CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

1.1.1 Schools of thought on Governance

Over last two decades, ‘good governance’ has emerged as both a theory and policy for development. Transparency, accountability, protection of human rights, supremacy of rule of law, participation and elimination of corruption are notions that form the core of the concept of ‘good governance’ (Aubut, 2004; Grindle, 2004; Minogue, 2002; Ngaire Woods, 1999; Rhodes, 2007; Weiss, 2000). The World Bank defined it as the manner in which power is exercised in the management of economic and social resources for development. A bureaucracy imbued with professional ethos and acting in furtherance of the above goals is crucial for its success.

In the West, writings of American Economist Walt Whitman Rostow (1960), the Israeli Sociologist Shmuel Eisenstadt (1966), and Stanford Professor Neil Joseph Smelser (1968) created further paradigmatic shifts in the then prevailing schools of thought about modernisation, governance and development. For instance, in a 1966 study of contemporary modernisation processes relating to decolonization, Eisenstadt pointed out that modernisation was always accompanied by disorganization and protest (S. N. Eisenstadt, 1974). Similarly, Smelser described the transition from traditional to modern societies as a process characterised by structural differentiation and economic take-off; he identified four critical areas (technology, agriculture, industry and migration) where changes were bound to occur in the move from traditional to modern societies. New social and political institutions had to be established to facilitate this process of change (Smelser, 2013). Further, Rostow defined five stages of this evolutionary process to achieve modernity: traditional stage, precondition for take-off, self-sustained economic growth (takeoff), drive to maturity and high mass-consumption society (Rostow, 1960).

By the mid 1970’s, the poor results of the national programmes on regional developments led to criticism of polarised development models. Barrios (2002) argued that in a context of centralised systems and undiversified regional economies, the strategy of development led to the configuration of enclaves (Barrios & Strobl, 2002). Consequently, paying more attention to local priorities emerged.

The merging of evolutionary and functionalist theories served as the basis for emergence of modernisation theory. Modernisation was considered a gradual progression from primitive, or
traditional, to more advanced societies with the aim of establishing a ‘modern’, industrialised, urban-based society. This theory offered the newly independent nations of the third world the promise of a guided transition to the state of a developed industrial society (Haynes, 2005). In Eisenstaedt’s words, “Modernisation is the process of change towards those types of social, economic and political systems that have developed in Western Europe and North America from the seventeenth century to the nineteenth and have then spread to other European countries, and in the nineteenth and twentieth centuries to the South American, Asian and African continents” (Shmuel Noah Eisenstadt, 1999).

The UNDP report (2004) discussed about ‘democratic crisis’ which involves erosive relationship between citizens and the state, and the perceived lack of responsiveness of governments to citizens’ needs. Diverse forms of institutionalizing participation have been proposed for bridging this gap. The model of New Public Management (Michael Barzelay, 2001; Mintzberg, 1996) emerged via the critique of a centralised, inefficient, unaccountable and overextended state. Some authors have gone to the extent of arguing that the public sector should incorporate an entrepreneurial dynamism to cater to the needs of people (Maddock, 2002). The whole idea is to apply business practices of corporate sector for non-profit cause; and the state functions as a facilitator, a catalyst and an articulator (Haynes, 2005). It means moving from a means-based to a results-based rationale. There would no more beneficiaries, but only ‘clients’ for public services.

1.1.2 Healthcare system

A health care system is a set of activities and actors whose principal goal is to improve health through the provision of public and private medical services (Anderson & Hussey, 2001). Since the WHO 2000 report, systems’ thinking has re-emerged as the cornerstone for improved health outcomes, and the consequent paradigm shift in policy making from disease-specific initiatives to strengthening of health system. One of the key factors behind this shift was the realisation among policy makers that a chronically ill health system would threaten the achievement of millennium development goals (MDG) (Hafner & Shiffman, 2013). Over the years, major global public health institutions have also echoed the views of world health organization (WHO) and started investing in health systems (GAVI, n.d.; Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008; World Health Organization, 2000b).

