Assessment of the Effectiveness and Implementation of the XVth Finance Commission and PM-ABHIM Health Sector Grants

Submitted to

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PREFACE

The Study Titled "Assessment of the Effectiveness and Implementation of XVth Finance Commission and PM-ABHIM Health Sector Grants" has been carried out by the National Institute of Public Finance and Policy (NIPFP), New Delhi at the behest of the National Health Systems Resource Centre (NHSRC), Ministry of Health and Family Welfare (MoHFW).

The study was carried out with the aim of exploring the achievements and effectiveness of the interventions under the health grants recommended by the XVth Finance Commission and the factors affecting them. The study unfolded in two stages, with the first stage focusing on comprehensive data analysis covering all states throughout the country, while the second stage cast a finer lens on the state level issues by focusing on six select states, chosen on the basis of variation in performance and region. Insights from both stages were synthesized to formulate recommendations for improving the design and implementation of such grants with a view to provide inputs for proposals by MoHFW towards the XVIth Finance Commission.

The study was carried out by a team led by Professor Mita Choudhury. Other key members of the team included Dr. Rolly Kukreja, Assistant Professor, NIPFP and Ms. Nitya Chutani, Research Fellow, NIPFP. The views expressed in this report are that of the authors and the members of the governing body of the institute are in no way responsible for them.

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New Delhi
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The cooperation and support extended by the nodal agencies and local officials from the six states — Odisha, Madhya Pradesh, Uttar Pradesh, Gujarat, Telangana, and Meghalaya, was critical in shaping the report in its present form. The insights shared by state-level officials from various departments, district-level officials of the health department, officials of local bodies and numerous personnel from health facilities in districts formed the foundation of the key learnings presented in this study.

At the institute, we are very grateful to Dr. R. Kavita Rao, Director of NIPFP, for her continuous support and mentorship, which were crucial in shaping the approach and ensuring the successful completion of this study.

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Executive Summary

The health grants recommended by the XVth Finance Commission was a landmark in federal finance in India. The grant was not only the largest ever award by any Finance Commission for the health sector, but also had the unique distinction of being the first of its kind earmarked grant-in-aid to local bodies. It instilled a new dimension in the design of grants for local bodies by Finance Commissions - a sector-specific grant with a two-fold objective. The novel form of fund devolution to local bodies had the potential to build the capacity of local bodies to engage in activities in a core social sector - health. The significance of the grant was also underlined by the fact that it was initiated in the backdrop of the COVID-19 pandemic, and was aimed at reinforcing the critical gaps in infrastructure at the base of the health pyramid (primary care) for better preparedness in future.

The unconventional nature of the grant necessitated a unique implementation architecture. Although the grants were assigned to local bodies, the pre-specified components of the grant required splitting the grant funds by components and routing these through three separate departments: Panchayati Raj, Urban Development and Health. This called for a close inter-departmental coordination at various levels of administrative machinery for implementation. Additionally, the grants were predominantly capital-intensive in nature involving complex and time-consuming processes.

In light of the unique design and implementation architecture of the grant, this study was undertaken to evaluate the performance of the grant, and derive insights on the factors that affected it. The analysis was carried out in two stages. In the first stage, a broad assessment of the performance of the grant across all states was carried out for the first three years of the grant. In the second stage, an in-depth analysis was conducted in six selected states (Odisha, Madhya Pradesh, Uttar Pradesh, Gujarat, Telangana and Meghalaya) to gain insights into ground-level implementation challenges. It involved key informant interviews and extensive consultations with stakeholders at the state, district, block, and facility levels.

The evaluation indicates that the performance of the grant has fallen short of its potential. Both the financial and the physical progress remain considerably behind the set targets. The complex unprecedented execution architecture posed severe implementation hurdles and hindered execution at various levels. The tied nature of the grant with rigid budget provisions placed within a centralized institutional arrangement for re-appropriation across components compounded the problem. Additionally, midway policy shifts in the grant period in the form of withdrawal of HR support, led to significant divergence of the allocations across components from the initial plan of states and this further retarded the pace of execution.

Discussions with implementation stakeholders in the six selected states provided insights into the challenges faced by individual states in utilizing the FC grant and the adaptations made to suit their state-specific context. States that promptly addressed the hindrances and challenges with swift course corrections and adaptive strategies, performed better. Pursuing timely re-appropriations and institutional innovations while adhering to the grant's guidelines was key to boosting performance in states.

Odisha, which ranked among the best performing states in the country with respect to the FC grant put in place an alternative arrangement for execution. After initial glitches in implementation through departments overseeing local bodies, the state handed over the charge of actual execution to agencies under the H&FW department. The departments of PR&DW and H&UD were used to channelize fund flows to agencies under the H&FW for actual execution. This ensured that the charge of actual implementation remained with the H&FW department without violating the DoE guidelines. The state also ensured synergies across multiple sources of funding to optimize outputs.

Telangana, which was also among the top-ranked States in terms of performance of the FC grant, was the only one among the selected states to involve both rural and urban local bodies in actual execution of the works. The state stands out as an example of how a central grant could be adapted to strengthen state-level initiatives. It also engaged in proactive planning and re-appropriations for optimal utilization within the constrained environment.

Both Madhya Pradesh and Uttar Pradesh struggled to secure releases after the initial 1-2 years due to non-conformity with the DoE guidelines. In Uttar Pradesh, the state also suffered on account of the centralized institutional arrangement for approvals and re-appropriation of funds. In both these states, lack of coordination between the Finance department and the Health department, in addition to inadequate preparedness and planning for the grant, posed significant bottlenecks in implementation. In Madhya Pradesh, the existing Public Private Partnership (PPP) model for delivering diagnostic services in the State also made it difficult to absorb funds related to the diagnostic infrastructure components.

In Gujarat, administrative processes proved to be a major stumbling block. Although funds were released to procurement and other implementation agencies, progress in terms of actual outputs in the diagnostic component was negligible. The state also undertook an integrated planning exercise for the schemes of PM-ABHIM, ECRP II and some state-led initiatives. While such an approach is conceptually welcome, it also took up substantial time. Thus, although the state had no issues in obtaining releases from GoI, actual outputs have been limited due to administrative issues.

In Meghalaya, the design of the grant was not conducive to the administrative setup of the state. Being a state covered under the sixth schedule of the constitution, PRIs were non-existent. DoE guidelines specified that the FC grants should be handled by Autonomous District Councils (ADCs), who had no past engagement in health-related activities. Village Health Councils (VHCs) were thus engaged in health-related activities at the grass-roots level, and were more appropriate to handle the execution. The ambiguity on the appropriate agency to release funds, and identification of an appropriate agency consumed nearly three years of time since the initiation of the grant.

