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Role of Panchayati Raj in HealthCare

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Abstract

It is commonly opined that decentralisation through Panchayati Raj Institutions (PRIs) can help in creating greater accountability in the Indian healthcare system. Health decentralisation is specially meant for peoples' participation, increased transparency and a higher degree of accountability to provide comprehensive and quality health services at the grassroots level.

The National Rural Health Mission (NRHM) visualises the provision of decentralised healthcare at the grassroots level. However, this scheme has some lacunas in reaching the needy, especially in the rural parts of India because of an ineffective and non-participatory role of PRIs in decision making. This has been ascribed to a malfunction in creating healthcare awareness and making the procedures complicated and chaotic for the local Panchayats

Keywords

Panchayati Raj Institutions, Public Health Institutes, capacity building, National Rural Health Mission

Introduction

PRIs are involved in health through Village Health Sanitation & Nutrition Committees (VHSNC) at the village level, and through planning and monitoring committees or hospital management committees at primary health centres (PHC), community health centres (CHC), and district hospitals (DH).

Panchayati Raj Institutions (PRIs) play a role in health care by providing basic health services, such as vaccination, and improving the regularity of health workers. PRIs also collaborate with health departments to maintain clinics and dispensaries in rural areas, which can help reduce maternal and infant mortality rates. As a decentralized body, it is the GP's responsibility to take relevant and appropriate measures for people's health and wellbeing. Universal goals of will be only achieved through local interventions.

PRIs are responsible for ensuring the availability of quality services for the community, especially the marginalized. These services include:

Healthcare, Drinking water, Sanitation, Infrastructure, Irrigation, Forestry, Waste management, Housing, Electrification, and Women and Child Development.

Some benefits of PRIs in health care include:

• Improved regularity of health workers

• Support in health promotion activities

• Improved availability and regularity of healthcare providers at the health centres

However, some challenges with PRIs in health care include:

• Unscientific distribution of functions

• Incompatible relation between the three-tiers

• Inadequate finances

• Lack of cordial relations between officials and people

• Lack of conceptual clarity

• Undemocratic composition of various Panchayati Raj institutions

Increasing people is participations advocated as a suitable development strategy due to several reasons. The merits of this approach lie in enhancing ownership and responsibility of the community leading to better management of programmes, better prioritisation taking in to account local needs and more focused programmes. In the case of health care delivery also, the same holds good. Community involvement in primary health care is expected to bring about following benefits: enhanced utilization of the existing health services, greater mobilisation of resources, improving health seeking behaviours and empowerment of the people due to the knowledge gain and being part of the processes

The public participation in health was highlighted in India at different points of time, as early asin 1946, the Bhore Committee report and later in all the national health policies. In 1992, the 73rd and 74th constitutional amendment provided a blueprint for people's participation in the implementation of social sector programmes. In the health sector, it was with the introduction of National Rural Health Mission 2005 that the importance of community involvement was explicitly outlined. The NRHM, which is renamed as National Health Mission (NHM), envisages ensuring accountability in health services delivery through involvement of communities. The concept of community involvement in NHM is known as "Community monitoring" or "COMM unitisationwhereby the community is empowered to take leadership in their own health matters

Given the advantages of local decision-making process in improving service delivery, the NHM clearly spells out decentralisation decision-making involving the Panchayatraj institutions at various levels of health care delivery. In this direction, it is recommended that all the health facility planning and monitoring communities involve elected representatives from the PRIs. The mechanism of involvement of PRI members in health is through Village Health Sanitation & Nutrition Committees (VHSNC) at village level; through planning and monitoring committees or hospital management committees at primary health centres (PHC), community health centres (CHC) and district hospitals (DH)(Fig.1). The planning and monitoring committees are also called "Rogi Kalyan Samithi (RKS)" which means patient welfare committee. The primary objective of RKS is to ensure quality health care with people's participation, accountability and transparency in utilisation of allocated funds.

The primary objective of RKS is to ensure quality health care with people's participation, accountability and transparency in utilisation of allocated funds. The main purpose of these committees is to jointly plan, implement and monitor the health activities at various levels. It is a key inter-sectoral collaboration initiative taken up by Health Department in partnership with the Panchayat raj institutions. These committees are democratically constituted bodies that provide platform for elected representatives and officials of PRIs/ municipalities and health officials to work jointly for the efficient functioning of public health institutions.

