



**Attaining the MDGs in India**  
**The Role of Public Policy and Service Delivery**  
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***ROGI KALYAN SAMITI***  
**HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH**

It was April 1, 2004. Dr. Ashok Sharma was sitting in his office, reviewing the innovations introduced by the Department of Public Health and Family Welfare to improve the quality of public health services in Madhya Pradesh. Dr. Sharma had recently taken over as Director of Public Health and Family Welfare. The Minister, who had just assumed office after the general elections, had asked him to make a presentation on the strategy for innovations in public health services delivery.

One of the innovations that Dr. Sharma was keen to present to the Minister was the *Rogi Kalyan Samiti* (RKS) model of granting functional autonomy to public hospitals to improve the efficiency and quality of hospital services. The *Rogi Kalyan Samiti*, or 'Patient Welfare Committee', a concept of managing public hospitals through community participation, was internationally recognized as a very successful model. It had received the Global Development Network 2000 Award as the most innovative development project (for mentions in the press see **Exhibit 1**). In effect, the concept had revolutionized the way hospitals were run in Madhya Pradesh, and had shown tremendously positive results.

On the other hand, infant, child and maternal mortality in Madhya Pradesh continued to be amongst the highest in India. In this context, Dr. Sharma thought, the *Rogi Kalyan Samiti* approach had the potential to help reduce these mortality rates. Increased efficiency and service quality in the state's public hospitals were crucial for child and maternal health in at least two ways. First, improving the efficiency and quality of hospital services was necessary for providing effective referral support to primary health care services. Second, it had now been recognized that most maternal deaths could not be prevented solely through primary health care services: availability of good quality hospital services was crucial. Dr. Sharma was convinced that an improved RKS would make an

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important contribution to achieving the Millennium Development Goals (MDGs), particularly those related to infant, child and maternal mortality.

However, Dr. Sharma was also aware of the weaknesses of the RKS model, particularly its apparently insufficient sustainability. The lack of professional management in the RKS and dualism in the management structures needed to be addressed. Although he was convinced that the RKS model would be continued, he realized that a new strategy had to be developed to revamp the approach. On the other hand, he knew that not all the parties involved would accept a change in the status quo, and so he needed to design a clear implementation strategy.

## **Madhya Pradesh**

With an area of 308,245 sq. km, Madhya Pradesh (MP) was the second largest state in the Republic of India. According to the 2001 population census, the state had a population of 60.385 million people, living in more than 55,000 villages and 394 towns of varying sizes<sup>1</sup>. The state was divided into 10 administrative divisions, 48 districts and 313 development blocks. Nearly 27% of the state's population lived in towns, most of which were small. Only three towns in the state had a population of 1 million. Nearly one fifth of the state's population was tribal, well above the national average of 8%.

Madhya Pradesh was one of the most rapidly growing states in India. From 1991-2001, the state's population increased at an average annual rate of 2.18%, higher than the national average. However, population growth in MP had been the slowest of the Hindi-speaking states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.

Madhya Pradesh was predominantly a rural state; the primary sector accounted for nearly 40% of the gross domestic product in 1999-2000 and more than 71% of the labour force in the state consisted of cultivators and agricultural labourers, with the figure rising to 85% in some rural areas. In terms of industrial development, Madhya Pradesh was quite backward; manufacturing accounted for less than 15% of the state's domestic product. Per capita income in the state in 1999-2000 was estimated at Rs 11,244 (US\$248)<sup>2</sup> and almost 62% of families in the rural areas were considered to be living below the poverty line.

However, there were many positive developments –in recent years– significant gains in literacy achieved through the concerted efforts of the state government, had led to a quantum jump in the female literacy rate – from 29% in 1991 to 50% in 2001. The total literacy rate had reached 64% in 2001, marginally less than the national average.

The state of health in Madhya Pradesh was amongst the poorest in India, with the third highest death rate and second highest infant mortality rate in the country, and the highest in rural areas. Prevailing high mortality rates reflected an abnormally high disease burden. An analysis of the indoor patients admitted in MP district hospitals in 1995-96 suggested that diseases of the digestive system accounted for more than 14% of total admissions, followed by diseases of the respiratory system (13.42%) and infectious and parasitic diseases (12.75%). More than 8% of total admissions were due to diseases and complications related to child birth.

