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GOVERNMENT OF KERALA

Abstract

PUBLIC SERVICES – TWELFTH REPORT OF THE KERALA ADMINISTRATIVE REFORMS COMMITTEE ON HEALTH SERVICE
DELIVERY—APPROVED—ORDERS ISSUED

PERSONNEL AND ADMINISTRATIVE REFORMS (AR) DEPARTMENT

G. O. (MS) No. 32/03/P&ARD.

Dated, Thiruvananthapuram, 6th October 2003.

Read:—G. O. (Ms.) No. 7/97/P&ARD dated 26-5-1997.

ORDER

In the Government Order read above, the Kerala Administrative Reforms Committee was constituted to recommend measures to simplify and streamline the present system of administration in the State. The Committee has submitted its twelfth report on Health Services Delivery.

Government have examined the report in detail and are pleased to approve the recommendations contained in the twelfth report of the KARC as modified below:

No.	Recommendations in the Twelfth Report of KARC	Government Decision on the Recommendations.
(1)	(2)	(3)

3.2. OFFSETTING THE FINANCIAL STRESS

3.2.1 The financial limitation on provision of health care by Government cannot be wished away. A realistic assessment of available resources has to be made. In order to eke out these resources, the following suggestions are made.

- (a) The Hospital Development Committees could be further activated. They may be given ideas for local resource raising and be given the freedom to utilize the resources subject to general guidelines. In fact the heads of the Hospital Development Committee along with the Doctors could be given joint training on improved hospital management with focus on community participation in management of hospitals. Accepted.
- (b) In all secondary and tertiary hospitals Pay Clinics may be started. In the case of secondary hospitals the local governments may be given the freedom to start Pay Clinics. Essentially, Pay Clinics would be on a voluntary basis for the specialists and would be conducted outside office hours. Fees may be charged as decided by the local government or Government and 80% of it given to the doctor and staff and the remaining portion set apart for Accepted.

improving the hospital functioning. The receipts should be kept as a separate fund and should not go into the general government revenue. The guidelines for setting up of model Pay Clinics may be seen in Annexure I.

- (c) The local governments may be given the freedom to upgrade hospitals or provide special services subject to the condition that the additional cost would be raised locally either through donations or through imposition of cess by the Village Panchayat or Municipality or through user charges. Accepted subject to the modification that the expression 'upgrade hospitals' is replaced by 'augment facilities in hospitals'.
- (d) In all hospitals where there is scope, a three-type self-targetting inpatient facility can be provided. A free general ward for poor patients, a cost-recovering pay ward for a small group of four to six patients and a cost-plus pay room facility for individuals who can afford to pay. (The additional income can be used for cross subsidizing the general ward.) Accepted.
- (e) In order to reduce the cost of drugs which is fast increasing due to the new trade regime, it is suggested that a Drug Formulary system for the whole State be designed starting with tertiary hospitals. The drugs should be prescribed as per the formulary with the essential drugs being given free and the non-essential drugs being given on payment. Companies can be asked to produce non-patented drugs without brand names for the exclusive use of the Government Hospitals. The quality can be assured through vigorous quality assurance checks as well as third party checks with severe penalties for non-compliance of quality standards. Access to these drugs may be provided to Non-Government hospitals also. Accepted.
- (f) Ultimately risk policy and pre-payment of some kind will have to be introduced. Unless this is made mandatory, risk pooling cannot be there. To start with groups like government employees, pensioners etc., which are easy to cover from the administrative point of view, may be brought in. After gaining experience, the coverage can be extended. Accepted.
- 3.2.2 A three-tier health system has to be designed. The minimum facilities available at each level should be determined and be made available at the earliest. For each level there should be a referral protocol. This would ensure that people do not crowd higher level hospitals unnecessarily. The referral protocol would have to be made applicable to private hospitals also if they intend to refer patients to the higher levels. Accepted.
- 3.2.3 Commensurate with this hierarchy of health facilities, specialization should also be spread rationally in Block/Taluk and District hospitals. KARC endorses the recommendation of the One-Man Commission, 1994 (Prathapan Commission) regarding specialization (Annexure II). There should be reservations in specialist courses for existing doctors subject to a strict bond for continued service. Facilities may be provided to the Doctors at the cutting edge levels to acquire further qualifications in general medicine. Alongside a cadre of hospital administrators need to be built up by providing specialized courses for volunteers from among doctors. The placement of doctors should be managed in such a way Accepted.

