Health Care for the Rural Poor: Decentralization of Health Services in Karnataka, India

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Introduction

All over the world, the governments are changing both their scope and mode of operations, building on the comparative advantages of both the state and the market (Pinto 1998). The emphasis is on market-oriented economic reforms and reduced government intervention with a view of optimizing public service provision (Rodrik 1996). This reconstruction effort is marked by a growing recognition that citizen (user of public services) also needs to be given a voice in the process through participatory partnerships (Vorratnchaiphan and Hollister 1998). These reforms, therefore, seek to make governments more responsive, cost-effective and accountable (Volcker and Winter 1994). Their thrust is on institutional restructuring, both by shaping rules and regulations that determine how people act, and the organizations that set the patterns of their productive relationships within the given institutional framework (North 1991; Brinkerhoff and Goldsmith 1992). The emergence of decentralization as government reform process in many developing countries since the mid-1980s is being widely viewed as the institutional panacea for effective service delivery and overcoming the bottlenecks to local development (Wunsch 1991; Bardhan 2002).

Decentralization implies transfer of authority and responsibility from the central government to the district and subordinate levels to make development more locally sensitive and participatory. In other words, it is assumed as involving a two-dimensional process--one that increases the sensitivity of the bureaucracy to local conditions and needs; and, second, wherein communities can participate in making decisions on their local requirements and priorities in a more direct and immediate manner based on a system of leadership accountability and transparent information. It is, thus, obvious that decentralization is expected to usher in more efficient institutions capable of greater responsiveness and more effective provision of local services. However, at the same time, studies also acknowledge that decentralization is a complex process that cannot be

recommended across the board without taking into account historical, political, social and geographic realities (Collins and Green 1994; Vaughan 1990). Drawing on different country experiments, studies recognize that the effects of decentralization depend on location-specific institutional design and suggest the need for a stronger focus on institutions in designing decentralized policies (Litvack *et al* 1998). Even if there is a strong political will and administrative mechanism to decentralize the service delivery many pertinent questions need to be addressed such as - decentralize to what level? To whom? What tasks? How to monitor? How to ensure community participation?

Objectives and Methodology of this Study

The delivery of health services in India remains poor, particularly in rural areas, due to lack of infrastructure and personnel, financial constraints, lack of awareness, poor accountability and transparency. Though the networks of the department have spread to almost every village, the availability and utilization of the services continue to be very poor and grossly inadequate. In this situation, can the PRIs make a difference in the delivery of health services? The philosophy behind bringing the line departments, including health, responsible for providing essential services, under the supervision of local elected bodies is to achieve an overall improvement in the delivery of services at the grass roots level. This can be facilitated through the interventions of PRIs by making health services responsive to local needs, more accountable to the local population, focusing on local problems, prioritizing the requirements, generating public demand for the services and efficient use of available resources.

It is now over ten years since the constitution Amendment-driven PRIs have been in place and now many questions need to be addressed regarding - How PRIs can be improved to ensure better service provision? What should be the powers and privileges of the elected representatives vis-à-vis the officials? What steps need to be taken to tackle the fund problems of the PRIs which is a major constraint facing the institutions? What is the nature of linkages between the PRIs, the line departments like Health, non-government agencies and the private sector in ensuring better provision of services? What is the nature of interaction between the people, service providers, and the PRIs and how does this interaction affect the functioning of the basic health care services? This paper attempts to explore these issues in the context of Karnataka in India, a state which is considered to be the pioneer in devolving powers to grass roots level elected bodies.

Methodology

A study of this nature and magnitude demands not only information and inputs from macro levels but also insights from grass roots level. Therefore, to begin with, discussions were carried out with health functionaries at all levels, starting from the Principal Secretary and Commissioner of State Health Department to ANMs and male health workers in the villages. Officials at the State Secretariat, Directorate, divisional, district and taluk levels were interviewed for this purpose. Institutions such as district and taluk hospitals, community health centers (CHCs), primary health centers (PHCs) and sub-centres were visited and their functioning examined. Functionaries of Panchayati raj institutions at district, taluk and gram Panchayat levels were interviewed to elicit their views and concerns. Detailed discussions were held with the Deputy Commissioners of the districts and Chief Executive Officers of Zilla Panchayats to assess the performance of the department and the existing inter-sectoral and inter-departmental co-ordination. In addition to these information, the findings and recommendations of major surveys, reports and research studies were reviewed for this purpose. Five districts in the state - Kolar, Uttara Kannada, Gulbarga, Chamarajanagar and Bijapur were selected for detailed investigation. These districts broadly represent all the administrative divisions and geographical regions of Karnataka. These districts were visited in 2001 as part of a major study at ISEC (sponsored by the Ford Foundation) to review the functioning of state health department to suggest measures to streamline the administrative machinery and service delivery system (Sekher 2001). However, the necessary additional information was gathered during the ongoing study at ISEC (sponsored by the World Bank) to prepare a district pilot in Karnataka to restructure the local environmental management for better public health outcome.

Health System Decentralization

In many countries, decentralization is often undertaken as part of a sectoral reform process. In this context, the world Development Report of 1993 states that a policy that can improve both efficiency and responsiveness to local needs is decentralization of the planning and management of government health services (World Bank 1993). In reality, health system decentralization takes many different forms, depending not only on overall governmental political and administrative structures and objectives, but also on the pattern of health system organization prevailing in the particular country (Mills *et al* 1990). It is generally believed that the decentralization of health sector would result in greater

community participation in local health activities, which, in turn, will lead to improved service quality and coverage. The following advantages are generally cited as justification for decentralization of health care services--

- A more rational and unified health services that caters to local preferences
- Improved implementation of health programmes
- Reduction in duplication of services as the target population are defined more specifically
- Reduction of inequalities between rural and urban areas
- Greater community financing and involvement of local groups
- Greater integration of activities of different public and private agencies
- Improved inter-sectoral co-ordination (Mills 1994; Wang *et.al 2002*; Kolehmainen-Aitkan 1999).

It is, thus, an accepted fact that health care cannot be achieved only through the department of health services. Experiences all over the world suggest that one pre-condition for enhancing health status is community participation. This, to a great extent, can be ensured through the active involvement of the civil society including non-governmental organizations (NGOs), locally elected leaders in health programmes as well as private service providers. Decentralized governance and local level participation can contribute to improving the health care facilities through better monitoring and supervision of the functioning of the health system at the local level. The small jurisdiction of decentralized local bodies allows the communities to adjust to local social and cultural particularities while the adoption of short and simple administrative process facilitates quick and focused responses to immediate needs.

There are varying experiences reported from different countries on whether decentralization results in improving the provisioning of health services. The experience of Botswana shows that a strong administrative structure is needed at district level for the effective decentralization of health services (Maganu 1990). On the other hand, the transfer of primary care clinics to municipalities in Chile has not resulted in extending coverage or in improving the quality of the services, mainly due to lack of professional supervision and poor planning by the area health services (Montoya - Aguilar and Vaughan 1990). The initial experience of 'trial and error method' of introducing decentralized decision-making in Netherlands has indicated that the process is too slow and too complicated because of the large number of structural changes to be implemented (Schrijvers 1990).

