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Will Health Grants to Local Governments by the Fifteenth Finance Commission Eventually Become a Victim of Mission Creep Syndrome?

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Abstract

While the health grants to local governments recommended by Fifteenth Union Finance Commission in the wake of Covid 19 pandemic lays emphasis on the trust-based approach to local governments and decentralization of health, the danger of Mission Creep can undo the potential and effectiveness of the grants to strengthen the primary health care sector. Lack of sensitization towards local governments; the misconception that local governments and its stakeholders are illiterate, weak and corrupt entities; absence of an institutional monitoring mechanism to conduct a follow-up of the recommendations made by the respective Finance Commissions; lack of co-ordination between various Ministries of union and state governments; and the erosion of cooperative federalism can all contribute to health grants falling prey to the vicious cycle of Mission Creep Syndrome.

Keywords: Mission Creep Syndrome, Union Finance Commission, Health Grants, Local Governments, Decentralization and Trust – Based Approach

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Introduction

The Union Finance Commission of India (UFC) is one of the strongest constitutional bodies in India today. The recommendations made by the UFCs[1] are conventionally accepted; a practice that has been adhered to by successive union governments, with a few exceptions. In recent times, the union government, while accepting all the major recommendations of the 15th UFC[2] has rejected its recommendation for 'special grants' worth Rs. 6,764 crore to Karnataka, Telangana and Mizoram for the financial year 2020-21. It has also asked the 15th UFC to reconsider the special nutrition grants worth Rs. 7,735 crore to the states (Shukla, 2020).

Though there have been criticisms regarding the decline of UFC as a constitutional institution (Thimmaiah, 2002), over the years, its credibility has strengthened as its recommendations, including those of the 15th UFC, fulfil the three criteria of "need, equity and efficiency" (Times of India, 2021). Owing to the rising fiscal needs and macroeconomic uncertainties resulting from the pandemic induced challenges, "the 15th UFC has emphasized on fiscal stability, equity, and enhancement of fiscal space through higher borrowing, with a fiscal exit plan for both union and states," (Chakraborty, 2021).

In India, the UFC and the Planning Commission were formed to promote fiscal federalism. While the Planning Commission of India, an extra-constitutional body established in 1950, was later dismantled in 2014, the UFC which was established in 1951 still exists. The UFC has turned out to be a unique constitutional body that has survived for the last 70 years. The major reason behind its success lies in the fact that each UFC comprised of competent experts. It is to be noted that the success of any official expert body like the Finance Commission depends upon the calibre and efficiency of the members and Chairperson.

The appointments and recommendations made by the UFCs over the years have been greeted with positive discussions in academic and policy-making bodies in the country. It is also interesting to note that each UFC in India had to face its own unique sets of challenges; for the 15th UFC, the COVID-19 pandemic was the biggest challenge of all. It is to be noted that "the COVID-19-induced macroeconomic uncertainties made the assessment and quantification of fiscal needs a challenging task for the Fifteenth Finance Commission" (Chakraborty, 2021). Despite the challenges posed by the pandemic, the 15th UFC have taken an excellent and careful approach to dealing with the "challenging task of dividing fiscal resources between the union and states" (Rao, 2021).

The paper is divided into eight parts. Part one discusses the concept of health grants, and part two discusses grants to local governments in the context of health grants. Part three of the paper focuses on health grants to local governments in detail, followed by part four which discusses the logic and necessity for introducing health grants, and assesses the status of grassroots healthcare institutions. This is followed by a separate section on other recommendations made by the 15th UFC in connection with health grants. Parts six and seven discuss *Mission Creep Syndrome* and reasons for the same, respectively. The paper ends with discussion and conclusions.

Part I - The Concept of Health Grants

The recommendations made by the UFCs of India over the years have played a pivotal role in strengthening fiscal federalism in India. It is also the first constitutionally-backed Commission to submit its detailed report, titled *Finance Commission in COVID Times,* in the midst of the pandemic. Like all other UFCs in the past, the 15th UFC also recommended grants-in-aid under revenue deficit grants, grants for local governments[3], grants for disaster management, sector-specific grants, and state-specific grants; in the wake of the COVID-19 pandemic, however, the 15th UFC has also introduced a new category called 'health grants for local governments' (See Table 1).

The total grants-in-aid support to the health sector over the award period[4] amounts to Rs. 1,06,606 crores, which is 10.3% of the total grants-in-aid recommended by the 15th UFC. This constitutes about 0.1% of GDP (Para 9.49, 15th UFC). The 15th UFC has stated that grants for the health sector will be unconditional. It is also interesting to note that the total grant-in-aid support to the health sector is more than Rs.1 lakh crore, spread over three components, making it the second-most important grant after revenue deficit grants[5].

Table 1: Break-up of Total Grants-in-aid Support to the Health Sector

Components	Amount
1.Sectoral Grants under health*	Rs. 31,755 crores
2.Health Grants for local governments**	Rs.70,051 crores
3.State-specific grants for health	Rs. 4,800 crores
Total grants-in-aid support to the health sector	Rs. 106,606 crores

*See Table 2 for Break-up of sectoral grants under health

** See Table 4 for Break-up of health grants for local governments

Source: Report of the 15th UFC

Before delving into the health grants for local governments, it is important to look into health sector grants earmarked by the 15th UFC in the wake of COVID-19 pandemic (See Table 2). The 15th UFC has also recommended state-specific grants for health amounting to Rs. 4,800 crores. These grants have been earmarked to build resilience against future pandemics, by building critical care hospitals and public health labs.