Background

It is generally believed that decentralisation through PRIs can facilitate greater accountability in the Indian healthcare system. A major step concerning policy decentralisation was taken in the year 1993 with the adoption of the 73rd and 74th amendments to the Constitution. These amendments gave more autonomy to the PRIs in India (Banerji, 2016). PRIs act as the main body of planning, execution and supervising the NRHM programme in the country.

Bheenaveni (2007) thinks that key steps for the success of the NRHM through Panchayats are: (a) Inter-sectoral convergence, (b) community ownership steered through the village level health committees at the Gram Panchayat (GP) level and (c) a strong public and private partnership.

These issues necessitate complete reorganisation or reformation at various levels of Panchayats for better regulation of local medical institutions, medical awareness, strengthening health workers and effective ground-level implementation. Experts think that the accomplishment of the NRHM significantly depends on the well-functioning of all the three levels of Panchayats with people‘s active participation. Also, the selection of health workers and supervision of their work can be effectively done by GPs, which can contribute to the success of NRHM (Laveesh& Dutta, 2009).

Some experts have opined that Zilla Panchayats (ZPs) are the prime implementing and monitoring agencies with respect to the NRHM at the district level. However, this agency has not been provided the necessary power and autonomy until today. At the Gram Panchayat level also, there must be a provision for enough autonomy to reallocate resources and change activities according to the needs of the respective GPs. As per the current plan of action, the NRHM mandates the progress of suitablevillage level health plans. However, this only forms one part of the district-level plans, which in turn decide the nature of grants that are earmarked at the GP level. Hence, the NRHM is often described as a partial decentralisation where more real decentralisation at the ground level is required (Sekher, 2006; Thomas et al., 2010).

Although the NRHM scheme allows greater flexibility in implementing various public health programmes, escalating important and timely interventions is a significant task. However, it is generally felt that more discretion and autonomy should be given to Gram Sabhas with respect to planning for various health programmes and financial issues. Experts opine that additional grants must be earmarked for GPs for their various extra activities. Here, ASHA (Accredited Social Health Activists) health workers and ANM (auxiliary midwife) workers can play a critical role in improving the use of public funds. They can encourage GPs to use public funds allocated to them for the community-based preventive/ promotive/rehabilitative health-related activities under the NRHM. But unfortunately, it is not happening at the ground level (Hammer, Aiyar, & Samji, 2007).

There is a need to have some programme aimed at building capacities of GPs with systematic local planning for the creation of more awareness about the NRHM among the rural folk. It is also important to create community awareness on various healthcare issues and make them active partners in various government health programmes so that every needy person can get some benefit in a more transparent manner. GPs can also collaborate with the private sector for a more effective public healthcare system.

Rural Development in Independent India

In the modern Indian context, the rural development is defined as integrated development of area and the people through optimum development and utilization of local resources- physical, biological and human and bringing necessary institutional, structural and attitudinal changes by effective service delivery which encompasses the economic field in agricultural, allied activities, rural Industries and the establishment of required social infrastructure and services in the areas of health, nutrition, sanitation, housing, drinking water and literacy with the aim of improving the quality of life f rural poor (Patel 1985). Satya Sundra identifies some aspects of rural development in Indian context as.

1. Changing in attitude of rural people towards development or transformation of village community.
2. Establishment of local self-government.
3. Provisions for basic needs such as drinking water, health care, better sanitation, housing and employment.
4. Promotion of communal harmony and unity, literacy, education and cultural activities. After independence, different initiatives were made for rural development for rural development in each five-year plan since 1951. The ministry of Rural Development was set up for this purpose which is a nodal department of two international organisations viz., the centre on Integrated Rural Development

of Asia and Pacific (CIRDAP) and the AFRO-Asian Rural Development Organisation (AARDO). The ministry consists of the following three departments:

Discussion and Analysis

The linking of the health sector to the Panchayati Raj system is a multifaceted chain procedure involving various stakeholders at different stages. The PRIs have often been dominated by the local elite, obstructed by politicians at the state level, and are mostly seen as advisory rather than decision-making bodies. The financial resources allocated to them are often inadequate, usually governed by the tied budget lines, leaving little flexibility at the local level to meet the precise needs of local people. However, based on the recent Union health budget, a new budget line has been introduced. This provides elasticity to the PRIs in using a part of the total health budget according to the local needs and new guidelines.
Although PRI officials take their own decisions on planning and budgeting of programmes, it seems that they are not in tune with the local requirements. PRI officials do not even consult GPs. According to them GP members are illiterates and they don't have any capacity to handle any health issue or crisis. Local politics in rural areas affects Government health officials in the decision-making process. The field survey shows that some or the other forms of conflict exist between the health department and PRIs. Hence dual responsibilities and controls upset and severely affect the quality of the public healthcare delivery system in rural areas.

