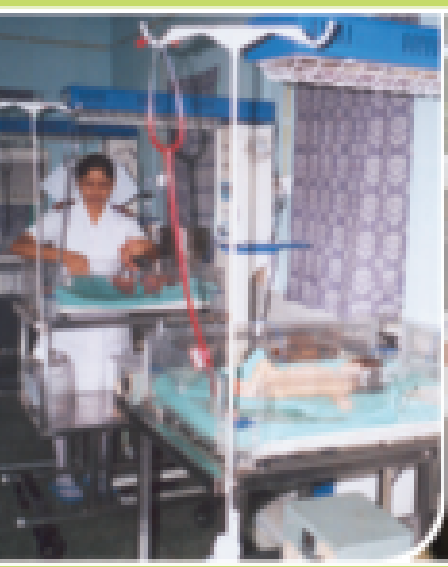
Health Systems Development Initiative: Reforms and Achievements

Government of West Bengal

2005 - 2009



DEPARTMENT OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF WEST BENGAL

"A light from our midst has become a guiding star…"

Dr. Tapas Kumar Sen

(1956 – 2009)

We deeply mourn the sudden demise of Dr. Tapas Kumar Sen, Technical Officer SPSRC – a passionate worker, a dependable friend and a wonderful person.

He worked ceaselessly to further the reform process of the department. His presence will be missed.

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The West Bengal Health Sector Reform Process

Health Systems Development Initiative (HSDI) is a programme to catalyse and implement the State's Health Sector Strategy (HSS). HSDI has initiated several important reforms and strengthened health systems to allow the National Rural Health Mission (NRHM) and other programmes to perform better. It has helped established effective linkages between programmes and provided the Department of Health and Family Welfare (DHFW) flexibility in administering the reform process. The Strategic Planning and Sector Reform Cell (SPSRC) continues facilitating the process with support from the Technical Assistance Support Team (TAST).

Health Sector Strategy (2004-2013)

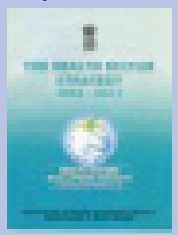
The DHFW formulated a Health Sector Strategy (HSS) in 2004 to address issues related to infrastructure, manpower, equipment and other essential services. The goal of the HSS is to improve the health outcomes of the poor in the state through strengthening the health system and improving public regulation of private provision of healthcare services.

Health Systems Development Initiative (2005-2010)

Government of West Bengal (GoWB) launched a programme titled 'Health Systems Development Initiative (HSDI)' on August 16, 2005. **HSDI aims at operationalising the Health Sector Strategy (HSS)**. The proposed support under HSDI helps the Government of West Bengal take forward key aspects of the HSS, with the state government simultaneously realigning its current spending priorities with it.

The purpose of the HSDI programme is 'enhanced and equitable utilisation of quality health services by the poorest and those in greatest need'.

The HSS has defined the following overall objectives:



- To improve the accessibility of poor and un-reached groups to curative, preventative, promotive and rehabilitative health services.
- To reduce maternal and child mortality, and the burden of communicable, non-communicable and nutrition-related diseases and disorders.
- To ensure quality at all levels of health and medical care services.
- To maintain excellence in education and research in medicine and all allied professions (including management).

The Mission of the Health and Family Welfare Department of the Government of West Bengal is to improve the health status of all the people of West Bengal, especially the poorest and those in greatest need.

The programme is expected to contribute directly to achieving key outcomes like significant reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR), increase in the proportion of institutional deliveries, significant increase in the coverage of child immunisation and reduction in the share of communicable / maternal / neonatal factors in the burden of disease from the state with special focus on the six poor performing districts - Malda, Murshidabad, Purulia, Coochbehar, Dakshin Dinajpur, and Uttar Dinajpur.

The programme has also helped direct additional financial resources to three priority and/or under-funded areas: primary sector, rural areas, and non-wage recurrent expenditures like drugs. The support has also enabled the state to address some difficult institutional reforms; in particular, removing vacancies in critical areas especially of front-line staff. These and other measures have contributed to improved patient satisfaction and quality of care provided by the public healthcare facilities. In addition, innovation and experimentation has led to several cutting-edge pilot initiatives which are now being scaled up.

National Rural Health Mission (2005—2012)

The National Rural Health Mission (NRHM, 2005-2012) is a seven-year omnibus broadband reform programme of the Government of India, which aims to enhance comprehensive primary health care services, especially for the poor and the vulnerable and integrates all vertical programmes under its fold. The Reproductive and Child Health (RCH) programme is the major flagship programme under NRHM, focusing on reducing maternal mortality and infant mortality. The reform goals of the HSDI and the NRHM are consistent with the HSS for West Bengal.

Vital Statistics

	WB	India	
• Total Fertility Rate (TFR)	1.9	2.68	(SRS2007)
• Crude Birth Rate (CBR)	17.5	22.8	(SRS2008)
• Crude Death Rate (CDR)	6.2	7.1	(SRS2008)
• Infant Mortality Rate (IMR)	35	53	(SRS2008)
• Maternal Mortality Ratio (MMR)	141	254	(RGI2004-06)

DFID and Technical Assistance Support Team

A Technical Assistance Support Team (TAST) was contracted by the UK Government's Department for International Development (DFID) in 2006 on behalf of the West Bengal state government to strengthen and support its strategic planning and sector reform process.

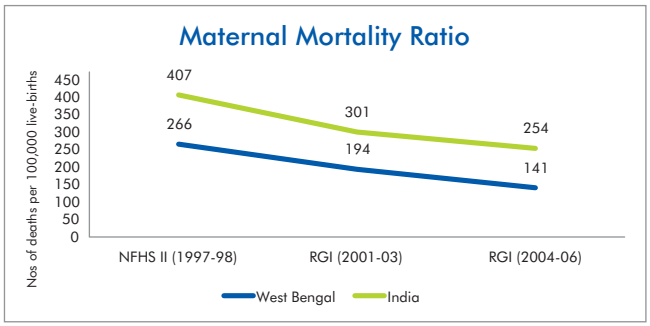
TAST is a technical assistance model put in place to accelerate health sector reforms. It is complementary to DFID's budget support to the Government of West Bengal. Set up as an autonomous external support team, the technical assistance processes are delivered in partnership with the DHFW. TAST is aptly placed within the government system and has developed close working relationships with the DHFW. The Mid-term review of HSDI notes 'TAST in West Bengal has become integrated with the main system and has been recognised as useful partners at all levels of the state machinery.' (IIHMR, July 2008)

The Strategic Planning and Sector Reform Cell (SPSRC)

A Strategic Planning and Sector Reform Cell (SPSRC), within the Department of Health and Family Welfare facilitates and supervises the change process. SPSRC assists in framing policies and recommending strategic options for various reform initiatives. The primary objective of the SPSRC is to act as a resource centre of the department as well as a nodal and dedicated cell for facilitating planning, reform, and donor coordination.