Table 2: Break-up of Sectoral Grants for Health

Sub-components	Amount
1.Critical care hospitals	Rs. 15,265 crores
2.District integrated public health labs	Rs. 469 crores
3.Support to the States to run DNB courses in district hospitals	Rs. 2725 crores
4.Training of 1.5 million workforce related to Allied health care	Rs. 13296 crores
Total	Rs. 31,755 crores

Source: Report of the 15th UFC

Under the sectoral grants for health, the 15th UFC has recommended a total of Rs. 15,265 crores for critical care hospitals. It includes Rs. 13,367 crores for general states, and Rs 1,898 crore for North-

Eastern and Himalayan (NEH) states. A total of Rs. 13,296 crores has been earmarked for training of the allied healthcare workforce. Out of this amount, Rs. 1,986 crores is allocated for NEH states and Rs. 11,310 crores for general states (para 9.60, 15th UFC).

Part II - Grants for Local Governments

The 15th UFC, in their report for 2020-21 had recommended total grants of Rs. 90,000 crores to local governments, in the ratio of 67.5:32.5 between rural and urban local governments. For the five-year period of 2021-26, the 15th UFC has recommended a total grant of Rs. 4,36,361 crores. The ratio of *inter se* distribution of the grants recommended for rural and urban local bodies gradually moves from 67.5:32.5 in 2020-21 to 65:35 in 2025-26 (15th UFC Report for 2021-26).

Of these total grants, Rs. 8,000 crores are performance-based grants for incubation of new cities, and Rs. 450 crores are for shared municipal services. A sum of Rs. 2,36,805 crores is earmarked for rural local governments, Rs. 1,21,055 crores for urban local governments, and Rs. 70,051 crores for health grants through local governments (See Table 3).

Table 3: Break -up of Total Grants Allocated to Local Governments

Components	Amount
1.Grants earmarked for rural local governments	Rs. 2,36,805 crores
2.Grants earmarked for urban local governments	Rs. 1,21,055 crores
3.Health Grants through local governments	Rs. 70,051 crores
4.Performance-based grants for incubation of new cities	Rs. 8,000 crores
5.Shared municipal services	Rs. 450 crores
Total Grants for Local Governments (2021-26)	Rs.4,36, 361 crores

Source: Compiled by the authors based on the data given in Report of the 15th UFC

Part III - Health Grants for Local Governments in Pandemic Times

In the wake of the COVID-19 outbreak, with worrying reports of the underfunded and understaffed health system in the country crumbling under the burden, the 15th UFC provided grants of Rs. 70,051 crores to strengthen the health care system at the grassroots level.

The grants for local governments have been earmarked for the health sector at the rural and urban government levels over the award period of five years (Table 4). The health grants recommended to be released in the financial year 2021-22 amount to Rs. 13,192 crores, which includes Rs. 8,273 crores for rural and Rs. 4,919 crores for urban local governments. The recommendations made by the 15th UFC reflect a scientific and thoughtful approach, rooted in the ground reality that primary healthcare infrastructure at the grassroots level crumbled in the wake of COVID-19, owing to poor facilities and shortage of funds.

It also points to the greater stress given to cooperative federalism. The 15th UFC, by incorporating the health grants to local government, shows its conviction about and acceptance of the important role played by the local governments in primary healthcare. It also shows a 'trust-based approach'

towards local governments and their efficiency in effectively handling the grants for strengthening grassroots healthcare infrastructure.

Table 4: Sector-wise Break-up of Health Grants by 15th UFC (Rs. Crores)

Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1.Support for diagnostic infrastructure to the primary healthcare facilities*	3478**	3478	3653	3835	4028	18472
Sub Centres (SCs)	1457	1457	1530	1607	1687	7738
Primary Health Centres (PHCs)	1627	1627	1708	1793	1884	8639
Urban PHCs	394	394	415	435	457	2095
2. Block Level Public Health Units (BHUs)	994	994	1044	1096	1151	5279
3. Urban Health and Wellness Centres (HWCs)	4525	4525	4751	4989	5238	24028
4. Building-less SCs, PHCs, CHCs	1350	1350	1417	1488	1562	7167
5. Conversion of Rural PHCs into HWCs	2845	2845	2986	3136	3293	15105
Total Health Grants (Rs. in Crore)	13192	13192	13851	14544	15272	70051

*Under the component "support for diagnostic infrastructure to the primary healthcare facilities", there are three sub components and they are SCs, PHCs and Urban PHCs.
** Please note that the Rs. 3478 is the sum total of (SCs -1457, PHCs -1627, Urban PHCs -394)
Source: Report of the 15th UFC

Through the allocation of the health grants to local governments, the 15th UFC has pioneered the process of ensuring the 'authority and accountability' in the domain of the devolution of health to local governments. The involvement of empowered local governments would also make health systems more accountable to the people. The decentralization of health will create a sense of responsibility (accountability) and a sense of ownership (authority), which will eventually lead to sustainability and longevity of public health institutions.

Part IV - Why the Health Grants?

In its report for 2021-2026, the 15th UFC has pointed out the reality that the COVID-19 pandemic has dismantled the healthcare infrastructure in the rural and urban healthcare facilities especially primary healthcare systems. According to 15th UFC, India has failed to ensure core public health functions and accountability in health service delivery. The 15th UFC has also listed the critical gaps in health infrastructure, such as inadequate numbers of Sub Centres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), doctors, nurses, and paramedics.

Prior to introducing the health grants, the 15th UFC has initiated intensive consultations and discussions on challenges in healthcare infrastructure at the grassroots level and even constituted a High-Level Group on Health Sector. Meanwhile, one of the major reasons for recommending the health grants was the reality that many of the primary healthcare institutions are understaffed and underfunded, and need to be financially empowered.

The 15th UFC has recommended 'health grants' for five major areas:

Support for diagnostic infrastructure for the primary healthcare facilities:

1. (a) SCs

(b) PHCs

(c) Urban PHCs

2. Block Level – PHUs

3. Urban HWCs

4.Building-less SCs, PHCs, and CHCs

5. Conversion of Rural PHCs into HWCs.

To understand the importance of health grants, it is essential to understand the status of grassroot healthcare institutions.