In Papua New Guinea, it is observed that decentralization has enabled the Department of Health to become revitalized and more technically competent (Reilly 1990). In Senegal, the strong political will at the highest level for decentralization and community involvement in health system management was coupled with a close integration of public and private health activities for operational purpose (Ndiaye 1990). Drawing lessons from Spain, Artigas (1990) suggests that the decentralization process should take place slowly after creating legal framework and autonomous administrations so that the authorities become aware of what services can be transferred. In Sri Lanka, the decentralization process paved the way for the active participation of non-governmental and governmental organizations in the activities of health teams at the village level (Cooray 1990).

The above brief review of country-wise experiences indicate that many countries (developed and developing) at different times have felt the need to institute large-scale organizational reforms that favour a greater degree of decentralization in the health sector for supporting the implementation of 'primary health care' and 'health-for-all' strategies. However, the contemporary interest in health sector decentralization in developing countries has not been sufficiently extended to the development of decentralized systems of human resource management, especially in the onset and process of decentralization (Wang *et al* 2002). The underlying problematic aspects of decentralization and human resources has been the lack of constructive policy dialogue between those responsible for the formulation and implementation of health sector reforms and stakeholders in the field of human resources. Kolehmainen-Aitken (1999) underlines the pre-requisites for decentralization of health services such as active involvement of health managers in the decentralized design, clear national resources allocation standards and health services norms, and regular system for monitoring. The one lesson that does seem clear from the existing experiences is that without proper planning and acknowledgement of the lessons from other countries, decentralization of health care can be disappointing at best and detrimental at worst. While a few developing countries have long-term experience with health sector decentralization its impact on the management and the services delivered has rarely been evaluated. Many country-study evidences confirm that poorly designed and hastily implemented decentralization has serious consequences for health service delivery, and so far we do not have an analytical framework to isolate or generalize the factors behind successful and unsuccessful decentralization (Gilson, Kilima and Tanner 1994; Kolehmainen - Aitken and Newbrander 1997).

The case studies from various developing countries provide mixed results. Some reveal that decentralization schemes are performed in a positive manner and pro-poor. In some other cases the responsiveness to the poor and development orientation is lacking. The positive and negative outcomes based on the case studies have been summarized in Table 1.

Table 1: Outcomes of Decentralization in Some Developing Countries

Case	**Outcomes**	
	Participation by/ Responsiveness to the poor	**Impact on social and economic poverty**
West Bengal, India	Good: improved participation and representation, improved responsiveness	Good: positive on growth, equity, HD, evidence lacking on spatial equity
Karnataka, India	Fairly good: improved representation, participation of poor less effective and responsiveness low	Neutral: did little to directly help pro-poor growth, or equity, HD and spatial equity indirectly benefited from funding allocations and development programmes
Colombia	Fairly good: participation/representation ambiguous, responsiveness improved	Fairly good: little evidence on growth or equity, but good results on HD, spatial equity
Brazil	Little evidence, but thought to be poor as spoils/patronage system run by powerful Mayors and Governors still dominant	Good on equity, HD in exceptional areas where state or federal programmes combined with decentralization, poor generally on spatial equity
Bangladesh	Poor: participation and representation low, responsiveness very low	Very poor on all criteria, undermined by corruption and political patronage
Ghana	Fairly poor: participation by poor and community groups improves, limited improvement in representation, but responsiveness low	Limited evidence shows that the resources involved are too insignificant to have made much impact, spatial equity may have improved through government allocations
Kenya	Very poor: politically run deconcentration scheme	Some impact on spatial equity through politically motivated redistribution
Nigeria	Very poor: low participation and representation, very bad record of responsiveness and lack of accountability	Poor: very bad record on equity, HD, spatial equity subject to political manipulation and urban bias

Note: HD – Human Development including public health services

Source: Crook and Sverrisson 1999

Community-based public health services inherently require involvement of community members, decision-makers, researchers and other specialists, apart from the stakeholders. Decentralized governance is an ideal process that will enable to bring these groups of people on a single platform. It can also give an opportunity for establishing

Table 2: Decentralization of Functions in Different Types of Decentralized Systems

Function	Description	Deconcentration to ministry field office	Devolution to local government	Delegation	Privatization
Legislating	Making laws on health matters	–	**	–	–
Revenue raising	Determining and implementing the mechanisms for raising money to finance the health system	*	**	**	***
Policy making	Determining the broad and detailed policies that the health system should follow	–	**	**	**
Regulation	Indirectly controlling the operation of non-governmental health services and providers by administrative mechanisms such as licensing	–	**	*	-
Planning and resource allocation	Formulation of long and short term plans for the development of the health system	**	**	***	***
Management	Personnel	*	**	***	***
	Budgeting and expenditure	**	**	***	***
	Procurement of supplies	*	**	***	***
	Maintenance	*	**	***	***
Intersectional collaboration	Communicating with other sectors and undertaking joint activities	*	***	***	***
Interagency coordination	Coordinating the policies and activities of various health agencies and providers	*	**	***	***
Training	Determining and implementing the training programmes for various categories of staff	*	**	***	***

Note: *** - executive responsibilities, **- some responsibilities, * limited responsibilities, – - no responsibilities

Source: Mills *et al 1990*

equity measures among various socio-economic groups. For example, prevention of diseases like cholera, typhoid, malaria and other communicable diseases require personal hygiene, increase in water quantity, improvement in water quality, food hygiene, and provision of drainage and sanitation facilities. Without involving people in preventing epidemics, the improvement of people's health may not be possible. Therefore,

decentralized institutions become an important instrument in the provision and monitoring of public health delivery system.

Based on both theory and experience, Mills *et al* (1990) have stated that decentralized health system could perform certain functions that might result in the effective delivery of health care services. The functions, which have been identified by them, have been presented in Table 2. The number of stars in the table indicates the extent of responsibilities of the administration for a particular function and a dash (-) indicates no responsibilities. However, it needs to be mentioned here that in many cases an ideal model of decentralized system may not necessarily be an effective one in real practice.

Indian Scenario:

In India also, a similar upsurge of interest on decentralized governance can be witnessed, particularly since the late eighties. Major institutional reforms have been introduced with a view to creating elected local government bodies that underscore the relevance of decentralization as an emerging development strategy in the country. In this regard, the institutional reforms for rural governance being introduced in the country following the 73rd Constitutional Amendment Act in 1992, is described as an important step forward in dealing with its development problems.

The broad framework for rural local self-governments (Panchayati Raj Institutions-PRIs) has been laid down in India under the 73rd Constitution Amendment Act. This has ushered in a greater degree of uniformity in the structure (three-tier), reservation for vulnerable and deprived communities (for SC, ST and women), and powers and functions (financial and planning) of these institutions with the objective of achieving faster social and economic development. The three-tier structures of the PRIs are Zilla Panchayat (ZP) at the district level, Taluk Panchayat (TP) at the intermediary/taluk level and Gram Panchayat (GP) at the village level. The Gram panchayat is the lower tier of the PRI system comprising a cluster of villages with a population of 5,000 to 7,000.