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<sup>1</sup> Government of India, 2001

<sup>2</sup> In May 2004, 1 Indian Rupee = 0.0221 USD

The Government of Madhya Pradesh aimed at achieving the goal of 'Health for All' through a primary health care approach, while a proper health policy was in preparation.

Both the public and private sectors provided health services to the people. Traditionally, public health care delivery systems had been the mainstay of health care delivery, but in recent years there had been substantial growth in the private health care sector, most of which was concentrated in large metropolitan areas. In both sectors, different systems of health care, including traditional *ayurveda*, modern allopathic, Unani, and homeopathic approaches were available.

The public health care delivery system could broadly be divided into hospitals and health centres. A health centre, among other things, had a pre-specified, clearly demarcated population to cater for, and delivered both health centre-based and community-based services. Hospitals, on the other hand, were expected to deliver a core package of hospital-based services, irrespective of the catchment area. All public hospitals had indoor admission facilities; many health centres did not.

In recent years, there had been considerable erosion of the efficiency and effectiveness of public hospitals, because of poor resource allocation and limited cost recovery. Most of the government budgetary support was confined to routine work and community-based activities such as immunization or prevention and health promotion. There was little scope for upgrading infrastructure and facilities in public hospitals through government budgetary support, with the result that public hospitals were finding it difficult to compete with the rapidly growing private health sector.

### **History of the *Rogi Kalyan Samiti***

The concept of granting functional autonomy to public hospitals first evolved at the district hospital level. In 1994, the Chief Medical and Health Officer of the Dewas Hospital submitted a proposal to the state government that constituted the basis for the *Rogi Kalyan Samiti*. Essential features of this proposal were recovery of hospital costs through user charges and using the raised funds in the development of the hospital. The concept, however, gained international recognition through the cleaning up and overhauling of the main hospital at Indore, where a system was designed to ensure a degree of permanency of the changes. Most important were the reallocation of space, the redefinition of administrative responsibilities. The *Rogi Kalyan Samiti*, simply translated as 'Patient Welfare Committee' constituted the management structure for innovations in the hospital. The exemplary task done in Indore under the RKS was internationally recognised through the Global Development Network Award 2000 as the most innovative development project.

The *Rogi Kalyan Smiti* based model of hospital management appeared to be in line with the government commitment to decentralize the public administration system and to promote population participation in the administrative and decision making processes and thus, was readily approved by the state government.

The state government had since concretised and standardized the RKS concept. *Rogi Kalyan Samiti* had been constituted in 43 district hospitals, 57 civil hospitals and 231 community health centres in the state. Detailed guidelines highlighting the constitution, roles, responsibilities and powers of the *Rogi Kalyan Samiti* were laid down by the state government, to be revised from time to time on the basis of the experiences from the field.

During the year 2003-04 alone, the *Rogi Kalyan Samiti* generated revenue of more than 88 million rupees (1.9 Million USD) in addition to the government budgetary allocations, mainly used to improve the services available.

### **The Concept and Structure of the *Rogi Kalyan Samiti***

The *Rogi Kalyan Samiti* had originally been conceived as a local level institutional arrangement with a focus on a needs-based approach of improving the availability and quality of hospital infrastructure and services. It was the local response to the problems being faced by a district hospital in delivering services to the people.

The *Rogi Kalyan Samiti* was constituted as a registered society under the Societies Registration Act of the Government of Madhya Pradesh, which laid down detailed guidelines for registering the *Samiti*. As shown in **Exhibit 2**, the *Rogi Kalyan Samiti* comprised two bodies - the *General* and the *Executive Body* (formed by selected members of the General Body). The General Body was responsible for policy formulation and decision-making while the Executive Body for implementing these decisions. The RKS members usually included government officials, political leaders, people's representatives, donors, professionals and leaders of the community. Some considered RKS with its mixed composition as a bit rare animal as it seemed to be functioning as an NGO, but with quite some involvement from the State government.

