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EFFICIENCY OF RKS AND OBSERVE THE AVAILABILITY AND UTILIZATION OF FUNDS BY RKS IN PHCS OF RAIGAD DISTRICT

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Abstract

Background: The existing health programs before the launch of NRHM, were vertical programs and lacked community ownership which remarkably impacted levels of efficiency, accountability and effectiveness.

Objective: To study the efficiency of RKS and observe the availability and utilization of funds by RKS in PHCs of Raigad district.

Methods: Study was conducted at Primary Health Centres (PHCs), located in Raigad District, Maharashtra State, which is the district under which Department of Community Medicine, M.G.M. Medical College, Navi Mumbai is located. Simple random sampling using table of random numbers**.**

Results: RKS is formed in all sampled PHCs & hence the scheme has lead to the involvement of the local self government. The local leader's involvement has lead to the external monitoring. However these leaders are more concerned about the services to their people than the general population in totality. Hence the politicization of the scheme may occur it is not implemented in its original spirit. The PHCs are receiving the grants under RKS scheme & hence said to involve the purchases of the equipments, instruments, etc. however this expenditure are not based on the real need of the PHC. As the concept of 24*7 PHC is still lacking, such a expenditure will lead to the unnecessary non - performing assets.

Conclusions: RKS however is just seen as a monetary scheme without much involvement of the general public & hence happened to be a political extension in the hospital working.

Keywords: Efficiency, RKS, PHCs, Raigad district

Introduction

The NRHM has emerged as a major financing and health sector reform strategy to strengthen States Health systems. The NRHM has been successful in putting in place large number of voluntary community health workers in the programme, which has contributed in a major way to improved

utilisation of health facilities and increased health awareness. NRHM has also contributed by increasing the human resources in the public health sector, by up-gradation of health facilities and their flexible financing, and by professionalization of health management. The current policy shift is towards addressing inequities, through a special focus on inaccessible and difficult areas and poor performing districts. This requires also improving the Health Management Information System, an expansion of NGO participation, a greater engagement with the private sector to harness their resources for public health goals, and a greater emphasis on the role of the public sector in the social protection for the poor. Health Services are provided to the community through a network of Sub-centres, Primary Health Centers (PHCs) and Community Health Centres (CHCs) in the rural areas and Hospitals and Dispensaries etc. in the urban areas. The Primary Health Care infrastructure in rural areas has been developed as a three-tier system.[1]

The lack of integration of sanitation, hygiene, nutrition and drinking water issues with striking regional inequalities laid the foundation for the launch of NRHM. One of the components of the Mission has been to reduce child and maternal morbidity & mortality with special emphasis on rural areas. Multiple national programmes addressed the same issues but failed to achieve the desired goals. NRHM has brought in integrated & flexible approach to the problem. In order to increase the public health expenditure in India which has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999, the Empowered Action Group (EAG) was constituted by order of the Government of India on 20 March, 2001, as an administrative mechanism, for the purpose of closely monitoring the implementation of the family welfare program.[2] The NRHM was launched in step wise manner in different states and Government of Maharashtra state adopted the programme in order to streamline their health system in 2007.

Rogi Kalyan Samiti (RKS) under NRHM, aims at increasing functional, administrative and financial autonomy of the decentralised health delivery system in rural area.[3] RKS established in order to strengthen the health delivery system, originated as a committee of people's representative at a hospital in Indore, Madhya Pradesh. This study was later incorporated in NRHM. RKS committed for the optimal utilisation of services, rendering transparency, & accountability of the health service providers to community. The public health care system, which has degenerated into a non-functioning behemoth, has in general lost the confidence of the people. Ironically decades old decaying public hospitals are still the only hope for a huge majority of the populace in the tribal and rural areas, inhabited by people who are most needy but least provided with adequate primary health care. Funding source for RKS is Annual Maintenance Grant, Untied Funds, proportion of user charges, & self generated funds. In the present study the community participation, resources generation, utilization, monitoring of RKS in selected PHCs of Raigad district were studied. Hence this study was conducted to study the efficiency of RKS and observe the availability and utilization of funds by RKS in PHCs of Raigad district.

