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Healthcare under the Panchayati Raj Institutions (PRIs) in a decentralised health system

Experiences from Hardoi district of India

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Abstract

Purpose – This paper aims to explore the challenges and benefits arising from the involvement of Panchayati Raj Institutions (PRIs) in the provisioning of primary healthcare in a decentralised health system of India.

Design/methodology/approach – A qualitative study design was used in this study. Data were collected through semi-structured interviews from 89 respondents selected from nine primary health centres across the district. A thematic analytical framework approach was used to analyse the data.

Findings – The research results indicate that there are several challenges resulting from PRIs involvement, including prioritisation of service providers and users, coercive unethical work and lack of communication. However, there are some benefits associated with the involvement of the PRIs in service provisioning, including improved availability and regularity of healthcare providers at the health centres.

Research limitations/implications – The implications of the findings suggest that the PRIs play an important role in healthcare provisioning; however, their involvement is ineffective due to their partial capabilities and approach, which creates a non-conducive environment.

Practical implications – Health issues are among the most important human concerns, and recognising and addressing the grassroot challenges help to locate, and overcome the challenges that hinder the smooth healthcare provisioning process.

Originality/value – National Rural Health Mission has recognised the PRIs as a platform to promote decentralised health planning and for achieving its goals in India. The PRIs are significantly involved in planning, monitoring and provisioning of primary healthcare services at grassroot level. This paper addresses the challenges and benefits that emerged due to their involvement.

Keywords Public health, Health services, Primary care, Patient care, Health leadership initiatives, Health services sector

Paper type Research paper

Background

The dominance of biomedical model in health systems was challenged by the Alma-Ata Declaration to overcome ineffective, culturally inappropriate and inaccessible primary healthcare among poor rural communities, which included a proposal that health

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systems should consider community participation as a core principle in managing primary healthcare (World Health Organization (WHO) and UNICEF, 1978). Following the Alma-Ata Declaration and the International Conference on Population and Development 1994, decentralisation of public health systems was introduced in India as part of broader reforms to improve the health sector performance through community participation (Ray, 2014). The decentralisation of health systems provided opportunities for community participation in health planning with a view that unless the people are involved in the planning process, it is impossible to evolve a meaningful, rational and cost effective healthcare system, which can provide appropriate healthcare to the people (World Health Organization (WHO) and UNICEF, 1978; Bhatia, 1993; Muraleedharan, 1994).

In India, the Panchayati Raj Institutions (PRIs) facilitate people's participation in all developmental activities at the village level (Sundaram, 1998; Sanyal, 2001; Bhatia, 1993; GOI, 2008; GOUP, 2014a). The PRIs hold very important positions in local communities, driving improvements across local, social determinants by planning and service provisioning through government development and welfare programmes (Pattanaik, 2006; GOI, 2008). Under the leadership of the PRIs, the administration is decentralised, and planning and implementation of the development programmes are done from the bottom (Dutta, 1993; Muraleedharan, 1994). In this way, the PRIs are significantly involved in planning, monitoring and provisioning of primary services at the grassroot level. This paper aims to explore the challenges and benefits arising from the involvement of the PRIs in provisioning of primary healthcare in a decentralised health system.

Decentralisation in India

Since the 1990s, decentralisation has emerged as a leading paradigm in India (Ghuman and Singh, 2013). It is understood as a political process, whereby power, authority, resources and service delivery responsibilities are transferred from the centre to the local authorities (Ghuman and Singh, 2013; Frumence *et al.*, 2014; Sanyal, 2001, p. 23; Litvack *et al.*, 1998; Rondinelli, 1981). The PRIs are the key drivers of decentralisation, which enable decentralisation of administration and democratisation of power (Sanyal, 2001). Decentralisation can be categorised into different types as given in Box 1.

