Assessment of Rogi Kalyan Samiti (RKS) in Madhya Pradesh

Dr. Nikhilesh Parchure	*Research Investigator*
Dr. Reena Basu	*Assistant Director*
Dr. Niklesh Kumar	*Field Investigator*
Mr. Raghubansh Mani Singh	*Field Investigator*
Dr. Jyoti Tiwari	*Research Investigator*

Population Research Centre

Dept. of General and Applied Gepgraphy
Dr. H. S. Gour Central University
Sagar (M.P.) 470003

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List of Acronyms

APL	Above Poverty Line
BMO	Block Medical Officer
BPL	Below Poverty Line
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
CS	Civil Surgeon
CSR	Corporate Social Responsibility
DH	District Hospital
EC	Executive committee
GB	General Body
GOI	Government of India
IEC	Information, Education, Communication
IPD	Indoor Patient department
IPHS	Indian Public Health Standard
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Government Organization
NHM	National Health Mission
NRHM	National Rural Health Mission
OPD	Out Patient Department
PHC	Primary Health Centre
RKS	Rogi Kalyan Samiti
SDH	Sub-District Hospital

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Assessment of Functioning of Rogi Kalyan Samiti (RKS) in Madhya Pradesh

1. Introduction

Adequate public funding i.e. spending by the government on basic health care services and secondary and tertiary care services is essential for providing affordable health care services for all citizens particularly for poor and marginalized sections of population. It is a major cause of concern that majority developing countries spent only marginally on public health which leave majority population out of access to affordable health services. Making provision of basic preventive and curative health services has been a major policy thrust for the government. India's National Health Policy, 2017 also envisage to provide free of cost health care services at all the public health facilities. It also calls for significant reduction in out-of-pocket expenditure on health by regulating the cost of drugs and medical supplies for making health services affordable even in the private health facilities. However, the issue of functioning of public health institutions and availability of proper infrastructure, manpower and health care services is paramount. Apart from this, upgradation of all the public health institutions right form District Hospital (DH) to Sub-Health Centre (SHC) Indian Public Health Standards (IPHS) is a major strategic intervention under the National Health Mission (NHM). The purpose is to provide sustainable quality care with accountability and people's participation along with total transparency.

Till recently the government was responsible for upkeeping of public health institution and their management at the local level. However, there is a general apprehension that this may not be possible unless a system is evolved for ensuring a degree of permanency and sustainability. Patient Welfare Committee or Rogi Kalyan Samiti (RKS) is a key intervention in this direction. RKS are setup at each public health facility right from District Hospital to Primary Health Centre.

Rogi Kalyan Samiti or Patient Welfare Committee or Hospital Management Committee is a simple yet effective management structure formed to facilitate and streamline the developmental activities with an objective to provide sustainable quality care with accountability and people's participation along with total transparency in utilization of funds placed at its disposal. To overcome the budgetary constraints for providing health

care services at the public health facilities, user charges were introduced. The RKS setup at each public health facility manages collection and utilization for user charges.

The Societies, a registered society act as a group of trustees for the hospital to manage the affairs of the hospital. It consists of members from the local Village Council Institutions, NGO's, local elected representatives and officials from Government sector who would be responsible for proper functioning and management of the Sub-District Hospitals, District Hospitals, CHC/ PHC. RKS is free to prescribe, generate and use its funds as per its best judgment for smooth Functioning and for maintaining the quality of services.

The National Rural Health Mission which has now been transformed into National Health Mission aims to carry out necessary architectural correction in the basic health care delivery system. Under NHM decentralization in decision making for effectiveness and responsiveness of the public health system has been envisaged. RKS are mandated with supervising the utilization of funds for health care delivery and to address local issues related to the facility based health care services. The objective behind setting up these RKS was to increase people's participation in issues of health care delivery system. The RKS initiative, pioneered in Madhya Pradesh recognized through the prestigious Global Development Network Award 2000 as the most innovative development project.

RKS in M.P. has the mandate to augment the facilities and the quality of care in public health care facilities. RKS is the hospital based management committee, registered as society under the Madhya Pradesh Societies Registration Act 1973. These management bodies entrusted with the core remit of patient welfare, augmenting hospital facilities and services with the participation of local people.

Earlier studies on functioning, operational processes, funding structures of RKS in states of Bihar, Uttarakhand, Maharashtra and Madhya Pradesh have pointed out lack of interest among RKS functionaries, inadequacy of their training in health facility management, problems associated with fund generation and its effective utilization. These studies have found issues related to competing interest among health functionaries and RKS members warranting revamping existing RKS structure and improving complacency in the functioning of RKS. Studies have recommended for a formal, more democratic structure of

RKS with approved guidelines for financial, human resource and infrastructure management of the facilities and grievance redressal for patients through the RKS.

In the year 2010, Department of Public Health and Family Welfare, Government of Madhya Pradesh after due diligence has approved RKS Charter for making RKS more responsive towards concurrent issues pertaining to public health care services delivery in the state. The charter also outlines guidelines for formation of executive and governing committees of RKS, roles and responsibilities of these committees and procedure to generate and utilization funds.

The programme implementation plan under NHM also calls for providing details of members of RKS and citizen charter display as mandatory disclosure. It also necessitates to publically displaying income and expenditure of RKS at each health facility.

Over the period, the process of funding for health care services has been rationalized and norms for financial discipline have been introduced under NHM. This has resulted in outcome based funding to health care facilities. During PIP monitoring it was reported that due to waiving off user charges for majority of health care services, source of income for RKS has reduced considerably. This is compensated by the state government by providing RKS grants to each level of health facility. The RKS grant is provided with certain conditions and areas where this grant can be utilized.

In the above backdrop it is pertinent to assess the functioning of RKS and its role in promoting quality services at public health facilities.

2. Objectives

1. To review government orders / guidelines pertaining to functioning of RKS.
2. To study perspective of RKS members regarding function of RKS.
3. To study the extent of resource mobilization by RKS across different levels of government health care institutions and the utilization of funds by RKS.
4. To assess the facilitating and inhibiting factors affecting the functioning of RKS.
5. To ascertain patients' awareness and perception about functioning of RKS.

3. Study Design and Sample

The study captured both primary and secondary data pertaining to functioning of RKS. Both qualitative and quantitative tools were used to collect primary data. Two high-priority districts – Raisen and Shahdol were selected purposively for the study. From each selected district, seven health facilities were selected which includes - a district hospital and a sub-district hospital, two CHCs and three PHCs. The CHCs and PHCs were selected considering the average monthly OPD and IPD patients in the last one year. Average monthly OPD and IPD cases reported in facility level HMIS data for the year 2016-17 in all the CHCs and PHCs were arranged in descending order and CHCs and PHCs with highest average monthly OPD/IPD were selected.

From each selected health facility a list of RKS members was obtained and 5-7 RKS members were selected randomly and were interviewed using in-depth interview schedule. An informed oral consent was obtained from each of the RKS members prior to interview. Exit interview of 10-15 randomly selected OPD and IPD patients from each visited health facility were also done. A semi-structured interview schedule was administered to respondents to assess the health care services availed by them and their awareness and perception about functioning of RKS. In all 58 RKS members were interviewed in-depth and 188 OPD/IPD patients were interviewed in the study. Data were entered, coded and univariate and bivariate analyses is done using MS Excel.