Trends in Health Outcomes

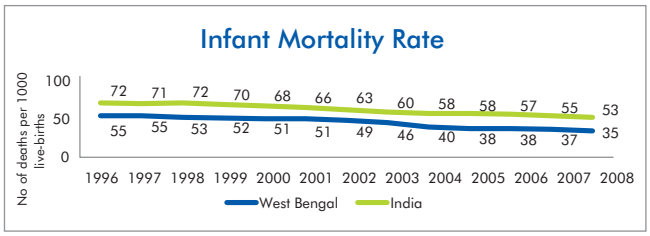
Maternal Mortality Ratio



The Latest round of Maternal Mortality (MMR) data released in 2009 shows that maternal deaths have reduced from 194 per lakh (2001-03) to 141 per lackh (2004-06). **This is among the highest drops in the country (27%) and much above the national average reduce.**

Special Bulletin on maternal Mortality in India 2004-06, Sample Registration System (SRI), Office of Registrar General of India.

Infant Mortality Rate (IMR)



The Infant Mortality Rate (IMR) in West Bengal is 35

Sample Registration System (SRS), 2007

"TAST in West Bengal has become integrated with the main system and has been recognised as useful partners at all levels of the state machinery".

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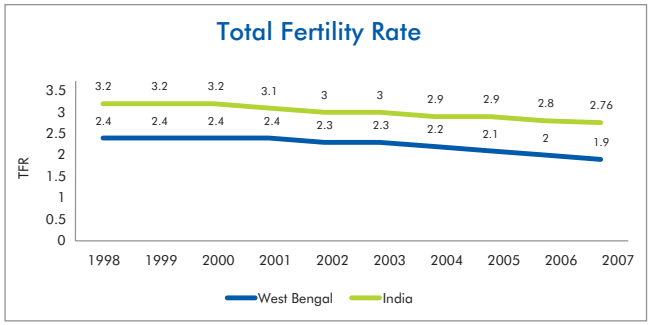
Total Fertility Rate (TFR)



The replacement level fertility (2.1) was achieved in 2005. The Total Fertility Rate (TFR) is now 1.9 which is one of the lowest in the country. SRS (2007) 'Replacement fertility is the total fertility rate at which women would have only enough children to replace themselves and their partner. at this rate, population growth reproduction will be approximately zero.'

Key Health Outcomes and Outputs

The health outcomes in the state have been consistently better than that of the national average according to almost all indicators. West Bengal can now be grouped with few relatively better performing states in terms of some vital statistics. The state has the fourth lowest birth rate after Kerala, Tamil Nadu and Punjab, the third lowest death rate (after Delhi and Jammu & Kashmir) and the fourth lowest IMR (same as Delhi and after Kerala, Maharashtra, and Tamil Nadu).

The share of institutional deliveries has increased from 43% (NFHS III 2005) to 60.2 % (UNICEF CES 2007). During 2004-07, the quantum of deliveries has increased at all levels of institutions; however, the rate of increase is much faster in (1) six poorest districts (30%, compared to 14% in remaining 12 districts), and (2) in lower level facilities (63.1% in PHCs and 33% in BPHCs, compared to 11% in district hospitals), thereby reducing patient load in higher-level facilities.

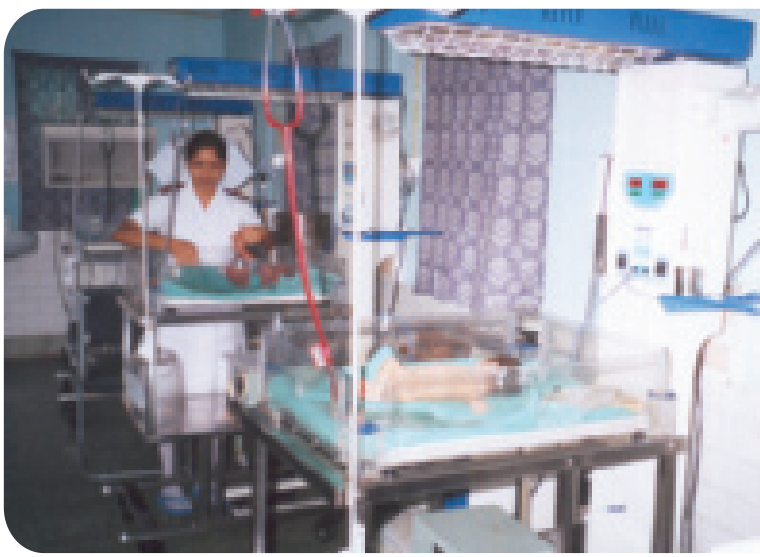
Progress in immunisation has been significant. The rate of full immunization of children below 2 years was as low as 41% in 1998-99. The rate has increased to about 75.8 % as per the latest estimates (DLHS 3, 2007-08). A child from a backward district like Murshidabad is now more likely to get fully immunized (61.4% full immunization coverage).

Access to Maternal and Child Health (MCH) care, especially for high-risk mothers and newborn babies, has been given a priority to sustain and improve the performance in these areas. Operationalisation of First Referral Units (FRUs) and functional Primary Health Centres (PHCs) at the block and lower level during HSDI period reflects serious intention of the department to provide easier access to emergency obstetric, neonatal and maternal health services. These FRUs have been made fully functional at district and sub-district levels. In addition, 29 FRUs have started performing caesarean sections at block levels. The initiatives have been supplemented by the Ayushmati Scheme, a recent partnership with private hospitals, through which 42 Rural Private Providers and 26 Urban Providers offer Comprehensive Emergency Obstetric Care services. In newborn care, a clear pattern of strategic intervention is visible to address different grades of sickness: (a) establishing Sick Neonatal Care Units (SNCU) in 6 districts (2 more shortly); (b) Stabilization Units at the block level; and (c) community-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI) programme at the village level.

The progress is outstanding especially in utilization of inpatient care. Hospitalization rates in the state increased from 1.5 % (of the whole population) in 1995 to 2.83% in 2004 (NSSO), and a recent estimate in 2007-08, is around 4.23% (IIHMR). The rapid upward trend reflects improved access to secondary care. Two unique features underpin this growth: (1) about 90% of inpatients from the poorest quintile use public hospitals (compared to 56% in India), and (2) the trend is more spectacular in 6 poor-performing districts where Bed Occupancy Rate (BOR) has increased by 30% points (compared to 3% points in 12 other districts) between 2003 and 2007.