Comprehensive planning for human resource engagement and related financing requirements in the newly upgraded units was absent in almost all States. Only Odisha had some planning on how its own state-level free diagnostics initiative NIDAAN could be funded in conjunction with other sources till the financial year 2026-27. Most States hoped to fall back on NHM for planning human resource personnel. Official circulars in Madhya Pradesh also indicated that the state was relying on NHM resources for expansion of manpower deployment.

Facility-level visits highlighted the potential of these grants in terms of service delivery improvements. There were substantial increases in the number of OPD footfalls and diagnostic tests in units that were made operational using these grants. These enhancements in service delivery can potentially bring about a decline in out-of-pocket expenditure (OOPE), easing financial burden of patients on account of healthcare expenses. With better planned structures and operational space, improvements in quality of service delivery in the newly upgraded structures were also evident. The criticality of human resource engagement was also apparent in numerous service delivery units. Upgraded units awaiting recruitments or those units with vacancies in clinical manpower encountered roadblocks in expanding service delivery. The use of multiple sources of funding to operationalize specific service delivery units also highlighted how complementarity between state and Central interventions can help produce outputs even when Central interventions are confined to specific areas.

As the grant period approaches its conclusion, several challenges remain in the context of the XV-FC health grants. The terminal year of the grant is underway, and it is unlikely that the remaining physical and financial targets can be completed within the XVth FC award period. In several states, construction works are in progress with sunk costs, and a discontinuation of the grant at this stage will lower the potential returns from the incurred investments. Also, a cessation of the grant at this stage will mean a partial address of the critical gaps in the foundation of the health system and a compromise on its resilience that was envisioned by the XVth FC. Considering a fresh capital grant to complete the unfinished agenda will be important in this context. Additionally, ensuring adequate deployment of medical and support personnel in the newly created units will be vital for achieving the desired outputs. States are likely to require some time to accommodate the anticipated human resource costs in their own budgets. In the interim, some financial support from the Central government on this account will facilitate increased outputs and quick returns from the investments.

For improved grant performance in future, a key change is required in the role of the district-level committee (DLC). In the XVth Finance Commission award period, the DLC was primarily assigned the task of monitoring and supervising the grant works undertaken by local bodies at the district level. In the way forward, the DLC should be empowered to decide whether local bodies have the capacity to undertake construction works. If not, the DLC should assign these works to an appropriate agency, including agencies under the health department as agreed upon by its members This revised framework will make it feasible to accommodate diverse grant execution models at the district level, including the kind of models adopted in states like Odisha and Telangana. In addition, providing some degree of flexibility to states on re-appropriation across components of tied grants and improving clarity on guidelines issued to states on operational aspects of the grant can be instrumental in improving the performance of such grants.

Importantly, the new approach to empowering local bodies could be a pioneering transformative reform to strengthen the capacity of local bodies over the medium term. Such a reform calls for an acclimation period and a five-year period is likely to be too short for realizing the potential of a significant reform of this kind. The XVth FC period has served as an orientation phase and the learning curve of states is beginning to rise. Continuity of this policy reform will be essential to fully reap its benefits.

Recommendations

A. General Recommendations

Medium-term Financial Support will be Needed to Complete the Tasks Set Forth by the XVth Finance Commission and Realizing Outcomes from the Investments

1. **To ensure that the physical targets set by the XVth FC are accomplished, financial support needs to be extended to states beyond the grant period. The upgradation of infrastructure will be pivotal for preparedness for future pandemics. The MoHFW may consider taking up this matter with the XVIth Finance Commission, requesting a specific-purpose health grant to help states meet the unfinished targets.**

The capital-intensive nature of the XVth FC grants and their execution architecture have retarded the pace of progress of these grants significantly. Less than 50 per cent of the FC allocations have been utilized leading to a shortfall in completion of physical targets under the grants. A substantial portion of these grants involved construction activities, which are associated with long-drawn processes for execution. The overlapping timeframe of the XVth FC health grant and PM-ABHIM also added a substantial load of construction works to be undertaken within a short span of time. Importantly, the unprecedented complex design of the XVth FC grants led to delays and setbacks in undertaking works in most states. The withdrawal of HR support midway of the grant period further disrupted the original plan of activities in states, adding to the slowdown in the pace of progress. The grants are approaching the end of the award period, and it is unlikely that bulk of the physical targets will be achieved within the remaining timeframe. In most states, work is in progress in a substantial number of physical units with sunk costs, and an abrupt discontinuation of these grants in a financial year (end of the grant period) is likely to impose severe disruptions to the ongoing activities in states. Also, both these grants were initiated in the aftermath of COVID-19 with a view to build up capacity of states to handle future pandemics, and a pre-mature closure of these grants will defeat that objective. **Extending financial support to states beyond the grant period will be essential to fulfill the unfinished agenda of the XVth FC. To that end, the MoHFW may consider requesting the XVIth Finance Commission to provide a capital grant to ensure that the critical gaps in the health system do not remain partially addressed.**

2. **Human resources in the upgraded physical infrastructure in states will be critical for realizing the outputs and returns from these investments. The fiscal burden on account of deployment of human resources in the newly upgraded service delivery units will be substantial, and states will need time to absorb these within their own budgets. The MoHFW may undertake suitable steps to seek financial support for human resource (HR) from the XVIth Finance Commission over the medium term.**

Service delivery units require a combination of inputs, the most critical of which is human resources. Reinforcing physical infrastructure alone will not result in expansion of health

services unless complementary inputs are made available. In the XVth FC health grants, provisions for human resources were made in at least 4 of the 6 components, but support for these was withdrawn after the first two years of the grant. Even in PM-ABHIM, the support for human resources was limited to the grant period, and states are expected to bear these costs thereafter. Most states are yet to draw up a comprehensive plan on human resource deployment in the upgraded units, and this poses uncertainty on the outcomes from these investments. A varying timeframe may be required for states to accommodate the added financial liabilities due to differences in fiscal contours and other manpower related parameters. Most States had fallen back on NHM budget when HR support was withdrawn from the XVth FC grants and have also expressed their intent to resort to NHM funds for meeting human resource costs arising from the Central initiatives in the short-run. However, this is likely to be feasible only to a limited extent as a substantial part of NHM budget is committed in nature, and there has been little expansion of resource envelope of NHM in recent years. Furthermore, going forward, the release of capital grants to states should be made conditional on submission of state-specific physical and financial plan for human resources and other inputs in the upgraded units for realizing the outcomes. This will help to firm up the path and the time horizon for realization of the outcomes of these grants.