		RKS Members		Exit Interview	
Raisen		**Existing**	**Interviewed**	**OPD**	**IPD**
DH	Raisen	12	8	18	7
SDH	Begumganj	10	7	6	4
CHC	Mandideep	6	3	13	4
CHC	Silwani	8	3	15	3
PHC	Bamhori	6	6	19	0
PHC	Obedullaganj	5	3	10	1
PHC	Devnagar	6	2	2	2
Shahdol					
DH	Shahdol	9	5	9	15
SDH	Beohari	12	5	0	18
CHC	Jaisinghpur	12	6	12	2
CHC	Gohparu	5	3	11	5
PHC	Nipaniya	8	0	0	3
PHC	Khannaudi	4	1	2	0
PHC	Lafada	5	4	2	2
PHC	Amjhor	6	2	3	0

4. Review of Guidelines on Functioning of RKS

First directive regarding establishment of RKS at district hospitals with detailed guidelines was issued in 1992. Further guidelines were issued for establishing RKS at sub-district hospitals (SDH) and community health centres (CHCs) in 1995 and later on for establishment of RKS at all the primary health centres (PHCs). Chief medical and health officers were instructed to initiate the process of establishing RKS in all the health facilities of the district. Subsequently directorate of health services has issued various guidelines regarding functioning of RKS, holding of meetings, decision making process and approval, funds management etc.

In order to bring uniformity in the governing rules and functioning of RKS at all the tiers of public health institutions a broad guideline in the form of RKS Charter was issued in 2010 vide No.F.8-2/ 2009/ 17/ Med-2 dated 28.10.2010. (http://health.mp.gov.in/rks/rks-english.pdf accessed on 16.01.2017) This charter provides detailed description of objectives of RKS, activities to be performed by RKS, structure and composition of RKS, powers and responsibilities of general body of RKS, powers and responsibilities of executive committee of RKS, devolution of financial powers to RKS, levy of user charges, financial management and accounting, state level monitoring and supervision.

A review of directives and guidelines issued regarding RKS during the year 2013 to 2016 revealed following observations.

In the year 2013, state has directed to ensure availability of free and generic medicines by establishing Mukhya Mantri Free Medicine Distribution Centres in all the public health facilities and issued directives to close all the medicine shops running in the hospital premises. RKS faced lots of problems in implementation of these directives. Many public health facilities specially district hospitals were earning rent from shops which are constructed through the RKS. DH Raisen, DH Shahdol, CHC Begumganj are still facing problems in recovery of unpaid rent from tenant shopkeepers.

In the same year, the state government issued directives to provide free diagnostic and pathological tests across all the public health facilities. Number of minimum essential diagnostic tests proposed to be provided free of cost were 48 at DH, 32 at SDH, 28 and CHC and 16 at PHC. Necessary equipments, materials and staffs had to be arranged by respective health facilities for free diagnostic tests. This directive has forced all the RKS to stop taking

user charges immediately. In the subsequent years many proposed activities of expansion, upgradation, additional infrastructure, regular maintenance and payment of salary of staffs recruited by RKS was severely affected. From 2013-14 onwards many RKS were left with no additional funds to organize health promotion activities and for augmentation of support services in the public health facilities.

In 2014 state government issued directives for evacuating all the private and red-cross medical shops running in the premises of public health facilities. In many places, shopkeepers and hospital administration were engaged in legal process due to this order. Consequently RKS became party in legal cases, as shops were rented or leased through RKS. State government further issued strict order to get the legal cases cleared by hiring services of public prosecutors. This has resulted in admonishing of decision making processes in RKS and a state of inactivity prevailed in executive committee and general body of RKS. Litigations are still pending at DH Raisen, DH Shahdol and CHC Begumganj where huge amount of rent remained unpaid.

In the same year, government issued another directives for optimal utilization of all the available infrastructures such as buildings, land etc. only for health services. This has prompted RKS to take appropriate steps for collecting information and to initiate the repair and maintenance of such available buildings and land.

In the year 2015, orders regarding user charges to be taken from patients were issued. Government directed RKS to levy user charges for OPD and IPD service, specialty care services such as Dialysis, CT Scan etc. and room charges for private wards from all the patients. Patients from below poverty line (BPL) category and patients availing services under national health programme and from women and children patients were excluded from any kind of user charges levied in all the public health institutions. Levying of user charges has increased financial strength of RKS, particularly at DH. In other health facilities in the periphery this decision has not increased any financial strength of the RKS since most of the patients coming to periphery level health institutions belong to exempted groups.

During this year state government had combined annual maintenance grant, untied grant and RKS corpus grant in a flexi-pool fund. This was created to facilitate prompt utilization of funds for services augmentation, repair and maintenance, purchase of emergency medicines and patient services. A set of revised guidelines were also issued regarding utilization of flexi-pool funds for specific purposes and to bar hospital

administration from spending funds on higher amount purchases. A unique approach of funding was adopted by considering HMIS data reported for OPD, IPD, major operations and lab tests conducted as indicator of service performance and fund for all the health facilities were sanctioned proportionate to the service performance. A mandatory provision for utilization of 50 per cent of flexi-pool funds only through or on recommendation of RKS was also introduced to public participation in management of health facility and supervision of health care services. This was envisaged to achieve financial discipline and optimal utilization of funds for small budget expanses at the public health institutions.

There were problems in utilization of funds due to lack of regular meeting of RKS bodies and consensus on areas of funds utilization. In many RKS meetings regarding sanctioning of funds could not be conducted and flexi-pool funds remained unspent and lapsed resulting in budgetary constraints in many important initiatives for upgradation and augmentation of public amenities. However, at few institutions RKS were also active in garnering public donations in the form of cash as well as infrastructure and generating funds from industries under corporate social responsibility (CSR). PHC, Mandideep in Raisen has augmented its infrastructure through public donations and through CSR funds.

In 2015 and 2016, state government observed some irregularities in renting and leasing out shops for commercial use on hospital land by RKS. In financial audit of RKS it was commented that RKS did not levy appropriate fee for registration of rend and leas deed from various tenants of shops and this was seen as loss of government revenue. State government had taken initiatives for recovery of revenue loss. Many RKS functionaries, particularly the in-charge MOs of the health facility were not aware of these facts and expressed their inability in understanding the procedures and management of RKS funds and legal consequences of any improper and mistakenly taken decisions.

It is imperative to mention that state government has given due importance to the RKS and its role and contribution in overall development of health care institutions. However, lack of monitoring and supervision in implementation of RKS guidelines, lack of involvement of RKS members in its functioning. Issues of coordination between state government, RKS and health institution need to be addressed. This will help in strengthening RKS mandate and it effectiveness.

5. Perspective of RKS members

There are general and executive bodies constituted for each RKS. Members from each body was contacted and interviewed. In all 58 RKS members were interviewed in-depth to understand their perspective on functioning of RKS. Category-wise number of interviewed RKS members is given in Table 1.