Box 1. Types of decentralisation

- Deconcentration is passing down of some of its administrative authority to lower officers of the ministry responsible for health which in turn, results in some dispersal of power (Sanyal, 2001; Ghuman and Singh, 2013; Rondinelli, 1981).
- Delegation refers to the transfer of authority and responsibility to the semi-autonomous institutions of the central government (Sanyal, 2001; Ghuman and Singh, 2013).
- Devolution is the most desirable form of decentralisation defined as legal transfer of power to democratically elected local political institutions and gives them freedom to take complete responsibility without referring back to the central authority. Under the devolution, the local level government is allowed to work supposedly as an autonomous institution taking supervisory role from the centre (Sanyal, 2001; Johnson, 2003).

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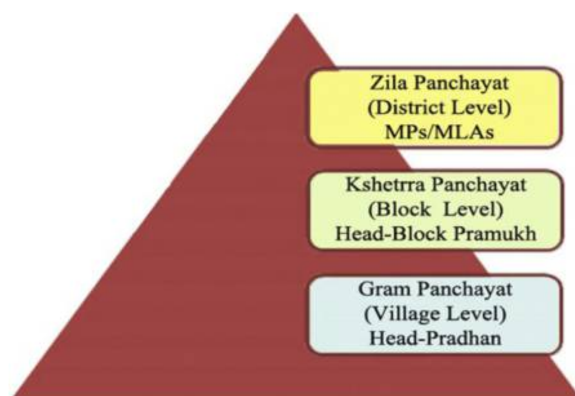
India has an extensive multi-tiered public health system, where healthcare services are delivered at three levels namely, primary, secondary and tertiary (GOI, 2014). These are characterised by the presence of several distinct systems of healthcare delivery such as government, non-profit, charitable organisations, corporate hospitals and smaller private clinics (Yeravdekar *et al.*, 2013). The primary healthcare services are delivered to the population through a network of sub-centres (SCs) and primary health centres (PHCs) (GOI, 2014). Decentralisation brings improvement in service delivery by enhancing responsibility, transparency through community participation and monitoring and decision-making in the service provisioning process (Ghuman and Singh, 2013). It was supposed that under the control of the local government (PRIs), the health resources would be used most efficiently, with more reasonable distribution of benefits and management of healthcare services (Sanyal, 2001). This illustrates that there is a need for an effective decentralised health system that can provide a favourable environment to the healthcare providers as well as to seekers to facilitate healthcare service provisioning (NRHM, 2005).

Panchayati Raj Institutions in India

The PRIs is a three-tier structure of rural local self-government, linking villages to the district, Figure 1 (GOUP, 2014a). The *Gram Panchayat* is the lowest democratically elected body in this three-tier system, which can be for a village or a group of villages. The *Gram Panchayat* derives its power from sub-national, i.e. the state government has responsibility to nurture and develop the *Gram Panchayats* (GOUP, 2014a). The chairperson, i.e. the *Pradhan* of each *Gram Panchayat* is chosen by direct elections under the superintendence of the state election commission on a five-year time interval (GOUP, 2014a).



Source: (Panchayati Raj Department, Government of Uttar Pradesh, 2014), Available from: http://panchayatiraj.up.nic.in/Acts%20And%20Rules%20Pdfs/Panchayat_Policy_and_Practices.pdf

Notes: MPs = Member of Parliaments; MLAs = Member of Legislative Assemblies

Figure 1. Three-tier structure of the PRIs in rural areas of Uttar Pradesh

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Evolution of Panchayati Raj Institutions in primary healthcare

Having recognised importance of the the PRIs by the Balwant Rai Mehta Committee in 1957 and the Ashok Mehta Committee in 1978, the constitution (73rd Amendment) act 1992 made radical changes in the realm of the local government and assigned 29 duties to the PRIs under the 11th schedule (Article 243 G) of the constitution (GOI, 1992; Mathur, 1998; Sanyal, 2001). The 73rd Amendment act empowered the *Gram Panchayats* to manage health and health-related activities at grassroot levels (Mathur, 1998; Pattanaik, 2006; GOUP, 2014a). Later, the National Population Policy 2000 and the National Health Policy 2002 laid stress on the implementation of public health programmes through local self-government institutions (GOI, 2002). Subsequently, the National Rural Health Mission provided a strong base to own, control and manage public health services under the PRIs (NRHM, 2005). Furthermore, to secure meaningful involvement of the community in the planning, implementation and maintenance of public health services at the village level, the mission formulated a health plan for each village through Village Health Sanitation and Nutrition Committee (VHSNC) under the chairmanship of the *Gram Panchayats* (GOI, 2015). The *Gram Panchayats* prepare micro health plans as per the need of its people for improvement in health, sanitation and nutrition (GOI, 2015).

