Where have they gone?

A study on the absenteeism of doctors and support staff in Primary Health Care Centres

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TO THE RURAL POOR

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DEDICATION

The report is dedicated to the memory of Dr. Poornima Vyasulu who encouraged and supported IDPMS to develop an insight into public health and issues of maternal health.

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RONYMS AND ABBREVIATIONS

ARS – Arogya Raskha Samiti
CSOs – Civil Society Organisations
CHC – Community Health Centres
DHO – District Health Office
FGD – Focus Group Discussion
ZP – Zilla Panchayat
TP – Taluka Panchayat
GP – Gram Panchayat
PRI – Panchayat Raj Institutions
PHC – Primary Health Care centres
MO – Medical Officers
SRS – Sample Registration System
TFR – Total Fertility Rate
IMR – Infant Mortality Rate
MMR – Maternal Mortality Rate
NRHM – National Rural Health Mission
MDG – Millennium Development Goals
NHP – National Health Policy
GDP – Gross Domestic Product
GoI – Government of India
GoK – Government of Karnataka

Executive Summary 1

In spite of serious efforts made by the national and state governments for improving the quality of human resources and infrastructure facilities there is wide spread and extensive dissatisfaction frequently expressed over absenteeism[1] among doctors and support staff, and poor quality of delivery of primary health care services. Absenteeism is a very worrisome issue and scarce resources are used in an inefficient manner, causing leakages. This is primarily due to under provisioning and ineffective utilisation of resources and the lack of accountability. In the Indian context, health is a state government subject (as different from central government). The state government is mandated to provide adequate health care facilities to its citizens. Health Policy of sub national governments will have a bearing on the quality of services provided. The Indian government is making every effort to increase financial allocation to the health sector in Karnataka, where the study was conducted. The Government of Karnataka is depending to a large extent on transfer of funds from the central government. Government expenditure on health in Karnataka is limping at around three percent of the total expenditure. In providing essential services, this presents severe constraints in real terms. Even at the present level of funds allocation, with seventy percent of funds going into personnel costs (salaries, travel etc), an hour of official time lost by doctors and paramedical staff is a loss of opportunity to translate the resources to effective usage.

In order to estimate the incidence of absenteeism among doctors and paramedical staff in primary health care centres in Karnataka, IDPMS conducted a study in Shimoga, Chitradurga and Bidar districts of Karnataka. This study covering 30 Primary Health Care centres (PHC) was supported by Results for Development Washington DC, USA. This study has focused on causes of absenteeism, loss of resources due to absenteeism and issues related thereto, with a view to suggest ways and means of reducing absenteeism and maximising –impact on the utilisation of public resources. The study included four unannounced visits to the selected PHCs and face- to- face interactions with available staff. Besides, Focus Group Discussions were held in selected PHCs with staff members, users and Arogya Raksha Samiti (ARS) members (formed under NRHM programme). Records available at the PHCs like the attendance and movement registers were studied. The staff population of PHCs was 173, consisting of 46 doctors, 17 male nurses, 57 female nurses, 24 pharmacists and 29 laboratory technicians. Out of this, 158 staff members were interviewed.

Key findings[2]

Generally it was observed that absenteeism was common across all staff categories. It was more during the beginning of the week as compared to middle of the week. Absenteeism was more the in backward district[3] as compared to forward districts. Staff members tend to be absent more in the morning consulting hours as compared to the afternoon. The study shows there is no significant difference between male and female doctors and staff, with respect to absenteeism rate. Out of 158 staff members who were interviewed, 41 reported that they stayed in official quarters. The study revealed that place of residence does not influence absenteeism. This study has shown that there is no link between age and absenteeism. Similarly, there is no link between length of service and absenteeism.

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1 For the purpose of the study, absenteeism is defined as non availability of doctor and medical staff to patients, due to official or other reasons, whenever patients approach the PHCs for treatment.

2 These findings are from the three sample districts and they are only indicative of general situation in PHCs of Karnataka state India.

3 Districts of Karnataka are defined as backward or forward based on the Human Development Index ranking given in the Karnataka Human Development Report 2005

Absenteeism rate was significant in all the districts. However, between the districts, absenteeism[4] was more in Bidar (64%), considered to be a backward district as compared to Shimoga (44%), a forward district. Absenteeism was significantly more (69%) in the morning as compared to the afternoon (38%)[5]. Since most of the staff members travelled from outstations, either they were absent or came late to the PHCs. Once they arrived, they continued to stay for the afternoon session as well. At the time of our unannounced visit, 11.6% of staff members were absent one time, 35.3% were absent two times, 16.8% of staff was absent three times and 20.8% of the staff was absent on all the four occasions. Among the absentees, 50% of the pharmacists were absent twice, followed by doctors- 41.3%, laboratory technicians -37.9%, male nurse-35.3% and female nurse-22.8%. Staff members tend to abstain more on Monday (65%) as compared to Thursday (51%).

Focus Group Discussions brought out the perceptions of the staff, users and the monitoring committee. Amongst the staff that participated, 47% said absenteeism was 'inevitable'. In the same staff group, 73% said that they would abstain from work only when there was an emergency. Other reasons that were given - no housing facility, poor transportation, and location of the PHC. In addition there were meetings and training programmes to attend and deputation. Further, they agreed that the consequences of absenteeism were manifold. Many of them - 47% said they suffered from work pressure, followed by deterioration in quality of treatment and, negligence. With regard to supervision from superior officers, the study reveals that on majority of the occasions, memos were issued, salaries were withheld and the matter was referred to higher officers. It was interesting to note that this response was from doctors regarding their subordinate staff. It was not clear from the doctors as to whether they were subjected to frequent inspections and monitoring.

Arogya Raksha Samiti, formed under the NRHM programme, is mandated to monitor the functioning of PHCs and manage the untied funds. It was surprising to learn from them that, in the last two years, not even once they had discussed the issue of absenteeism. They said that no action was taken against staff members who were repeatedly absent. The users held their views on absenteeism. They said, due to non-availability of staff housing with proper security, lack of drinking water and electricity facility, most of the staff travelled to the PHC from outstations. Due to poor transportation facility, on most days, doctors and staff came late and left early. Their arrival and departure depended on timings of the transport facilities. There were consequences due to absenteeism. There was wastage of resources and quality of service was hampered. With a conservative estimate, and assuming that doctors and other staff only attended to patients without doing other administrative and extension works, the annual wastage per staff was 117,000 Indian rupees. The doctors did not give, on an average, more than five minutes to a patient.

From the study the following policy issues have emerged.

- Absenteeism is a nebulous issue and needs serious consideration.
- Policy makers should consider the issue of absenteeism while framing policies.
- There is an urgent need to streamline monitoring and supervision of PHCs and PHCs in backward districts should get special attention.

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[4] For the purpose of calculating absenteeism rate, doctors and staff members who were not in the facility on all the four unannounced visits were considered 100% absent, those who were absent on three occasions were considered 75% absent, those who were absent on two occasions were considered 50% absent, those who were absent on one occasion were considered 25% absent and those who were present on all the four occasions were considered 100% present.

[5] All the PHCs were visited both in the morning and afternoon sessions.

- Incidence of absenteeism should be well publicised at the local level as well as at the state level.
- There is need to design and implement a rational incentive and disincentive mechanism to minimise absenteeism.
- Occupancy of the staff housing quarters should be monitored regularly.
- Local level monitoring should be put in place by empowering the Taluka Panchayats giving them authority over functions, functionaries and funds of the PHC. They should have power to enforce sanctions. Stringent measures should be taken to prevent those who have decision-making powers using their offices for private profit.
- Local communities and user associations should be actively involved in monitoring.
- Right to Information should be used effectively so that users and citizens are informed about absenteeism.
- Creating a separate health administration system and separating the extension activities from clinical activities should be considered.
- Separate public health cadre should be created.
- Performance standards should be fixed and providers should be made accountable to local governance and community.
- Vacant posts should be filled immediately.
- Civil society organisations should train the local community to raise awareness regarding their legitimate entitlements.
- Social accountability should be institutionalised.

2 Background

Governments in developing countries spend substantial amounts of money on public services including health care. In India, public spending on health has increased from 0.22% of GDP in 1950-51 to 1.05% of GDP during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years.

The total expenditure in the health sector, which includes government spending, private sector and out of pocket spending, is 5.2% of the GDP.

Of this, about 17% of the expenditure is public health spending and the balance being private out-of-pocket expenditure. In per capita terms, it increased significantly from less than Re 1/- in 1950-51 to about Rs. 215/- in 2003-04. However, in real terms, it is around Rs. 120/- for 2003-04. This is considered far below the recommendation for low-income countries.[6]

Though there is a strong case for enhancing allocation for public spending on health (Government of India intends to spend at least 2-3% of GDP), it is equally important to see how effectively those funds are spent. One region with small expenditure can achieve what another with a large expenditure fails to, because of differences in accountability standards, alertness of users and efficiency, among other reasons. "While a certain volume of social expenditure is necessary to improve living standards, it may not be a sufficient condition".[7] In spite of serious efforts made by the national and state governments for improving the quality of human resources and infrastructure facilities.

There is large-scale dissatisfaction frequently expressed by users over absenteeism among doctors and support staff, and poor quality of delivery of primary health care services.

This is primarily due to under provisioning and ineffective utilisation of available resources and lack of accountability.

Millennium Development Goals (MDGs) represent commitment from developing countries to take effective measures to reduce poverty and hunger, to address ill health, lack of education and lack of access to clean drinking water. It is expected that these goals will be met by 2015. Within these, health-related goals assume importance. India has set the target of reducing the Infant Mortality Rates (IMR 30) by two thirds, reduce Maternal Mortality rate (MMR 100) by two thirds, and minimise or eradicate malaria and other major diseases, including HIV and AIDS.