Table 1: Number of RKS members interviewed by district

RKS member category	Raisen	Shahdol	Total
Public Representative	3	5	8
District level health official	2	1	3
Medical personnel from host facility	13	8	21
Govt officials from other department	11	9	20
NGO, Social Worker, Donors	3	3	6
Total	**32**	**26**	**58**

Background characteristics: Table 2 shows the background characteristics of RKS members. One-fifths of all the RKS members were females. Majority RKS members were in the age group of 36-55 years and have studied graduate and above. Caste-wise representation in RKS is skewed and majority respondents belong to other caste category.

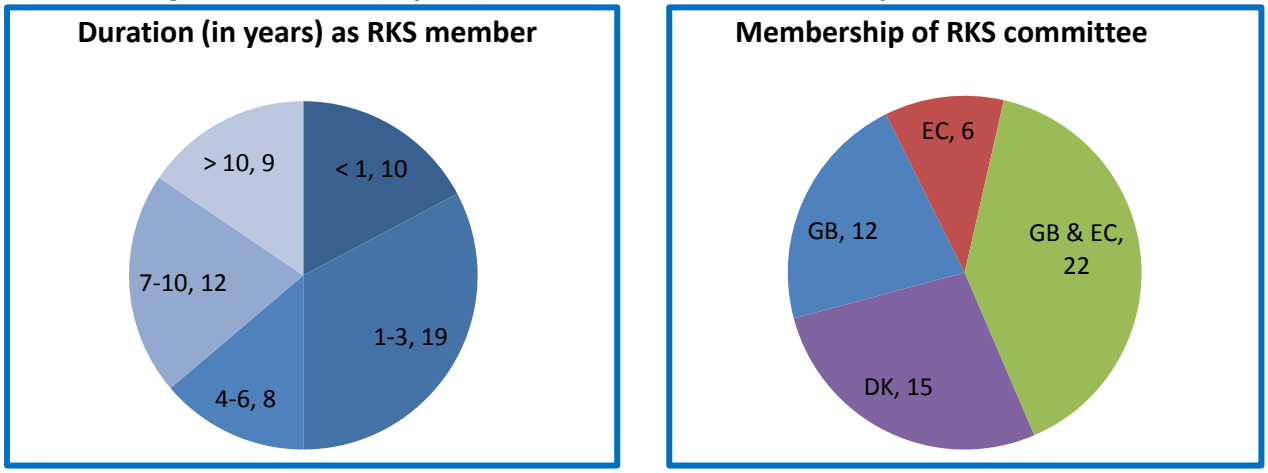
Table 2: Number of RKS members by their background characteristics

Background Characteristics		Public Rep.	District level health official	Medical personnel from host facility	Govt officials from other department	NGO Social Worker Donors	Total
Gender	Male	5	2	20	14	6	**47**
	Female	3	1	1	6	0	**11**
Age (Years)	<= 35	2	0	2	3	1	**8**
	36-45	3	0	7	2	1	**13**
	46-55	2	0	4	11	3	**20**
	>= 56	1	3	8	4	1	**17**
Education	No schooling	3	0	0	0	0	**3**
	Hr. Sec.	4	0	0	1	0	**5**
	Graduate	1	0	15	5	2	**23**
	Post Graduate	0	3	6	14	4	**27**
Caste	Scheduled Caste	1	0	3	2	0	**6**
	Scheduled Tribe	3	0	0	0	0	**3**
	Other Backward Caste	2	0	3	2	1	**8**
	Other	2	3	15	16	5	**41**

Constitution of RKS: RKS members were asked about the duration since they have become RKS member and about the RKS committee in which they are serving as member.

Information about frequency of RKS meetings and number of meetings attended by RKS members was also sought. For nearly one-third of respondents, duration since they have become RKS member was 1-3 years (Figure 1). Medical personnel from host institution had been serving for longer duration of 3-10 years in RKS in comparison to other RKS members.

Figure 1: Duration (in years) as RKS member and membership of RKS committee



It is found that except three respondents, no respondent had received any training or orientation about formation and functions of RKS and about their role as RKS member. Majority of the respondents informed that they are member of both general body and executive committee of RKS. Fifteen respondents didn't know whether they are member of general body or executive committee. This shows lack of continuous involvement of RKS members in activities of RKS. Members belonging to other government departments had very scanty idea regarding RKS and its functioning. In many instances government officials from other department are called just to attend the RKS meeting. They were not given any formal training or orientation about the RKS. Many respondents from health department or from host institutions asserted that since they are working in the institution no special training or orientation is needed as many things are known to them by experience.

Only one-fourth of all the RKS members affirmed that regular RKS meetings are held in each quarter which is also mandatory as per RKS charter. Twenty-three RKS members informed that RKS meetings are held as per the requirements and there is no fixed timings for RKS meetings, eight members didn't know about frequency of RKS meeting. It was observed that mostly medical personnel and district level health officials are involved in RKS

meetings. These meetings are held to take decisions on matter of immediate importance or to resolve any issue as per the directives received from state health department.

Table 3: Number of RKS meetings attended in last 6 months

	None	1	2	3	4
Public Representative	2	1	0	0	0
District level health official	1	1	0	0	0
Medical personnel from host facility	9	7	0	3	0
Govt officials from other department	3	4	2	1	0
NGO Social Worker Donors	4	1	0	0	1
Total	**18**	**14**	**2**	**4**	**1**

Nearly one-third of all members did not attend any RKS meetings during 6 months preceding the survey. Nearly one-fourth attended only one RKS meeting in this duration (Table 3). It is imperative to mention that schedule to RKS meetings could not be followed either due to lack of quorum or non-availability of key officials such as president, public representative for meeting. In as many as 12 health facilities out of 15 visited facilities RKS general body meeting was not held in the previous year during the survey.

CMHO in both the visited districts (Raisen and Shahdol) informed that local MP (Member of Parliament) is the president of DH level general body of RKS. Due to paucity of time, occasional visit by local Member of Parliament to DH, the general body meeting of RKS is generally conducted with review meeting of district health society. There is hardly any formal general body meeting held at DH level RKS. Date of last GB and EC meetings of RKS held at visited health institutions is given in Table 4.

Table 4: Date of last GB and EC meetings in visited health institution in Raisen and Shahdol districts

	Raisen			Shahdol	
Health Institution	**GB**	**EC**	**Health Institution**	**GB**	**EC**
DH Raisen	12.05.2017	09.05.2017	DH Shahdol	--	03.07.2017
SDH Begumganj	28.08.2016	17.08.2012	SDH Beohari	16.07.2016	14.05.2015
CHC Silwani	07.09.2016	24.07.2017	CHC Jaisinghnagar		04.12.2015
CHC Obedullaganj	22.07.2010	23.06.2017	CHC Gohparu (Pali)	10.05.2012	23.11.2012
PHC Mandideep	27.05.2017	20.01.2014	PHC Nipaniya	06.09.2016	26.05.2016
PHC Bamhori	--	07.03.2013	PHC Amjhor	20.07.2017	07.01.2016
PHC Devnagar	02.12.2016	03.03.2016	PHC Khannaudi	--	--
			PHC Lafada	11.01.2012	12.02.2012

It is imperative to mention that public representatives such as Member of Parliament, Member of Legislative Assembly, president of district panchayat and block panchayat who are also president of general body of RKS at respective levels from DH to PHC could not be available for in-depth interview due to their pre-occupation with local body elections in Shahdol district and ongoing monsoon session of legislative assembly. President of RKS of DH Raisen is also the union external affairs minister therefore could not be contacted.

