CHAPTER - 5

DISCUSSION

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CHAPTER 5

DISCUSSION

5.1 DISCUSSION ON DIMENSIONS, DIFFICULTIES, AND DERIVATIVES

The building blocks of the health system consist of adequate and ready-to-use infrastructure; availability of a competent and motivated workforce; provision of timely, accurate and reliable information; availability of optimal financial resources; availability of timely and sufficient logistics; and last but not the least, good governance. Allocation and utilization of resources would influence the equity, efficiency and thus quality of services. In Indian context health services are driven predominantly by supply side factors, especially in rural areas. Patients and community members have hardly any voice or note of dissent. Success stories are limited to geographies wherein the local governmental responses are proactive in terms of providing need-based services at the door steps, which are accessible, affordable and acceptable to the general public.

The constitutional provisions envisage a federal structure but unitary spirit, wherein states act as sub-national units, assigned with specified political and fiscal authorities. Further, the constitution gives the central government residual authority and considerable sovereign discretion over the states, implying a relatively centralized federation. The 73rd and 74th Constitutional Amendments of 1992 for the first time realised the importance of devolution of more powers to local self-government institutions - Panchayats for rural areas and Municipalities for urban areas (Singh, 1994). The impact and experience of such reform has been highly variable, ranging from attempts at Gram Swaraj (or village self-rule) in Madhya Pradesh to political recentralization in Karnataka (Johnson, 2003). While sporadic success stories are trickling in, this concept has miles to travel.

Interest in health sector reform began in Odisha in the mid-1990s, with introduction of two historic events: (i) the formation of the House Committee of the Orissa Legislature chaired by the Health Minister that dealt with important decisions related to health care, such as user charges, autonomy to major hospitals, and abolition of private practice by government doctors; (ii) the recommendations of the British government’s Department for International Development (DFID) to introduce certain systemic changes in three M’s - maintenance, mobility and medicine (Gupta, 2002).
The agenda of local self-governance is taken forward in health sector by formation of functional gaon kalyan samiti (GKS) at village level, RKS at facility level (from PHC onwards to tertiary hospitals) and ZSS at district headquarters level. Stakeholders from diversified departments of the government and elected representatives govern these institutions. As an epitome of shared governance in public health, the RKS undertakes multiple responsibilities and executes a variety of functions aimed at improved accountability and enhanced quality of care, in turn, reduction of mortalities & morbidities through better governance.

Post 2005, major health program investments in India are routed through the national health mission (NHM), in turn, through local self-governing institutions, such as, the (RKS) at all three tiers of service delivery, namely, PHC and CHC, DHH and medical college hospital (MCH). The ZSS at district (sub regional) level acts as the nodal centre for planning and monitoring of health programs. The RKS is entrusted with the responsibility of planning, monitoring and supervising program implementation of health units, improving quality of services, and ensuring transparency and accountability in decision making. Concepts, such as, efficiency (technical and allocative), determinants of performance, quality of care, health outcomes, and performance measurement are intricately linked with the discourse of decentralisation in health.

The key findings from this review indicate that decentralisation or local self-governance in public health sector has multiple dimensions in conceptualization, complexities in measurement, and byproducts for consideration. For instance, the capacity of RKS in successful governance of health units would be contingent upon contextual factors, such as, cooperation among members, leadership capabilities, involvement in day-to-day functioning of health units, sense of ownership of the health units, genuine / vested interests of decision makers, and involvement of the community. Weighing different implementation strategies, monitoring and measuring the outputs at facility and community level, and facilitating flow of information to the top would depend upon the willingness on the part of the local self-governing institutions to provide feed-in and receive feedback.
5.2 DISCUSSION ON THE PROCESS AND NATURE OF LOCAL DECISION MAKING (FGD, IDI, AND NPO)

Discussion on FGD is presented as per the original sequence of data collection, in four segments of composition, governance within RKS, functioning of RKS, supportive environment.

5.2.1 Composition

Membership

A cross-sectional study in Uttarakhand found that though several facility level indicators had improved due to establishment and functioning of RKS, knowledge and awareness about existence and objectives of such a local governing institution had not percolated down to the community (Rawat et al., 2009). Another past study examined the causal model about the effect of participation in decision making on perceived influence, role conflict, role ambiguity, social support, absenteeism, and overall job satisfaction, among others. It concluded that participation in decision making appeared to be an important causal determinant of role strains, which were, in turn, important precursors of both individual and organizational outcomes (Jackson, 1984). In another study, the authors concluded that a positive relationship existed between organizational commitment and knowledge sharing (Han, Chiang, & Chang, 2010).

Although women are major health care users as well as providers, but it was found that they were under-represented in decision-making in health care. From among the members who participated in the FGDs, only about one-fifth of the members were women, mostly the nursing personnel. There is an urgent need to ensure more adequate (gender sensitive) presentation of women in those decision making institutions. (Gijsbers Van Wijk, Van Vliet, & Kolk, 1996).

