The health sector in West Bengal – some policy issues

West Bengal – curious mixture

- IMR / MMR /CBR/CDR numbers of institutional deliveries are not bad at the all-India level.
- Evidence of sustained effort & investment in primary healthcare & a fair amount of external assistance
- or does it reflect the general improvements in HDIs as a whole?
- Interesting issues that require close look at the numbers & the time frame. Has not been done so far.

- Availability of doctors / nurses infrastructure – however is poor vis-à-vis other advanced states, on an average.
- Very heavy dependence on the public sector – anomalous vis-à-vis other advanced states (total OPD Patients nearly 95 million in 2010)
- Kolkata – centric development. Periphery neglected in the public as well as the private sector.
- Changing disease profile.

- Question – What is the way forward?
- Consolidate primary infrastructure? Expand? Not expand?
- Expand secondary / tertiary? Where? In the districts? How?
- In the public sector /PPP? Purely private?
- Will it be correct to presume that further reductions in MMR /IMR will come through greater investments in higher tier institutions? What is the global evidence? Ideal division of resources between primary /secondary/ tertiary?

- Unwillingness to work in villages – across the spectrum of medical personnel.
- Certain policy decisions have hurt primary healthcare
- WBMES / WBHS split.
- Skewed incentives in favour of WBMES
- Do we force doctors to go to the rural areas? Because positive measures have not helped?

- Capacity of the state to delivery and enforce standards
- Flailing state
- Local supervision – mixed results. Close links of local leadership with white collar unions.
- Use IT – some promise [OPD tracking, Procurement]
- Disciplinary mechanism – weak, time consuming
- Fines – on the lines of Nitish Kumar & Shivraj Chouhan – one way

- **OPD Status monitoring system**
  - All heads of institutions report the performance of the concerned Outdoor Patient Departments through sms.
  - The performance reports contain details about OPD – time of opening & doctors attendance.
  - An sms server at the head quarter receives reports and provides feedback.
  - The sms server analyses the report and prepares management and citizen centric information.
  - The citizen centric part of the information gets published in the departmental web site for general viewing.

Propose to be extend

- Collection of OPD information
- Collections and collation of information on admission, refer-in, refer-out, discharge of patients of each department
- OPD ticketing
- Bulk SMS regarding health camps / polio delivery
- alerts and messages regarding important orders of the health department
- Instant reporting on infant and maternal death

- Health Bank – one stop shop for finance, information & services
- Move towards Universal Health Care – Srinath Reddy – High Level Expert Group
- Macroeconomics & Health – defined packages for primary, secondary, tertiary
- What do these mean for a flailing state?
- What has been the Arogyashree experience in A.P.?

Interesting findings from a study on "Hospital Efficiency in West Bengal", Department of Economics, Calcutta University Drs. Arijita Dutta, Arpita Ghose, Satarupa Bandyopadhyay, Aniruddha Mukherjee, B.R. Satpathi

- analyse inputs /outputs
- barriers to services
- assess patients perceptions
- efficiency analysis across health facilities

It debunks certain widely held myths

- Extreme infrastructure shortage
- Grossly underfunded
- Inducting doctors or equipment will help
- Hospitals should expand
- PPP always works
- Patients are absolutely dissatisfied

- Severe inequality in distribution of secondary hospitals, equipment & manpower.
- Sub-optimal use of available infrastructure
- Manpower shortages are manifest. But even this is suboptimally used. Index for doctors' involvement – total OPD doctor hours actually held to total OPD doctor hours possible with doctors in position (IDI).
- IDI average is 0.44. Correlation coefficient between the number of doctors & IDI is (-0.56), significant at 1%. More the doctors in a facility, the less they work.

- Units near Kolkata have good infrastructure, but their Bed Occupancy Rate is 52.93% and IDI is abysmally low at 0.39.
- People come for 'good' doctors & multi-speciality treatment.
- Richer people grab more than their share
- Lengthy, cumbersome processes deter the poorer segment more.
- Patients want better availability of medicines.

- Poor supervision of PPP
- Highest input slack for doctors & Gr D.

Two most scarce resources are sub-optimally utilized.

Analogy

- A giant, rusty flywheel – the health system. Difficult to move. No quick gains. Supervision – intensive
- Easier to rapidly turn smaller, newer peripheral flywheels – NRHM, HSDP, BHP, WBSAPCS, new super-specialities, more high end equipment, insurance schemes. But do these help turn the bigger wheel?
- Can we improve healthcare without turning the bigger wheel?

- A possible short / medium term scenario?
- Consolidate gains in primary.
- Incentivise service in remote & difficult areas & in special child / mother care centres
- Expand supply of nurses.
- Expand supply of doctors through PPP in medical education and/or all India recruitment
- Encourage / incentive multi skilling for doctors / nurses
- Short term fellowships that add to professional stature
- O & M contracts for poorly performing public facilities.