The WHO (2007) explicitly recognised governance as a key pillar of health system building blocks framework. The significance of decentralised governance of health systems as to improve decision making at local levels in different tiers of health service delivery is constantly growing. In India,
this has special importance for governments, policy makers and administrators of health services in view of geographic vastness and socio-economic diversities on one hand, and ever-growing health needs and expectation of the population on the other. Further, there is scant empirical evidence examining the effects of decentralisation on HSP, particularly on efficiency and quality of health care services. Therefore, the debate on whether or not decentralisation improves equity, efficiency, accountability and quality of services continues to generate curiosity among scholars and policy makers. Assessment of HSP through macro-level indicators at the national level has only limited value; much more useful information for policy makers could come from sub-regional level (district/institution) assessment of performance, particularly in a country as diverse as India (Haines & Cassels, 2004b; Heywood & Choi, 2010; Shengelia, Tandon, Adams, & Murray, 2005)

1.1.3 Local self-governance
Decentralisation, also known as local self-governance, is the process of transferring power, authority, resources, functions and service delivery responsibilities from the central government to the lower-level institutions in a political administrative structure (Bardhan, 2002; Thomas J Bossert & Beauvais, 2002; Jean-Paul Faguet, 2004; Rondinelli, Nellis, & Cheema, 1983; Salmon, 2010). ‘Power’ is the ability to influence people, while ‘authority’, power conferred for a purpose. In the context of governance of public health systems, the latter is more often referred to than the former. Decentralisation or local decision-making, as is often understood, is recognised as an important means of improving service delivery (Agrawal & Ribot, 1999; Larson & Ribot, 2004; Litvack, Ahmad, & Bird, 1998). Improved efficiency and effectiveness, accountability, responsiveness, community participation, service integration and intersectoral coordination are considered as the key benefits of decentralisation. Further, it is argued that shared governance would be knowledge-based; foster decision making at the point of service, improve direct communication between the clients and decision makers, and ensure accountability (Fallis & Altimier, 2006). However, the evidences generated on the impact of such a reform are inconclusive (Andrei, Mitruţ, Constantin, & Oancea, 2009; Arredondo, Parada, Orozco, & García, 2004; Barankay & Lockwood, 2007; T. Bossert, Chitah, & Bowser, 2003; Thomas John Bossert & Mitchell, 2011; Frumence, Nyamhanga, Mwangu, & Hurtig, 2013; Kaur, Prinja, Singh, & Kumar, 2012; Khaleghian, 2004; Pena & Solé-Ollé, 2009; Winter, Murphy, Crespin, & Boucar, 1996).

Local self-governance in health sector connotes transfer of fiscal, administrative, and political authority from the Ministry of Health to peripheral institutions for efficient and effective health service delivery. In India, the decisive principles for such transfers are based more on geo-political compulsions than on empirical priorities. Historically, the debate about decentralisation and its role
in effective governance dates back to 1907 that marks the establishment of the Royal Commission on Decentralisation (World Bank, 2000). In 1948, there was a constitutional debate between Gandhi and Ambedkar on *Gram Swaraj* or ‘self-rule’ (V. N. Alok, 2011). Subsequently the recommendations of Balwantrai Mehta Commission (1957) to implement the *Panchayat* structure at district and block levels, and of the Asoka Mehta Committee (1978) to consider the district as the administrative unit, were dealt with cautiously (Government of India, n.d.-d). By the time the L.M. Singvhi Committee (1986) proposed to enshrine local self-governments constitutionally, the difficulties of governing such a diverse country through centralised governance was more than evident (Singhvi, 2001). Consequently, in 1993 the 73rd and 74th Amendments to the Indian Constitution established *Panchayat Raj Institutions* (PRI) in rural areas and Municipalities in urban areas (Government of India, 1992).

Decentralisation has two critical components: participation and accountability. Participation in democracy is concerned mainly with increasing the role of citizens in choosing their local leaders and in providing inputs into new models of local governance. Accountability on the other hand is the degree to which local governments have to explain what they have or haven’t done (Burki, Shahid Javed, Guillermo Perry, and William R. Dillinger, 1999). Increased participation might further the cause of political and social inequality rather than giving more power to the voice of the poor in local decision-making (McEwan, 2005; Molyneux, 2002). The question is whether the decentralisation process accomplishes stated goals of efficiency, equity and quality of health services (Collins & Green, 1994; Heywood & Choi, 2010; Mills, 1994).

### 1.1.4 Local self-governance in Odisha

In Odisha, decentralisation as a health sector reform, argued to improve efficiency of health units, was introduced in a phased manner. *RKS* were established at health units to foster local decision making which in turn could improve efficiency, service productivity and quality. *RKS* as local self-governing institutions are composed of political and civil society representatives, health service providers, administrators/managers and other department officials. However, opponents argue that such reforms are often accompanied by profound changes in the way publicly funded services are resourced, and human, financial and material resources are managed (Riitta-Liisa Kolehmainen-Aitken, 2004). Since the 2000 WHO report, studies have focused on the efficiency of health care systems of industrialised countries (Comanor, Frech, & Miller, 2006; Hadad, Hadad, & Simon-Tuval, 2013). Moreover, almost all studies in the past focused on measuring outputs, but have not been able to examine the inputs and processes from the point of view of key stakeholders (Balaguercoll, Prior, & Tortosa-Ausina, 2010; De Vries, 2000; O’dwyer & Ziblatt, 2006; Porcelli, 2009b,
Balaguer et al argued that the likely efficiency gains from enhanced decentralisation increase over time (Balaguer-Coll et al., 2010). An analysis of opinions of local elites by De Vries indicated that the support for decentralisation was more closely related to existing institutional arrangements, and to the degree to which it was expected to influence one's own position, than to its inherent merits (De Vries, 2000).