In outpatient care, the market is still dominated by Rural Medical Practitioners (RMPs). However, new strategies are in place to counter this dominance. Most notable among them is mobile health camps at every GP sub-centre in which approximately 5 million people were treated in 2007-08. In addition, all basic medicines are made available to all primary health centres to cater to more outpatients.

Sick New Born Care Unit



Strategic Areas of Health System Development Initiatives

The HSDI focuses on some key elements of the HSS. The medium term outcomes were set against certain milestones within each strategic area. The highlights of achievements, challenges and the lessons learnt are shared, in this journey of sector reform initiative.

Strategic Area 1: Strategic and Policy Framework

HSDI 2010 Outcomes

- Annual Department of Health and Family Welfare (DHFW) plans and budgets operate within a rolling sector strategy framework, a 3-5 year public expenditure planning exercise
- The DHFW plays a stewardship role in overseeing implementation of the health sector strategy
- New donor programmes are harmonised around the DHFW strategy. District planning processes are well established and respond to local health priorities

Achievements

- SPSRC has taken the lead in guiding all districts in preparing District Health Plans (DHP) for 2009-10, aligned with the Mid-Term Expenditure Framework (MTEF)
- A 3-year perspective district plan is in progress at all levels (from Gram Panchayat to State level)
- Preparation of a monitoring framework for Public-Private Partnership (PPP) initiatives
- Support in strengthening data for Health Management Information Systems (HMIS)
- Preparation of an HR Database is in progress
- Support for an Urban Health Strategy and an e-governance plan

The strategy has contributed to developing institutional capacities, generating awareness, establishing a monitoring arrangement to oversee the implementation process, and a bottom-up planning process linked not only to the DHFW's budget and priorities in a rolling framework, but also with real needs especially of the poorest, vulnerable, and socially disadvantaged groups has been established.

There has been remarkable progress in building the institutional capacity of the DHFW. At the state level, the Strategic Planning and Sector Reform Cell (SPSRC) of the department has been equipped with adequate manpower. The SPSRC is fully functional and leads on:

- Guiding all districts in preparing District Health Plans for 2009-10
- Supporting regional review meetings led by the Minister in Charge
- Analyzing key district indicators
- Preparing a monitoring framework for Public-Private Partnership (PPP) initiatives
- Strengthening Hospital Management Information Systems (HMIS)
- Developing an HR database, updating and maintaining it
- Supporting an Urban Health Strategy and an e-governance plan
- The Urban Health Strategy has been prepared by the Department of Health and Family Welfare and the Municipal Affairs Department.
- There was about 70% increase in on-budget health spending in 6 poor districts in 2008-09 as compared to 2007-08.
- The on-budget absorption capacity of the DHFW has been steadily improving - on an average 88% of the on-budget fund is being utilised since 2005-06 and it reached 90% in 2008-09
- All 18 districts prepared annual plans and budgets for 2009-10.
- SPSRC facilitates decentralised planning processes for 2010-11 to 2012 -2013, a 3-year plan from the Gram Panchayat level up to the state level. This is aligned to the MTEF and rolling sector strategy framework. Financial planning is being supported by tailor made software.
- A Mid-Term Expenditure Framework (MTEF) was prepared for 2009-12, which formed the framework for preparing the Annual Budget for 2009-10.

DHFW has made several efforts to communicate and mainstream reforms

for more information log on to www.wbhealth.gov.in

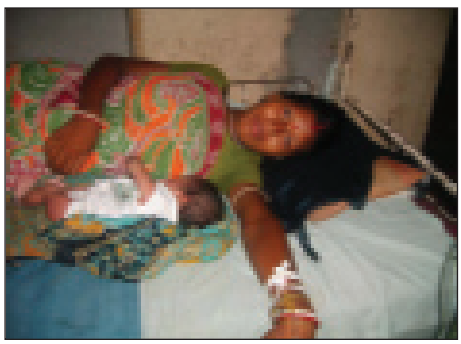
Strategic Area 2: Additional measures to meet HSS targets and MDGs

HSDI 2010 Outcomes

- Mortality Rates reduced from baseline of 51 to 35 by end of project
- Maternal Mortality Ratio reduced from baseline of 250 to 150
- 50% increase in institutional deliveries in poorer districts (baseline < 35%)
- 50% increase in child immunization rates in poorer districts (baseline < 30%)

Achievements

- Implementation of a web-based monitoring system for First Referral Units (FRUs)
- 27 of 29 FRUs have Blood Storage Units (from 14 in 2007-08)
- Deliveries in FRUs increased from 63,160 (2007) to 66,367 (2008)
- Collecting data on status of ongoing upgradation for FRUs through software
- Infrastructure development for improving access to maternal and child health care
- Voucher scheme and Ayushmati schemes introduced

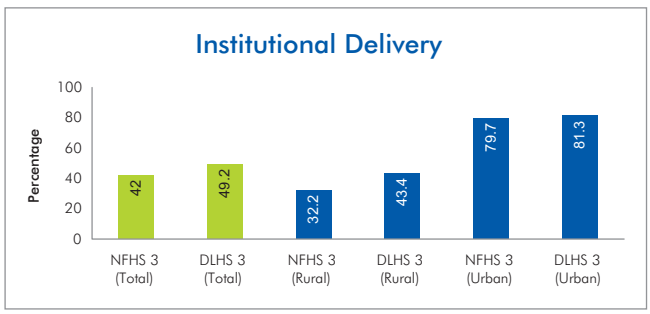


Mother and child, soon after delivery at a Ayushmati Facility

The HSDI focus in this area is to reduce MMR and IMR, which has been achieved to an appreciable extent. This, has been achieved by adopting three strategies: (1) bring more pregnant women within the institutional arena for services related to birth, delivery, and emergency obstetric problems (2) provide a continuum of clinical and home based neonatal care services to reduce newborn mortality (NMR) (3) ensure that all children receive immunization services before their third birthday. Further, the strategies must target the poor and socially excluded groups, especially in rural areas.