Support for diagnostic infrastructure for the primary healthcare facilities: Diagnostic services are critical for the delivery of health services, and the health grants are intended to fully equip the primary healthcare facilities so that they can provide some necessary diagnostic services. According to Rural Health Statistics (RHS 2019 -2020), there is no adequate modern diagnostic services available in Primary Healthcare facilities.

Status of Rural and Urban Sub-Centres (SCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs)

A three-tier system comprising of SCs, PHCs, and CHCs are the main pillars of the Primary Healthcare System in India (See Table 5). According to RHS 2019-2020, there are a total of 1, 55, 422 SCs in rural areas and 2,517 SCs in urban areas. In the case of PHCs, there are 24,918 in rural areas and 5,895 in urban areas (also known as urban PHCs). There are 5,183 CHCs in rural areas and 466 in urban areas.

Table 5: Details of SCs, PHCs, and CHCs in Rural and Urban Areas in India

States/UTs	SCs		PHCs		CHCs	
	Rural SCs	Urban SCs	Rural PHCs	Urban PHCs	Rural CHCs	Urban PHCs
Andhra Pradesh	7437	21	1142	243	141	57
Arunachal Pradesh	356	7	119	5	60	0
Assam	4659	21	946	56	190	2
Bihar	9112	1168	1702	325	57	7
Chhattisgarh	5205	364	792	45	170	4
Goa	218	0	55	4	6	0
Gujarat	9162	0	1477	318	348	14
Haryana	2617	0	385	100	118	13
Himachal Pradesh	2092	12	564	24	85	7
Jharkhand	3848	0	291	60	171	6
Karnataka	9188	247	2176	358	189	19
Kerala	5410	0	784	148	211	16
Madhya Pradesh	10226	0	1199	277	309	21
Maharashtra	10647	2	1829	846	278	140
Manipur	418	0	85	8	17	0
Meghalaya	440	3	119	24	28	0
Mizoram	311	59	57	8	9	0
Nagaland	395	20	130	7	21	0
Odisha	6688	0	1288	89	377	7
Punjab	2950	97	427	100	143	12
Rajasthan	13480	50	2094	383	548	66
Sikkim	147	6	24	1	2	0
Tamil Nadu	8713	0	1420	464	385	15
Telangana	4744	97	636	249	85	10
Tripura	965	36	107	5	22	0
Uttarakhand	1839	8	257	38	56	12
Uttar Pradesh	20778	0	2880	593	711	12
West Bengal	10375	0	913	456	348	0
Union Territories						
Andaman & Nicobar Islands	124	0	22	5	4	0
Chandigarh	0	0	0	48	0	2
Dadra and Nagar Haveli and Daman and Diu	94	3	10	3	4	0
Delhi	12	246	5	541	0	23
Jammu and Kashmir	2470	22	923	49	77	0
Ladakh	238	0	32	0	7	0
Lakshadweep	11	0	4	0	3	0
Puducherry	53	28	24	15	3	1
All India Total	1,55,422	2517	24918	5895	5183	466

Source: RHS 2019 -2020. Data as on March 31, 2020

Block Level Public Health Units

A CHC/ PHC/ Sub-divisional or Sub-district Hospital, are the major public health units functioning at the block level. The public health system at the block level across states in India does not have a uniform pattern. For instance, in some states, a CHC at the block level serve as First Referral Unit (FRU). At present, the public healthcare system at the block level is not well equipped to handle public health emergencies.

Following the outbreak of COVID-19 pandemic, the Government of India has proposed Block Level - PHUs in around 3,382 blocks in 'High-Focus States', including Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttarakhand, and in three North-Eastern States, namely Assam, Manipur, and Meghalaya (National Health Systems Resource Centre, 2021). The support for establishing 1,048 Block Level - PHUs in these states are covered under the PM Ayushman Bharat Health Infrastructure Mission, from the resources from the 15th UFC health grants to local governments.

Urban Health and Wellness Centres

In 2018, the union government announced Ayushman Bharat Program with two major components: (1) HWCs for delivering comprehensive primary health care services, and (2) Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB- PMJAY), provides health assurance up to Rs. 5 lakh per family per year for secondary and tertiary healthcare hospitalizations (Press Information Bureau, 2021). The beneficiaries eligible for AB-PMJAY are selected on the basis of deprivation and occupational criteria listed under the 2011 Socio Economic Caste Census.

The HWC component of the Ayushman Bharat Program aims to upgrade around 150,000 primary healthcare facilities into functional HWCs. It has also been suggested that all urbanPHCs to be upgraded as Urban HWCs by March 2020. This process is ongoing. In the wake of COVID-19 pandemic, the importance of Urban HWCs has increased. Be it a pandemic or endemic disease, Urban HWCs if properly operational can facilitate decentralized delivery of primary health care, covering a relatively smaller population per HWC. It could create a monitoring mechanism, as well as channel to disseminate information on public health issues to the community around them.

Building-less SCs, PHCs, CHCs

According to RHS 2019-2020, there are around 47,518 SCs in rural areas that need buildings to function. (See Table 6). The SCs are one of the most peripheral points of contact between Primary Healthcare Systems and the local community. However, SCs are often in a poor condition; out of the total existing 1,55,404 SCs, only 1,07,886 are housed in government buildings. Those SCs, PHCs, and CHCs that are functioning in rented or rent-free buildings are considered as 'building-less', and they have to be shifted to government buildings. For these building-less SCs, PHCs, and CHCs, the 15th UFC has granted a total of Rs. 7,167 crore.