The charter for the *Rogi Kalyan Samiti* included a set of well defined roles and responsibilities (see **Exhibit 3**), such as the upgrading and maintenance of the hospital's structure; the creation of a 'better atmosphere'; the generation of additional resources through cost recovery schemes, using hospital property and land; management, training, orientation and incentives for staff; and the management of resources, equipment and waste, etc.

The RKS could decide on additional fundraising. For example they could use hospital property to generate income, or freely apply user charges. In the hospitals, the heads of department were responsible for the decisions taken in their wards, including the use of additional funds generated, and decisions relating to staff. This active involvement of physicians was considered to be one of the success factors of the RKS. **Exhibit 4** shows a list of other activities carried out by the RKS.

### **RKS Results**

Since the start of *Rogi Kalyan Samiti* and its state-wide extension not much information about the performance of *Rogi Kalyan Samiti* was available. The Directorate of Health and Family Welfare of the state government maintained some data on RKS income and expenditure. Even though a well defined system of monitoring the performance of *Rogi Kalyan Samiti* did not exist, there was evidence that *Rogi Kalyan Samiti* had been quite successful. Public hospitals in the state had been able to generate additional resources through non-budgetary channels. These additional resources were used to improve hospital services by meeting routine hospital needs such as X-ray films, reagents for pathological

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<sup>3</sup> See Footnote 2.

investigations, emergency drugs and medicines, etc. In the fiscal year 1995-96, when the model was first adopted by the government for replication in all public hospitals, total revenue generated by Rogi Kalyan Samiti was of the order of Rs 5,9 million (0,13 million USD). This amount increased to more than Rs 88 million (1,94 million USD) in the fiscal year 2003-04. It seemed that the increase in the revenue generated by the public hospitals through non-budgetary channels reflected the community's capacity to pay for hospital services, and was considered as an indicator in terms of the movement towards increased hospital autonomy.

The additional resources helped the public hospitals to improve facilities and quality of service, which resulted in an increase in hospital attendance by both out-patients and in-patients. As a proportion of total government budgetary expenditure, the revenue generated was insignificant, but when subtracting salaries and wages from the total budget, this proportion became a significant 44% in 2001-02.

### **RKS: A Model for Hospital Autonomy**

Recently, a review of the *Rogi Kalyan Samiti* model in the context of the autonomy of public hospitals had concluded that this model, with some modifications, could become a politically viable and operationally feasible model for increasing the autonomy of public hospitals. But the report had identified a number of issues that needed to be addressed before it could serve as a model for hospital autonomy.

One issue was the **unequal distribution of the non-budgetary resources**. The RKS had no control over the government budget, while non-budgetary income, mainly from user charges, was used for investments in facilities. Larger hospitals had more revenue, while smaller hospitals and primary health centres often did not even have enough to make the most basic improvements. There were no provisions for sharing the non-budgetary income generated between the different sized hospitals.

The report proposed an area approach, in which the non-budgetary income generated by all public hospitals in, say, a district, were pooled to constitute a consolidated fund at the district level, and managed by the District *Rogi Kalyan Samiti*. Resources would then be allocated to different public hospitals in the district out of this consolidated fund, on the basis of the performance of the hospitals and a pre-decided and agreed-upon formula for improving the quality of hospital services. This formula would take into consideration the location of the hospitals, the morbidity and mortality profile of the area, income generated through non-budgetary channels, and the hospitals' performance, including the quality of services. Alternatively, instead of pooling all resources generated by the hospitals through non-budgetary channels, a proportion of such resources could be contributed to a 'consolidation fund' which would support those public hospitals which had only a limited capacity to generate non-budgetary resources on their own. But Dr Sharma thought that the bigger hospitals would oppose this approach.