While the primary onus of funding human resources will continue to lie with state governments, in the interim, the HR funding requirements arising out of the Central financing initiatives like the XVth FC and PM-ABHIM health grants will have to be met through a coordinated and combined effort by the Centre and States. In this context, central support will be key to bridging immediate deployment gaps and ensuring quick returns from the investments in the medium term.

Mode of Execution for Improved Effectiveness of Grants: Attaining Health Goals and Empowering Local Bodies

3. **From the point of view of empowering local bodies, the XVth FC health grants have marked a new beginning. A pioneering reform of this kind calls for an acclimation period, and the XVth FC period has served as an orientation phase for that purpose. States are beginning to climb the learning curve, and this is likely to diminish the hurdles in execution of such grants going forward. Health grants for medium-term support (refer recommendation 1) may be continued to be routed through local bodies to reap the full benefits of the reform and ensure that the step towards decentralization of health to the third-tier of the Government is not reverted too soon.**

Empowerment of local bodies call for continuity in policies. The XV-FC health grants marked a significant step towards decentralizing health governance through a first of its kind devolution to local bodies. Although the empowerment of local bodies was envisioned in the 73rd and the 74th Amendment of the Indian Constitution in the early 90s,

the *de-facto* devolution of funds, functions and functionaries to the third tier of the government has been limited in the past. In most states, even when functions had been assigned to local bodies, lack of adequate functionaries and even lesser devolution of funds have bounded their role in delivery of basic health services.[2][3][4][5][6] Both the XVth FC and the Department of Expenditure (DoE) acknowledged this, and suggested that the engagement of local bodies in delivery of health services be carried out in a phased manner.

In the first phase of local body empowerment through the XVth FC health grants, a sizeable part of the health grant could not be actually devolved to local bodies. In a few cases where FC grants were released to local bodies (as in Odisha and Telangana), there were challenges on account of capacity constraints of local bodies. The performance of the grant suffered heavily on account of execution challenges arising from a *de novo* implementation architecture and unfamiliarity with the new fund-flow mechanism at the level of states. Also, there were ambiguities in the guidelines (See Section F in "Overview of State-level Implementation Issues for details), which possibly led some states to inadvertently deviate from the prescribed DoE norms, resulting in roadblocks in obtaining releases. **With better exposure and acquaintance over time, execution hurdles stemming from non-compliance with DoE fund-flow guidelines are likely to reduce substantially, and a higher volume of funds are expected to flow to local bodies. If a similar architecture of devolution of health grants to local bodies is adopted by the XVIth FC, the actual flow of funds to these bodies is likely to improve, marking a step forward towards empowering the third tier of the government.**

With expectation of increased fund flows to local bodies in the next phase, the District-level Committee (DLC) should assume a more central role in the execution of health grants. As per the Operational Guidelines of DoE 2021, a DLC was required to be set up in each district under the Chairmanship of District Collector/Deputy Commissioner with the Chief Medical Officer of the district as the convener of the Committee. The Committee required representation from the department of Health, Panchayati Raj, Urban affairs and representatives from all tiers of rural and urban local bodies in the district. The role of this committee was relatively small in the XVth FC period as a substantial portion of the grants could not be released to local bodies at the district-level. Also, MoHFW allowed states to execute certain components of the grants by state-

[2] Ministry of Panchayati Raj. (2025, February 13). Status of Devolution to Panchayats in States– An Indicative Evidence Based Ranking 2024. Government of India. https://cdnbbsr.s3waas.gov.in/s316026d60ff9b54410b3435b403afd226/uploads/2025/02/2025021411289591 81.pdfP

[3] World Bank. 2007. India: Synthesis Study of Public Financial Management and Accountability in Urban Local Bodies. © World Bank. http://hdl.handle.net/10986/7666 License: CC BY 3.0 IGO.

[4] Banerjee, I. M. A. N. (2022). Problems of urban self-governance in India. Nagarlok, 53(3), 1-24.

[5] Rao, M. G., Raghunandan, T. R., Gupta, M., Datta, P., Jena, P. R., & Amarnath, H. K. (2011). Fiscal decentralization to rural local governments in India: Selected issues and reform options. National Institute of Public Finance and Policy.

[6] NCAER (2008) An Index of Devolution for Assessing Environment for Panchayati Raj Institutions in the States: Empirical Assessment 2008.

level agencies. This was possibly done keeping in view the limited capacity of local bodies in certain jurisdictions and diversities in prevalent modes of health sector operations across states.

In the way forward, the DLC should be assigned the autonomy and flexibility to decide whether the timely execution of construction works (completion of physical targets) can be carried out by the Zilla Praishad/urban local bodies in any district. If the Zilla Parishad or the urban local bodies do not have the capacity to undertake the timely construction of works, the DLC should request the Panchayati Raj and the urban development departments in the district to release the funds to agencies under the health department or any other suitable agency as agreed upon by the members of the Committee. Notably, the role of DLC in the way forward will be conceptually different from its earlier role at the district-level. In the XVth FC period, local bodies were required to execute the works and the DLCs were assigned a supervisory and monitoring role in overseeing these works. In the proposed framework, the DLC will be the decision-making body on identifying an appropriate agency for execution of construction works. The decision should be taken keeping in view the capacity of local bodies, the burden of other sectoral/departmental responsibilities on local bodies, and suitable local considerations. Importantly, such assessments should not be based on a pre-specified set of criteria developed at the state-level as there are significant differences in local institutions and parameters across districts. In particular, the criteria for this assessment should be determined by DLC at the local level to accommodate context specific nuances and diverse operational modalities. This approach will allow a range of choices for execution models of such grants in future, including the Odisha and the Telangana model. In Odisha, the PR department transferred the grants to the Health Department at the district-level to carry out actual execution. On the other hand, in Telangana, local bodies carried out some construction activities themselves and some others through agencies of the Health Department. Both these models can be accommodated in the revised DLC centred framework. The autonomy provided to DLC in execution decisions will help to uphold the true spirit of decentralization and empowerment of local bodies in the spirit of the FC grants.