Table 6: Details of SCs functioning in Government Buildings, Rented Buildings, and Rent-Free Buildings in Rural Areas of India

States/UTs	Total No. of SCs	No. of SCs functioning in Government Buildings	No. of SCs functioning in Rented Buildings	No. of SCs functioning in Rent Free Buildings	No. of SCs to be housed in Government Buildings
Andhra Pradesh	7437	2326	4811	300	5111
Arunachal Pradesh	356	356	0	0	0
Assam	4659	3626	695	338	1033
Bihar	9112	3756	3250	2106	5356
Chhattisgarh	5205	4160	573	472	1045
Goa	218	93	122	3	125
Gujarat	9162	6358	147	2657	2804
Haryana	2617	1714	362	541	903
Himachal Pradesh	2092	1630	25	437	462
Jharkhand	3848	2422	1219	207	1426
Karnataka	9188	5075	1481	2632	4113
Kerala	5410	3818	586	1006	1592
Madhya Pradesh	10226	7926	1223	1077	2300
Maharashtra	10647	9069	1417	161	1578
Manipur	418	332	19	67	86
Meghalaya	440	428	2	10	12
Mizoram	311	311	0	0	0
Nagaland	395	313	3	79	82
Odisha	6688	4897	1624	167	1791
Punjab	2950	1848	29	1073	1102
Rajasthan	13480	10621	1205	1655	2859
Sikkim	147	146	1	0	1
Tamil Nadu	8713	6290	2420	3	2423
Telangana	4744	1273	2694	777	3471
Tripura	965	777	38	150	188
Uttarakhand	1839	1296	506	37	543
Uttar Pradesh	20778	17124	3642	12	3654
West Bengal	10357	8580	1332	445	1777
Union Territories					
Andaman & Nicobar Islands	124	124	0	0	0
Chandigarh	0	NA	NA	NA	NA
Dadra and Nagar Haveli and Daman and Diu	94	69	15	10	25
Delhi	12	1	8	3	11
Jammu and Kashmir	2470	872	1598	0	1598
Ladakh	238	207	31	0	31
Lakshadweep	11	8	0	3	3
Puducherry	53	40	13	0	13
All India Total	**155404**	**107886**	**31090**	**16428**	**47518**

Source: RHS 2019-2020. Data as on March 31, 2020

States like Andhra Pradesh, Gujarat, Karnataka, Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Telangana, Uttar Pradesh, West Bengal, Assam, Manipur, and Meghalaya have significantly higher infrastructure gaps, as they have higher number of SCs to be moved to government buildings.

Building-less PHCs

The PHCs are often the first point of contact for the people living in rural and remote communities. The poorest of the poor often find PHCs as their first and last resort. However, majority of the PHCs do not have adequate infrastructure facilities to even provide treatment to the ailing (See Table 7). States like Bihar, Chhattisgarh, Jharkhand, Maharashtra, Madhya Pradesh, Uttar Pradesh, Karnataka, Gujarat, and Rajasthan have a higher number of PHCs are not housed in government buildings, i.e. 'building-less PHCs'.

Building -less CHCs

CHCs are the third tier of rural healthcare institutions. The CHCs serve as referral centres to primary healthcare institutions or PHCs, to make modern healthcare services accessible to rural people, and to ease the overcrowding in district hospitals. As on March 31, 2020, there are 5,183 CHCs functioning in rural areas of the country; of these, 4997 CHCs are functioning in government buildings, and a total of 186 CHCs have to be moved to government buildings (See Table 8).

Conversion of Rural PHCs and SCs into HWCs

The union government has envisaged the creation of 1,50,000 HWCs, by transforming existing SCs and PHCs, as the basic pillar of Ayushman Bharat to deliver comprehensive primary healthcare. The 15th UFC has proposed to provide support for necessary infrastructure for the conversion of rural PHCs and SCs into HWCs, so that they are equipped and staffed by an appropriately trained primary healthcare team (Report of the 15th UFC, 2021-26).

Table 7: Details of PHCs functioning in Government Buildings, Rented Buildings, and Rent-Free Buildings in Rural Areas of India

State/UTs	Total No. of PHCs	No. of PHCs functioning in Government Buildings	No. of PHCs functioning in Rented Buildings	No. of PHCs functioning in Rent-free Building	No. of PHCs to be housed in Government Buildings
Andhra Pradesh	1142	1126	1	15	15
Arunachal Pradesh	119	119	0	0	0
Assam	946	946	0	0	0
Bihar	1702	986	362	354	716
Chhattisgarh	792	677	0	115	115
Goa	55	22	3	30	33
Gujarat	1477	1226	3	248	251
Haryana	385	301	14	70	84
Himachal Pradesh	564	485	6	73	79
Jharkhand	291	160	17	114	131
Karnataka	2176	2020	69	87	156
Kerala	784	775	7	2	9
Madhya Pradesh	1199	1092	107	0	107
Maharashtra	1829	1707	122	0	122
Manipur	85	79	2	4	6
Meghalaya	119	118	1	0	1
Mizoram	57	57	0	0	0
Nagaland	130	123	0	7	7
Odisha	1288	1255	0	33	33
Punjab	427	362	5	60	65
Rajasthan	2094	1963	21	110	131
Sikkim	24	24	0	0	0
Tamil Nadu	1420	1390	0	30	30
Telangana	636	636	0	0	0
Tripura	107	107	0	0	0
Uttarakhand	257	227	18	12	30
Uttar Pradesh	2880	2626	218	36	254
West Bengal	913	913	0	0	0
Union Territories					
Andaman & Nicobar Islands	22	22	0	0	0
Chandigarh	0	NA	NA	NA	NA
Dadra and Nagar Haveli & Daman and Diu	10	10	0	0	0
Delhi	5	5	0	0	0
Jammu and Kashmir	923	714	209	0	209
Ladakh	32	32	0	0	0
Lakshadweep	4	4	0	0	0
Puducherry	24	24	0	0	0
All India Total	24918	22333	1185	1400	2585