1.1.5 Health system strengthening
The ‘health system strengthening’ approach has gained momentum in the last decade. Many national governments and even global health institutions have started investing in systems strengthening (Government of India, n.d.-a, 2010a, 2010b, 2011; World Health Organization, 2007, 2010). Evidences indicate that the health system’s performance in achieving the objectives of efficiency, quality and equity is contingent upon the width of ‘decision space’ at the local level. The functional areas of finance, service autonomy, recruitment rules, access rules and departmental rules normally have very narrow ‘decision space’ at local level. On the other hand, the administrative environment comprises of factors, such as, support for supervisors, enabling work environment and efficient funds flow. Decentralisation is considered an effective governance mechanism to promote HSP (Hafner & Shiffman, 2013; Naimoli, 2009; Ooms et al., 2008; Rowe, De Savigny, Lanata, & Victora, 2005). The thin line of difference between governance and management is explained in terms of the roles, focus and outputs. The former is related to visioning and policy development, while the latter is mainly day-to-day implementation.

1.1.6 National health policy, 2002
The National Health Policy of India (2002) aims at achieving an acceptable standard of health for the population. The country has a long term goal of improving health outcomes through a robust and responsive health system, delivering efficient and high quality health services that are equitable, accessible, affordable and acceptable to the general public (Government of India, n.d.-d, 2002). Among the many-fold challenges that the health system encounters today, managing the workforce, developing incentive-based payment mechanisms, and institutionalizing local monitoring will have long-term impact on efficiency of health units (World Health Organization, 2007). Studies point out that most regions would miss the MDGs for health because of slow progress in addressing these challenges (Planning Commission, 2011). Health workforce constitutes the most critical and dynamic facet of the health system for effective service delivery, and therefore performance of the health system is contingent upon success of reforms related to workforce management. In the last decade, state governments have introduced several measures to improve local accountability,
enhance skills and build competence of the health workforce as to improve efficiency of health service delivery (Gottret & Schieber, 2006).

1.1.7 The National Rural Health Mission (NRHM)
The National Rural Health Mission (NRHM) aimed to provide universal access to affordable, equitable, and quality health care. Since its inception in 2005, the mission has increased availability of finance, improved infrastructure for health delivery, established institutional standards, trained health care staff and provided technical support. Further, it has facilitated financial management, assisted in computerization of health data, mandated decentralised mechanisms (village health and hospital committees) for service delivery and community monitoring of services. In a sense, it has revived a neglected public health care delivery system. NRHM also aimed to bring private sectors to help in the rural health. Arguably the NRHM has injected new hopes into the health care delivery system in India. However, it continues to face diverse challenges, which need to be addressed if its goals are to be achieved in the near future (Mahal, A. S., Debroy, B., & Bhandari, 2010). To quote the government of India, thus:

“The NRHM was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. Under the NRHM, difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention were needed. The thrust of the Mission was on establishing a fully functional, community, owned, decentralised health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality” (Ministry of Health and Family Welfare. Government of India, 2013).

Initially the mission was launched by the Ministry of Health for 7 years (2005-12) for improving health care delivery through architectural corrections across rural India. The scheme proposed a number of new mechanisms for healthcare delivery including training local residents as Accredited Social Health Activists (ASHA) (Ministry of Health and Family Welfare. Government of India, 2013).