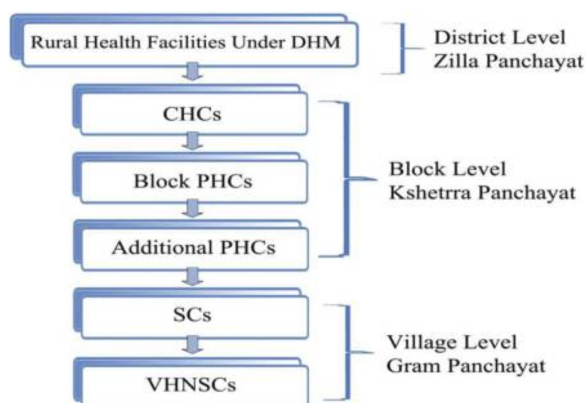
The involvement of Panchayati Raj Institutions in primary healthcare in Uttar Pradesh

Currently, healthcare activities at the district level in Uttar Pradesh are performed under the District Health Mission (DHM), and it is headed by the *Zilla Panchayat*; an advisory and apex body of the PRIs (Figure 1). The DHM control, manage and guide all public health institutions in the district: the community health centre, the PHC and the sub-centre (SC) Figure 2 (GOI, 2005; GOUP, 2014b). The management of these health facilities is undertaken by the hospital management committees (HMCs) headed by the PRI leaders Table I (GOI, 2005). By holding key positions in the HMCs, the PRIs are actively involved in planning, monitoring and implementation of healthcare services at the grassroot level.

Research context

Both the PRI leaders and healthcare service providers are functionaries of different departments, i.e. the Department of Panchayati Raj and the Department of Health and Family Welfare respectively. Besides, the PRI is a political body and the leaders are in possession of power, and they have been empowered to enquire physical attendance and misconduct of certain public personnel (GOI, 2005; Ray, 2014). Along with this, the village communities are stratified on the basis of caste, class, occupation and place of residence (Beteille, 1965). Following the social structure of the villages, it is not possible to consider the decentralisation process outside the caste-class-power politics of the community (Joshi and George, 2012).

The involvement and responsibility of the PRIs in healthcare activities are progressively increasing with the launch of new welfare and development programmes. Therefore, an understanding of their involvement requires an analysis of the web of interpersonal relationships which cut across axes of departments, caste, class, panchayat and party (Beteille, 1965) especially, here in healthcare provisioning. Hence,



Source: Demographic Profile and Health Care Delivery System. Uttar Pradesh National Health Mission, Government of Uttar Pradesh, India. Available from http://upnrhm.gov.in/site-files/monitoring_and_evaluation/Annual_Health_Report_2012-13_New.pdf

Notes: CHC – community health centre; FRUs = first referral unit; MSAs = maternity sterilisation annexes; SCs = sub-centres; VHNSCs = village health nutrition and sanitation committees

Figure 2. The levels of involvement of the PRIs in rural healthcare system

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this study addresses the research question as to how the PRIs have made an impact on the provisioning of primary healthcare in a decentralised health system.

Methods

Study area

The present study was conducted in the Hardoi district of the Uttar Pradesh, a state in the northern region of India. Hardoi was purposively selected as, it is the third high priority district for service delivery indicators under the Uttar Pradesh National Health Mission (NRHM, 2014). It is also one of the largest and poorest districts of Uttar Pradesh with poor health indicators (GOUP, 2015). The district level administration comprises five *Tehsils*, 19 Blocks and 191 *Nyaya Panchayats* with a population of 40,91,380 (The Hardoi, 2015). The rural primary healthcare delivery system of this district has 432 SCs and 62 PHCs (GOI, 2014). The health services are mostly provided by these health centres and to a small extent by privately owned clinics in the rural areas of the district.

