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Distributive politics of the central government with the health budget

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Abstract[1]

Distributive politics/pork-barrel politics was popularized by the researchers in the United States in the 1960s. It showed that incumbent governments try to allocate disproportionately high public expenditure to their constituencies to get re-elected. The allocation is for new programmes with big outputs and high visibility at the expense of cost-effective projects. This paper argues that the National Democratic Alliance (NDA) governments in recent years have been playing distributive politics with Union health budgets. The initial years of 21st century saw the Indian central governments make three major interventions, namely Prime Minister's Swasthya Suraksha Yojana (PMSSY), National Rural Health Mission (NRHM) and Rashtriya Swasthya Bima Yojana (RSBY). The United Progressive Alliance (UPA) government (2004-2014) redesigned PMSSY to upgrade large number of Government Medical Colleges whereas the NDA government (2014-present) set up AIIMS like institutions, neglected NRHM and renamed RSBY raising the sum assured to a visibly high amount. It refused to accept the recommendations of XV Finance Commission (FFC) to fill the health infrastructure deficits that resulted in many lives lost during COVID-19. Post-COVID Union health budgets too show the neglect of primary care and national disease control programmes promoting large projects under central control confirming the play of distributive politics.

Key Words: Distributive Politics/Politics of Pork-Barrel, UPA and NDA Governments, PMSSY, NRHM, FFC, Union Budget.
JEL Codes: H5, H6, I180, P0

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[1] The usual disclaimers apply.

Introduction

The general argument that political economy impacts health of a population is well-known and there is considerable research on this subject in the Indian context. But there is one dimension of political economy which has hardly attracted much attention in India, namely the political party running the government distributing public funds to constituencies to get the incumbents/party re-elected. Indian studies on the political economy of government spending are largely influenced by Srinivas (1955) known for conceptualising "vote bank" politics as political parties following a fixed agency-clientele model of catching "vote bank", or concentrating on poor, middle class, or rich people, or regions. The basic argument is that different groups and categories are available for mobilisation in terms of their collective interests. It is assumed that group affiliation, particularly caste and community affiliation, can be used to mobilise support for a party or a candidate.

Vote bank as defined by Srinivas entailed obligation and reciprocity. In its pristine formulation it had three constituents: a village middleman, a political party, and local constituents. These actors were connected by two overlapping patron-client relationships: the first one between the political party and the local middleman who worked for the party and the second one

between the middleman and local constituents. The middleman, acting for the political party, would supply different kinds of benefits to citizens in exchange for their electoral loyalty (Breeding, 2011). Vote bank politics continues to persist. Parties still select middlemen with varying degrees of agency and rich parties supply to poor voters. But obligations and reciprocity have increasingly turned symbolic. Citizens can receive benefits without necessarily voting for the party. What, however, needs to be noted is that the materials that change hands are funded by political parties.

The late 1960s and early 1970s brought about a change in the "vote bank politics" with the rising electoral competition at all levels of the polity (Wilkinson, 2007). For the first time in 1967, in eight out of the 14 states, parties opposed to the Indian National Congress won a majority of the seats. The immediate response of the politicians to the intense competition was to increase the supply of clientelist resources. Prime Minister Indira Gandhi brought about a transition from party clientelism to state clientelism initially by nationalising commercial banks and making available priority sector loans to rural and small-scale industries and later by launching centrally sponsored schemes (CSS). The budget speech of the Prime Minister introducing the budget for the year 1970-71 for the first time talked about "policies which reconcile the imperatives of growth with concern for the wellbeing of the needy and the poor" (GoI, 1970. P.1). Special

schemes for small farmers, rural work programmes, slum clearances, housing, and so on find a mention in the Union Budget. The next budget saw the budgetary provision of a scheme for the educated unemployed (GoI,1971.P.2). The emphasis on these schemes continued in the next few budgets.

By that time a breakup of the Indian National Congress had taken place and electoral competition was heating up and the society too was changing. The proportion of literates had increased and the dependence on traditional village patrons had weakened considerably (Krishna, 2007). Villages were demanding electricity, a road, a school, a health centre and CSS were being designed to meet these demands. States too began designing programmes to meet the needs of specific population groups, for example, 'Adarana' scheme of TDP (Ravinder, 1999). While the CSS and state sponsored schemes were aimed at improving the chances of political parties to get re-elected, soon the incumbent legislators were demanding avenues for attracting public expenditure to their constituencies. It gave rise to the MPLAD (MP-Local Area Development) scheme in 1993 to enable members of parliament to recommend development works in their constituencies. States too followed with MLA-LAD funds.

Analysing the flow of public expenditure for garnering votes, Wilkinson (2007) suggested that as India's economy advances, vote bank politics will shift from narrow, specific interactions

between political parties and citizens to more organized pork-barrel projects. Hardly any study followed Wilkinson's suggestion with the lone exception of Sharma (2017). It tested the hypothesis of pork-barrel politics during the dominant party era (1972-1989) and in the coalition era (1996-2012) in Indian politics. In the dominant party era, Sharma (2017) concluded that *"This offers fascinating insights into the realm of resource distribution driven by political motives, commonly known as the pork-barrel politics. However, it does not completely clarify the exact sequence or order of these preferences"* (Sharma, 2017; p.29). In the coalition era, the ruling party at the centre used policies to get votes from the states where a different party was ruling. *"… they use widely advertised and cleverly named schematic grants to create goodwill for its party in states"* (Sharma, 2017; p.35). The study concluded that there is pork-barrel politics in coalition era but not in the dominant era. Sharma's inconclusive results are largely owing to his formulation of the problem. Any test of pork-barrel politics needs to look for policy outputs that are divisible, geographically distributed and have high visibility (as elucidated below). Sharma fails to posit the problem in these terms.