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that remote areas get the doctors and other personnel without difficulty. Special incentives are already there for admission to post graduate courses. The system could be rationalized and made more transparent. For doctors working in identified remote hospitals, special facilities may be provided for accommodation and additional incentives granted for education of children etc.

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3.2.4 There should be regulation of hospitals in the private sector through law. The focus should on minimum infrastructure facilities, basic staffing norms, maintenance of ethical standards and management of hazardous waste. The regulation should also enable grading of hospitals and prepare reporting systems, which have to be adhered to by the hospitals. Accepted.

3.2.5 For strengthening the doctor- patient relationship, clear management protocols would have to be prepared at each level. There should be absolute transparency in allotment of beds and in various queuing systems for accessing facilities. Some kind of social audit of hospitals may be arranged through Committees of eminent citizens of the locality. A complaint procedure may be prescribed in hospitals and a clear system for redressing grievances prescribed. Ultimately what is required is a Patients' Charter, which clearly indicates the services, he can expect and the minimum standards assured within existing constraints. Accepted.

3.2.6 In order to bring about inter-disciplinary linkages Councils may be set up at the State, District and local government levels with representatives of the three systems of medicine. The State Council could be chaired by the Secretary (Health) and the District Council by the District Collector. The State Council should lay down guidelines for co-ordination and co-operation. The Councils at other levels would facilitate implementation of these guidelines and give feed back to the State Council. Accepted.

3.2.7 For the hospitals transferred to local self governments the following recommendations are made.

(a) The minimum infrastructure standards required and the desirable level envisaged may be identified and an action plan prepared by the local governments to reach these levels with the resources available in their hands. The medical officers concerned should facilitate preparation of such action plans based on general guidelines to be issued by the Government. For areas which have comparatively deficient facilities, compensatory assistance would be needed to cover existing gaps between them and the developed areas. Accepted.

(b) A Community Health Planning Handbook may be prepared and training given to local governments for preparation of participatory health plans at the local level. Accepted.

(c) Management manuals have to be prepared for each kind of hospital. These manuals should have one portion explaining the obligatory aspects relating to hospital running and another portion, which is advisory in nature to promote efficient management. Accepted.

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3.2.8

As regards administrative and other issues raised by the Task Forces, KARC would make the following recommendations:

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| (a) | The fixing of the time of functioning of hospitals and dispensaries may be left to the local governments who may take a decision after seeking the opinion of the Hospital Development Committee. | Accepted. General guidelines will be issued in this regard. |
| (b) | There is tremendous scope for specialized Ayurvedic treatment to people from outside the State as well as outside the country. The department of ISM may link up through the department of Tourism and advertise their facilities widely. This could result in useful additional income to the department. | Accepted. |
| (c) | In the case of Homoeopathy Department, it is recommended that uniform staff pattern may be fixed for Homoeopathic dispensaries consisting of one Medical Officer, one Pharmacist and one Attender. | Accepted. |
| (d) | In the case of pharmacist it must be ensured that only qualified persons are appointed in future. It cannot be considered as a promotion post for non-technical people. For those who are already in service, special training may be given and they be asked to pass an examination. | Accepted. |
| (e) | A pool of four vehicles may be provided to the department for conducting medical camps. These vehicles could be allotted to the district by the Director of Homoeopathy. | Accepted. |
| (f) | More powers of the Director could be delegated to the district level officers both in ISM and Homoeopathy Departments. | Accepted. |
| (g) | A training programme may be launched both in ISM and Homoeopathy Departments. Existing institutions may be utilized for providing inservice training to the professional staff. At least 2% of the Plan allocation may be set apart for the training expenses. The training programme may be drawn up in consultation with the respective teaching colleges. | Accepted. |

The Administrative Department of the Secretariat and the Heads of Departments concerned will issue necessary orders for implementing the recommendations approved herein.

By order of the Governor,

DR. K. M. ABRAHAM,
Secretary to Government.

To

The Principal Secretaries/Secretaries/Special Secretaries to Government.

All Departments of Secretariat including Law and Finance.

All District Collectors and all Heads of Departments.

The Director of Public Relations.

The Accountant General (A&E) Kerala, Thiruvananthapuram.

The Principal Accountant General (Audit) Kerala, Thiruvananthapuram.