Participants in this study suggested to fix evidence-based criteria to become members of RKS: “There should be criteria to become a RKS member. What is their involvement with the public? Whether they are social workers? Even a ‘rickshaw wala’ can become a member”. (Focus group discussion, 2:29). Some participants advocated to remove the political representatives from the RKS GB and EB membership: “Naturally political people are taking the upper hand in RKS. Political people should be removed from this”. (Focus group discussion, 1:15)
Meetings and participation

Respondents showed their concern about the mentality of RKS members, especially the PRI members and suggested to orient them for better involvement: “Something should be done to improve their mentality, their responsibility towards an organization. I mean specifically non-medical persons like the PRI members; they are not willing to attend. Without their presence the meetings are a complete failure”. (Focus group discussion, 8:44). Participants specifically suggested to rework on the composition of the RKS to address the issue of irregular meeting and insufficient attendance: “Maximum members should be from health side, so that the quorum of the meeting is maintained. Unless quorum of the meeting is maintained, we cannot conduct GB meeting. (Focus group discussion, 4:30).

Some participants suggested for incentives to RKS members to ensure they attend on time: “Will everyone come if we give them some incentives? No, they will not. I don’t think incentives will work. Giving incentives for a meeting will be injustice.....if we keep a fixed day meeting that could be a solution.....Also in the health department, on that day the meeting should be conducted in all the blocks on that fixed day. On that day there should not be any other programmes or meetings.....the members from other departments should be more sensitized”. (Focus group discussion, 4:36). Involving the Ward in-charges in the meetings was perceived to be crucial for redressal of day-to-day problems: “In charge of every Ward should be involved in the RK meeting. Along with training hand holding support is also required. Hospital manager should be empowered and along with that there should be a separate manager for the OG word for managing the issues”. (Focus group discussion, 6:48).

Similarly some participants opined to involve the nursing staff, pharmacists and other wings to participate and voice their opinion: “Every week they should call one staff nurse, pharmacist, blood bank person and everyone else from each wing and should ask what problems are there in their wing and suggest different ways to solve them. And issues which are out of their capacity they should send it to the government. If this can be done then RKS functioning can be better”. (Focus group discussion, 8:29).
**Motivation and efficiency**

There are distinct viewpoints about team motivation as different from individual levels of motivation. The theory of interdependent regulatory dynamics proposed by Park et al presents the process of allocation of efforts and resources to attain individual goals and team goals; it identifies the multiple pathways through which teams coordinate and regulate their collective efforts over time (Park, Spitzmuller, & DeShon, 2013). Motivation has direct consequences on performance. Rowe et al argued that ‘health-worker practices are complex behaviours that have many potential influences’. The authors argued that simple dissemination of written guidelines is often ineffective, and that supportive supervision is generally effective (Rowe et al., 2005).

A study in Uttar Pradesh found the decision of expenditure of untied funds of CHCs and PHCs was taken in the meeting of RKS, but members from other sectors such as PRI, education, revenue department etc. usually did not attend the meeting. Most of Medical Officers in charge (MOi/c’s) were not aware regarding availability of untied fund. It concluded that periodic orientation, regular monitoring of utilization of untied fund at each and every level is needed (Janzik & Herstatt, 2008). In this study, participants suggested to opposing viewpoints to incentivise the RKS members for better participation and motivation: “RKS is a social institution so incentives will at all not help. It will only increase vested interest and other ill behaviours”. *(Focus group discussion, 5:60).* Another group of participants advocated for incentives: “If the GB members could get some support for transportation then it would have been better but that is not being done”. *(Focus group discussion, 12:6).*

5.2.2 Governance within RKS

**Meaning of decentralisation**

Various viewpoints emerged when asked about their understanding of decentralisation in health sector in Odisha. One of the participants explained the meaning of decentralisation as: “ADMO (med) is the representative of the hospital, DPM is the representative of NRHM and CDMO is the representative of overall health system of the district etc… so the idea of overall decentralisation we have been talking since years; now it has percolated down to the lowest level of institutions in terms of functioning”. *(Focus group discussion, 8:25).*
**Awareness of roles**

Role clarity is a very critical to executive the functions. Past studies in organizational set-ups have pointed the need for the leadership to educate and train the members in a team about the common objectives to be achieved. Organizations, especially healthcare institutions, operate in complex environments. Though the context of functioning of a PHC is different than that of a CHC or a DHH and vice versa, but the functions entrusted with the RKS are similar in all three levels of service delivery. Members drawn from different walks of life need to be brought to a common understanding to perform optimally.

Some participants specifically suggested to train the nursing cadre, especially those in senior positions: “Senior nursing supervisors still they have 5- 7yrs of service so they should also be trained on hospital management for 1 or 2 months at least like ICU training. I think their capacity building can be done by this. Since they have joined they have not been given any type of administrative training. They are still unaware of manpower planning, hospital planning, capacity building and leadership qualities”. *(Focus group discussion, 11:22).* Some participants further suggested to train a member soon after induction into RKS: “When a person is selected s/he should be sensitised about RKS, he should know why he is a member. The minister selects and tells that these are all members. It should not be like that”. *(Focus group discussion, 13:5).*

**Autonomy at work**

Past studies have unravelled the constructs of team and individual autonomy and studied the interplay between team autonomy, self-efficacy, and social support in determining individual autonomy of team members. One study found that individual autonomy was related not only to the level of team autonomy, but also to self-efficacy and social support. It further inferred that in highly autonomous teams, individuals experiencing moderate support from co-workers and supervisors reported higher individual autonomy than members experiencing either low or very high support *(van Mierlo, Rutte, Vermunt, Kompier, & Doorewaard, 2006).*

Task certainty is about a person’s or a team's prior knowledge about the type and nature operational problems that are likely to arise at work, and the best way of dealing with those. Results from a longitudinal field study showed that higher levels of task uncertainty were initially associated with
reduced performance (quality of treatment). Under conditions of enhanced team autonomy, a positive relationship emerged between task uncertainty and team performance (Cordery, Morrison, Wright, & Wall, 2010).