Measures to strengthen primary health care facilities:

- Construction of 1982 Gram Panchayat headquarter sub-centres with facilities for normal deliveries and OPD services



- 176 Block Primary Health Centres (BPHCs) were upgraded to 30-bedded rural hospitals.
- 365 Primary Health Centres (PHCs) are planned to be upgraded as 10-bedded, 24×7 service and institutional delivery facilities.
- 60 facilities were made into First Referral Units (FRUs) in two years (2006-2008) to provide emergency maternal and obstetric care.
- Ensure functioning of 29 FRUs through a regular online monitoring software
- Follow up and review of problems at FRUs

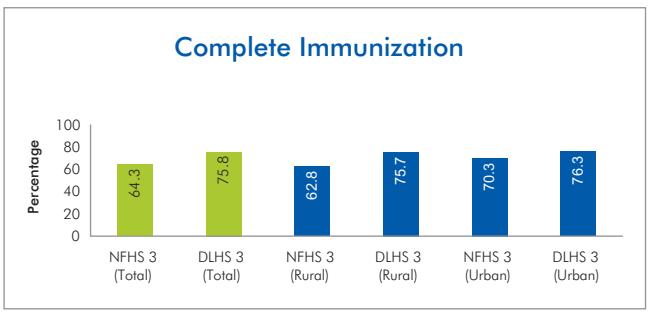
Improvements in low performing districts are also quite appreciable. Total number of deliveries as reported by the facilities ranging from district hospitals to block primary health centres in the six poor performing districts was about 136,671 in 2005 which is 178,868 in 2008 indicating an average annual growth rate of 10%.

Gram Panchayat Head Quarter Sub Centre under construction

Three-tier intervention for newborn care in the child health care package

- Community-level Integrated Management of Neonatal and Childhood Illnesses (IMNCI), a model piloted in Purulia district with UNICEF support, has been adopted and extended to other districts.
- Middle-tier intervention: Stabilization Units selected at Block Primary Health Centres in five districts which will operate as first referral units for sick newborn babies.
- Upper-tier intervention: Operationalising Sick Newborn Care Units (SNCU) at district hospitals for babies who need intensive care. Six SNCUs are already functional.

The progress in immunization has been more spectacular. For example, by National Family Health Survey (NFHS) estimates, the percentage of fully immunized children in the state has reached about 64% in 2005-06 from a mere 34% in 1990-91. The 2007-08 DLHS 3 (District-Level Household Facility Survey), estimate is even higher, i.e. 75.8%.



The process of strengthening infrastructure has been complemented with several other initiatives:

- Distribution of hypothermia prevention kits (consisting of a baby wrap, socks, cap, mosquito net and a saree for the mother) for all deliveries at rural hospitals and below.
- A Public-Private Partnership initiative, known as the Ayushmati Scheme, to provide free institutional deliveries and emergency obstetric care in private hospitals for mothers below the poverty line. Ayushmati coverage increased 5 times between 2007-08 and 2008-09.
- Improvement in implementing financing for institutional deliveries - Janani Suraksha Yojana (JSY): increase in beneficiaries by 30% in 2008-09 over that in 2007-08
- Voucher scheme introduced for transporting pregnant women to a health institution, primarily JSY beneficiaries who are below the poverty line, or who belong to scheduled caste/schedule tribe communities. The number of beneficiaries increased by 28%.
- Partnerships were developed with local NGOs to establish and make functional 'health service delivery points' in remote areas of the Sunderbans.
- A strong network of Mother NGOs and Field NGOs was established in under-served areas of 71 blocks in the state.

The mother and her new born received the hypothermia prevention kit (HPK) at a BPHC

Key indicators in public health have recorded improvement over last few years:

- The Annual Case Detection Rate in TB at 122/100,000 and cure rate was consistently more than 84%
- Leprosy prevalence declined from 1.24 (March '06) to 0.98 per 10,000 (March '09)
- Incidence of malaria decreased in endemic districts

a) Cases: From 159,646 (2006) to 89,443 (2008)

b) Deaths: From 203 (2006) to 104 (2008)

API: Malaria			
2005	2006	2007	2008
2.32	1.86	1.06	1.08

Strategic Area 3: Organisation and Management Systems

HSDI 2010 Outcomes

- Stronger oversight role provided by the Department of Health and Family Welfare towards public and private health systems
- Public sector has a strong results-based management system in place
- 50% reduction in absenteeism by end of project (baseline: 43% absenteeism in Primary Health Centres).
- At least 90% of rural hospitals / Block Primary Health Centres / Primary Health Centres are fully staffed (baseline: 16% vacancies for Primary Health Centres)

Achievements

- Review made and agreement on restructuring of public health areas like filling up and creating new posts in public health
- Review of Non Medical Technical Personnel (NMTP) cadre personnel
- PPP cell at state and district level cell constituted
- Urban Health strategy developed
- Hospital management cell constituted and functional
- Role of Assistant Chief Medical Officer (ACMOHs) strengthened and training designed
- Clinical Establishment Act streamlined
- Dashboard monitoring extended to the district level
- Sufficient progress in HR recruitment and posting

This milestone focuses on three components: (1) Human resource management and human resource development (2) decentralization, and (3) Health Management Information Systems (HMIS). While the first component is related to actions taken to improve quantity, quality, and management of health manpower, the second component is concerned about issues related to decentralization and consequent local oversight. Finally, the third component is connected to improvements in HMIS especially in the context of monitoring performance.

Human Resource Management and Human Resource Development

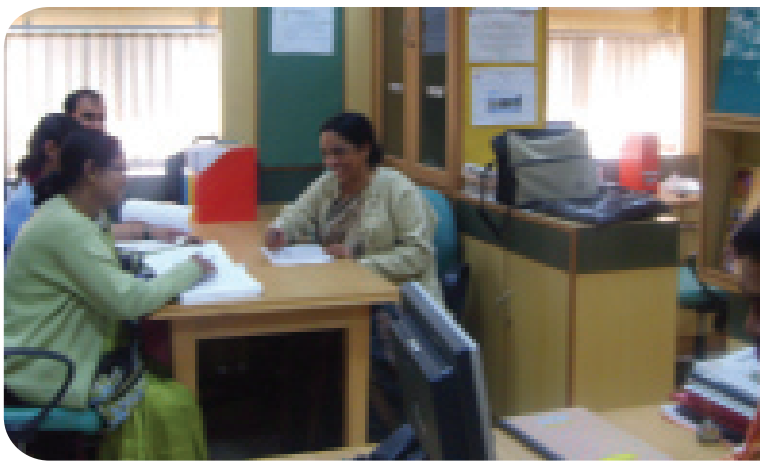
- Reorganisation of West Bengal health sector cadres in 2004 in the Department of Health and Family Welfare.
- 200 Auxiliary Nurse Midwife (ANM) and General Nurse Midwife (GNM) teaching posts were established.
- Out of a total vacancy of 1,137 Medical Officers, steps are underway to fill up 678 positions.
- 2,349 ANMs have been posted of which 1,421 are in the 6 poor performing districts.
- Rules on recruitment, postings and transfers of posts have been prepared.
- Additional posts have been created to support sick newborn care units.
- Increase in ANM training schools will support staffing of rural hospitals, Block Primary Health Centres, and Primary Health Centres.
- A draft ANM training policy and training calendar have been developed.
- HR functions to include incentives, performance management, and motivation.
- HR database – data to be updated by districts through web-enabled software.