The National Rural Health Mission (NRHM)[8] is an ambitious health programme of the Government of India (GoI). The budget allocation for 2005-06 was Rs. 56000 million. The Government of India intends to have an annual increase of 25-30%. Budget estimate for 2010-2011 is Rs. 170380 million. The goals of this programme are broadly convergent with MDG. Through this programme, the GoI plans to increase public spending on health and move towards the set target. Health being a state subject under the Indian Constitution, states and sub-national governments is primarily responsible for implementation of programmes and GoI transfers funds to states under specific programmes and schemes. However, success depends on initiating appropriate

6 National Rural Health Mission Government of India.

7 Raghuram and Ray The State of Civil Society Meeting Health Needs, Reaching Equity HIVOS India 2000

8 The National Rural Health Mission (NRHM) is a flagship program of the Government of India. '*National Rural Health Mission aims to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operational zing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.*

policy reforms, developing suitable institutional mechanisms, where users and community have a role to play and there is effective and efficient utilisation of allocated public resources. Policies of the state governments will have a bearing on health expenditure and delivery of quality services.

> While the GoI intends to spend 3% of GDP on health, the priority of state governments accorded to healthcare appears to be decreasing.

As seen in the decreasing proportion of health expenditure over the years in almost all states. In effect, less money, per capita is being spent by the government, as a percentage of state income.[9]

Skilled doctors and experienced support staff are key to the delivery of quality health services. Skilled human resources are responsible for socio economic development of a country. Bulk of the budget allocation in the health and education sectors goes for salaries and allowances of front line officers and support staff.[10] There are instances when these funds sometimes do not reach the intended recipients. Sometimes they also remain unspent. The Nalanda[11] study has revealed that the drawing authorities could not utilise the funds due to gaps in information, tight time schedules and administrative problems in withdrawing money. In a situation like this, the absence of frontline and support staff from their duty stations will obviously have an adverse impact on the quality of services.

Available literature on absenteeism among doctors and school teachers have shown that increased public spending has not resulted in improved public service delivery. In the Indian context, both doctors and paramedical staff play a major role in addressing health issues at PHC[11] level. Unfortunately, the issue of absenteeism has not been discussed sufficiently, if at all, in the policy framework of the Indian health system. Not many research studies have been done at local level to gather evidence for effective advocacy. There has been no proper attempt to quantify the impact of absenteeism on efficient delivery of services and on the inefficient deployment of funds that could lead to leakages.

The Study Context

For effective delivery of health services, professionally qualified and skilled human resources are an important prerequisite. Despite various efforts made to create human resources, there remains a gap in human resources at primary care levels. For instance, at the national level, there is an overall shortage of 7.8% for doctors, 5.3% of PHCs do not have doctors, approximately 41% PHCs do not have laboratory technicians and 17% PHCs function without pharmacists.[12] Though unfilled posts do not absorb budgetary resources, they will have a detrimental impact on the quality of services. As bulk of health budget constitutes salaries and wages[13] for the health staff, absenteeism or non-availability[14] of doctors and support health staff would adversely affect the quality of the service and possibly lead to wastage of resources.

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9 Analysis of public-expenditure on health using state level data-Ramesh Bhat Nishant Jain June 2004

10 70% of the expenditure on health is for salary payments and in education sector 82-90% is the salary bill of their total expenditure. 'Expenditure on Education and Health at Local Level- A study in Karnataka'. CBPS 2007

11 The National Health Policy envisaged a three tier structure of primary, secondary and tertiary health care facilities to bring health care services within the reach of the rural population. 1. Sub Centre for every 3000-5000 population, PHC for every 20,000-30,000 population and CHC Community Health Centre(CHC) for covering population of 80,000-100,000.Primary Health Care Centre is the first place of contact where in rural community come in contact with a doctor and attendant paramedical staff to have relief from illness and ailments. Further Taluk Health Centres at the block level and District Hospitals provide secondary services.

12 Rural Health Statistics Ministry of Health and Family Welfare. GoI,2007

13 90% of non-plan funds are for salaries and wages.

14 Absenteeism and non-availability of doctors and support staff have been used interchangeably. When doctors are not available to the patients due to other official/ personal engagements, patients have to seek health services from other sources.

Besides shortfall of doctors and paramedical staff another factor that relates to absenteeism is lack of incentives for the doctors working in rural areas. It is a generally accepted fact that doctors prefer to practice in urban areas as they offer opportunities for professional enhancement, education, better amenities and a comfortable family and social life. With opening up of economy and the Indian middle class having enough surplus money, numerous multi-specialty and high tech hospitals have come up in urban centres. Further, the national and state governments are encouraging corporate and private sectors to open hospitals in tiers two and three urban centres by providing several incentives. The scenario in rural areas is quite different. There are not enough qualified doctors available and with regional imbalances, there is an unequal distribution of doctors. There are no proper incentives in place for doctors to serve in rural areas.[15]

Of late, Karnataka and a few other state governments in India have invited NGOs, charity organisations and medical colleges to adopt and run the PHCs. Though this is not an unwelcome move, it indirectly prompts the State to abdicate from its primary responsibility of providing primary health care and to place state assets at the disposal of private health service providers. Such move might discourage citizens to access PHCs; and instead, spend money to get private services. In many instances, such PHCs have become referral centres for high tech tertiary hospitals. What do citizens get when they visit PHCs? They see doctors and nurses absent (due to vacant positions or for other reasons), poor infrastructure, and lack of medicine supply.[16]

A study, conducted in South Asian countries, has shown that the absenteeism of doctors and schoolteachers in India was about 43% and 25% respectively.[17] Another study conducted in Rajasthan, one of the backward states[18] in India, has shown that low quality of public health delivery had an adverse impact on people's health.[19] Absenteeism was 45% in Sub Centres and 36% in PHCs and CHCs (Community Health Centres). A study conducted by Public Affairs Centre, Bangalore, India, has revealed that overall Citizen Satisfaction was less than 50% for the public services in the city of Bangalore and additional resource hardly had any impact.[20]

Though in respect of health infrastructure and staff position, Karnataka state where the present study is conducted has made progress, it is facing constraints like non- availability of doctors, paramedics, poor monitoring and insufficient accountability mechanisms. A good appraisal system is not in place with associated incentives and disincentives for good or poor performance. Added to this are problems related to governance (Program Implementation Plan document on NRHM). It has been suggested that management and control of health facilities should be brought under Gram Panchayats[21] and that the community and users should be actively involved in monitoring PHC services. However, this has brought out the failure of the state to set up an effective accountability system. Due to absenteeism of doctors and support staff, the benefits of the expenditure incurred on them do not reach the intended beneficiaries, pushing the poor and underserved population to avail of private services.

This study has made an attempt to analyse absenteeism among doctors and support staff and understand the causes as well as impact of absenteeism in thirty Primary Health Care centres in three districts of the State of Karnataka, in south India.

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15 In the month of September-October 2009, PHC doctors in Karnataka went on a total strike demanding revision of wages and improvement of working conditions. They submitted their resignations. They resumed work after many northern Karnataka districts faced the fury of floods. The Government promised to look into their demands, but no progress was made. Again in January 2010, they reminded the state government about their unfulfilled demands.

16 Jeff Hammer 2007. Publicly provided primary health care and health

17 Missing in Action: Teacher and Health Worker Absence in Developing Countries, *Journal of Economic Perspective, Volume 20, November 1-Winter-2006 ps 91-116*

18 As per the Human Development Index

19 Abhijit,Deaton and Duflo, 2004

20 Public Affairs Centre Bangalore.

21 With the 73rd amendment to the Indian Constitution states have set up a three tier system of governance in the districts namely, Zilla Panchayat, Taluk Panchayat and Gram Panchayat.

Overview of Health Situation in India and Karnataka

Health is not merely absence of sickness. It is a state of positive well-being. The World Health Organization (WHO) has defined health as a state of complete physical, mental, social and spiritual well-being. India, being a signatory to Alma Alta declaration, is committed to the goal of Health for all by 2000. Judging by various research reports and indicators, India has to traverse a long way before this goal is achieved.

The public health investment in the country, over the years, has been comparatively low, and as a percentage of GDP has declined from 1.3% in 1990 to 0.9% in 1999.

Some of the policy initiatives outlined in the National Health Policy of Government of India -1983, National Health Policy of 2002(NHP 2002) narrate shortfalls in several areas. Though the overall life expectancy is 64.6 other outcomes are far from satisfactory.

> The Infant Mortality Rate (IMR) was 70 per 1000 live births and Maternal Mortality Rate (MMR) was 408 per 100000 live births, which was one of the highest in the world.

When we look at the status among several states, the best performing state of Kerala has an IMR of 14 and MMR of 35, as compared to some of the backward states like Bihar with IMR of 64 and MMR of 707 and Uttar Pradesh with IMR of 84 and MMR of 707. While national averages in most of the indices are themselves at unacceptably low levels, they have masked the wide disparities among states and lack of access to public health services to the vulnerable and undeserved population. The health standards are grossly inadequate.

NHP 2002 declared that its main objective was to attain an acceptable standard of good health among the general population of the country. It envisaged increasing access to decentralised public health system by improving the infrastructure, ensuring a more equitable access to health services across social and geographical expanse of the country. The policy set the following goals to be achieved by 2015.

How does the situation look now? The MMR has reduced from 301 per 100,000 births in 2001-03 to 254 in 2004-06. The IMR is down to 55 per 1000 births as per the data of 2007 and the Total Fertility Rate (TFR) of 2.7, (as revealed by the Sample Registration System, 2007) has been achieved. Though the situation at the national level looks satisfactory, many concerns and challenges continue to exist. Out of 24 million deliveries that take place, 15% are likely to develop complications. Institutional delivery is around 47%. With proper measures, around 67,000 deaths could be avoided per year. Lack of community ownership of public health programmes impacts standards of efficiency, accountability and effectiveness. There are striking regional inequalities.

Curative services favour the non-poor: for every Re.1 spent on the poorest 20% of the population, Rs.3 is spent on the richest clientele. Hospitalised Indians spend an average 58% of their total annual expenditure on healthcare services. Over 25% of hospitalised Indians fall Below Poverty Line because of hospital expenses. Over 40% of hospitalised Indians borrow heavily or sell assets to cover expenses.[22]

The targets that were fixed under NHP 2002 are yet to be achieved and many of them figure as targets for NRHM that ends in 2012. Further, the targets are part of MDG.

As per the Directive Principles of State Policy in the Indian Constitution, the State is obligated to provide health and medical care to all its citizens. The state governments are mandated to set the priorities and provide leadership. The Government of India facilitates the process and transfers funds for the national programmes. With this proviso in mind, let us look at the health status in Karnataka, where this research is conducted.