Study design

A qualitative study design was used in this study to conduct in-depth interviews with the respondents with a view that the interviews yield rich insights into people's experiences and opinions (May, 2001, p. 120). A semi-structured interview schedule was used to explore the experiences of the respondents about the involvement of the PRIs in primary healthcare service delivery. Hardoi is a large district (population wise) and the number of health centres is quite high; therefore, it was divided into four zones to cover the entire district for the study. From each zone, two PHCs were randomly selected.

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Table I. Review of the health committees showing involvement of the PRIs in healthcare provisioning under District Health Mission

Health programme/committee	Governing body/chairman	Purpose	Level of involvement	Time interval of meeting
District Health Mission	*Zilla Parisad*	Planning, monitoring and progress review Locating the needs of people and programmes	District level	3 months
District Program Management Unit	Chief medical officer	Secretariat for both committees	District level	–
Hospital Management Committees: A–District Level Hospitals Management Committee	District magistrate	Review of the health services provided to OPD/IPD patients in the past 3 months and planning for the next 3 months	District level	3 months
B–CHC/PHC Level Management Committee	*Block Pramukh*	Review of the health services provided to OPD/IPD patients in the past 3 months and planning for the next 3 months	Block level	3 months
C–Village Health Sanitation and Nutrition Committee	*Pradhan*	Review of the health services provided to OPD/IPD patients in last 3 months and planning for the next 3 months	Village level	Per month
Rogi Kalyan Samiti/Patient Welfare Society	Medical officers of different hospitals levels	Ensure utilisation of health services to the poor	District/block/village level hospitals	Per month

Sources: The table is constructed on the basis of information extracted from the Government Orders (Government Order 2014 and Government Order 2005) passed by NHM, Government of Uttar Pradesh and Government of India respectively; Available from: http://upnrhm.gov.in/site-files/gogl/fy2013-14/GO-District_Heath_Mission.pdf; http://nrhm.gov.in/images/pdf/nrhm-in-state/state-wise-information/uttar-pradesh/notidication.pdf

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Because the last PHC (ninth) chosen was nearest to the district hospital therefore, in total, there were nine PHCs that were selected for the study.

Selection of the study respondents

This study draws on the research data collected for a doctoral thesis. The present paper is based on a total sample of 89 respondents: 44 healthcare service providers and 45 service users. In all, five service providers (out of 15 sanctioned by the government at each PHC in rural areas GOI, 2014) across cadre (Table II) were randomly selected from each sampled PHC (except one where only four respondents were interviewed due to the unavailability of health workers). Likewise, at least five service users of different villages were randomly taken from each PHC with a view to cover the maximum coverage area under the health centre. The specified respondents were chosen for the study because of their direct involvement in the delivery of and access to healthcare services. Of those approached for interviews, around 60 per cent service providers and service users agreed to be interviewed. The medical officers and pharmacists agreed to be interviewed after knowing the purpose and content of the study. Some of the grassroots health workers like Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM) and Lady Health Visitor refused due to time constraint and busy schedule. Some of the service providers expressed their unwillingness to participate in the study as they did not wish to speak anything about their work in public. Figure 3 shows the study flow chart.

Data collection techniques

Data were collected through in-depth interviews using a semi-structured interview schedule between January and April, 2014. The interviews with the service providers took place at the PHCs office or visitors room and lasted between 40 and 70 minutes. Whereas, the interviews with the service users were conducted at the places of their comfort in the hospital premises and continued for between 30 and 90 minutes. All respondents were informed about the purpose and the content of the study and were asked for their verbal consent. The respondents were told about their right to refuse participation in the interviews, and anonymity and confidentiality of the respondents were assured. The interviewer conducted the interviews with the help of a trained person who performed the role of taking notes and recordings of the interviews. To

S.N	Profession	No. of respondents
1	Medical officers	9
2	Pharmacist	6
3	Lab technician	4
4	ANMs	9
5	ASHAs	9
6	LHVs	2
7	Multipurpose workers	2
8	Health supervisor	1
9	Health education officer	1
10	Block prog. manager	1
Total		44