The politics of Pork-barrel, or distributive politics is applicable only to certain policy areas, namely those in which the policy outputs are divisible and in which the outputs are geographically distributed (Strom 1975). The term "distributive" comes from Theodore J Lowi (1964): "Distributive policies are characterized

by the ease with which they can be disaggregated and dispensed unit by small unit, each unit more or less in isolation from other units and **from any general rule"** (emphasis added) (p. 690). Even though its application is restricted, the theory would seem to have a fairly wide scope. In the United States context, it has been applied to highways program, the economic development program, the flood control of rivers and harbor area, defense procurement, and most of the federal grants-in-aid programmes.

One of the most elementary facts of political life in democracies is that incumbent politicians have an advantage when they run for re-election. Incumbency advantage occurs as voters choose incumbents over challengers as a risk aversion strategy. Incumbents on their part seek opportunities to enhance re-election chances through **greater visibility** in their districts. A characteristic of a pork-barrel project is that the benefits are geographically targeted whereas the costs are dispersed through general taxation. All liberal democratic constituencies provide representatives with incentives to allocate **economically inefficient projects** (Weingast et al., 1981: 654). Pork-barrel politics is a particular type of constituency service (Ferejohn, 1974). Whereas most constituency service is directed toward the individual citizen, pork-barrel politics benefits the representative's geographic constituency as a collective good, a **highly visible project.** Pork-barrel politics influences the distribution of public works expenditures (Murphy 1974). In such appropriations, many

districts receive expenditures in excess of what a **rational apportionment of resources to needs** would justify (Pennock, 1970).

Substantive research contribution on distributive theory of policy-making in the context of United States since the 1960s has argued that members' districts (constituencies) benefit by government spending or budget support. These take two major forms namely pork-barrel and patronage. Numerous studies have analyzed the benefits flowing into constituencies and helping re-election of incumbent members of Congress. The two classic studies of the Congressional Pork-Barrel focused on large-scale federal projects (Maass,1951; Ferejohn,1974). In these systematic studies of specific distributive policies, solid evidence of the political manipulation of these projects was found, but only through the early 1960s. Other examinations of grant programmes (Arnold,1979; Plott,1968; Rundquist and Ferejohn 1975; Strom,1975) and defense programmes (Goss,1972) from roughly the same time period found similar evidence of pork-barreling. Alvarez and Saving (1997) found that pork-barrel was alive and well during the 1980s. They went one step ahead and showed that "Across the four different operationalization(s) of pork-barrel behavior it was clear that **new programmes (measured in dollars or program numbers) mattered much more** for incumbent electoral success than existing programmes" (emphasis added) (p. 823).

Political parties are the gate keepers of democracy and they decide candidate selection, set policy agenda, and launch election campaigns. Cox and McCubbins (1993) assert the primacy of political parties in Congress arguing that the majority party structures the committee system to serve the party's needs, including re-election of enough incumbents to maintain majority status" (p.1156). Alvarez and Saving (1997) show that during the 1980s politics of the pork-barrel were crucially dependent on the political party of the office holder and benefited Democratic incumbents strongly, while Republicans benefited weakly or not at all.

Mani and Mukand (2007) define public goods as being less visible if it is harder to assess government competence, based on observed outcomes. These differences in visibility can arise because of two reasons. First, if some public good outcomes are intrinsically harder to directly observe or measure; second, a reason for lower visibility of a public good arises due to a public good's "complexity"- in that a large number of factors apart from government competence affects its outcome. In the case of such complex public goods, it is harder to isolate the role of the government's competence in determining their outcome-even if the outcome itself is easily observable.

Differences in visibility across public goods affect their provision because governments provide multiple goods and services.

Accordingly, voters' assessment of a government's competence and hence their voting decisions are based on the government's performances on a vector of outcomes. If outcomes of same tasks are harder to observe or measure, it is harder for voters to assess a government's ability based on these tasks. "Governments, being in the business of maximising their electoral possibilities, are aware of this. Since outcomes depend both on the ability of the government and the resources allocated by it, the government has an incentive to allocate relatively more resources to high visibility public goods, so as to project high ability" (p.507). Political competition and democratization decrease the relative amount of resources allocated to the less visible public good because resources are scarce, allocation has to be made across a multiplicity of public goods, and government's gains from allocating more resources to "visible" public goods is more.

In the context of health and education in India, outcomes are observable but the ability of the central government's competence is not easy to observe as there are multiple factors and inputs associated with it. In the case of primary and secondary healthcare, institutions are under the control of the state governments, the civil bureaucracy is that of the state government and medicines and consumables are supplied by the state government. Under-provision and poor administrative ability by the state government will affect outcomes. On the other

hand, an institution like AIIMS is under the control of the central government and the name itself carries lot of prestige. So, setting up an AIIMS guarantees high visibility and increases the chance of re-election of the incumbent government.

