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Health Governance Reforms in Maharashtra: New Forms of 'Soft Authoritarianism with A Democratic Face'?

Dipak B. Abnave
Research Scholar
Centre of Social Medicine and Community Health,
Jawaharlal Nehru University,
New Delhi-110067
Email: dipakabnave@gmail.com
Ritu Priya
Professor,
Centre of Social Medicine and Community Health,
Jawaharlal Nehru University,
New Delhi-110067
Email: ritu_priya_jnu@yahoo.com

This paper traces the conceptual shifts in health governance globally and the reforms of health governance in India with implications for the health service system in Maharashtra, mainly focused on the National Rural Health Mission (NRHM). It examines the structures and processes of decision-making as the critical element of health governance. The study observes that, with the implementation of NRHM, there have been significant changes in health governance that emphasized on strengthening management, decentralization of decision making and community participation. The study findings lead us to the conclusion that the governance transition with new structures and value framework developed under the NRHM shaped health governance as "soft authoritarianism with a democratic face".
[Key Words:** Governance, Health Sector Reforms, National Rural Health Mission, Democratization, Community-based Monitoring**]

Introduction

Governance is the process by which societies or organizations make their important decisions; determine whom they involve in the process and how they render accountability. (Graham et al. 2003:1). Governance is also defined as the exercise of authority, direction, and control of a public or private organization (Goodsell 2006). It provides a value framework for policy. It includes policy development, goal setting, planning and monitoring progress toward strategic objectives.

In the 1980s, there was a global demand for increased socio-economic development with a thrust for economic and governance restructuring at the

international level (Klijn 2012). Governance strengthening has also been one of the prime agenda in Indian development discourse, with transition in the model of governance through introduction of structural changes in decision making and policy planning processes. It has been influenced by processes of globalization and economic restructuring.

Global health governance emerged when 'international health diplomacy' evolved around international politics on controlling of infectious diseases at a global scale. The diplomacy strategies have been extended to the realm of general health services through international organizations, states and non-state actors through lobbying and networking (Fidler 2001:842-43).While health sector reforms were adopted in India since the 1990s, structural changes have been introduced in the health services decision-making processes most widely since the mid-2000s through implementation of the NRHM. The NRHM has been the largest and most multi-dimensional effort at 'reforming' the health services of the public system (Shukla and Sinha 2014). However, the NRHM governance model has not been explored adequately, including its role, functions and structures. Hence, the present study focused on processes of decision-making within the NRHM, attempting to understand the health governance transition in India in the state of Maharashtra.

The study began by examining the conceptual shifts in health governance at global and national levels. We briefly summarise some relevant elements here.

Section I: Transitions in Governance: Governance is the subject of multiple definitions and interpretations in the social sciences, used with great variation and often ambiguity. We reviewed transitions in governance as evidenced in three dimensions: as structural changes, conceptual shifts and new frameworks for assessing governance performance.

Structural Transition

There have been four phases in models of governance. The first phase began in the early 1950s as 'Public Administration'. It transited in the 1980s to the Public Management approach. During the 1990s efforts were made to alter public administration to the New Public Management of a neoliberal strategy, while in the early 2000s New Public Governance added a democratic value framework.

Public Administration: Public administration is seen as an instrument to implement the constitutional and operational goals of welfare policy through bureaucratic administrative systems. It has to operate within prevailing political settings and engage in decision-making, planning, formulating objectives and goals (Cheema 2004). Conventional public administration was critiqued on the issue of corruption that was seen to be causing the unreliable delivery of public services. It was also seen as too rigid, involving time-consuming and costly administrative processes, with more attention to procedures than outcomes, and mechanisms were inadequate to enable citizen's participation due to bureaucratic control (Cameron 2004). Efficiency was reduced by limited management capacity and insufficient human resources. This undermined the

legitimacy of the state and created pressures to overcome these challenges (Brinkerhoff and Bossert 2013). Thus both internal and external factors contributed to the need for restructuring of public administration. Incorporating public management approaches was seen as the first alternative to tackle the problems associated with public administration.

Public Management: Public management focused on the application of private sector management principles in the public sector such as 'efficiency' in resource allocation, consumer orientation and consumer satisfaction (Hill and Lynn 2004; Fukuda-Parr and Ponzio 2002). The citizenship under welfare state moved to a 'consumer-ship'. While this phase introduced the idea of market principles to the public system in India, in practice they were operationalized through New Public Management (NPM) in the next phase.