1.1.8 National Rural Health Mission in Odisha
In Odisha, the state government showed its commitment for NRHM as early as in 2005. The Gazette notifications of June 2005 and the modification orders of December 2005 are indicative of the state’s preparedness to implement the programme under the guidance of government of India.
The state government’s notification dated 31st Dec 2005 stated, thus, “Government of Odisha in partial modification of the departmental resolution reconstituted the State Health Mission for ensuring integrated primary health care services, especially to the poor and vulnerable sections of the society, as envisaged in the NRHM. The Mission aims at achieving the goals of National Population Policy, the National Health Policy through improved access to affordable, accountable and reliable primary health care services” (Ministry of Health and Family Welfare Government of Odisha, 2005)

1.1.9 Local self-governance through RKS under NRHM

In the Indian context, the high burden of malnourishment among children, high mortalities and other pregnancy-related complications brought back the focus to improving access to care through establishment of a wide network of public health facilities, and implementation of several outreach programs. Such efforts got a boosting after the formal launching of National Health Mission (NHM), earlier termed NRHM, in April 2005 (Government of India, n.d.-a; National Rural Health Mission, 2010; World Bank, 2012). Universal access to affordable, equitable, and quality health care became the key objectives of public health system. Improved funds availability, ready-to-use infrastructure, higher institutional standards, availability of trained human resources, and decentralised governance became the immediate goals.

In this context the historical 73rd and 74th Constitutional Amendments (1992) conferred more powers to the Gram Panchayats (GP) for rural- and Municipalities/Notified Area Councils (NAC) for urban/peri-urban areas, respectively. Many decision-taking responsibilities were devolved to people’s representatives (Government of India, n.d.-d). In Odisha, the formation in 1998 of the state health & family welfare society and the amalgamation of district health & family welfare societies in 1999 were key milestones. Subsequently, for public service delivery health institutions, such as, hospitals and health care centres, RKS’ were formed as institutions of local decision making to take the public health system agenda forward.

Each public health institution in Odisha from medical college to PHC has a RKS as to facilitate community control, ensure quality enhancement, comply with minimal quality benchmarks, and foster local accountability and transparency in governance (Government of India, n.d.-b, 2010a, 2010b). The RKS comprises of health service providers, officials in administrative/managerial role, elected representatives of PRI, and officials from other departments (including independent members), though such categories are neither tightly compartmentalised, nor mutually exclusive. Broadly, the functions of RKS can be classified into five thematic domains: a) Governance
(accountability, responsiveness and transparency); b) Infrastructure (construction, and maintenance, purchase and out-sourcing); c) Human resources management (HRM) (hiring, transfer and training of staff); d) Financial resource management (cost-cutting measures, resource generation); and e) Quality improvement (supervision, modernisation, quality assurance and accreditation) (Government of India, n.d.-b).

1.1.10 Health infrastructure in India
As per the Rural Health Statistics (RHS) 2014, as on 31.3.2014 the status of public health facilities function in the Country is as under: 1, 52,326 Sub Centres (SCs); 25,020 PHCs; 5,363 CHCs; 1024 Sub-divisional Hospitals (SDHs) & 755 DHHS in the country. There are 8800 PHCs that are operational as 24X7 facilities. First Referral Units (FRU) provides comprehensive obstetric care services including like caesarean section, new-born care, emergency care of sick children, full range of family planning services, safe abortion services treatment of STI/RTI availability of blood storage unit and referral transport services. Number of FRUs has increased significantly from 955 in 2005 to 2632 in 2014. There is a shortfall of 36346 SCs (20 per cent), 6700 PHCs (23 per cent) and 2350 CHCs (32 per cent) (National Health Mission. MoH&FW. Government of India., n.d.)

1.1.11 Concept of efficiency
Efficiency has several connotations, as it operates through various levels to influence the immediate service productivity and long-term health outcomes. Therefore, a complete analysis of performance also involves the measurement of effectiveness, including attainment of policy objectives (Porcelli, 2009b). Further, studies suggest that political decentralisation is said to be associated with higher government efficiency among high GDP per capita countries and lower government efficiency among low GDP per capita countries (O’dwyer & Ziblatt, 2006). In India, thus, good quality of local self-governance in health units ought to lead to improved efficiency of service delivery. Our assumption is efficiency affects and is affected by good governance, overall functioning of health units, and satisfaction of health workforce with existing provisions. Consequently, effectiveness and health outcomes, such as, access, quality and appropriateness could be improved.

1.1.12 Efficiency measurement
Efficiency may be measured by various proxy indicators ranging from outputs, such as, reduction in absenteeism, to higher outcome/impact level indicators, such as increase in life expectancy per unit of health care and non-health care inputs (Frogner, Frech, & Parente, 2015). Technical
Efficiency Score is often used to measure efficiency at facility level: it considers weighted sum of outputs as numerator and weighted sum of inputs as denominator.