[22] Mission document NRHM 2005-2012.

Table-1 : Goals set by Government of India

Eradicate polio	2005
Eliminate leprosy	2005
Eliminate kala afar	2010
Eliminate lymphatic filariasis	2015
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50% on account of TB, Malaria and other vector and water borne diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/100,000	2010
Increase utilisation of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
Increase share of Central grants to constitute at least 25% of total health spending	2010
Increase state sector health spending from 5.5% to 7% of the budget Further increase to 8%	2005 2010

Source: National Health Policy, GoI, 2002

Health status in Karnataka

Karnataka's achievements are better than the national averages. The TFR is 2.1, IMR is 47 and MMR is 213, which are lower than the national averages. Major demographic and health indicators are as follows:

Though there are achievements there are also challenges. There are regional disparities within the state. The High Power Committee for Redressal of Regional Imbalances (HPC-FRRI) 2001 (also known as Dr. Nanjundappa Committee), has highlighted the regional disparities in health infrastructure and service facilities, especially between South Karnataka and North Karnataka. In addition, the 1999 and 2005 Karnataka Human Development Reports have brought to light regional disparities. The six districts of Hyderabad Karnataka namely Bidar, Gulbarga, Raichur, Bellary and Koppal and Yadgir (the last two of which are very recently formed), along with two districts of Bombay Karnataka

Table-2 : Demographic and health indicators

Sl.No.	Item	Karnataka	India
1	Population (2001) Census Million	58.25	1028.61
2	Crude Birth Rate (SRS 2007)	19.9	23.1
3	Crude Death Rate (SRS2007)	7.3	7.4
4	Total Fertility Rate (SRS 2007)	2.1	2.7
5	Infant Mortality Rate (SRS 2007)	47	55
6	Maternal Mortality Ratio (SRS 2004 - 2006)	213	254
7	Sex Ratio (Census 2001)	965	933
8	Population below poverty line in percentages	20.04	26.1
9	Female Literacy rate (2001 Census)	56.9	53.7

Source: NRHM, Government of Karnataka State Report

Bijapur and Bagalkot are considered as most backward.[23] There are district wise imbalances and differences as indicated below:

Table-3 : District Wise Selected Key Indicators of Karnataka. (In percentages)

Good performing districts*

District	Female Literacy	Girls married < 18 years	Current users of family planning methods	Birth order 3 and above	Safe Delivery	Complete Immunisation	Composite Index
Hassan	59.32	15.2	75.1	19.7	69.7	92.8	81.55
Shimoga	67.24	16.5	69.3	22.8	83	92.9	80.37
Kodagu	72.53	22	70.6	18.8	79.4	94.8	80.06
Dakshina Kannada	77.39	4.5	63.7	32	91.5	86	78.77
Uttara Kannada	68.48	15	66	27.2	86.1	89.9	76.11
Udupi	74.02	4.5	63.7	32	91.5	86	75.9

[23] At the time of reorganisation of the state in 1956, some of the districts from the neighbouring states of Maharashtra, Andhra Pradesh were integrated with the then Mysore State Karnataka state was formed.

Average performing districts*

Mandya	51.62	37	71.7	26.1	61.9	88	75.86
Mysore	55.81	47.9	65.4	23.9	69.7	92.7	75.
Bangalore (R)	78.98	21.05	63	16.4	79.1	83.7	75.34
Bangalore (U)	78.98	37	60.1	26.1	90.6	77	75.19
Chitradurga	54.62	30.05	59.9	34.4	53.8	88.4	73.98
Tumkur	57.18	27.1	61.3	27.3	63.5	88	73.97
Dharwar	62.2	36.5	61.2	37.4	65.3	74.8	73.03
Chamarajanagar	43.02	47.9	65.4	23.9	69.7	92.7	72.18
Chickmagalur	64.47	37	71.4	26.1	78	83.5	72.13
Kolar	52.81	33.5	57.1	29.7	59.2	90.6	71.92
Gadag	52.58	36.5	61.2	37.4	65.3	74.8	69.72
Belgaum	52.83	55.8	61.8	36.7	68.6	64.8	68.75
Haveri	52.58	36.5	61.2	37.4	65.3	74.8	65.66

Poor performing districts*

Bellary	46.16	44.2	50.4	48.6	54	52.6	65.54
Davangere	58.45	35.5	59.9	34.4	53.8	88.4	65.43
Bijapur	46.19	64.8	47.1	43	50.1	53.2	62.86
Bidar	50.01	67.6	50.6	52.9	52.5	50.33	60.55
Raichur	36.84	57.1	45.4	52.8	48	37.2	58.34
Gulgarga	38.4	47.7	39.2	53.7	47.7	25.3	58.31
Bagalkot	44.1	64.8	47.1	43	50.1	53.2	54.7
Koppal	40.76	57.1	45.4	52.8	48	37.2	53.09

Source: National Commission on Population, GOI, 2001.

Note: *- The classification is based on the composite index. Human Development Report Karnataka 2005.

The poor performing districts have the lowest health indicators as compared to the rest of the state. Added to this, the rural-urban disparities, rather than diminishing, are getting exacerbated. The IMR in rural areas is 64 as compared to 24 in urban areas (HDR report of Karnataka 2005). Equity is a key policy thrust area for Karnataka. The health status of the Scheduled Castes and Scheduled Tribes is far lower than the total population. Under-nutrition among pregnant women and infants continues to be a cause of concern.

The percentage of children having severe anaemia in the age group of 6-35 months is highest in Karnataka when compared to the other three southern states.

Primary health care infrastructure

In Karnataka, the number of PHCs[24] has increased six times, from 365 at the end of Sixth Plan (1981-1985) to 2195 at the end of March 2008, during Eleventh Plan (2007-2012). During the corresponding period the total number of PHCs in the country increased from 9115 to 23458 (2.5 times). Similarly, Sub Centres increased from 4984 to 8143(63%). However, the expansion was not evenly distributed across the state. In terms of population covered, South Karnataka has a better ratio when compared to Hyderabad and Bombay Karnataka regions. Out of 2195 PHCs, 79 (3.6%) do not have their own buildings. The average population served by Sub Centres has marginally decreased by 4%, from 4461 in 2004 to 4284 in 2008, whereas the population served by PHCs there is a significant decrease of 25% from 21418 in 2004 to 15909 in 2008. Number of beds per 100,000 population has almost remained stagnant at 88(2004). With the up-grading PHCs to CHCs and starting additional taluk hospitals, there could be further addition to the number of beds provided.

Doctor to population ratio is 1:9385 (2008) and doctor to patient ratio is 1:6346 as compared to the corresponding figures for 2004, which are 1:3240 and 1:2167 respectively. Nurse to bed ratio of 1:7 shows an improvement over 2004 figure of 1:9. It is needless to add that in respect of the above indicators, South Karnataka has performed better when compared to other parts of the state. A more equitable distribution of resources is necessary to bridge regional imbalances. Though overall performance has improved over a period of time, Karnataka still lags behind its three neighbouring states.[25]

Human resources

Table-4 : Staff position in Primary health care centres of Karnataka

Staff	Required (R)	Sanctioned (S)	In position (P)	Vacant (S-P)	Shortfall
PHC Doctors*	2195	3528	2814	714	***
Health Assistant (Male)	2195	1302	837	465	1358
Health Assistants (Female/LHV/ANMs)	2195	1209	1170	39	1025

Note: * One doctor per PHC. There are 2195 PHCs. Figures are as on March 2008. It is expected that every PHC should have at least one qualified medical -officer.

There are 2195 PHCs and all of them have doctors. However, 968 PHCs are functioning without lab technicians and 375 PHCs do not have pharmacists. Only 368 PHCs have a lady doctor. It is learnt, that the state government has taken measures to fill the vacancies in PHCs. With the gradual conversion of PHCs to provide facilities for 24 hours on all the seven days in a week, the state government has plans to

[24] PHCs serve a population of 30,000, CHCs serve a population of 120,000 and sub centres serve a population of 5000

[25] Karnataka Human Development Report 2005

recruit additional doctors, specialists, and paramedics. As these are on contract basis, it is gathered that the response is lukewarm.

Having good infrastructure and improved human resources in place, does not necessarily guarantee reduction in absenteeism of doctors and paramedics. Effective accountability and monitoring mechanisms must be put in place.

Health status in the selected districts

Bidar, Chitradurga and Shimoga are the districts in Karnataka chosen for the study (more details in chapter VII). The following table gives details of health status in the three districts.

Table 5 : Demographic and health indicators in the selected districts

Districts	Bidar	Chitradurga	Shimoga
Population	1,502,373	1,517,896	1,642,545
Decennial Population growth Rate(1990-2001)	19.6	15.6	13.1
Density of population / sq. km	276	180	194
Sex Ratio	949	955	978
Sex Ratio in 0-6 age group	941	946	956
Literacy Rate	60.9	64.5	74.5
Female Literacy	50.16	54.62	67.6
% of urban population	23.0	18.1	34.8
Girls married below 18 years (%)	67.60	30.05	16.50
Safe delivery (%)	52.50	53.80	83.00
Complete Immunisation (%)	50.30	88.40	92.90
Beds per 100,000 population	67	88	110
Rural population served per PHC	28756	22405	19376
No. of PHCs	42	57	57
Composite Index (%)	60.55	73.98	80.37
HDI	0.599(21)	0.627 (16)	0.673(5)

Source: GoK , Department of Health and Family Welfare mohfw.nic.in/NRHM/state%20 Files/Karnataka.htm 2008-2009.

Shimoga, located in the Western Ghats, is one of the most culturally enlightened districts in the state, with a great deal of political vibrancy. On all counts of development, it is one of the better performing districts. Chitradurga, located in the mid-region of the state, is a rain-fed agricultural area and is usually faced with drought. Bidar, which is at the northern tip of the state, is farthest from the state capital. It has strong economic and social relationship with the neighbouring states of Maharashtra and Andhra Pradesh. Before its integration with Karnataka, Bidar belonged to the erstwhile Hyderabad State, and is considered to be backward.