Table II. The selection of the health worker across cadres

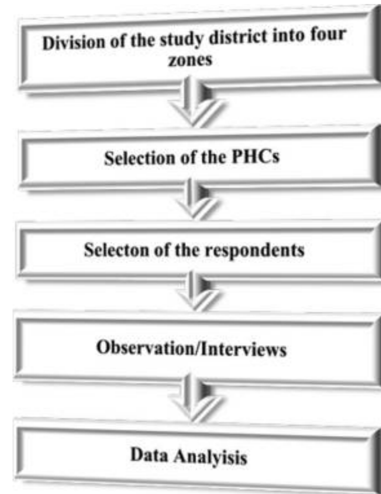

Figure 3.
Study flow chart

make the interview easier, a topic guide was prepared. All the interviews were conducted by the interviewer in the local language (Hindi) to reduce the language barrier.

Data analysis

All the interviews were digitally recorded after obtaining the respondents' consent and were transcribed verbatim. The data were then translated from Hindi into English. Subsequently, a thematic analytical approach was adopted to analyse the data. Rigor of the results was enhanced by this method because it permits the researcher to read and re-read the transcribed qualitative data vigilantly (Van Manon, 1990; Rice and Ezzy, 1999; Yates *et al.*, 2013) in the process of identifying the emerging themes. From the interviews, a number of key themes emerged, and the results are presented in accordance with them. Reflection of the recognised themes enabled the extraction of the phenomenon of interest (Barreca and Wilkins, 2008), discovery of meaning (Van Manon, 1990) and encouraged the understanding of existing experience (Whitehead, 2002).

Results

From the analysis, several sub-themes were generated which have been categorised into two broader issues: benefits associated with the involvement of the PRIs and challenges associated with the involvement of the PRIs. To present the findings, we have included a number of quotations from the study participants to support and illustrate the messages that were conveyed. The names of the respondents and health centres have not been shown in the discussion so as to maintain confidentiality. The study findings have been presented under the following themes and sub-themes:

The socio-demographic profile of interviewees

These characteristics are shown in Table III. Among the 44 healthcare providers, 24 were male and 20 were female with a mean age of 37.2 years. Around one-fourth of the service users were unschooled. The general category of caste stands for upper caste

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Background characteristics	Service providers (n = 44)	Service users (n = 45)
Gender		
Male	24 (54.5%)	19 (42.2%)
Female	20 (45.4%)	26 (57.7%)
Age (mean, SD)	37.20 (6.6)	35.84 (9.0)
Education level (n, %)		
Illiterate	Nil	11 (24.4)
Primary	4 (9.09)	16 (35.5)
High school	2 (4.5)	8 (17.7)
Intermediate	14 (31.8)	8 (17.7)
Undergraduate and above	24 (54.5)	2 (4.5)
Religion (n, %)		
Hindu	43 (97.7)	36 (80.0)
Muslim	1 (2.2)	9 (20.0)
Others	Nil	Nil
Category (n, %)		
General	19 (43.1)	12 (26.6)
OBC	17 (38.6)	17 (37.7)
SC/ST	8 (18.1)	16 (35.5)

Table III. The socio-demographic profile of interviewees

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people and the markers SC/ST indicate people belonging to the lower castes. Further, the caste-based profile has been used to show the patterns of discrimination.

Benefits associated with involvement of the Panchayati Raj Institutions

The study findings revealed two sub-themes which signify the benefits occurred. The benefits identified include improved regularity of health workers and support in health promotion activities.

Improved regularity of health workers

Pradhans[1] are the residents of the village/area and are informed about all activities at the village level which compels health workers to work more consciously as any complaint of irregularity or misconduct against them can become a threat to their jobs. In this way, the regularity of health workers across cadres has been improved at health centres as well as at the field. Similar responses were obtained at all the health centres from almost all the respondents. One of the respondents explained:

> The health workers like ANM and ASHA who work at the village level are regularly visiting the field/households due to the monitoring of the Pradhans. Therefore, the coverage of antenatal check-ups and institutional deliveries has been enhanced in this area (Medical Officer, Male, 42 Years).

