

Local governance system for management of public health facilities: Functioning of *Rogi Kalyan Samiti* in North Eastern States of India

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Abstract

In India, the National Rural Health Mission envisaged of having committees with civil society representation at all publicly financed hospitals known as *Rogi Kalyan Samiti* (RKS), with mandate to enhance governance in hospitals. There are limited evidences about functioning of these committees in many states, especially in North Eastern (NE) states. This paper analyses the perspective of RKS members and relate to changing community- health system structure for improved governance. The study was conducted in three states Manipur, Meghalaya, and Tripura of NE Region of India. Using stratified sampling design, 14 RKS/facilities were selected from Manipur, 15 from Meghalaya and 11 from Tripura. Two key informants (mainly, president/secretary of RKS) were interviewed using a semi-structured pre-tested questionnaire in local language. The major areas of RKS operationalization identified include; constitution, finance management and activities related to health systems strengthening. RKS was constituted during 2006-07 with governing body following issuance of government of India guidelines. The funds (grants and User Fee) were utilized for purchase of furniture, bio-medical waste management etc. The governing body meetings focused mainly on ensuring services; in Tripura 72% of RKS had regular meetings and have shown improvement in functioning of facilities. Formation of RKS model paved way to a new beginning for strengthening health system with involvement of local leaders, civil society to improve governance. The functioning is derived by availability of resources, capacity of committee members and the bureaucratic process. Revision in functioning of RKS model is essential towards self-sustainability and bridge between community-health systems.

Keywords: *Rogi Kalyan Samitis*, Patient Welfare Societies, Local Governance, Public health facilities, India.

Introduction

Health facilities in India were often criticized for poor management in ensuring health care needs of the community.¹ With the introduction of reform initiatives during 1991, local management of resources at health facilities, purchase of health services, drugs, and other social protection measures were reinforced.² Following the implementation of National Rural Health Mission (NRHM) in 2005, *Rogi Kalyan Samitis* (RKS) or Patient Welfare Society (PWS) or Hospital Management Committee (HMC), were formed at all publicly funded facilities. An unconditional grant is provided by the Ministry of Health and Family Welfare, based on the level at which the facilities are functioning with the mandate to enhance governance in hospitals and ensure services.³

A total of 31,516 RKS societies are registered in India (as on 31st Dec 2013) of these 1,943 committees are registered in North Eastern States.⁴ Following registration, the functionality of these committees is not clearly understood, like roles and responsibilities of members, increasing accesses to services, and accountability. This paper here analyses the perspectives of RKS members and suggestive approaches for changing community-health system structure for improved governance.

Practice Points

- Health facilities in India were often criticized for poor management in terms of ensuring adequate service delivery and not addressing health needs of community.
- *Rogi Kalyan Samitis* (RKS) was first piloted in 2006 in order to strengthen health systems and encourage community participation to increase accountability, generate resources and improve management of hospital with greater autonomy of decision making process.
- It was noted that documentation of decision making process during the Governing Body and Executive Committee meetings were limited in relation to those activities that have financial implications.
- Budgetary allocations and utilization of locally generated resources was low and dependent on the capacity of the leadership and/or members.
- RKS as local governance model is a futuristic until the members/leadership appreciate the powers vested in these committees.