Source: RHS 2019-2020. Data as on March 31, 2020

Table 8: Details of CHCs functioning in Government Buildings, Rented Buildings, and Rent-Free Buildings in Rural Areas of India

States/UTs	Total CHCs in Rural Areas	No. of CHCs functioning in Government Buildings	No. of CHCs functioning in Rented Buildings	No. of CHCs functioning in Rent Free Buildings	No. of CHCs to be housed in Government Buildings
Andhra Pradesh	141	141	0	0	0
Arunachal Pradesh	60	60	0	0	0
Assam	190	190	0	0	0
Bihar	57	57	0	0	0
Chhattisgarh	170	160	0	10	10
Goa	6	6	0	0	0
Gujarat	348	298	0	50	50
Haryana	118	113	2	3	5
Himachal Pradesh	85	83	1	1	2
Jharkhand	171	171	0	0	0
Karnataka	189	181	8	0	8
Kerala	211	211	0	0	0
Madhya Pradesh	309	304	5	0	5
Maharashtra	278	270	2	6	8
Manipur	17	17	0	0	0
Meghalaya	28	28	0	0	0
Mizoram	9	9	0	0	0
Nagaland	21	21	0	0	0
Odisha	377	377	0	0	0
Punjab	143	132	0	4	11
Rajasthan	548	530	2	16	18
Sikkim	2	2	0	0	0
Tamil Nadu	385	385	0	0	0
Telangana	85	85	0	0	0
Tripura	22	22	0	0	0
Uttarakhand	56	56	0	0	0
Uttar Pradesh	711	642	47	22	69
West Bengal	348	348	0	0	0
Union Territories					
Andaman & Nicobar Islands	4	4	0	0	0
Chandigarh	NA	NA	NA	NA	NA
DNHDD*	4	4	0	0	0
Delhi	NA	NA	NA	NA	NA
Jammu and Kashmir	77	77	0	0	0
Ladakh	7	7	0	0	0
Lakshadweep	3	3	0	0	0
Puducherry	3	3	0	0	0
All India Total	**5183**	**4997**	**67**	**112**	**186**

Source: RHS 2019-2020. Data as on March 31, 2020. DNHDD – Dadra and Nagar Haveli and Daman and Diu

Part V - Other Health Related Recommendations by 15th UFC

The 15th UFC recommendations are not limited to health grants. The Commission recommends measures should be taken to assign a larger role for nursing professionals, and the concept of nurse practitioner, physician assistant, and nurse anaesthetist should be introduced for better utilisation of nursing professionals.

It also said that the Medical Council of India (MCI) or National Medical Council (NMC) should develop small courses on wellness clinic, basic surgical procedures, anaesthesia, obstetrics and gynaecology, eye, ENT etc. for MBBS doctors, and encourage AYUSH as an elective subject for medicine undergraduates (Report of the 15th UFC, 2021-26). The 15th UFC also recommended that an All India Medical and Health Service under Section 2A of the All-India Services Act, 1951 must be constituted, to alleviate the inter-state disparity in the availability of medical doctors.

a) Nurse Practitioners

India needs an alternative general medical practitioner to overcome the severe shortage of doctors and nurses in rural as well as urban areas. At present, the rural and underprivileged regions in the country are in need of general medical practitioners (Kodi & Sharma, 2021).

A nurse practitioner is a registered nurse with advanced training and education; like a general physician, they can help with all aspects of patient care including consultation, diagnosis, and treatment. However, unlike physicians, the nurse practitioners cannot perform surgical procedures independently.

As per Indian Public Health Standards, PHCs require 25,650 doctors across India, to tend to a minimum of 40 patients per doctor per day for outpatient care, and here the services of nurse practitioners can prove helpful to an extent. Since 2007, there have been attempts to introduce the nurse practitioner courses; so far, however, nothing has materialized. The National Health Policy in 2017 and 2019 have also put forward the importance of nurse practitioners, especially for healthcare delivery at the grassroots level.

While it took a pandemic for India have to understand the significance of nurse practitioners, countries like USA and Canada had the nurse practitioner system since the 1960s, and UK since the 1980s (Maier et. al, 2016). Following the 15th UFC recommendations, the Ministry of Health and Family Welfare (MoHFW) has also emphasized the need of nurse practitioners for effective healthcare delivery at the primary healthcare institutions, and is actively considering introducing a cadre of nurse practitioners to address the shortage of doctors in rural areas.

b) All India Medical and Health Services

It is a worrying reality that primary healthcare institutions don't have enough health workforce. Though the number of health facilities in rural India have considerably increased, convincing medical graduates to work in rural areas is a challenge in itself. The lack of good living standards, including inaccessibility of basic amenities, are the major factors that often prevent them from offering their service in rural areas.

The 15th UFC has proposed that an All India Medical and Health Services Cadre should be organised along the lines of the Indian Administrative Service (IAS): "Given the inter-state disparity in the availability of medical doctors, it is essential to constitute an All India Medical and Health

Service as is envisaged under Section 2A of the All-India Services Act, 1951. For this purpose, the Union Public Service Commission (UPSC) would need to do annual recruitments, based on the state-wise requisitions by each state government.", (Report of the 15th UFC).

The MoHFW and state governments have attempted various strategies to attract doctors to rural areas, including compulsory rural postings and linking rural postings to admission into postgraduate courses. However, results have not been promising, as these initiatives found only a few takers.