New Public Management: The third phase of governance, New Public Management (NPM), was introduced by Osborne and Gambler. It came as part of the post-1990s neoliberal economic policy changes. It continued the previous trends of public management and added some element of linkages external to the public sector, emphasizing outcome-based partnerships with the private sector in service provisioning (Hood 1991). It called governments to be customer-driven and adopt market-like competition, innovations, and entrepreneurial strategies (Osborne 1993). The major limitation of this approach was that it focused on the technical and cost-cutting aspect to bring efficiency in the public sector without addressing democratic values. It limited the citizen-state relationship, especially the rights approach to services. Considering these challenges, post-2000s witnessed the New Public Governance approach.

New Public Service (NPS) under the New Public Governance: Robert and Janet Denhardt coined the term New Public Service (NPS) as part of the New Public Governance. NPS was defined as a system of values, institutions, and policies to deal with economic, political, and social affairs. It included interactions between the state, civil society, and private sector for fulfilling responsibilities towards citizens (Denhardt and Denhardt 2000:552-53). It articulated the role of the state as creating institutions to establish political power and law and order; the private sector to create employment and income opportunity; and civil society to play a mediator role for social and political interaction. The essence of governance is to foster interaction between these three actors to promote people-centered development (de Durand 2016; Denhardt and Denhardt 2000).

The NPS approach is a new conception and not much debated in social science literature. It came as an alternative approach to NPM, focused conceptually on citizenship and people-centered governance. With a new 'entrepreneurial pattern' to deliver public goods and services and state playing a mediating role to channelize this process.

Thus governance structures shifted across these four phases with both internal and external factors contributing to these shifts. Internal limitations of conventional public administration provided space for introduction of market led management principles and value frameworks into the public sector (Hood

2004). Governance in India has shifted through these phases, with elements of each stage of governance frequently co-existing or overlapping with others. We examine the journey of ideas since the 1990s in the next section.

Conceptual Transition and Assessment Frameworks of Governance

In 1989, the concept of governance was first used for developmental planning by the World Bank in the Sub-Saharan African context (Haruna and Kannae 2013). A survey of development aid by international organizations showed that it had not been utilized for the intended purpose. This was attributed to a crisis of governance in public service systems, leading to the argument that the primary need of these countries is to strengthen governance capacity (World Bank 1992, 1994). In 1992 the report titled 'Governance and Development' pointed out that elements of the definition of Governance as "the exercise of political power to manage a nation's affaires" have changed, and was now defined as "the manner in which power is exercised in the management of a country's economic and social resources for development" (World Bank 1992:1).

Within a span of two years, World Bank reports showed a further shift in conception to 'good' governance, "epitomised by predictable, open, and enlightened policy-making (i.e. transparent processes); a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions, and a strong civil society participating in public affairs; and all behaving under the rule of law" (World Bank 1994:7).

Decentralization is one of the major governance reforms on the agenda, aimed at reducing the role of central government and administration, replacing command and control economy to a market economy, increasing intergovernmental competition (Coskun and Hayrettin 2008:179-80). It has strengthened the space for the private sector, promoting democratization in the context of a free economy (Santino 2001).Thus it is argued that 'good governance' makes governments more accountable, less corrupt and hence more efficient developmentally (Harlow 2006).

In the present international development approach, a global health governance assessment framework has become essential. Conventional parameters to assess performance in public administration were focused on financial management and following of laid down procedures. With the governance transitions, efforts have been made to develop governance frameworks by a range of international agencies depending on their vision and mission (Fidler 2001). World Bank, International Monitory Fund and ADB carry the agenda of economic development with management and their assessment framework focuses on economic corruption. The USAID, OECD and DFID governance frameworks underpin democratic values and principles of justice (Orr 2002). Sustainable human development is the latest agenda of the UNDP governance framework.

Health Governance Frameworks

Following these there have been remarkable changes in understanding of health systems and their performance assessment. Pan American Health Organization (PAHO) envisaged an Essential Eleven Public Health Functions framework and World Health Organization (WHO) introduced the domains of stewardship framework. In 2000, the WHO and PAHO came up with qualitative governance frameworks that reflected reformulation in public health functions of the state.

Reviews of the various post-1990s health governance frameworks reveal that the frameworks concentrate on health service system issues such as financing, service delivery, and performance and are largely silent on the determinants of health. Another common aspect observed in framework review is that they uniformly acknowledge the role of the private sector and non-state actors in health systems strengthening. However, there is ambiguity in the scope and levels of involvement of non-state actors, and there is common silence about their regulation (IIPA 2013). While the pro-market perspective views this as an opportunity to promote the private sector, health governance has also become part of the current discourse to create more inclusive and better-managed public health (Banda and Simukonda 1994). It has been argued that health systems governance is facing challenges because of the changing role of the state, private sector and civil society in creating equitable access and also because of the increasing critiques of conventional medical services and re-examination of traditional systems for beneficial contributions (Priya 2005).