The report pointed out concerns about the **pattern of utilization** of the non-budgetary resources. Only a small proportion of the additional revenue generated was utilized in improving hospital services, while about 43% of the expenditure was related to construction and building maintenance, 12% was incurred on medicine, and another 12% on equipment. The numbers seemed to suggest that the RKS were more concerned with physical infrastructure than the quality of services. Possible explanations included the

strongly felt need to improve the hospitals' physical infrastructure, as the normal budget was too limited for this, and the demand for hospital services had increased considerably with the rapid increase in population. Another factor seemed to be related to the RKS' lack of technical knowledge, so that simple and direct investments in public works were easier to handle through the principles of public administration, than more complex managerial issues: little was spent on the development of the technical skills and expertise of the professional hospital staff and/or in building managerial capacity, particularly developing a comprehensive hospital management information system.

The report identified another flaw: the *Rogi Kalyan Samiti* had resulted in a **dual management and administration system** at the hospital level. The regular staff of the hospital were not under the administrative control of the *Samiti*, and nor was the government budgetary allocation to the public hospitals. The budget was allocated to the hospital superintendents, who had been accorded necessary administrative and financial powers to operate the budget. RKS controlled only those resources which were generated through the non-budgetary channels. This dual system of managing the hospital had created a number of problems. There were frictions between the regular staff appointed by the government and the staff on RKS contracts, as the regular staff of the hospital, other than the superintendent, had no working or reporting relationship with the *Rogi Kalyan Samiti*.

The report suggested that it might be better to confer a more constructive and active role to the *Rogi Kalyan Samiti* by developing a comprehensive business plan, consolidating the budget (the government allocation) with the additionally generated resources. This comprehensive business plan and consolidated budget would then constitute the basis for some type of performance agreement between the hospital management staff, the *Rogi Kalyan Samiti* and the state government. It was not clear that all parties would agree to this. The arrangement required that the government budgetary allocations would be channelled through the *Rogi Kalyan Samiti*, and additional freedom and autonomy would be given to the hospital staff for local-level decision-making, missing in the quasi-government controlled RKS.

The **relationship between the RKS and the state government** also remained ill-defined. Technically, the RKS system was registered as a society under the Societies Registration Act and is independent organization beyond administrative or managerial government influence. But the government controlled the RKS by the nomination of government officials in ex-officio capacity, who, at least technically, could prevent the RKS from taking decisions contradictory to government policies and programmes. This approach bore the risk that the RKS would have little initiative on their own to improve hospital services, in clear contradiction to the initial idea of the RKS. It seemed that often all RKS decisions were driven by bureaucratic thinking and not by the needs of the institutions or the people. But since the state government and the *Rogi Kalyan Samiti* were jointly responsible for managing the hospitals and improving hospital services, their relationship needed to be more clearly defined, and administrative and managerial processes better established. This would allow the identification of a clear role for the RKS, which lay somewhere between an organizational arrangement, a decentralized governance approach, a model of community participation and a model for functional autonomy.

### **The Field Functionaries' Perspective**

Dr. Sharma was aware of the issues raised in this and other critical assessments of the RKS system, but he thought that there was enough scope for further rationalization of the

structure. In order to get a personal impression, he arranged to discuss the issues with a number of field – level functionaries. These discussions led to a series of insights, some of them confirming the findings of the report:

- The *Rogi Kalyan Samiti* lacked the professional capacity and expertise to manage the hospitals. Neither the General Body nor the Executive Body had real managerial capacity or professional orientation. If the *Rogi Kalyan Samiti* were to function as autonomous organizations committed to the professional development and management of the hospitals and improvements in the quality of hospital services, then it seemed that their professional competency and expertise in managing the public hospitals had to be improved.
- Many members of the *Rogi Kalyan Samiti* were ex-officio government officials. They had limited knowledge and experience of the technical issues of effective hospital management and service quality improvements. As these officials were rotated frequently, there seemed to be a lack of continuity and consistency from the official side.
- There was only a small representation of hospital staff on the *Rogi Kalyan Samiti*. The hospital superintendent was the ex-officio member secretary of the *Samiti*. The only other hospital staff member on the *Samiti* was one senior doctor nominated by the hospital superintendent. There was no representation of other categories of hospital staff: nurses, paramedical workers, administrative personnel, etc.
- The Executive Body of the *Rogi Kalyan Samiti* was headed by a bureaucrat (the collector) who, in most cases had very limited knowledge and experience of hospital management. It seemed that it would be more appropriate were the Executive Body of the *Rogi Kalyan Samiti* more oriented towards hospital management.