Materials and Methods: This Community Based Cross Sectional Comparative Observational Study was conducted at Primary Health Centres (PHCs), located in Raigad District, Maharashtra State, which is the district under which Department of Community Medicine, M.G.M. Medical College, Navi Mumbai is located. Duration of study was August 2011 to November 2013. Simple random sampling using table of random numbers

Study Sample: There are 15 talukas & 52 PHCs & 287 sub-centres in the Raigad district. Out of total 15 talukas, 7 are selected randomly in order to represent the total district. Only 7 talukas are chosen due to time & resource constraint. The each taluka has 2-6 PHCs. Randomly selected talukas are considered in totality & hence all PHCs under these talukas are chosen for the study. A Sub-centre is selected using the convenient sampling. A Sub-centre located near to the PHCs is selected for the interview of ANM & ASHA worker.

All the selected PHCs were informed in advance regarding the study along with official letter from District Health Officer (DHO) along with questionnaire to be studied in order to obtain the old data of 2005 or 2007 whichever is available in order to serve that as base line data.

Sampling size determination- Population served by the individual PHCs are indirectly assessed by the records maintained in the PHCs & crossed checked by the records at Taluka Health Office (THO).

Inclusion criteria:

- All the selected PHCs are chosen those who are responded to the preliminary communication over telephone.

Exclusion criteria:

- All those PHCs who are not responded to the preliminary communication,
- All those PHCs who are not responded to the questionnaire along with proper & authentic records, PHCs who doesn't divulge the data

Sampling unit: Individual Taluka & PHCs were randomly selected & Sub-centers using convenient sampling.

Data collection: The study was conducted in four phases.

Phase I: Designing study tool

A pre-designed, pre-tested semi structured questionnaire in English & local language, Marathi was developed under expert guidance. The questionnaire contained information about following aspects:

- General demographic information of the PHCs
- Details of present status of various differentials of NRHM.
- Past track record of the individual PHCs in various differentials of NRHM.

Phase II: Pilot study

The questionnaire was pilot tested in 2 individual PHCs of neighboring area of the MGM Medical College & Hospital, Kamothe, Raigad, for the clarity of language, understanding of questions and to assess the feasibility of study. The questionnaire was then modified as per the local language and validated by a panel of experts of the institute.

Phase III: Ethical considerations before commencement of the study

Permission to conduct the study and ethical clearance was obtained from the Institutional Ethics Committee. Participants i.e. ANMs & ASHAs were fully informed about the purpose, procedures, benefits and risks of participation in the study. Participation in this study was voluntary; as such no participant was forced to take part. Participants were informed that all records pertaining to the study will be confidential, and that numbers instead of names will be used to identify participants.

Phase IV: Main study:

Simple Random sampling was used to select individual talukas & hence all PHCs under the jurisdiction of these talukas are considered for the study. The PHCs who are willing to share the data of their performance was visited. The Sub-centers was contacted for the availability of ANM & ASHA and their time for visit is noted & followed for the interview. ANM & ASHA who were informants, were explained the purpose of the study. Written informed consent was obtained from the individual ANM & ASHA. Those ANM & ASHA who consented to participate in the study were interviewed. ANM & ASHA were interviewed with help of pretested predetermined semi structured questionnaire.

Data analysis: Data was recorded on a pre-designed proforma and managed on Excel spread sheet. All the entries were double checked for any possible key-board error. Data was analyzed using SPSS