The issue taken up for analysis here is, does the Indian Central government follow a pork-barrel policy as regards budget allocation for health? Do allocations flow into highly visible projects with the aim of re-election of the incumbent party candidates? Is it achieved by announcing new projects at the cost of adding to already existing infrastructure, despite being less cost effective? Does the central government divert funds from the low visible projects under the control of state governments? The method adopted to develop the argument is the following. First a description of the evolution of the Central government's entry into health (a state subject) through Five-Year Plans (FYPs) and vertical programmes is presented (Section 2); it ends with the no FYP era where the restrictions set by rules are done away with allowing the central government the freedom to decide the number and location of projects. Next, an illustration of how PMSSY and NRHM are used by the NDA and UPA governments respectively, the former going for large projects with high visibility compared to the widely spread, need based projects of the UPA era is presented (Section 3). The continuation of the theme of not funding additions, howsoever necessary, followed by NDA is shown in rejecting the

recommendations of the FFC (Section 4). Analysis of post – COVID budgets is carried out to show the neglect of national disease control programmes and the promotion of AIIMS by the ruling front (Section 5). The paper concludes that the central government plays distributive politics with the health budget (Section 6).

2. Emerging Role of the Central Government in the Healthcare Sector in India

The constitution of India is a comprehensive document that covers all aspects of governance of the country and specifies the distribution of powers and responsibilities between the central and state governments. The seventh schedule specifies the roles and responsibilities in three lists namely, Union list, State list, and Concurrent list. Health is in the state list of Indian constitution (Rao and Choudhury,2008).

After independence, the health programmes and expenditures were guided by the FYPs and the recommendations of various committees. The Ministry of Health and Family Welfare developed programmes with the aim of meeting the targets set in the FYPs. Indian population in the immediate post-independence period suffered heavily from the burden of infectious diseases. Hence, in the 1950s and 1960s, the entire focus of the Indian health sector was to eradicate/control the infectious diseases (Duggal,2001) and on building infrastructure. Over the long

period numerous vertical disease control programmes – for example, National Malaria Eradication Programme (NMEP) - were launched through various FYPs.

One of the first major responsibilities under healthcare directly administered by the central government was the Central Government Health Scheme (CGHS) started in 1954 for serving or retired central government employees and their families. Later in 1956, to foster excellence in all facets of healthcare, an All-India Institute of Medical Sciences (AIIMS) was established as an autonomous institution through an Act of Parliament modelled on Johns Hopkins University in the United States. While presenting the bill to establish the institute, then Health Minister Amrit Kaur remarked in the parliament that "Medical Education must, above all, take into account the special needs of the country from the point of view of affording health protection to the people"

In 1975, Government of India initiated the Integrated Child Development Scheme (ICDS) to serve the population under the age 6, its objectives included preventive health services, as well as pre-school non-formal education through a comprehensive program for child development. It is implemented through a network of Anganwadi Centres in rural and urban areas (Kapil,2002; Drèze,2006). After a long gap of thirty years, in the initial years of 2000s, three major programmes were launched by

the Government of India. In 2003, the Government of India announced PMSSY, with the objective of correcting regional imbalances in the availability of affordable and reliable tertiary healthcare services across the country. It focused on the establishment of new AIIMS like institutions. With the launching of the NRHM in 2005 during the UPA regime, the focus shifted to meeting the health needs of the poor in the rural areas. The mission focused on improving healthcare infrastructure, maternal and child health, immunization, communicable disease control, and health promotion. In 2008, the Government of India rolled out the RSBY aimed at providing health insurance cover of up to Rs 30,000 for Below Poverty Line (BPL) households.

Healthcare is a state subject under the Indian constitution. However, the central government has come to play a significant role in healthcare by designing various vertical programmes aimed at eradicating communicable diseases and developing the health infrastructure for population control. As the burden of communicable diseases decreased over time, the central government identified the need to address other healthcare issues, such as correcting the regional imbalances in the provision of tertiary care and the strengthening of the public healthcare sector for providing better access to services and bringing down MMR and IMR. In the context of global call for Universal Health Coverage, India too began thinking of financial protection against catastrophic healthcare expenditure. The nature, scope, and

funding of these programmes varied depending upon the political party in power to achieve different health goals.

3. Politics of 'Visibility' versus Need: An Appraisal of PMSSY

In the last twenty-five years, the NDA held power at the Centre during 1998-2004, and 2014 onwards and the Indian National Congress led UPA was in power during 2004-2014. PMSSY, NRHM and Pradhan Mantri Jan Arogya Yojana (PMJAY) were the key programmes launched by the Central government during this period. These three initiatives reflect the political will of two distinct national coalitions- NDA and UPA.

PMSSY was announced in 2003 by Prime Minister Atal Bihari Vajpayee of the BJP led NDA government in his Independence Day speech: *"I know what people in underdeveloped states have to suffer due to the lack of good hospital services there. Therefore, under Prime Minister's Swasthya Suraksha Yojana, six new hospitals with modern facilities, like those available at All-India Institute of Medical Sciences in Delhi, will be established in backward states in the next three years"* (Prasar Bharati Archives, 2003). It was launched in March 2006 during the UPA regime.

The design of PMSSY underwent a major transformation in the hands of UPA government. While Vajpayee's address mentioned correcting imbalances by setting up new AIIMS like institutes, the

scheme as formulated in 2006 had an additional component of upgrading existing Government Medical Colleges (GMCs). Both the components sought to build super specialty departments, and hospital beds, and add medial education seats both under graduate and post-graduate.

Following from the objectives of the scheme six AIIMS were proposed to be set up in Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Rajasthan and Uttarakhand. These states were chosen based on an analysis of social indices and availability of health infrastructure. New AIIMS were funded 100 percent by the central government (CAG, 2018). But for the upgradation of GMCs, states have to partly share costs- with 20 percent initially and 40 percent in Phase IV. Each AIIMS was expected to cost around Rs.820 crore whereas, the cost of upgradation of GMCs was around Rs.120 crore (CAG, 2018).