Source of Funding of RKS: RKS members were asked about the sources of fund of RKS. Out of 58 RKS members interviewed, only 37 could tell the source of RKS funds. Majority among them were medical personnel of host facility, followed by government officials from other department. Majority RKS members said that user charges are source of RKS funds followed by rent received from the shops etc. managed by the RKS. It is surprising to note that only 11 RKS members knew that government provides financial grant to RKS which is a major source of RKS funds.

Table 5: Number of RKS members aware of source of RKS funds

Category of RKS member	No. of RKS Members Responded	Source of RKS Funds (Multiple Responses)				
		Govt. Grant	User Charges	Rent	Public Donation	Other
Public Representative	3	1	2	2	1	1
District level health official	3	1	1	3	2	2
Medical personnel from host facility	17	7	11	4	5	2
Govt officials from other department	8	2	2	6	2	1
NGO Social Worker Donors	6	0	4	2	1	0
Total	**37**	**11**	**20**	**17**	**11**	**6**

RKS members were also asked about the share of user charges in total RKS funds. Forty RKS members responded about the share of user charges in RKS funds and 18 RKS member did not know about the share of user charges. Majority RKS members said that share of user charges in RKS funds is more than 50 percent. None of the RKS members from other government department had any information regarding share of user charges in RKS funds. It was observed that majority of RKS members were not aware about details of RKS funds received and its expenditure. Although the financial audit of RKS funds are done as per the requirement. Majority RKS members also affirmed that financial audit of RKS funds is done regularly.

Few of the surveyed health institutions had rented shops and land property to generate additional resources (Table 6). Nearly half of the RKS members told that no property has been rented out by RKS for generating additional funds. It is imperative to mention that some of the health institutions are facing legal disputes for unauthorized construction, auction and renting properties.

Table 6: Number of RKS members saying property is rented by RKS for additional funds

	Yes	No
Public Representative	2	1
District level health official	1	1
Medical personnel from host facility	5	14
Govt officials from other department	7	1
NGO Social Worker Donors	2	3
Total	**17**	**20**

It was observed that 22 RKS members were aware of guidelines issued for utilization of RKS funds and 16 RKS members were not fully aware of these guidelines (Table 7). Some of the RKS members informed that mostly decision about the utilization of RKS funds are discussed in the executive or general body meeting and only expenditure of funds is presented. Details about process of approval, sanction and procedure of RKS funds utilization are not discussed with all the members.

Table 7: Number of RKS members know about guidelines for RKS funds utilization

	Yes	No
Public Representative	1	2
District level health official	2	0
Medical personnel from host facility	12	7
Govt officials from other department	4	4
NGO Social Worker Donors	3	3
Total	**22**	**16**

Mechanism of sharing decisions taken by RKS with general public do exists. Primarily decisions regarding introduction of user charges, any government directives on health care services and initiation of new patient services etc. are shared with the public. Decisions regarding procurement of equipments, hiring of staffs for clinical and non-clinical support

services, outsourcing of services and construction etc. which have financial implications are not shared with public. It was observed that none of the visited health facility has displayed list of RKS members with their contact details for public.

Table 8: Number of RKS members who says - RKS decision shared with public

	Yes	No
Public Representative	0	3
District level health official	1	1
Medical personnel from host facility	8	11
Govt officials from other department	6	1
NGO Social Worker Donors	4	1
Total	19	17

A mandatory disclosure of income and expenditure of RKS funds was also not observed at any of the visited health facility. Table 8 shows that half of the RKS members affirmed sharing of RKS decisions with the public, but at the same time, 11 medical personnel from host facility who are also RKS members accepted that RKS decisions are not shared with public in any form.

6. Perspective of patients regarding RKS

One of the objectives of the study is to ascertain the perspective of patients regarding facilities available at various health institutions and to understand their awareness about RKS. In all 188 patients in the two districts (Raisen: 55%; Shahdol: 45%) who came for OPD and IPD services were interviewed. Table 8 provides socio-demographic characteristics of interviewed patients.

Majority respondents were females in both the districts. One third of the respondents were illiterate and less than one-third of them had 10 or more years of schooling. Half of the respondents were housewives who had come to the health facility for availing treatment. More than one-third (38 percent) of respondents were in the young age group of less than 24 years. Nearly half of the respondents belonged to other backward

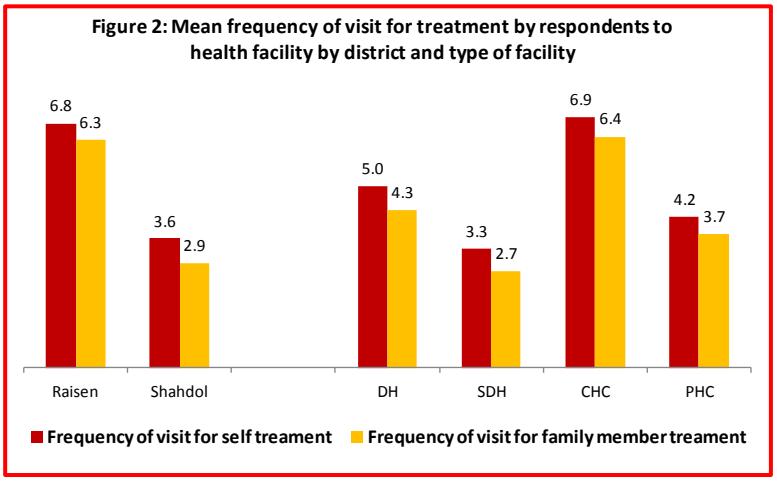
caste category. One-third of respondents in Shahdol district were scheduled tribe. Little less than half of the respondents had mid size family of 5-7 members

Table 9: District-wise percentage distribution of interviewed patients by their socio-demographic characteristics