Organization Development

- Personnel have been recruited for hospital management and public relations.
- Strengthening Rogi Kalyan Samities – registered societies in hospitals that take on the role of people's representatives in hospital management.
- Hosting a Directorate of Drug Corporation website
- Strengthening District and Block Programme Management Units through capacity enhancement and conferring responsibility of programme management to respective management units.
- District and block level computerization has made communication much easier and faster.

Knowledge Management:

- The State Resource Centre (SRC) acts as the knowledge base for the Department of Health and Family Welfare (DHFW),



Government of West Bengal. The SRC, through a set of planned activities, creates a platform for sharing information on various aspects of health reform.

- A total of 341 Receive Only Terminals (ROT) (1-way video 2-way audio system) has been installed in all the blocks of the state. This infrastructure facilitates discussion, review meetings, training and feedback, awareness generation, and clarifications on specific programmes.
- A Demographic Surveillance Cell has been set up in Birbhum

Decentralization

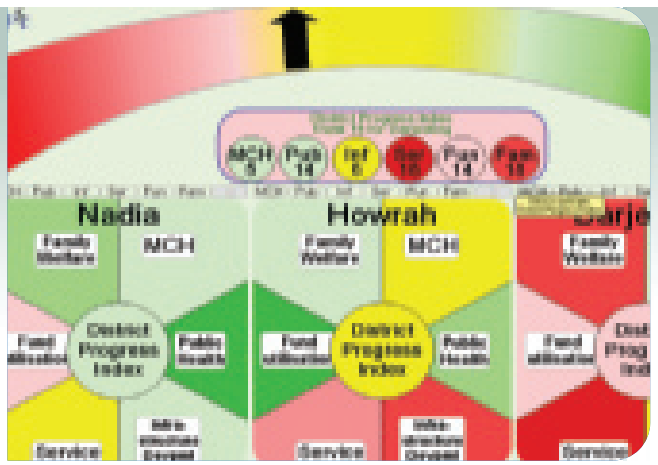
- Formation of autonomous societies, such as the Department of Health and Family Welfare Society at the district level, Block Health and Family Welfare Society at the block level, and Rogi Kalyan Samitis from Medical College till BPHC level). Each society has representatives from Panchayati Raj Institutions (local governing bodies), and the health administration as lead members.
- Decentralising health planning at the Gram Panchayat, block, and district level
- Delegating key responsibilities of local management to PRIs such as monitoring health activities, constructing and upgrading sub centres and primary health centres, recruiting Accredited Social Health Activists (ASHAs), and bringing together various stakeholders (ANMs, Anganwadi workers, and ASHAS).

Health Management Information Systems (HMIS)

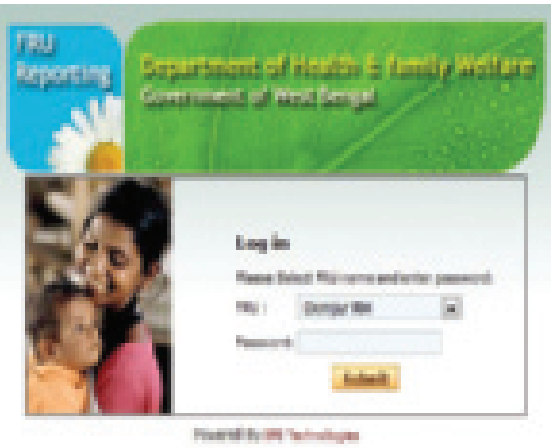
- Software-based solutions for improved management information system are being developed
- The Dashboard tool has been developed to give a simple visual representation of performance in terms of various parameters:
  - Dashboard monitoring is being used for district reviews by the Department of Health and Family Welfare
  - Block-level indicators developed
  - Software is being developed to host the Dashboard on the departments website
- Monitoring software has been prepared to manage First Referral Units
- Comprehensive on-line tools for financial planning and monitoring have been developed
- Regional Review Meetings are held quarterly, chaired by the Minister in Charge (MIC) with all key district officials.
- Hospital information systems have been strengthened with more detailed information.
- A Government Correspondence System (GCS) has been introduced in the department to improve creating and retrieving government orders and other communication as well as make key government orders available to all officials.
- An HR database has been developed. This will help track every staff – permanent and contractual – in the entire public health system.
- A database is being developed to store and index all government orders.
- Appointments:

	State		6 focus districts	
	2007-08	2008-09	2007-08	2008-09
No. of specialists (in service)	106 113	13 63	50	5
No. of Medical Officers-Contractual	633	881 40	237	306
No. of nurses	1408	1310	255	628

The Dashboard Tool – helps in effective review of district / block performance



FRU Monitoring Software – ensures continued functioning



Key Strategic Area 4: Health Financing

HSDI 2010 Outcomes

- Health spend as share of government of West Bengal's budget expenditure would be 7% by 2010 (cf 3.9% in 2004-05)
- Primary health spends as share of total health spend to reach 55% by 2010 (cf 35% 2003-04)
- Sector-rolling Medium Term Expenditure Framework (MTEF) provides the framework for annual budgets
- Essential medicines made available in all rural hospitals, block primary health centres, and primary health centres by 2008
- Pilots for community health insurance schemes completed and scaled up
- Out-of-pocket expenses for primary care reduced among target communities

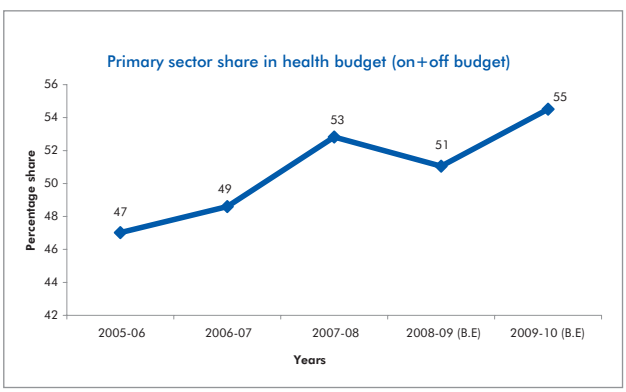
Achievements

- Health (on-) budget doubled since 2005-06
- Increased allocation towards primary health sector
- Increased expenditure on medicines and consumables
- Public Expenditure Review and Medium Term Expenditure Framework developed and updated
- Financial Planning and Monitoring Software being developed
- Off-take of demand side schemes, like Janani Suraksha Yojana (JSY), Ayushmati, and referral transport improved remarkably
- Availability of drugs in public facilities improved
- Scope and coverage for Illness Assistance Fund improved and sustained

HSDI contributed in bringing about structural changes in the public finance framework to accelerate and provide support in other action areas. This has implications on providing priority to public health expenditure entailing steady growth in the share of health spend in the total budget, reallocation of resources more in favour of primary health care, and reducing the out of pocket expenditure especially of the poor.