**Accountability**

Improved accountability has become synonymous with improving HSP. Better accountability seems straightforward, but it contains a high degree of complexity, since conceptual and analytical clarity is required. Studies on accountability in global governance in health have identified current 'grand challenges' related to governance in health and concluded that the present approach to global health governance was inadequate, as major changes are necessary (Gostin & Mok, 2009). Brinkerhoff proposed for higher accountability for reduction of abuse, compliance with procedures and standards, and improvement of performance/learning (Brinkerhoff, 2004).

One of the members suggested to fix accountability with the government servants and not with the PRI leaders: “Because accountability will be there along with responsibilities. If CDMO and MOIC will be there then there will be no problem because they are government employees; and they are accountable to the government. But in case of political persons, they will start doing monopoly”. (Focus group discussion, 6:3)

**Transparency in governance**

In recent years, there has been increasing interest in being transparent (provision of information to the public). The so called “transparency and accountability” (T/A) interventions intended to improve the quality of public services and governance in developing countries. However, reforms based on transparency do face obstacles of collective action and political resistance (Kosack & Fung, 2014).

'Transparency' is widely canvassed as a key to better governance, increasing trust in public-office holders. There are exceptions to Jeremy Bentham's famous dictum that 'the more closely we are watched, the better we behave'. Many local governments and state governments instead of fostering a new culture of openness in governance, tend to tighten and centralise flow of information to the public (Hood & Heald, 2012). A recent study concluded that the breadth of
challenges facing the health workforce requires strengthening health governance as well as human resource systems in order to effect change in the health system (Kaplan, Dominis, Palen, & Quain, 2013).

5.2.3 Functioning of RKS

Administrative decisions
A recent study from Uttarakhand found that even though RKS was established in all selected CHCs, their main focus was on infrastructure strengthening and emergency care, basic laboratory and diagnostic services, transport and waste management. Moreover, most of the community members were not aware regarding the existence, objectives and the activities of RKS (Rawat et al., 2009). However, members of the Governing and EB were not matching with the guidelines. They could not specify their individual roles. The authors recommended for periodic assessment of quality of work, opinion of beneficiaries and of the health workforce (Shrivastava & Bobhate, 2012).

Participants in this study recommended to specifically position MOs who are trained on public health and management: “If MO i/c had only been involved in administrative work then it would have been a different issue....in such places like CHC and all, MO should look after only administrative work. (Focus group discussion, 5:14). Further, some participants opined for a non-clinical person for administration of health units: “There should one from non-clinical background for administration, then things would be better” (Focus group discussion, 5:17). Whereas, another group of participants advocated for an administrator from medical background to lead the RKS’ mandate: “There should be one exclusive administrator from medical background for these 16 RKS functions. If it is someone from non-medical background also, it will be chaos”. (Focus group discussion, 5:34).

Financial decisions
The findings of our study has similarity with another Uttarakhand study which found that the flow of the central grant was smooth. However, only about half (53.30 per cent) of total funds available were utilised during the study period. Similarly, one study from Kerala found lower proportion of resources being allocated to health by local Panchayats than that allocated by the state government.
prior to decentralisation. Decentralisation brought no significant change to the health sector. Active panchayat support to PHCs existed in only a few places, but wherever it was present, the result was positive (Varatharajan, Thankappan, & Jayapalan, 2004).

Members felt RKS needed more financial envelope from the State: “RKS needs more financial support….then hospitals day to day management could be effectively managed. We could have done more work if there is sufficient amount of funding”. (Focus group discussion, 6:42). “RKS grant should be increased to 20 lakhs and we had suggested for FRU grant increase, now we are getting INR 45 per bed per day that should be hiked to around 80 INR per bed per day”. (Focus group discussion, 11:17). Specific recommendations with regard to the financial powers of MO were made: “The amount that MO can spend in this CHC should be increased, then things will improve”. (Focus group discussion, 4:54).

**User fees collection**

Imposition of user fees is a debatable issue. Experiences across the globe have given in-conclusive evidences on the subject. However, what is more or less accepted is the fact that too much of experimentation with it could be detrimental to utilization of services. Moreover, a unit increase in the fees structure must commensurate with the explicit quality improvement in the health units.

**Local responsiveness**

A Chinese study pointed out the importance of ‘culture’ in framing internal rules and regulations. It further found that the perceived emphasis on cost-control led to more profitable private hospital, but had lower levels of patient satisfaction. It concluded that Managers should consider whether the work culture enables them to respond effectively to the changing organizational priorities (Zhou, Bundorf, Le Chang, Huang, & Xue, 2011). In another study, the authors advocated that the local decision makers need to identify the causes of the observed inefficiencies and take appropriate measures to increase efficiency of hospitals (Jat & Sebastian, 2013).