Most of the respondents (75) reported that the *Pradhans* take punitive actions if they find any complaint against the health workers missing their regular field visit/health centre duty. They reported the inappropriate activities of the health workers to the higher authorities of the health department. I will quote one of the respondents:

> ANM of this area was very reluctant to household visit. The issue of her irregularity was raised by the villagers. The Pradhan took action and also reported this incident to the higher authority of the hospital management. After this incident, she became regular to the SCs and field visit (Patient, Female, 28 Years).

Support in health promotion activities

Almost half of the health workers (21) articulated that the *Pradhans* help them and convince the people to attend health talks and participate in other village health activities. The *Pradhans* are influential individuals in the villages; therefore, people of the villages are inclined to mind their instructions. It enhances the awareness about benefits of health programmes among the villagers. This sentiment finds echo in the statements of one of the respondents:

> In my area, people preferred home deliveries and never attended health talks. The Pradhan helped me in convincing the people to attend health talks and to use public hospitals. As a result, now people of my area are much more aware of the benefits of the government health plans and schemes (ASHA, 32 Years).

Around one-fourth of the service providers (12) expressed that the *Pradhans* take suggestions from the health department for controlling water and sanitation-related problems like malaria, diarrhoea and cholera. They contact the health centres in case of any emergency or when they need any intervention. I will quote one of the respondent:

> Pradhans report us if there is any need of medical intervention. Some of them even take necessary primary preventions (Pharmacist, Male, 35 Years).

Almost half of the health service providers, especially ANMs/ASHAs, have reported that the *Pradhans* support them in organising village health nutrition days (VHNDs), as voiced by one of the respondents:

> There was no proper place to organise the VHND in this area. The Pradhan helped us to organise VHNDs in the *Panchayat Ghar* (ANM, 38 Years).

Challenges associated with involvement of the Panchayati Raj Institutions

Despite very limited benefits associated with involvement of the PRIs, there are a number of challenges that have risen, which hinder the smooth healthcare provisioning process. These challenges have been categorised into three categories, namely, coercive unethical work, prioritisation of service providers and users and lack of communication and coordination.

Prioritisation of service providers and users

It was found that the PRI leaders do not support and coordinate equally with all healthcare providers in service delivery. Their support, monitoring and other involvement were largely influenced by the health worker's caste and electoral support to them. The PRI leaders prioritise one provider or care seeker over another which further affects the rendering and utilisation of healthcare services. The caste of the healthcare providers or the seekers is a major variable that shapes the perception of the PRI leaders about others. Similar responses were recorded from all the study respondents. This finding is evident with the following response of a care seeker:

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> The ANM and the Pradhan are of the same caste. She has the support of the Pradhan; therefore, she occasionally comes to the health center and hardly visits the field. If she visits; she only visits the households of her own caste (Patient, Male, 30 Years).

The PRI leaders were also found to be non-egalitarian in the dissemination of information and the distribution of resources to the people, as explained by almost all the respondents. I will quote here:

> They always pass on the information to those of their own caste, family relations or those who support them during the elections. They decide upon the beneficiaries of government schemes keeping these aspects in mind (ANM, 34 Years).

Coercive unethical work

According to the respondents, being local level political leaders (*Pradhans*), they use their political power in healthcare service provisioning as per their convenience and advantage. Almost all selected healthcare service providers revealed that more or less they all were pressurised at some point to conduct unethical work by the PRI leaders. The intensity and type of pressure depended upon the cadre and caste of the healthcare providers, as reported by the respondents:

> We are forced to indulge in malpractices by the PRI leaders. In many cases: we feel bound to inform the police about the incidence; however, we are stopped from doing so by the PRI leaders. They in fact force us to make medical reports of the patients for medico legal purposes (Medical Officer, Male, 35 Years).

The problems of the lower level functionaries like ASHA and Anganwadi Workers (AWW) were reported to be more complicated than the medical officers. They are pushed to perform physical labour at the houses of the PRI leaders. These practices have also been reported by the respondents of other health centres:

> Working with the PRI leaders is a tough task. They do not provide adequate support in service delivery. They invite us to their houses for paper work and force for house chores (ASHA, 32 Years).