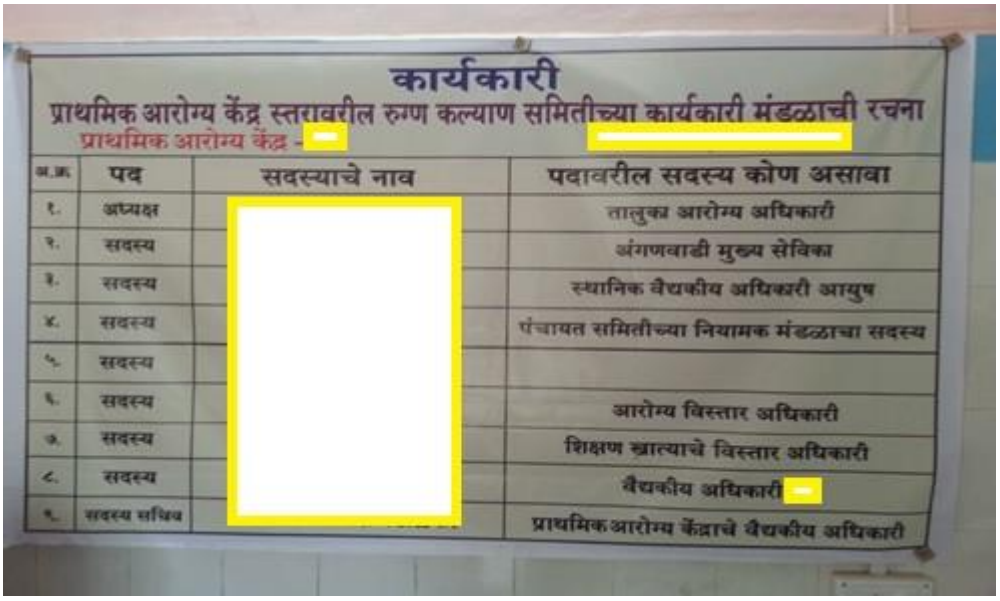
17.0 Further statistic analysis was performed with the help of statistical tests such as z- test. The level of significance was set at 5%. All p value less than 0.05 will be treated as significance

Results: The RKS was a body who is suppose to look after the hospital functioning. It is based on the concept of that community participation at the grass root level will help to realize the community about its stake in the government hospitals. Hence a committee was formed & registered with the government in order to receive the funds under Rogi Kalyan Samiti, who is supposed to look after the daily working of the PHCs.

IN the present study it has been found that the RKS are formed in all PHCs with their display of list of members in the hospital. The list includes the political, social & health sector members. However RKS is found to be taken as a concept where the hospital receives money. The innovations are missing in the field of money generation or its expenditure apart from the prescribed format as given by the government of Maharashtra. Hence RKS is found to be the dependent body which functions as per the government orders. Hence RKS is not generating any resources by its own.

RKS as it is a body or committee should be accountable to the general public in its dealing with the funds receipt & expenditure. However in the study it has been found that the body is not working or not working up to the expected mark. There is no accountability to general public as there is no communication to the community like holding meetings with gram sabha, verification of records by the independent body or verifying with actual beneficiaries regarding the benefits of RKS. Hence the monitoring is quite weak.

There is display board put up in all health facilities showing names of members but there is no display of number of meetings of RKS held in the respective PHCs.



RKS is an innovative method to bring the involvement of community in the hospital. Hospitals are blamed for the lack of services & the main reason for the displacement of poor people to the private set up hence incurring the out of pocket expenditure which lead to the poverty.

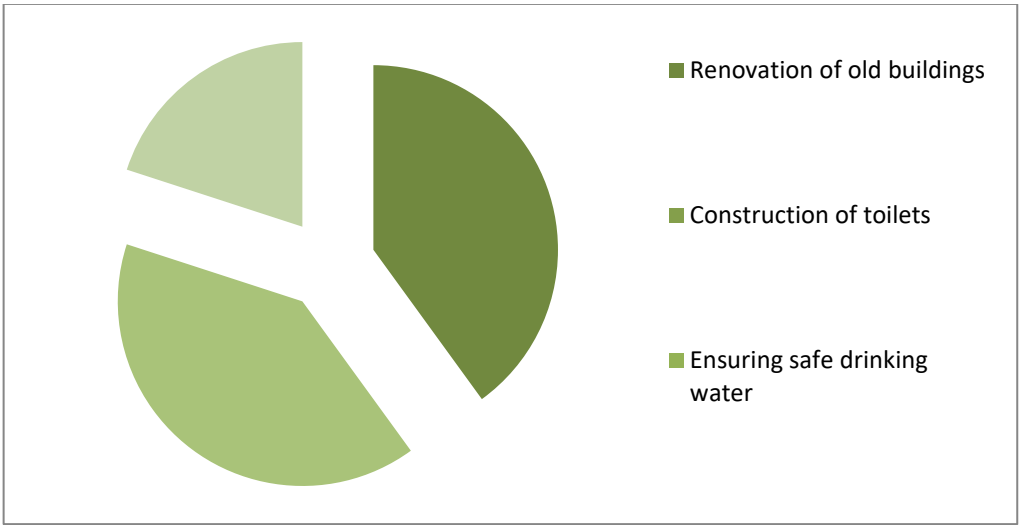
None of the PHC was found to have the mechanism or measures for problem solving by RKS. The patient or relative of the patient was treated as a burden & hence their problems are not looked after. The measures like Social audit, Jan sunwai / Jan Samvad, Public scrutiny of action taken, etc. were not found in any of the PHCs. There are no steps taken by RKS in educate the community in maintenance and upkeep of the hospital, nominate volunteers in maintenance and upkeep of the