The Private Secretary to Chief Minister/other Ministers/Leader of opposition

The Additional Secretary to Chief Secretary.

The General Administration (SC) Department.

ANNEXURE I

GUIDE LINES ON 'PAY CLINICS' IN GOVERNMENT HOSPITALS

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ard.
1. 'Pay clinics' may be started in all Secondary and tertiary Hospitals, including Hospitals of Indian System of Medicine as well as Homoeopathic Hospitals. The organization and running of the 'Pay clinics' will be the administrative responsibility of Local Self Government Institutions to which the Hospital concerned is vested. The clinic will be run by a Managing Committee constituted by the Local Body, and function under the overall supervision of the concerned Standing Committee of the Panchayat/Municipality/Corporation. The decision to start the clinic and the constitution of the Managing Committee will be taken as per the resolution of the concerned local body.
 2. The Managing Committee of the pay clinic may consist of the following :—
 - (1) Chairman of the Standing Committee dealing with health of the concerned local body : Chairman
 - (2) Superintendent/Medical Officer in charge of the Hospital/PHC : Member Secretary
 - (3) One non-official representative of the Hospital Development Committee : Member
 - (4) One official representative of the Hospital Development Committee other than Medical Officer in charge : Member
 - (5) One Member of the Health Standing Committee of the local body : Member
 - (6) Secretary/Executive Officer of the local body : Member
 - (7) One representative of the Hospital staff* (The Nursing Superintendent/The senior most Head Nurse of the Hospital) : Member
 3. All the existing infrastructure in the hospital like building, furniture, other equipments of the hospital will be used for running the pay clinic. Additional facilities can be built up/procured by the local body according to actual requirements.
 4. The minimum requirements of a 'pay clinic' unit may be the following:—
 - One consultation room for Medical Officer.
 - Room/space for the visiting patients. (Sufficient seating with comfortable chairs and one bed or cote for very serious/tired patients brought to the clinic for resting or waiting outside the clinic.)
 - A cash-cum-enquiry counter.
 - An examination room adjacent to the consultation room or an examination bed with required privacy in the consultation room.
 - Nursing cum dispensing room.
 - Furniture including chairs for seating the patient/persons accompanying the patient.
 - Other ordinary medical equipments required by the doctor for examining the patient. A separate telephone with extension will be provided in the pay clinic.
 5. One unit of the pay clinic will be manned by one doctor, one nurse and one attendant in addition to a cashier cum assistant at the counter. Except the doctor, others can service more than one unit.
 6. The pay clinics could normally function from 4.30 p.m. to 8.30 p.m. every day; the working time can be increased according to demand/staff availability later, at the discretion of the Managing Committee.