The DLC should have regular meetings with SLC to appraise the SLC on the developments in the district with respect to the work under the FC grants. To that end, the decision of DLC on the choice of executing agency and its underlying rationale should be communicated to the state-level committee. In an extreme case, if no agency at the level of district is found to have the requisite capacity to undertake the timely completion of works, the DLC should convey this to the State-level Committee (SLC) for an appropriate action. The physical targets for construction in the FC grant period will also be finalized and approved by the DLC based on the proposal/inputs provided by the district health department. The first draft of the plan of work under the FC grant should be drawn up by the district health department in consultation with stakeholders at various levels of the administrative setup. This should be done keeping in view the complementarity and synergies across various sources of funding like NHM, PM-ABHIM, FC grants and state budget. This is similar in spirit to the provision of District Health

Action Plan (DHAP) proposed earlier by MoHFW in the guidelines issued for the XVth FC health grants. The approved plan of work under the FC grant will be then communicated to the state-level committee (SLC). Also, the DLC will be responsible for actively monitoring progress through monthly meetings, and reporting these to the state-level committee. It should also be authorized to undertake course correction as and when required to ensure timely completion of works. In general, a dynamic and iterative assessment of the evolution of capacities of local bodies will be undertaken by DLCs to facilitate quick adaptation to evolving ground realities, fund-flow timings, and inter-departmental coordination in any given year. The state may issue standard operating procedures (SoPs) to elaborate on the DoE guidelines on the roles and responsibilities of DLCs.

Importantly, the role of the district-collector/magistrate will be central to the functioning of the DLC and the successful execution of the FC grants. Being the chairperson of the DLC, the district collector needs to play a proactive role in all the three aspects of planning, execution and monitoring. Ensuring the active engagement of local bodies in sector-specific activities and overseeing their capacity evolution over time will form a core responsibility of the collector. Additionally, the collector should play a key role in resolving issues related to land identification, assessment of the capacity of execution agency, timely commencement and completion of works, ensuring inter-departmental coordination, initiating course corrections, if required, and resolving all bottlenecks in implementation at the local level. The collector will also be responsible for reporting all decisions taken by DLC to the State-Level Committee (SLC). Field-level discussions in Telangana suggested that the district collector could play a crucial role in mediating local challenges. Similarly, the officials of Telangana mentioned that the ease of inter-departmental coordination was crucially dependent on the pro-activeness of the district-collector.

The recurring components of the grant funds may be routed through the health departments of states for operational ease. If a medium-term support for HR engagement in the newly constructed facilities is considered by the XVIth FC (refer recommendation 2), these may also be implemented through the health department using established processes. Over time, as implementation progresses in a phased manner and local bodies build adequate capacity, these responsibilities may be considered for transition to the DLC in the long run. Importantly, even in states like Karnataka, which has a relatively high degree of decentralization, funds for recurring health expenses are handed over by local bodies to the health department at the district-level for execution. For the component concerning procurement of diagnostic infrastructure, the current arrangement for routing funds through agencies under the health department as prescribed by DoE and MoHFW may continue. In the Sixth Schedule areas, where Panchayati Raj Institutions are not in place, the mode of implementation (including the recipient of funds) may be determined by the respective State Governments.

In sum, the XVth Finance Commission marked a significant step towards decentralization of health governance to local bodies, and this structural shift should not be reversed too soon. The capital grants recommended to complete the unfinished works initiated under the XVth FC (recommendation 1) should continue to be routed through local bodies. A substantive reform of this nature calls for an adaptation period and the XVth FC period has served that purpose. **Continuity in the reform will be essential to reap the full benefits of the reform and bring about a transformative change in the capacity of local bodies.**

4. **Tied health grants recommended by Finance Commissions may be released to States as a flexible pool to accommodate differences in health system characteristics and operational modalities in states.**

States are at different stages of health system development with considerable variation in baseline health infrastructure and other state-specific characteristics. This divergence poses difficulty in utilizing a uniform rigid and tied structure of fund allocation across components. In the context of the XVth FC health grants, several states faced a mismatch of recommended allocation *vis-à-vis* the need in certain components calling for re-appropriation of funds. Also, in certain components, utilization was relatively low due to the nature of recommended interventions, initial structure of health systems or operational modalities in states. A typical example of this is the outsourcing model for diagnostic services in Madhya Pradesh, which made it difficult to utilize funds in the Diagnostic Infrastructure component. Similarly, the initiative of urban HWCs[7] was new, and needed time to pick up momentum in fund absorption. In such cases, a strict segmentation of budget allocation with limited flexibility for re-appropriation across components at the level of states hinder effective budget execution. Moreover, for every instance of re-appropriation, states had to approach the National-level Committee (NLC) for approval, adding to delays on account of administrative processes. In a time-bound FC grant, such delays result in underutilization of funds. Releasing funds to States in the form of flexible pool is likely to help in adapting to the diverse character of states and improve the performance of such grants. Also, some degree of flexibility is required to accommodate divergence between prescribed cost norms and actual costs in states, so as to reduce the need for additional administrative processes on account of cost revisions. For construction activities, States' Schedule of Rates (SoR) may be used as a basis for allowing unit cost variations across States.

5. **Multiple guidelines on the operational aspects of the grant should be done away with and a single guideline should be issued to bring in greater clarity on the modes of execution of the grant at the state-level.**

In the XVth FC grant period, a dual set of technical and operational guideline was issued to States. The department of expenditure (DoE) issued a guideline on the matter in July

[7] HWCs or Health and Wellness Centres have come to be known as Aayushman Arogya Mandirs (AAMs) now. Hence, HWC and AAM have been used interchangeably

2021, following which the Ministry of Health and Family Welfare (MoHFW) issued a guideline a month later. There were differences in the two guidelines and this possibly led to a lack of clarity regarding the flexibility states have in implementation decisions.[8] The ambiguity likely led to varied interpretations, resulting in inconsistent implementation and delays in fund releases due to DoE guideline violations. To address this, a single, detailed communication on the technical and operational aspects of the scheme should be issued to states and multiple departments may refrain from issuing guidelines to the same effect. States may also be oriented and sensitized on these guidelines.

B. State-Specific Observations

1. **Streamlining Lengthy Administrative Processes in Gujarat:** Administrative processes in Gujarat seemed to pose a major hindrance in execution of the XVth FC grant. In particular, the iterative process for procurement of diagnostic infrastructure resulted in a situation where none of the diagnostic equipment and instruments that were to be procured centrally by the Gujarat Medical Services Corporation Limited using the FC grants for FY 2021-22 could be procured till February 2025. A recent report of audit of Public Health Infrastructure and Management of Health Services in Gujarat by the Comptroller and Auditor General (CAG) of India has also highlighted similar issues in procurement of equipment in the state. These processes need to be reviewed and streamlined for better realization of outputs.

