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Decentralisation and Healthcare: A Gender Perspective

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Decentralised planning was initiated in Kerala in 1997, which resulted in the transfer of substantial resources to local bodies. The local bodies were expected to spend money for services rendered by the transferred institutions such as Public Health Centres. In view of the high morbidity of Kerala and the growth in lifestyle –related ailments, the local bodies were encouraged to invest considerably in the health sector. After a faltering start, most local bodies now allocate money for infrastructure and various services provided by the health centres for allopathic, ayurvedic and homeopathic systems of treatment. It has also been found that most of those who use the public health system are women. This paper looks at the allocation and expenditure in the health sector in Thiruvarpu Gram Panchayat in Kottayam district from 2009 to 2016. It then seeks to make an analysis of the gender dimensions of this allocation and expenditure by dividing the projects carried out in the health sector into three categories, namely women-specific, women-friendly and women-neutral and undertake a gender benefit incidence analysis.

Key words: gender, decentralisation, health, Kerala, local bodies

Introduction

From 1997 onwards, Kerala introduced participatory planning at the local level with the original goal of transferring 35 to 40 percent of the state's plan (development) funds to local bodies to be spent by them having regard to broad sector guidelines issued by the state government. It resulted in the transfer of an average of around 25% of the plan funds to local bodies, which is the highest in India. The process started from needs appraisal in the local assemblies and ended with the granting of approval to the plan by the District Planning Committee consisting mainly of District level elected functionaries. Many scholars have hailed the scale of Kerala's effort comparing it as a case in "empowered deliberative democracy" akin to the experiment in Porto Alegre (Fung and Wright 2003; Heller 2003).

Primary and secondary healthcare institutions were transferred to the local self-governments (LSGs) as part of the decentralisation process in the state. A significant budget allocation was also made with the People's Planning Campaign to equip the LSGs to assume these responsibilities. Decentralisation was expected to strengthen the public healthcare network all over the state to address the new challenges emerging in the healthcare sector. Health reformists argue that decentralization can enhance the participation of local communities in decisions regarding health policy objectives, goals, strategies, planning, financing, implementation and monitoring, which are important to improve the health outcomes (Lieberman, 2002).

In Kerala, by the middle of the 1990s, administrative decentralisation and decentralised planning paved the way for transfer of health care institutions up to the district level to the Panchayati Raj Institutions (PRI). All health care institutions except General Hospitals, Women and Children Hospitals and Speciality Hospitals have been transferred to the three- tier PRIs and up to 40 % of the plan fund of various sectors including that of health sector is being disbursed through these institutions. Thus, Kerala became the first state in the country to initiate administrative decentralisation in an extensive way including in the health sector. A government level expert committee has identified some of the lacunae such as the lack of technical support from the department, the absence of a public health perspective in planning, unnecessary construction work and repetitive nature of most projects with a focus on field level medical camps and drug purchases. (GOK, 2013:18)

Kerala is known for the prevalence of three systems of medical treatment starting at the grass roots level. Hence each panchayat has been entrusted with the responsibility of overseeing the functioning of a PHC under each of the three systems manned by a qualified medical practitioner. This allows a range of choices for the patients. For treating children, homeopathy is often preferred. Elderly persons with mobility-related problems invariably go to the ayurvedic doctor. For ailments requiring quick relief, allopathy is preferred.

Review of Literature

There are a number of general studies related to decentralisation and health. However, there is hardly any study that looks at the intersection between gender and decentralisation of public health. General studies on decentralization of health sector identified some problem-areas. They include benefit spillover effect, which means the benefits being made use of by people belonging to another panchayat, and the continuation of a pre-existing body like Hospital Development Committee in the new panchayat set-up (Narayana and Hari Kurup 2000). Another study reveals

the close relationship between women's health and intersectionality. Caste interacts with socioeconomic variables on health by magnifying or buffering their effect on health. Small household landholdings, which are linked with poor health, yielded high level of health problems among SC/ ST women, and to a lesser extent among OBC. Forward caste women are buffered from the negative effect of small household landholdings. Caste and socioeconomic

willing to respect the health functionaries as professionals and not interfere with their professional duties, but request their assistance with the due processes of decentralization (Ramanathan et.al., 2005, p 108 -109).

During the early stages of the decentralised plan campaign, the PHC was functioning primarily as an adjunct of the health department. The constitution of Standing Committee on Health and Education

Thiruvarpu, a Gram Panchayat in Kottayam, Kerala, relating to the period from 2009 to 2016. It then seeks to make an analysis of the gender dimensions of this allocation and expenditure by dividing the projects carried out in the health sector into three categories, namely, women-specific, women-friendly and women-neutral and undertakes a gender benefit incidence analysis. This began in the early seventies in an effort to understand who gains and