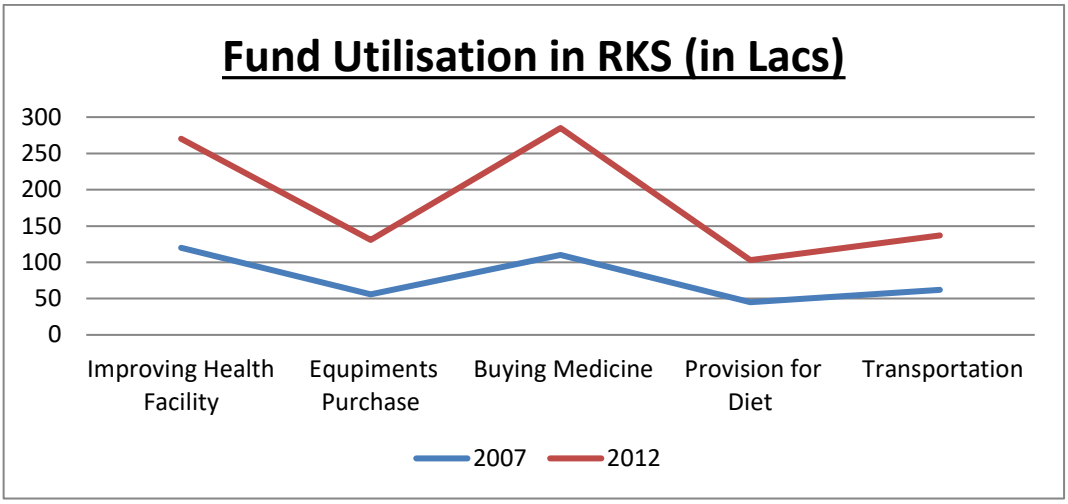
hospital, holding meeting in maintenance and upkeep of the hospital, training in maintenance and upkeep of the hospital, etc.

User fee or the fee paid for the OPD / IPD paper was considered as money generated by Rogi Kalyan Samiti (RKS) & is retained within the facility for local use in all PHCs. There is however no records showing this RKS funds have been audited since inception. The only control on RKS is the checks & balances in the form of THO office, NRHM office & DHO office who periodically ask for the statement of expenditures.

A system of external monitoring of RKS by PRIs i.e. monitoring by PRIs (ZP), evaluation by state authorities, service / performance evaluation by independent agencies, etc. has not been done in any of the sampled PHCs. PHC disseminating important Public Health Information in the form of advertisement in newspapers, magazines, hoardings, websites, etc. is not observed in any of the sampled PHCs. All PHC are found to be on paper based rather than web based hence no information is available on e- records. This is the old way of working & hence hindrance to the transparency of the working of PHCs.

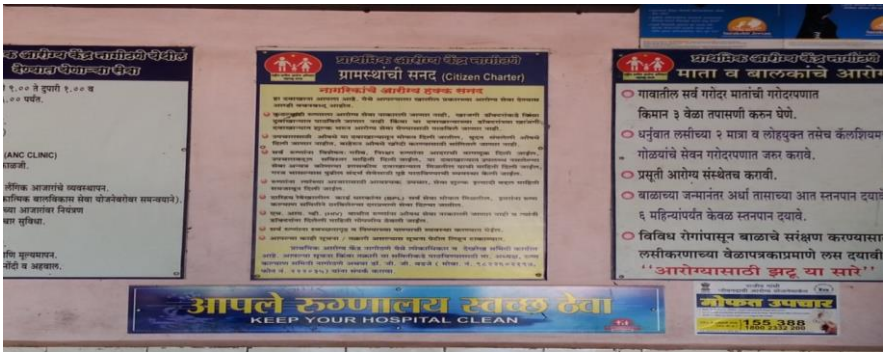
Fund Utilisation of RKS as received from the government is spent on improving health facility buildings, buying Equipment, buying Medicine, provision of Diet, provision of Transport, subsidizing the Cost for BPL patients, etc.





Meeting of RKS are said to be happening but no concrete results are visible in the conditions of PHCs. Governing body meeting & Executive body meeting were held. Decisions taken on developing systems for enhancing Transparency, Accountability and Credibility of the public health initiatives are not visible. Decisions reflect any Initiatives for Collection of Feedbacks and suggestions of patients for redressal of grievances are also missing.

Patient Charter is the display of rights of the patient which the hospital is promised to give. This the minimum rights of the patients for which the patient can complain & can demand its fulfillment. Patient Charter was visible on the outside wall of the PHCs, mostly in the waiting areas of the PHCs. However most of the Patient Charter is in English rather than the local language & also only 3 PHCs has displayed the patient charter in the premises.



Display public information on services provided e.g. The User Fees, Sufficient Stock of Drugs Available; etc should be displayed in the hospital. This is an extension of the patient charter. However most of the PHCs don't display this information barring the 3 PHCs.

The simple system of Complaint and suggestion boxes are placed in most of the PHCs however they are found unused or their location is not even visible to the common people visiting the hospital. The other mechanisms like collection of Feedback from the Patients, Redressal of Grievances, Specific Mechanism Initiated, etc. are missing from all the sampled PHCs. Hence the RKS has been not effective in attending to the concerns on time nor is it able to identify the unmeet need of the people for the kind of services they require.

Important decisions taken at the RKS for proper functioning of the hospital like renovation of old buildings, construction of toilets, ensuring safe drinking water, providing uninterrupted electric supply to operation theatres, labour rooms and for maintaining cold chains & appointing contractual non-technical support staffs for better functioning of the hospital. However only 2 PHCs have till the time of survey were able to utilize the fund for the infrasture purpose & 4 PHCs already have a setup in new buildings.

Discussion:

Communitization is an important strategy of NRHM to ensure that the programme reaches at the community level. It includes involvement of Panchayat Raj Institutions formation of hospital management committee i.e. *Rogi Kalyan Samiti* and also the provision of community worker known as ASHA at the community level. The main findings are discussed below:

All the PHCs have formed & registered the RKS. This is similar to the IIPS study which shows the all the surveyed PHCs had formed and registered Rogi Kalyan Samities. However, 14 of the surveyed PHCs had displayed board showing number of members of Rogi Kalyan Samiti & as per the IIPS study which is a similar to the present study. As per the IIPS study the provision of ambulance services through RKS was available in almost half of PHCs. This has been changed in the present study which shows the all ambulances are through RKS.

All the PHCs receives the money electronically as compared to the IIPS study which shows RKS fund has been transferred electronically by 10 of the surveyed CHCs.

Untied fund, Health Sub-Centre and Gram Panchayat - ANMs reported that the grants are spent to purchase drugs (38), paying of power/telephone bills (arranging transport and for arranging facilities like water cooler etc. This is similar trend of money spend in all sampled PHCs. This is similar in the present study.

The flow of the central grant was found to be smooth. The expenditure however is below the mark in absence of predefined protocols. Only 53.30% of total funds available were utilized during the study period. Approximately three-fourth of the funds was utilized in civil work (32.70%), furniture and electrical works (28.28%) and in fuel (12.98%). This study is conducted by the Rawat CM, Pandey

S, Awasthi S, Tekhre YL, Kumar R, Nandan D, [4] A rapid appraisal of functioning of Rogi Kalyan Samitis in Uttarakhand, 2009 has similar finding as that of the present study in Maharashtra.

Conclusion:

RKS however is just seen as a monetary scheme without much involvement of the general public & hence happened to be a political extension in the hospital working.

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