The progress of the scheme was as follows. Following the announcement of establishing the six AIIMS in 2003, they were launched in 2006. The next batch of 16 AIIMS were announced only after 2015 in Phases IV and V of the scheme. The timelines of the upgradation of GMCs are as shown in Table 1. In sharp contrast to the setting up of AIIMS, the upgradation of 58 GMCs was planned during 2006 to 2013 with additional 13 by 2016. This period did not see any announcement of AIIMS, except one. It may be noted that the NDA regime announced the first six

AIIMS in 2003 which were brought to fruition by the UPA in 2006. The UPA regime focused on the upgradation of GMCs. The NDA regime that came back to power in 2014 while sanctioning the already planned 13 upgradations of GMCs did not propose any more, focusing entirely on setting up of many more AIIMS.

Table 1. Status of Upgradation of 75 GMCs

Phase	Cabinet/CCEA Approval	GMCs covered	Status as of May 2023
I	Original-2006 Revised-2010	13	All completed
II	2009	6	All completed
III	Nov-2013	39	35 completed
IV	Aug-2016	13	3 completed
VA	IMS, BHU (Dec-2016) SCTIMST (Feb-2017)	1 1	Completed Likely to be completed 2022-23
VB	RIO IMS BHU (Sept-2018) IGIMS, Patna (2019)	1 1	Completed Likely to be completed 2022-23

Source: https://pmssy-mohfw.nic.in/ accessed on 18.05.2023.
Notes: CCEA-Cabinet Committee on Economic Affairs;GMC–Government Medical College;IMS-Institute of Medical Sciences;BHU–Banaras Hindu University;SCTIMST–Sri Chitra Thirunal Institute of Medical Sciences and Technology;IGIMS-Indira Gandhi Institute of Medical Sciences

The geographical distribution of GMCs selected for upgradation and the AIIMS are presented in Table 2. It is evident that the first set of AIIMS were located in the states which reported low health indicators and where health infrastructure and provision of healthcare services were known to be poor. The GMCs selected for upgradation were distributed across the length and breadth of the country and also widely within states because it was well known that though medical colleges were present super specialty (tertiary care) departments were lacking. Thus, it was aimed at filling a felt gap not only in the backward states but across India. Further, proposals were sought from the states as they were partners in the upgradation of GMCs. Thus, both the establishment of AIIMS in the first phase and the upgradation of GMCs could be said to meet the objective of correcting imbalances in the provision of tertiary care and of improving the quality of medical education. But the approach of the two regimes to correct the imbalances was different. While the NDA launched large infrastructure projects fully under the control of the central government, the UPA went for the upgradation of existing GMCs by setting up super-specialty wings in them.

Table 2. Location of GMC Upgradation and AIIMS

State	GMC Upgradation	AIIMS
Andhra Pradesh	Vijayawada, Anantpur, Tirupati	Mangalgiri
Assam	Guwahati, Dibrugarh	Guwahati
Bihar	Muzaffarpur, Darbhanga, Patna, Bhagalpur, Gaya	Patna(1), Darbhanga
Chhattisgarh	Bilaspur, Jagdalpur	Raipur(1)
Delhi	Delhi	
Goa	Panaji	
Gujarat	Rajkot, Ahmedabad, Surat, Bhavnagar	Rajkot
Haryana	Rohtak	Manethi/Majra
Himachal Pradesh	Shimla, Tanda	Bilaspur
Jharkhand	Dhanbad, Ranchi	Deoghar
Jammu, Kashmir	Jammu, Srinagar	Awantipur, Vijaypur
Karnataka	Bellary, Hubli, Bengaluru	
Kerala	Kozhikode, Alappuzha,Thiruvananthapuram	
Madhya Pradesh	Rewa, Jabalpur, Gwalior, Indore,	Bhopal(1)
Maharashtra	Aurangabad, Latur, Akola, Yuvatmal, Mumbai, Nagpur	Nagpur
Odisha	Berhampur, Burla, Cuttack	Bhubaneswar(1)
Punjab	Patiala, Amritsar	Bhatinda
Rajasthan	Udaipur, Kota, Bikaner, Jaipur	Jodhpur(1)
Tamil Nadu	Thanjavur, Tirunelveli, Salem, Madurai	Madurai
Telangana	Adilabad, Warangal, Hyderabad	Bibi Nagar
Tripura	Agartala	
Uttarakhand		Rishikesh(1)
Uttar Pradesh	Jhansi, Gorakhpur, Allahabad, Meerut, Lucknow, Varanasi, Aligarh, Agra, Kanpur	Gorakhpur, RaeBareilly
West Bengal	Bankura, Malda, Siliguri, Kolkata	Kalyani

Source: pmssy-mohfw.nic.in
Note: 1 in parenthesis in third column indicates the announcement in 2003/2006.

As regards the setting up of AIIMS, two observations may be made. Firstly, one or two AIIMS are sought to be located in states where already five to six medical colleges have been upgraded. Secondly, around 40 percent of the AIIMS established in Phase IV are located in towns where a GMC has already been up-graded. It is difficult, then, to believe that this is aimed at correcting the imbalances in the provision of tertiary care services. The motive of 'awarding' an AIIMS is obviously intended to achieve other political objectives.

