CHAPTER - 7
RECOMMENDATIONS

- General recommendations
- Specific recommendations
- Policy implications
- Scope for further research
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7.1 GENERAL RECOMMENDATIONS

- The mandates of RKS do not have matching competence, experience and expertise of its governing members. Provision of regular and refresher training programmes need to be considered on priority basis. On-site hand-holding support to the RKS may be envisaged as an investment for achieving long-term organizational objectives.

- Mere formation and norming of the RKS along with financial envelopes may not yield the desired results in terms of its optimal performance. It is critical to recognise that heterogeneity of its composition makes this institution exceptionally complex. Substantial investments must be made with respect to staffing, personnel administration, performance management and change management in real-life settings, as in case of a health unit.

- The enablers and barriers for various health programmes operate through the common window of health system building blocks framework. But addressing the bottlenecks need deep understanding of contextual factors. Therefore, policy makers need to carefully consider local factors while deciding the quantum and quality of ‘decision width’ for each tier of service delivery units.

- The gap between training needs and trainings offered to the RKS members is very wide. A locally-monitored capacity building plan could not only help in improving the knowledge and understanding of the RKS members, but also create an enabling environment for achievement of institutional mandates (efficiency, responsiveness and quality).

- The need for proper grievance redressal system at each level of service delivery can’t be overstated in order to restore the trust and confidence of patients and community members.

- Successful governance of health units is a multi-faceted task. Only RKS may not be able to address a lot of local issues, including physical access. Involvement of other line
departments has paramount importance in this. Departments of panchayat raj, rural development, and women & child development need to work ‘hand in glove’ with the health department for addressing such issues.

- The need to announce regulatory framework for RKS membership has emerged as a priority. Educational qualification and work experience for RKS membership were recommended by key stakeholders. Though these seem to contravene the spirit of democratic governance principles, government may dwell on this subject for consensus building.

- RKS members may be compensated through monetary and intangible incentives as to reduce absenteeism and improve participation in RKS meetings.

- Improvement of behaviour of doctors/service providers would need interventions in medical and nursing education. Steps may be taken to make medical / nursing education more patient-friendly and rural-focused.

- Understanding the concept of ‘quality’ is the first step before health units could be accredited to national agencies. Steps may be taken to impart training on the health workforce about importance and dimensions of quality in different tiers. The state health system resource centre (SHSRC) and public health institutions could play critical roles in this.

- Time is appropriate to envision the medium-term and long-term skill mix and skill enhancement strategies for the health workforce in Odisha. Sensitizing health workers and supervisors about the benefits of local decision making could improve efficiency of health units.

- Local health units with technical support of district/state agencies need to recognise the determinants of patient satisfaction. Functional and clean toilets, courteous and passionate behaviour of service providers, and availability of waiting space at health centres may be considered as priority areas for non-clinical quality improvement.
- Government of India has proposed establishing quality assurance cells at district level units – a step in the right direction. Those cells may be mandated to work closely with the RKS for improvement of overall functioning of the health units.

### 7.2 SPECIFIC RECOMMENDATIONS

- There should be clear-cut division of roles and responsibilities between the state and district administration with respect to management and governance of health units. The authorities might have to readjust their roles to that of a ‘facilitator’. They should pay closer attention to monitoring and incentivizing local authorities, rather than micro-managing implementation of health programmes.

- RKS don’t seem to have the desired expertise to monitor and control programme implementation. Thus, spelling out a checklist of warning signals is important to ensure local resolution of critical issues.

- Setting the agenda of RKS meetings in advance, following consultative process during meetings, and incentivizing members may be considered as key strategies to overcome irregularity in meeting schedules.

- The local decision-makers must develop humanistic viewpoints, anticipate and prepare the basket of essential services for each tier of service delivery, invest in capacity building of the staff, develop policies for retention, and closely monitor processes and outcomes.

- Many of the interventions to address system-centric factors (physical access, non-clinical provisions, waiting time) need stronger inter-sectoral coordination, while most of provider-centric factors (behaviour, time spent with the clients, dignity and privacy of clients) could be addressed through appropriate medical education reforms.

- The patient-centric factors (out of pocket expenses, knowledge and satisfaction) need sensitization of the public and involvement of community health workers.

- Conscious efforts must be made by the RKS to develop community involvement-feedback platforms for better governance of the health units.
• The knowledge base and understanding of health workforce about importance of quality in peripheral health units may be improved through continued education and refresher training.

• Planning medium-term and long-term skill mix and skill enhancement strategies, supporting research to identify bottlenecks at work and performance monitoring, and sensitizing MOs about the benefits of local decision making process could further improve efficiency of health units.

• Optimal utilization of existing human resources for health (HRH) could serve as the best medium-term approach for governments that operate challenging environments. Government of India has proposed establishing quality assurance cells at district level units – a step in the right direction. Those cells may be mandated to work closely with the RKS to address the immediate needs of efficient decision making at local levels.

7.3 POLICY IMPLICATIONS

• Although international agencies and domain experts advocate decentralisation as a tool to improve equity, in Odisha context, there is no clear cut evidence in support of it.

• Geo political and cultural diversities between and within districts force us to realise that self-governance is the best futuristic option for the citizens. However, an inefficiently governed and unaccountable structure could be self-defeating.

• Government may consider investing in infrastructure, funds availability and cleanliness of the health units. Contract management, outsourcing of cleanliness services and cash-flow forecasting are popular strategies to address the existing gaps within the system.

• The quality of local self-governance could be improved under the constant monitoring and supervision of a state core team as to improve efficiency of health units, motivation of health workforce and satisfaction of patients.
• A moderate level of decision space at local level in areas of financial allocation, re-appropriation, organizational rules, and human resources deployment could improve the performance of health units. Piloted evidences may be generated through rigorously controlled studies.

7.4 SCOPE FOR FURTHER RESEARCH

• The future direction of enquiry should focus on generating context-specific evidence of the effects of local decision making on the entire spectrum of performance, with special emphasis on efficiency, community participation, human resource management, and quality of services.

• There is a need to examine the relationship between individual differences of RKS members and district performances. Higher mortalities and poor health indicators on the one hand, and positive viewpoint of health workers about the role of RKS and of health services on the other, necessitates further enquiry in controlled settings.

• Feasibility of replacing physician-based care with team-based care must be investigated further through the lens of decentralised planning and management.

• How health seeking behaviour and out-of-pocket expenditure patterns are related to local self-governance, need further scientific scrutiny.

• A pilot implementation research may be carried out to address the following research questions: Can orientation and training of RKS members improve decision taking capacities of RKS? Can a more empowered RKS improve service utilization? What are the best strategies to mitigate inter-personal barriers to effective functioning of RKS?