One of the members suggested to orient the RKS members to improve their sense of local responsiveness: “There should be orientation of PRI members. Their responsiveness will definitely increase”. (Focus group discussion, 8:45).
Service delivery
A multi-centric study from Gujarat and Odisha found that Gujarat fared higher in terms of health system decentralisation compared to its Odisha counterpart (Raut & Sekher, 2013). Another study from Karnataka found that absenteeism was common across all staff categories. It was more in backward as compared to forward districts. Gender, age, length of service didn’t have any link with absenteeism (Sadananda & Bhat, 2010).

Quality of care
A study in India found good management practices in a facility were highly correlated with better quality of care. Almost all PHCs in the country fall far short of government minimum standards – one of the main reasons behind people opting for private providers even for outpatient services (Powell-jackson, Acharya, & Mills, 2013). Another study found that RKS is yet to bring out quality component to the health services being provided through facilities. This can be attributed to structural and managerial weakness in the system. It concluded that the progress of the RKS can further be enhanced by giving due priority to critical areas (Adsul & Kar, 2013). There is not much of a different situation with respect to private health sector either. A study in Maharashtra found poor standards of care in many cases, and few or no qualified nurses or a duty MO in attendance (Bhate-Deosthali, Khatri, & Wagle, 2011).

Member participants suggested to ensure that materials used in the hospital should be purchased from the funds of the hospital and shouldn’t be outsourced: “To maintain quality of cleaning and laundry services the bidding document should have no money for the materials. The materials hospital should buy and they will only use that material. They will only provide man power and... Because once you buy the materials you know the quality of the material and you have full control on the quality of the material. Once you provide them finances for buying materials there will be problems”. (Focus group discussion, 11:20)

5.2.4 Supportive environment
Trust and confidence of patients
Health care systems offer important means for interaction of individuals with their government. The World Health Surveys in a controlled study found that HSP factors are associated with trust
in government. Taken together, ‘higher technical quality of health services, more responsive service delivery, fair treatment, better health outcomes, and financial risk protection accounted for a 13 percentage point increase in the probability of having trust in government’ (Rockers & Laugesen, 2012).

**Enabling factors**

Organizational value is intricately related to organization culture (OC). It is a much neglected area for research in public health sector in India. A recent study examined the organizational values in the government run PHCs in India and dwelled upon a wide range of variables, such as, openness; confrontation; trust; authenticity; collaboration; and autonomy. Openness was the most important perceived organizational value followed by Confrontation and Trust while Autonomy and Collaboration were the least appreciated and practiced values. It concluded that the overall culture in PHCs could be improved by encouraging free sharing of ideas and expression of feelings and thoughts (Purohit, Patel, & Purohit, 2014).

Some participants suggested for a paradigm shift in governing the health units: “*Now we are seeing that our CDMO does not have any qualification. To look after the administration if there would have been an IAS or OAS officer then it would have been much better*”. *(Focus group discussion, 13:13)*. Some participants felt that the RKS must be given with powers to deal with local problems: “*Government is complicating these local problems by establishing RKS. The RKS must have administrative powers to deal with these local problems*”. *(Focus group discussion, 2:35)*.

**Systemic barriers**

A study from Kerala found Panchayats in Kerala allocated a lower proportion of resources to health than that allocated by the state government prior to decentralisation. Active panchayat support to PHCs existed in only a few places, but wherever it was present, the result was positive (Varatharajan, 2004).

Specific suggestions from the participants to overcome systemic barriers included speciality in administration, more powers for the HM and refresher for the RKS members. “*A public health professional should be deployed because he can look after management and administration and*
for to maintain IPHS more man power is required and proper infrastructure and equipment’s should be provided”. (Focus group discussion, 13:14). “HM should be given more powers. They should select some competent persons based on the background of hospital management and a proper interview and give that responsibility”. (Focus group discussion, 13:7). “There is a need of refresher or orientation of the RKS members. But no such steps have been taken”. (Focus group discussion, 5:45).

Convergence
Studies have conceptualised PHC governance at three levels, depending on who influences the supply and demand of PHC services in a community and how. It is now recognised well that the style of functioning of health system actors have considerable impact at different levels of governance of PHC delivery; and that governance failure at one level can have a chain reaction at another level (Abimbola, Negin, Jan, & Martiniuk, 2014).

5.2.5 Observations from IDIs and NPOs
The panchayati raj institutions (PRI) play critical roles in furthering decentralised planning and programme implementation. The NRHM recognised the importance of decentralisation in management of health programmes. Consequently, the powers, functions and funds earmarked for health units are transferred to the local frontline health functionaries, along with decision taking roles as to utilise the funds for the welfare of the patients. Government of India in 2006 advised the health units across the country to establish RKS under NRHM as to provide high quality health care services with transparency, better accountability and people’s participation.