On the basis of these discussions with the field – level functionaries, Dr. Sharma got the impression that the normative government guidelines on the constitution, roles and responsibilities of the *Rogi Kalyan Samiti* prevented it from becoming a real decentralized, people-based system for autonomous hospital management. The number of interesting innovations and initiatives had declined with the decrease in the early levels of enthusiasm, as the administrative-dominated executive bodies focused more on public works than on real hospital management.

### **Other Experiences**

In order to find inspiration in the decentralization of and popular participation in hospital-based service delivery, Dr. Sharma reviewed initiatives in different states. He found that there had been some attempts towards the decentralization of public health care delivery systems, although the contexts and contents of decentralization differed significantly from state to state.

In *Andhra Pradesh*, powers had been delegated to a parental organization. There was no hospital-level decentralization, although the parental organization, the *Andhra Pradesh Vaidya Visharad Parishad*, enjoyed significant levels of functional autonomy. The primary

purpose of decentralization in Andhra Pradesh had been revenue generation and increasing financial self reliance. People's involvement and greater accountability had not been the prime considerations in this decentralization process, as they had been in Madhya Pradesh.

In Gujarat, the state government had contracted autonomous NGO hospitals to provide health services, decentralized some of the supervisory responsibilities to the regional health directorate, and allowed a number of departments within specialized hospitals to assume a significant degree of autonomy.

The underlying theme of decentralization seemed to be to increase income through non-budgetary resources. However, accountability and popular participation had not been the focus in the initiative in Andhra Pradesh. In Gujarat, on the other hand, early measures to delegate powers to regional directors had been reversed.

### **The Way Forward**

Dr. Sharma knew that whatever he did, he would be judged in terms of the achievement of the Millennium Development Goals (MDGs) as outlined in the Madhya Pradesh Population Policy 2000. For him RKS seemed to be a good tool. On the one hand, it actively involved people, communities and representatives in the management of health services delivery, a good way to raise awareness for the MDGs. Additionally, good hospital management was crucial in relation to the risk of death due to complications in pregnancy and childbirth, infancy and early childhood. Additionally, hospitals provided indispensable support for the primary health care services needed for preventative functions. In this sense, the success of the RKS was essential.

Having reviewed the whole RKS experience, the different reports, and the impressions from the field, Dr. Sharma believed that the *Rogi Kalyan Samiti* approach was a politically viable and operationally feasible model for decentralization of public health care delivery, as it would have a positive impact on efficiency and service quality. While reflecting on how to convey the message to the Minister, Dr. Sharma thought about how to address the issues identified, and how an expansion and replication of the RKS system could best be realised. He prepared a reform proposal to give a renewed emphasis to the decentralization of the public health care delivery system in general, and public hospitals in particular, using the concept of *Rogi Kalyan Samiti* as the model. The synthesis set out preconditions which should be in place for realising the full potential of the *Rogi Kalyan Samiti* model, and assessed the extent to which these conditions had been met.

Dr. Sharma hoped that his proposal could secure political approval for the *Rogi Kalyan Samiti* – based model for the decentralization of the public health care delivery system. □

## Exhibit 1

*ROGI KALYAN SAMITI*  
HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH

**Press Releases**  
**Global Development Network Award to *Rogi Kalyan Samiti***

**GLOBAL DEVELOPMENT NETWORK AWARD GOES TO INDIAN PROJECT**

The bane of India today is the government having too little to spend on poor people and whatever little it spends going mostly as salaries to government employees who are accountable to none, says the Business Standard (India). But there is good news in Madhya Pradesh which has over the late nineties pioneered a system of decentralized healthcare that holds great promise, the story says, noting that the *Rogi Kalyan Samiti* initiative has just won the Global Development Network award for the most innovative development project. The network is sponsored by, among others, the World Bank, the Ford Foundation and the Japanese Bank for International Cooperation. The jury included World Bank President James Wolfensohn and economists Joseph Stiglitz and Amartya Sen.