The political objective becomes evident when we analyse the gap between the date of announcement or foundation laying and the election date (Lok Sabha or Assembly). It may be seen from Table 3 that close to 70 percent of the announcements preceded the election by less than one year. Around 50 percent of the foundation stone laying was within four months of the election date. And close to 80 percent of the foundation was laid less than one year before the election. As elections take place once every five years, activities of announcement and start of work closer to the election suggests the political motive. The high visibility was clearly aimed at getting the attention of constituents.

Table 3. Gap Between Election Date and AIIMS Announcement/Foundation Laid Date

Class interval	Number of AIIMS	
	Announcement	Foundation Laid
Less than I month	0	2
1 – 4 Months	4	10
4 – 8 Months	2	3
8 months - 1 year	7	2
1 - 2 year	4	2
2 - 3 year	3	1
Others	2	1+1*
Total	22	22
Note: * Foundation not laid in Darbhanga Source: Compiled from the Appendix Table-1.		

The establishment of AIIMS was a costly endeavour with each AIIMS costing around Rs.820 crore. In contrast, the upgradation of GMCs required a significantly lower investment of only around Rs.120 crores. This stark difference in cost highlights the financial implications associated with the two components of the scheme. If the objective of correcting the imbalances in tertiary care provision could be achieved by upgrading GMCs, then why should one take up the high-cost alternative of setting up AIIMS? The answer would lie in the fact that AIIMS is a large infrastructure project with high 'visibility' entirely controlled by the central government. The upgradation of GMCs does not give such 'visibility' as it only adds to existing health infrastructures and they are under the control of the state governments. As shown in the literature, when 'visibility' of a project is the political goal, both economically efficient projects and rational apportionment of resources to need would be compromised is

illustrated in the setting up of 16 AIIMS after 2016 and not focusing on the upgradation of GMCs.

4. Post-COVID Healthcare Priorities: Rejection of the Fifteenth Finance Commission Recommendations

This section analyses the manner in which the recommendations of the FFC on health sector has been treated by the Government of India and draws inferences regarding the approach taken by the NDA government to primary care and human resources development.

The FFC presented two reports one for the year 2020-21 and another for the years from 2021-22 to 2025-26. The Report for the year 2020-21, in addition to the discussion of the basic tax sharing, revenue deficit grants, local government (LG) grants, and disaster response grants discussed the broad contours of sectoral grants and preparatory work to be undertaken by the state governments and different Ministries/Departments of the Union Government in regard to sectoral grants. The Government of India, while accepting the recommendations of the Commission on tax sharing, revenue deficit grants, LG grants, and disaster response grants, requested the Commission to review the recommendation on nutrition grant and only accepted 'in principle' the recommendations on sectoral grants–euphemism for not accepting them.

The FFC presenting its second report in November 2020 soon after the first wave of COVID-19 highlighted the fault lines of the Indian health sector in great detail. The Commission's assessment of India's health infrastructure showed that the deficits is high at all levels starting from the primary care. On the human resources front the picture is equally stark. The Commission was of the view that poor public spending for long is the cause of these deficits at all levels of infrastructure and human resources. The FFC followed a path taken by the XIII Commission and decided to recommend sector specific grants. Eight different sectors were identified and health in particular was discussed in great detail devoting an entire chapter.

The importance given to the health sector may be gauged by the fact that it appears in Volume I of the main report. Here too it appears in two chapters with emphasis on two different dimensions. In Chapter 7, the Commission's assessment of the existing gaps in the healthcare delivery system in both rural and urban areas led them to make recommendations of item-wise and year-wise grants as shown in Table 7.17 of Volume I of the report (Table 4).

Table 4: Sector-Wise Break-up of Health Grants

Components	2021-22	2022-23	2023-24	2024-25	2025-26	Total
Support for diagnostic infrastructure to the PHC facilities	3478	3478	3653	3835	4028	18472
Sub-centres	1457	1457	1530	1607	1687	7738
PHCs	1627	1627	1708	1793	1884	8639
Urban PHCs	394	394	415	435	457	2095
Block level public health units	994	994	1044	1096	1151	5279
Urban HWCs	4525	4525	4751	4989	5238	24028
Building-less Sub-centres, PHCs, CHCs	1350	1350	1417	1488	1562	7167
Conversion of rural PHCs and sub-centres into HWCs	2845	2845	2986	3136	3293	15105
Total health grants	13192	13192	13851	14544	15272	70051
Source: Table 7.17, Main Report, FFC (2020).						

As is clear, the focus of these grants is the Health and Wellness Centres (HWCs). In particular, the Commission acknowledged the lack of attention paid to urban health systems and municipalities, and recommended that urban HWCs would get more than a third of the overall health grants under the LG head. By making this grant unconditional, the Commission also addressed one of the factors responsible for the poor utilisation of sector-specific grants, namely the conditionalities.

Health appeared again in Chapter 9 of the Main Report. It is unusual for the FC to focus on any sector in its main report; they would normally appear in annexures. The importance of the sector and the need for devolving resources at this juncture was brought out by the Commission as, *"Unlike past Commissions, we have consciously decided to devote greater attention and resources to the health sector as it has acquired urgency in the context of the COVID-19 pandemic."* (FFC, 2020.p.263). The grants recommended by the Commission ran as follows: The total grants of Rs 1,06,606 crore for the health sector (10.3 percent of total grants) are divided into two parts. Grants aggregating Rs 70,051 crore mostly for primary care (Table 4) would be released through the LG grants. The second part called sectoral grants of Rs 31,755 crore was meant to meet the expenses of critical care hospitals, integrated labs, and training of health workforce.