With the emergence of three-tier decentralized bodies, we have nearly three million elected representatives in about 2, 20,000 panchayati raj institutions in India. As can be seen from Table 3, the average population covered by a Gram Panchayat is 3,194, with considerable variation among the states. Population per Taluk Panchayat (Block Council) is

considerably larger, with an average of 1,20,000. Population per Zilla Panchayat, the highest rural level, is quite large, with an average of 1.43 million in 2001. In Karnataka, the population per GP is about 6,000. At the Gram Panchayat (GP) level approximately one member is elected for every 400 population and at the Taluk Panchayat level one member for every 10,000 population. Similarly, for every 40,000 population, one member is elected to the Zilla Panchayat, The representation ratio between citizens and their elected representatives is much larger in urban Karnataka, compared to rural areas.

Table 3: Number of PRIs and Population per PRIs in Indian States –2001

States	No. of GPs	Population per GP	No. of TPs	Population per TP	No. of ZPs	Population per ZP	Total PRIs
Andhra Pradesh	21944	2517	1095	50433	22	2510179	23061
Arunachal Pradesh	2013	431	79	10993	12	72369	2104
Assam	2489	9341	203	114527	21	1107095	2713
Bihar	12181	6091	725	102344	55	1349084	12961
Goa	188	3591	-	-	2	337564	190
Gujarat	13316	2380	184	172270	19	1668296	13519
Haryana	6059	2471	114	131306	19	787834	6192
Himachal Pradesh	3037	1805	75	73098	12	456864	3124
Karnataka	5659	6152	175	198938	27	1289411	5861
Kerala	991	23786	152	155076	14	1683677	1157
Madhya Pradesh	22029	2010	313	141478	45	984056	22387
Maharashtra	28711	1941	320	174164	33	1688864	29064
Manipur	166	10953	-	-	4	454556	170
Orissa	5254	5940	314	99397	30	1040353	5598
Punjab	12369	1297	138	116259	17	943749	12524
Rajasthan	9188	4709	237	182564	22	1966713	9447
Sikkim	159	3022	-	-	4	120122	163
Tamil Nadu	12607	2766	384	90805	28	1245332	13019
Tripura	540	4904	23	115134	4	662018	567
Uttar Pradesh	52029	2528	809	162596	70	1879146	52908
West Bengal	3360	17183	341	169310	17	3396158	3718
India	**214289**	**3194**	**5681**	**120468**	**477**	**1434756**	**220447**

Source: Calculated by the author based on the information on PRIs (www.indiastat.com) and rural population from the Census of India-2001.

Under the new decentralized government set-up, about one-third of the elected representatives are women. Nearly one third belongs to backward and marginalized communities. The working group on decentralized planning and PRIs states that "one of the significant achievements of the provisions of the Seventy-third Amendment Act concerning reservation of seats to political offices in favour of women and the disadvantaged sections of the rural community is that it had improved their awareness and perception levels and had created an urge in them to assert their rightful share in the decision making process at the local level" (Government of India 2001). Table 4 presents the state-wise number of elected members at three-tiers of PRIs in 2003. Interestingly in Karnataka, nearly 44 per cent of the GP members are women, highest in India.

Table 4: Number of Elected Representatives in PRIs in India- 2003

State	Gram Panchayat		Taluk Panchayat		Zilla Panchayat		Total No.
	Members	Women	Members	Women	Members	Women	
Andhra Pradesh	277, 027	68, 736	19, 536	4, 919	1, 459	364	298, 022
Assam	23, 471	7, 851	2, 148	746	390	117	26, 009
Bihar	156, 582	40, 553	15, 676	4, 065	1, 572	410	173, 830
Chattisgarh	166, 214	41, 913	3, 545	906	389	95	1 70, 148
Goa	1439	457	@	@	50	17	1, 489
Gujarat	152, 303	1, 312	5, 263	1, 180	1, 004	274	158, 570
Haryana	73,002	18, 356	3, 272	842	423	109	76, 697
Himachal Pradesh	25, 371	6, 822	2, 220	562	338	87	27, 929
Karnataka	89, 343	35, 922	3, 537	1, 375	930	339	93, 810
Kerala	13, 259	4, 801	1, 638	629	307	105	15, 204
Madhya Pradesh	314, 847	106, 491	6, 456	2, 159	734	248	322, 037
Maharashtra	255, 194	77, 548	4, 284	1, 407	2, 081	658	261, 559
Manipur	1, 722	611	@	@	61	22	1783
Orissa	118, 961	31, 414	8, 415	2, 188	1, 150	296	128, 526
Punjab	75, 968	27, 108	2, 480	813	279	89	78, 727
Rajastan	153, 732	39, 450	7, 165	1, 908	1, 372	364	162, 269
Sikkim	1, 195	322	@	@	121	29	1, 316
Tamil Nadu	97, 458	26, 181	6, 570	1, 770	656	173	104, 684
Tripura	5, 685	1, 895	299	106	82	28	6, 066
Uttar Pradesh	683, 383	230, 865	51, 870	18, 580	2, 126	788	737,379
Uttaranchal	261, 915	18, 041	3, 225	1, 133	345	119	265, 485
West Bengal	51, 200	11, 497	8, 579	1, 923	723	156	60, 502
India*	2,999,271	798, 146	156, 178	47, 211	16, 592	4, 887	3,172,041

Note: Data have not been recorded for all the states @ - Taluk does not exist.

Source: Panchayati Raj Update 2003

The Act has ushered in changes by providing wide-ranging powers and functions to the local-level constitutional bodies for ensuring participation in planning and implementation. PRIs are responsible for 29 functions including health and sanitation, hospitals, primary health centres and dispensaries, drinking water supply, women and child

development. However, the functions and powers devolved to the panchayats vary considerably across the states. The reality is that many states are ways ahead compared with others in bringing about administrative and political changes by amending the state level Panchayati Raj Act and providing the power and resources to make decentralized planning and governance meaningful. The state governments were supposed to transfer to panchayats functions pertaining to 29 subjects. As can be seen from Table 5, the states of Karnataka and Sikkim have transferred funds, functions and functionaries with regard to all the 29 subjects to the PRIs. Kerala, West Bengal, Rajasthan and Tamil Nadu have transferred the 29 functions to the PRIs but not the funds and functionaries (Pal 2004).

Table 5: Status of Devolution of Departments/Subjects to PRIs in Indian States.