Health finances in the selected districts

Table-6 (Rs. In million)

Districts	Account Head	2006-07		2007-08		2008-09	
		Plan	Non-plan	Plan	Non-plan	Plan	Non-plan
Shimoga	2210Medical and rural health	36	134.9 (120.6)	33.36	165.4 (150.4)	36	132.3 (116.7)
	2211 Family welfare	58.32	2.98 (2.31)	75.81	4.65 (3.94)	86.37	3.5 (2.34)
Chitradurga	2210 Medical and rural health	33.51	108.4 (92.08)	34.31	135.0 (118.1)	37.83	172.4 (154.7)
	2211 Family welfare	26.31	16.95 (15.11)	52.12	22.5 (20.56)	72.32	37 (34.53)
Bidar	2210 Medical and rural health	33.97	102.45 (92.5)	40.24	112.3 (102.0)	55	136.9 (126.3)
	2211 Family welfare	28.13	0	43.27	0	64.68	0.9
Karnataka	2210 Medical and rural health	959.1	288.54 (249.15)	1029.4	3780.2 (3347.4)	932.79	4425.35 (3913.8)
	2211 Family welfare	47.4	56.83 (51.73)	114.1	73 (67.69)	152.97	109.14 (86.92)
GoI	2210 Medical and rural health	39.5		42.7		42.93	
	2211 Family welfare		1351.4		1619		2107.3
Total			2397.4		2805.2		3236

Figures in brackets show expenses on salary

Source: Link Documents GoK

Bidar, as a backward district, received increased allocations in the last three years as compared to the other two districts. During 2007-08 and 2008-09, the allocation to Bidar as a percentage of the total state health budget to districts, is 3.17 and 3.31, where as the corresponding figures for Shimoga, a forward district is 4.35 and 4.78, and for Chitradurga it is 3.47and 4.11. Nearly 95% of the Family Welfare budget is for family planning and related activities; and to a large extent this is met by the GoI. The staff salary accounts for 90% of the non- plan budget. Absenteeism of doctors and support staff would mean that the resources allocated for salaries of the staff are not converted into effective outputs.

3 Study Objectives

Overall objective of the study is to estimate the absenteeism rate among doctors and paramedical staff working in PHCs, analyse the causes for absenteeism and estimate loss of resources due to absenteeism. The specific objectives are:

1. To estimate the absenteeism ‑rate according to the different categories of medical staff at PHCs.
2. To find out the determinants of absenteeism.
3. To ascertain the financial loss due to absenteeism.

In addition, the study envisages giving suitable policy recommendations for the_‑use of resources in an effective and efficient manner.

Study Hypotheses

1. The incidence of absenteeism is higher in backward districts as compared to forward districts.
2. The incidence of absenteeism is more in higher among qualified medical professionals, as they have ample opportunities to have a private practice.
3. As women have family commitments, their absenteeism is higher compared to their male counterparts.
4. The farther the location of PHCs to towns, the higher the rate of absenteeism.
5. Absenteeism is more during the beginning and end of the week as compared to the midweek. Or absenteeism is related to the days of the week.
6. People are more absent nearing their retiring age.

Methodology

The methodology for conducting the study was to make surprise visits to the selected PHCs on four occasions. On each occasion,[26] data regarding the staff members who were present or absent were recorded. Before collecting the data, a list of staff members who are on the pay roll was made. Temporary staff and those who were on night shift were not considered. The administrative staffs were excluded from the study. Questionnaires for the staff were administered and recorded. Similarly, facility survey questionnaires were filled. The data was gathered by interviewing the doctor and, if the doctor was not available from the next responsible person. Secondary data from the PHC was gathered.

For the purpose of calculating absenteeism rate, staff members who were not in the facility on all the four visits were considered 100% absent, those absent on three episodes were considered 75% absent, those

[26] The field investigators visited the PHCs in the morning at 9 AM and in the afternoon at 2 PM on Monday and Thursday

absent on two occasions were considered 50% absent, those who were absent once were considered 25% absent and those present on all the four occasions were considered 100% present.

Sampling

Absenteeism (non-availability of doctors for the patients) is one of the key factors in addressing the health issues at Primary Health Care centres. Therefore, it was proposed to study the absenteeism of medical staff and its impact on the people. For this purpose, it was decided to conduct absenteeism study in thirty PHCs of three districts. We employed two- stage sampling described below.

In a rural public health care system, PHC is the first point of contact for a patient where s/he receives primary health care services. The PHC consists of a medical officer and attendant nurses, health workers, pharmacists, laboratory technician and administrative staff. Though there are Sub Centres under the PHCs, they are mainly extension centres and doctors are expected to visit once a week. The PHC is the first point of contact for a citizen where s/he is entitled to the services of a doctor and auxiliary staff like nurses, technicians and pharmacists. The study involved selection of PHCs on a random sampling basis. We employed two-stage sampling – at the first stage three districts were selected and at the second stage, ten PHCs from each of the three chosen districts were selected.

Karnataka state is divided into 30 districts. Before selecting the PHCs, it was necessary to select the districts. As described in earlier chapters, there are regional inequalities and development is not uniform across the state. Using the HDR (2005)[27] of Karnataka, districts of the state were classified into three groups namely: good performing, average performing and poor performing districts. One district from each category was randomly selected. Shimoga, (relatively forward) Chitradurga (mid-range district) and Bidar (backward) were the districts chosen from each category.

Shimoga district has many distinct characteristics. It is located in the Western Ghats, which is the habitat of biodiversity with rich flora and fauna. Culturally it is very rich and has produced many famous literary and political personalities. Further, it has given Karnataka four chief ministers. The current chief minister too hails from the district. It is closer (compared to the other districts in the study) to Bangalore and has good road and rail connectivity. It draws the attention of the political leaders. Bidar, a backward district, is at the northern tip of the state bordering the states of Andhra Pradesh and Maharashtra. It has not received due attention with regard to education and health. It is distant from Bangalore, the capital of Karnataka and does not draw much attention. Chitradurga, located at a distance of about 200 kms, is from Bangalore city is in the heart of Deccan Plateau and has rich mineral resources and many historical places to visit. However, it receives poor rainfall and livelihood is dependant on dry land for agriculture. The district has remained relatively backward in spite of many political leaders hailing from the district.

[27] At the time of preparing the HDI report there were 27 districts.

A list of all the PHCs located in these districts was obtained. From this list, thirty PHCs, ten PHCs from each district were selected at the second stage, on a random basis using random number tables. The selected PHCs are follows:

Table-7 : List of selected PHCs

Sl.No.	Districts		
	SHIMOGA (5)[28]. PHCs-57	CHITRADURGA (16) PHCs-57	BIDAR (21)PHCs-42
1	Haranahatti	Naikanahatti	Dubalgundi
2	Megaravalli	Yaraballi	Hallikhed(K)
3	Hosuru	Hasidavanahalli	Dongapur
4	Talaguppa	Bharamasagara	Hallarga
5	Purappe Mane	Baguru	Mannaskhalli
6	Thogarse	Kalamarahalli	Hedgapur
7	Shiravanthe	Parasurampura	Mudhol(B)
8	Yadur	Thalaku	Hulsoor
9	Kumsi	Kyasapura	Rajeshwar
10	Yenekoppa	Tallikatti	Waravatti

Data sources

As described earlier, data was gathered by making unannounced visits to the selected PHCs. Both doctors and the paramedical staff were interviewed with the help of a questionnaire. In addition, facility survey was conducted. Focus Group Discussions were held with the staff, users and the Arogya Raksha Samits (ARS), formed under the NRHM to monitor the PHCs) at randomly selected PHCs in all three districts. This was done to elicit the views and opinions of different stakeholders. Both structured and open-ended questionnaires were used for data collection. In addition, secondary data was collected from records available at the PHCs with regard to attendance and leave availed and movements of the doctors and paramedical staff outside the PHCs. Additional secondary data was collected by reviewing literature from various sources, including documents of GoI and GoK, Census records and health related policy documents.

Questionnaires developed for the survey purpose were field tested in one of the nearby PHC and necessary corrections were incorporated. A separate questionnaire was developed for collecting general information and recording absenteeism and individual health care workers in the PHCs.

[28] Figures in bracket refer to the HDI rank as per Karnataka Human Development Report 2005.

Field Study

Measurement of absenteeism

Absenteeism can be defined in different ways**.** Absenteeism is habitual failure to appear, especially for work or other regular duty or voluntary non-attendance without valid reasons, habitual evasion of work or wilful absence from work. It is the rate of habitual absence from work or duty.

There are different causes for the employee absenting himself or herself from work - maybe s/he is sick or has to attend to personal work or there is a death in the family. The absence may be authorised (casual leave or long leave or even leave without pay) or unauthorised.

All government employees in Karnataka are governed by Karnataka Civil Rules, which is framed by the government.[29] It clearly declares an employee as absent from duty, if s/he is on leave, or on deputation to a permanent or temporary post, or s/he is working on a special job which is not related to her/his work, or when s/he is not able to join her/his new posting due to transfer or s/he is not at her/his position due to suspension from duty.

Usually, the doctor and other paramedical staff go on official purposes: attending meeting at district head quarters, court cases, health camps, visiting Sub Centres, deputation to other PHCs, participating in professional improvement programmes etc. On such occasions, the doctor or paramedical staffs are not available for attending to citizens who visit the PHC. *Therefore in this study, absenteeism is considered to have happened when the concerned staff member scheduled to be available, but is not present for rendering services to the patients.* However, as a rule, government employees, who are on official duty outside their work place, are paid for the days when they are not present on their jobs, as they have been on official duty. Therefore, in this study we have used both 'non availability' and 'absenteeism' interchangeably. In a typical market mechanism, there is a clear accountability between the provider and the client; be it a service or a product. It is the responsibility of the provider to satisfy the client after selling the product or the service. Otherwise s/he can go to an appropriate forum for redressal or compensation.[30] His remuneration or fee or product price is dependent on the quality of service he provides. This accountability mechanism is absent in a public service delivery mechanism. *For the purpose of this study, non-availability of doctors and paramedical staff to the patients is considered as good as absenteeism.*

For measuring absenteeism in this study, an absence index was developed using a four-visit unit, which is explained in section VII on Methodology.