The main thing about these "samitis" is that it is an idea that has worked, says the story. There are now over 600 government hospitals all over Madhya Pradesh under them. Hospitals which have come under the management of these samitis have seen a 25 percent rise in their patients.

A *Rogi Kalyan Samiti* is registered as an NGO and is allowed to take over the management of the hospital that it is set up for. It can use the premises and assets of the hospital, raise additional resources and spend them in running the hospital and improve its facilities. Its resources are an additionally, beyond what the government spends. They are raised through donations from the community and most significantly by levying user charges graded by people's ability to pay. The latter is fixed entirely through self-certification and the experience is that very few cheat. The money raised by the samiti does not have to be deposited with the government and can be used by the samiti as it sees fit.

What this experiment has revealed is that people, including the poor, are happy to pay as much as they can for a bit of decent healthcare, says the story. And there is enormous local enthusiasm in improving facilities and installing modern equipment like those to conduct CT scan and ultra-sonograph in their local hospital. The administrative innovation that the samiti represents is giving power to the providers. Instead of all the administrative powers being confined in the hospital superintendent, under the samiti management it is passed onto the departmental heads.

Source: Business Standard, India, June 2001.

The Award for the Most Innovative Development project went to S.R. Mohanty of India for the *Rogi Kalyan Samiti* Project, which involves management of public hospitals through community participation. The project began in 1994 when plague was reported in the Indian State of Madhya Pradesh, raising concern about unclean and dilapidated public hospitals. Under Mohanty's leadership the community cleaned and overhauled the seven-story, 1,000 bed hospital at the core of the district's health care system and went on to rehabilitate other health care facilities elsewhere in the state. Mohanty received a degree in management from the Indian Institute of Management, Ahmedabad, in 1981. He is currently managing director of the Madhya Pradesh State Industrial Development Corporation.

Source: DevNews Media Centre.

## Exhibit 1 (continued)

**Note on the Global Development Network Website**

*Rogi Kalyan Samiti: Management of Public Hospitals Through Community Participation*

**An innovative project for the management of public hospitals through community participation in the state of Madhya Pradesh, India**

**by Mohanty, S.R.**

**Produced by: Global Development Network (GDN), 2000**

Ironically it was the plague scare of 1994 that woke up the sleeping health care behemoth of the central Indian state of Madhya Pradesh.

As the panic of an impending epidemic swept across western and central India, the District Magistrate of Indore, SR Mohanty, 35, combined with the people of the industrial town, devised an innovative plan to overhaul the health delivery system of the town to restore people's faith. The seven storey, 1,000 bed Magharaja Yashwant Rao Hospital had never been cleaned in nearly half a century of its existence.

In the two months that it took to completely refurbish the hospital from scratch, the germ of a new idea was born. The government hospital was handed over to a committee of people's representative called the ROGI KALYAN SAMITI (RKS) to bring about a permanence in maintenance and augmentation of facilities.

People's participation with only very basic control in hands of the state apparatus proved so successful that it was replicated over each of the 61 districts in the state covering as many districts hospitals and 450 smaller primary and community health centres.

Today more than Rs 370 million has been collected and spent by various RKS bodies for improving facilities in these hospitals in the state, which is multi-times more than the state could put into the system.

Mohanty feels people essentially want to help themselves and good governance is about showing them the way and not interfering.

Source: Global Development Network, [www.gdnet.org](http://www.gdnet.org)

## Exhibit 2

*ROGI KALYAN SAMITI*  
HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH

**Composition of the RKS - District Level Committee**

The constitution of the RKS at district level is fixed by governmental decree. The composition of the **RKS District Level Committee** seeks to combine government officials, political leaders, peoples' representatives, donors, professionals and leaders of the community, as seen in the table. Under the overall supervision, superintendence and control of the RKS, the district level **Executive Committee** is to be formed by selected members of the RKS and headed by the Collector of the district. Similarly, for hospitals at the PHC and CHC level, the RKS and their respective ECs have members and relatively junior officials, as notified by the government.

