Local Governments and the Public Health Delivery System in Kerala

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Lessons of Collaborative Governance

By

Jacob John and Megha Jacob

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Dedicated to all members of Jacobs' family
in Delhi and Kerala.

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PREFACE

The Kerala model of the public health delivery system clearly shows that coproduction between government and civil society or collaborative governance can improve health services, efficiency, equity, and better health outcomes. It indicates the significance of collaborative governance in tackling the problems in the delivery of public health services in a developing country. The imperative role of local government institutions in Kerala in the delivery of public health services, in the context of the joint responsibilities of local government institutions and the staff of public health institutions under the control of the state government of Kerala, is a lesson for many developing countries. In view of the shortage of resources in developing countries, it has become more urgent than ever before to adopt innovative techniques. This book discusses the successful experiences of collaborative governance in Kerala for the consideration of all developing countries in the formulation of action plans for the strengthening of public health delivery systems. The hospital management committee (HMC) of a public health institution under the leadership of the elected head of the concerned local government plays a vital role in its management. A HMC is a democratically constituted body that provides a platform for officials of local government and public health institutions to work jointly for the efficient functioning of a public health institution.

The initiatives of local government institutions have activated the spirit and willingness of communities to be involved in the improvement of public delivery systems. There is a good scope for mobilising local resources for the implementation of public health projects under the initiatives of local government institutions in developing countries. This book derives, by and large, from the insights of my study on the "Effectiveness of Panchayat Raj Institutions in the Health Care System of the State of Kerala," sponsored by the Planning Commission, Government of India. We are indebted to the officials and patients of various public health institutions, elected representatives, officials of local government institutions, the state government of Kerala, and representatives of non-government organisations for providing valuable information during our field survey. I also thank several individuals who have helped me in the process of writing this book. We acknowledge the invaluable inputs provided by Dr. N. J. Kurian and Dr. Jos Chathukulam, the research

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LIST OF ABBREVIATIONS

ANM	Auxiliary nursing midwifery
CHC	Community health centre
TH	Taluk hospital
DHS	The department of health services
DMO	District medical officer
HMC	Hospital management committee
IP	Inpatient
KMSCL	Kerala medical services corporation limited
NRHM	National rural health mission
OBC	Other backward communities
OP	Outpatient
PHC	Primary health centre
PHI	Public health institution
PRI	Panchayati Raj Institution
SC	Sub-centre

CHAPTER ONE

THE EFFECTIVENESS OF LOCAL GOVERNMENT INSTITUTIONS IN A PUBLIC HEALTH CARE SYSTEM: THE EXPERIENCE OF DEVELOPING COUNTRIES

The Experience of Developing Countries

Developing countries, irrespective of their differences in socio-political systems and levels of economic development, face several serious problems in the health sector. The current experiences of most developing countries witness the declining allocation of public funds for the health sector, increasing inefficiency in the utilisation of funds for public healthcare, inequality in the access to public healthcare services, and increasing costs of health services especially for serious and chronic illnesses and accidents.

There is an urgent need for institutional reforms in the health sectors of developing countries, even though some of them have initiated some reforms in a limited way. The inefficient use of public funds in the public health sectors of developing countries in the context of poverty, unemployment, inaccessibility of health services to treat chronic ills, and poor management of services require essential institutional reforms (Cassel 1995). The policies and strategies of developed countries cannot address these peculiar situations, and hence a new model that suits most developing countries is required. Many of these developing countries have a market-linked delivery system, while a few have a highly socialised delivery system. Though China has a socialised health delivery system, half of the medial expenses are financed by out-of-pocket payments, indicating a less-socialised financing system (Liu 2011). However, structured decentralisation has not yet been introduced in China.

Nigeria has a system of decentralised delivery of primary health services, though it has several problems, such as ambiguity in the sharing of responsibilities between the three tiers of local governments. The spread of the Ebola virus in four West African countries has revealed a weak link between the health governance system and local communities. The absence of the trust between the authorities of the health governance system and local communities has caused a delay in preventing the spread of Ebola (Mishra 2015)

In 2001, Indonesia introduced certain measures to improve its decentralisation exercise, and a significant number of central government functionaries were transferred to the local governments. However, the local governments have not yet been given the power to appoint or dismiss these personnel. Along with that, schools, hospitals, and health centres were transferred to the local governments. In the absence of external audits of local governments their accountability is lowered, resulting in the persistence of corruption, which is a matter of concern (Hoffman and Kaiser 2002).