States/UTs	No of departments/subjects transferred to panchayats with		
	Functions	Funds	Functionaries
Andhra Pradesh	13	05	02
Arunachal Pradesh	-	-	-
Assam	-	-	-
Bihar	-	-	-
Jharkhand	-	-	-
Goa	-	-	-
Gujarat	-	-	-
Haryana	16	-	-
Himachal Pradesh	23	02	07
Karnataka	29	29	29
Kerala	29	15	15
Madhya Pradesh	23	10	09
Chhattisgarh	23	10	09
Maharashtra	18	18	18
Manipur	22	-	04
Orissa	25	05	03
Punjab	07	-	-
Rajasthan	29	-	-
Sikkim	29	29	29
Tamil Nadu	29	-	-
Tripura	12	-	-
Uttar Pradesh	13	12	09
Uttaranchal	13	12	09
West Bengal	29	12	12
A and N Islands	-	-	-
Chandigarh	-	-	-
D and N Haveli	03	-	03
Daman and Diu	29	-	-
Lakshadweep	06	-	-
Pondicherry	-	-	-

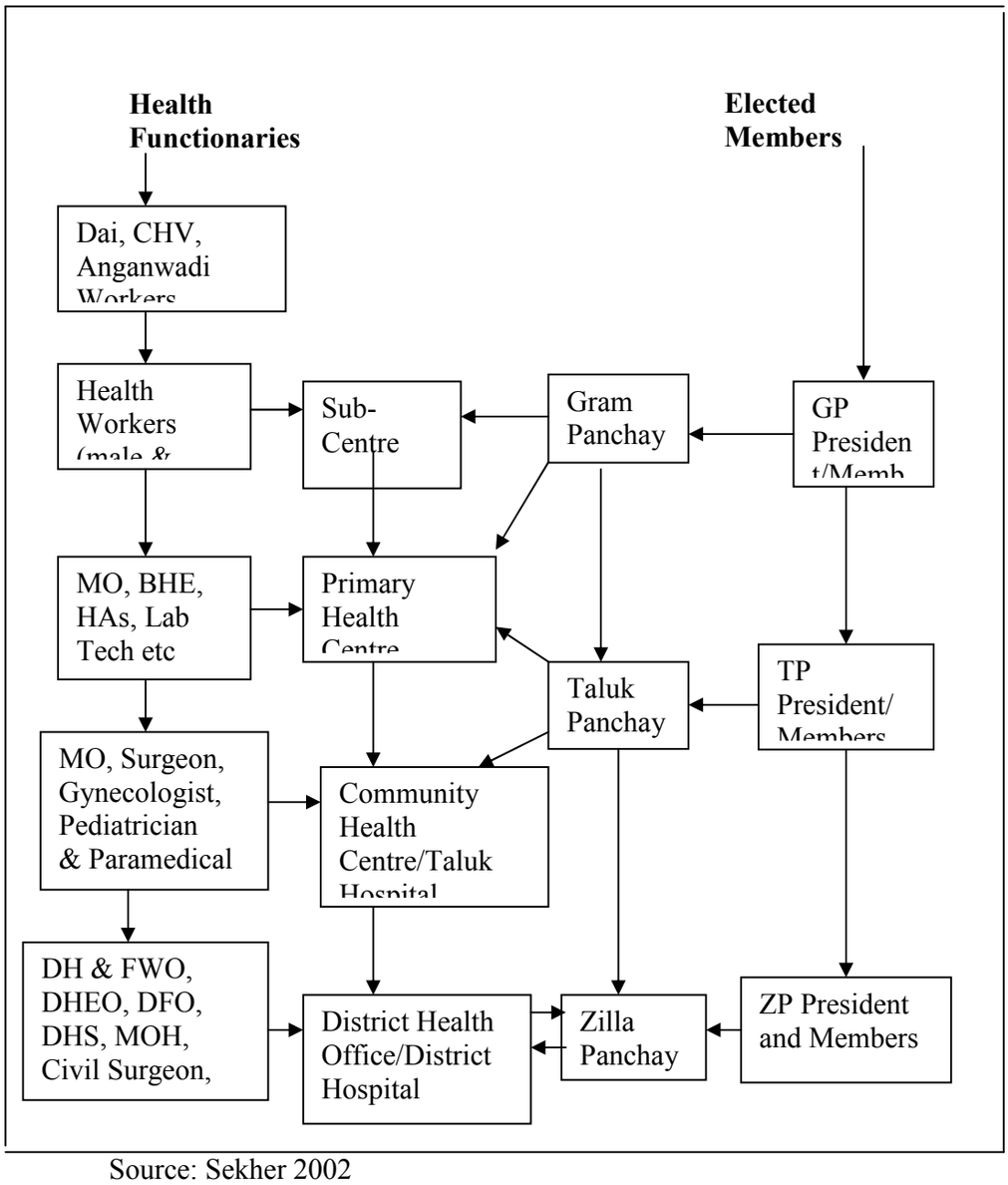
Note: In Delhi, the panchayati raj system is yet to be revived.
Source: Pal 2004

In most of the states, the experiences of the functioning of the panchayats reveal that while elections have been held regularly, the states have been slow in devolving power to the panchayat bodies. In some states the line departments still exercise the powers of supervision and control over the schemes of subjects transferred to the panchayats (Govt. of India 2001). In general, the existing situation with regard to functions, finances and functionaries of panchayats shows that, with some exceptions, the status of panchayats in terms of making them autonomous in the areas of their operation is not very encouraging. The constitutional amendment alone cannot be effective if demand for decentralization does not arise from the grass roots. A strategy comprising of constitutional amendment and social mobilization is essential for strengthening the panchayats in the light of the experiences of the last one-decade.

Linkages between PRIs and Health Department at District Level:

PRIs can evaluate and monitor the progress of work or performance of various functionaries whose work is placed under their jurisdiction. It is evident that, in general, GP is in touch with the functionaries of Sub Centres and PHC coming under its jurisdiction. Similarly, Taluk Panchayat has linkages with Primary Health Centres and Community Health Centres. Taluk Panchayats may have control over the Medical Officer and other health functionaries of PHC and CHC. Similarly, at the district level, the District Health and Family Welfare officer is responsible for the management and supervision of the health care services. There is a direct link between District Health Office and the Zilla Panchayat. The district health officer (DHO) in consultation with the Zilla Panchayat implements most of the health, disease control and family welfare programmes. In Karnataka, all the health care institutions and hospitals except the District Hospitals, are placed under the authority of DHO. Chart 1 shows the linkages between PRIs and functionaries of the health care system at the district level in Karnataka.

Chart 1: Linkages between PRIs and Health Care System at District Level in Karnataka



Source: Sekher 2002

It must be noted that there are several alternative models through which the services are delivered even today not just within the country but also within the state. For example, in the externally aided projects, there are different institutions that aim to install the infrastructure and deliver the services (Table 6). Many of these projects also ensure the active involvement of PRIs and NGOs in program implementation.

Table 6: Extent of Decentralization in the World Bank Assisted Health Projects in India.

	Project	Level of Decentralization			
		Administrative Implementation	**Managerial Monitoring**	**Financial**	**Partners at Grass Roots**
1	National Tuberculosis Control Project	District Society	Poor, through District TBC	Directly from MOHFW	Active involvement of NGOs in some areas
2	National Cataract Blindness Control Project	District Society	District Program Co-ordinator	Directly from MOHFW	Stress on NGOs and Private Ophthalmologist: Lack of Co-ordination
3	National Leprosy Elimination Project	District Society	Poor, through supervisor and paramedical worker	From GOI to states to Societies	Poor participation of NGOs
4	National Malaria Eradication Project	PRIs and local Malaria societies	Poor, only at the state level.	Funds disbursed to PRIs	Community based Approach and Malaria Link Volunteers.
5	Family Welfare Project	Three-tier system and setting up of FPAI and SCOVA at the District Level	State level Management Units	From GOI to state	Limited Community participation
6	Reproductive and Child Health Project	District Family Welfare Bureau and PRIs	Target free Approach, However Direct Monitoring of GOI on poor performing Districts.	From GOI to state and Directly from GOI to SCOVA and First Referral Unit	Emphasized on active Involvement of NGOs, PVOs, CHWs and AWWs

Source: Gupta and Gumber 1999

Standing Committees and their Functioning:

It is mandatory to constitute various standing committees at three tiers of PRI system. The standing committees can be seen as mechanisms for building co-ordination between different functionaries, representatives and the people. At the Zilla Panchayat level, the Education and Health standing committee monitors the functions like health services, hospitals, water supply, family welfare and other allied matters. The Chairperson of the

Standing Committee presides over the meeting. All the Departmental Officers concerned with the subject matters on the agenda must attend the meeting. In the General Body meeting of the ZP, the proceedings of the Standing Committees are proposed for approval by the chairperson or members of the Committee. Apart from standing committees there are other committees and a series of meetings in which PRIs and line departments take decisions together and review the status and performance of various projects and programs (like disease surveillance committee).

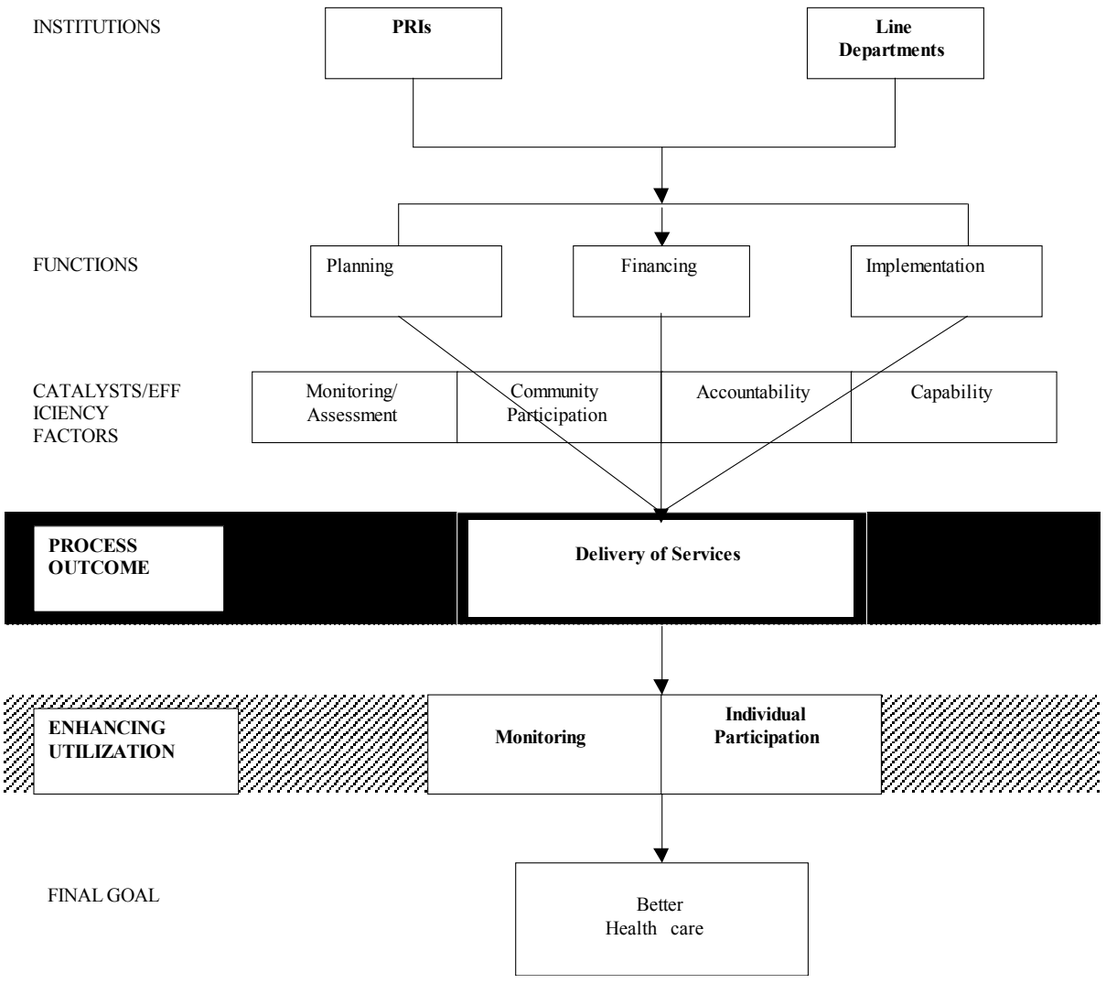
It is important to note that even though there are standing committees at GP, TP and ZP levels, the committee meetings at the GP and TP levels were hardly held or never took place. Meetings of Standing Committee on health and education at the ZP level were held regularly and important decisions regarding vacancies, purchase of drugs and equipments, control of epidemics etc. were discussed. In general, it is observed that this standing committee functions effectively to a certain extent, though DHOs complain that there were a few incidences wherein the committee interfered in the functioning of DHO, particularly with regard to the purchase of drugs and transfer of medical officers (Sekher 2001). The standing committees at the GP level were practically defunct. Even in the general meetings of GP and TP, issues relating to health and sanitation received very little attention, an indication of the low priority given to health in comparison to other "developmental" issues (see Appendix A for a review of the topic of discussions at the PRI and Standing Committee meetings in one district of Karnataka).

Based on an analysis of the minutes of the meetings of the general body/standing committee of two Gram Panchayats and two Taluk Panchayats coming under the Mysore Zilla Panchayat, it was found that issues related to vector control and incidence of diseases never or very rarely came up for discussion.. Though health matters were discussed at the GP and TP meetings, the emphasis was on issues related to appointment/transfer of personnel and infrastructure development. Water supply related problems attracted many debates; the quality of water was never discussed. With regard to the meetings of the ZP Standing Committee on education and health, the minutes clearly indicate the importance given to the purchase of drugs and equipments, supply of milk and bread to the hospitals, construction/repair of hospital buildings, and absence/vacancy of medical personnel.

Analytical Framework

An analytical framework for delivery and monitoring of health services at local level has been presented here (Chart-2). The analytical frame is based on the ultimate goals fixed for the empowered institutions, viz. the PRIs and the line departments. The goals clearly are for achieving most optimal health outcomes in the present context. The constitution, the Karnataka Panchayati Raj Act of 1993 and so on specify these obligation and goals. To achieve these goals, these lead institutions should formulate strategies, prepare plans and provide financial solutions for implementing the plans. The overall direction has to come from higher-level authority, in the present context, from the state level policies.