However, a key challenge in measuring efficiency lies in making the outputs comparable, which vary widely by providers, patients and geographic areas (Fiscella, Franks, Gold, & Clancy, 2000; Newhouse, 1994; Schuster, McGlynn, & Brook, 1998). Quantifying risk adjustment of episode-based measures, attributing patient-related outputs to specific providers (inputs), accounting the adjustment measures for multiple providers, and differentiating proprietary grouper methodologies are some of the other challenges (Milstein & Lee, 2007). Finally, identification of ‘outputs’ of the health system is a daunting task as it depends on a number of factors, such as, the increase in quality of life, equity and access to services etc that are difficult to measure (Porcelli, 2009a).

The popularly used data envelopment analysis (DEA) and data stochastic frontier models have had limited success in evaluating efficiency of a variety of primary health care units. Moreover, efficiency score provides a way of differentiating efficient from inefficient production units, but it offers no guidance about the degree of efficiency or inefficiency (Porcelli, 2009a).

Sebastian and Lemma estimated the efficiency of 60 health posts in Ethiopia, considering the number of health workers as inputs and health education sessions as outputs (Sebastian & Lemma, 2010). Studies by Amado and Santos, Marschall and Flessa, Milliken et al have used consultations, case load, and patient visits, respectively, as output indicators (Amado & Santos, 2009; Marschall & Flessa, 2009). Kirigia et al used DEA-based Malmquist productivity index to assess the technical and scale efficiency and productivity change in various settings: they used total number of duty hours as inputs and considered the number of pap smears collected, family planning clinics held, antenatal care and post-natal care sessions held, number of children immunised, etc as outputs (Kirigia et al., 2011; Kirigia, Emrouznejad, Sambo, Munguti, & Liambila, 2004; Osei et al., 2005). Other studies categorised the outputs into gross indicators, such as, admissions and preventive medical sessions (Kontodimopoulos, Nanos, & Niakas, 2006; Masiye et al., 2006).

1.1.13 Access to primary care
Access to a primary health care facility is projected as a basic social right (Gruskin, Mills, & Tarantola, 2007). Sometimes the concept of coverage is equated with access, and sometimes with utilization. Whether or not these concepts are same is difficult to answer - probably neither. Functional coverage characterises the catchment areas of health facilities and is assessed in terms of (a) passive coverage (utilization of health facilities), and (b) active coverage (penetration into
the population). It can be more appropriate to think of access, utilization and effectiveness as determinants of effective coverage (World Health Organization, 2001).

1.1.14 Quality of healthcare

The concept of quality in health care, its determinants and dimensions of measurement are being debated across the globe. Health professionals and organizations working in health sector are now actively seeking more effective ways of understanding quality and ways and means to improve it. On one hand, quality of health services is being incrementally realised through an accumulation of scientific knowledge on service delivery mechanisms, and through introduction of overall reforms around clinical education and patient care policies, on the other hand, the same concern for quality has not yet been fully emphasised upon as a priority for policy makers due to other competing demands and limited resource availability. There is a significant body of evidence, including through systematic reviews, demonstrating ‘what works’ in clinical practice, but there is poor availability of evidence to guide as to ‘how’ to successfully translate such evidences into policy and practice (Lavis, Posada, Haines, & Osei, 2004). In India, with sluggish reduction of mortalities and progressively higher need for better quality health care services to the vast majority of rural population has thrown several challenges to policy makers.

Reproductive and child health (RCH) care being the most resource-driven public health intervention, this expectation has brought back the focus on the growing interest in quality of RCH services. The WHO definition of RCH extends beyond the physical health and includes mental and social well-being. Since the beneficiaries of RCH are women and children, assessment of quality must take into account the social context in which women live, their role and position in the family, workload, contribution to decision-making, and their ability to pay for services (Calnan et al., 1994).

The concept of quality, as defined by Donabedian, is a ‘property’ of health care that runs from one end of the spectrum to the other and manifests itself through various “attributes”, such as, the technical aspects of care, the context, and the nature of the patient-provider relationship, that is, whether the patient finds the provider understanding, courteous, informative, and respectful of privacy (R Al-Qutob, S Mawajdeh, L Nawar, 1998). Bruce’s broad definition of quality includes the ways in which individual users are treated by the system. In the context of family planning services, it was proposed to include technical competence, provider-client information flow, choice of methods, interpersonal relations, follow-up and continuity mechanisms as key factors (J. S. Akin & Hutchinson, 1999; Ben-Zvi, 1989; A. M. Epstein, 1990).