In Pakistan there are no elected local governments, though the Devolution of Power Plan (DOPP) was introduced by the military government of General Pervez Musharraf in 2001. This decentralisation initiative has given local governments limited powers with respect to resource mobilisation and expenditures. The major attraction of this reform was the transfer of responsibility of delivering most public services, including health, to the local governments. This resulted in establishing the supremacy of local government over bureaucrats. But these reforms could not prove that the quality of the delivery of public services was improved (Cheema and Adnan 2005). Military governments in Pakistan tend to promote local governments; civilian governments do not show much interest in nurturing grassroots democracy. Decentralisation ought to form a part of a country's broader democratic and political culture. Local governments have a distinct sphere being closest to the citizens even on the lowest rung in a government. Moreover, they should be given sufficient administrative and financial autonomy, and unless these elements are institutionalised the sustainability of decentralisation programmes in Pakistan will be risky (Alam and Abuzar Wajidi 2013). Developing countries have varied experience when it comes to the role and effectiveness of local government institutions in public healthcare systems.

The Indian Experience

India witnesses widening differentials in health outcomes mainly caused by socioeconomic inequities and inequities in provision and access to health services. In spite of India's poor performance on health outcomes, its policies have increasingly focused on the establishment of a wide network of public health service delivery systems. Most of the Indian states have fared poorly in health outcomes. Several scholars have emphasised the need for addressing the persistence of inequities in health and access to health services in India. Key areas that require attention in this regard include the introduction of innovative systems of monitoring and the evaluation of progress towards equitable health outcomes and strengthening democracy in the functioning of public health delivery systems (Baru et al. 2010).

The Twelfth Five Year Plan (2012–17) has given emphasis to reducing the huge shortage of human resources in the health sector in India. It has been reported that the shortage of doctors is about 76%, alongside 52% of nurses. The draft of the National Health Policy 2015 (NHP) clearly indicates the need to enhance the NHP 2002's target of the overall public health expenditure from 2% of gross domestic product to 2.5%. It is pertinent to understand that the "out of pocket" (OOP) expenditure was 2% of gross domestic product in 2012 in India. It is a matter of serious concern that around 60% of OOP expenditure is incurred on medicines, which indicates the need for ensuring access to affordable medicines for the poor in the country. Mental healthcare and occupational health are the other components of healthcare that need the attention of the Government of India.

India has a three-tier form of government, comprising federal, state, and local governments. In line with the national policy of the federal government, the state and local governments implement public health programmes in India. Interstate variability in health outcomes is increasing and there are notable differences between the southern and northern states of India. The basic health infrastructure is missing in Jharkhand and Bihar, where the utilisation rate is abysmally low (23% and 7%, respectively) against the all-India figure of 33% (Goel and Khera 2015). The inability of a state government to address the problems in the area of the public health delivery system has compelled local government institutions to join hands with the state government in improving its functioning. The National Rural Health Mission (NRHM), a programme of the Government of India, envisages the implementation of healthcare programmes through a

decentralised healthcare system with the involvement of local governments and communities. In fact, panchayats, the rural local government institutions, play a critical role in the planning, implementation, and monitoring of the NRHM. The Eleventh Five Year Plan (2007–12) emphasised the need for the greater involvement of local government institutions, right from the village to the district levels, in the public health delivery systems of their respective jurisdictions. The NRHM has sought to empower the rural local government institutions at each level, i.e. village panchayat, intermediate panchayat, and district panchayat, to take leadership in controlling and managing the public health infrastructure at district and sub-district levels. The formation of a village health and sanitation committee in each village within the overall framework of the gram sabha (village assembly) is an essential step under the NRHM. The Twelfth Five Year Plan (2012–17) focused on strengthening the initiatives taken in the Eleventh Five Year Plan in respect of expanding the reach of healthcare and setting up a system of universal health coverage in India. Some initiatives have been started to ensure the community involvement in planning, management, oversight, and accountability with the active involvement of local government institutions and civil society.