While the shortage of health workers is a worrying trend, the absence of decision-makers with background and expertise in health is also worrisome. While there have been talks about All India Medical Services on the lines of IAS, there has been little or no discussions on All India Medical and Health Services before the current recommendations. The All India Medical Services, if put into practice, will also be responsible for holding the administrative responsibilities pertaining to the district medical officer, project officers of various disease control programmes, and the various ranks of secretaries in the Union health ministry, the state health departments, and the heads of all other areas in the health sector.

All India Medical and Health Service would help in recruiting doctors and health workers to grassroot areas. The COVID-19 pandemic has reinforced the importance of All India Medical and Health Service cadre (Nankani, 2022). The development of such a service for public health administration was also advocated by a parliamentary committee on health in March 2021 (Belagere, 2022). In addition to that, the Indian Medical Association (IMA) has also demanded the establishment of the All India Medical Services.

Such a medical cadre will have the potential to close the long-standing gap between public health information and decision-making. The pandemic has made us realize the importance of health professionals, not just in responding to the pandemic in health institutions, but also at the various level of the government. Perhaps a mix of All India Medical Service and All India Medical and Health Services would be the right fit, and it should be part and parcel of the post-COVID healthcare policy in India.

c) Increase the Spending on Health

The 15th UFC, has strongly recommended that health spending by states should be increased to more than 8% of their Budget by 20226. Further, it also recommended that primary healthcare should be the number one fundamental commitment of each and every state, and that primary health expenditure should be increased to two-thirds of the total health expenditure by 2022. It has also recommended that the public health expenditure of the union and states together should be increased in a progressive manner to reach 2.5% of GDP by 2025 (NITI Aayog 2020 -21, Working Paper).

Part VI - The Problem of Mission Creep

Funds and grants allocated by the UFCs are transferred in two stages. In the first stage, the funds are transferred from the union government to state governments and from the states to local governments. These fund transfers were earlier governed by stipulations and conditions imposed by the union government, which may not be based strictly or solely on the recommendations of the UFC. However, the 14th UFC (in Para 9.80) made it clear that "...there is a need to trust and have respect for

local bodies as institutions of local self-government, and that no more conditions may be imposed by either the union or the state government, which go beyond those made by the 14th FC".

The 14th UFC was thus the first Finance Commission to openly declare "trust-based approach to local governments", emphasizing that all local governments are required to utilize almost all the grants on the functions assigned to them. The 14th UFC also clarified that "no further conditions should be imposed by either the Union or the States in this regard". However, these recommendations were not followed in letter and spirit by both union governments (Ministry of Finance - MoF - and Ministry of Panchayati Raj - MoPR) and state governments, and this has led to "*Mission Creep*"[7].

For instance, the introduction of Gram Panchayat Development Plan (GPDP) as a necessary condition for the receipt of 14th UFC funds have undermined the recommendations of the Commission. "There has been 'Mission Creep' by the MoF and MoPR through the imposition of more conditionalities upon Panchayats and States, over and above those suggested by the FC" (Centre for Policy Research, 2019)

It is also surprising to note that the states like Kerala, Tamil Nadu, and Karnataka, which have a legacy of decentralization, also took multiple steps that violate the letter and spirit of the recommendations of the 14th UFC. For instance, Kerala[8] has merged the Plan Funds allocated to local governments by the state government and funds earmarked by the 14th UFC (under the name Development Funds). Therefore, the 14th UFC grants were subjected to rigid conditionalities imposed by the Government of Kerala. As a result, these funds were transferred to the treasury accounts of the Gram Panchayats in Kerala instead of depositing it in the bank accounts of each Panchayat. It resulted in an inordinate delay in the release of funds, and the Panchayats lost the grants and interest rate which would have been accumulated on it. This is an explicit violation of the recommendations laid out by the Union Finance Commission.

In Tamil Nadu[9], in the case of settlement of electricity and water charges, as per the guidelines prepared by the Government of Tamil Nadu for administering 14th UFC (Basic & Performance Grants), "Village Panchayats should settle their dues towards electricity consumption charge to Tamil Nadu Generation and Distribution Corporation (TANGEDCO) and water charge to Tamil Nadu Water Supply and Drainage Board (TWAD) as 1st charge from 14th UFC". It is a fact that streetlights and water supply are basic civic functions of every local government, as is also mentioned in Section 110 of the Tamil Nadu Panchayats Act, 1994. However, directions for settlement of electricity and water charges to service providers as the first priority item from the 14th UFC is against the spirit of decentralization & recommendations of the FC. This is considered as a 'Mission Creep'.

Attempts were also made to 'divert' some award amount from the 14th UFC while depositing the same in a 'protected envelope' (Account No. 2) to operative exclusively for the payment towards TWAD and TANGEDCO. Since the Village Panchayats have little freedom on the operation of this Account No.2, it is against the letter and spirit of the 14th UFC to deposit a share of the UFC awards in the said Account. Similarly, Karnataka[10] introduced the 'Escrow Account System' to divert the grants from 14th UFC to Gram Panchayats.

Will the Health Grants lead to Mission Creep?

Though the 15th UFC has clearly stated that that "no conditions or directions other than those indicated by the Finance Commission should be imposed either by the union or the state

governments, or any authority, for releasing the grants for health". However, it needs to be seen whether the recommendations made by the 15th UFC will be implemented as intended. So far, no major empirical studies or assessments have been made to monitor and review whether the funds allocated to local governments by the UFCs are reaching them without fail. There should be an independent mechanism to check the 'Mission Creep Syndrome'.