Measurement of variables

Unannounced visits were made to all the PHCs on two different days of the week, namely Monday and Thursday. On each of the visited days, absence was observed at two specific times namely 9 AM and 2.00 PM. A staff member was considered as absent if s/he was not physically present at the facility during the

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[29] Karnataka Civil Service Rules Volume I Finance Department of Karnataka Government. 2001 and Karnataka financial code

[30] Understanding government failure in public health services. Hammer and others Economic and Political Weekly October 6 2007 Vol XLII pages 4049-4057

four specified unannounced visits.[31] This was recorded for both the doctors and paramedical staff.

A team of ten persons, with graduate degrees, were selected from each of the three districts. These were identified as field investigators. They were given one day's orientation training for effectively conducting different surveys in the district. The survey was conducted under the supervision of researcher or supervisor in each district.

After recording the observation of absenteeism at 9 AM, field investigators collected details of the medical staff from the Medical Officer (PHC doctor). After collecting this data, field investigators conducted individual surveys with medical staff whose presence or absence makes a considerable impact on the patients. The categories of staff interviewed are doctor(s), male and female nurses, pharmacists and laboratory technicians. Information on staff members who were not available on entire days and on both visits was collected from the Medical Officer. In his/her absence, it was collected from the next responsible person.

First visit

Before starting the study, a list of staff members, sanctioned for the facility and were on the roll was collected. Later, administrative staff and those who were on contract were eliminated. Care was taken to exclude from the study those who were on night duty in case of twenty-four hour PHCs. Thus, a list of staff members that were permanent and working during the daytime and were directly related to providing service to the patients was prepared.

The first surprise visit was scheduled on Monday, 26th October 2009 for fifteen PHCs (Five PHCs from each of the three districts) simultaneously. Then, on the subsequent Thursday, 29th October 2009, surprise visits were scheduled for the remaining fifteen pre-selected PHCs in all the three districts. During each visit, absenteeism was noted at two times, namely, 9 AM and 2 PM. It was ensured that absenteeism was recorded only after the PHCs opened for the morning session and after the lunch break in the afternoon session.

Details of the scheduled visits are as follows

[31] To arrive at the absenteeism rate, average of the four visits was considered

Table-8 : Schedule of visits

26/10/2009 (Monday)	29/10/2009(Thursday)
SHIMOGA	
Hosur	Kumsi
Holehonnur	Shiravante
Talaguppa	Yennekoppa
Harnahalli	Yadur
Megaravalli	Togarsi
CHITRADURGA	
D.S.Halli	Bagur
Talikatti	Kyasapur
Kalamarahalli	Yaraballi
Ramjogihalli	Thalaku
Gopalanahalli	Yalagodu
BIDAR	
Hallikhed(K)	Waravatti(B)
Dongapur	Halaburga(B)
Dublugundi	Muchalamaba
Hedgapur	Mudhol(B)
Hudgi	Belur

Second visit

A second surprise visit was scheduled on Monday, 21st December 2009 and Thursday, 24th December 2009 for the same set of PHCs as in the first visit, but with the interchange of the weekdays. Apart from recording the absenteeism of medical staff members at 9 AM and 2 PM, additional information on both reporting and exit time of morning and evening sessions was recorded.[32] This information was used to estimate the effective time each staff member was present in the facility.

After recording the observation of absenteeism at 9 AM, field investigators collected the details of other medical staff from the medical officer. After collecting the data, field investigators went conducted individual surveys with medical staff whose presence or absence makes greater impact on the patients. The staffs that were interviewed included doctor(s), male and female nurses, pharmacists and laboratory technicians.

[32] The field investigators during the field visits observed and recorded

Information on the staff that was not available the entire day on both visits is missing. The distribution of the individual staff interviews is as follows

Table-9 : Distribution of staff interviews

District	Doctor		Male Nurse		Female Nurse		Pharmacist		Lab Technician	
	P	NA	P	NA	P	NA	P	NA	P	NA
SHIMOGA	12	0	5	0	16	0	5	1	9	0
BIDAR	18	4	9	0	23	4	6	1	10	2
CHITRADURGA	12	0	3	0	13	1	10	1	7	1
Total	42	4	17	0	52	5	21	3	26	3

P= present, NA=not available

In addition, secondary data including leave details and visit to other official work was obtained for previous three years from movement registers maintained at health care centres.

Data Analysis

Analysis of absenteeism – application of statistical test

To understand the significant difference, if any, with respect to absenteeism rate among various groups, statistical tests were used. As the data is non- parametric and not following the normal distribution, variations (i.e. standard deviations) are high. The Kruskal- Wallis one- way analysis of variance test was used. When there are only two groups to be analysed, Mann-Whitney Test was used.

The test statistic for Kruskal- Wallis Test:

$H = 12/n\_(n+1)\ [-? (R_j^2/n_j)] – 3(n+1)$, -where -j = 1 to k,
k= the number of groups
n_j = the number of observations in the j^{th} group
n= the number of observations in all groups combined
R_j= the sum of the ranks in the j^{th} group

The test statistic for Mann-Whitney Test:

$T = S\text{-}n\ (n+1)/2$
n= number of sample observations
S= sum of the ranks assigned to the sample observations

Absenteeism of staff with respect to districts 4

It is likely that incidence of absenteeism is more in backward districts as compared to forward districts.

Table-10 : Absenteeism with respect to districts

District	(N) Staff	Mean Absenteeism rate	Std. Deviation
Shimoga	48	.4479	.36084
Bidar	77	.6461	.30713
Chitradurga	48	.4583	.27931
Total	173	.5390	0.33

Kruskal-wallis Test: P-value=0.0001*

Bidar, the backward district has higher rate of absenteeism compared to Shimoga, considered a forward district. Absenteeism rate among the districts is significant. From an analysis of the Focus group Discussions (FGDs), it was observed that, Shimoga has a better supervision from higher officials as compared to Bidar.

Absenteeism with respect to designations

Another hypothesis the study wanted to test was whether the incidence of absenteeism was more in higher qualified medical professionals, as they have ample opportunities for lucrative private practice outside.

In this regard, proxy variable used for higher qualified professional was the doctor and medical officer. Even though mean absenteeism rate of doctors seemed to be less compared to other staff, there was no evidence to suggest that absenteeism rate was higher in one category compared to the others. This was statistically not significant.

Table-11 : Absenteeism with respect to designation

Designation	(N) Staff	MeanAbsenteeism rate	Std. Deviation
Doctor	46	.4946	.32270
Male Nurse	17	.6029	.28033
Female Nurse	57	.5307	.35377
Pharmacist	24	.6146	.27563
Lab Technician	29	.5259	.35572
Total	173	.5390	.32840

Kruskal-wallis Test: P-value=0.616(NS)

Doctors play a key role in providing health care services to the citizens. Their absenteeism is likely to have high impact on the quality of services. Besides attending to the administrative matters, they are responsible for the functioning of Sub Centres; they have to attend meetings called by district health officers and other

senior district officials. They may have to attend to court cases and conduct post-mortem. When the doctor is absent, the PHC bears a gloomy and empty look. There are instances, when the untrained local staff will attend to minor ailments (Cf: Documentary film produced by CBPS, Reproductive Health in Chitradurga District). While conducting the field study in one of the districts, it was observed that one of the pharmacists, who has remained in the PHC for a long period without transfer, has established a private pharmacy store. Though doctors perform many administrative duties, it is seen that paramedical staff too perform administrative work and move outside PHC for extension and administrative work. (See table-24). There are instances where paramedical staffs, like pharmacists are absent or the posts are vacant, doctors do that additional job. This will have an impact on the productivity of doctors and quality of services. Posting of an additional doctor could, to a great extent, reduce non-availability of doctor and therefore improve efficiency. There is a need for regular monitoring of the staff. During the FGDs, both the staff and users said, supervision from superior officers was poor. Even the Arogya Raksha Samithi (ARS)[33] members said they have not discussed the issue of staff absenteeism. This is a cause of concern.

Absenteeism with respect to gender

The study wanted to examine whether absenteeism among women was higher compared to their male counterpart as they have family commitments.

Table-12 : Distribution of staff according to gender

Gender	Frequency	Percent
Male	97	56.1
Female	76	43.9
Total	173	100

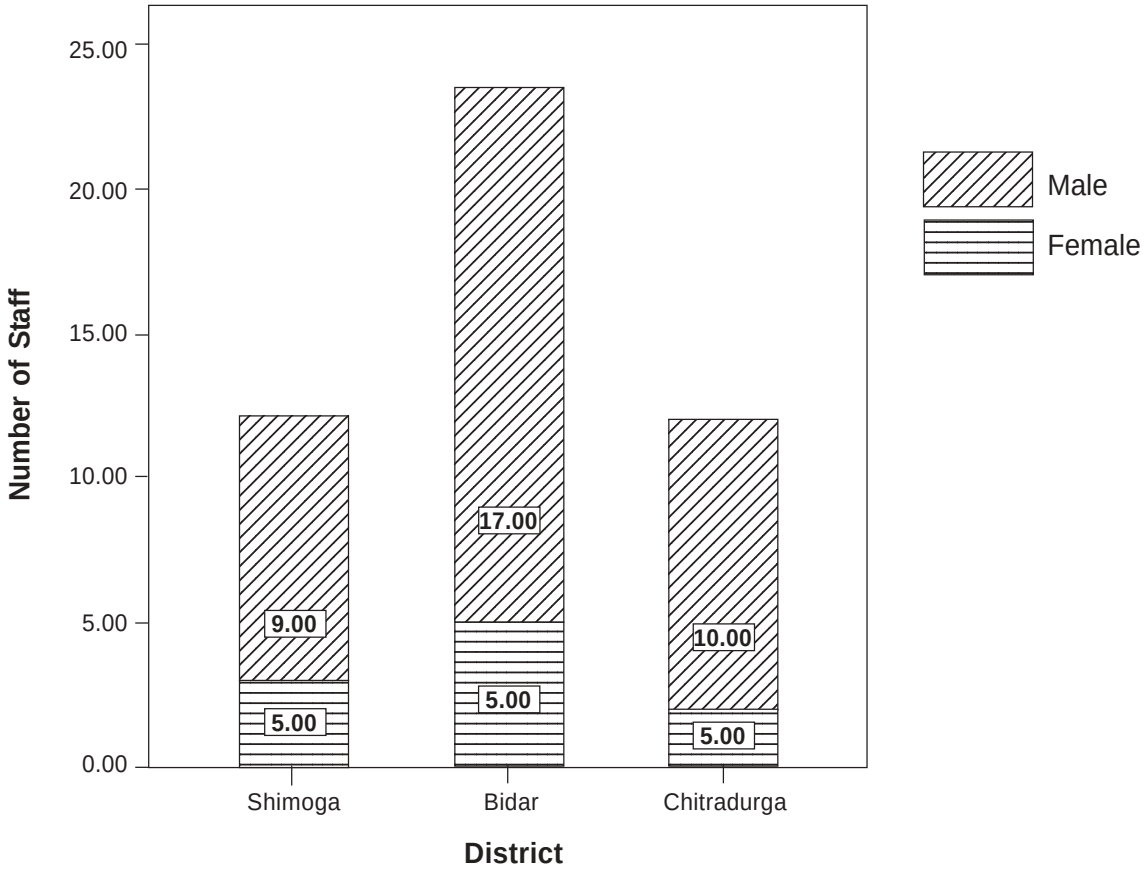
Women represent 43.9 percent of the total medical staff. This higher percentage is mainly due to the female nurses. When we take the gender-desegregated data only for doctors, a different picture emerges. Out of forty doctors in thirty PHCs, only ten are women (21.74%). Gender wise distribution of doctors across the three districts is as follows