Respondents felt the selection of members and composition of RKS was not done on the basis of any pre-decided criteria. Consequently, the inherent motives of members were not clear from the beginning. Consensus building in taking difficult or non-popular decisions was often difficult, as senior and more powerful members would impose their viewpoints on others. Respondents further pointed out that in many instances, the democratization of functioning of RKS was not possible owing to several conflicting views and interests of the members. Vested interests overshadowed the specific duties. Further, poor level of participation of non-members posed several operational
challenges in successful implementation of decisions. The typical hierarchical pattern of hospital management also posed additional challenges. Sense of equity and gender neutrality were almost non-existent in the RKS platforms. There was no special attention to the needs and participation of women in these decision making bodies, though a majority of beneficiaries of the government health system are women and children. For instance, the nursing personnel were not adequately represented in the RKS committees.

The RKS are registered under the Society Registration Act of 1860 – an age old Act with no teeth to bite. Accountability, transparency and foundational strengths of the Act are questionable not only from the point of view of today’s changing environment but also from the perspective of the variety of complex, specialised tasks that the RKS is expected to deliver. The philosophy of ‘how much of decentralisation’ is decided centrally which mars the very concept of decentralised decision making in health sector.

The foundational strength of RKS is based on a project specific mandate, as under NRHM. Moreover, the Society Registration Act has many inherent limitations in the Act itself with respect to internal governance of the institution. One of the major concerns with regard to functioning of RKS was that of unlimited responsibilities but with very limited powers. Members were not entitled to take several policy-related decisions for betterment of the health unit. There was no scope for differential powers or context-specific solutions, as guidelines for management of RKS were developed centrally and disseminated down the line. There was no room for consultative development of guidelines.

With respect to the current roles of RKS and local responsiveness, one of the participants summed up, thus: “The government has taken a step to increase the annual grant to RKS. That is welcome. Regarding huge constructions, RKS is not taking up – only small repairs; bigger works are done by line departments. The RKS need to supervise these works as well. Grievance redressal boxes are displayed in each of the wards. Not a good response is coming from people. We are opening once in a week. Mostly false complaints are coming. In a month, when we compile, hardly 20-30 suggestions are coming. Complaints about food was there and we have addressed that.
Disinfection or cleaning of the hospital also being flagged off from time to time”. [IDI Participant 1, Senior Official and RKS member].

Another respondent felt the need for higher funding allocation to RKS to be effective: “The funds flow should be increased. Everything is increasing”. She further adds: “I had one excellent accountant. She was very sincere. At the end of the day I used to ask her the statement. Some things will definitely be here and there”. [IDI Participant 4, Senior Official and RKS member].

The need for imparting training and orientation to RKS members was acutely felt by most of the respondents during interview: “Training and exposure there are really in any programme. From planning to implementation, these are needed”. [IDI Participant 4, Senior Official and RKS member]. Another respondent pointed out the importance of cross-cultural learning: “We should go to another better hospital. RKS members should visit and learn. Koraput, Puri etc are better hospitals. Bolangir has higher load, so it needs improvement”. [IDI Participant 3, Senior Official and RKS member].

One IDI participant explained a success story in a DHH by giving instances of job enrichment exercises, innovative approaches to solve local problems and distribution of responsibilities across the line authority: “In fact recently I have done job descriptions (JDs) for senior specialists who are also proactive good doctors. I have included them in hospital management. Somebody will look after laundry, somebody looks after waste management, somebody on general cleanliness. Unless they sign, I will not release salary. Each SN will sign the medicines, quality of supplies, reports to the HM, ADMO Med etc. We finalise analyse the compliance. RKS members have visit registers to give remarks. That empowers them”. [IDI Participant 5, Senior Official and Ex-Member of RKS and RKS member].

5.3 DISCUSSION ON RKS MEMBERS’ PERCEPTION AND EXPERIENCE
Leadership and governance is one of the six pillars of WHO-proposed building block framework on health system strengthening (World Health Organization, 2000b, 2007). The goal is to support a health system that aims to protect lives; prevent, treat and control diseases; and maintain population health (World Health Organization, 2000b). Even though Maun et al have questioned
the success of shifting power from officials to citizens in improving the quality and efficiency of care, the outcomes of such reforms might vary in different contexts (Maun, Wessman, Sundvall, Thorn, & Björkelund, 2015). In governance of health units, the roles and responsibilities of RKS members in annual health plan preparation is a critical step towards improving effectiveness of their functioning. Whereas, concerns related to involvement of other department officials and establishing local priorities could pose serious challenges to the very existence RKS in attainment of common objectives. The authority for transfers, promotions and postings of health workforce are vested with the state government, except for periodic arrangements at district level to deal with district cadres, such as, the nursing professionals and paramedics. One possible mechanism to delegate more powers to the RKS could be through legislative route. The Society Registration Act of 1860 and provisions therein have flexibilities to perform, but power/authority and transparency in decision-making are not priorities of the Act. Responsibilities must commensurate with authority and expertise. Needless to say, one needs to adopt a cautious approach to ascertain the inherent expertise of RKS in taking rational decisions with respect to local hiring and human resource management practices - this needs further scrutiny (Fallis & Altimier, 2006).