Part VII - Reasons for 'Mission Creep'

1. Trust Deficit: There is a lack of sensitization towards local governments on the part of public institutions and various government departments at the Union and State level. There are lot of misconceptions about local governments and functionaries. The general perception is that the elected functionaries and staff at local governments are weak, corrupt, and illiterate, and that transferring huge funds directly into their hands would be catastrophic. It is also important to keep in mind, as M Govinda Rao points out, that "...while the intention of the Commission [is] to further the process of fiscal decentralisation to the sub-state level by placing eligibility conditions to the states for the local bodies to receive grants, the problem is that the states may not have the incentive to undertake the suggested reforms, as they are not going to be the losers, and the public pressure may not be strong enough to force them to undertake them." (Rao, 2021) The importance of induced pressure from below is very much a catalyst in empowering the grassroot institutions.

2. No Institutional Mechanism: At present there is no institutional mechanism to monitor and review the implementations and fund allocations based on the recommendations of the UFCs and the resultant institutional vacuum. Once a union or state Finance Commission submits their report and recommendations, that Finance Commission ceases to exist. This has created an institutional vacuum of great lengths. Meanwhile, the 15th UFC in its recommendations for fiscal architecture for the 21st century has suggested the creation of a new Independent Fiscal Council. According to the 15th UFC, "the Independent Fiscal Council will be an advisory body with powers to access records required from union as well as states to ensure better compliance to act as a repository of fiscal data," (Para 13.56, 15th UFC). In addition to that, the 13th UFC has recommended the appointment of a committee by the Ministry of Finance to monitor the implementation of fiscal rules and later to evolve as a fiscal council (Rao, 2021). Fiscal Responsibility and Budget Management (FRBM) review committee also mooted for the same. Meanwhile, there are valid criticisms about how a council appointed by the Finance Ministry and reporting to the same Ministry can remain independent (Rao, 2021). As a result, the 14th UFC recommended the FRBM Act should be amended so that the Parliament can appoint an Independent Fiscal Council. However, the government has not taken any action in this regard.

3. Lack of Coordination: There is a lack of co-ordination between the Ministries of Finance, Health and Family Welfare, Panchayati Raj, Housing and Urban Affairs, and Rural Development, when it comes to proper allocation of earmarked funds or implementation of the recommendations of the Finance Commissions. There is little or no coordination at the horizontal level between these Union Ministries, and the same co-ordination deficit is visible in respective state departments too. This lack of uniformity has led to an institutional vacuum when it comes to the monitoring and

implementation of 15th UFC recommendations. Even the NITI Aayog, despite preparing four rounds of National Health Index, has a sceptical attitude towards local governments in general.

4. Absence of Healthy Cooperative and Competitive Federalism: Though the Finance Commission aims to promote fiscal federalism between Union and States, the importance of cooperative and competitive federalism in ensuring a balance of fiscal federalism cannot be ignored. There have been complaints that different Finance Commissions were favouring different states.

For instance, there are widespread complaints that "a much smaller favour was shown to Andhra Pradesh by the Tenth Finance Commission, when it adjusted 50 % of the revenue loss on account of introduction of prohibition to the estimated revenue for purpose of working out the non-plan revenue deficit" (Thimmaiah, 2002). Then in the case of the 11th UFC it was reported that the Commission favoured West Bengal compared to many other poorer states (Thimmaiah, 2002).

There was controversy over the 15th UFC's Terms of Reference that stipulated that data for fiscal devolution will be based on the 2011 Census[11]. While the population is an important factor in determining the tax revenue distributed, the South Indian states protested because their share will get cut as they have less population growth between 1971 and 2011 due to adoption of population control measures. The Southern states alleged that they are simply being punished for checking the population growth while the North Indian states are being rewarded for their poor implementation of population control programmes. The 15th UFC, by keeping the weightage of 2011 population at 15% and giving an additional 12.5% to demographic performance (which is the inverse of fertility rate), has shown sensitivity to the concerns of these states (Rao, 2020).

Part VIII -Discussion and Conclusion

The health grants to local governments have the potential to strengthen decentralization and devolution of funds in terms of health. It is worth mentioning that, while making such recommendations, the 15th UFC has made sure that it introduced pandemic-induced reforms without comprising on constitutional principles, and also sustained a balance between fiscal and federal transfers between the union and the states and among the states.

The pandemic has not only hampered the growth prospects of the economy, but also exposed the underfunded and understaffed primary healthcare system in India, and the 15th UFC also cites this as the biggest reason for introducing health grants or targeted grants linked to performance-based criteria for certain sectors. The 15th UFC states that "Involving PRIs as supervising agencies in these primary healthcare institutions would strengthen the overall primary health care system". Strengthening the local governments in terms of funds, resources, health infrastructure will equip them to play a catalytic role in healthcare delivery.

Further, the suggestion for introducing the All India Medical and Health Services and nurse practitioners have the potential to strengthen the number of doctors, nurses and other paramedical staff at the grassroots level. It can resolve the human resource paucity at the grassroots level. For instance, every allopathic doctor in India caters at least 1,511 people, which is much higher than the WHO norm of one doctor for 1,000 people. Much more worrying is the shortage of trained nurses, with a nurse-to-population ratio of 1:670 as against the WHO norm of 1:300.

In terms of health infrastructure also the situation is deeply disappointing; the RHS 2019-20 points out that there is a significant shortfall in the number of centres required, ranging from 23% of SCs to 28% of PHCs to 37% of CHCs. The RHS 2019-20 also points out that there is severe deficit of public health facilities in states including Bihar, Jharkhand, Uttar Pradesh and West Bengal. The recommendations by the 15th UFC can help a great deal in constructing an equitable healthcare system for the marginalized and the poorest of the poor.

Through the allocation of the health grants to local governments, the 15th UFC has pioneered the process of ensuring the 'authority and accountability' in the domain of health is devolved to PRIs. The involvement of local governments and empowering them would financially also make the health systems more accountable to the people. The decentralization of health will create a sense of responsibility (accountability) and a sense of ownership (authority) that will lead to sustainability and longevity of public health institutions.