Section II: Health Governance Transition in India: Establishment of Indian public health system began in the pre-independence period under British rule. The Bhore Committee (1946) recommended a comprehensive structure for a modern medical service system, including the health administration. Over the decades, various committees, commissions and expert contributions have given it shape, but the recommended structure was never achieved. In the 1980s and 1990s, globalization and liberalization led changes impacted on the public health system. Post-2000, NRHM framed a new institutional structure for public healthcare governance.

NRHM has been critiqued as reflecting concepts of NPM, with ideas derived from managerialism, originating from the new institutional economics for promoting markets and competition as a way to ensuring access to services through what it called as promoting efficiency in service delivery (Dasgupta and Qadeer 2005; Larbi 2003).

Attempting to strengthen the public rural health services, one of the key concerns of NRHM was how to professionalize the management of public health system so that it could absorb the increased flow of funds and convert this investment into improved health outcomes (Sarma 2013). Innovations in management included a monitoring and accountability framework (NHSRC 2012).

Another view highlighted the NRHM's attempt to undertake 'architectural correction' of the health service sector to improve the provision of services ensuring quality and equity (Priya 2011). Rural health system strengthening through the NRHM included an attempted change in decision-making structures and processes with some critical and normative dimensions of NPG. The NRHM implementation framework involved inclusiveness through decentralisation and participatory approaches to planning at all levels incorporated new multi-stakeholder models of management and inclusion of other systems of medicine. States were required to prepare their Programme Implementation Plans, focusing on their special needs and innovations to fulfill the objectives of the NRHM. District plans and societies were meant to act as vehicles of decentralized governance. According to NHSRC report (2012), 636 districts prepared plans in 2011-12, as compared to 310 in the first year of the NRHM. The plans have helped to integrate the activities of vertical programs and different departments including Disease Control, RCH, HIV/AIDS and AYUSH to some extent.

Year 2012 was the end of timeline of the NRHM and Eleventh Five Year Plan. To carry forward the public health system strengthening agenda, the Government of India constituted the High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) in 2010 and incorporated it in the 12th Five Year Plan in 2012. Both acknowledged the governance changes that the NRHM had initiated. The HLEG report points out that management techniques and regulation frameworks have improved (HLEG 2011). The Twelfth Five Year Plan converted the NRHM into a National Health Mission (NHM) covering all rural and urban areas (Patel et al. 2015; Planning Commission 2013), and continued the same direction of governance changes.

Therefore, implementation of NRHM provides a good example to examine the nature and outcomes of NPM and NPG in the health system of India.

Section III: Exploring Health Governance Transition under NRHM in Maharashtra: An empirical inquiry was conducted to examine changing processes of governance and their implications for decision-making at meso and micro levels in one state of India, Maharashtra.

Methodology

The history of governance in general and health services in particular in Maharashtra was reviewed to reconstruct the changing structures and value frameworks. The process of decision-making in five stages, namely policy formulation, planning, operational guidance, implementation and monitoring of health services, was studied under the NRHM from the national to the village level. It used purposive and snowball sampling to select respondents according to five actors in governance, i.e. the public administrators, political leaders, policy planners, civil society and community members. Locating the empirical study in Pune district of Maharashtra, it explored the processes of decision making under the NRHM from the village to the state level and observed the

consequences of governance changes through empirical study in two blocks, one with implementation of 'community based monitoring and planning' and one without this element.

A Health Systems Governance (HSG) Principles framework adapted from Siddiqi et al. (2009) was used to guide the exploration. It includes ten demains as principles of governance: Strategic long-term vision with a comprehensive strategy; Participatory decision-making processes; Rule of law and regulation policy; Transparency in decision-making on technical content of services and allocation of resources; Responsiveness to regional and local population health needs; Equity and inclusiveness; Effectiveness and efficiency, with quality of human resources, communication processes and capacity for implementation; Accountability; Information generation, collection, analysis, dissemination; and, an Ethics framework. Relevant findings are accordingly summarized below.

1. **Strategic vision:** The strategic vision of any institution or programme on health and human development indicates a broad and long-term perspective, with a sense of strategic direction. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded (Siddiqi et al. 2009). The strategic vision for health service governance under NRHM in Maharashtra has come from the national NRHM implementation framework. However, larger vision for governance of Maharashtra emerged from its historical, cultural, social and political processes, which is reflected in regional planning under NRHM.