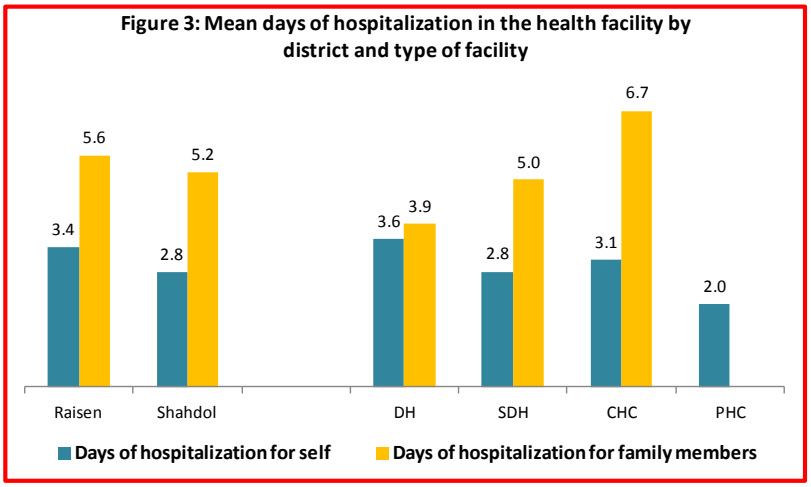
Characteristics		Raisen N = 104	Shahdol N = 84	Total N = 188
Type of health facility where interviewed	DH	25.0	28.6	26.6
	SDH	9.6	21.4	14.9
	CHC	41.3	35.7	38.8
	PHC	24.0	14.3	19.7
Residence	Rural	53.8	81.0	66.0
	Urban	46.2	19.0	34.0
Gender	Male	31.7	26.2	29.3
	Female	68.3	73.8	70.7
Occupation	Govt Service	2.9	4.8	3.7
	Pvt Service	2.9	1.2	2.1
	Farmer	10.6	7.1	9.0
	Business	1.0	0.0	.5
	Housewife	51.0	51.2	51.1
	Other	31.7	35.7	33.5
Caste	Scheduled Caste	13.5	8.3	11.2
	Scheduled Tribe	11.5	33.3	21.3
	OBC	46.2	48.8	47.3
	Other	28.8	9.5	20.2
Age	< 20	14.4	8.3	11.7
	20-24	18.3	35.7	26.1
	25-29	20.2	25.0	22.3
	30-34	16.3	10.7	13.8
	>= 35	30.8	20.2	26.1
Years of Schooling	No Schooling	31.7	29.8	30.9
	1-5	16.3	11.9	14.4
	6-9	23.1	29.8	26.1
	>= 10	28.8	28.6	28.7
Household size	1-4	30.8	40.5	35.1
	5-7	49.0	44.1	46.8
	>=8	20.2	15.4	18.1

Figure 2 shows the average frequency of visit to health facility is higher in Raisen district for self treatment. CHC was the most frequently visited health facility for treatment followed by DH. The mean number of visits at CHC by respondents was 5.0 at DH. It was found that majority respondents on an average visited 6.3 times to a health facility for

treatment of their family members in Raisen district and only 3 times in Shahdol district. It was also observed that nearly one-third of the respondents had visited health facility for the first time for availing treatment for their family members.



Respondents were asked about number of days of hospitalization for themselves and for their family members during 1 year prior to survey. Figure 3 shows that on average, respondents from Raisen district were hospitalized for 3.4 days and those in Shahdol for 2.9 days. Mean duration of hospitalization of family members of the respondents was more in CHC (6.7 days) as compared to DH (3.9 days).



Respondents were asked about the purpose of their current visit to the health facility. For 84 percent respondents purpose of current visit to health facility was their own treatment, 14 percent had come for treatment of their family members and rest had come

for treatment of themselves as well as their family members. Further, current visit of 65 percent respondents was for OPD services and remaining had come for IPD services.

Various services in the health facility are mandated to be provided free of cost including medicines, pathological tests, food, transportation. General cleanliness, availability of clean drinking water, adequate attention from staffs, checkup from doctors during hospitalization are also required to be provided to patients. RKS has a defined role in monitoring of availability of all these provisions for better user satisfaction.

It was observed that 98 percent respondents had received free medicines and diagnostics services across all the facilities. Only three respondents in Shahdol at one of the CHC had to purchase medicines. Table 10 shows that nearly one third respondents had to pay for transportation while coming to hospital and only 13.5 percent respondents got free transport facility for returning to home from hospital. It may be mentioned here that not all the respondents required transport facility, as most of the respondents had come by their own vehicles. In Shahdol 38 percent respondents had to pay for transportation while coming to health facility. Majority respondents affirmed that facility for safe drinking water and guidance and help was available to them during their visit to the health institutions.

Seven percent of respondents interviewed at CHC informed that health worker asked for money for services and four percent of respondents interviewed at DH also informed regarding health worker asking money for services.

Table 10: Percentage of respondents who availed services and facilities

Services / Facilities	District		Type of Health Institution			
	Raisen	Shahdol	DH	SDH	CHC	PHC
Paid for transportation for coming to hospital	24.0	38.1	40.0	37.5	31.5	10.8
Got free transportation for drop back to home	11.7	15.9	8.3	18.5	11.0	21.6
Any health worker ask for money for any services	1.0	4.8	4.0	7.1	1.4	0.0
Got clean drinking water in the hospital	88.3	79.5	79.2	96.4	79.5	91.9
Got proper guidance / help for health services	88.3	93.9	87.5	85.7	94.5	91.9

All IPD patients were asked about the services and facilities they received. Majority (94 percent) of IPD patients reported to have got clean beds during hospitalization; they also reported about daily cleaning of wards. In Raisen district nearly 70 percent of

respondents received food during hospitalization, all the respondents in Shahdol got good during hospitalization. Patient's examination by a doctor at least once in a day was reported by 83 and 91 percent IPD respondents at Raisen and Shahdol districts respectively. All IPD respondents from DH and 66 percent IPD respondents from PHC were examined atleast once a day by a doctor during hospitalization (Table 11).

Table 11: Percentage of IPD respondents who availed services and facilities

Services / Facilities	District		Type of Health Institution			
	Raisen (N=22)	Shahdol (N = 42)	DH (N=22)	SDH (N=22)	CHC (N=15)	PHC (N=9)
Got clean bed during hospitalization	95.7	93.3	81.8	100	100	100
Noticed regular cleaning of ward during hospitalization	82.6	100	100	81.8	100	100
Got food during hospitalization	69.6	100	95.5	100	86.7	55.6
Asked to purchase medicines / consumables during hospitalization	17.4	2.2	18.2	0.0	0.0	11.1
Got adequate attention from nurse during hospitalization	91.3	100	95.5	95.5	100	100
Doctor examined at least once every day during hospitalization	82.6	91.1	100	86.4	86.7	66.7

Table 12 shows that about one fifths of respondents in Raisen district and six percent in Shahdol had complaints about services and amenities available in the respective health facilities they had visited. Nearly one among ten respondents at CHC and PHC had any complaint about the services and amenities.

Table 12: Percentage of respondents by awareness and quality parameters of health care services

Services / Facilities	District		Type of Health Institution			
	Raisen (N=104)	Shahdol (N = 84)	DH (N=50)	SDH (N=28)	CHC (N=73)	PHC (N=37)
Have any complaint regarding any services or amenities in this hospital	19.2	6.0	14.0	17.9	12.3	10.8
Know the names and phone number of doctor (s) of this hospital	19.2	14.3	16.0	17.9	20.5	10.8
Know about RKS	4.8	3.6	8.0	0.0	5.5	0.0

Only one fifths of respondents those visited CHC for services knew the names and phone numbers of doctors of the hospital. It was found that awareness about the RKS is very minimal among the respondents. Only eight percent of respondent who had visited

district hospital and six percent of respondents who had visited the CHC knew about the RKS. none of the respondents at SDH and PHC were aware of RKS.