7. The pay clinics should not in any manner, what so ever, adversely affect the normal functioning of the hospital and it should not reduce the availability of any service to other patients in terms of quality, quantity, or time.
8. Pay clinics of different specialities may be established in Taluk/District hospitals and above.
9. Attending to patients at the clinics will be based on priority coupons issued at the counter preferably with the help of a computer.
10. The patient will have a choice in selecting the doctor, he/she will be attended by the doctor of his/her choice only.
11. The Doctors, Nurses, Attendants, Cashier or other persons to be appointed at the pay clinics will be decided by the Managing Committee of the pay clinic.
12. The Medical Officers/Surgeons/other medical staff of the hospitals concerned will be posted only after ascertaining their willingness and will be given preference as per seniority for being engaged at the pay clinics.
13. If sufficient number of doctors and other medical staff of the hospital are not willing or not available for being engaged in the pay clinics. Doctors or other medical staff retired from the Government Service or from private service may be appointed by the Managing Committee on contract basis for a specified period.
14. Qualified and registered doctors and medical staff like House Surgeons. Nursing Trainees can also be appointed in these pay clinics as part of their field attachment/training. Unemployed doctors and nurses with required qualification and registration can also be appointed if medical personnel as mentioned above are not available.
15. The rate of fees charged at the pay clinics will be decided or fixed by the Managing Committee taking into account the overall expenses including the remuneration to be paid to the doctors so as to ensure that the pay clinics can be run on a no-loss, no-profit basis. Different rates can be fixed for different specialists.
16. The fees collected will be deposited in a separate fund in a savings bank account to be opened in a scheduled Commercial/co-operative bank. It will be operated jointly by the Chairman and Member Secretary of the Managing Committee.
17. Out of the consultation fees charged from the patients up to a maximum of 60% may be paid to the doctors engaged in pay clinic, as their remuneration in proportion to the number of patients attended by them. Out of the consultation fees charged another 20% could be paid to the cashier/nursing staff/attendant sharing on an equal basis. If only one staff is engaged, it could be paid to him/her in full. The remaining 20% may utilized for the other administrative expenses. The remuneration to the doctors/ staff could be paid on a weekly/ fortnightly/monthly basis as fixed by the Managing Committee. While fixing/charging 'fees' in addition to the consultation fees, service charges, registration fee, etc. can also be charged for meeting other recurring or unforeseen expenses of the clinic. (Eg: Salary of the Cashier, etc.)
18. More than one doctor can be engaged for a pay clinic with combined or shared staff. Sharing of the remuneration to the staff will then be on the basis of the total consultation fees collected.
19. Other clinical, Para-medical services including X-ray, ECG, Scanning, Lab Services, Ambulance Service etc. can also be made available for these patients at the pay clinics on payment basis at rates fixed for each type of services. Neethi Medical Stores or Dhanvanthiri Kendra type of medical stores can also be linked with pay clinics. The staff who have to work extra should also be given pro-rata remuneration out of the fees charged from the pay clinic patients. But the entire payment of fees charged should be credited to the same fund account of the pay clinic and shared between the different services according to the due share of each. However the entire management and transactions will be in accordance with the decisions of the Managing Committee or the rules framed by the Managing Committee specially for the purpose.
20. The entire transactions of the pay clinic will be accounted on a commercial basis in 'double entry' system. It will also be subjected to audit by the Chartered Accountant appointed by the Managing Committee on annual basis.
21. The audited accounts along with status reports should be placed before the Executive Committee of the local body concerned for scrutiny and approval. Copies of such reports should also be published in the Hospital Development Committees.
22. The entire standards of services at the pay clinic should be fixed in advance and published in a notice board at the pay clinic conspicuously, and updated periodically.
23. Drop-in boxes for depositing complaints/suggestions by the public should be placed in front of the pay clinics and it should be opened regularly in the presence of the visitors by any one of the members of the Managing Committee and action will be taken promptly after placing them in the meetings of the Managing Committee.
24. The Managing Committee of the pay clinics will meet as often as possible and on a regular basis on a fixed day every month.

25. Properly printed payee's receipts with carbon duplicates will be issued to the patients for every payment tendered by him at the pay clinics. But duplicates may not be necessary if receipts are generated using computer.
26. The steps taken for ascertaining the willingness of persons for posting as doctors and other medical staff at pay clinics, fixing rates etc., and other procedures and the communications in this behalf should all be open and transparent.
27. All possible steps have to be taken by the Managing Committee to make the pay clinics attractive both for the medical staff and the patients/public alike. The Managing Committee may identify perks in kind and include them as part of the rewards or incentives for the medical staff engaged in the pay clinics. Illustratively they might include the following:—
- (i) Reimbursement of cost of fuel charges for the vehicle owned and used by the doctors, on a monthly basis. (Monthly ceiling can be fixed)
 - (ii) Reimbursement of telephone charges this can be limited to the rent charges + local call charges (Subject to a fixed limit, say, 500 local calls) including proportionate service tax charged by the BSNL.
 - (iii) Providing Cell Phone connection, which can be limited to reimbursement of cost of recurring charges or cost of pre-paid mobile phone cards on a monthly or bi-monthly basis as applicable.
 - (iv) Reimbursement of a actual house rent, subject to a ceiling of up to 50 % of the rent paid.
 - (v) Refrigeration charges, say 25% of electricity charges.
 - (vi) Reimbursement of cost of books, periodicals, newspapers, etc. subject to a monthly ceiling of Rs. 1000 or quarterly ceiling of Rs. 3000.
 - (vii) Mess charges or refreshment charges while on duty in the pay clinic.
 - (viii) To and fro Air tickets for attending one national conference/seminar on medical profession within India, per year.
- (Note:—These items are illustrative and may be added other type of perks and concessions as decided and negotiated by the Managing Committee)
28. The Pay clinics may in due course honor various types of important credit cards also for treatment and services rendered. Tie-ups with insurance companies for giving treatment on the basis of medical insurance policies and getting reimbursement directly from insurance companies could also be explored and put into effect at the discretion of the Managing Committees or local bodies concerned.
29. In the pay wards run by KHRWS at least a portion up to 50% of the accommodation available may be set apart for the patients admitted through the pay clinics for which the Managing Committees will negotiate with the authorities of the KHRWS.