The manner in which the government handled the finance commission's report for the year 2020–21 was unprecedented (Narayana,2021). The same approach continued as regards the recommendations of the second report too. The government did not accept any of the recommendations on state-specific or sector-specific grants, and the health sector grant is no exception. The health grant in the LG grant, has, however, been accepted because of the mandatory nature of Terms of Reference about resource allocation to local bodies. However, as may be seen in Table 6 below, the accepted health grants included in the LG

grants is not flowing in full to the states (the budget estimate for 2022-23 was Rs. 13192 crore whereas the revised estimate was only Rs. 8895 crore).

The grave tragedy that struck India during the multiple waves of COVID-19 is well-known. The severe health infrastructure deficits were one of the factors behind the numerous deaths due to the pandemic. The FC drafting a report during the COVID times could not ignore the reality and took a path often not trodden by Commissions of having a full chapter analysing the health sector. The recommendations of the Commission were aimed at preparing the country to face another pandemic. But the NDA government did not find it necessary to accept the recommendations when the outgo on it would not have been larger than all the money spent on the AIIMS built over the years.

5. Healthcare Allocation and Recent Union Budgets

Allocation for healthcare in the union budget falls into three categories: FC grants, Department or Ministry of Health and Family Welfare (MoHFW), and Ministry of Ayush. AYUSH is a priority under National Health Mission. The total allocations to the healthcare sector are presented in Table 6. The FFC grants once accepted are fixed for the period 2021-22 to 2025-26. But in 2022-23, it is seen that only around 70 percent of the unconditional health grant has flown to the states. Obviously,

investment in PHCs, Sub-centres, and clinical laboratories must have suffered in some states.

Although the share of Ministry of Ayush has been less than 3 percent of the total budget, the allocation and expenditure on it has been growing at more than 20 percent every year. Both Department of Health and Family Welfare and Department of Health Research (DHR) have hardly seen an increase in the budgetary allocation during the last few years and expenditure has either remained stagnant or decreased. Increase of expenditure in 2023-24 BE over 2022-23 RE is 12.84 percent but when compared to the 2022-23 BE, it is just 3.83 percent. And within the DHR, ICMR accounted for about 50 percent of the expenditure in the 2020-21 actuals, which went up to almost 80 percent in the next three years. The healthcare sector needs a continuous increase in allocation, especially during pandemic times which is not to be seen in the budgets of the NDA government.

Table 5. Healthcare Allocation in the Union Budget 2020-21 to 2023-24 (Rs in crore)

Department	2020-21 Actuals	2021-22 Actuals (%Change over 2020-21 Actuals)	2022-23 BE (%Change over 2021-22 Actuals)	2022-23 RE (%Change over 2021-22 Actuals)	2023-24 BE (%Change over 2022-23 BE)	2023-24 BE (%Change over 2022-23 RE)
FC Grants on health		12251.82	13192	8895	13851	13851
Vaccination		35438	5000	967	0.01	0.01
Ministry of AYUSH	2292	2359 (2.92)	3050 (29.29)	2845.75 (20.64)	3642 (19.41)	3642 (27.97)
MoHFW	77569	81779.85 (5.43)	83000 (1.49)	76370.4 (-6.62)	86175 (3.83)	86175 (12.84)
DHR	3125	2690.61 (-13.89)	3200.65 (18.96)	2775 (3.14)	2980 (-6.89)	2980 (7.39)
a. ICMR	1612	1841 (14.21)	2198 (19.39)	2117 (14.99)	2360 (7.37)	2360 (11.38)
Source: Various Union Budget Documents						

Decomposition of allocation towards MoHFW (Table 7) and Central Sector Schemes on health and NHM (Table 8) reveals that the allocation and expenditure of the central government's establishment of hospitals and regulatory bodies has seen a rise, and their expenditure frequently exceeds the allocation. The allocation and expenditure on Central Sector Schemes implemented by the states has seen a fall over the years. In comparison to 2020-21 Actuals of Rs 21,818 crore, the allocation has seen a fall of between 20 and 40 percent during the next three years. In sharp contrast the allocations for the central institutes

like AIIMS have seen a steady increase. The CSS have also seen hardly any change in their allocation from 2021-22 onwards.

As regards the allocation for Central Sector Schemes, it may be seen that the bulk of it has gone for setting up of AIIMS leaving little for national disease control programmes (Table 8). The fall has been from Rs 14978 crore in 2020-21 to Rs 5,455 crore in 2023-24 BE putting the burden of running the disease control programmes entirely on the states. More or less similar is the picture with NHM. Whereas the allocation for NHM has not fallen, larger amounts are being drawn from it under Human Resource for Health and Medical Education for upgrading the GMCs leaving lower amounts for the strengthening of PHCs.