2. **Aligning approaches of Centre and State for delivering Diagnostics services in Madhya Pradesh:** Diagnostic services in Madhya Pradesh were pre-dominantly outsourced via PPP mode, and bulk of the XVth FC funds for diagnostic support was used up in reimbursing contracted agencies in the outsourcing mode. This was not in alignment with the conceptual framework of the XVth FC and PM-ABHIM, which laid a thrust on strengthening in-house infrastructure for diagnostic services. Although the state recognized the need for augmenting in-house capacity, the need to adapt the FC grants in the state's current operational setup within a limited period left little choice for the state. Alignment of the approaches of Centre and States can potentially enhance the outputs from such initiatives in future, and help achieve long terms goals of the health sector.

3. **Improving Planning and Coordination at the State-level:** In both Madhya Pradesh and Uttar Pradesh, the XVth FC health grants were not provided for in the budgets of the nodal departments in the first year of the grant. This led to delays in release of funds from the Finance department to the nodal departments. Even after the first year, budget provision for the entire grant was made in the budget of the Health Department, which was not in conformity with the DoE guidelines on fund flows. Additionally, when penal interest was paid by the Finance Department to the Health Department, it was initially booked under a wrong accounting head and needed subsequent correction, consuming

[8] This concern has been discussed in detail in the Section on "Overview of State-Level Implementation Issues" under the heading "Ambiguity in Central Guidelines on the Expected Role of Local Bodies."

valuable time. Better planning and coordination at the state-level can help in avoiding such setbacks.

Overview of State-Level Implementation Issues

A. Challenges in Executing FC Health Grants through Departments Governing Local Bodies and Implications

Of the six states chosen for state-level analysis, only Odisha and Telangana adhered to the DoE guidelines on routing funds through departments overseeing both rural and urban local bodies. However, both these states faced significant hurdles in carrying out the works through local bodies.

Alternative Arrangements to Expedite Work: In Odisha, in the first year of the grant (2021-22), the Panchayati Raj and Drinking Water Department (PR&DW) was expected to undertake the works in the rural components. Although funds were released by the Finance department to PR&DW on time, bulk of the work remained uninitiated for several months, leading to a near standstill progress in those components. To expedite the progress, the state withdrew the responsibility of executing the works from the PR&DW and handed it over to the Department of Health and Family Welfare (H &FW) from the second year (2022-23) onwards. Even in the urban component (FU6), funds were transferred by the Finance department to the Department of Housing and Urban Development (H&UD), which were then passed on to H&FW for actual execution of works. Thus, an alternative arrangement was put in place, whereby the charge of actual execution of works remained with H&FW, while the PR&DW and H&UD merely acted as conduits for fund flow. Notably, local bodies were not involved in the actual execution of works despite adhering to the DoE guidelines. In principle, this violated the spirit of the XVth FC grants.

In Telangana too, a part of the funds released to the Municipal Administration and Urban Development Department (MA&UD) were eventually released to H&FW department for incurring recurring expenditure.[9] Only capital expenditures in the form of construction works were assigned to rural and urban local bodies.

Progress in Components Executed through Local Bodies: Unlike Odisha, the rural local bodies of Telangana were actually assigned the task of undertaking construction work of building-less SHCs and PHCs under the FR1 component, and this was in alignment and vision of the XVth FC. However, the progress of this component both financially and physically was remarkably low. By the end of the first three years of the grant 2023-24, less than 20 per cent of the funds allocated in this component was utilized, and not a single SHC or PHC completed. Even in the urban component FU2, which was assigned to urban local bodies in 2023-24 for the construction of UPHC, the progress was yet to gain momentum.

The sluggish progress in the construction work assigned to local bodies however, needs to be read with caution. It must be borne in mind that part of the lag in progress could be due to the delays

[9] See details in Section B in the Telangana report.

in transferring funds from the Finance Department to the Panchayati Raj and Rural Development department (PR&RD). Notably, in Odisha, where funds were released on time and the actual execution was done by H&FW, the progress of the same component was significantly better. Even in Madhya Pradesh, where delay in releases of funds by the Finance department was relatively less, and actual execution of the component was handled by H&FW department, the progress was relatively better.

Officials revealed that the agencies of PR&DW and H&UD departments faced several bottlenecks in executing the FC grants. At the outset, the departments were burdened with various other sectoral responsibilities and could not take up the newly assigned work of the FC health grant on a priority basis. Also, the officials were of the view that there was a lack of ownership at PR&DW for the health-related works *vis-à-vis* the core activities of their parent departments. This leads to a situation where the main stakeholder (H&FW) is excluded from the position of control, while the other executing agency prioritizes its own core departmental activities. In Telangana, there was an instance when the PR&RD returned the proceedings for construction of 200 SHCs due to preoccupation with other construction assignments. Even in Uttar Pradesh, as per the officials, the departments overseeing local bodies expressed reservations and unwillingness to undertake the designated activities.

Delay in initiation at Various Levels due to Complex Architecture: Initial ambiguity on the execution agency for the XVth FC grants also led to delay in commencing work in several states. In Telangana, initially, the health department proposed that the PR&RD hand over the funds to District Health Society for Implementation. This was met with opposition, and after significant deliberations, the PR&RD retained the responsibility of undertaking the works under the component. These processes consumed time. Similarly, in Meghalaya, nearly three years were consumed to resolve the ambiguity of who should be entrusted with the assignment of the XVth FC work in the absence of local bodies.

The delay in Meghalaya primarily stemmed from the fact that the design of the XVth FC grant was not conducive to the unique administrative structure in the state. Being a state covered under the sixth schedule of the constitution, PRIs were absent, and the administrative powers of the tribal areas rested with the Autonomous District Councils (ADCs). The DoE guidelines specified that the FC grants should be handled by Autonomous District Councils (ADCs) in close coordination with the health department at the district-level, but the lack of historical involvement of these bodies in health-related activities, led to ambiguity in whether or not funds should be released to these agencies. The state was engaging Village Health Councils (VHCs) to undertake health related activities at the grass-roots level, and this made it more apt for the state to involve these agencies in FC grant execution. The ambiguity on the appropriate agency to release funds led to the long delay, and the decision to transfer the responsibility to VHCs could be taken only in 2024.