While the 14th and 15th UFCs adopted a trust-based approach towards local governments, a section of policy and development experts still view local governments as 'corrupt' and 'inefficient'. . It is also disappointing to note that there have been no major active discussions on the significance of health grants allocated to local governments in the wake of Covid 19 pandemic[12], With even the media only highlighting the surface-level fact that the 15th UFC announced health grants to local governments.

The 14th UFC laid the foundations for the trust-based approach and the 15th UFC by imbibing this spirit of trust-based approach introduced the category of health grants to local governments in the wake of Covid 19 pandemic. Though the recommendations made by the 15th UFC are historic, it is also important to note that the lack of sensitization towards local governments, misconceptions about local governments and their stakeholders, absence of an institutional monitoring mechanism to conduct a follow-up of the recommendations made by the respective Finance Commissions, lack of co-ordination between various Ministries of union and state governments, and the erosion of cooperative federalism have jointly led to 'Mission Creep' in the distribution and allocations of grants and funds from the Finance Commission to state and local governments. The above discussions and facts lead us to believe that, unless there are serious efforts to address the trust deficit towards local governments from the part of union and state governments, the health grants announced by the 15th UFC may eventually become a victim of 'Mission Creep' Syndrome as well.

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Notes

[1] UFC was set up under Article 280 of the Constitution and their major responsibility is to evaluate the state of finances of the union and state governments and to lay out recommendations for the sharing of taxes between them and to formulate the principles determining the distribution of taxes among the states. Promoting fiscal stability and strengthening cooperative federalism is also among the primary responsibilities of the UFC. The UFC is appointed by the President of India every five years.

[2] The 15th UFC was constituted in 2017. In 2019, the union cabinet approved the 15th UFC to submit its first report for the fiscal year 2020 -21. The union cabinet also extended the term of the 15th UFC by one-year to October 30, 2020 to present the final report covering 2021-22 Financial Year to 2025-26 by October 30, 2020.

[3] Following the 73rd and 74th Amendments, so far four UFCs (11th UFC to 14th UFC) have given their recommendations for local governments. Each UFC highlighted the critical issues faced by the local governments and made recommendations to address them. Since the 10th UFC was constituted in 1992, a year before the Amendments came into force, its ToR did not specify considering grants for the local governments. However, it still recommended grants, which were equivalent to 1.38% of the divisible pool to the local governments.

[4] 2021-2026

[5] The 15th UFC has recommended a post-devolution revenue deficit grant of Rs. 2,94,514 crore for 17 states from 2021-22 to 2025-26 (Chapter 10, 10.19 Para 12.57, pg. 371).

[6] India's overall allocation for health and well-being has soared by 137% in the financial year 2021-22. The Union Finance Minister Nirmala Sitharaman in the Union Budget presentation pointed out that the "budget outlay for health and wellbeing is (pegged at) Rs 2,23,846 crore in BE (budget estimate) 2021-22 as against 2020-21 budget estimate of Rs 94,452 crore, an increase of 137 per cent".

[7] Mission Creep is a gradual or incremental shift from the original goals, objectives, scope, and commitment of a project or mission, so that the original purpose/idea begins to be lost (Oxford Dictionary).

[8] The 14th UFC submitted its Report for the period April 1, 2015 to March 31, 2020 on December 15, 2014. In 2019 and 2020, the first author undertook a field visit in selected 30 GPs from all the 14 districts in Kerala to assess the fiscal devolution of grants to local governments. As part of the field visit, a number of discussions were held with elected functionaries and panchayat level official functionaries and they said that they are not directly receiving the grants in the bank account of the respective Panchayats and instead it is going to the treasury accounts where the Panchayats can only draw from the account as per the treasury rules. They said that it had resulted in inordinate delays in the receipt of their entitled funds. The allocation of the proposed plan size as 'Development Fund' to local governments is the sum total of three sources including Plan Fund, UFC awards and World Bank supported, 'Kerala Local Development Service Delivery Project' (Nair and Moolakkattu, 2018). It is also stated that grants to local governments by UFCs where subsumed in the 'Development Funds' devolved by the state government (Report of the Comptroller and Auditor General of India on Local Government Institutions, Government of Kerala, 2016).

[9] The first author conducted an extensive fieldwork in the selected 19 Village Panchayats in Tamil Nadu as part of a study assigned by Madras Institute of Development Studies (MIDS), Chennai in 2021 (Ananth Pur and research team, 2020- 21). The findings and inferences regarding the 14th UFC were obtained during the field visit. Previously, as part of the District Level Monitoring in 2018 in 60 selected Village Panchayats in Tamil Nadu, the same inferences were made.

[10] In 2018, and 2019 the authors as part of the District Level Monitoring visited 10 GPs each in 20 districts in Karnataka. The following inferences were made and observed during the field visits in the given time period. As per the state government order (Government Order No: GAP10 GPS 2015, Bengaluru, dated 10-03-2015), 25% of the 14th UFC awards had been deducted and deposited under Escrow Account of the respective Panchayats.

[11] All the previous Commissions that are up to the 13th UFC only used the 1971 Census data and the 14th UFC gave 10% weightage for the 2011 Census data.

[12] On January 8, 2022, Gulati Institute of Finance and Taxation (GIFT), a policy and research institute based in Thiruvananthapuram, Kerala and Kerala Economic Association (KEA) conducted a webinar on the state's health sector as part of the public lecture series (webinar) on 'Kerala Economy in Transition.' Though the participants noted that inadequate funding is the major hurdle for the development of public healthcare system, none of the participants (including a number of eminent public health experts) mentioned about the health grants allocated to local governments by the 15th UFC. Kerala, being a 'role model' in terms of health and decentralization and devolution of funds should facilitate more discussions on health grants and the public health experts should take a conscious effort to sensitize the public and local governments about the health grants to local governments.