The NRHM has sought amendments to acts and statutes in states to fully empower rural local government institutions in the effective management of the public health system, while also encouraging the devolution of funds, functionaries, and functions to these institutions to build capacities of elected representatives and user group members for the improved and effective management of the health system. As health is a concurrent subject in the constitution, state governments are majorly responsible for health provisioning. Under the NRHM programme, the district is the key institutional unit for the planning, budgeting, and implementation of public health services. Some states like Kerala, West Bengal, Maharashtra, and Gujarat have already taken initiatives in line with the guidelines of the NRHM, and their experiments have shown the positive gains of institutionalising the involvement of local government institutions for the management of the health system. There has been resistance from several other state health departments to devolve funds to local government institutions. Many states are quite slow in implementing these policy changes, with state level variations being a great concern.

Several scholars have analysed diverse problems in the health delivery system in the context of the role of the local government institutions. Anant Kumar (2008) investigated several grave challenges confronted by Jharkhand in the health sector. A sizeable share of the population remains

deprived of basic healthcare facilities, despite the NRHM and other health initiatives by the government and related agencies. The solution is to make the public health system accountable, affordable, and accessible through improved management of resources and the enhanced role of local government institutions and communities. According to Rama Baru et al. (2010), the review of the NRHM has shown interstate variations in the uptake of the programme and serious gaps in the availability, deployment, and retention of medical and paramedical personnel. The study found that, given the number of programmes focusing on the poor and socially marginalised, the need arises for enhanced public investments and greater synergies at different levels of implementation within and across ministries. Some scholars have examined the relationship between health expenditures and welfare outcomes in the quality of institutions. The devolution of powers, i.e. finances, functions, and functionaries, to rural local government institutions has enabled households in accessing the quantity and quality of healthcare services (Bhalotra and Clots-Figueras 2011). The devolution of powers to rural local government institutions has strengthened the gram sabha, resulting in the enhanced deliberations of health-related issues in the gram sabha and improved health services. Moreover, women, compared to men, benefit more from increased public healthcare due to the expenditure of Panchayats (Hans et al. 2015). Local government institutions and the community have to play an increasing role in the delivery of health services in India (Report of the Expert Committee on Leveraging Panchayats for Efficient Delivery of Public Goods and Services 2013).

Various policy initiatives taken within the framework of the eleventh and twelfth five year plans have resulted in the enhanced role of local governments in the delivery of public health services in a few states. In a state like Kerala, local governments and the health personnel of the state government hold joint responsibilities in the public health delivery system. So far, no attempt has been made to carry out a study on the effectiveness of local government institutions in the healthcare system in the context of any Indian state with a focus on the impact of duality and the role of bureaucracy. It is important to study the local government institutions with respect to the functioning of public health institutions in India, a prominently developing country. In this book, Kerala's health model has been examined in detail.

Experience of Kerala: a Unique Dual Role System in the Management of Public Health Delivery Services

Kerala, one of the 29 states of India, has a distinct public health delivery model. Dreze and Sen attributed the achievements of Kerala to social development, in comparison to other Indian states where they happened through "public action." "Public action" means not only state initiatives, but also social actions taken by members of the public (Dreze and Sen 1989; 1995). The development experience of Kerala proved that social security can be achieved through public action that aims at promoting the basic entitlements and capabilities of people (John 2009). However, the "public action," which has contributed much to the improvement of quality of life in Kerala, lost direction during the latter part of the 1990s (Oommen 2000). "Nothing, arguably, is as important today in the political economy of development as an adequate recognition of political, economic and social participation and leadership of women. This indeed is a crucial aspect of development as freedom" (Sen 1999). It was during this period that state government, under the framework of the 73rd and 74th Constitution Amendment Act, devolved several powers to local government institutions. The inability of the state government to address the problems in the area of public health delivery system efforts compelled local government institutions to join hands with the state government in improving the functioning of public health institutions. The local governments in Kerala are given most of the institutions and functions relating to social and human development. All the institutions barring medical colleges and big regional hospitals have been transferred to the local governments (John 2006). A study of Kerala's decentralisation of the health sector (Narayana and Hari Kurup 2000) argues that three basic problems of decentralising the healthcare sector—namely spillover effect, role and relevance of a pre-existing body (hospital development committee [HDC]), and the minimum level of healthcare service to be provided by the healthcare institutions—have not been adequately addressed. This study analysed the decentralisation of the healthcare sector in Kerala and the associated problems as perceived by the elected members of local government. Various issues of the public health delivery system in Kerala were highlighted in some of the recent studies. These studies emphasised the need for enhancing investments by the government in the social sectors focusing on health. The government of Kerala has to work out an agenda for the equitable distribution of health services along with crafting a credible public health system in the state. It should strengthen public

health institutions and improve primary health centres epidemiologically and financially (John 2011).

Scope of the Study

Kerala is the front-running state that devolved powers to local governments in line with the letter and spirit of the Constitution of India. Kerala is the only Indian state that devolved powers to local governments in the health sector, and the state has increased the capacity of local governments in the area of health institutions. The transfer of public health institutions from state government to local governments, namely panchayats and municipalities, has led to the participation of local communities in the management of public health institutions. The transferred healthcare delivery institutions are not administratively under the complete control of the panchayats or municipalities as certain powers remain with the state government, resulting in dual controls and responsibilities. The system of dual responsibilities and controls of local government institutions and state-run public health institutions has provided a reasonably good level of public health services in Kerala. Unlike most of the Indian states, Kerala has devolved more powers and functions for the management of health services to local government institutions. Decentralisation of the health care sector in Kerala has caused certain peculiar situations, such as dual controls over the staff and duality of monitoring and responsibilities. In this context, it is quite relevant to capture the picture of the functioning of public health institutions in Kerala. Local government-led community participation in the delivery of public health services is a unique experience. Some scholars have reported that coproduction between government and civil society or collaborative governance can improve health services, efficiency, and equity, providing better health outcomes (Kickbusch Ilon and Gleicher David 2012; Dubé L et al. 2009). A field survey-based study has been carried out to assess the performance of the functioning of public health institutions in Kerala. The current study covers a unique model of a better-performing public health delivery system prevailing in Kerala while most of the other states witness widening differentials in health outcomes, mainly caused by inequities in the provision and access to health services. With the collaborative efforts of the government of Kerala and local government institutions, several health projects are executed with well-designed monitoring and evaluation systems towards equitable health outcomes. Strengthening democracy in the functioning of the public health delivery system is another key aspect of this approach. We discuss the new system of collaborative governance

of the public health delivery system with reference to its special significance in a developing country.

We have also documented a few successful experiences of hospital management committees set up under the joint leadership of the elected heads of the local government institutions and medical officers of the respective public health institution where a state government official looks after the management of a public health institution in Kerala. There is a detailed discussion in this book on the hospital management committee, a democratically constituted body that provides a platform for the elected representatives and officials of local governments and health officials to work jointly for the efficient functioning of public health institutions. The study covers several other innovative ways of delivering health-related projects with the involvement of a panchayat- or municipality-led local community. It highlights the scope for replicating the model of a collaboration of local government and state-run public health institutions in other Indian states as well as select developing countries.

The basic parameters of the present study involve three key features: local government institutions, health departments, and public health institutions. Local government institutions are local-level bodies to identify, formulate, implement, and monitor development and welfare programmes. One of the major functions of the rural and urban local government institutions, according to the 73rd Constitution Amendment (Article 243 G) and the 74th Constitution Amendment (Article 243 W), respectively, is to prepare plans for economic development and social justice and implement them. Under 73rd and 74th Amendments of the Indian Constitution, two separate schedules were added (Eleventh Schedule and Twelfth Schedule) listing 29 subjects for rural and 18 subjects for urban that could be devolved to the local government institutions. In the case of rural local government institutions, out of these 29 subjects the 23rd is about health and sanitation, including hospitals, primary health centres, and dispensaries. For urban local government institutions, out of 18 subjects, 6th is public health, sanitation conservancy and solid waste management. The main objective of the 73rd amendment was to create a new rural local government system, namely the panchayat with people's participation providing good governance at the grassroots level. On the other hand, the main objective of the 74th amendment was to create a new urban local government system, namely a municipality with people's participation providing good governance at the grassroots level. All 29 subjects mentioned in the eleventh schedule of the constitution have been transferred to the rural local government institutions in Kerala, and their

functions are clearly demarcated among the three tiers of rural local government institutions. Similarly, all 18 subjects mentioned in the twelfth schedule of the constitution have been transferred to the municipalities in Kerala, along with the demarcation of their functions. The present study also examines how local government institutions and public health institutions have been performing their obligations with respect to delivery of the public health services.