Several states also experienced delays in release of funds from the Finance department holding back the initiation of work under the grant. In Madhya Pradesh and Telangana, the time taken to release funds for several components ranged between 6-10 months. Due to this delay, the Finance department had to pay penal interest to the health department to be eligible for the next tranche of funds from the Government of India. This consumed time to begin with. Additionally, in Sates

like Madhya Pradesh and Uttar Pradesh, due to the unprecedented nature of the grant, the penal interest was booked into the wrong budget head at the first go, leading to more snags in the fund flow process.

There were also delays in releasing funds from nodal departments to the actual execution agencies. In Odisha, there were instances where the time taken to transfer funds from the PR&DW department to H&FW at the district-level was over six months. Even in Madhya Pradesh, for the portion of funds pertaining to urban local bodies the time taken by the Directorate of Urban Administration and Development (UADD) under the Department of Urban Development and Housing to release it to local bodies took up a minimum time of six months.

Cascading effect: The initial setback due to delays in transfer of funds and penal interest payments followed by the coordination and adaptation struggles of states arising from the involvement of multiple departments and tied components, created a cascading effect on progress of works in all subsequent years. The capital-intensive nature of the grant involving complex processes associated with construction activities exacerbated the effect, making it nearly impossible to adhere to the timelines of the grant. Some of the components also involved new initiatives, which required planning and adjusting to state-specific contexts, leading to a relatively long gestation period.

B. Re-appropriation Requirements Arising from the Uniform Tied Nature of the FC Grants added to Administrative Hurdles

The XVth FC grant was tied to six specific areas of intervention with distinct allocation for each component in every state. Due to differences in state health systems and the local context, several states faced a mismatch in fund allocation *vis-a-vis* their needs across components. Minutes of the meetings of the National-level Committee indicate that States like Kerala and Andhra Pradesh had limited scope for spending in the component of 'Building-less Sub Health Centers (SHCs)', Arunachal Pradesh in the component for 'Diagnostic Infrastructure', Tripura in the 'Urban component' and Rajasthan, Odisha, Bihar and Tamil Nadu towards the recurring expenses in the component of "Conversion of SHCs and PHCs into HWCs'. These States approached the NLC for flexibility in re-appropriation, and had to submit revised proposals for using the defined allocations. These administrative processes consumed valuable time in the initial stages leading to a delay in commencement of work.

Re-appropriation was also necessary as utilization of funds in states varied depending on the state-specific operational modalities and initial structure of health systems. A typical example of this is the case of Madhya Pradesh, which used a predominantly outsourced PPP model for diagnostic services. In the PPP mode of engagement, the scope of spending in the components related to diagnostic infrastructure (FR3 and FU5) was limited, as bulk of the funds were used to reimburse the private party engaged for delivering diagnostic services. Being demand driven, utilization of funds was low and called for re-appropriation. Similarly, the utilization of funds in the urban component (FU6) depended on the initial conditions of states. In Odisha, UHWCs was a new initiative, and this retarded the pace of utilization of funds in the early years. Subsequently, unutilized funds in this component had to be re-appropriated towards other components. In contrast, in Telangana, the State already had a network of Basti Dawa Khanas (BDKs), which was

an analogue of UHWCs, and the funds could be easily utilized to expand this network. Even within the same component, there are differences in state-specific focus and nature of interventions leading to differential rates of utilization. Madhya Pradesh directed much of the allocation under FU6 for construction activities and had a relatively low utilization, while many others used it to meet recurring expenses, which have better absorptive capacity. In general, fund utilization rates in different components vary across States due to differences in local conditions and operational modalities. The mid-way withdrawal of support for human resources also resulted in the need for significant re-appropriations across components.

The re-appropriations and the revised proposals could be approved only by the National-level Committee (NLC) and states had to reach out to NLC for every revision of proposals and re-appropriations. This added administrative processes leading to delays in the administration of these grants. In the case of Uttar Pradesh, such an arrangement also a led to a miscommunication on the initial and the revised proposal in the year 2021-22, due to which the state had to return a part of the initially released funds to GoI. This created further hindrances in executing actual works. Till the field visit was undertaken for this study in January 2025, the State could not obtain any further releases from GoI after the first year.

C. Mismatch between Prescribed and Actual Unit costs of Construction

Divergence between the prescribed unit costs and the actual costs of implementation posed further glitches to execution. Components such as CCBs have a relatively longer timeline, over which, factors such as GST revisions, state's revisions of their Schedule of Rates, and inflationary pressures increase the cost of construction. Officials from Gujarat highlighted issues with GST revisions affected cost of materials in terms of CCB constructions. Even for smaller construction projects such as SHCs and PHCs, officials in Madhya Pradesh reported that the prescribed norms fell short of the costs dictated by the Schedule of Rates (SoR) of the state. States like Gujarat and Odisha were also at a disadvantage on the prescribed costs due to their disadvantageous geographical location. Odisha being a coastal state needed modified foundations increasing costs, while Gujarat lay in an earthquake prone zone necessitating stringent and expensive construction codes.

The funding gaps in the prescribed unit costs and the actual costs were filled by tapping into the state budget. This added to the administrative processes required for initiating the construction work.

At the other end of the spectrum, there were cases where the actual costs in certain components were lower than the prescribed costs making it difficult to absorb the entire allocation. In the component of Urban HWCs or U-AAMs, states like Odisha and Gujarat reported that the provided unit costs were higher than the actual requirements. In Odisha, the officials reported that the amount provided for rent under this component was significantly higher than actual renting costs in the state. This contributed to the low utilization of funds in this component. Similar issues were also expressed by district level officials in the district of Kheda in Gujarat, where the provision for rent far exceeded the actual requirement.

D. Criticality of Human Resource Planning for Functionality of Physical Units Built under the XVth FC Grants and PM-ABHIM

The investments undertaken through the XVth FC health grants and PM-ABHIM will not translate into expanded health service delivery unless complementary inputs are put in place. The most crucial of these inputs is human resources. Guidelines indicate that the newly constructed diagnostic units IPHL and BPHU will require an expanded cadre of specialists and laboratory technicians. Similarly, the newly initiated Urban AAMs will require medical officers and other supporting staff for operations. Conversion of SHCs and PHCs into AAMs will also require additional staff strength. Also, bulk of the CCBs are still under construction but as these come to fruition, more HR will have to be recruited. These imply a large and impending financial burden on account of human resource engagement in the newly constructed units.