1.2 RATIONALE
The decentralisation debate in health is acquiring new momentum as an increasing number of developing countries in Asia and several states within India are adopting conditional cash transfers programs (CCT) as the main strategy to address poor access to health care services. Theoretical analyses do not allow us to draw any definitive conclusions regarding the superiority of centralised or decentralised systems in terms of their respective economic and programmatic efficiency, which makes empirical studies necessary. However, the empirical literature examining the effects of decentralisation on both allocative and productive efficiency has, until recently, been virtually non-existent and, indeed, continues to be somewhat scarce in the Country. Thus, the debate on whether or not decentralisation improves equity, efficiency, accountability and quality of care continues.

Performance management, expansion of line management autonomy, reducing administrative overheads, and outsourcing service delivery (e.g. public-private partnerships, competitive tendering, etc.) are but some of the challenges that the public health sector is facing today. Until recently, community participation in planning was almost non-existent. However, the intentions to transform weak public institutions into effective and accountable ones has brought the focus back to the agenda local self-governance. Even though the relationship between decentralisation, community participation and good governance is not clear-cut, it is argued that local governing institutions play an indispensable role in promoting the general welfare of the people owing to their physical proximity to citizens.

After the economic liberalization of 1992, the need and importance of decentralised planning was perceived to be crucial for success of implementation of health programmes. The flagship RCH programme demanded bottom-up planning, demand-driven and need-based prioritization, and effective monitoring. The programme envisaged remarkable reduction of under-five mortalities and maternal mortalities through community- and facility-driven interventions. Off late, the realisation that many of the preventable mortalities are attributed to a poor state of preparedness of our health system has triggered renewed interest on the subject of HSP assessment and modalities for strengthening the health system. The focus was for the first time shifted to ‘quality’ of services.

The launching of NRHM in 2005 was envisaged under the sub-structure of existing local governing institutions, and to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups (Sharma, 2009). The mission aimed at bringing about architectural corrections to the health system as to improve health outcomes. Further, all major health programme investments were routed through the state health society to the district and down below to local institutions, including the PHCs, CHCs and district headquarters hospitals (DHH) for their
effective implementation. Formation of RKS for each peripheral institution and of Zilla Swasthya Samiti (ZSS) at the district level was envisaged to reduce systemic barriers (Government of India, n.d.-c). The RKS was entrusted with the responsibility of planning, monitoring and supervising the programme implementation at local DMHUs.

The NRHM has put rural public health care firmly on the agenda, though there are challenges in implementation of various programmes under its gambit. On physical infrastructure, medicines and funding, procedural problems might be more easily overcome, whereas on human resources, and to the extent these impact actual availability of services, structural issues of some complexity need careful resolving with a definite long term investment in the training and education of paramedical and medical staff, and close monitoring & supervision of their performance.

In Odisha, decentralisation as a strategy, argued to have positive effects on the allocative efficiency of health units, was introduced in a phased manner. RKS’ were formed at service delivery institutions to address the local decision making needs and, in turn, improve efficiency and quality of services. However, opponents argue that this strategy is often accompanied by profound changes in the way publicly funded services are resourced, and human, financial and material resources are managed (Riitta-Liisa Kolehmainen-Aitken, 2004).

The rationale for undertaking a focused review is informed by several considerations. First, various development theories, and policies emanating therein, advanced health as a development goal and also created an environment for propagation of alternative policies. Secondly, after the 1978 ‘Alma-Ata’ declaration, governments vowed to ensure community participation towards attainment of health for all. In India, subsequent to the launching of NRHM, much attention was paid to ‘communization’ through local decision making; but the what’s and how’s of this process required much better understanding (Sinclair & Whitford, 2015). Third, state governments are grappling with issues of poor retention of human resources, adverse fiscal discipline, over-centralised procurement and contracting procedures, erratic supply of drugs and logistics, and low compliance of health service delivery points with pre-defined national standards. Last, many local governments are increasingly facing pressure to introduce reforms, mostly around governance processes.

Earlier studies have identified numerous demand-side factors as important barriers to healthcare utilization, but there is scant literature on the current state of affairs with regard to the functioning of local governance institutions in public health sector (Metcalfe & Adegoke, 2013). Authors have further argued that good governance and management of health services at peripheral level are
strongly associated with improved population health outcomes (Farag et al., 2013; Hu & Mendoza, 2013; Rajkumar & Swaroop, 2008). Thus it is important to examine the perception of key stakeholders about the nature and process of local self-governance. This study focused on examining the roles, involvement and experiences of RKS members in the functioning of peripheral health units in Odisha. The study assessed the knowledge, perception and practices of RKS members about their own ability and willingness to address local health systems related issues, such as, recruiting staff, generating and using funds, strengthening drug procurement and logistics supply, developing infrastructure, and organizing training for the staff. The study would not only identify the gaps but also would substantially inform the policy makers, because ultimately it is the government that decides on the policies, controls and distributes resources, and brings about reforms.