Regional imbalance in economic development set the strategic vision for governance in Maharashtra, shaping the administrative structures and development initiatives. Despite being one of the developed states of India, Maharashtra is known for inequalities in distribution of resources, and a regional governance structure was developed in response to political demands from the under-resourced regions (Mishra 2008; Paranjape 2007). The historic Nagpur Agreement (1953) and Akola pact articulated the principles of regional governance (GoM 2013). A second influence in the state was the co-operative movement which played an important role in decentralized, democratic decision-making and agricultural financing (Baviskar 1969; Vandeplas et al. 2013). Thirdly, the Panchayati Raj movement contributed to the processes of decentralization, making the district a key unit of local governance (Mohanty and Parigi 2004). Under NRHM, Maharashtra has adopted various governance strategies and approaches to deal with regional inequalities. Maharashtra has six divisions for general administrative purposes aimed to decentralize administrative decisions and policy implementation processes, to suit regional development needs. Under the NRHM, unlike the national structure, Maharashtra State Health Mission has addressed regional imbalance issues through making divisions as a sub-state layer above the district level, and unlike the general administration in the state, it has tried to make the system more

effective by forming eight (instead of the six) administrative divisions for better governance.

However, the district level plans have been only financial allocation format filling exercises, with nothing on local priority activities and strategies. Our study finds that the State structure of planning and decision-making is dominated by higher authorities, with the village and taluka levels having no say in priority-setting.

2.Participation and Consensus Orientation: Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures (Siddiqi et al. 2009). Participatory decision making was a central strategy under the NRHM implementation plan. It formally created participatory structures, both vertical and horizontal, with elected representatives, civil society organizations and community members at each level: the Rogi Kalyan Samiti (RKS), Village Health, Nutrition and Sanitation Committee (VHNSC), Panchayati Raj Institutions (PRI) involvement, and Community-based monitoring and planning (CBM).

Evident in the field work district was the challenge that, while the participatory structures have been created at all levels, power has not been transferred to the lower levels or to the community members to any significant extent. Decision making is dominated by the health administrative bureaucracy, technocrats and clinical practitioners within the health system. The VHSNCs being given strict ‘guidelines’ violated their right of deciding use of the annual ‘untied' grant. Experience of ASHA, ANM, MPW, Anganwadi workers showed that lower level health care providers have little space to influence the decision-making processes either in local implementation or planning. In some parts of the study area, it was found that traditional cultural and socio-political actors dominated the processes of participatory governance and controlled the committees, including misuse of funds. The RKS was to operate as a participatory support group for patient welfare, but in the study area decisions of RKS fund utilization were controlled by PRI members and administrative health authorities.

Community-based monitoring (CBM) was one initiative that has been unique to Maharashtra in its extent and continuity, and it did give the community some voice for improving service delivery. CBM has been implemented in areas of 13 districts in Maharashtra. It was facilitated by civil society organizations, assisted people to monitor health services, and administrators to take their feedback. Development of the CBM process included capacity-building, training of trainers, community assessment, public dialogue and state-level facilitation (Shukla et al. 2014). It is claimed that the power structure within the health service system has been challenged by democratization through CBM. The need of governance has been viewed for improving efficiency, but through CBM it has become a political governance

initiative (Shukla 2013). Thus, CBM provides a potential structure for implementing direct democracy in the delivery of health services.

However, there is still inadequate ownership of CBM by the local people, with dependency on civil society organizations. Also, the pressure is for better implementation within the framework of presently planned services but none for questioning the framework based on local priorities. In such a situation, the civil society operates as a pressure group and 'watch-dog' on the public health service system as well as mobiliser of communities for better implementation of top-down plans. But it is unable to institute significant improvements due to structural flaws such as the shortage of personnel and the lack of decision-making structures at taluka level.

Inter-sectorial co-ordination was one element of participatory planning at all levels, but it did not happen to any significant extent due to systemic barriers and work culture of the administrative and technocratic system. Neither has civil society taken this up as a priority issue.

3.Rule of Law: The rule of law considered as legal frameworks or common code of conduct pertaining to health should be fair and enforced impartially (Siddiqi et al. 2009). Rule of law ensures that the government and its organizational system, people and non-state actors are accountable. The NRHM implementation framework developed a clear role and responsibility for every organizational setup and each actor, and along with this it developed a regulatory framework. At the service delivery level, a citizen's charter provided guidance and transparency for entitlement of services. However, there is no effective mechanism to address the violation of right to health care as listed in the charter.