Financial support for human resources was built in both the XVth FC health grants and PM-ABHIM for a limited period. In the FC grant, financial support for HR was withdrawn after the first two years, i.e. since 2023-24. Even in PM-ABHIM, HR support was limited to the scheme period 2025-26. States were expected to take over the financial burden on account of HR after the scheme period. It may be noted that many of the units undertaken for construction under the XVth FC and PM-ABHIM are still under construction, which implies that bulk of the HR requirement will actualize after the scheme period. From states' perspective, these initiatives have created financial liabilities for future that would need to be adjusted within their fiscal contours.

Of the six States visited by the study team, only Odisha had engaged in some planning for human resources and meeting the recurring expenditure for units constructed under PM-ABHIM. In the absence of state sector plans in most states, there exists an implicit understanding that a part of the future HR costs would be absorbed under NHM. Notably, in 2023-24, when HR support was withdrawn from the XVth FC health grants, many states absorbed these into the NHM approvals. There is also some evidence that states depend on NHM funds for planning health personnel. In Madhya Pradesh, of the 46,491 newly sanctioned positions for health personnel in July 2024, more than half (27,838) were planned to be recruited through NHM.

The challenge of shifting HR cost to NHM is posed by the limited availability of resource envelope under NHM. Discussions with state officials highlighted that a sizable part of the NHM resource envelope is already being utilized for meeting committed expenditures, leaving little room for accommodating additional expenses. Any additional booking of HR expenses under NHM will necessitate increases in the NHM resource envelope.

Importantly, both the XVth FC health grant and PM-ABHIM were initiated roughly around the same time, and this has generated a substantial need for human resource engagement within a short span of time. Consequently, the financial obligation of states on account of HR has increased sharply within a short span of time, giving them a limited adjustment period to absorb these expenses into their own budget.

E. Utilization Criterion and Fund Absorption under PM-ABHIM

Availability of funds in PM-ABHIM has been low *vis-à-vis* allocation in most states. Several states have attributed this to the stringent conditionality of releases under the scheme. In PM-ABHIM, 75 per cent utilization of funds is required to obtain the next tranche of release. As per the officials of state governments, the components of the scheme include both capital and recurring expenses, which follow different patterns of execution and disbursements. Civil works, being capital intensive progress at a slower rate and entail staggered payments tied to construction milestones. On the other hand, recurring expenses are periodic in nature and occur at a more predictable schedule. When these are combined under a single component, delays in civil works can significantly reduce the overall utilization rate, even if recurring expenses are being disbursed regularly. This creates a structural constraint in meeting the utilization benchmark, holding up further release of funds.

F. Ambiguity in Central Guidelines on the Expected Role of Local Bodies

Vision of the XV-FC

The report of the XV- FC acknowledged that the limitations of the health system was brought to the fore by the Covid pandemic and

> ***"considered this to be an opportune time to involve the third tier in the health sector and extend additional resources to it to strengthen the primary health system at the grass root level."***

The FC also envisioned involving local bodies in a **supervisory** role in primary health care institutions to strengthen the health system. It also mentioned that a phased approach should be adopted in entrusting local bodies with these new roles-

> ***"Involving panchayati raj institutions as supervising agencies in these primary health care institutions would strengthen the overall primary health care system."*** Notably, the FC report also states ***"We also recommend that representatives of the urban local bodies and all three levels of panchayati raj institutions should be involved by entrusting them, in a phased manner, with the responsibility of supervising and managing the delivery of health services."***

DoE Recommendations on Role of Local Bodies

The Department of Expenditure (DoE) and the MoHFW issued guidelines, which formalised and outlined the expected roles of local bodies. The guidelines by the DoE issued in July 2021 highlight two important points in relation to assignment of implementation responsibilities-

a. They recognized that the intervention components identified by the XVth FC report are technical in nature and require experience and exposure in the relevant subject.

b. They acknowledged that local bodies have not been involved in direct handling of primary health care functions in all states and a sudden transfer of these responsibilities to lower levels may not produce the desired results.

"The components identified by the Fifteenth Finance Commission for strengthening primary health care infrastructure and facilities in both rural and urban areas are mostly technical in nature and require experience as well as exposure in the relevant subject. Since, in all States, local bodies have not hitherto handled primary public health functions directly therefore, suddenly transferring the responsibility of the delivery of primary health care services to the local bodies especially at the lower levels during these critical times may not produce the desired results."- (page 7 para 7)

Given these identified limitations and the mandate of the XVth FC calling for **involvement** of all three levels of local government, **the guidelines designate the Zilla Parishad/District Panchayats as the implementing body for the rural components**. With the view that the District Panchayats are better equipped with health and engineering resources to handle this function, the guidelines specify that they should work in close coordination with the District Health Department under the supervision of the Collector. At the same time, they called for active involvement of the Block and Village Level Panchayats in planning and monitoring functions.

In terms of implementing agencies, the DoE guidelines made an exception for the components concerning procurement of diagnostic infrastructure, recognizing that this activity involves economies of scale, technical expertise and standard processes. They allowed for the centralised purchase of such equipment at the state level. This is explained in Page 8 Para 8 of the DoE guidelines–

"As local bodies hitherto have largely not handled such public health functions, therefore, the State Level Committee (SLC) may decide about the procurement of the approved components of medical equipment, diagnostics etc. under 'Support for diagnostic infrastructure' component through a mechanism which may include central purchase(at State level) with the aim to ensure purchase of quality products at reasonable/competitive prices in an efficient manner after following the due processes, procedures and practices with the prior approval by the National Level Committee. For the centrally (at State level) procured items, it must be ensured that the selected vendors/companies do deliver the items of store at the intended destination (where these are required to be installed/utilized). State Level Committee may also work out a mechanism for the payment for centrally procured items of stores to the concerned vendors/companies."

At the same time, the DoE guidelines institutionalised the collaborative framework between the Zilla Parishad and District Health Department envisaged by the XVth FC, in the form of the mandated setting up of District Level Committee (DLC). The DLC would be headed by the District Collector/Deputy Commissioner and include officials of the Health, Panchayati Raj and Urban Affairs Departments as well as select representatives from all three tiers of rural and urban local bodies in the district.