About one-third (34 percent) of all the respondents expressed their satisfaction about the services and facilities received at the health institutions. In Raisen 25 percent and in Shahdol 45 percent respondents expressed their satisfaction from the services and amenities. Around 10 percent of all the respondents suggested about improving existing infrastructure in terms of increasing bed capacity, more space for patients, availability of ambulance, drinking water facility, operation theatre etc. Increase in number of doctors, posting of female doctors, child specialists etc. was suggested by 12 percent of respondents. Availability of x-ray, sonography, pathology including increase in number of test, adequate supply of medicines was suggested by 11.7 percent respondents. Nearly one-fifth of the respondents complained about inadequate arrangements for cleanliness. Respondents suggested for improving toilet facility, regular cleaning of toilets and daily cleaning of wards and hospital premises and provision of dustbins in the hospitals. Few respondents were critical about the rude behaviour of staffs, non-punctuality of doctors and inadequate IEC for patient awareness.

It is pertinent that all these systemic management falls under domains of RKS functions. Most of the respondents are not aware that suggestion for improvement and complaints regarding inadequacy of services and infrastructure are to be reported to RKS and RKS members are key stakeholders in overall management of health care facility. Despite all the complaints and scope of improvement suggested by the respondents, none had ever approached to any hospital authority for any help. This reflects lack of mechanism to reach out to patients through RKS.

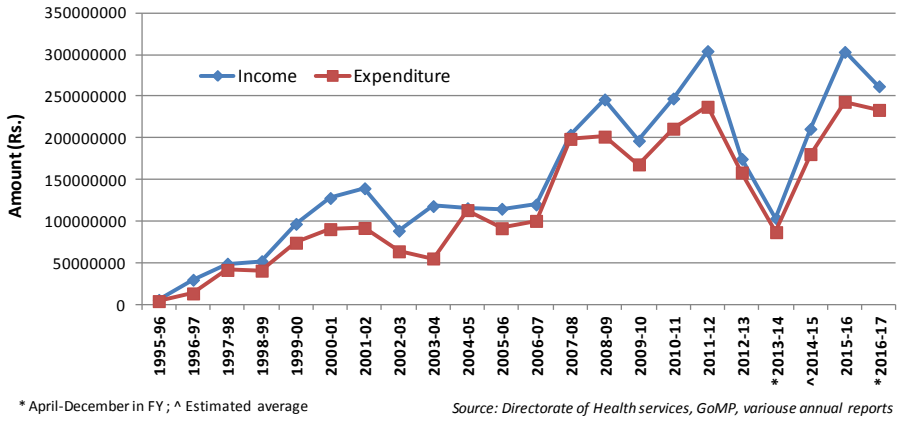
7. Resource mobilization and utilization of funds by RKS

Primarily the RKS was mandated to mobilize resources for upkeeping of health facility, improving infrastructure and creating additional services and amenities for better patient satisfaction. It was observed that despite clear instructions and guidelines, majority of RKS have no systematic information regarding list of RKS members, their roles and responsibility, financial outlay including income and expenditure.

Processes of RKS functioning were also not properly documented in the form of minutes of the meeting, financial audits, resource management and monitoring of health care services. There is negligible involvement of ex-officio RKS members, community leaders and PRI members in functioning of RKS.

Figure 4 shows that after launch of NRHM in 2005 more financial resources were provided to RKS for management of health institutions. Data on income and expenditure of

Figure 4: Income and Expenditure of RKS, M.P.



* April-December in FY ; ^ Estimated average

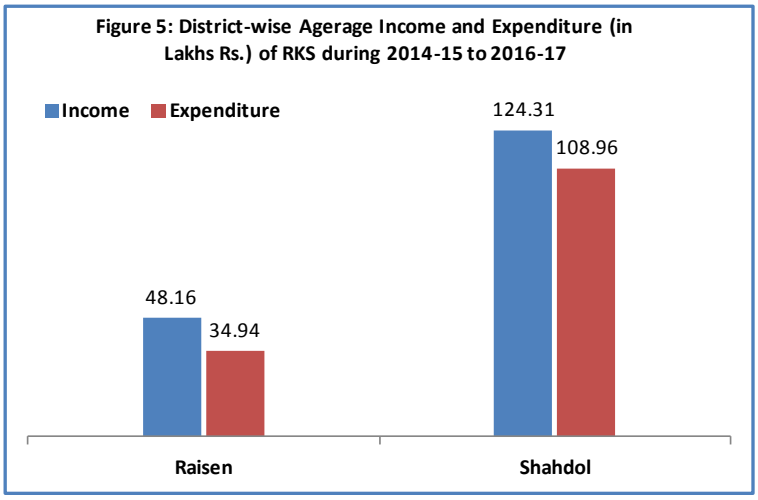
Source: Directorate of Health services, GoMP, variouse annual reports

RKS shows that RKS have garnered cumulative income of Rs.331 crores during 1995 to 2016. The total expenditure of RKS was Rs. 270 crores in this duration.

To understand the resources mobilized and available for RKS to perform its functions details of income and expenditure from each of the visited institutions was collected. It was observed that details of RKS income and expenditure are not properly maintained at all the visited the visited health institutions. Except DH Raisen and CH Beohari no other health institutions have detailed information on RKS income and expenditure. Details of RKS income and expenditure provided by CHC Mandideep, was also displayed publically.

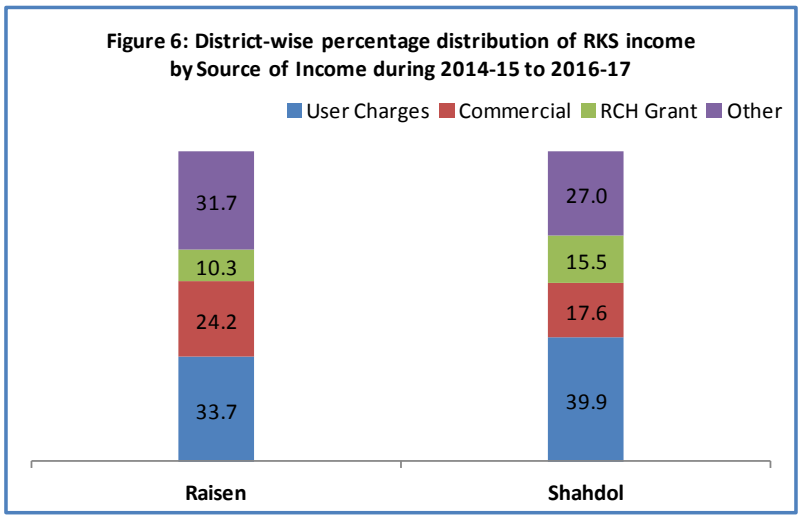
Figure 5 shows that in Shahdol average income of RKS from the visited health institutions is much higher than that of RKS from Raisen district. On an average 72 percent of RKS income was spent in Raisen and 87 percent in Shahdol during 2014-15 to 2016-17.