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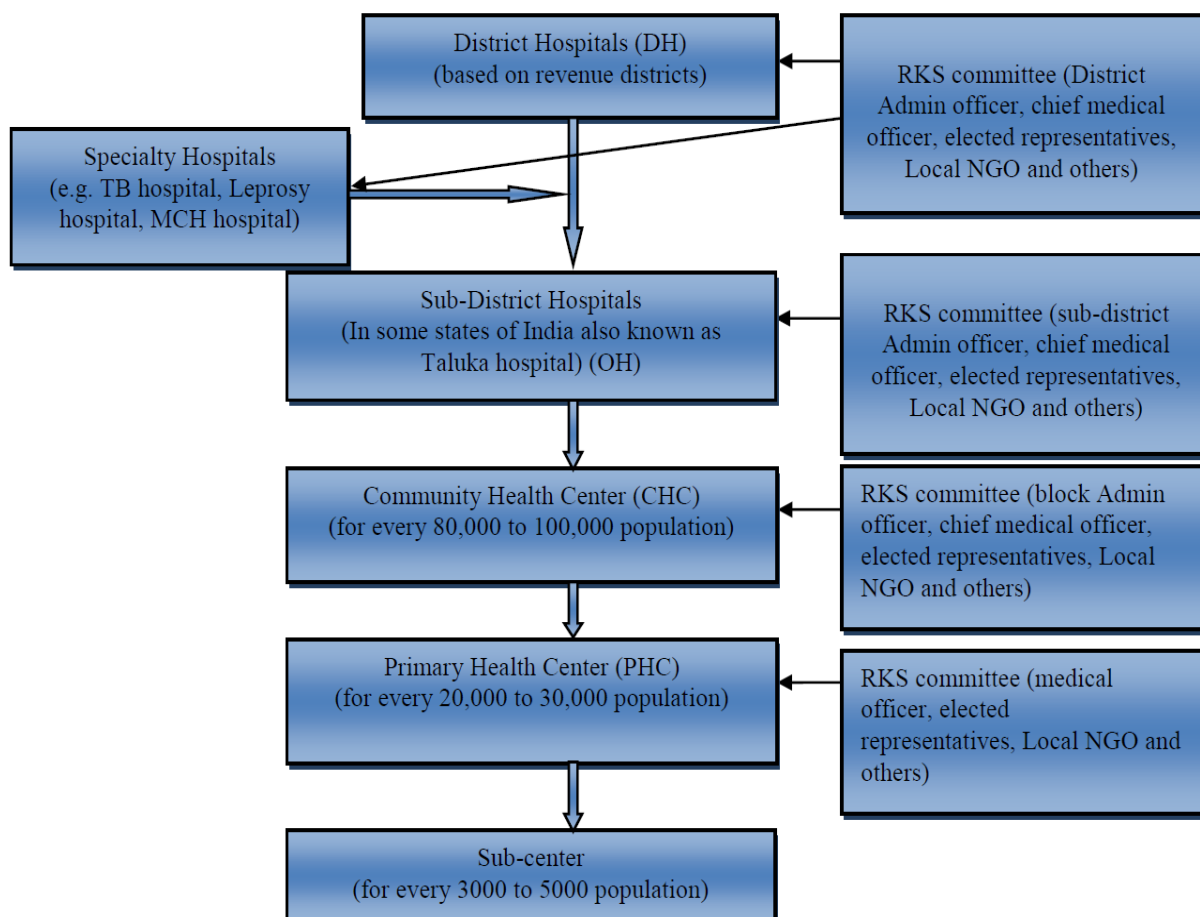
Rogi Kalyan Samiti model of India

The *Rogi Kalyan Samiti* was first piloted in Madhya Pradesh, as a facility based institution mechanism to improve management of hospital with greater autonomy of decision making.⁵ This model had many revisions to be adopted across country before being part of the NRHM in 2006. Currently, the society is formed with representations from people’s representatives, non-government organizations, local elected leaders and officials from the public health system. The objective of formation of RKS is multifaceted which could be broadly grouped under as follows: (a) health systems strengthening – through accountability of service provider, bringing in dimensions of transparency, facility up-gradation, generate resources; and (b) community participation – citizen carter, accountability to system through constant feedback and voluntary service provision to facility. These can be grouped into the larger discussion of 'Health Governance'. Health Governance, as discussed above involves inputs from all sections of society, civil, public and community towards achieving a common goal.⁶ The key indicators that one can use to measure governance are listed as, dynamic leadership, degree of peoples participation, development framework, effective service provisions, transparency, and monitoring.⁷ Many of these indicators though not explicitly stated are within the framework of governance and are part of the RKS mandate.

The functioning of RKS is through a formal registration of committee under the Society Registration Act of 1860 in the name of the respective health facilities.⁸ The health facilities in India are established based on the population norms and RKS are formed at the level of Primary Health Center (PHC) and above (Fig 1). Under the core activities, RKS has to address the needs of the patients at respective public health facilities and infrastructure needs of facility to ensure quality service to patients; ensure/monitor cleanliness and maintenance of hospital building and premises. Opportunities are also available for engaging private providers available locally for clinical services (e.g. Anesthetic services), non-clinical services (e.g. Housekeeping services), and diagnostic services. Other activities would include resource generation through community donations, User Fees, fees for special services etc.