Further, there is scant literature examining the perspectives of the health workers about the influence of RKS on improving efficiency of local decision making, service productivity and quality of services. This study aimed to assess the perception and satisfaction of health workforce about the role and influence of RKS on the functioning of DMHUs at primary and secondary tiers of health service delivery in Odisha. The specific objectives were to a) analyse perspectives of health workers about key public health service delivery components, as seen through the lens of RKS, in priority and non-priority settings; b) examine their self-perceived importance of and satisfaction with various health service provisions; c) compare composite scores between PD and NPD; d) identify predictors of satisfaction at work; and e) discuss suggestions to improve performance.

Quality is a more significant predictor of utilization of maternal health care than access. The State has become increasingly interested in assessing the quality of health care services. Assessing outcomes has merit both as an indicator of the effectiveness of different interventions and as part of a monitoring system directed to improving quality of care as well as detecting its deterioration (A. M. Epstein, 1990; Mendoza Aldana et al., 2001). The second common review mission (CRM) report echoes the general finding in the high focus states that, “given the problems of the past, expectations of providers and even of the public had been set at very modest levels. The system is in danger of stabilizing at this low level of expectations and outputs, and even as one appreciates the effort that has gone in to reach this level, there is a need to set higher standards. There is much more that needs to be done, if the increased patient load and utilization of services was to manifest in increased outcomes” (Nair H and Panda R., 2011).
Quality has several connotations (Atkinson & Haran, 2004). Improving the quality of RCH services requires identification of its basic ‘ingredients’. Quality assessment studies usually measure one of three types of outcomes: medical outcomes, costs, and client satisfaction (J. S. Akin & Hutchinson, 1999; Al-Abri & Al-Balushi, 2014; Andrew W. Fisher, 1971; Newman, Gloyd, Nyangezi, Machobo, & Muiser, 1998; Speizer & Bollen, 2000; Uzochukwu, Onwujekwe, & Akpala, 2004). Several studies in West Asia and North Africa by a subgroup of the Reproductive Health Working Group (RHWG) have focused on the clinical outcomes (Al-Qutob, Mawajdeh, & Bin Raad, n.d.; Mawajdeh & al-Qutob, 1993). The question is what concepts, or dimensions, of quality of health care should be measured and how, in principle, should they be measured? (E. Kelley & Hurst, 2006). The study examines how satisfied are the consumers and their overall experience with the care provided at the peripheral health units in Odisha.

Applying a general management framework, service delivery was considered as the ‘existential’ function of the health system, and inputs, processes and outputs as ‘operating domains’ that dynamically interact with one another and determine the nature and landscape of individual and population health. Attempt was made to analyse the dimensions and determinants of HSP; discuss the methodological challenges in dealing with performance measurement; and propose derivatives in the form a conceptual framework that is holistic in approach and specific in context.

In this study the roles, involvement and experiences of RKS members in the functioning of peripheral health units in Odisha were assessed. Further, understanding the knowledge, perception and practices of RKS members about their own ability and willingness to address local health systems issues, such as, availability of staff, fund flow, drugs and equipment’s, infrastructure, and training status would not only identify the gaps but would have substantial policy relevance because ultimately it is the government that decides on the policies, controls and distributes resources, and brings about reforms. Further, I assessed the perception and experience of health workers at primary and secondary tiers of health service delivery units in Odisha. Specific questions related to their work environment, motivation, satisfaction and influences of local decision making were examined.

An attempt was made to assess the perceived quality of health care services being offered at primary and secondary tier institutions in Odisha; to analyse the relationship between local decision making and perception about quality; and to identify factors influencing perception of quality in Odisha context. The specific questions this section aimed to answer were: what was the perceived quality of services amongst service users? Was there any association between decentralised service
delivery and perceived quality of care? What are the factors influencing perception of quality? An attempt was made to decipher quality of healthcare system as a whole. Thus, during analysis I have included the resources, the activities, the management, out of pocket expenses, and satisfaction of patients (Mawajdeh & al-Qutob, 1993). Satisfaction was further dissected into components, such as, waiting times, behaviour of providers, knowledge of service provisions, availability of medicines, and non-clinical facilities at the health units (Atkinson & Haran, 2004; E. Kelley & Hurst, 2006; Khan, M. E., Mishra, A., Sharma, V., & Varkey, n.d.; Lohr, Yordy, & Thier, 1988).

This study specifically examines how satisfied are the consumers and their overall experience with the care provided at the peripheral health units in the state.