It was pointed out by RKS members in Shahdol district that majority funds in the tribal dominated district received under various tribal welfare schemes and part of all the public funds are earmarked for health care institutions.



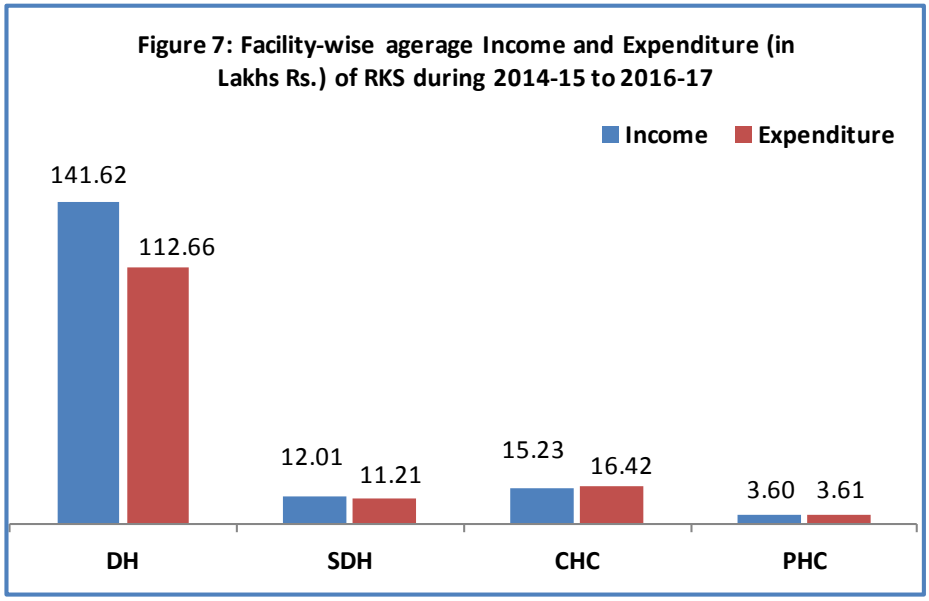
In DH Shahdol, RKS also received funds through donation and CSR for upgradation of infrastructure and resources for health.

The sources of RKS funds mainly comprises of user charges, commercial income in the form of rents, lease of shops etc., government grant through RCH, NHM etc. and other charges received from earnest money from tendering services for parking, outsourcing services, by organizing health camps and funds received under various national health programme etc. Figure 6 shows the percentage share of various sources of RKS income during 2015-15 to 2016-17. User charges constitute more than one-third of all the income of RKS in both the districts. Commercial charges in the form of rent from shops, tender fee etc. is 24 percent of RKS income in Raisen and 18 percent in Shahdol district.



It was observed that there is no uniformity in maintaining RKS income and expenditure. Financial books are maintained but they are not in order. In SDH Begumganj RKS fund were used for construction activities, which is not permitted as per RKS guidelines.

Data of RKS income and expenditure for various types of health facilities shows that major share of RKS income is spent by CHC and PHC (Figure 7). It was observed that visited CHCs and PHCs have excess expenditure over income from RKS.



It was observed that major share of RKS expenditure is spent on payment of HR. Majority institutions have recruited HR for support services such as DEO, housekeeping, security staff etc. in all the visited health institutions. Expenditure on HR is nearly 30 percent of all the RKS spending.

It was observed that frequent changes in the guidelines pertaining to generation and utilization of funds by RKS has created uncertainty in continuation of RKS activities. This has also resulted in utilization of RKS funds in activities which are not permitted in the guidelines. Some of the RKS which have sufficient funds are not able to utilize it for necessary activities due to government guidelines.

8. Conclusion and Recommendations

In most developing countries, provision of basic preventive, promotive and curative services is a major concern of the government and decision makers. With growing population and advancement in the medical technology and increasing expectation of the people especially for quality curative care, it has now become imperative to provide quality health care services through the established institutions.

In India after launch of NRHM, up-gradation of all public health institutions to Indian Public Health Standards (IPHS) has been taken up. This is a major strategic intervention under the National Rural Health Mission (NRHM). The purpose is to provide sustainable quality care with accountability and people's participation along with total transparency. Establishment of Rogi Kalyan Samiti (RKS) or Patient Welfare Committee / Hospital Management Society (HMS) are a step in this direction.

Madhya Pradesh is the state where RKS were first established. Since its inception in 1995, gradually RKS were established in all the public health institutions. Over the period functioning of RKS has been streamlined through various guidelines. The objective was to promote public participation in management of health care facility and monitoring of proper utilization of funds for upgradation of health care services and infrastructure.

Analysis of recent directives issued regarding functioning of RKS shows that decision taken by RKS in the earlier years on construction, leasing out properties on health institution land, renting of shops were prohibited. This has resulted in sudden drop in the revenue generation capacity of RKS. Moreover, RKS of the DH, SDH and CHC had to face lots of legal disputes as deposit money was taken from the shop tenants. In Raisen, action was initiated against defaulters for non-payments of rent and lease rent.

User charges were introduced in 2013 and again withdrawn in the subsequent years. This also resulted in mitigating regular income sources of RKS. Majority RKS in rural periphery areas were grossly affected by withdrawal of user charges. In the subsequent years NHM untied grant were linked with the number of OPD/IPD patients at the respective

health institutions. This has resulted in insufficient funding for many rural health institutions and most the untied grant was spent without any active involvement of RKS.

The study has found that majority RKS are not properly constituted as per the RKS charter issued in 2010 by GoMP. Mostly executive body of RKS are well constituted and control all the activities of RKS. General body of RKS which primarily involve public representatives such as members of parliament and member of legislative assembly were found to be inactive due to non-availability of PRI members. At periphery level, particularly at PHC and CHC in rural areas, RKS have not even listed PRI representatives as its member.

It was observed that regular meetings of RKS do not take place at any of the visited health institutions. Majority RKS members, other than medical officers and block and district level health officials were not fully aware about objectives of RKS and their roles and responsibilities as RKS member. Ex-officio members from other government departments are not actively involved in RKS decisions. Any change in the person concerned in any government department is also not reported to RKS.

The study has found that interaction of other RKS members with officials from department of public relations, public health engineering, state electricity board, public works department, women and child development is minimal due to pre-occupation of these officials in their regular work. None of the RKS members from other government departments were aware of funds received by RKS and its utilization.

RKS members from the host health institutions such as medical officers, civil surgeon, chief medical and health officer were critical about the involvement of block level revenue officers i.e. Sub District Magistrate (SDM) and Tehsildar as chairman of RKS at SDH and CHC. It was pointed out that revenue officials do not give enough time for conducting regular meetings of RKS. At times release of RKS funds for any activity gets delayed due to lack of coordination and active involvement of these officials.

Decisions taken by RKS are not shared with public except changes in user charges. In majority health facilities it was observed that mandatory disclosure of RKS funds to public is not done. Decision of RKS regarding new construction, hiring of manpower, services and spending of funds on purchase is not displayed publically. On few occasions, in Raisen, decisions taken in RKS meetings were shared with public through news papers.