Increased allocation

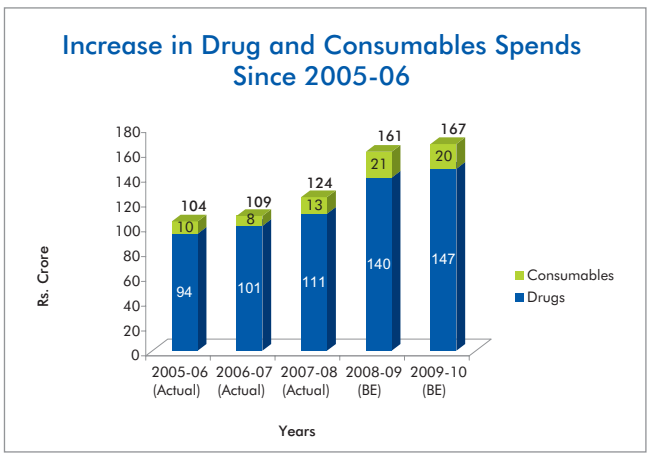
- Significant rise in health spend from Rs.15,060 million in 2005-06 to Rs. 30,320 million in 2009-10
- Rise in allocation of funds (on and off budget) by 39% in 2009-10 over that in 2008-09.



- Allocation for spending in the primary health sector in the total budget increased from 47% in 2005-06 to 55% in 2009-10.
- The budget for medicines rose by 56% in 2009-10 as compared to 2005-06.
- A Public Expenditure Review (PER) was conducted in 2004-05
- A Medium Term Expenditure Framework was prepared for 2006-11 and has been updated covering the period 2009-12.

Reduction in out-of-pocket expenses

- There have been significant efforts for reduction of out-of-pocket expenses by demand side schemes like JSY, Ayushmati and referral transport. Number of beneficiaries has increased by 30% for JSY, 44% for Ayushmati and 40% for referral transport from 2007-08 to 2008-09.
- Standard Treatment Protocols, including prescription practices, have been developed and are being piloted in two districts.
- The Illness Assistance Fund at state as well as district levels provide financial support to poor patients. In the year 2008-09, 12,229 people were benefited from the fund.
- User-charges from OPD tickets, fees for paying-beds, charges for diagnostic tests etc. are retained in secondary hospitals. From the total user charges collected in each facility, 40% is kept by the facility and the remaining 60% is deposited in the Corpus Fund of the District Health and Family Welfare Samiti.
- Free beds and dietary services are made available to the BPL population.



Strategic Area 5: Access and Demand

HSDI 2010 Outcomes

- Reduction in share of Burden of Diseases from communicable /maternal /neonatal / nutritional deficiency from the current 50% baseline
- Pilots for new service delivery models in remote districts completed, and scaled up with plans and resources
- Health Seeking Behaviour Survey in poor performing districts shows over x% increase in number of people seeking treatment from both public and good quality private providers (baseline and target to be developed by Yr 2)

Achievements

- Access and Demand Strategy developed
- Special Schemes have been approved and implemented in 6 poor districts amongst which GP level 24X7 maternal transport network through local means have been approved in 4 districts
- 4000 vulnerable villages have been identified and a cascade model of monitoring model has been planned for them

One of the major focuses of HSDI is to develop and implement a strategic approach to mainstream Access and Demand issues in HSS. The approach is focused on reducing health inequities through better targeting of health interventions and maximizing their impact on the poor and the most vulnerable, especially women, children and the currently un-reached population. As an important step towards this direction, a strategy paper was prepared by the DHFW in 2007 which presented a strategic framework for mainstreaming access and demand issues.

- Innovative schemes from 4 districts viz., GP level 24X7 maternal transport network through local means approved. Special schemes for vulnerable groups are being led by the SPSRC.
- 4,000 vulnerable villages have been identified. District officials were informed about the villages under their respective districts. Simple cascade model of monitoring the vulnerable villages is being developed.
- Mobile Health Clinic Services are being organized by NGOs in remote areas of the Suderbans. Regular outpatient services are provided with mechanized boats
- Sunderbans master plan for overall improvement in the health status of the area has been developed
- Accredited Social Health Activists(ASHAs) are appointed in poor performing blocks
- Mobile health camps are being organized in Gram Panchayat headquarters. Head Quarter Sub Centre to act as and 'additional PHC' in the future. More than 55,600 camps were held during 2008-09 in which more than 443 million patients were treated

ASHAs

- Better off-take of JSY, Ayushmati ,and Referral Transport schemes meant for poor and vulnerable
- Referral transport is being arranged at a subsidized rate in each block.
- Ground-level workers, such as auxiliary nurse mid-wives and anganwadi workers, are being equipped with a basic medicine kit and training for serving the poor.
- Health reform communication to service providers at the state level resulted in a series of mini workshops (health dialogues) and newsletters.

Strategic Area 6: Public-Private Partnership

HSDI 2010 Outcomes

- Regulatory system for private and public sector health sector providers fully functional
- Public-Private Partnerships (PPPs) leading to improved service delivery for all, especially the poor

Achievements

- Consolidation and up-scaling of ongoing activities
- Diagnostic services in Rural Hospitals
- Mobile clinics in Sunderbans with support from NGOs
- Child birth services through PPPs in remote areas of Sunderbans
- Ayushmati Scheme involving private hospitals for safe delivery
- Appointment of external agency to evaluate all PPP programmes
- Appointment of agency to manage and monitor the performance of PPPs

NGO run Ambulance Service

The following initiatives were taken up within this strategic area:

- A PPP policy has been developed identifying priority areas and options for involving the private sector.
- A PPP cell was established at the state headquarters of the department in January 2007 and also at district level with nodal officers in 2009.
- The cell is involved in:
  - organizational review of the units governing PPP initiatives
  - review of all major PPP initiatives
  - development of PPP initiative monitoring formats
- An agency has been appointed to manage and monitor the performance of PPPs:
  - Responsibility for PPP monitoring at the district level identified
  - A terms of reference prepared for district PPP cell initiatives
- NGO-run ambulances are functioning in blocks to provide referral services.
- Establishment of CT Scans and MRI Scan Units in tertiary and secondary hospitals.
- Private partners have been invited to provide select diagnostic services in 43 rural hospitals and 40 Block Primary Health Centres.
- Mobile clinics have been established in the Sunderbans.
- Child Birth Service centres have been set up by local NGOs to provide institutional delivery services in Sunderbans.
- The Ayushmati Scheme was implemented allowing poor women to deliver free of cost at select private hospitals.
- Local Self-Help Groups started supplying dietary services to patients in rural hospitals, Block Primary Health Centres, and Primary Health Centres.
- Voucher schemes for transport of pregnant women are being piloted in 3 districts.
- 21 ANM training schools under PPP have been set-up.
- Out-sourcing of non-healthcare services such as diet, scavenging, security, bio-medical waste management services, and mechanized laundry units for 30 hospitals in Kolkata.