The quality of MNH care is dependent on availability of personnel, funds and logistics support. The study findings could be used to strengthen the national-level policy for improving the quality of MNH care at the facilities (Islam et al., 2015). For better availability and management of funds, the guidelines have been circulated to all States/Union Territories (UT) by government of India. Funds to the tune of INR 100,000 per PHC, 200,000 per CHC/SDH and INR 500,000 per DHH are released to the concerned RKS, every year. On the one hand the RKS members are seeking more funding support from the state, but the difficulties in utilization of such funds are often discussed in various platforms, including review meetings. Moreover, irregular audits and irrational request for additional funds raise serious questions about the ability of RKS in planning, implementing and monitoring development activities in compliance with the overall financial guidelines. RKS is considered as a local self-governing institution to improve the local management responses and in turn, strengthening health system preparedness for improved service delivery. However, we find that decentralised decision-making by RKS does not have a commensurate collective knowledge, experience and expertise for governing health units.
Individual factors, such as, experience, qualification and non-monetary incentives could play critical role in ensuring involvement of RKS members in local self-governance.

The District Level Household Survey-3 (DLHS-3) report has pointed out that the constitution and utilization of ‘untied RKS funds’ in the CHC and DHH had been relatively successful; however, the implementation of programs by RKS proved problematic at the PHC level. We find higher sense of satisfaction about the involvement of members in decision making, but poor training status and higher need for training. Thus, poor knowledge and understanding of possible newer service delivery strategies, poor information about their responsibilities, and non-responsive-ness to the patients’ rights could possibly act as underlying factors for poor functioning of RKS at PHC level. In fact, some of the health units didn’t have the citizen’s charters displayed, as observed by the researcher during data collection. On the other hand, the members had high level of self-satisfaction about their contribution to the health system. These findings are reflective of low level of expectation, poor role clarity, and may be, of a sense of complacency. A recent study has indicated that inadequate support systems for capacity building and training of local decision makers are constraints which weakened the impact of RKS (Saltman, R., Busse, R. and Figueras, 2006). Our study confirms the earlier similar inferences. Periodic trainings need to be considered as a potential solution, and provision of hand-holding support to the RKS may be envisaged as a long-term option to achieve the overall objectives of strengthening governance of health units.

Majority of the respondents acknowledged the importance of ability to plan and spend the budget with higher flexibility; ability to initiate innovative health service programs, to hire contractual staff, and to be able to set district priorities for ensuring effective local choice. Irregular meeting schedules and erratic decision-making processes, on the other hand, could act as serious systemic barriers to effective shared governance in the DMHUs (Sundewall et al., 2011; Swanson et al., 2012). About the perception on importance of organizational factors, the mean scores for most of the factors were higher than 4 in a scale of 0-5 – this is in conformity with existing evidences about Herzberg’s motivators and hygiene factors (Herzberg, 2003). The gap between training needs and trainings offered to the RKS members is very wide which could be cemented through a locally-monitored capacity building plan – this could not only help in improving the knowledge and understanding of the RKS members, but also create an enabling environment for improving
utilization of services. Proper grievance redressal system (e.g., mandatory display of citizens’ charter, complaint box) may be ensured in order to improve involvement of patients and the community. The functioning of RKS at the PHC and CHC level needs special emphasis because often these health units act as the first point of contact between service seekers and service providers.

Setting the agenda of meetings in advance, following consultative process during meetings, and provision of hand-holding support by the higher level institutions may be considered as potential strategies to overcome these problems. Conducting regular and productive review meetings by the RKS was considered a major challenge because of poor role clarity, non-availability of members and their conflicting priorities. The state government may develop a mechanism to frame stronger eligibility criteria, including work experience and qualification to enter RKS GB, and provide non-monetary incentives to the members in order to strengthen their involvement in governance of health units.

5.4 DISCUSSION ON HEALTH WORKERS’ PERCEPTION AND EXPERIENCE

It is now widely accepted that decentralisation or shared governance is a difficult concept to define and measure, as it encompasses a wide variety of institutional arrangements and reforms. Similarly, efficiency score has a limited utility in judging the effectiveness of health services. At the same time, past studies have indicated both negative and positive correlations of local governance with its presumed impact on various health outcomes. For instance, Robalino et al. (2001) found negative cross-country relationship between decentralisation and infant mortality (Robalino & Picazo, 2001). Zhang and Zou (1998) reported negative effect of decentralisation on provincial growth in China (Wei et al., 2011).

A motivated and committed health workforce is essential for optimal performance of health units. In India, policy makers and implementers of decentralisation at DMHU level have paid much attention to the immediate goals of forming and norming the structure and composition of RKS, and fixing their financial envelopes, but the human resource implications of such establishments need a closer scrutiny. It is critical to identify and recognise the elements that make such an arrangement as RKS an exceptionally complex institution of local decision making, especially
from the point of view of improving service productivity. In the discourse of decentralisation and human resource management (HRM), studies have identified a number of key points that are organised around human resource (HR) planning/staff supply, personnel administration, and performance management. The importance of the management of change is also being highlighted in some studies. There is renewed emphasis to include human resources as a key issue in health system strengthening. Consequently, the concern about the impact of local self-governing institutions on the motivation, satisfaction and performance of health workforce is being increasingly felt. However, global experiences and lessons of different countries on this aspect have not yet been widely shared.