1.3 RESEARCH PROBLEMS

1.3.1 Exploring process and nature of local decision making under RKS

Assessments of HSP at the national level have only limited value (Haines & Cassels, 2004a; Heywood & Choi, 2010). Much more useful information for policymakers could come from district level assessments of HSP, particularly in a country as diverse as India (Tandon, 2005). It is well known that the local decision making institutions in peripheral health units deal with formidable challenges in addressing inter-sectoral convergence, governance issues, including role of PRIs, management of health units, improving fiscal discipline and local self-governance, improving quality of health service delivery, and empowering local community. Such operational challenges will continue to examine the character not only of these local institutions but also of the policy makers. There is also a need to explore and assess the effects of such arrangements on efficiency of functioning of health units, experiences of decision makers and perception of the patients and community about the quality of services being offered in the health units. Some authors have argued that social audit for community action is the call of the day to ensure that dreams of Mahatma Gandhi for Swaraj come true (Nandan, 2010).

1.3.2 Assessment of functioning of RKS in health units

The state continues to grapple with issues of poor retention of human resources, poor fiscal management, centralised procurement and contracting procedures, erratic supply of logistic and poor public health service accreditation. These issues make it even more interesting a case to study the depth and breadth of decentralisation in health sector in the last decade. Therefore, the present study aims to focus on the performance of local decision making during post NRHM era.

1.3.3 Assessment of perspectives of health workers on efficiency
Assessing the perception (opinion and satisfaction) of health workers about the influences of RKS on efficiency of peripheral DMHUs pertaining to service delivery at primary and secondary tiers in Odisha could provide critical information about the future reforms around local self-governance in health. The main objective was to explore their views on key indicators of health service delivery through the lens of RKS; to assess their satisfaction on critical components of health services, including quality of care.

1.3.4 Assessment of perceived quality

The growing interest in the quality of reproductive health services over the last decade has emanated from a concern with the high levels of maternal mortality and morbidity in developing countries, including India. For instance, with respect to the progress on vital health indicators in the country, the IMR has declined from 57/1000 live births in year 2006 to 50/1000 live births in the year 2009. Of this, the decline in rural areas was more (from 62/1000 live births to 55/1000 live births). In urban areas, the decline in IMR was from 39/1000 live births to 34/1000 live births. The rate of decline across the sexes, in both urban and rural areas, was the same. At the all-India level, by 2012 at the current rate of decline, we would have reached an IMR of 44/1000 live births, well short of the goal. Maternal mortality ratio (MMR) has reduced from 254/100000 live births in 2004-06 to 212/100000 live births in 2007-09 (SRS), a reduction of 42 points over a three year period or 14 points per year.

It has now become imperative to provide quality health care services through the established institutions to address the issue of high mortality and morbidities. However, services have not been successful in gaining the faith and confidence of the people because of a multitude of system-driven and individual-centric factors, such as, non-availability of sufficient skilled human resources, poor infrastructure, lack of accountability in local governance, paucity of resources, and non-involvement of the community. Financial protection against medical expenditures is far from universal as only about 10 per cent of the population in the country care covered with some or other medical insurance. The Government of India has made a commitment to increase public spending on health from less than 1 per cent to 3 per cent of the gross domestic product during the next few years. Increased public funding combined with flexibility of financial transfers from centre to state can greatly improve the performance of state-operated public systems (Kumar et al., 2011).

1.3.5 Assessment of out of pocket expenditure

Globally, an estimated 100 million people are plunged into poverty every year because they have to pay directly for the health services they use at the point of delivery, including purchase of drugs
and cost of transport and food, as Out Of Pocket Spending (OOPS). The situation is particularly serious in India, where market regulation and social protection measures are inadequate. In the state of Odisha, the total OOPS on all types of medical care is even higher than the national average. The total estimated OOPS on health care is approximately 80 per cent of total health expenditure by the state (compared with a national average of 71 per cent). Medicines account for the major share of OOPS in public hospitals (73 per cent in rural and 77 per cent in urban areas) - higher than the national average of over 67 per cent and 62 per cent respectively. About two thirds (65 per cent) of OOPS is attributable to outpatient care, 27 per cent to inpatient care and 3 per cent to childbirth. Further, the OOPS burden is disproportionately higher for using higher tier facilities (such as DHH) as compared to CHCs and PHCs for the same ailments, and on those with non-communicable diseases, which often entail regular repeat outpatient visits (Government of Odisha, 2012). Therefore it is critical to assess the perception and experience of patients and the community at large on satisfaction, about the ability and willingness to pay, and about factors contributing to satisfaction.