A PPP policy was developed in 2006 identifying priority areas and options for involving the private sector.

Strategic Area 7: Assets and Supplies Management

HSDI 2010 Outcomes

- Operations and management systems are fully functional
- Basic Drugs are available in primary health centres and Rural Hospitals

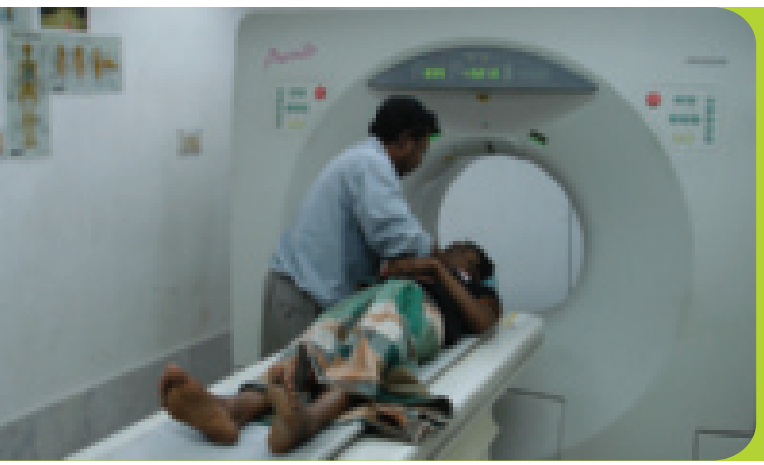
Achievements

- Primary health infrastructure handed over to Panchayti Raj Institutions (PRIs)
- Drug Corporation established, soon to be operationalised
- Integrated Hospital Management Cell constituted
- Quality Assurance System for hospital management documented and implemented in secondary level hospitals

The progress in this area was measured on three aspects: (1) asset management (2) drug supply management and (3) drug availability with special reference to progress on promoting rational drug use through the supply and retail of generic medicines. Regarding asset management, there has been a considerable change in approaches. Maintenance and renovation of infrastructure at the primary level have been handed over to the PRIs which were erstwhile done through the Public Works Department (PWD). This strategy was further complemented by ensuring a sizeable amount of flow of untied and maintenance funds to facilities to help facility managers address urgent maintenance needs.

Some of the key activities undertaken in the strategic area are:

- Integrated Hospital Management Cell (IHMC) was constituted and is functional:
  - Guidelines, plans, and draft agreement for bio-medical waste management were prepared and issued to all hospitals
- Quality Assurance (QA) System
  - A state working group on QA was made functional
  - Pilot initiatives on quality assurance are taking place in Chinsurah, Howrah, and Ranaghat district hospitals
  - A scale-up of QA systems in other district hospitals is being planned
- Systems were put in place to ensure efficient procurement of equipment.
- A preventive maintenance system is being piloted in 3 districts which encourages maintenance of equipment through local resources.
- Availability of essential and generic medicines has improved, especially at primary level health facilities. A Public Expenditure Tracking Study (PETS) for drugs has been conducted to identify areas for improvement in drug planning, procurement and supply.
- West Bengal Medical Services Corporation, an autonomous specialised unit for drug procurement has been registered and will be started operations soon.
- Annual Maintenance Grants are given to health facilities and untied funds are also being given to Rogi Kalyan Samities to meet emergent expenses.



Integrated Hospital Management Cell (IHMC) was constituted in 2008 to monitor and support hospitals in the state

Strategic Area 8: Procurement and Financial Management

HSDI 2010 Outcomes

- Fiduciary Risk Assessment in 2006 shows reduction in risks compared to the 2004 baseline

Achievements

- A Medium-Term Expenditure Framework (MTEF) group formed and MTEF prepared
- Internal audit strengthened
- A focal person within the Strategic Planning and Sector Reform Cell (SPSRC) identified for procurement reforms
- Fiduciary risk significantly reduced in 2007 review

The recommendations made through fiduciary risk mitigation plans are being effectively addressed by the department. This in turn has strengthened financial management, procurement, and overall monitoring of health systems.

Initiatives like setting up the MTEF group ensure continuous support to risk mitigation activities. Strengthening internal audit and improving procurement practices have introduced transparency in the department's functioning.

Financial management:

- An MTEF group has been set up within the SPSRC and MTEF has been prepared for 2006-10 and updated for 2009-12.
- An integrated on-budget and off-budget financial software has been developed for queries, information tracking and planning.

Development of Financial Monitoring Software

- A comprehensive financial monitoring software is being developed which will cover the entire cycle of district financial planning, fund transfers, progress updation, and reporting against plans. This will facilitate online data reporting, analysis and output monitoring which help faster and better decision-making.

Internal Audit:

- New formats have been developed covering areas such as hospital receipts, hospital diet etc. Audit personnel have been trained on the new formats. The trainings took place in Murshidabad, Siliguri, Barddhaman, Paschim Medinipur, and Kolkata.
- Internal audit has been introduced for District and Block Health and Family Welfare Samities.

Procurement

- A focal person has been identified within the SPSRC for procurement reforms and overseeing implementation of the procurement manual.
- The West Bengal Medical Services Corporation has been set up with the following objectives:
  - Efficient procurement and supply of quality medicines in time to all hospitals
  - Efficient procurement of equipment and their regular maintenance, including supply of chemicals and reagents to hospitals and medical colleges
  - Construction and maintenance of health facilities

By constant follow-up, handholding and support through internal audit, there has been a significant reduction in the outstanding audit paras of the department. (From 3500 in 2004-05 to 1811 in 2006-07 approx.)

Challenges: bottleneck to reforms

There are a few key challenges which needs to be addressed to sustain the benefits of HSDI:

1. **Lack of monitoring at the district and levels below:** Sustainability of benefits accrued during the last 3-4 years requires focused attention on local bottlenecks. The quality of service encompassing all facets of the health service delivery needs to be enhanced. There is need for establishing a strong monitoring mechanism for all aspects of the health systems delivery. At the facility level, Rogi Kalyan Samitis (RKS), which are empowered with funds and flexibility, need to use their autonomy and play a stewardship role to ensure quality of services at the facilities.