The RKS model has an inbuilt decision making process, First - the Governing Body (GB); that committee meet annually to review the process of enhancing services like hospital policy formulation, contracting-in or contracting-out of services, exemption policy for User Fees collection, resource generation (arriving at fee structure for various services at facility). Secondly, the Executive Committee (EC) would implement the decisions made by governing body and update about the progress during quarterly review

Figure 1: Schematic Outline of Health System structure and RKS



meetings. Thirdly – the Monitoring committee (MC) is an independent body derived as subset of governing and executive body involving other key stakeholders to review the progress of implementation and advice on policy arenas.

Materials and Methods

The North East Regional Resource Center (NERRC) which is a technical support agency for implementation of NRHM in the region undertook the study in three of eight North Eastern states of India during March/April 2011 over a period of three months. The first state was Manipur (105 registered RKS committees) and the second was Meghalaya (146 registered RKS committees) and the third, Tripura (117 registered RKS committees). Using stratified sampling method, three districts were randomly selected from Manipur, and from these districts 14 facilities which had registered RKS were also selected randomly. By adopting similar method, 15 facilities were randomly selected (from three out of seven districts) in Meghalaya and 11 facilities from (from two out of four districts) the state of Tripura (Table 1).

A semi-structured pre-tested interview questionnaire tool (in local language) was used for interviewing with two key informants identified per facility involved as member or as any other destination in the RKS structure. Consent was obtained before administering the tool in local language of respective state. During the course of study, other members of RKS and the health facility officials were also interviewed. In addition to these researchers also interacted with the program officers at the district, sub-district and state level to

gather insights about the functioning of RKS. Information regarding meetings, expenditure, stock and others were verified to validate the responses.

Overall, a cross-sectional survey methodology was adopted to gather information in major areas of RKS operationalization; constitution of bodies, finance management and activities related to health systems strengthening.

Results

Constitution of bodies

RKS in Manipur and Meghalaya was formed in the year 2006-07 with a governing body (GB) and an executive committee (EC). Medical Officers of respective facilities were member secretary of governing body in all three states. In Tripura, RKS was constituted in the year 2006-07 with only governing body. Interestingly in Tripura all the facilities with RKS had more than 10 governing body meetings and the minutes were used for analysis. More than 50% facilities in the state of Meghalaya had less than 10 meetings (Table 2). Monitoring committee was only found in Thoubal and Chandel district hospital along with reports.

About 60% of facilities in Meghalaya never conducted EC meeting. Only in facilities of Thoubal district of Manipur 100% EC meetings was observed. Whereas in Tripura all most all health facilities had conducted EC meetings and the minutes of these meetings were available. Nearly 72% of RKS had regular meetings and has shown improvement in functioning of facilities with increase in OPD load by 20% and IPD load by 10%.

Table 1: Selected health facilities in study districts

State	Manipur		Meghalaya		Tripura	
	No.	Sample	No.	Sample	No.	Sample
DH	8	1	7	1	2	2
CHC	16	4	29	4	11	1
PHC	80	8	109	8	79	3
Other Hospitals (OH)*	1	1	3	2	15	5
Total	105	14	148	15	107	11
Percentage		13%		10%		10%

OH includes Sub-divisional hospitals, speciality hospitals, etc. DH: District Hospital, CHC: Community Health Center, PHC: Primary Health Center

Table 2: Number of Governing Body (GB) and Executive Committee (EC) meetings held in study districts

States	Districts	Since formation								In last six months					
		GB	EC	GB	EC	GB	EC	GB	EC	GB	EC	GB	EC		
		<5	Never	5 to 10	10 to 15	15 to 20 (>20)	At least one	2 or > 2	Never						
Meghalaya	Jaintia Hills	2	4	1	1	0	0	3	1	3	0	3	2	0	4
	West Khasi Hills	3	4	2	1	1	1	0	0	1	1	5	1	0	4
	South Garo Hills	1	2	2	1	0	0	0	0	2	1	0	0	0	2
Manipur	Imphal West	0	2	1	2	1	0	2	0	1	2	3	7	0	2
	Thoubal	0	0	0	0	0	0	7	7	0	0	7	0	0	0
	Chandel	0	2	1	1	1	0	1	0	0	1	3		0	2
Tripura	North Tripura	0	0	0	0	4	0	1	6	2	2	1	4	2	0
	South Tripura	0	0	0	0	1	0	5	5	3	2	3	1	0	2

Table 3: Health Facility constitution with members of bodies and percentage balance on allocation

State	Type of Facility	Year	Governing Body		Executive Committee		Total fund*	% of balance**
			Chair Person	Member Secretary	Chair person	Member secretary		
MG	OH	2006	SDO	MS	SDO	MS	1.3	0%
MG	CHC	2007	SDO (Civil)	MOIC	Does not exist		1.1	0%
MG	PHC	2007	BDO	MOIC	Does not exist		0.8	0%
MG	DH	2006	DC	MS	Does not exist		2.0	0%
MG	PHC	2007	BDO	MOIC	BDO	MOIC	0.8	1%
MG	OH	2007	DC	MS	DMNHO	MS	1.3	4%
MG	CHC	2007	BDO	MOIC	Does not exist		1.1	4%
MG	PHC	2007	BDO	MOIC	Headman	MOIC	0.8	5%
MG	PHC	2008	BDO	MOIC	Does not exist		0.4	6%
MG	CHC	2007	BDO	MOIC	MO	MOIC	0.8	8%
MG	PHC	2007	BDO	MOIC	Does not exist		0.8	9%
MG	PHC	2007	BDO	MOIC	Does not exist		0.7	21%
MG	PHC	2007	BDO	MOIC	Does not exist		0.8	22%
MG	PHC	2007	BDO	MOIC	Does not exist		0.7	25%
MG	CHC	2007	SDO	SDMNHO	Does not exist		0.5	26%
MN	OH	2006	NGO member	MS	NGO member	MO	2.5	0%
MN	PHC	2006	Village head	MOIC	Does not exist		0.9	0%
MN	PHC	2007	Village head	MOIC	MOIC	Pharmacist	0.9	0%
MN	PHC	2007	MOIC	Village head	Village head	MOIC	0.9	1%
MN	CHC	2006	BDO	MOIC	MOIC	SMO	1.3	2%
MN	CHC	2006	SDO	MOIC	Nagar Panchayat	MOIC	1.3	4%
MN	PHC	2007	Nagar Panchayat	MOIC	MOIC	MO	0.9	5%
MN	PHC	2007	Village head	MOIC	MOIC	GNM	0.9	5%
MN	PHC	2006	Village head	MOIC	No Executive committee exist		0.9	6%
MN	CHC	2006	Nagar Panchayat	Mo-IC	MOIC	SMO	1.3	7%
MN	CHC	2006	SDO	MOIC	MOIC	SMO	1.3	8%
MN	PHC	2006	Village head	MOIC	Does not exist		0.9	10%
MN	DH	2006	DC	MS	MS	SMO	2.5	13%
MN	PHC	2006	District Panchayat	MOIC	No Executive committee exist		0.9	24%
TR	PHC	2008	Does not exist		Panchayat	MO (i/c)	0.2	0%
TR	OH	2006	Does not exist		BAC	SDMO	1.3	0%
TR	CHC	2006	BDO, Kumarghat	MO (i/c)	Panchayat	MO (i/c)	1.3	1%
TR	PHC	2007	Does not exist		BAC	MO (i/c)	0.2	3%
TR	DH	2006	DM	MS	District Panchayat	MS	2.5	7%
TR	OH	2007	SDM	SDMO	BAC	SDMO	1.3	13%
TR	DH	2007	District Panchayat	MS	SDM	MS	2.5	16%
TR	OH	2006	Does not exist		SDM	SDMO	1.3	20%
TR	OH	2006	Panchayat		MO (i/c)	SDM	1.3	25%
TR	PHC	2006	BAC	MO (i/c)	MO (i/c)	Panchayat	0.2	1%
TR	OH	2007	Panchayat		MO (i/c)	Panchayat	1.3	Na

MG = Meghalaya, MN = Manipur, TR – Tripura, MO- medical officer, MOIC – medical officer in-charge, SDMO – medical officer, MS – medical superintendent, GNM – graduate nurse midwifery local community based health worker, Panchayat – local people representative body; Administration - Sub Divisional Magistrate (SDM), District Collector (DC), Sub Divisional Magistrate, SDO – sub divisional officer, BDO – block development officer Chairman, Block Advisory Council - BAC. (One USD = 45 INR in 2010) PHC= Rs.150,000/- (Untied Fund- Rs.25,000 + Maintenance Grant - Rs.50,000 + Corpus Fund- Rs.100,000/-) CHC=Rs.250,000/- (Untied Fund- Rs.50,000 + Maintenance Grant -Rs.100,000/+ Corpus Fund Rs.100,000) Source: NRHM website. Data as on 31st December, 2010

*Total fund received in 5 years (2006-07 to 2010-11) (Rs in Millions)

**% of balance available (after 5 year)

Financial Management

RKS in the state of Manipur received 100% grant entrusted to the committee from 2006-07 to 2010-11 and 90% of this grant was utilized. Additional resources were generated through User Fees levied for services. On an average from the 14 facilities included in study, a total of Rs 32,176 (1USD = INR 62) was collected in the financial year 2010-11.

The second state Meghalaya, RKS funds were released in the year 2008-09. The utilization of finances were almost 100% and User Fee was one of the core resource generation activity.

On an average from 15 facilities included in study, about Rs 66,000 (USD 1074) was generated. Highest amount was collected from the district hospital (Jowai Civil Hospital – Jaintia Hills) of about Rs 540,000 (USD 8794) in 2010-11. In one of the PHC, (Nartiang), community people had contributed for purchase of equipment's in the facilities through RKS which accounted for Rs 160,000 (USD 2605) over the last 5 years.

The third state Tripura received 100% grant from year

of formation in 2006-07. Data on User Fees collected could not be retrieved from PHCs visited. However, district hospitals had collected more than Rs 300,000 (USD 4886) in the year 2010-11. The funds were utilized for purchase of furniture, computers, and stationeries, and other equipment's like LCD, phototherapy unit, electronic weighing machine, etc.

Overall, the district hospitals and other hospitals showed highest percentage on balance of budget against allocation. The balance of amount is inclusive of the User Fee amounts pooled into RKS. Whereas in Community Health Centers (CHCs), the average balance of budget against allocation was less than 10%. The PHCs from Meghalaya and one PHC from Manipur had balance amount >20%. Four PHCs, District Hospitals (DHs) and one CHC had 'Zero' budgetary balance in the assessment year. However, we couldn't co-relate with the year of constitution, and with decision making process.

Health Systems strengthening

Data analysis in area of health systems strengthening highlight that budget allocated was utilized for procurement of furniture's and equipment's, 10% of amount was spent on painting. Overall, the cleanliness and hygiene aspect was still ignored at facilities. All most all committee visited; lacked, the review of out-patient and in-patient case load, community out-reach activities of health system. Issues related to patients for e.g., transport, waiver of user fees, were addressed through governing body resolutions. All most all medical officers/programme officers interacted during the study at health facilities informed, the meetings focused mainly on ensuring services, especially transportation services. Among other than infrastructure support, 100% facilities from Manipur received support for procurement of First Aids Kits and in organizing health camps. Support for similar activities was extended to facilities of Meghalaya (100% for First Aids and 60% for organizing health camps).

The supportive supervision visits was informed by officials from 9 out of 15 facilities included in Meghalaya and their visits were limited to record verification. In state of Manipur, the block programme management unit of Thoubal and Chandel district had conducted three monitoring visits. Officials from Tripura informed about visits by supervisors, however no records were available for analysis during the study period.

Discussion

The National Rural Health Mission aimed at institutionalizing 'Local Governance' system for health at respective facilities; wherein communities decide on services, and also enable in health-systems strengthening through a participatory governance approach. Local governance in border term represents collective decision and action to address needs of community within the accountability framework to

bridge community-system gaps.⁹ RKS or PWS as institutional mechanism as primary structures to govern, execute and monitor activities of health facility locally. The governing body has the mandate of having a development framework, strategies (resource generation) and operational framework for effective implementation, and ensure transparency. The executive committee ensures implementation of day-to-day functioning. Third structure being the community monitoring mechanism of services provided. From an economist perspective, these structures are reviewed as an input based model to increase utilization of resources based on local needs for an expected output of quality services.¹⁰

The constitution of the Governing Body and Executive bodies were coterminous with the issuance of Government of India guidelines. The release of budget for respective committees was also linked with the registration of committees under the 'societies act' of India.⁸ In our study, we highlight three combination models – one where GB chairperson is from the administrative system (Meghalaya), two GB chairperson from panchayat (Manipur), third a mixed group (Tripura). Irrespective of existence of committees, all facilities conducted governing body meetings (except for two in Tripura). One of the limitations of this study is that the minutes of governing body meetings were not analyzed due to non-availability of record and therefore we couldn't compare between the models.

The study findings are in line with the report of the Comptroller and Auditor General (CAG) that highlight; RKS had one committee as governing body/executive body and meetings were not held on regular basis.¹¹ These findings could be related to findings from evaluation report of government of Meghalaya, where organizers expressed difficulty in organizing the meetings and were dependent on availability of Chair Person (table 3).¹² However, in Maharashtra, RKS had two bodies with defined roles and responsibilities (GB to formulate policies and EC to execute decisions).¹³ As a result committees were able to utilize the grants available at the institutions/facilities and found to have effective co-ordination in implementation. During the discussion with interviewee we were informed that members were more focused on budgetary items than non-budgetary items in GB/EC meetings. Under non-budgetary items focus was on ambulance support services given the geographic terrain of region. Similar finding was observed in study from Uttarkhand where focus was on ensuring ambulance services to transport patients from community to healthcare facilities.¹⁴

Finance management is driven by the guidelines of ministry of health and family welfare, government of India. In a federal structure states have authority to review and revise the guidelines as an in additionally to grant. The state of Rajasthan revised budgetary allocations to include recurring and non-recurring expenditure under the croupous grant.¹⁵ Similar guideline is issued by government of Tripura directed

officials for regular meetings and removed user fees at primary-level facilities (PHCs).¹⁶ This information may be co-related with the regular meetings in state of Tripura and 'Zero' user fees at PHCs. However, the district Hospitals in Tripura had collected nearly Rs 300,000 and had utilized for purchase of furniture's. Study from Maharashtra, regardless of the performance of health facilities the utilization of User Fees was limited.¹³

In many study facilities considerable amount of funds were available to spend, as the utilization of the funds were low. We were informed that members depend on direction of signatories (chairperson) for utilization of grants as their understanding about roles/responsibilities was found to be limited and similar finding was observed in a study from Druvesh, Thane district, Maharashtra.¹⁷ Evidence from developed state – Tamil Nadu highlight that together with optimal utilization of grants in facilities showed improved services, infrastructure, and equipment's compared with facilities without RKS.¹⁸

In order to sustain RKS intervention, the capacity of RKS members needs to be enhanced in areas of health-care services, system strengthening and finance management. A revision in functionality of RKS model is essential directing the roles towards governance. One can review the current model along the lines of indicators proposed by UNDP directing towards assessing the capacities of managers to changing health systems scenario in India. The reforms involving multi-stakeholder partnerships and collaborations with a new set of management skills is the need of hour.¹⁹ Newer study designs or tool kits need to assess the governing functions of health program managers and management committees in delivering equitable health services.

Conclusion

The RKS model as changing community- health system structure for improved governance is an innovative intervention. Formation of these models has paved way to a new beginning for strengthening health system with increased involvement of local leaders, civil society etc to improve local governance. However, the functioning is derived by availability of resources, guidelines, committee members and the bureaucratic process. Facilities where local leaders were involved in budgetary utilization was 100% and were also able to generate resources locally. The capacity of the members of the respective bodies needs to be built for enhanced understanding of healthcare delivery system.

Approaches, of supportive supervision would be an option to assess their roles and responsibilities to address the needs of the community. Though this model is replicated across the country there are variations in performance that needs to be acknowledged. More research is needed to bring about revisions in RKS model that make this model self-sustainable.

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Conflict of interest

The author has declared that there is no competing interest.

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