Chart 2. Analytical Framework: Delivery and Monitoring of Public Health Services at the Local Level



Source: Sekher *et al 2004*

The main functions translate the policies or strategies into services through infrastructure, programs and schemes. However, the effectiveness of the service delivery depends on a number of factors. In any efficient system of delivery of services, there has to be well laid-out mechanisms that ensure provision of necessary inputs - infrastructure, personnel, resources; a monitoring mechanism that provides information on a systematic basis for corrective actions, forums for interaction with other stakeholders, clear accountability mechanisms, to name a few of the components. These components improve the outcome of the efforts in terms of planning, finance and implementation. The delivery of services is still only an intermediate step towards realizing the goal of better health care. Even when the services are available, the utilization depends on how individual users of the service make use of the services provided. The PRIs need to manage the available systems to obtain the best results for the community. As agents who are empowered to manage the system of service provision and at the same time as representatives of the community they have the best opportunity to provide the optimal services.

Health is one crucial area of social sector and, in the era of globalization, the extent to which the decentralized institutions succeed in ensuring health facilities has important implication for social and gender justice, which is one of the declared goals of decentralization in India. It is assumed that the involvement of panchayati raj institutions in the implementation and management of health services would facilitate focused attention on vulnerable social groups, emphasize preventive measures and re-orient the health programmes to meet the specific local needs. This is because, despite the existence of an extensive health infrastructure, a vast majority of the population in India has no access to basic health care facilities. Health facilities are seldom used by the poor in the country due to distance, lack of medicines, absence of health personnel, and lack of sympathetic attitude of the health staff (Peters *et al* 2002).

Despite the existence of an extensive rural health infrastructure network (see, Appendix B), a vast majority of the rural population in India has no access to basic health care facilities. It is also documented that the poor have higher levels of mortality, morbidity and malnutrition than the rich. The prevalence of diseases like diarrhoea and anaemia are more common among low-income households compare to others (IIPS and ORC Macro 2000). Due to poverty and illiteracy higher percentage of poor do not seek treatment when they are ill. The National Sample Survey indicates that about 24 per cent of the poorest quintile does not seek medical care compared to 9 per cent of the richest quintile. Apart

from poverty and low levels of education poor management of public health system is responsible for the deteriorating health conditions. It is argued that by the re-assessment of priorities and better management practices, India's health outcomes could be substantially improved (Das Gupta and Rani 2004). The primary health care systems need to be strengthened to reduce the burden of disease through appropriate preventive, promotive and curative services. The primary health care system mainly depends upon the functioning of primary health centers (PHC) and sub-centers. Unfortunately most of the PHCs are under-staffed and lack basic facilities like water, telephone, electricity and vehicle. Many sub centers (to cover a population of about 5000) exist only on paper. Poor health of rural masses is essentially a failure of the public health delivery system. Whenever there is an outbreak of epidemic, killing a large number of people, the public health care system comes under severe criticism (like Plague outbreak in Surat). However, what is happening every day but is not noticed by public is the death and sufferings of thousands of women, children and poor due to diseases, which are entirely preventable and easily curable. The poor utilization of public health services underline the fact that mere expansion of health infrastructure will not yield the desired results. Appropriative administrative measures and monitoring mechanism can solve this problem to a great extent; it is here that the rural local bodies can play an important role.

Decentralization is expected to bridge the existing gap between service providers and clients to a great extent. Clients can help tailor the service to their needs. Clients can monitor the functioning of health services since they are present at the point of service. However, for the panchayati raj institutions (PRIs) to be effective in health service delivery, more responsibilities need to be given to them in the sector-specific budget allocations, revenue-raising powers and improved human capital through access to qualified personnel and training. Both National Health Policy (Government of India 2002) and National Population Policy (Government of India 2000) reiterate these crucial issues while recognizing the importance of panchayati raj institutions in planning and implementing the health programs in the country (Appendix C).

It is apparent from the experience in India that the PRIs have succeeded in carving out a role for themselves in improving the quality of health care services by monitoring regular attendance of health care functionaries as well as by exerting moral pressure on the staff not to avoid regular duties (Islam 2004). The attendance of doctors and paramedical staff improved considerably under the constant monitoring of local leaders in many PHCs and

hospitals of Karnataka (Sekher 2001; Aziz *et al* 2002). A study conducted by CINI (2003) in five states in India notes that the current functions of the PRIs vis-a-vis health are not in place as yet. The PRIs have not been fully entrusted with health functions, although this is an area of responsibility that has been outlined in the formation of the sub-committees of the PRIs across the states. It is important to develop a system linking health administration (including the health service system) with PRIs as part of phased reform taking into consideration the uneven development of PRIs in different states (Gupta and Gumber 1999).

Observations from the Field:

1. The interventions of Panchayat Raj Institutions are successful to a great extent for making the health personnel accountable to the public. The absenteeism among doctors and paramedical staff is the major reason for the poor functioning of PHCs and lower utilization of health facilities. Medical Officers were never ready to respond to local situations and requirements, and used to spend considerable time on private practice either in a clinic or at home. Many local leaders took interest to ensure the availability of doctors and ANMs in their area. One panchayat member told during discussion – "Earlier the doctor here was very irregular and he used to visit the PHC once in a week. We complained to the higher authority and nowadays, he is attending the PHC regularly." During a visit to the Community Health Centers and PHCs it is observed that there is significant improvement in their functioning and doctors were willing to listen to the public, particularly poor.
2. Karnataka has relatively better health infrastructure in terms of number of sub centers, PHCs and CHCs in proportion to the population, as per the norms prescribed by the central government. But the mere existence of a health Institution does not ensure its satisfactory functioning and utility to the common man. Many of them lack basic facilities like electricity, water, telephone, vehicle and staff quarters. One Panchayat member narrated the situation in his nearby PHC- " Whenever there is a doctor, there are no nurses to provide services. When both are available there are no medicines. When medicines are available, there is no refrigerator to keep". Some Gram Panchayats took initiative in improving the health infrastructure by mobilizing funds locally.
3. One common complaint against the public health system in India is the lack of medicines mainly due to pilferages and irregular supply. Drugs supposed to be given to

the patients free of cost were sold out or charged and bribes became a normal thing in the day-to-day functioning of government hospitals. Many Panchayat members, during discussions claimed that they were able to contain these practices. Under the watchful eyes of local leaders the corruption in drug purchase and supplies was controlled to a great extent.

4. In Karnataka 60 per cent of the total budget for the purchase of drugs and equipments were given to the Zilla Panchayats. The DHO in consultation with other officers prepared the inventory of items to be purchased and sent the list to the ZP Standing Committee for deliberation and approval. This ensured that the available funds were properly utilized for the purchase of good quality medicines, which are really necessary.