2. **Inequity in institutional deliveries and outpatient care:** Recent evidence indicates that physical distance to a qualified health service provider, higher out-of-pocket expenses, and poverty still act as strong barriers to institutional deliveries. Deliveries at institutions are also constrained because general curative care and newborn care are not available or poorly available at such facilities. Unqualified providers (RMPs) in the outpatient market are still quite widely prevalent and their presence restricts access to qualified providers. Recent initiatives to address these issues need to be scaled up urgently.

3. **Need for reduction of out-of-pocket health expenditure:** Despite increasing public investment, out-of-pocket expenditure for institutional health care is still high. Several studies including the user satisfaction and PETS study, indicate that drugs and diagnostic tests constitute the majority of out-of-pocket expenses incurred by a client at public health facilities. The evidence underlines a strong supplier-driven demand for drugs in public hospitals. Measures to hedge against such untoward practices need to be institutionalised.

4. **Inadequate regulation of the private market:** Despite private sector catering to a relatively smaller share of non-ambulatory healthcare in West Bengal, their regulation is important for the complementary and responsible growth of the private sector. There is need for more effective implementation of the Clinical Establishment Act and other regulatory norms. The challenge remains not only in applying the regulatory tools (e.g., CE Act) but also in making the other stakeholders (e.g., MCI, Associations like FOGSI,IAP etc.) play more effective self-regulatory roles.

5. **Financial Management:** Several reforms have been initiated to strengthen financial management, but a large amount of fund remains underutilised, particularly the off budget and RKS funds. Health care providers need more capacity and competency to expend RKS funds

6. **Finishing the unfinished agenda in HR:** There is dearth of manpower, in particular the doctors at all levels which has hit the reform process adversely. There is urgent need to generate, recruit and retain man power at different health facilities in the state. At the state level, a comprehensive HR policy headed by a HR cell (or, a dedicated HR person in the short run) is required to address all HR issues. At the ground level, diverse activities make it imperative to strengthen HR management at peripheral level. There is an urgent need to finalise the HR data base for better management and future planning.

A journey of learning...

The West Bengal Health Systems Development initiative has slowly and steadily created a new environment for strategic planning, equitable resource allocations, service delivery, and flexibility in approaches and convergence with nutrition. The main results have been described earlier. In this section, key lessons learnt during the process of introducing health reforms are assessed:

Government's commitment, programme flexibility, and technical support – three equally important ingredients for a faster reform process: The achievements of HSDI lies with 1) government's responsiveness and willingness to change (2) flexibility of the programme and (3) contribution from the Strategic Planning and Sector Reform Cell and the technical support team to make change possible .

Making the system work for change at the district level or below: It is important to institutionalise reform processes at the state level. However, it becomes more difficult to develop strong ownership at the district level or below. The HSDI's emphasis on ownership, oversight, and demand issues have made inroads at the district and block levels too. Gram Panchayats, blocks and districts are taking an overwhelming interest in preparing plans that will go on-line.

Building trust between stakeholders: The implementation of the Health Sector Strategy / HSDI strongly shows there has to be trust amongst stakeholders, like (a) health providers and PRIs for effective local management (b) people and health care providers for credibility of institutions (c) government and private providers for functional PPP initiatives (d) people and local PRIs for credibility of oversight, and so on. The interventions were found to be more successful where these relations are strongly built.

Alignment with NRHM and convergence with other departments (DWCD, PRDD): HSDI's focus on key reform areas helped to create a congenial internal environment for change. It also initiated and strengthened some reforms (HR, decentralization, access and demand) thus creating enough space for NRHM and other programmes to function effectively. The flexibility of off-budget funding has enabled better and effective functioning especially at the grassroot levels.

Technical assistance and its relevance - An important learning is to assimilate technical assistance into the functioning of the Department of Health and Family Welfare (DHFW) on a regular basis. The technical assistance process within HSDI has enabled the DHFW to identify areas for expert support and identify the best mechanisms to access it. Guidance provided by the Technical Assistance Team (TAST) has been mainly in two ways (i) support from members of TAST itself (ii) support in specific areas through contracted technical assistance provided by experts. SPSRC is now apt at using technical assistance in framing policies, planning, implementation, and evaluation

HSDI 2010 OUTCOMES

- Underweight in children (0-3 years) reduced from baseline of 43.5% to 35%
- Percentage of children (0-3 years) breast fed within one hour of birth increases from 24% to 29%
- Percentage of children (0-5 months) exclusively breastfed increases from 59% to 80%
- Percentage of children (6-9 months) receiving complementary feeding increases from 56% to 80%
- Percentage of children (12-23 months) receiving one dose of vitamin A in the last six months increases from 41% to 55%

Background

The Health Systems Development Initiative (HSDI) initially focused only on the health sector. In West Bengal, malnutrition remained a persistent problem which was reiterated in NFHS 3 (2005-06). Realizing the central role of nutrition in improving maternal and child health outcomes and achieving the goals stated above, the Government of West Bengal and the UK Government's Department for International Development (DFID) incorporated nutrition in the HSDI design. A detailed diagnostic enquiry and wide consultations helped to build consensus in the state and develop the design for the nutrition component. The Department of Women and Child Development and Social Welfare (DWCD), which implements the centrally sponsored Integrated Child Development Scheme (ICDS), is mandated to improve the nutritional status of children and pregnant women and thus was designated as the nodal department to address nutrition inequalities among women and children. The nutrition component of HSDI came into existence in early 2008.

Achievements

- A State Nutrition Strategy developed and disseminated
- A State Nutrition Strategy and Monitoring Unit (SNSMU), established in the DWCD to strengthened the ICDS system
- A comprehensive state training plan for all levels of ICDS functionaries has been developed and is under implementation. Training content includes both program and management related issues
- Master trainers at the state and district level, including all CDPOs and ICDS supervisors, have been trained and one cycle of cascade training was given to (approximately 80,000) anganwadi workers
- State plan for behavior change communication developed and under implementation
- Construction of anganwadi centres in six poor-performing districts. This contributes to improved access to the centres for vulnerable groups and minorities. For quality control, a standard design for construction was prepared complete with a pre school area, kitchen, toilet, and play area. District administration was involved in supervising construction.
- Convergence with health sector strengthened through planned regular interactions, availability of micronutrients, and first line treatment drugs in anganwadi centres; clear role of anganwadi workers in village health; nutrition day roll-out by the National Rural Health Mission
- State monitoring team constituted with responsibility for both financial and programme monitoring
- Process underway to introduce web-enabled MIS, with a special focus on tracking nutrition indicators and improved financial management
- Procurement strengthening processes have been initiated

Promoting appropriate infant and young child feeding (IYCF) practices is a key intervention to reduce malnutrition

STRATEGIC PLANNING AND SECTOR REFORM CELL

DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL