



Original Research Article

Are Patient Welfare Societies Effective in Strengthening Health Care Delivery Systems: Evidences from Uttarakhand State, India

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ABSTRACT

Background: In order to ensure provision of sustainable quality care with accountability and people's participation, the Government of India envisioned the development of a management structure in every health facility under the National Rural Health Mission (NRHM). With this vision, a management structure called Rogi Kalyan Samiti or Patient Welfare Society was developed in every health facility. The aim of this study is to assess the structure, functioning and perception of stake holders on of patient welfare societies in Uttarakhand state of India.

Methods: The study was conducted among 125 stakeholders from 6 districts in Uttarakhand state, India including government health providers and members of patient welfare societies and 980 randomly selected patients who availed services from health facilities at different levels.

Results: Structure and concept of patient welfare society has been well accepted in all health care facilities. However, the meetings of the societies mostly held once in 5-6 months. A majority of members (75%) were present in the meetings, except frequent absence of members from local elected bodies. In 90% of health facilities plans were made and executed hastily to utilize the available funds under NRHM. There was limited participation of members other than health department. A significant proportion of funds under different sources was spent on "other items" and not separated into specific items. 32% of inpatients incurred out-of-pocket expenses on laboratory investigations, radiological tests and medicines.

Conclusion: The study provides the evidence for the need for development of guidelines which clearly define the purpose and organizational structure including roles and responsibilities of individual actors of patient welfare society, which needs to be supplemented with periodic capacity building of members. The society should be developed as a democratically run system and strengthened with inclusive and participatory processes to make them functioning more effectively.

Key words: Patient welfare society, accountability, flexible financing, community participation.

Key Messages

Implications for policy makers

- Patient welfare societies can be an operationally feasible model to improve the functioning of health facilities through community participation.
- Limited capacity building efforts, lack of active participation from non-health departments and undemocratic decision making process hinder the functioning of societies.
- Regular meetings, continuous review of decisions and actions taken, regular audit of society accounts and review by its members, improved reporting and documentation etc., can lead to greater transparency, accountability and credibility to the society.

Implications for people

- The findings of this study will help improve the functioning of health facilities in rural areas through community participation.

INTRODUCTION

India's National Rural Health Mission (NRHM) seeks to provide accessible, affordable and quality health care to the rural population, by increasing the spending on health infrastructure and improving the health care services delivery at the community level. ⁽¹⁾ Under the mission, up gradation of health facilities for better community participation and accountability is strategized as a vehicle of flexible funding by the government to help raise the quality of care, by making the health service delivery system more responsive to meet people's needs with equitable access. This required the development of a proper management structure called *Rogi Kalyan Samities* (RKSs) or Patient Welfare Societies in all health facilities. RKS is known in different parts of the country as Hospital Management Committee, *Jeewan Deep Samiti*, or *Swasthya Kalyan Samiti*. In Uttarakhand state, it is called *Chikitsa Prabandhan Samiti*. The Ministry of Health & Family Welfare, Government of India issued guidelines on basic structure, framework, constitution, functions and activities of the society at various levels and allowed states to make certain changes as per state specific context. ⁽¹⁾

RKS functions as a registered society under the Societies Registration Act of

government of each state which acts as a group of trustees for the health facilities to manage the day to day activities. ⁽²⁾ The society comprises of two bodies- Governing Body (GB), which is responsible for policy formulation and decision making while Executive Body (EB) for implementation of the decisions taken by the GB. These bodies consist of members from local government institutions (panchayat raj institutions), non-governmental organizations, local elected representatives, health providers and administrators of the government health facilities. Guidelines of the society give a set of well defined roles and responsibilities of each body to make the society fully functional.

Under NRHM, funds are released to these societies in the form of seed money, maintenance grants and untied funds. The societies also collect user charges on certain services/registration charges at facilities as per the guidelines issued by the respective state governments. They are free to prescribe, generate and use funds for smooth functioning of the health care facilities and maintaining the quality of services.

There have been limited evidences on the functioning of patient welfare societies in India. A study conducted in Uttar Pradesh, one of the largest states in India raised issues like lack of active participation of all members, undemocratic

decision making process, lack of documentation on details of meetings, absence of grievance making mechanism and lack of orientation of members. ⁽³⁾ Another study in Haryana state showed that though meetings of societies took place frequently, in most of the time such meetings were conducted in informal way without advance intimation of agenda to the members. The study observed that though all health facilities were collecting user charges, but only a part of this revenue was utilized for improvement of health facilities and considerable expenses were incurred on 'miscellaneous' head. ⁽⁴⁾

However, a study conducted in Madhya Pradesh state had indicated that over the period of time the society was able to generate and spend larger amount of money for improvement of hospital facilities. Patients were satisfied with the services received from the hospital and there was equal access to all patients, medicines and diagnostic facilities were available to many of them. Most of the patients were also satisfied with the behavior of the doctors and other hospital staff. ⁽⁵⁾

Another study of Community Health Centres (CHCs) in Uttarakhand state observed that the society existed according to guidelines at all CHCs, but noted a shortfall of members in society of every health facility. The funds received by the society was mainly utilized for development of physical facilities and infrastructure of the CHCs, provision of basic facilities for the patients, purchase of medicines, development of basic laboratory facilities and transportation, and contracting out of specialist services. However, the study highlighted certain multifaceted issues ranging from non-availability of proper expenditure guidelines to involvement of unmotivated members burdened with additional responsibilities, as also low knowledge and awareness levels among the

community. The study also found patients were not satisfied with the availability of medicine, availability of specialist care, and increasing number of referrals to district hospitals. ⁽⁶⁾

A recent study of the society in Maharashtra state ⁽⁷⁾ at district and block level has shown that these societies are yet to bring out quality component to the health services being provided through facilities. The authors attributed this to structural and managerial weaknesses in the system. The study concluded that the progress of the society can be enhanced by giving due priority to critical areas like building capacity of members of society, improving reporting and documentation, participatory decision making and improved community participation.

Available studies on patient welfare societies in Indian states have revealed that there are many issues at organizational and implementation levels. However, few studies have also shown that these societies could be viable and operationally feasible models for strengthening health system at grass root levels. In addition, increasing participation of community members in identifying, prioritizing and organizing health service delivery is expected to enhance the improvement and utilization of health services at peripheral levels. The present study was conducted to assess the structure, functioning and perception of major stake holders on these societies in Uttarakhand state of India.

MATERIALS AND METHODS

This study was conducted in 6 districts of Uttarakhand State in India during June - July 2010. The study units comprised of 6 district hospitals (DHs), 3 sub-district hospitals (SDHs), and 12 community health centres (CHCs) and 22 primary health centres (PHCs). The sources of information included both primary and secondary data.

Primary data was collected through detailed interview of major stakeholders viz. 125 health administrators and health providers (state health administrators, chief medical officers, district programme managers and hospital superintendent /medical officers in-charge of selected health facilities), and randomly selected members of patient welfare societies through semi structured interview schedules. In order to elicit the views of patients on these societies, 980 randomly selected patients (10% of outpatients and 20% of inpatients) from the select health facilities were interviewed using detailed interview schedules.

Official records and registers related to minutes of meetings, funds receipt and utilisation, financial audit certificates, government orders, fund utilization guidelines and memorandum of association were reviewed. The data was verified and checked for data errors during coding and data entry. The quantity data were analyzed using SPSS 21.0 (IBM SPSS Statistics Version 21). Qualitative data were analyzed thematically. Data were triangulated by combining responses from interviews with observations of researchers and secondary data. Ethical clearance for the study was given by the Institutional Review Board of National Institute of Health & Family Welfare, Government of India.

Findings:

Structure and functioning of societies: Societies formed in all health facilities were registered under the Society Registration Act. All health facilities were following the society guidelines issued by the government of Uttarakhand. The societies constituted at district and sub district hospitals were chaired by the district magistrate with chief medical superintendent of the hospital as the member secretary. Members of the society included chief medical officer of the district, treasury officer of the district, 4 members from the hospital, representative of member

of parliament, chief medical officer of the district, chairperson of municipality, chief district programme officer, junior engineer of water supplies department, representative of local body and non-government organisation. The societies constituted at CHCs were chaired by chief development officer with medical officer in charge as the member secretary. Members of society include member of panchayat raj institution, block development officer, deputy chief medical officer, 3 members from the facility, member of legislative assembly, doctor representative AYUSH (Ayurveda, Unani, Siddha and Homeopathy), assistant treasury officer, member from integrated child development project, representative from agriculture department, junior engineer of water supplies department, representative from private health sector, representative of local body and non-government organisation. The societies in PHCs were chaired by block development officer with medical officer in charge of PHC as secretary. Other members were deputy chief medical officer, member of PRI, block development officer, doctor (Ayurveda, Unani, Siddha and Homeopathy), assistant treasury officer, member from integrated child development project, one representative from private health sector, president of the village, village development officer and representative of non government organization. Number of members in the societies varied from one health facility to another ranging from 8 to 12 members. Since the positions were defined in the guidelines, automatically the members changed for period of every 5 years.

Meetings of the society: According to the guidelines issued by the Government of India, every health facility should organize at least one meeting in every quarter of the year. It was observed that meetings of the societies mostly held once in 5-6 months.

There was no evidence of monthly meetings held in health facilities. The decisions regarding hospital improvement measures such as infrastructure development, purchase of health supply materials and maintenance were taken, in most cases on a democratic manner based on majority consent and reportedly active participation by members.

Agenda for the meetings were prepared in advance in all health facilities. Health facilities followed three methods of preparing the agenda for the meeting. In the first method, which was common in 60% of cases, the officer-in-charge, of the hospital / health facility who is also the secretary of the society, usually records the requirements of the hospital/ health facility with help of other health staff. In second method, a core committee constituted at health facility level, for this purpose discusses and prepares the list of priority requirements. Under the third method, health facility in-charge calls internal meetings of all key officials in the facility and take note of all requirements. Usually the requirements for each health facility are prepared separately for curative and preventive activities. As requirements are many and resources are less, each facility would then prioritize the requirement and prepares the agenda to be placed before the meeting. It was found that the agenda was prepared at least 10 days prior to the meeting in all health facilities. While 80% of the health facilities circulated the agenda to its members well in advance, 20% of health facilities, particularly most of PHCs not circulated agenda in advance to its members, but there was no understanding of required minimum time to inform the members about the various meetings and documents to be sent along with agenda of the meeting.

The meeting was conducted only after the approval of agenda, date and time for the meeting by the chairperson. Once the

meeting is fixed, the secretary informs the members' at least a week in advance. The meetings generally take place at the health facilities. It was found that a majority of members (75%) were present in the meetings, except frequent absence of members from local bodies. Generally, minutes of the meetings were recorded and read to members during the meeting and only in DHs and SDHs, the approved minutes were circulated among members after the meetings.

The study observed several challenges in organizing the GB meetings of the society. Firstly, many times meetings of GB had to be cancelled at end point due to preoccupation of chairpersons, who were busy in other government activities. Secondly, some of the members from other department of government could not attend the meetings due to other emergency/preoccupation. Thirdly, representatives of local bodies particularly in case of CHCs and PHCs, frequently avoid meeting due to non-reimbursement of travelling charges for them for attending meetings as there was no such provision for payment of travel charges. Finally, some of the members were not aware of the issues in health facilities and therefore, they were not concerned to resolve the issues and did not actively participate in decision making process.

Health facility planning: It was noted that in most (90%) of the health facilities plans were made and executed hastily to utilize the available funds under NRHM. The planning process ideally start in the month of April every year, and the plan preparation be completed by June. The resources are made available to the society by June every year. The societies are expected to complete the execution of the plan in the forthcoming six to eight months. As per the guidelines, every society should develop a perspective plan and annual plans should be guided by

this plan. Ideally every health facility should have a vision of where it wants to reach along with an analysis of where it is presently.

Inter-sectoral convergence: A health facility is not a stand-alone operation and it requires the co-operation of other departments like electricity, revenue (for land related issues), public works department, water supply, local self-

governments etc. The societies are the appropriate vehicle for bringing convergence with the other health related programmes like integrated child development, water supply and agriculture. The presence of members of these departments ensures their ownership and contribution. However findings of this study revealed limited participation of members other than health department.

Table 1: Purpose of flexible financing to public health facilities under NRHM

	Type of grant	Objective
1	RKS grant	For smooth functioning of the health facility and maintaining the quality of services
2	Untied funds	Conducting various health activities, including Information, Education and Communication (IEC), household surveys, preparation of health registers, organization of meetings at the village level, etc.
3	Annual maintenance grant	For improvement and maintenance of physical infrastructure

Table 2: Funds Received under various heads in each level of the health facility (in `Rs.)

Sl.No	Type of grant	District Hospital	Sub District Hospital	Community health centre	Primary health centre
1	RKS grant	5,00,000	1,00,000	1,00,000	1,00,000
2	Untied funds	Nil	Nil	50,000	25,000
3	Annual maintenance grant *	Nil	Nil	1,00,000	50,000

Note: * sometimes annual maintenance grants are released to district hospitals located in difficult terrains areas.

Table 3: Funds utilization pattern in different health facilities during 2008 – 2012 (in percentage)

Health facility	Type of grant	Average funds per facility used (Rs)	Construction	Medicine & consumables	Furniture & equipments	Printing & IEC activities	Repair & maintenance	Others	Total
District Hospital	RKS grant	16811905	-	39.4	8.3	2.4	10.2	39.6	100
	AMG*	14555505	12.8	25.7	8.2	3.4	13.8	36.1	100
	User charges	9616998	-	35.5	7.4	2.5	20.8	33.8	100
Sub district hospital	RKS grant	11999852	3.5	73.2	13.6	4.3	5.4	-	100
	User charges	8740320	-	48.7	2.2	6.7	12.8	29.5	100
Community Health Centre	Untied funds	258560	18.0	11.0	25.0	9.2	12.0	24.8	100
	RKS grant	471793	2.0	10.5	45.0	4.5	22	16.0	100
	AMG	444248	32.0	-	4.8	-	52.0	11.2	100
	User charges	542218	2.4	7.2	3.0	10.6	17.0	59.8	100
Primary Health Centre	Untied funds	119443	-	12.0	27.0	19.0	22.0	20.0	100
	RKS funds	370838	7.3	5.0	43.4	2.1	30	12.2	100
	AMG	245323	29	-	9.8	2.3	58.0	0.7	100
	User charges	75705	-	3.8	6.0	20.7	22.5	47.0	100

Note: * few of district hospitals in the state were released AMG as special case

Allocation of NRHM funds: NRHM aims at increasing the functional, administrative and financial autonomy of health facilities at

various levels. It introduced an innovative approach of flexible financing to public health facilities whereby funds was allocated

under the budget head, “NRHM Additionalities”, through which the central government made provisions of Rogi Kalyan Samiti grant (RKS grant), untied funds and Annual Maintenance Grant (AMG) for the different health care facilities (Table.1 and 2). The purpose of the funds is to decentralize the planning and implementation of innovations, taking into consideration local situations. Guidelines for utilisation of these funds were also issued to health facilities at various levels. Untied funds could be used to meet shortage of fund required to complete an activity planned under AMG or RKS fund and vice versa and thus the activities planned under these heads are overlapping to a greater degree. Health facilities also collect user charges from patients which are utilized for improvement of health services.

Utilization of funds: Data from DHs during 2008-2012 (Table.3) revealed that almost 39% of RKS funds and nearly 26% of AMG respectively used for purchase of medicines and consumables. However, a significant portion of these funds were spent on “other items” i.e 39.6% of RKS grant funds and 32% of AMG. On the other hand, data from SDHs showed that a major portion of the RKS funds (73.2%) was utilised for purchase of medicines and consumables while none was spent under the head “other items”.

An analysis of data from CHCs revealed that 25% untied fund and 45% of RKS grant were used for purchase of equipments and furniture. 18% of untied fund was used for construction, and 11% for purchase of medicines and consumables and nearly one-fourth (24.8%) was used under “other heads”. 84% of AMG was used for construction, repair and maintenance of facilities.

A closer analysis of spending pattern in PHCs reveals that 27% untied funds was used for purchase of equipment and

furniture, 22% on repair and maintenance and another 20% on “other items”. Out of RKS grant, 43.4% was spent on furniture and equipment and 30% on repairs and maintenance while 87.2% of AMG was spent on construction, repairs and maintenance. Such utilisation appears as one of the top ‘preferences’ for spending both these major funds.

User charges are the major source of funds for the societies in both the DHs and SDHs. However, as per the guidelines from the Uttarakhand government 50% of revenues collected from the patients shall be deposited in treasury and remaining 50% shall be utilised for improvement in hospital services through societies. The analysis of utilisation of user charges across health facilities showed that 59.8% of user charges in CHCs and 47 % percent in PHCs were utilized on “other items”. However, in the case of sub district and district hospitals, 48.7% and 35.5% respectively was used for purchase of medicines and consumables while almost 29.5% and 33.8% respectively was used for other items.

The analysis revealed issues of non-transparent ‘combined’ or “other” expenses which are not separated into specific items, and in 30% health facilities expenses under this head were high. The items which fall under this category were not mentioned clearly and it is not known on what items these amounts were actually spent. Since the expenditure on AMG and RKS is not specific, technically all the expenses go by the suggestions given in the NRHM guidelines.

Citizen Charter: The citizen charter enables patients to know about what services are available in the health facilities, and the means through which complaints regarding denial of services will be addressed. According to guidelines citizen charter must be displayed at a prominent place in the health facility. Further, the citizen charter

should reflect commitment to provide access to available services and facilities without discrimination; commitment to provide emergency treatment, if needed on reaching the health facility; location of all health facilities and schedule of the available staff with complete information of their visits; commitment to provide written information on diagnosis, treatment being administered; record complaints and respond at an appointed time and record availability of sign boards displaying the available drugs and the timings of service availability, number of beds etc.

Users of the health facility should understand the commitments made in the charter. User would not insist on service above the standards set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user. Instructions of the health care professional would be sincerely followed by the user.

The study observed that only 80% of health facilities had citizen charter available with them despite the presence of society in all these facilities. Only 54.7% of health facilities had fixed complaint box and 50.0% had suggestion box fixed at the reception/near registration counter. It is interesting to note that 85% of patients were not aware about citizen charter, almost 90% were not aware about suggestion boxes available in health facilities. However only 15% of patients noticed the presence of complaint boxes in health facilities but hardly they complained about services. The society should review the citizens' charter, and see that the services mentioned are actually provided in each facility. In majority of CHCs/ PHCs (75%), there was no proper grievance redressal mechanism. It is important that complaints of patients need to be recorded, and all of them need to be submitted at the subsequent meeting of society, along with the action taken/

proposed. The society should conduct annual reviews and copies of these reviews should be made available to the district and state health authorities.

Patients' perception: DHs and SDHs are the major source of health care providers in the state. Therefore these hospitals have a huge patients load both out-patients and inpatients and it is difficult to handle the patients with their expected level of satisfaction. The findings revealed that 45% of respondents in DHs and 25% in SDHs reported some issues in availing hospital services. According to them long waiting time to receive treatment and non-availability of medicines in the hospital were the major problems. However, most of them were satisfied with the cleanliness and other infrastructure facilities in hospitals. Further about 37% of all respondents indicated that medicines were partially available and they had to purchase some medicines from the market. It is pertinent to note that more than 90% of the OPD respondents were satisfied with the overall services provided by the health facilities.

Generally, CHCs and PHCs in the state do not have much patient load and patients can complete the procedures with in short period of time. However, in this study 36% of the respondents faced the problem of long waiting time and almost similar proportion complained about non-availability of medicines and 20% faced the problem of non-availability of doctor.

Getting admission in the inpatients ward is too difficult in government hospitals because of huge patient load. However, the findings indicated that only 10% patients faced some difficulties in getting admission in the hospitals. Nearly two-thirds (67%) of them rated the cleanliness of hospital premises, ward and hospital toilets as good. They were also satisfied with facilities like drinking water and diet facilities. About three-fourths (69%) of them reported that

hospitals procedures were comfortable to them. Though availability of medicines has been a major problem in most of the government hospitals, the findings revealed that more than two-thirds of the patients received all medicines from the hospital during the treatment. However, almost one thirds of all IPD patients (32%) incurred out-of-pocket expenses on laboratory investigations, radiological tests, medicines etc. Nearly 87% of the IPD respondents satisfied with the overall services provided by the hospital. It was also seen that hospitals with availability of adequate human resources, medicines and diagnostic facilities recorded high level of patient satisfaction and vice versa.

DISCUSSION

Structure and concept of patient welfare society has been well accepted in all health care facilities. Funding arrangements made by the state and NRHM were in place and accessed by the societies in all health facilities. Members from varied backgrounds including health care providers, members from community and other Government departments have come together to provide evidence that the model is one that can work.

Many of the health facilities made significant contributions in asset creation. Few hospitals established blood bank, palm ventilator, enhanced laboratory facility, construction of trauma centre. Equipments like nebulizer, ultrasound tracking device, software for health insurance, dressing rooms for surgical centre, generator sets, invertors, refrigerators, water purifiers, furniture's and minor equipments for laboratories were some of examples. Few societies could motivate locally influenced people to donate equipments, ambulance, generator sets including maintenance of garden and parking facilities.

Though some major repair and maintenance works were done in few health facilities, in majority of health facilities particularly in CHCs and PHCs a lot of improvements need to be carried out though these facilities utilised available funds. However, the DLHS-3 report finds that constitution and utilization of untied RKS funds in the CHCs and DHs have been successfully implemented; however, the implementation of RKS proved problematic at the PHCs level. ⁽⁸⁾ This study found that a significant proportion of funds under different sources have been spent on "other items" and not separated into specific items, and in few CHCs and PHCs these expenses are very high. The findings of this study are similar to an earlier study conducted in Haryana state. ⁽⁴⁾ Activities like IEC, outreach services etc., have received low priority with regard to utilisation of funds.

In DHs and SDHs a significant amount was spent on purchase of medicines despite the state level procurement and supply of medicines, local flexible funds are also being utilised for medicines, which raises the question of insufficiency of state and district supply of medicines. Another notable finding is that activities like IEC, outreach services etc., have received low priority with regard to utilisation of funds through societies in all health facilities.

The findings also revealed that many of the expenditure were done on adhoc basis without properly analysing the local specific needs. These findings were also reflected in the report of fifth common review commission of NRHM. ⁽⁹⁾ In fact, the development of annual action plan is the first step in utilising sources of funds under NRHM viz. untied fund, AMG and RKS fund. The plan should be approved by the GB of the society before its implementation. The plan should reflect gaps in providing quality health services in the respective health facility as well as in

villages in its jurisdiction but also should be based on availability of resources. The plan could be reviewed after every GB meeting and expenditures shall be made in accordance with the approval. Each activity planned in the facility should have some rationale so that the impact of the utilisation could be assessed.

There are many issues that exist at both organizational as well as operational level. Recent studies reported various issues like absence of regular meetings of stakeholders, autocratic decision-making, thereby diluting the purpose of establishing such societies, inadequate support systems for capacity building, weak monitoring system. ^(7,10) This study showed that there have been limited understanding among society members on various aspects including constitution, guidelines of the society, responsibility and powers of the GB and EC, utilization of funds and financial procedures and individual roles as members among members in non-health sector. Like the findings of USAID, this study also observed that in most of the health facilities regular quarterly meetings of the CPS were not organized. ⁽³⁾ Although, the invitation for the meeting is sent to the members but the guidelines for minimum time of informing the members, addition of the agenda along with the invitation were not practiced in many health facilities. There were issues like lack of attendance, utilization of funds on other activities rather than improvement in services, lack of engagement with community and users, lack of feedback from users on service provision and lack of active participation from members have been noticed. The limited understanding about various aspects of society could lead to lack of interest and involvement among members especially who are not part of the public health system.

One of the major functions of the society is planning, implementation and

monitoring of the annual plan for which the funds are available through the local representatives and monitoring the day-to-day activities of the health facilities. In order to improve the planning process and quality of the plan itself there is a strong need to provide training on how to strengthen the planning process and to upgrade the quality of the process and the plan. Though the GB of each society should act as a monitoring body, a fully operating monitoring system is yet to be functional.

One needs to understand how equity issues were addressed by the societies and how was the governance mechanisms contributed to the objectives. Almost 50% of health facilities, it was found that NRHM funds including user charges from services were used for activities not related to patient services whereas in others, the resource mobilization was far from satisfactory. Equity was found to be a serious issue even in nomination of community representatives in the GB of society.

Patient welfare society has been an important step under NRHM to increase community participation in the management of the health facilities. This has to be strengthened with inclusive and participatory processes involving members from community, health and non-health sectors. Involvement of member's right from the planning stage is important. In many places community participation was limited to token representation. Community was not aware of the existence of such society and even if they knew they were not aware of its functions. Building ownership within the community and ensuring accountability towards them is important. Therefore is a need to empower and to generate awareness among the community.

The societies can play an important role in the community monitoring of health programmes that are being operationalised by the government. Similarly, the

community representatives in the society could be useful in raising additional resources for the hospital. They can participate in the schemes of government of India like tracking mother and child, as they would be able to reach out mothers and children in remote areas where the government staff alone cannot reach.

There are also issues related to lack of proper grievance redressal mechanisms. There were no such significant decisions which reflect any initiatives for collection of feedbacks and suggestions of patients for redressal of grievances in any of the health facility. There were hardly any decisions of developing systems for enhancing transparency, accountability and credibility of the public health initiatives. These issues were also highlighted by studies done in three north eastern states in India. ⁽¹¹⁾ There is a need for greater transparency in the functioning of the societies and the hospitals which could include regular audit of the society accounts, its review by the members, corrective action, presentation of Action Taken Report (ATR), and its review by the society members in the meetings. Transparency with the community at large demands that the public knows the services offered at the hospital

With regard to convergence, the society has the potential to operationize convergence of various departments and schemes; however, there are no efforts in that direction. Ownership of the staff in health facilities and administration was found to be exceptionally high. This has also led to the lack of integration with other departments.

Patient welfare society is a strategy to improve the quality of management responses and thereby, facilitate improvement in delivery of health services as well as health outcomes. A facility based analysis of PHCs in India has shown that decentralized decision-making by these

societies do not have a strong effect on the provision of delivery care at PHC level. ⁽¹⁰⁾ In our study a significant number of patients in DHs and SDHs reported non-availability of medicines though a majority of patients satisfied with aspects such as cleanliness, drinking water facilities and waiting facilities in the hospitals. Almost one-thirds of patients at CHCs reported non-availability of medicines and doctors and similar proportion were also not satisfied with the waiting facilities, cleanliness, and drinking water facilities etc in these facilities. There is limited recognition patient welfare societies or the citizen's charter as well as limited awareness on mechanisms to share complaints and suggestions in most of the facilities. More than 95% of the patients were not heard of such societies. They were also ignorant about the suggestion box and compliant box etc.

There are not many efforts to instil motivation and develop capacities of society members. Lack of motivation of society members could lead to non participation and the lack of compliance with the guidelines in letter and of society. Earlier trainings have been very broad based, limited to providing information already existing guidelines. Training should be imparted on all aspects towards effective functioning of these societies. Periodic capacity building and involvement of every member in the decision making process is essential for a democratically run system. Earlier studies and reports have revealed that inadequate support systems for capacity building and training are constraints which weaken the impact of society. ^(7,9,12) In this study 70% of society members did not receive any training on how to utilize the hospital autonomy assigned by the societies. There was expressed need for training of members at all level of health facilities, to build a better understanding of roles, responsibilities and

guidelines among members, as well as increase interest and involvement of members in meetings. The members should be given training on how to raise additional resources; whether in cash or in kind. Training should also be given on assessment of public needs, especially on the disease patterns in the community. Planning for community based preventive measures including awareness generation activities in association with the health facilities.

CONCLUSION

Our study results show that patient welfare societies can become an operationally viable model by periodic capacity building, active participation of members in decision making process, bringing in transparency, accountability and partnership with community. Enhancement of inter-departmental convergence would facilitate the functioning of health facilities and improve overall health status of the community. Regular meetings, directing funds for patient services, feedback from users and community awareness would definitely make a substantial difference to the health service provision in the districts.

Recommendations

The guidelines for patient welfare societies should clearly define the purpose and organizational structure including roles and responsibilities of individual actors of society, which needs to be supplemented with periodic capacity building of members. Further, guidelines need to be minimized and suggestive rather than directive to remove the hindrances in responding to local needs. The society should be developed as a democratically run system and strengthened with inclusive and participatory processes. Community ownership should be promoted through continued dialogue, having information/help desk in hospitals where people can understand the role of these bodies. Efforts should be made to identify and collate best practices of societies across the country which

could be shared with others to encourage and motivate them.

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