Table 7. MoHFW- Allocation and Expenditure, 2020-21 to 2023-24

Department	2020-21 Actuals	2021-22 Actuals (%Change over 2020-21 Actuals)	2022-23 BE (%Change over 2021-22 Actuals)	2022-23 RE (%Change over 2021-22 Actuals)	2023-24 BE (%Change over 2022-23 BE)	2023-24 BE (%Change over 2022-23 RE)
Centre's establishment expenditure (Direction, Admn, Hospitals in Delhi etc)	5547	5824 (4.99)	6857 (17.73)	6913 (18.69)	7698 (12.26)	7698 (11.36)
Central	21818	15097	15163	11869	8820	8820

Sector Schemes (AIDS Control, Zoonotic Diseases Surveillances)		(-30.80)	(0.43)	(-21.38)	(-41.83)	(-25.69)
Other Central Sector Expenditure (Statutory and Regulatory such as MCI, Food Safety…)	226	308 (36.28)	335 (8.77)	635 (106.17)	639 (90.75)	639 (0.63)
Autonomous Bodies (AIIMS, JIPMER...)	7565	8459 (11.82)	10022 (18.48)	10348 (22.33)	17323 (72.85)	17323 (67.40)
Centrally Sponsored Scheme (CSS)	39569.16	49280.9 (24.5)	47634.07 (-3.3)	41762.56 (-15.3)	47347.23 (-0.6)	47347.23 (13.4)
Source: Various Union Budget Documents						

Table 8. Central Sector Schemes on Health and NHM, 2020-21 to 2023-24

Department	2020-21 Actuals	2021-22 Actuals (%Change over 2020-21 Actuals)	2022-23 BE (%Change over 2021-22 Actuals)	2022-23 RE (%Change over 2021-22 Actuals)	2023-24 BE (%Change over 2022-23 BE)	2023-24 BE (%Change over 2022-23 RE)
A. Centre Sector Scheme	21818	15097.44 (-30.8)	15163.22 (0.4)	11868.63 (-21.4)	8820.27 (-41.8)	8820.27 (-25.7)
B. PMSSY	6840	9269.51 (35.5)	10000 (7.9)	8269.56 (-10.8)	3365 (-66.4)	3365 (-59.3)
C. Net Centre Sector Scheme (A-B)	14978	5827 (-61.1)	5163 (-11.4)	3599 (-38.2)	5455 (5.7)	5455 (51.6)
D. NHM	37080	32958 (-11.1)	37159.73 (12.7)	33707.66 (2.3)	36785.26 (-1.0)	36785.26 (9.1)
E. Human Resource for Health and Medical Education	5386	5051 (-6.2)	7500 (48.5)	4083.37 (-19.2)	6500 (-13.3)	6500 (59.2)
F. Net NHM (D-E)	31694	27907 (-11.9)	29660 (6.3)	29625 (6.2)	30285 (2.1)	30285 (2.2)
Source: Various Union Budget Documents						

An analysis of the budgetary allocation for health by the central government in the post COVID period shows the following. FC grant for health under the LG has been cut by around 30 percent for the first time in 2022-23 when overall budgetary allocation for health has hardly shown an increase during the last five years. Central Sector Schemes wherein come the numerous national

disease control programmes have seen larger funds flowing to PMSSY leaving less and less for the national programmes. Allocation for NHM has stagnated and larger amounts are being spent on upgradation of GMCs leaving less for NHM and strengthening PHCs.

In sum, the NDA government is spending more on big projects, new projects which have high 'visibility' to the neglect of continuing programmes addressing the needs of a larger vulnerable population.

6. Conclusion

This paper sought to test whether distributive politics or politics of pork-barrel holds as regards the central government spending on healthcare by the recent NDA governments in India. It holds when expenditures are on new projects that are big and have high visibility to the neglect of other continuing projects which are small and outcomes of which are difficult to measure. It holds when expenditures are not bound by any general rule and do not follow any rational allocative principles which in turn could be inefficient. During the first six decades after independence, the FYPs carried out need assessment, set the targets and allocated funds based on generally agreed formulae. The national disease control programmes and later NHM were bound by these principles. Abolition of the Planning Commission in 2014 meant absence of FYPs, need assessment and setting targets. It also

meant freedom from any general rule of allocation opening the doors for distributive politics.

The announcement of six AIIMS like institutions under the PMSSY in 2003 was based on some semblance of need assessment. The correcting of regional imbalances in the provision of tertiary care as the ground rule was clearly formulated in 2006 while launching the PMSSY. It brought home the point that there could be two approaches for correcting the imbalances, namely a high cost, stand-alone AIIMS, or a low-cost upgradation of GMCs in partnership with the states. The UPA governments during 2004-2014 went for the latter, whereas the NDA governments which came later chose the former. The politics of pork-barrel was clear. In sharp contrast, the much bigger NRHM launched by the UPA government was entirely rule bound and had clear targets and allocations for each of the states.

The refusal to accept the recommendations on health sector grants of the FFC is a continuation of the NDA government's political inclination with large projects of high visibility. The FFC recommendations were aimed at preparing the public healthcare system to face another pandemic by strengthening the PHCs with diagnostic laboratories and setting up of district level hospitals. These were continuing projects (not new projects) with low visibility. The neglect of these was taken to the extreme by

reducing the health grants within the LG grants in 2022-23. The same theme gets reflected in the last four budgets where larger and larger funds under central schemes went for PMSSY, and NHM funds were allocated for increasing seats in medical colleges neglecting the goal of strengthening the primary healthcare system.

Health is a state subject. Central budget allocations came in to fill the gaps in disease control, population control, medical education and functioning of the public health system. But the last ten years have witnessed increasing share of funds under each going for setting up of centrally controlled, large, stand-alone projects with high visibility for political gains. The distributive politics of the NDA government is clear.