A majority of health workers in our study felt that a positive change had taken place in the governance and quality of service delivery owing to the RKS. Reduction of absenteeism, improvement in local governance, motivation and performance of staff were attributed to RKS, as emphatically perceived by the PD respondents. Similarly, reduction in waiting time, improvement in waste management and local accountability indicate that the health workforce have taken RKS as a desirable instrument in improving efficiency. However, in the absence of a comparable baseline, deriving an inferential causality on this finding goes beyond the scope of this paper. A possible explanation to such findings could be derived out of the general population health (as reflected in the IMR) status, its relationship with efficiency of local decision making process, and perception of the health workforce. Needless to point out here that in the NPD about a third of the respondents didn’t observe any change in the infrastructure; about one-fourth respondents didn’t feel that there was any change in the pattern of staff absenteeism after RKS started functioning; and about two-fifth respondents didn’t observe any improvement in funds availability in last three years. Such findings need to be further corroborated with secondary data from these health units.

Infrastructure, funds availability and cleanliness were perceived to be the top three important indicators for efficiency measurement of a health unit. It was also found that higher proportion of respondents from the PD were satisfied with these three existing provisions, as compared to the NPD. Therefore, it was apparent that there was higher need to focus and invest on the part of the government in these three specific areas. Further, a relatively less proportion of respondents were satisfied with the behaviour of their co-workers – this suggests that there is an immediate need for
refresher and continued medical education focusing on best client management practices, response
time management and responsiveness improvement at work. RKS was perceived to have strong
influence on the individual and organizational performance, as reflected in the composite scores
which may be reflective of a desirable consequence of RKS’ existence. Further, quality of
governance and satisfaction was found to be strongly linked and absenteeism was found to be
directly linked to governance and satisfaction. Therefore, any attempt to reduce absenteeism must
address governance issues. Therefore, the functioning of RKS and satisfaction of the health
workforce with exiting provisions were found to be strongly linked to the overall satisfaction score.
Thus, for improved staff satisfaction, the quality of local self-governance must be ensured.
However, respondents suggested the government to reconsider modalities of holding meetings,
structure and composition of RKS and commitment of the members.

The evidently significant PD-NPD differences in the perception of health workforce could be
explained in three possible ways: higher proportion of respondents from PD ranked the influences
of RKS as ‘high’ or ‘very high’ in almost all domains except on service delivery, and on
importance of infrastructure, funds and cleanliness of health units - this could partly be explained
by their low level of understanding and expectation. This could also mean that the health workforce
deployed in districts with poor population health status have relatively lower level of expectation
from the public health units. Yet another perspective of such an observation could be that the RKS
in PD are actively and efficiently discharging the designated responsibilities due to pressing local
priorities in view of the poor population health status. Further, there could possibly exist a weak
link between RKS functioning and satisfaction of health workforce due to overwhelming effects
of other intermediate, process related variables. There is a need to specifically examine the
individual characteristics of leadership and socio-political context of districts to find out the
reasons for such distinct differences. Higher IMR and poor health indicators on the one hand and
positive perception of health workers about RKS functioning, and satisfaction about various
provisions of health services on the other, necessitates further probe, in controlled settings, into
the level of aspiration, role clarity, and understanding of local priorities of the health workforces
across regions.
Reallocation of roles and responsibilities always affects the behaviour of health workforce. After establishment of RKS, local health workers and the managers (often the doctors) are entrusted with more responsibilities to improve the way health services are targeted, organised and managed. To deliver their roles effectively, the workforce needs an appropriate skill mix matching the local needs. In order to foster development of such a strategy, the RKS could need authority for new recruitment and revision of the existing personnel structure (Riitta-Liisa Kolehmainen-Aitken, 2004). However, very limited powers towards creation of new posts, job enrichment, and HRM could play as a bottleneck in effective delivery of responsibilities. Our findings confirm earlier literature on LMICs that indicate very little evidence that decentralisation had resulted in creation of new posts, job re-profiling, or an improved staff mix (Wang, Collins, Tang, & Martineau, 2002). Poor quality care during hospital births and lack of healthcare personnel are directly related to mortality reduction and quality improvement measures (Islam et al., 2015; Koblinsky et al., 2006; van den Broek & Graham, 2009). Local decision making could effectively address local needs, but with certain pre-conditions, such as, good planning, cooperation and informed analysis of processes through a strong information management system (Riitta-Liissa Kolehmainen-Aitken, 1999; Maun et al., 2015; Peters, Chakraborty, Mahapatra, & Steinhardt, 2010). However, given that the general understanding about dimensions of quality of health services was poor among the health workforce, this finding could be used by the state government and governments in other similar settings to introduce further reforms around medical and nursing education, local decision making and participatory governance.

5.5 DISCUSSION ON PATIENTS/CARERS’ PERCEPTION

The ultimate purpose of measuring patient satisfaction on health care services is to improve the quality, outcomes and / or effectiveness of interventions. In the absence of coverage the question of quality would not arise. Satisfaction with both clinical and non-clinical, or utility, services is equally important from the point of view of a manager. Earlier studies have concluded that primary care is important in improving health outcomes but that the precise aspects of primary care, which are most important, are not clear (Kiran, Hutchings, Dhalla, Furlong, & Jacobson, 2010; Levene, Bankart, Khunti, & Baker, 2012; Soljak et al., 2011). The quality outcomes framework (QOF) has advocated to analyse data in four domains - clinical; organisational; patient experience; and additional (Honeyford, Baker, Bankart, & Jones, 2013).
In this study, most of the respondents visited the health units for 1 to 2 times during last one month, indicative of the importance of continuity in contact that patients seek to have with the primary and secondary health care services. Therefore, special emphasis should be laid down to the functioning of lower tiers of health care system. We have observed that awareness on availability of free medicines was excellent among the study population, but there was a lot of scope for improving knowledge about availability OPD and IPD services. Information, education and communication (IEC) tools are often used at peripheral health centres with limited success, but having basic knowledge and awareness about various service provisions is as critical from patients’ perspective as ensuring availability from the providers. Both are pre-requisites to improve utilization of services.