ANNEXURE II

EXTRACT FROM THE REPORT OF ONE MAN COMMISSION
(PRATAPAN COMMISSION) 1994

FORMATION OF SPECIALITY CADRE

In the Kerala Health Services, till now, Speciality Cadre does not exist. However, certain Speciality units are created in Major Hospitals like General Hospitals and District Hospitals. Speciality Units sparingly established in other hospitals like Taluk level Hospitals have no uniform pattern.

Many Postgraduates and Super Specialists are available in Kerala Health Services in the general list. Since they are working in a situation where adequate facilities like equipments, technical assistance do not exist, their expertise is not fully utilized by the public. This situation is neither beneficial to the public nor to the specialists.

In the promotional avenue, in vogue, even senior specialists are promoted and posted to purely administrative posts of very high responsibility, merely considering their seniority in the service. Such promotion takes away specialists to administrative posts for which the specialist has no experience at all. Consequently the public suffer, on the one hand due to under utilisation of the expertise and on the other hand, consequent inefficiency in the administration. High Power Committee on Health (Dr. Pai Committee) has recommended creation of speciality units in Taluk Level Hospitals, Intermediary Hospitals, District Hospitals and General Hospitals. The Commission is of the same opinion and endorses the recommendation of the "Pai Committee". The Commission recommends to establish speciality cadre in all hospitals having 100 or more beds in a phased manner.

Consequent to the recommendation of the Pai Committee, speciality units have been established in major hospitals like General Hospitals. District Hospitals and in some special hospitals. The Commission also recommends that unit system should be established in all other hospitals having 100 beds and above as early as possible. In establishing such a system in the hospitals the following pattern is recommended.

UNITS TO BE ESTABLISHED

1. Medical
2. Surgical
3. Obstetric & Gynaecology
4. Paediatric
5. Eye (Ophthalmic)
6. E. N. T. (Ear, Nose & Throat)
7. Orthopaedic
8. Dermatology & Venereology (skin & V. D)
9. Psychiatry and One Specialist in Anesthesiology & One Specialist in Radiology

Considering the general nature and necessity, the following specialities should have at least two units each wherever possible.

1. Medical
2. Surgical
3. Obstetric & Gynaecology
4. Paediatric

BED STRENGTH OF UNITS

It is desirable to have a minimum number of 10 beds for each unit in the case of:

1. Medical
2. Surgical
3. Obstetric & Gynaecology
4. Paediatric

In the case of other specialities, the minimum number of bed desirable is 5 (five).

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unit may have upto 30 beds maximum, when the bed strength of the hospital is more than 105, the bed strength of the units may also be increased proportionately by adding equal number to Medical, Surgical, Obstetrics & Gynaecology and Paediatric Department to make the unit strength upto 30 beds each and there after to other departments:

PATTERN OF A 105 BED HOSPITAL

	No. of Specialists	No. of Beds	
		Minium	Maximum
Medical Unit	2	10×2=20	2×30=60
Surgical Unit	2	10×2=20	2×30=60
Obstetric & Gynaecology Units	2	10×2=20	2×30=60
Paediatrics Units	2	10×2=20	2×30=60
E.N.T. Unit	1	5×1=5	1×30=30
EYE Unit	1	5×1=5	1×30=30
Ortho Unit	1	5×1=5	1×30=30
Skin & V. D. Unit	1	5×1=5	1×30=30
Psychiatry Unit	1	5×1=5	1×30=30
	13		
Anesthesiologist	1		
Radiologist	1		
TOTAL DOCTORS	15	105	390

In the Kerala Health Services, at present, there are ample number of specialists and super specialists in many disciplines. On establishing separate speciality cadre the available specialists and super specialists can be placed in the speciality units. The Commission does not recommend to recruit specialists afresh at this stage. While doing these exercises the Commission is of the opinion that the existing Rank Seniority should be given priority when specialists are identified to occupy various posts. The same principles may be applied in the case of super speciality also.

The generalists who might acquire post graduation then and there should also be taken to the speciality, if opted for.