Health officials should not be under the obligations of the elected representatives of PRIs at any cost while preparing the health plans. The responsibility of PRIs, especially in human resources management, financial management, planning and problem-solving is very vital. PRIs have some sort of control on the lower-level health staff only. In many cases, PHIs cannot go against the wish/desire of the elected representatives. In some cases, some health officials have a nexus with PRI representatives for various personal reasons. It is found that in a few cases the capacity of the health officials in monitoring and appraisal of various health programmes are continuously connected with the added official responsibility and are over-burdened. The health administrators must be given some extra discretionary powers for timely decisions (Bossert et al., 2010)

At the Gram Panchayat level also, there must be a stipulation for sufficient independence to reallocate funds and change activities and programmes according to the local needs of the concerned villages/blocks. As per the current plan of action, the NRHM restricts the preparation of suitable village level health schemes by GPs. However, the district level plans by the ZP that approves the nature of grants and programmes are fixed at the GP level. Hence, the NRHM is often described as a partially decentralised system whereas a more real devolution of power at the ground level is necessary today. Although the NRHM scheme allows better elasticity in implementing a variety of required public health programmes, increasing significant and appropriate interventions of GPs in a more meaningful manner are the need of the hour.

It is generally opined that more discretionary power should be given to Gram Sabhas/Panchayats with respect to the planning of a variety of local health programmes including monetary issues. Further, locating NRHM functions within the GP and implementing essential health programmes by the village health committee will make the health-for-all scheme an achievable reality. Effective coordination between the concerned PRI members and Government health officials may be helpful in breaking social and cultural hurdles in implementing NRHM sub-programmes. Health policy experts say that the NRHM privileges the ZP as the key implementing body without providing the necessary discretion and autonomy at the GP level to reallocate resources and change activities according to its needs. Although NRHM mandates the development of the village level health plans, they only form one component of district-level schemes, which in turn determine the quantum and nature of funding that is allocated for the GP level (NRHM, 2012, 2013 reports.

The major problem is that different political parties have control over the state health administration, PRIs and NRHM officials for various reasons. Thus, some amount of caution is needed in devolving requisite powers to PRIs within the NRHM. Moreover, one more serious and vital issue is related to the financial powers accorded to PRIs under the NRHM programme. The PRIs have very limited financial resources of their own, and hence, are hugely dependent on Government grants. Until and unless PRIs are empowered with financial resources, their involvement in strengthening the rural health service delivery will remain only supplementary rather than decisive

Both PHIs and PRIs are jointly responsible for the implementation of public healthcare schemes in rural India. The PRIs are responsible for providing infrastructure for the PHCs/CHCs. The study found that the PRIs don't have the required technical skills in handling some of the health issues. In most cases, local politicians are not interested in public healthcare issues. However, the upgradation of the PHCs/CHCs largely depends on a political decision. PRIs need more capacity-building measures without which they are unable to provide any professional support to the NRHM programme.

The majority of the PHI staff accuse PRIs of unnecessary intervention in their work. Even today most PHCs/CHCs are working without any fundamental facilities in the rural parts of Karnataka. Manpower shortage is also a big issue. Doctors are not ready to serve in rural areas because of their remoteness and other issues. The private practice of government doctors is also causing a major problem. The Government is ready to pay more than ₹125,000 monthly salary to a doctor. But doctors are not ready to serve in the rural parts of the state. In Northern Karnataka, the situation is very pathetic. Here, many Taluk/District hospitals are running without required doctors, equipment and other fundamental facilities and the PRIs are not really decisive.

Conclusion

There are enough reasons to suggest that the PRIs engagement in improving the key health indicators will become a reality in India. Decentralisation is a prerequisite for the success of any health-related programme. However, absenteeism, low quality in healthcare, low satisfaction levels and unbridled corruption have hit 108 Indian Journal of Public Administration 66(1) public health services in India. This has led to mistrust of the system and the rapid growth of private service. Quality PRI engagement is the only way to realise the Government's large-scale community health programmes impacting the marginalised and vulnerable sections of society. This necessitates capacity building to have skilled manpower and an administrative system that can address many complex issues pertaining to the local health care system.

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