Table-13 : Distribution of doctors according to gender

Designation	Gender				Total
	Male		Female		
	count	%	count	%	
Shimoga	9	75.0%	3	25.0%	12
Bidar	17	77.3%	5	22.7%	22
Chitradurga	10	83.3%	2	16.7%	12
Total	36	78.3%	10	21.7%	46

[33] Under NRHM, Arogya Raksha Samithis have been formed to monitor the functioning of PHCs. So far they have been mainly focusing on the management of untied funds provided to PHCs.

Lady doctors prefer not to work in PHCs. There could be various reasons, including women doctors might not be willing to go to rural areas due to family obligations, poor infrastructure facility, safety and security to stay in family quarters or the husband employed elsewhere. On the other hand, most of the women patients who visit the PHCs wanted lady medical officers. This was confirmed during our FGDs. In Bidar, both ARS members and users complained of shortage of lady medical officers. The state government should formulate an appropriate recruitment policy to have preferential opportunity for lady doctors to take up government jobs in rural areas.



Distribution of doctors according to Absenteeism rate for gender-desegregated data for overall staff as well as doctors was separately calculated. The statistical test did not establish any relationship between the gender of doctors and staff with absenteeism. Even among doctors there was no significant different between male and female doctors.

Table-14 : Absenteeism according to gender

Gender	(N)Staff	Mean Absenteeism rate	Std. Deviation
Male	97	0.5412	0.32412
Female	76	0.5362	0.33592
Total	173	0.5390	0.32840

Mann-Whitney Test: Mann-Whitney U=3684.0; P-value=0.995(NS)

Table-15 : Gender disaggregated absenteeism for doctors

Doctors	(N) Staff	Mean Absenteeism rate	Std. Deviation
Male	36	0.4653	0.31709
Female	10	0.6000	0.33747
Total	46	0.4946	0.32270

Mann-Whitney Test: Mann-Whitney U=139.5; P-value=0.286(NS)

Lady doctors in Bidar informed us during the interview that two of them were on deputation. They had taken permission from higher authorities to have flexible working hours. There is a clear slackness in supervision and monitoring. There is a failure of governance and accountability. Both the doctors and staff agreed with these observations during our discussions with them. Even users complained about lack of overseeing from higher officers.

Absenteeism with respect to location of PHC

Another assumption was that farther the location of PHCs to the towns, higher the rate of absenteeism.

Table-16 : Absenteeism vis-à-vis distance to the nearest town

Distance from PHC to nearest Town	(N) Staff	Mean Absenteeism rate	Std. Deviation
0-10Kms	9	0.5133	0.26571
11-15Kms	12	0.5233	0.19057
More than 15 Kms	9	0.4456	0.24073
Total	30	0.4970	0.22456

Kruskal-wallis test: P-value= 0.741(NS)

Most of the PHCs are located close to an urban centre. Of the PHCs, 30% are located at distance of more than 15 kilometres. However, this factor does not make any difference to absenteeism. Further, we examined the distance of PHCs from nearest paved road. Most of the PHCs are located very near paved roads. Many of the sampled PHCs are within half a kilometre from paved roads and are fairly well connected by road. This should have made a significant influence on absenteeism. But it was not so.

Further, we analysed the impact of the distance from the residence to the PHC, on absenteeism. We analysed data related to location of residence of doctors and paramedical staff and distances to the locations of the PHC.

Absenteeism rate according to distance from residence to PHC

Table-17 Absenteeism with respect to distance from residence to PHCs

Distance	(N)Staff	Mean Absenteeism rate	Std. Deviation
0-2Kms	86	0.4884	0.30656
2-10Kms	20	0.5625	0.35239
10-20Kms	29	0.5000	0.29124
20+Kms	23	0.4565	0.31670
Total	158	0.4953	0.30970

Kruskal-Wallis Test: P-value=0.724 (NS)

It is interesting to note that most of the staff members stayed within twenty kilometres from PHCs. Of the total staff, 67% stayed within a ten Kilometre distance. Since they stayed so near to PHCs, what were the reasons for absenteeism? Travelling and transport cannot be the major factors, though that has been stated repeatedly. It indicated lack of accountability and supervision.

When we analysed the relationship between absenteeism and residential status, it was clear that this had no impact on absenteeism.

Absenteeism according to residential status

Table-18 : Residential status

Residential status	(N) Staff	Mean Absenteeism rate	Std. Deviation
Not staying in Govt Quarters	117	0.5107	0.30512
Staying in Govt Quarters	41	0.4512	0.32220
Total	158	0.4953	0.30970

Mann-Whitney Test: Mann-Whitney U=2101.0; P-value=0.220(NS)

Whether the PHCs were located away from the nearest urban town or whether doctors and paramedical staff stayed in government quarters or not, had no significant effect on their absenteeism. Even though quarters were allotted to the staff they preferred to stay at the nearest taluk centre, as they would have better education facilities for their children, civic amenities and social environment. The state government has issued notifications and orders, directing doctors and other staff to stay in quarters; else they would be inviting administrative disciplinary actions. It is to be ascertained whether those who stated that they were staying in quarters, actually stayed there or not. During our informal discussions with some of the doctors and staff members, we came to know that though on record some of them stated to be staying in the quarters, in reality, they preferred to stay at the nearest urban centre. More than 70% of the staff during FGDs said that they stayed in nearby taluk centres and commuted daily to PHCs. When the quarters are

allotted, why do doctors and paramedical staff not want to stay? In any employment scenario commuting to the workplace is understood to be a responsibility of the employee. The assumption that providing quarters and other facilities would improve the quality of services needs to be examined further. In spite of providing all amenities, absenteeism would continue to be a cause of concern, if there was no proper supervision.

Absenteeism is more during the beginning and end of the week as compared to midweek

The study examined whether absenteeism was more during the beginning of the week as compared to midweek; in other words, was absenteeism related to the days of the week.

Table-19 : Absenteeism (Monday and Thursday)

Day	(N) Staff	Mean Absenteeism rate	Std. Deviation
Monday	173	0.6561	0.42649
Thursday	173	0.5173	0.39948
Total	346	0.5867	0.41841

Mann-Whitney Test: Mann-Whitney U=12084.5; P-value=0.001*

There was a significant difference between the means of groups.

As most of the staff does not reside in the village or in the premises of PHCs and travel daily, they tend to be absent at the beginning of the week or come late to the PHCs, whereas in the middle of the week the incidence of absenteeism was less. Some studies have shown that at the end of the week the incidence of absenteeism was more as compared to middle of the week.

Absenteeism with respect to age

The study wanted to examine whether incidence of absenteeism was more during the final years of service when the staff would retire.

Table-20 Absenteeism with respect to age

Age	(N) Staff	Mean Absenteeism rate	Std. Deviation
20-29Years	57	0.4781	0.32828
30-39Years	67	0.5336	0.33681
40-49Years	30	0.5917	0.32486
50-59Years	19	0.6579	0.27902
Total	173	0.5390	0.32840

Kruskal-Wallis Test: P-value=0.217(NS)

It is clearly seen from the above data that

> Absenteeism rate is less (0.4781) with younger staff between the age group of 20-29 years and the trend positively increases as age advances.

Absenteeism is highest (0.6579) among the senior staff between the age group of 50-59 years who are on the verge of retirement.

However, the analysis showed that there was no significant difference in the -absenteeism rate among the other age groups.

Similar trend was observed when we looked at the absenteeism rate versus length of service. Even in this case, when hypothesis was tested, it was found that there was no statistically significant difference in the mean absenteeism rate among the staff with differing length of service.

Incidence of absenteeism with respect to work experience

Table-21 Absenteeism with respect to length of service

Work Experience	(N) Staff	Mean Absenteeism rate	Std. Deviation
1-4years	81	0.4537	0.30133
5-9years	32	0.4922	0.30110
10-20years	25	0.5300	0.35590
20+years	20	0.6250	0.27506
Total	158	0.4953	0.30970

Kruskal-wallis Test: P-value=0.255 (NS)

Incidence of absenteeism during two different sessions

Since absenteeism rate was calculated taking two different timings, the data was analysed to examine whether different sessions had any influence on absenteeism.

Table-22 Absenteeism during two different sessions

Sessions	(N)Staff	Mean Absenteeism rate	Std. Deviation
Morning	173	0.6965	0.39117
Afternoon	173	0.3815	0.40218
Total	346	0.5390	0.42639

Mann-Whitney Test: Mann-Whitney U=8946; -P-value=0.0001*

The staff members tend to be absent more during the morning sessions as compared to the afternoon sessions. Since most of the staff members travelled from outstations, either they abstained from work or came late to the PHCs. Once they arrived, they stayed for the day; however this was dependent on the timing of the bus service.