It was observed that RKS in both the districts are not actively involved in organizing health awareness campaigns, national health programmes and IEC activities. Periodic visit to health facility by RKS members other than health officials for monitoring of ongoing activities proposed by RKS, fund utilization and patient feedback is not observed. There is no visible active presence of RKS in management of health care facilities in any of the visited health institutions in both the district.

Study revealed that majority respondents who visited health institutions for OPD or IPD did not know about RKS. Respondents, however, reported about availability of certain amenities and health care facilities. Many respondents pointed about the problems in getting health services due to non-availability of staffs, particularly at periphery level health institutions, lack of cleanliness, and unclean toilet facility in health centres. These problems are essentially forms the domain of RKS functions.

The study has found that Rs.330 crores of income has been garnered by RKS in health institutions in Madhya Pradesh during 1995 to 2016. The total expenditure of RKS has been Rs. 270 crores in this duration. There is no established mechanism for maintaining regular database of income and expenditure, guidelines issued regarding functioning of RKS, decisions taken by RKS and conduct of periodic meetings of executive and general body of RKS at respective health facilities. Majority of RKS funds are spent on providing salary of recruited staffs for support services, minor repairs, printing of stationery etc.

Study has found that abolishing user charges has affected resource generation capacity of RKS. This has resulted in limited participation of RKS in activities of health institutions. RKS has remained non-functional and only following government orders

without taking any initiative at their own for management of health institutions. Most of the RKS now functions symbolically without proper monitoring and supervision.

Study suggests following recommendations for streamlining RKS functions and its visibility in effective management of health care services and utilization of funds.

- Restructuring of RKS is essential. Training and orientation of existing and newly appointed RKS members about health programmes and policies should be given at regular interval. This will ensure their active participation in management of health institutions. ***Instead of funds based management, activity based mandate need to be given to RKS.***
- Names and contact details of RKS members should be mandatorily displayed at all the health facilities and periodic updation of this information need to be ensured.
- Most of the funds are provided to health facilities under NHM, are programme specific and comes with the guidelines for using these funds. There is no role of RKS in utilization of these funds. ***RKS should act as monitoring body and ensure timely completion of programme.***
- Mechanism for public display of activities of RKS and regular interaction of RKS with general public in the form of Jan Sunwai or public hearing, grievance redressal etc. should be devised.
- RKS should be allowed to monitor and supervise functioning of essential infrastructure and services such as cleanliness, regular electricity supply, water supply, ambulance facility, condition of buildings, residential quarters etc.
- Untied funds, government grants provided to RKS need to be essentially displayed publically and every decision taken or work accomplished by RKS should be given wide publicity. This will ensure visibility of RKS.

Constituent members of RKS at various health institutions as per RKS charter, M.P.

Sr	RKS Members	DH		SDH		CHC		PHC	
		EB	GB	EB	GB	EB	GB	EB	GB
1	In-Charge Minister of the District	--	C	--	--	--	--	--	--
2	Member of Parliament, Lok Sabha.	--	M	--	--	--	--	--	--
3	MP from Rajya Sabha (will self-nominate) to any one district	--	M	--	--	--	--	--	--
4	All MLA of the district*	--	M	--	C				
5	President Jila Panchayat	--	M	--	--	--	--	--	--
6	Mayor of M. Corp./President of Municipality/ ULB	--	M	--	--	--	--	--	--
7	District Collector	C	MS	--	--	--	--	--	--
8	Chief Medical Health Officer	M	M	C	M			--	--
9	Two senior MO (one should be one lady doctor preferably)	M	M	--	--	--	--	--	--
10	District Programme Officer, Dept of Women and Child Devp.	M	M	--	--	--	--	--	--
11	Executive Engineer, Public Works Dept	M	M	--	--	--	--	--	--
12	Commissioner/Chief Municipal Officer, M. Corp./Committee	M	M	--	--	--	--	--	--
13	Donor* (with donation >= 100,000/-)	M-1	M-1	--	--	--	--	--	--
14	One person from NGO/Rotary/Lions	M	M	--	--	--	--	--	--
15	One Social Worker (with proven track record in health) nominated by Exec Committee & ratified by General Body	M	M	--	--	--	--	--	--
16	Hospital Administrator/Manager	M	M	--	--	--	--	--	--
17	Civil Surgeon	MS	M	--	--	--	--	--	--
18	SDO / Magistrate	--	--	M/C	M	M/C	M	--	--
19	President Janpad Panchayat / Nagar Palika / Nagar Panchayat	--	--	--	M	--	M	--	C
20	CEO Janpad Panchayat	--	--	--	M	--	M	--	--
21	DE/Assistant Engineer, MPEB	--	--	--	M	--	M	--	--
22	SDO, Public Works Dept	--	--	M	M	M	M	--	--
23	SDO, Police	--	--		M		M	--	--
24	Donor* (donated Rs 50,000/)	--	--	M	M	M	M	--	--
25	Press Representative	--	--	--	M	--	M	--	--
26	Senior Medical Officer nominated by CMHO	--	--	M-2 (L)	M	M-2 (L)	M	--	--
27	Child Development Programme Officer	--	--	--	M	--	M	--	--
28	In-Charge Civil Hospital, BMO In-Charge CHC	--	--	--	MS	--	MS	--	--
29	Two social workers with proven track record in health activism (proposed by the Executive Committee and ratified by the collector)	--	--	M	--	M	--	--	--
30	In-Charge Civil Hospital (in case of Civil Hospital RKS)	--	--	MC	--	--	--	--	--
31	Block Medical* (in case of Community Health Centre-CHC)	--	--	--	--	MS	--	C	M
32	Tehsildar /Naib Tehsildar	--	--	--	--	--	--	M	M
33	Sub Engineer, Public Works Dept	--	--	--	--	--	--	M	M
34	Sub Engineer, MPEB	--	--	--	--	--	--	M	M
35	Women and Child Devp Supervisor (Head-Qtr position)	--	--	--	--	--	--	M	--
36	Donor* (with donation <= Rs 25,000/)	--	--	--	--	--	--	M-2	M-1
37	Three people's representatives. (preferably two of which should be from the Gram Swasthya Samiti ratified by SDM)	--	--	--	--	--	--	M	--
38	In-Charge Medical Officer Hospital	--	--	--	--	--	--	MS	MS
39	President of Health Committee	--	--	--	--	--	--	--	M
40	Nagar/Gram Panchayat female Member	--	--	--	--	--	--	--	M

C- Chairman; M-Member, MS-Member Sectary

*(If multiple donor - donated maximum will be member) / 1. At DH level RKS - The collector is mandated to chair the meeting, in his absence, the CMHO to preside the proceedings. The Executive Body will meet at least once every quarter. 2. At CHC level RKS - Sub-Divisional Officer/Magistrate (in absence of CMHO, Member SDM will chair the meeting) 3. At SDH/CHC level RKS - In case of absence of CMHO, the SDM will chair the meeting in case of CHC and the In-Charge Civil Hospital in case of Civil Hospital RKS

Photographs of RKS study field survey in Raisen District

Photographs of RKS study field survey in Shahdol District