5. In 2001, nearly 24 per cent of the posts were vacant in Karnataka health department. However, in certain crucial cadres the vacancy position was alarming. Nearly 50 per cent of the Pharmacist posts and 39 per cent of the Lab technician posts were lying vacant. Even in the case of medical officers, the vacancy level was around 17 per cent. One immediate solution to overcome the rampant vacancy position is contractual appointment at the district level. The State government has given permission to district administration to fill up vacancies locally on contract basis. Taking advantage of this provision many panchayats have been able to get health personnel appointed from the locally available persons, which also ensured their regular attendance in health centers.

6 Any meaningful involvement of grass root level leaders can only be possible by creating health awareness and by imparting training about their duties and responsibilities in the provision of the primary health care of the communities. Given the relatively lower educational attainment of panchayat members, lack of exposure to any kind of governance outside (majority of the women members are housewives and belong to deprived communities) and political inexperience, their participation in the PRI system and ability to discharge their responsibilities would not be very effective. They need to be sensitized, and motivated about the health problems in their area, existing health programs and how they can help their electorate. The evaluation of a health-training program in Karnataka revealed that the training contributed significantly not only towards enhancing the level of awareness and self-confidence among local leaders, but also towards improving their performance with regard to the provision of

basic health care in rural areas (Sekher 2002). In Karnataka, television was used as a powerful medium to sensitize the grass roots leadership on health issues. Informal channels such as television proved effective in initiating important attitudinal and behavioral changes at grass roots level, where a majority of the people may have had little formal education (Sekher 2003).

7. There are many overlapping of functions between the three tiers of local bodies and this can be a source of confusion and administrative delays in program implementation. To overcome this problem, the state government has come out with activity mapping wherein specific responsibilities have been identified at three levels. A particular job/responsibility has been given to a particular level so that overlapping can be avoided. The distribution of responsibilities of PRIs with regard to health and sanitation including hospitals, primary health centre and dispensaries has been given in appendix-D. With regard to health care, the ZP is responsible for providing physical infrastructure, co-ordination of communicable diseases programmes, school health programmes, IEC campaigns and planning of rural sanitation programmes. The specific activities identified for the GP include chlorinating of village tanks and wells, spraying of DDT, construction of sanitary latrines, cleaning of roads and drainage, formation of village health committees, and mobilization of people for family planning and immunization camps. GPs are also responsible for the supervision of activities of ANMs. They are also supposed to report the outbreak of epidemics and help emergency medical relief services.

8 During the field trips and discussions with officials, it was observed that women panchayat members took more interest in monitoring the health facilities. Many women leaders felt that in most cases the health needs of women got neglected and were attended to only when it became a crisis. Some women members asked the health workers to regularly visit their villages for providing the ante-natal care.The women panchayat members have started motivating the untrained dais in their villages to undergo the training at the PHCs.

9 There is a need to simplify the administrative procedures, particularly those involving the ZP and Health Department. DHO needs to obtain the permission of ZP on all matters. Many times these administrative bottlenecks have caused delay in taking necessary actions.

10 Village health plans should be drawn up by the GPs for improving the local environment in a systematic manner. To begin with, these plans should contain a domestic waste

disposal system; plans to remove water logging conditions; build community level public convenience, organize 'clean village days' at least twice a year; organize vector control programs as per schedule; ensure testing of water quality as per schedule; and produce a charter of citizen rights.

11 The GPs are responsible for enforcing public health laws such as Anti-Food Adulteration Act (with laboratory support at the district level). But there is very little understanding of the implications of this responsibility at that level. There are no standard formats for issuing licenses, no checks, no efforts to improve the quality. Actually the GPs could insist on the condition that any new house/ building that is constructed should have adequate sanitation facilities. Such requirements should become part of the GP bye-laws and the necessary instruments for enforcement of the obligations should be provided to the GPs by the state level authorities. The model bye-laws need to be framed at the GP level for enforcing the requirements relating to sanitation and food safety. Mechanisms to implement these obligations under the bye-laws need to be constantly reviewed and support mechanisms developed.

12 The GP level amenity committee is one forum to monitor the health conditions in the village. This forum should optimally use the services of health personnel. The GPs at present lack the necessary outreach to mobilize the community for the public health programs on a sustained basis and they may also not be a forum to provide continuous interaction with the community. For example, the members of GP who get elected may not be the best people to undertake tasks relating to public health. The GP should form a Health Committee or a Health Club, which would be a community organization with specific agenda. In addition, the organization should be free to carry out works relating to health issues. The community organization should be encouraged to raise their own additional funds. Women should be given a special role in these organizations. These Health Clubs should be responsible for the implementation of the Health Plan for the village.

13 At present there are no systematic monitoring mechanisms to assess the working of the amenities/facilities from the point of view of their impact on health. It is necessary to develop a systematic mechanism by which information is available to decision-makers to act and improve the situation. The PHC should send Health Compliance Report upon execution of any project like water supply, toilet facilities and construction of drainage to the PRIs. PHC should also send water test reports (bacterial contamination) on monthly basis to PRIs. PHC should file vector control reports regularly indicating the possibility of epidemic outbreak and required measures to prevent such calamities. The standing

committees/GPs should discuss the reports and initiate action. The co-ordinated efforts of PHCs and PRIs can prevent epidemics and improve health situation, without any additional financial resources.

14 Various inter–sectoral forums that exist at different levels in the PRI system need to be activated. The diseases surveillance committee at the district and taluk levels should be made functional. At the GP level, the amenities committee should have the active participation of PHC staff.

Concluding Remarks:

The whole idea of decentralized governance is based upon some key factors like people's participation, accountability, transparency and fiscal transfers. Our observations from Karnataka indicate that placing health services system under the control of Panchayati Raj institutions has resulted in an overall improvement in the services delivery. Being closer to the people, the PRIs are in a position to meet the needs and preferences of people. The health personnel are found to be accountable to people and there is a significant improvement in the attendance of doctors and paramedical staff in discharging their duties under the watchful eyes of the local leaders. This has resulted in better functioning of PHCs and CHCs and improved utilization of public health care facilities. Karnataka has been one of the states where decentralized governance has been pursued more aggressively by transferring functions, funds and personnel to the PRIs. The experience so far is encouraging though there is a necessity to streamline the administrative procedures and evolve mechanisms for better coordination between line departments on the one hand and PRIs and line departments on the other. The coordinating mechanism between the line departments and decentralized bodies still remain ambiguous in many aspects. The recently developed activity mapping in Karnataka, where specific responsibilities were assigned to each tier of decentralized bodies, has helped in significantly reducing the overlapping of functions between GP, TP and ZP. It is also necessary to orient and train the PRI members and health functionaries about their roles and responsibilities in providing better health services. Given its reasonably good track record in the decentralization of power, authority and finances, Karnataka provides a good opportunity for PRIs to demonstrate their capability in improving the health service delivery for the benefit of the poor. We need to wait and see how effectively PRIs can be used as a vehicle for better health service delivery. This, to a great extent, depends upon the cooperation, coordination and mutual trust between health bureaucracy and Panchayat leadership.