The table given below indicates that, out of 173 observations, 11.6% of the staff has abstained once, 35.3% have abstained twice, 16.8% have abstained thrice and 20.8% of staff abstained on all four occasions. It is also clear from the table that since staff tend to abstain more from morning sessions, more staff members have not been present for work twice, among them pharmacists have abstained the most (50%). It is likely that pharmacists have to visit the district stores or the district health offices for collection of drugs, as the drug supply to the PHCs is rather irregular. (IDPMS, Brookings 2008)

Table-23 : Number of times staff were absent (%)

Designation	Number of times Absent from the work				
	Present all the Times	Absent 1 Time	Absent 2 Times	Absent 3 Times	Absent 4 Times
Doctor	17.4%	13.0%	41.3%	10.9%	17.4%
Male Nurse	5.9%	11.8%	35.3%	29.4%	17.6%
Female Nurse	19.3%	14.0%	22.8%	22.8%	21.1%
Pharmacist	4.2%	8.3%	50.0%	12.5%	25.0%
Lab Technician	20.7%	6.9%	37.9%	10.3%	24.1%
Total	15.6%	11.6%	35.3%	16.8%	20.8%

Field Perception on Absenteeism

Apart from field data collection and interaction with the staff, we conducted Focus Group Discussions (FGDs) and looked into secondary data available with the PHCs. The outcome of these exercises has revealed factors that need to be discussed.

Every PHC maintains a movement registers. Any staff member who moves out of the PHC has to enter details of his/her movement, for example attending meetings, attending training or any other reason. The data was collected for three years 2006-07, 2007-08 and 2008-09.

The veracity of the data was not examined. It was interesting to know that all the staff members spent time on administrative work and training took up a major portion of their time. In addition, doctors and support staff had gone to other PHCs as in-charge staff. The possibilities were that either the posts were vacant or the persons did not come for work at the PHCs. On an average three to five positions at PHCs are vacant. Nearly 62% of pharmacists and 24% of lab technicians and 45% of nurses' positions are vacant (IDPMS Brookings 2008). While there was shortages of staff, pharmacists for example, the staff that are working are absent from work and in some cases using time for private profit like the instance of a pharmacist mentioned earlier.[34] The paramedical staffs assists the doctor in discharging his work effectively, when they are absent, the laboratory section or pharmacy unit may have to be closed or managed by a substitute person who may not be competent to do so. Laboratory technicians and pharmacists spend maximum time on administrative works as compared to doctors. The administration system is weak and inefficient.

[34] While conducting the interview, four doctors accepted that they are doing private practice. Many more doctors could be doing private practice.

Effectively, for about 32% of total time, services of the doctor are not available for users in PHCs. With the non-filling of vacant posts, this could be around 40%. The issue of non-availability of staff is beyond just filling up of vacancies or improving infrastructure or enhancing salaries. There is a systemic failure. Suitable policy measures need to be initiated so that there are effective monitoring mechanisms.

Table-24 : Average number of days doctors and support staff members were absent from PHCs in the last three years

	Doctor		MaleNurse		FemaleNurse		Pharmacist		Lab Technician	
	count	%	count	%	count	%	count	%	count	%
Meeting convened by DHO/Minister etc	11	11.34	3	6.12	2	5.13	8	13.79	5	8.77
To attend health camp/Tubectomy	4	4.12	2	4.08	3	7.69	3	5.17	3	5.26
To visit sub centres	17	17.53	7	14.29	3	7.69	5	8.62	5	8.77
For administrative work	7	7.22	2	4.08	1	2.56	11	18.97	14	24.56
To attend other PHCs as I/C	6	6.19	3	6.12	2	5.13	8	13.79	10	17.54
Anganawadi visit training etc	40	41.24	18	36.73	19	48.72	11	18.97	8	14.04
Personal reasons	12	12.37	14	28.57	9	23.08	12	20.69	12	21.05
Total	97		47		37		58		57	

Focus Group Discussions

During the FGDs with the staff of PHCs, ARS members and local PHCs users, issues related to housing facility, transportation, supervision by superiors, shortage of staff, working on deputation and lack of infrastructure were raised. Out of thirty PHCs, two PHCs from each district were randomly selected. The staff members of those PHCs, ARS members and users from villages where the PHCs were located were chosen for FGD. We conducted 18 FGDs. In the discussion, 57 male and 41 female community members participated. Nearly 70% of the members complained about late arrival and early departure of the staff members, including doctors. They said transportation was one of the reasons. This caused inconvenience to patients. Most of the staff members did not stay in the village and travelled from various urban centres. The participants complained about PHCs having only in charge doctors, especially in Bidar. They were angry at poor monitoring by senior officers. They felt the staff was behaving as if there was none to question them. Of the members, 80% said that the staff did not stay in the village where the PHC was located. According to the community the main reasons were, lack of education facility and socialisation,

lack of water and power supply to the quarters. The community members had no idea about the role of ARS. PHC users in Shimoga said that the PHCs were supervised; sometimes ministers have made visits. They talked about newly constructed PHCs that do not have full complement of staff.

From six PHCs, thirty staff members participated in the FGDs (twenty male and ten female). They gave obvious reasons for absenteeism or coming late to work. Of these, 47% said absenteeism was '*inevitable*'! Nearly 70% of the staff said, lack of residential quarters was a reason for absenteeism. Transportation (67%), education for children (43%), training (43%), sickness (37%), and festivals (23%) were the other reasons cited. If the absenteeism was inevitable, can we conclude that it was intentional and there was absolutely no monitoring from senior officers? The reasons like sickness, festivals are not very convincing. However, the participants were very strong in expressing the consequences of absenteeism. They complained about work pressure, poor quality of treatment, dissatisfaction with work and negligence. What about any punitive action? Of the staff members, seventeen percent said that memos are issued and in some cases salary was withheld and matter was referred to higher officers. However, seven percent of them said no action was taken against absenteeism.

Views expressed by ARS members were equally interesting. In the FGDS there were 23 members of ARS. Of these, 60 percent were not satisfied about the functioning of ARS and PHCs. Further, 40 percent were not satisfied with the services provided by PHCs. It was surprising to know that all the members said that not even once had they discussed absenteeism either in the meetings or reported to the higher officers; neither have they taken any action. They have complained about shortage of staff to higher officers.

While conducting facility survey, interactions were held with doctors and paramedical staff. Majority of them expressed family and personal reasons as the major cause for absenteeism. Performing in-charge official duty at other PHCs, training and deputation were the other reasons. While participating in the FGDs and personal interactions, the reasons given by the staff members were not convincing and they looked more like a justification.

The findings from the FGDs have confirmed the outcomes of the data analysis. They too, have pointed to the poor monitoring and failure of the system.

Consequences of Absenteeism

Absenteeism will have a bearing on the quantity and quality of services and utilisation of services by the rural community.

In addition, it has direct and indirect cost implications. Productivity of staff gets reduced and, there would be an increased workload, for the staff present, resulting in stress and job dissatisfaction.

Patients have to approach private sector health service providers and incur expenditure.

Another way of looking at the consequence of absenteeism is to estimate budgetary wastage- amount of money spent on salaries to the staff that are absent or have gone on duties other than attending to the patients.

In order to estimate the total time spent by the service providers, during the second round of unannounced visit, the entry and exit time during both morning and afternoon sessions for all the staff members, including doctors, were recorded. From this data, we found that doctors on an average worked for four and half hours,

male nurses for five hours and fifteen minutes, female nurses worked for only three hours and twenty –five minutes, laboratory technicians worked for four hours and pharmacists worked for merely three hours. On an average, the total worked hours by all the staff members was three hours and fifty- six minutes.

Table-25 : Distribution of salaries of different staff members (Indian Rupees)

Designation	(N)Staff	Mean Salary	Std. Deviation	Minimum	Maximum
Doctor	42	17608.2381	5485.69883	10985.00	35600.00
Male Nurse	17	12267.5294	5032.36488	6940.00	20480.00
Female Nurse	52	9428.6731	4206.35222	6250.00	28000.00
Pharmacist	21	11318.1905	3704.16723	7275.00	20000.00
Lab Technician	26	11123.5385	2947.61220	6700.00	20150.00
Total	158	12438.4747	5470.46312	6250.00	35600.00

For estimating the wastage of resources the following method was used.

Average monthly salary is taken from the respondents, based on what they said during the interviews.

Number of staff considered =158
Total salary of 158 staff (per month) = Rs. 1965279.00
Mandatory hours to be worked by each staff (per day) = 7 hours
Average number of hours worked = 3_hours, 56 minutes =3.93hrs (see explanation below)

Average salary of a staff per hour= 1965279/ (158*25*7) = Rs 71.08
Average salary of a staff per hour according to his actual worked hours= 1965279/(158*25*3.93)
= Rs 126.60

Average wastage of resources per staff per hour =126.60-71.08 = Rs. 55.52

Average wastage of resources per staff per year=55.52*7*25*12= Rs.116598.83_($2535).

For 158 staff wastage of resources is 116598.83*158=Rs.184,22,615 ($400,530).

As it is a matter of great concern, policy makers need to pay urgent attention to this.

Alternately, if the absenteeism rate were considered instead of worked hours, the wastage of resources would be around 14 million rupees. This needs be an issue for further investigation.

From the PHC records, average number of patients who visited the PHCs every day during last three years was recorded. In Shimoga average number of patient's visiting PHCs every day was 66, for Chitradurga this was 67 and for Bidar it was 111. Considering the average number of hours doctors were present it was found that the doctor could not spend more than five minutes per patient. It is assumed that the doctor would use his/her time only to examine patients and s/he does no other work. Otherwise, he would be spending much less time on each patient. (For further details, refer IDPMS study: Following the Public Health Delivery Trails. Brookings 2008)

5 Options for the Future

The study has highlighted the issue of monitoring and supervision. Why there is so little monitoring? What has gone wrong? Is this because it is difficult to monitor, or is this due to the fact that monitoring costs are prohibitive, or that PHCs are located at faraway places? The reasons may be varied. There may be legitimate reasons for absenteeism like deputation or meetings. However, evidence suggests that there is a systemic failure. There is inherent weakness in the current centralised supervision and monitoring system of the health department. The study has amply demonstrated poor monitoring. Currently the process is centralised with the Department of Health and Family Welfare and it has virtually collapsed. There is a failure of governance and accountability. The staff is not held accountable to a standard performance.[35]

While there may be other options before the government (more details are in Section XIII) one of the options that could be thought of is to decentralise the monitoring and supervision system. Government of Karnataka has transferred the subject of health to the local self- government. The Zilla, Taluk and Gram (ZPs, TPs and GPs) have a role to play.