Objectives

The main objective of the study is to assess the effectiveness of local government institutions in the healthcare system in Kerala. The specific objectives are carrying out a study on the role of local government institutions in the healthcare systems in Kerala and critically examining the structure of public health institutions and devolution of functions, funds, and functionaries to local government institutions. It also analyses the role of bureaucracy of state governments and examines the impact of duality of responsibilities and controls in the healthcare system, discusses the access to health services at each level of health institutions of various social classes, gender, and age groups, and identifies problems and deficiencies on account of the duality of controls and responsibilities, suggesting measures to improve the rural health delivery system. The study formulates an action plan for the increased participation of the local government institutions in the health delivery system and draws lessons from the experience of Kerala, the state that has transferred its public health institutions to local government institutions well in advance, providing the "best practices" of local government institutions for dissemination among various Indian states and developing countries.

Empirical Study: Methodology

This study is primarily empirical. Primary data was collected from public health institutions and local government institutions through a sample survey and case studies. The respondents of the survey included officials, beneficiaries, and other stakeholders of rural public health institutions and elected representatives, officials, and other stakeholders of local government institutions. Six districts of Kerala have been selected out of the existing 14 for the purpose of the field study. Their selection is based on the following criteria:

- The selection of districts from northern, central, and southern regions
- The selection of distinctive districts from coastal, plain, and hilly regions
- Scanning the best performing district and poor performing district in terms of health indicators

The selected six districts are Alappuzha, Kottayam, Malappuram, Pathanamthitta, Thiruvananthapuram, and Thrissur. From the selected districts, public health institutions such as District Hospitals, Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub Centres (SCs), along with their respective local government institutions, have been studied in detail. The selection of these institutions was carried out using the random sample method. The primary data covered the period from 2005 to 2014. The secondary data covered the period after the enactment of the 73rd and 74th Constitutional Amendment Act, 1992.

Primary Data*:* Utmost care was given to covering districts from the northern, central, and southern regions, along with those in coastal, plain, and hilly regions. Moreover, the categories of best and worst performing districts in terms of health indicators were also included (see Table 1.1 below).

From the six selected districts, different tiers of public health institutions were taken for a detailed study. The public health institutions are classified into four broad categories, which are:

- District hospital
- Community health centre (CHC)/ Taluk hospital
- Primary health centres (PHC)
- Sub centres (SC)

All the categories of public health institutions were covered by the survey. From each district, 1 district hospital, 2 community health centres/Taluk hospitals, 4 primary health centres, and 6 sub-centres were taken. Thus, a total of 6 district hospitals, 12 community health centres/Taluk hospitals, 24 primary health centres, and 36 sub-centres were studied. The selection of district hospitals, community health centres (CHCs)/taluk hospitals, primary health centres (PHCs), and sub-centres (SCs) was carried out using the random sample method (see Table 1.2 below).

Table 1.1. Selection of districts for the field study

Total number of districts in Kerala	14
Number of districts covered by sample study	6
Criteria for selection of districts purposively	• Cover district from northern, central, and southern regions • Cover district from coastal, plain, and hilly regions • Cover best-performing and poor-performing districts in terms of health indicators
Selected Districts	• Alappuzha • Kottayam • Malappuram • Pathanamthitta • Thiruvananthapuram • Thrissur

From public health institutions, respondents covered by the survey were medical officers, health officials (other than medical officers), health workers, and patients/beneficiaries. Out of the surveyed 96 medical officers, 78 were from allopathic institutions and 18 were from ayurvedic and homeopathic institutions. A total of 612 beneficiaries were interviewed, out of which 540 were treated at allopathic institutions with the remaining 72 at ayurvedic and homeopathic institutions.

Table 1.2. Sample survey: selection of public health institutions

Public Health Institutions	Health Institutions (No.)	Medical Officers of PHI (No.)	Health officials/ health workers (other than medical officers) (No.)	Patients (No.)
District hospital	6	6	6	120
CHC/Taluk hospital	12	12	12	120
PHC	24	24	24	120
SC	36	36	36	180
TOTAL (a)	**78**	**78**	**78**	**540**
Ayurvedic hospitals/ dispensaries	12	12	12	60
Homeo hospitals/ dispensaries	6	6	6	12
TOTAL (b)	**18**	**18**	**18**	**72**
Total Public Health Institutions ([a]+[b])	**96**	**96**	**96**	**612**

Note: Ayurvedic and homeo hospitals/dispensaries are covered by the survey as these institutions are also transferred to local government institutions.

After the selection of public health institutions, the respective local government institutions were taken for a detailed analysis. The selected public health institutions were located within the jurisdiction of the selected local government institutions.