The respondents expressed that the PRI leaders misuse their power to compel health workers for taking a share in the untied fund of the VHSNCs as their benefit. Similar responses were recorded in all sampled health centres. These findings were evident with the following response of a health worker:

> VHSNC has been formed to take collective actions on issues related to health and its social determinants at the village level. The Pradhan is the chairman of this committee and holds joint bank account with me for the committee fund. The Pradhan never attend committee meetings, and demand funds from the committee's untied fund for their personal use. This is really frustrating (ANM, 40 Years).

Lack of communication and coordination

There was a communication gap between the PRI leaders and the health workers. The PRI leaders are reported to be busy in other activities; therefore, they hardly communicate and coordinate with the health workers. Also, it was found that the PRI leaders avoid communicating with the lower cadre health workers. Parallel results were found throughout the study:

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> The Pradhans are generally not available when I wish to discuss any health issue with them. I belong to a different department and fall into the lower level in the health system hierarchy. Because of my lower cadre, they do not give importance to communicating and coordinating with us (Health Supervisor, Male, 50 Years).

Following inappropriate behaviour of the PRI leaders towards service providers, they feel themselves to be working under dual administration, i.e. the PRIs and the health department. As a result, they avoid communicating with the PRI leaders to relieve themselves from the dual monitoring and additional workload. Similar responses were reported from other health centres across the cadres:

> We belong to the health department yet, we are forced to work under the administration of the local the PRI leaders. Their involvement has increased our problems; therefore, we avoid communicating with them (Medical Officer, Male, 33 Years).

Discussion

In present study, involvement of the PRIs in healthcare provisioning has been evaluated to gauge the PRIs role and effectiveness in augmenting primary healthcare in a decentralised health system.

The study shows that the PRIs has simultaneously affected both the service providers as well as users. Several benefits and challenges were reported by the respondents. When it comes to the benefits, the availability of and the accessibility to the healthcare providers has increased along with support in health promotion activities. However, it was also found that the health workers who find support in these the PRI leaders do not regularly visit the health centres and households, and take their duty for granted. In this way, the availability of the healthcare providers is limited. Some of the respondents came up with the view that the PRI leaders do not disseminate information about beneficial schemes to everyone. Information is selectively passed to the people whom they are close to. Hence, accessibility also has limitations in many ways, and the benefits are not enjoyed equally by all the people. Moreover, these benefits depend on the effort and commitment of the PRI leaders, i.e. how they serve their people.

Being local level politicians, the PRI leaders obtain political support from state and national level political parties and their leaders. With support of these political leaders, they are more powerful and often there are instances of their involvement in corruption and illegitimate practices (Jaffrey, 2014). They misuse their power and compel health workers for the illicit expenditure of VHSNC untied fund. Most of the time, they demand a share in the untied fund for their personal use. The ANMs have to maintain the records of the expenses. It has been reported by the respondents that usually the *Pradhans* do not provide the bills of the expenses. Because of this, the ANMs refuse to withdraw the untied fund as they are fearful of being charged in fraud cases. Consequently, most of the VHSNC fund remains unused and is returned to the government account (GOI, 2012). According to the Ministry of Health and Family Welfare report, "the highlights from the reports of the regional evaluation teams during 2011-2012" the district did not spend the VHSNCs amount of Rs 10,56,000 for the year 2010-2011 (GOI, 2012). This means that around 106 VHSNCs of the district have not used their funds in the same year. Thus, the resources were cropped prior to their utilisation by the unfair conduct of the PRI leaders.

The frontline health workers (ASHA, ANM and multipurpose health workers male and female etc.) form the major portion of the health worker cadre in the primary

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healthcare system (George, 2010; Razee *et al.*, 2012). Most of these providers get posting in the same area to where they belong and some get in nearby areas (Lehmann and Sanders, 2007). The *Pradhans* being residents of the same village/area are aware about the socio-economic conditions of these health workers. It has been reported by the respondents that the opportunity to get any type of support from the PRI leaders for the service provider and the users depends upon the caste and electoral support on a larger scale. Following the social dynamics of the villages, these health workers are maligned by the *Pradhans* for vested interest. The PRI leaders have been reported to use bottom-level functionaries for house chores, and if they deny, they are charged with avoidance. They are also compelled to set the preferences in healthcare delivery according to the PRI leaders. In this way, the frontline health worker suffers most from the activities of the PRI leaders in service provisioning.