INITIAL SETTING UP OF SPECIALITY CADRE

Having established speciality units in hospitals having 105 bed or more, speciality cadres may be established. Available specialists in the services should be identified and suitably placed. For doing this exercise, option from all postgraduate may be obtained as a first step. Only one speciality will be allowed to one person; however he may have postgraduate qualification in more than one discipline. Option once exercised should be final unless he had exercised re-option before he was assigned to a specialist post. Separate seniority list of each speciality discipline should be maintained.

Posting to the speciality units may be strictly according to his existing rank seniority. The time of acquiring post graduation is not taken into consideration at all. No differential treatment is given to Diploma holders and Degree holders, during the first placement to unit system.

LEVEL OF SPECIALIST CADRE

A. Senior Specialist:—Specialists having higher seniority will be posted to speciality units in General Hospitals and Special Hospitals. They will be designated as "Senior Specialist". The proposed scale of pay for them is Rs. 4500-7300 with a Specialist pay of Rs. 500 per mensem.

B. Specialist:—Speciality units in the District Hospitals will be filled-up with "Specialists" in the scale of pay of Rs. 3700-5700 with a special pay of Rs. 400 according to their rank seniority.

C. Junior specialist:—Speciality units in the "Intermediate level hospitals (Taluk Hospitals, Community Health Centres and other Hospitals) will be created. All speciality units will be filled-up with specialists from the general list strictly according to the seniority in the existing Public Service Commission rank list. They will be designated as "Junior Specialists" and placed in the proposed scale of pay of Rs. 3000-5000 with a specialists pay of Rs. 300 per mensem.

PROMOTION WITHIN THE SPECIALITY CADRE

Vacancy linked promotion from Junior Specialist to specialist and Senior Specialist strictly according to the ranking in the specialist cadre seniority is proposed.

DIRECT RECRUITMENT THROUGH PUBLIC SERVICE COMMISSION

When suitable candidates with specific qualification are not available in the Health Services for promotion or placement, fresh recruitment is proposed for such posts.

OPTION AND REOPTION

Option should be obtained from all post-graduates in services to be included in the specialty cadre. Others when acquire post-graduation should exercise option immediately, Option once exercised will be final unless re-option exercised before assigning to a specialist post.

RECOMMENDATIONS

1. *The Commission recommends to constitute to separate cadres belonging to different specialities.*
2. *Promotion within the cadres should be done according to the seniority in that particular cadre (discipline) subject to the availability of vacancy.*
3. *When a non-post-graduate in the general list acquires a post-graduate qualification at any time and opted for speciality cadre he will be placed as the then junior most in the lowest level of speciality cadres subject to availability of vacancy at the same time protecting his original pay and allowances.*
4. *All post-graduates in the Kerala Health Services Department except those who are posted as specialist may be sanctioned qualification allowance at the rate of Rs. 300 for Degree holders and Rs. 200 for Diploma holders.*
5. *Three levels of specialists are recommended:*
 - (i) *Junior Specialists: in Taluk Hospitals and other Hospitals having 105 beds and above in the scale of pay of Rs. 3000-5000.*
 - (ii) *Specialist in the scale of pay of Rs. 3700-5700 in District Hospitals.*
 - (iii) *Senior specialist in the scale of pay Rs. 4500-7300 in General Hospitals and Special Hospitals.*
6. *Specialists are not entitled to Post-Graduate allowance.*
7. *All specialists who are posted as unit chiefs may be given specialist pay at the rate of Rs. 300 per mensem for Junior Specialist and Rs. 400 per mensem for Specialist and Rs. 500 for Senior Specialist.*
8. *Option can be exercised for only one Speciality even if one is qualified in more disciplines.*
9. *A specialist or non-specialist when posted as Superintendent of a hospital where speciality cadre is established (i.e. Hospital having more than 105 beds) may be given a charge allowance of Rs. 500 per mensem.)*
10. *Option to speciality cadre should be obtained from all post-graduates in service and their seniority in the respective discipline (cadre) should be assigned according to their seniority in the existing Public service Commission list. No differential treatment to Diploma/Degree holders need be considered at this stage.*
11. *The non-post-graduates in the general list, when acquire post-graduate qualification should exercise option as soon as they acquire post-graduation and they may be posted to the concerned speciality as and when vacancy arises as the then junior-most in the cadre of Junior Specialist.*
12. *Re-option to go to general list may not be entertained, option had been once exercised, unless opted to become Junior-most in the existing general lists at the same time protecting present pay and allowances.*