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APPENDIX

Table 1. Location of AIIMS and the Gap Between the Election Date and AIIMS Announcement/Foundation Laid Date

Sl. No.	States	Location of AIIMS	Date of Announcement	Date Foundation laid	Date of Assembly election	Date of Lok Sabha Elections	Gap Between Announcement and Election Date	Gap Between Foundation Laid and Election Date
1	Bihar	Patna	Aug 15, 2003	Jan 20, 2004	Feb 2005; Oct and Nov 2005	April 20 and May 10, 2004	8 Months Before LS	3 Months Before LS
2	Chhattisgarh	Raipur	Aug 15, 2003	Jan 20, 2004	Dec 1 2003	April 20 and May 10, 2004	4 Months before AS; 8 Months Before LS	3 Months Before LS
3	Madhya Pradesh	Bhopal	Aug 15, 2003	Jan 20, 2004	Nov 27, 2003	April 20 and May 10, 2004	3 Months before AS; 8 Months Before LS	3 Months Before LS
4	Odisha	Bhubaneswar	Aug 15, 2003	Jan 20, 2004	April 20-26, 2004	April 20 and May 10, 2004	8 Months Before AS and LS	3 Months Before LS
5	Rajasthan	Jodhpur	Aug 15, 2003	Jan 20, 2004	Dec 2003	April 20 and May 10, 2004	4 Months before AS; 8 Months Before LS	3 Months Before LS
6	Uttarakhand	Rishikesh	Aug 15, 2003	Jan 20, 2004	Feb 14, 2002	May 10, 2004	9 Months before LS	4 Months Before LS
7	Uttar Pradesh	RAS Bareilly	Feb 2009	Oct 8, 2013	Feb 8 – Mar 3, 2012	April– May 2009; April 7- May 12, 2014	2 Months After LS	6 Months Before LS

8	Andhra Pradesh	Mangalgiri	July, 2014	Dec 19, 2015	April 30 and May 7 2014	May 7, 2014	2 Months After election AS, 2 Months After LS	1 year and 7 Month After AS and LS
9	Maharashtra	Nagpur	July, 2014	April 14, 2019	Oct 15, 2014; Oct 21, 2019	April 10, 17 and 24, 2014; April 11, 18, 23, 29, 2019	3 Months Before AS, 3 Months After LS	3 days After LS election started (in between election), 6 Months Before AS
10	Punjab	Bhatinda	Feb 28, 2015	Nov 25, 2016	Feb 4, 2017	April 30, 2014	2 Years Before LS election; 10 Months Before LS	less than 2 Months
11	West Bengal	Kalyani	July, 2014	Early 2016	April 4-May 5, 2016	April 17, 24, 30, May 7, 12, 2014	1 year and 9 Months Before AS; 2 Months After LS	Early 2016.same year
12	Assam	Guwahati	Feb 28, 2015	May 26, 2017	April 4–11, 2016	April 7, 12 and 24, 2014; April 11, 18, 23, 2019	1 year and 2 Months Before AS election; 10 Months After LS	1 year and 1 month After AS election, 1 year and 11 Months Before 2019 LS
13	Bihar	Darbhanga	Feb 28, 2015	Foundation not laid	Oct 12-Nov 5, 2015	April 7 - May 12, 2014	8 Months Before AS election; 9 Months After LS	Foundation not laid

14	Himachal Pradesh	Bilaspur	Feb 28, 2015	Oct 3, 2017	Nov 9,2017	May 7, 2014; May 19,2019	9 Months After LS election, 2 year and 9 Months Before AS	1 month Before AS election, 1 year and 7 Months Before 2019 LS
15	Jammu, Kashmir	Awantipur	Feb 28, 2015	Feb 3 2019	Nov 25-Dec 20, 2014	April 1,18,23,29, 2019 and May 6, 2019	2 Months After AS election	2 Months Before
16	Jammu, Kashmir	Vijaypur (Samba)	Feb 28, 2015	Feb 3, 2019	Nov 26-Dec 20, 2014	April 1,18,23,29 2019 and May 6, 2019	2 Months After AS	2 Months Before
17	Tamil Nadu	Madurai	Feb 28, 2015	Jan 27, 2019	May 16, 2016 and Oct 26, 2016	April 11-19 May 2019	1 year and 3 Months Before AS	3 Months Before LS
18	Uttar Pradesh	Gorakhpur	July, 2014	July 22, 2016	Feb 11– 8 Mar 2017	April 7-12 May 2014	2 Years and 7 Months Before AS;2 Months After election After LS	7 Months Before AS
19	Gujarat	Rajkot	Feb 1, 2017	Dec, 2020	Dec 9 and 14, 2017; 1 and 5 Dec 2022	April 23, 2019	10 Months	1 year and 8 Months After LS; 2 Years Before 2022 AS

20	Jharkhand	Deoghar	Feb 1, 2017	May 25, 2018	Nov 30 –20 Dec 2019	April 29, 2019; May 6,12,19 , 2019	2 year and 2 Months Before LS and 2 years and 9 Months Before AS	1 year and 6 Months Before AS; 11 Months Before LS
21	Telangana	Bibi Nagar	Feb 9, 2017	April, 2023	Dec 7, 2018; By Dec 2023	April 11– 19 May 2019; April to May 2024	1 year 10 Months Before AS	8 Months Before 2023 AS; 1 year Before 2024 LS
22	Haryana	Manethi/ Majra*	Feb 1, 2019	2023	Oct 21, 2019	May 12, 2019; April to May 2024	8 Months Before AS, 3 Months After LS	1 year Before 2024 LS

Source: https://pmssy-mohfw.nic.in/ ; Respective AIIMS's website; https://eci.gov.in/elections/election/.
Notes: * location changed to Majra in 2022; AS- Assembly Election, LS – LokSabha Election

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