The local level government has been ineffective in dealing with the public complaints as the higher castes continue to exploit the lower caste (Jaffrey, 2014). The perception of the PRI leader's about the care providers with regard to the caste and class has created certain barriers for village outreach health activities. The PRI leaders are empowered to enquire physical attendance, misconduct and monitoring of certain public personnel; however, their participation has created hassle for the health providers. The health workers who belong to their caste and family relation, and always stand in support of them, enjoy all types of liberty in performing their job. On the contrary, the other health workers face a lot of challenges even if they perform better. In this way, the decentralisation process has generated a biased system in primary healthcare. The caste internalisation in the decentralised system of healthcare leads to dissatisfaction and distrust among the service providers and service users and lessens the accessibility and utilisation of public healthcare services.

The health workers of the primary healthcare system suffer from numerous system-related problems like high work load, poor working conditions, inadequate infrastructure and manpower and insufficient supporting facilities (Coutinho *et al.*, 2000; Dasgupta, 2005; Kruk *et al.*, 2010, George, 2010; GOI, 2011). Moreover, involvement of the PRIs has added impediments to the healthcare providers across cadres, as the accountability of healthcare providers has been extended for two different departments, i.e. the Department of Panchayati Raj and the Department of Health and Family Welfare. Being different departmental representatives, the PRI leaders are not able to understand the fundamentals of healthcare. Following the diverse and unsolicited experiences of the PRIs involvement, communication between the functionaries of both departments becomes more complicated. Consequently, the healthcare providers avoid communicating with the PRI leaders as they compel them to perform unscrupulous practices.

Decentralisation of healthcare services is one of the prime targets of government plans and schemes, and the PRI leaders are the drivers of theses developmental schemes at the village level (NRHM, 2005; Pattanaik, 2006). However, it has been previously shown that most of the PRIs leaders are either uneducated or minimally educated (Sekher, 2003). They have not received any basic training of healthcare management; therefore, they do not understand the fundamental issues and problems of healthcare provisioning. Their biased decisions and inappropriate behaviour discourage the healthcare providers as well as the service users. Therefore, to make decentralised democratic planning more effective and functional in healthcare, it is imperative to

sensitise these grassroot level leaders about their new roles and responsibilities (Sekher, 2003), ensuring that they can be reformed in their intention, approach and dedication to accomplish the aim of the decentralised health system.

The present study is significant as it explores the present scenario of decentralised healthcare provisioning.

Limitations

The study is limited to the PHCs only. The SCs were not included in the study; however, the care providers of SC level were included in the study. Likewise, only the *Gram Panchayats* are considered as a whole to represent the PRIs for this paper. Due to the largeness of the coverage area under the primary health centres, it was a challenging task to interview the healthcare providers as well as the service users. Therefore, the experiences of the PRI leaders could not be obtained. Further, future studies can be undertaken using the experiences of the PRIs. Because the paper is also limited to a small number of respondents, the findings of the study cannot be generalised for the other districts of Uttar Pradesh.

Conclusion

The outcomes of the PRIs involvement in healthcare provisioning are mixed. On a larger scale, it has generated a lot of impediments in provisioning of primary healthcare at the grassroot level. The involvement and responsibility of the PRIs in healthcare activities are gradually increasing with the launch of new welfare and developmental programmes; however, the distribution of welfare benefits by the PRI leaders is largely biased. The PRIs play a very important role in healthcare provisioning; however, their involvement is ineffective due to their partial capabilities and approach, which creates a non-conducive environment. Health issues are among the most important human concerns; therefore, there should be a provision for rigorous monitoring and supervision of the PRI leaders so that they can reform their approach to serve the people better.

Note

1. Chairperson of the *Gram Panchayat*.

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