Appendix: A

PRI Meetings and Issues for Discussion: An Analysis of the Minutes of the Proceedings

Name of PRIs	Types of meetings	No. of meetings	No of Issues discussed	Incidence of diseases	Water supply		Sanitation		Vector control	Health matters (infrastructure, personnel, purchases, other works)				Developmental works (not related to health)	Miscellaneous
					Community	School	Community	School		Medicines and equipments	Hospital Food	Infrastructure	Personnel, supervision,		
Mysore ZP	**Standing committee (HE)**	**11**	**188**	–	–	**3**	–	**3**	–	**13**	**10**	**13**	**12**	**72**	**62**
Hunsur TP	Standing/ General body	4	17	–	3	–	–	–	–	2			1	8	3
	Special	1	8	1									3	1	3
	Total	**5**	**25**	**1**	**3**					**2**			**4**	**9**	**6**
Mysore TP	Standing/ General body	4	38		6		1					4		24	3
	Executive*	2	30				1						1	15	13
	KDP **(quarterly)	1	8		2							2	1	2	1
	KDP (monthly)	1	12		1									10	1
	Total	**8**	**88**		**9**		**2**					**6**	**2**	**51**	**18**
Ummat-tur GP	Standing/ General body	12	45		7		4							10	24
	Emergency	1	2		1										1
	Total	**13**	**47**		**8**		**4**							**10**	**25**
Aspath-re Kaval GP	Standing/ General body	9	48		2		1	2				1		17	25
	Emergency	1	1												1
	Special	1	1											1	
	Total	**11**	**50**		**2**		**1**	**2**				**1**		**18**	**26**
Total meetings and issues discussed		**48**	**398**	**1**	**22**	**3**	**7**	**5**	**0**	**15**	**10**	**20**	**18**	**160**	**137**

Note: * – Meetings of secretaries of GP ** – KDP-Karnataka Development Programme involving all the departments and chairpersons of elected bodies and standing committees. WATSAN project (both at the village level and at schools) supported by UNICEF is being implemented in Mysore District.

Source: Sekher *et al* 2004

Appendix: B

Health Care Workforce and Health Facilities in Public and Private Sectors in India.

Indicator and measure	Value
Doctors	
Total number (1998) (includes all system) (CBHI)	1,109,853
Population per Doctor	880
Percentage of doctors in rural area (1981) (census)	41
Percentage of all doctors in private sector (estimated)	80-85
Nurses	
Total number (1996)	867,184
Population per nurse	976
Doctor per nurse (1996)	1.4
Hospitals	
Total Number (1996)	15,097
Population per hospital	56,058
Percentage of Hospital in private sector	68
Estimated total number of hospitals	71,860
Estimated population per hospital	11,744
Estimated percentage of hospitals in private sector	93
Hospital beds	
Total number (1996) (CBHI)	623,819
Population per hospital bed	1,357
Percentage of beds in rural areas	21
Percentage of beds in Private sector	37
Estimated total number of beds	1,217,427
Estimated population per bed	693
Percentage of beds in private sector	64
PHCs	
Total number	22,975
Rural population per PHC	27,364

Note: PHCs, primary health centers. The estimate for manpower is based on medical council lists. The estimate for the number of hospitals and beds are based on the extent of underestimation in government (Central Bureau of Health Intelligence (CBHI) data found in Andhra Pradesh in a 1993 census of all hospitals by the Director of Health Services and the Andhra Pradesh Vaidya Vidhan Parishad; they found 2,802 hospitals and 42,192 hospital beds in the private sector in Andhra Pradesh as against only 266 hospitals and 11,103 beds officially reported by CBHI in that year. Thus, compared with the official (CBHI) data, the number of private hospital was larger by a factor of 10.5, and the number of beds by factor of 3.8.

Source: as cited by Peters, *et al* 2002.

Appendix: C

Extracts from the National policy documents of Government of India

Role of Local Self-Government Institutions

"NHP-2002 lays great emphasis upon the implementation of public health programmes through local self-government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resource normatively allocated for disease control programmes, will be provided by the Central Government".

-National Health Policy-2002.

Decentralized Planning and Programme Implementation

"The 73rd and 74 the Constitutional Amendment Act, 1992, made health, family welfare, and education a responsibility of village panchayats. The panchayati raj institutions are an important means of furthering decentralized planning and programme implementation in the context of the NPP 2000. However, in order to realize their potential, they need strengthening by further delegation of administrative and financial powers, including powers of resource mobilization. Further, since 33 per cent of the elected panchayat seats are reserved for women, representative committees of the panchayats (headed by an elected woman panchayat member) should be formed to promote a gender sensitive, multi-sectoral agenda for population stabilization that will "think, plan and act locally, and support nationally". These committees may identify area-specific unmet needs for reproductive health services, and prepare need-based, demand-driven, Socio-demographic plans at the village level, aimed at identifying and providing responsive, people-centered and integrated, basic reproductive and child health care. Panchayats demonstrating exemplary performance in the compulsory registration of births, deaths, marriages and pregnancies, universalizing the small family norm, increasing safe deliveries, brining about reductions in infant and maternal mortality, and promoting compulsory education up to age 14, will be nationally recognized and honoured".

- National Population Policy-2000.

Appendix: D

Activity Mapping: Health and Sanitation, Including Hospitals, Primary Health Centers and Dispensaries

Activity	Distribution of Functions		
	Zilla Panchayat	Taluk Panchayat	Gram Panchayat
Health care	1. Plan through health committees to provide physical infrastructure 2. Coordinate communicable diseases program with the State 3. Coordinate construction and maintenance and supervision of PHCs 4. Maintain district ISM (Indian System of Medicine) hospitals 5. Conduct Epidemiological surveys Periodically 6. Promote school health programs 7. Organize health awareness rallies and camp	1. Assist in supervision and maintenance of sub centres and development of field staff 2. Supervising mid-day meals schemes for school children 3. Organizing health and family welfare camps and conduct demonstration-cum-exhibition programs on health, family welfare and sanitation 4. Assist in supervision of Indian Systems of Medicine (ISM) dispensaries	1. Assist in the formation of village health committees comprising Panchayat members, representatives of villagers, Village Health Guide (VHG), Trained Birth Assistant (TBA) and Multipurpose Health Workers 2. Upkeep of village sanitation, clearing of roads and drainage 3. Mobilize and organize people for health and family planning and immunization camps 4. Coordinate and supervise construction of sanitary latrines.
Sanitation	1. Plan rural sanitation programs 2. Promote Information, Education and Communication (IEC) campaigns	1. Organizing and supervising sanitary marts 2. Formulating plan for assisting in the construction of sanitary latrines. 3. Assisting in inspection / assessment of quality of public health inputs and services.	1. Chlorinating village tanks and wells and spraying of DDT. 2. Assisting in the construction of individual sanitary latrines 3. Reporting outbreak of epidemics 4. Assisting in coordinating emergency medical relief services

Source: Karnataka State Gazetteer, August 22, 2003

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