Minister in Charge of the District	Chairman
Chairman of the District <i>Panchayat</i>	Member
Mayor/Chairman of the Municipal Body	Member
District Collector**	Member, Chairman Executive Committee
Superintendent of Police	Member
Chief Medical and Health Officer*	Member
One Member of the Legislative Assembly	Member
One Senior Doctor*	Member
CEO of the District <i>Panchayat</i> *	Member
CEO of the Municipal Body*	Member
Executive Engineer PWD and Electricity Board*	Member
Two donors (one nominated*)	Member
Two leaders of the community	Member
Secretary Red Cross	Member
President Indian Medical Association	Member
Civil Surgeon*	Secretary

\* *Members of the (district level) Executive Committee*

\*\* *Chairman of the Executive Committee*

## Exhibit 3

*ROGI KALYAN SAMITI*  
HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH

**RKS: Roles and Responsibilities**

**RKS Roles and Responsibilities**

*The roles and responsibilities of the Rogi Kalyan Samitis were defined as follows:*

- The RKS would be registered societies and be set up in all medical colleges, district hospitals, and community health centres.
- The RKS would have people's representatives, health officials, local district officials, leading members of the community, representatives of the Indian Medical Association, members of the urban local bodies and *Panchayat Raj* representatives, as well as leading donors as their members.
- The RKS, for their functioning, would be deemed not to be government agencies, but almost NGOs.
- The RKS could utilize all government assets and services to impose user charges. They would be free to determine the quantum of charges on the basis of the local circumstances.
- The RKS could raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies.
- The RKS could utilize surplus land available in the hospitals for commercial purposes or to construct shops and lease them out (subject to some broad guidelines issued by the government).
- The RKS could take over and manage canteens, rest houses, stands, ambulance services, and other facilities within the hospital complexes owned or managed by the government.
- Private organizations offering high-tech services like Pathology, MRI, CAT SCAN, Sonography etc could be permitted to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS.
- The funds received by the RKS would not be deposited in the state exchequer but would be available to be spent by the executive committees constituted by the RKS.
- As a result of the RKS system coming into effect, the government would not reduce the budgetary allocation traditionally received by the hospitals.

## Exhibit 4

*ROGI KALYAN SAMITI*  
HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH

*The RKS would be free to use funds according to their best judgment. Different RKS bodies had used these funds for a diverse set of purposes as outlined below:*

1. Ensuring regular maintenance, repairs and necessary construction/expansion of the physical facilities in the hospitals.
2. Ensuring cleaning, security, hospital waste management, MIS and other hospital services through private agencies.
3. Providing improved facilities by addition or upgrading of OT complexes; sonography, burns units; ICCU; pediatric units (ICU); CAT-scan units; centralized pathological set ups etc.
4. Purchase of equipment, chemicals, furniture and other necessities for efficient running of the hospitals.
5. Providing improved medical facilities through the purchase of modern equipment through donations received, and if required through loans from financial institutions.
6. Providing a better atmosphere, facilities for attendants and ensuring improved medical facilities in general.
7. Introduction of appropriate methods of disposal of medical waste.
8. Provision of medical care to the poor and needy, free of cost or at highly subsidized rates as compared to private hospitals.

Exhibit 5

*ROGI KALYAN SAMITI*  
HEALTH SECTOR DECENTRALIZATION IN MADHYA PRADESH

**Broad Objectives of the RKS**

**Broad Objectives of the RKS**

- Improve the hospitals, upgrade the equipment and modernize the health services.
- Ensure discipline in the institutions and supervise the staff.
- Establish affiliations with private institutions to upgrade services.
- Undertake construction and expansion in the hospital buildings.
- Ensure optimal use of hospital land according to government guidelines.
- Improve participation of the committees in the running of the hospitals.
- Ensure scientific disposal of hospital waste.
- Ensure proper training for doctors and staff.
- Ensure subsidized food, medicines and drinking water to the patients and their attendants.
- Ensure proper implementation of National Health Programmes.
- Ensure proper use, timely maintenance and repair of hospital equipment and machinery.