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Local health governance: A study in Uttarakhand

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Abstract
Introduction: More than fifty years ago, the United Nations adopted the Universal Declaration of Human Rights (United Nations 1948). The Declaration embraces human rights concerns, which are presented in 30 articles.
Methodology: The research is done scientifically to solve the research problem. The methodology adopted for the present study is descriptive and analytical which is based upon scientific tools such as quantitative and qualitative. The purpose of the present study is to explore and evaluate the status of health governance provided by the public health system and the pattern of utilisation of those services by the community of study areas.
Discussion and Analysis: PRIs or local governance are the constitutional setup in India for grassroots development of the rural areas. Health is one of the subjects assigned to the PRIs in our country. In 1993 the government brought a new PRI Act with more powers and decentralisation to the local bodies.
Conclusion and recommendation: 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.

Keywords: Governance, authorities, partnership, UNESCAP

Introduction

One universal definition of the term “governance” does not exist and international organizations apply different explanations to interpret the concept of “governance”. The World Bank defines governance as “the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them” (World Bank 2010c).

These definitions demonstrate the complexity of the governance concept and despite the effort made by the World Bank and several other organisations, there does not exist any simple way to measure its quality. The underlying terms most commonly used to describe and define governance are policy formulation, accountability, transparency and partnership. Other terms also frequently applied, are rule of law, effectiveness and efficiency, equity and stewardship. Neither the World Bank nor the OECD include stewardship as a stand-alone term in definitions and evaluations, however, the World Health Organization has described stewardship as the essence of good governance (World Health Organization 2000). Stewardship is yet another concept which is hard to define and therefore difficult to measure. The World Health Organization identifies several elements of stewardship, inter alia; having the broad strategic vision for improving populations´ health, formulating health policy, exerting influence, building partnership and ensuring accountability and transparency. Despite the absence of the word “stewardship” in many of the definitions of governance, stewardship is recognized as one of the fundamental factors affecting governments´ accountability and responsibility in securing the welfare of nations, exercised through trust and legitimacy (World Health Organization 2007b).

In 2009, the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) presented a short and simple definition of governance which will be referred to in this thesis, namely "the process of decision making and the process by which decisions are implemented (or not implemented)” (Sheng 2011). Although short, this definition is quite precise and the phrase “process of decision making” embraces, in my view, a successful, corruption-free managerial execution of the authority showing respect to citizens by including them in the policy process. UNESCAP recognizes governments as one of the most important actors in decision-making and the implementation of decisions, although they also identify the media, international organisations, donors and others as important players in the process (Sheng 2011). UNESCAP applies similar categories as the World Bank to prescribe governance quality, although it uses eight categories in comparison to the six outlined by the World Bank: (i) Accountable; (ii) Responsive; (iii) Transparent; (iv) Participation; (v) Equitable and Inclusive; (vi) Follows the rule of law; (vii) Effective and Efficient; and (viii) Consensus oriented.

It can be argued that accountability and responsiveness are two of the fundamental requirements of good governance. Accountability and responsiveness ensure that decisions are made by authorities that have the responsibility to respond to the needs of the population and to keep promises, often made through an election process. It includes the obligation of governments to provide information regarding their decisions and actions and to justify them to the public (World Bank 2007a). This implies that decisions and consequent actions must be enforced transparently with easy access to understandable information and imposed in accordance with established and accepted rules and

regulations (Sheng 2011). Good governance includes fair participation in the decision making process, permitting stakeholders to freely express their opinions. Given scarce resources, good governance also requires an effective and efficient use of resources, where an effort is made to reach a consensus around major decisions. Good governance also requires that the end result of all major decisions are equitable and in the best interests of the whole community (Sheng 2011).

The categories of good governance, presented by the UNESCAP and the World Bank, apply to all levels of governance; global, national, regional, organizational and even to households. The categories are also inter-related as it is for example unlikely that anyone in power can be responsive if not accountable at the same time. And if someone in power does not allow for fair partnership while dealing with social affairs s/he is not working transparently. Furthermore, there is an interaction between the governance of different sectors within a society. The Ministry of Health is the principal governing body of the health system; however other factors affect public health and health outcomes that fall under other ministries. Infrastructure, such as roads, is an example of something that can have significant impact on access to health care center, especially in rural areas in less developed countries and roads do not fall under the Ministry of Health. Other broader social and economic politics and legislative functions also play a role such as the preparation of new bills in ministries or parliaments regarding issues affecting nations´ welfare (Siddiqi et al. 2009). Even global governance can affect governance within national health systems such as in countries heavily depending on aid and are therefore capable of having an impact on the sustainability and performance of health systems and ultimately health outcomes (Siddiqi et al. 2009). However, as central governments are the main body responsible for nations' welfare, governance on national level plays the most important role for health outcomes in every society (United Nations 1993). This applies to all countries irrespective of their type of health systems providing public and/or private health care, as the national government makes the regulatory framework both for the public and the private sectors. This applies to health system financing mechanism and incentives (World Bank 2012), allocation of resources and accessibility of health care services. Furthermore, national governments formulate the general vision for national health, generate health policies, implement the policies and allow for partnership in the overall process.