Many respondents didn’t receive services at least once during last one month. Finding the reason(s) for non-availability of such services was outside the purview of the present study. However, more often than not, operational challenges, such as, irregularity in attending duty on the part of service providers, irregular home visits by the community health workers, and poor behaviour of service providers act as barriers to restoration of trust and confidence of patients, especially in rural set-ups. About two-third respondents resided at a distance of one kilometre or more from the nearest health unit and about two-fifth didn’t have access to ‘all weather’ roads. This only reinforces the need for involving other departments while addressing the issue of improving ‘physical access’. Departments of panchayat raj, rural development, and women & child development need to work very closely with the health department for efficient delivery of services many of which have a bearing on immediate and medium-terms health outcomes.

Though majority of patients had to wait for less than an hour to consult a doctor, most from PD were non-complaining about various non-clinical provisions and were reluctant to talk about issues, such as, ‘tips’ given to the service providers. This could be explained in part by a relatively low socio-economic status of the respondents from PD, and partly by low level of expectation from the health delivery system. This argument is further strengthened by the fact that there was an extremely poor understanding among all interviewed patients about the concept of ‘quality’.
Interprofessional education (IPE) is an important contributor to ensuring interprofessional collaboration and, ultimately, improving the quality of health care (Parker et al., 2012).

Physical access was indeed poor in PD. The fact that majority of respondents resided at a distance of more than five kilometers from the place of service delivery raises several corollary questions related to the government’s intentions to spend and overcome the general infrastructural bottlenecks. Higher proportion of PD respondents ranked the behavior of providers as ‘excellent’ or ‘very good’. The NPD respondents waited longer, and higher proportion of NPD patients also received providers’ attention for \(>5\) minutes. On the other hand, higher proportion of PD respondents perceived that the average time spent with the providers was ‘optimal’ – these could be resultants of poor level of knowledge and low expectation.

Higher proportion of NPD clients availed private facilities in last one year, indicative of their better paying capacity and willingness. In terms of out-of-pocket (OPE) spending and perception about such expenses incurred on travel, drugs & tests, and as ‘tips’ to service providers, the PD respondents perceived it as ‘too much’ as compared to the NPD. The disadvantages of applying general theories economy that ‘health’ has relatively high price elasticity could be far more damaging in such circumstances.

Factors, such as, income, physical distance, and doctors’ behavior was found to be very strongly associated with patient satisfaction. Our findings are similar to other studies (Mendoza Aldana et al., 2001). Therefore, governments need to seriously consider differential subsidy on the basis of objectively measurable indicators, such as, per capita income and education levels, rather than on broader social norms, for categorization of population at block/sector level. For improving road conditions, pro-active involvement of other departments need to be seriously thought of, while improving behavior of doctors/service providers might require reforms in the medical/nursing education system. In the existing medical/nursing curriculum there is very little to offer to the students on personal behavior and aptitude to serve in rural areas. It is also a fact that several attempts in the past aimed at bringing reforms in medical education have ended up with very limited success. However, the need for engagement of health workforce in the rural public health centres is too high to ignore such attempts.
Though a relatively higher proportion of PD respondents was satisfied with the services being provided in peripheral health units, most of the respondents especially from NPD were not sure about the influence the RKS on quality improvement. Further, very few had actually received any direct benefits from the RKS. Thus, the objective of addressing local needs of the population somehow seems to have suffered. Provision of toilets and availability of waiting place were found to be essential needs of the patients, whereas in reality hardly any attempt was made by the RKS to address both. Pilot studies have reported significant improvement in the quality and coverage of RCH services within two years of intervention that included reorientation of service providers on managerial, technical and supervisory skills; community education; and strengthening of information-feedback system. However, process indicators, such as, early registration for antenatal check-up (ANC), compliance with iron and folic acid (IFA) supplements, referral of high risk pregnancies, neonatal care, management of diarrhoea and respiratory infection didn’t improve to the desirable extent (Lal, 2001).

Health-care managers are increasingly interested in client perceptions of clinic service quality and satisfaction (Alden, Hoa, & Bhawuk, 2004). We suggest that there are two principal dimensions of quality of care for individual patients; access and effectiveness. In essence, do users get the care they need, and is the care effective when they get it (Campbell et al., 2000). The government of India’s intentions to universalise primary health care as an existential function of the health department necessitates rigorous preparation at each level of the three-tier public health care delivery system (Government of India, n.d.-a) (National Rural Health Mission, 2010). Local self-governance was conceived as one of the key milestones to facilitate community participation in decision making and quality improvement of health services. Over the years, the spectrum of services has widened but somehow emphasis on quality has not been reiterated. The system needs to be geared up to address such dual challenges in order to attain an acceptable level of client satisfaction.