There is a strong case for TPs to monitor and regulate the functioning of PHCs.

GPs may not be an appropriate authority as PHCs could cover villages spread across more than one GP. Taluk Panchayaats can exercise authority and power if they have control over funds, functions and functionaries. However, the system envisaged under NRHM speaks about the role of GPs; but it is yet to be operationalised. Committees constituted under the NRHM tend to be accountable more to the department than to the local government. They seem to be functioning as a parallel system. This is subject for a separate discussion.

In this context it is important to give TPs the necessary authority and power to take punitive action. Above all, this would ensure accountability to the people without need for targets and transfers.[36] This is likely to invite resistance from service providers. Enough safeguards must be incorporated so that the system is not used for generating private profit. Governance at local level can be made effective if the three tiers get enough authority and power in letter and spirit.

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[35] Mr Halsey Rogers, "Missing in Action: Teacher and Health Worker Absence in Developing Countries.' Chowdhry and Hammer

[36] Dr. Antia Equity and Health Hivos India 2000

Summary and Conclusions 6

While Government of India has taken steps to increase health expenditure, much depends on state governments initiating appropriate policy reforms. This needs to be done by developing suitable institutional mechanisms where users and community have a role, and there is effective and efficient utilisation of allocated resource from public resources. Policies of the state governments have a bearing on health expenditure and delivery of quality services. State governments are unable to provide necessary budget support and depend on transfers from the national government. Besides shortage of doctors and paramedical staff, the existing staff members are reluctant to go to rural areas. Therefore, having good infrastructure and improved human resources in place do not necessarily guarantee reduction in absenteeism of doctors and paramedics. For this, effective accountability mechanisms and monitoring have to be put in place. Vacancies and absenteeism reflect that at many facilities, services are not available when patients demand health care. (Hammer, 2007) Regardless of whether health service providers are available or not the cost of PHCs include the cost of salaries of service providers resulting in wastage of scarce resources.

Results of our study were drawn from four unannounced visits made to sample PHCs in three districts of Karnataka chosen randomly from forward, relatively backward and backward districts. This study has made an attempt to focus the attention of policy makers on the causes of absenteeism and their consequences on delivery of quality health care. The study has highlighted the poor health governance and lack of accountability. This pertains to the selected districts and PHCs. This study could give an indication of the situation likely in other districts of the state.

Absenteeism was less (44%) in Shimoga, a forward district, as compared to Bidar (63%), which has a dismal health indicator. In Chitradurga, one of the mid range districts, absenteeism was 46 percent. Being a district of political significance, Shimoga has a better monitoring system; whereas Bidar, located in the northern corner of the state and not visible to the political system, has poor monitoring and supervision. The incidence of absenteeism has not varied across doctors and paramedical staff and male and female staff. Place of stay like residential quarters or staying in the PHC villages or near urban centres have not influenced absenteeism. Likewise, the location of PHCs from the nearest urban centre has not influenced absenteeism. However, absenteeism was more on Monday, the beginning of the week as compared to middle of the week, Thursday. Those who travel daily from far places, tend to extend their holiday. Irrespective of length of service or age of the staff, absenteeism is prevalent. Absenteeism was more in the morning sessions as compared to afternoon sessions.

There are direct and indirect consequences of absenteeism. On an average, per staff, annually 117,000 (Indian rupees) of budgetary resources are wasted. Doctors can spend no more than five minutes on each patient.[37] All these inferences lead to the conclusion that poor over seeing and monitoring by superior officers. Though there is a supervision and inspection manual, but it is only on paper and rarely implemented. It looks as if there is no political will to take action. Probably this should not be used from a political platform, as this may become a vote-catching political strategy (Hammer, 2005).

This research is not intended to apportion blame on the health department or the health staff. The study aims to highlight a major systemic problem in getting health care to poor people.

Roger, quoting from the study says “While official rules provide for the possibility of punitive action in cases of repeated absenteeism, disciplinary action is rare”. Our field study echoes this view. Teachers and health workers are almost never dismissed.[38] In any government employment it is very difficult to dismiss

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[37] For more details see IDPMS study Brookings 2008

an employee, due procedures that have to be followed and it is a long-drawn affair, consuming a lot of time. There are administrative tribunals that dispense judgments in case the employees appeal against actions of the government. There are instances where employees have gone on leave for years without proper notice and taken up employment elsewhere and reported to work after their tenure of employment.[39] Quoting the study of Hammer Roger "Despite India's 25 percent teacher absence rate, only one head teacher in the sample of nearly 3000 Indian government-run schools reported a case in which a teacher was fired for repeated absence".[40] In FGDs, as well as in personal interactions, the PHC staff agreed that there was hardly any case of removal of staff due to recurring absence.

A key issue that has emerged from this study is that

> While designing health policies, absenteeism has not been considered.

Policy makers have not brought absenteeism on the agenda for discussion.

There are different options open for the state government to consider. Increase of salary to the staff could be one option. Rural government doctors have been demanding higher salaries and allowances and they went on strike in September 2009.[41] They resumed duty after the outbreak of flood and after the state government promised to consider revision of pay. However, when this did not happen they threatened to go on strike again and very recently the government has come out with a revised pay package that has given a substantial raise.[42] Since the frontline staff in PHCs, namely doctors, pharmaceuticals, and laboratory technicians are well- organised and have better bargaining power with the state, their relationship with the informal client (patients) population is unequal. While increasing the salary, care should be taken that high performance standards and effective incentive and sanctioning mechanisms are put in place. Though there could be reasonable arguments for enhancement of their pay and allowances, performance-linked incentive mechanisms have to be brought into force.

> Lack of awareness among the clients to demand their entitlements and poor participation of community in over-seeing is due to lack of accountability in governance.

Another possibility is monitoring by local communities. Though this is a welcome suggestion, this might not be effective unless they have power to take suitable actions.[43] They lack the power to make service provider perform better.

Health services at the PHC level include preventive, curative and outreach services. Some of the activities like, health education, conducting immunisation camps, malaria, leprosy eradication programmes may not need direct intervention of doctors. These activities could be shifted to a separate health administrative set up and use the services of doctors for hospital and clinical services. Of course, this should go along the lines of the national health policy. The national government intends to introduce a three and half years Bachelor Rural Medicine and Surgery (BRMS). These doctors are expected to meet the need for health care personnel

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38 Ibid Rogers

39 While having preliminary discussions with the doctor and staff of a PHC on the outskirt of Bangalore, we came to know that a lady doctor was absent for two years and reported to have gone on study leave but there was no replacement.

40 Ibid Rogers

41 Ibid 8

42 February 10 2010 paper notification. Doctors during our field study informally mentioned that it is prohibitively expensive to study a medical course. It would become necessary for the doctors to find avenues which are available in urban and semi urban centres where in they can peruse a career of their own and compensate to a certain extent the cost they have incurred to complete the medical course. Besides, they want to go for higher specialization which is again an expensive proposition.

43 Duflo Rajasthan study India

in rural areas. This has raised lot of questions and concerns. This should not send a wrong message to rural patients that they would get an inferior standard of health service as compared to urban citizens.

Some innovative attempts have been made in primary education sector where local community and parents could choose teachers and public money follows the pupils. A similar approach could be adopted in health sector with money following the patients as opposed to facilities (Hammer 2005).

Under NRHM, several monitoring committees have been set up involving Panchayat Raj Institutions (PRI) and community organisations. Since NRHM is a time bound programme, these institutions are likely to stay only for the period of the project. They do not function as part of PRI intuitions and is seen more as a departmental set up. As a departmental set up, they are likely to lose their ability and power to monitor and hold service providers accountable. It would be useful if they were brought under the direct control of PRIs, as there already exists provisions under PRI Act to have such committees. These committees should be institutionalised and they would continue beyond the time frame of NRHM.

Under Mahatma Gandhi Rural Employment Guarantee Act Scheme (MGREGA) it is mandatory that social audit is done as part of the scheme. It is an enactment of the Parliament. Similar provisions for making social accountability as part of public expenditure monitoring should be made through a Parliamentary enactment. This will give mandatory powers to the PHC users to hold service providers accountable.

RECOMMENDATIONS

- The study has shown that absenteeism is a nebulous issue and is requires to be given serious consideration. Policy makers must consider the issue of absenteeism while framing policies.
- Monitoring and supervising of PHCs in backward districts should get special attention.
- Occupancy of quarters should be monitored regularly.
- There is need to design and implement a rational incentive and sanctioning mechanism to minimise absenteeism.
- Local level monitoring could be put in place by empowering the Taluka Panchayats and giving them authority over functions, functionaries and funds. They should have power to enforce sanctions. Enough measures should be taken to see that those who are having decision-making powers do not use their offices for private profit.
- Local communities, users associations should be actively involved similar to the 'Stop drug stock out' campaign envisaged by Civil Society Organisations
- Regular inspection of providers should be made and incidences of absenteeism should be well publicised.
- Right to Information should be used effectively, so that users and citizens are informed about absenteeism.
- Creating a separate health administrating system and separating the extension activities from clinical activities should be considered.
- Separate public health cadre should be created.
- Performance standards should be fixed and providers should be made accountable to the local community.
- Vacant posts should be filled up immediately.
- Civil society organisations should train the local community to bring awareness about their legitimate entitlements.
- Social Accountability should be institutionalised.

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District Health Officer, Chitradurga District, Karnataka.

District Health Officer, Bidar District, Karnataka.

Medical Officers of the selected 30 PHCs in Shimoga,
Chitradurga, Bidar districts.

Pharmacists of the 30 PHCs in Shimoga, Chitradurga,
Bidar districts.

Laboratory Technicians of the 30 PHCs in Shimoga,
Chitradurga, Bidar districts.

Male and female nurses of the 30 PHCs in Shimoga,
Chitradurga, Bidar districts.

Dr.Vinod Vyasulu, Director, CBPS, Bangalore.

Dr. Shobha Raghuram, formerly Regional Director,
HIVOS, Bangalore.

Dr.Veerashakhappa, Professor ISEC, Bangalore.

Deputy Secretary, Budget & Resources,
Government of Karnataka.