4.Transparency: The general meaning of transparency is that the decision-making process and why a decision was made should be clearly communicated in the public domain. (Siddiqi et al. 2009). To bring transparency, district level information was uploaded on the state website and for peripheral levels; flexible financing with bottom up participatory planning was evolved. However, it was evident in the study area that there are very selective transparency mechanisms at all levels. Neither the process of financial decision-making nor of service priority setting is transparent to the peripheral workers or the people.

The CBM initiated bottom-up participatory processes did, however, work as pressure on government authorities to make decisions transparent to some extent. Health awareness information and messages were made available at village level in study areas through wall posters and boards at health centres.

5.Responsiveness: Responsiveness of health institutions and work processes should ensure that policies and programs cater to the health and non-health needs of the users (Siddiqi et al. 2009). Efforts to serve the needs of the citizens often have to balance competing interests in a timely, appropriate and responsive manner. To some extent the public services addressed the health care needs of the population and integrated all disease control programmes under the NRHM. However, even the NRHM focus remained on reproductive and child

health. For other critical health related issues people continued to depend on private health care providers. NRHM generated space for non-allopathic health care through AYUSH, however AYUSH doctors in the rural health services were largely providing allopathic health care, losing this objective. The CBM processes too did not take up this issue.

6. Equity and inclusiveness: Under NRHM, equity mechanisms included special attention to geographically marginalized and tribal areas for strengthening health service institutions and increasing availability of health services to socio-economically marginalized sections. The composition of various health committees including CBM and VHNSC created space for participation of marginalized sections in decision making processes. However, since there has been no culture of participatory processes in the health services, the inclusion does not become functional.

7. Accountability: Policy planners in government, the private sector, and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders (Siddiqi et al. 2009). Under the NRHM, internal and external audit mechanisms were developed for financial accountability along with mechanisms for monitoring of implementation and review of strategies. The latter included setting up of an effective Health Management Information System (HMIS), an annual Common Review Mission (CRM) by teams of internal and external members, Concurrent evaluation surveys periodically, and CBM by civil society and community actors. HMIS and CRMs did create some element of accountability and responsiveness in the administrators and service providers at higher levels, but at the ground level it was CBM that appears to have worked better.

8. Intelligence and Information: Information is vital for providing evidence to decision making and creating the strategic vision for health policy planning (Siddiqi et al. 2009). The NRHM has used IT for enabling setting up of an effective HMIS. It has also encouraged use of the HMIS generated data for monitoring and planning. The Programme Management Units at all levels have been effective in generating and using the data. The Right to Information (RTI) Act 2005, implemented in Maharashtra as in other parts of the country has also created political pressure at some level by citizens asking for information.

9. Ethics: Ethics is a commonly accepted principle of health care, important to safeguard the interest and rights of patients (Siddiqi et al. 2009). It includes respect for autonomy, non-maleficence, beneficence and justice. However, no ethical framework was developed for NRHM implementation processes, nor was it found as a stated principle of service delivery in any policy document.

10. Effectiveness and efficiency: Major efforts were made to bring effectiveness and efficiency under NRHM through the setting up of Programme Management Units (PMU) from state to district levels. There was also considerable increase in budgetary allocation for rural healthcare, resulting in up gradation of infrastructure and increased utilization of services. New management cadre for the PMU contributed significantly to efficiency in HMIS

data generation and monitoring, documentation of planning, and fund flows. Additional doctors, nurses and paramedics were also recruited under the NRHM on a contractual basis. However, what has remained as a major bottleneck to effectiveness of services is the continuing shortage of health care providers. This has larger systemic determinants that were not addressed by the NRHM.

Conclusion

There has been need for changes in health governance both for strengthening services and their coverage, as well as to make them more democratic, responsive and accountable to the people they are meant to serve. There is a prevailing mix of positive and negative change processes, but the governance shifts seem to be adding structures rather than transforming functioning. The NRHM attempted to provide universal access to equitable, affordable and quality healthcare through a new governance system. However, the study in Maharashtra found that governance transition with new structures and value framework developed under the NRHM were unable to make much dent in the top down planning processes and transit towards bottom up approaches, or to give greater value to people's experience and knowledge. It did not bring any attention to a major issue faced by people in their interactions with the health system the lack of ethics in medical practice. It has strengthened the management structures of generalist administrators with symbolic inclusion of marginalised sections, and thereby shaped health governance as "soft authoritarianism with a democratic face". Its experience highlights the limitations of NPG without conducive changes in the social-political-bureaucracy ethos and system-wide institutional changes within the health system.

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