Governance within health systems also plays an important role for health outcomes. As resources are limited, governance within health systems plays and important role for the utilization and distribution of the scarce resources. Therefore, governance within health systems is an important determinant for the overall efficiency and equity of the health sector (Brinkerhoff, Bossert 2008).

Methodology

The methodology adopted for the present study is descriptive and analytical which is based upon scientific tools such as quantitative and qualitative. The purpose of the present study is to explore and evaluate the status of health governance provided by the public health system and the pattern of utilisation of those services by the community of study areas. The logic behind the selection of the study area, sampling design, procedure of data collection and its analysis has explained in the subsequent sections of the study. From Upper Himalaya region Bhatwari block has 97 village, Middle Himalaya region Chaukhatia block has 167 and from lower Himalaya Bahadrabad block of Haridwar has 139 village.

Total 20 villages (5 village from Bhatwari, 8 from Chaukhatia and 7 from Bahadrabad) were selected from the total 403 village of all three regions which is 5% of the total village. The responders also selected based on number of household of villages as per the census 2011. Form Upper Himalaya region 111, Middle Himalaya region 102 while lower Himalaya region 382 responders were selected. The 20% responders was selected from the total of household (census 2011). The highest number of responders were selected from lower Himalaya because the number of householders is just double of both other regions. The villages were selected in a way that out of total villages 50% village is nearest to the selected block head office, and the another 50 % is distant from the block head office but the distant village is identified not only on the basis of distance but also located in the opposite direction from the block head office or any other government institutions. The purpose behind the selection of villages nearer to and far away from block head office was to know the impact of distance factor on the utilisation of services

Table 1: List of villages and Village wise total population and households and selected household

\\District	Name of block	List of selected village	Total population	No of house hold	Selected householders for as a responders
Uttarkashi	Bhatwari	5	2457	555	111
Almora	Chaukhatia	8	2078	511	102
Haridwar	Bahadarbad	7	10849	2977	595
Grand Total		20	15384	2977	595

Selection of Sample Households

The sample size of households for the present study has been fixed at about 20 percent of total number of household from the selected villages. The total house hold selected for study is 2977 (555 population selected from Uttarkashi, 511 from Almora and 1911 from Bahadrabad blocks) according to 2011 census the 20% percent sample size of the household number selected for study approximately is 595. Hence in the present study we have taken 595 sample population. Further this 595 sample households were distributed respectively according to the population of all three districts or regions

Collection of Data

Both primary and secondary data were used in the study. The study is mainly dependent on primary data. Hence relevant data was collected from field survey. Interview schedules were designed separately for selected households and personnel of households of the study area. Informal chat with village leaders, social workers, and local representatives was done to access the necessary information.

Data Processing and Analysis

All data checked for inconsistencies, missing values, and incompleteness, then entered into SPSS- 20 for further

analysis. Descriptive statistics, including frequencies and proportions, will be computed and presented in the form of text and tables. The binary logistic regression analysis will be performed to identify factors associated with health care utilization for the meaningful interpretation of results. Enter method will be used to select candidate variables having a P-value of <0.2 in the bi-variable analysis and entered to the multi variable analysis for controlling the possible co-founders. Adjusted odds ratio (AOR) with 95% CI will be estimated to show the strength of association. Data analysis and case descriptions would include description, statistics, cross tabulation, frequency, correlation etc.

Study Finding or Result

The highest number of BPL responders for Haridwar (23) while equal number of percentage were participated from Uttarkashi and Almora (3). The highest percentage illiterate and above then graduate in Almora while lowest percentage of illiterate and postgraduate responders from Haridwar. More 60% of responders were the between 19- 50 years in which 60% from Haridwar district. The largest number of responders below the age group of <18 years from Haridwar while Haridwar contributed lowest number of people age group >51 years. Across the districts only 20% responders were in government and private jobs while more 60% have involved in agricultural activities and own business while 20% are not doing anything. Interesting was that Individuals were in jobs in which less than 10% are in government department while rest 90 percent were in private sectors.

The statistics suggested that both mountain districts were more dependent on health services on government system while plane district was more dependent on private health system while across three districts or three regions (upper Himalaya, lower Himalaya and plan area) majority of population access private health care services. The findings also indicated 20% population also access health services from other stream in which more than 90% utilizing AYUSH services both formal and informal. The findings also indicated that local panchayat motivated people in early stage of disease for screening, isolation and treatment across the three districts. The study also revealed that AYUSH professionals are easily accessible at community level especially in upper and middle Himalaya regions while allopathic or modern facility is easily accessible lower Himalaya or plane regions. The local panchayat members also have very effective coordination with ASHA, ANM and Anganwadi workers which actually served at household across the three districts. During the discussion it also became very clear that large numbers of NGOs, Individuals and other organizations not only mobilized community for screening, isolation and treatment but also distributed humanitarian aids during the COVID time.

The findings also suggested that the members of local governance also play significant role to motivate people coming from outside the area/ district/ state for screening and isolation. Large number of village panchayat made their own role and regulation so that appropriate COVID behaviour can be ensured properly. Local governance also manage effectively the coordination between health system and community across the three districts.

The study also assessed the choice of health facility selected by people during the COVID time and also try to understand the reason of selection. Around only one third of population received primary health and investigation services within 5 kilometre range while rest 75% of population have to travel more than 5 kilometre distance to reach public health facility. The local governance play a crucial role not only motivating health workers and professional but also provide other support to their families and facilitate better coordination with higher authorities. The study indicated that dissemination of health education was also the only effective tool which can saved life of people. Accredited Social Health Activist educate community various level and make sure all villagers would follow COVID instruction strictly. The study findings suggested that in Uttarkashi more than half education program were organized by local panchayat members by the help of community health workers

Total 595 responders graded the performance of local panchayat based on their performance in respective areas. It clearly indicated that panchayat members basic life skills such as coordination, negotiation, financial management, planning and monitoring was below the 50% which also limited their performance certain extent. The finding also suggested that specific training and exposure on health program and interventions also totally negligible. The finding also revealed that the local panchayat members of Haridwar district was much better position to understand various aspects health as compare to Uttarkashi and Almora.

Discussion and Analysis

PRIs or local governance are the constitutional setup in India for grassroots development of the rural areas. Health is one of the subjects assigned to the PRIs in our country. In 1993 the government brought a new PRI Act with more powers and decentralisation to the local bodies. 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 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).

Further, locating health schemes 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 health sub-programmes. Health policy experts say that the health programme 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 health 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 health officials for various reasons. Thus, some amount of caution is needed in devolving requisite powers to PRIs within the health department. Moreover, one more serious and vital issue is related to the financial powers accorded to PRIs under the health 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 (Gupta, 2010).

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 up gradation 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 health programme. The majority of the health system 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 Uttarakhand. 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. Uttarakhand, the situation is very pathetic. Here, many Block/District hospitals are running without required doctors, equipment and other fundamental facilities and the PRIs are not really decisive.

The transfer of health system staff to administrative control under the PRIs gives a good result when elected representatives and health service provider's officer's work in good coordination. Understanding and sharing of information between these two segments is very vital. In the majority of cases, PRIs have played a good role in improving the functions of health facility in the state. The quality of service and the supply of medicines have also increased now. Moreover, absenteeism among medical staff has also decreased today because of the PRI role. The service of health providers and the paramedical staff also needs to be improved soon. However, the study found that better quality service has increased in many public health facility that are close to the urban areas of Uttarakhand.

Different standing committees on health are a vital and integral part of the PRI system. The Village Health and Sanitation Committee (VHSC) and the Arogya Raksha Samithi (ARS) are also playing both advisory and executive roles in improving government health programmes. The Committee work also includes sanitation, nutrition and funds allocation. The creation of new PHCs and the monitoring of disease mapping will be based on the recommendations of the standing committee on health. These committees are very well placed in the preparation of village health plans. Some of the industrialists and the individuals are also now donating money to the PRIs. The Health Management Service (HMS) is getting revenue from patients in the form of the 'user fee'.

The service norms of the health officials come under the jurisdiction of PRIs. However, they are continuing as state government employees and only their salaries are being distributed through the ZP. The State Health/District society is responsible for the recruitment, postings and promotion of health personnel within Uttarakhand. PRIs have limited control over health officials regarding the service norms. Only certain disciplinary actions can be initiated by PRIs against the PHI staff. These steps also need some modifications.

Given the mixed pattern of utilisation of healthcare facilities of both the private and public sectors, as reported by the respondents, an inquiry was made into the reasons behind the utilisation of private facilities. These reasons serve as clues towards understanding the gap in public health facilities. The prominent reasons cited are the unavailability of doctors in public facilities and the better treatment and related issues in private hospitals. Apart from these prominent reasons, the other reasons cited were convenience, time-saving, immediate attention and behaviour of the staff. This indirectly hints at the limitations of public health facilities. To bring about a change in the grassroots health system, different health providers need to be very responsive in terms of designing specific programmes to cater to the needs of the local community.

One of the major roles of the PRI is to implement various Government health schemes according to the local needs. The VHSC can play a key role in the effective implementation of the JSY scheme. The system should try to bring in an institutional framework and empower Panchayats for a sustainable movement. There is a need to educate elected local government functionaries on the need to support and encourage the movement with local NGOs. The State government should allocate more funds in the budgets. The funds should mainly be used to train doctors, nurses and volunteers and Panchayat functionaries to hold an health awareness programme for people and establish a network of facilities to promote institutional deliveries.

Conclusion and recommendation

The study concluded that local governance (three tier panchayat) is only one tool which can improve individual,

family, community, society and governance as well as government effectiveness, efficiency, transparency and accountability in the health outcomes. It is made very clear that local panchayat make significant difference in health outcomes at community level. World Health Organization also recognized the efforts made by millions of ASHAs (Accredited social health activist) – Community Health workers - in rural areas of India. The all ASHAs are the part of local governance and their selection, appointment, capacity building and health delivery supervise directly by Gram Panchayat. The multi nodal and multi modal health system also manage at community level through the Village Health Nutrition and Sanitation committee which is a subcommittee of Gram Panchayat.

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