Flexibilities Allowed by the MoHFW

The MoHFW guidelines issued in August 2021 following the DoE Guidance note focus on the component by component implementation mechanism. For instance, the guidelines of the MoHFW with reference to the component for construction of SHCs, PHCs, and CHCs, state that-

> "***As the component is only for infrastructure work, as per the decision of the State, the activity may be done through the engineering wing of the State level department or through Zilla Parishad engineering wing. As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities."***

With reference to the role of local bodies in the same component, the guidelines state that-

> ***"Local Bodies (District and Block) should be actively involved in the monitoring of the progress of the construction work. To the extent possible, institutional arrangements such as JAS / VHSNCs should be utilized for this purpose."***

With respect to the recruitment of HR under the conversion component, the same guidelines state that-

> "***Most of the State Health Departments have developed effective modalities for recruitment of Human Resources for Health such as Medical Officers, Nurses, Lab Technicians, Pharmacists and other para-medical staff, through mechanisms such as a State / District level agency of government or through empanelled agencies. Under National Health Mission, States/UTs are supported to deploy such agencies. States have been undertaking these human resource recruitments through these empanelled agencies, which have established transparent and systematic Procedures."***
>
> ***"As the allocation under this component includes substantive funding for HR related components, the operational diagnostic costs of PoC tests and independent monitoring, DoE's Guidance Note (Para 8 at Page 8) which has been reiterated again at sub-point 10 under para 1.4.2 of Chapter 1) may be referred for further action to ensure timely payment of remuneration and incentives of the primary healthcare team working at these SHC level HWCs."***

The DoE Guidance note (Para 8 at Page 8) quoted in the aforementioned MoHFW guidelines allows for centralised procurement of diagnostic infrastructure at the state level and leaves it up to the states to arrive at the payment mechanism for such procurement. The MoHFW guidelines mentioned in the paragraph seem to suggest that such centralised payment could be applied for HR related components as well.

In terms of the role of local bodies in the conversion component, the MoHFW guidelines further add that-

> ***"Local Bodies (District and Block) should be actively involved in the monitoring of all the functional SHC and PHC level HWCs, without restricting such monitoring to those HWCs, which are supported under this component of FC-XV. To the extent possible, the institutional arrangements such as JAS / VHSNCs should be utilized for this purpose."***

With respect to the Urban HWC components, the MoHFW guidelines say that –

> ***"As the component involves multiple activities such as Infrastructure upgradation /provision of essential drugs and diagnostics / team based incentives and remuneration to HR and other HR related components, besides the operational diagnostic expenditure of PoC tests and independent monitoring, as per the decision of the State, DLC should ensure that the funds under this component are to be sent by the Urban Local Bodies in-time or in-advance to the State level agency (either State Health Society) or to the District level agency (District Health Society), as per the local context.***
>
> ***Some States may opt for releasing the money to the Urban Local Bodies excluding the funds required for State level / District level agency activities for this component, as per their context as decided at the State level."***

With respect to the role of the local bodies in the UHWC component, the guidelines state that-

> ***"Concerned Urban Local Bodies should be actively involved in the planning and monitoring of all the functional urban-HWCs."*** and that-
>
> ***"Capacity of the urban local bodies for all components of the FC-XV will need to be improved, by the state by undertaking the requisite trainings through state level institutions."***

With reference to the diagnostics component, the DoE Guidance note allowed for centralised procurement given the economies of scale and technical expertise required, which were reiterated in the MoHFW guidelines-

> *"**As stated in the DoE's Guidance Note (Para 8 at Page 8), on the grounds of economies of scale, standard processes, quality assurance and required technical expertise, State level committee may decide about the procurement of the approved components of medical equipment, diagnostics, medicines, other consumables, etc, through a mechanism which include Central purchase at State level and for the centrally procured items, the State level Committee may also work out a mechanism for the payment of such centrally procurement items."***

Similarly, with respect to the BPHU component, the MoHFW guidelines prescribe the same modalities for procurement of infrastructure as for the diagnostics component, and for Human Resources as prescribed under the conversion component.

Piecing both sets of guidelines (DoE and MoHFW) together seems to suggest that-

a. In terms of capital works, while District Panchayats were designated as the implementing agency by the DoE, the construction activities could be done through the engineering wing of the State level department or through Zilla Parishad engineering wing going by the MoHFW guidelines. The MoHFW guidelines additionally mention that the state could decide on the mechanism for payment for such *"centrally executed activities"*.

b. In terms of diagnostic infrastructure, both sets of guidelines explicitly allow for centralised procurement at the state level and allow states to decide on payment mechanisms.

c. In terms of recruitment of HR, the MoHFW guidelines posit that states' Health Departments have developed effective modalities to carry out such recruitment. For HR payments, the MoHFW are indicative that the DoE's prescription for centralised procurement of diagnostics could be referred to and followed.

d. In terms of the urban component of U-AAMs, the MoHFW guidelines prescribe that funds for this component should be sent by the Urban Local Bodies to either the State Health Society or District Health Society depending on the context.

e. In terms of all components, the MoHFW call for active involvement of local bodies in planning and monitoring of activities.

The major takeaway that emerges from a close examination of these guidelines is that there was a lack of clarity in defining the flexibility available to states in decisions regarding implementation-

- For instance, while the DoE guidelines and MoHFW guidelines both state that the execution of the construction works would rest with the Local Bodies, and they could either carry out these works through their own engineering wing or through the engineering wing of the State Department. To this, the MoHFW guidelines add that " ***As per DoE's Guidance Note dated 16th July 2021 (Para 8 at Page 8), the State may decide the mechanism for the payment of such centrally executed activities."***

- While the aforementioned DoE note was pertaining to the diagnostics procurement component, the reference to the same note under the construction component guidelines seemed to indicate that states could carry out these activities at the centralised level and choose the payment mechanism for the same.

- This can be potentially interpreted as being in contradiction to the prescribed fund flow where funds had to go to the local bodies.

The execution by local bodies is explicitly called for by the DoE guidelines, while the MoHFW guidelines modified this directive by allowing for instance, the transfer of funds from the ULBs to SHS/DHS for urban HWC components, or by mentioning construction activities in the same vein as centrally executed activities.

This ambiguity in the guidelines potentially might have led to varying interpretations across states, resulting in inconsistent implementation practices.

To summarise, the XVth FC report underscores that the objective of the Health Grants being channelized through Local Bodies was to involve them in supervision and management of health services delivery in a phased manner. Perhaps stemming from the varied levels of capacity development of local bodies across states, it is important to note that the XVth FC report refrains from making an explicit directive that these grants should be executed by local bodies. The explicit involvement of district level local bodies as implementing agencies was introduced by the DoE guidelines, while the MoHFW guidelines issued subsequently attempted to allow for some flexibility in the execution of components. However, the ambiguity in the essential modalities of implementation put forth by both these sets of guidelines, implied that they were prone to misinterpretation/differential interpretation by states. This potentially could have led to the violation of the necessary fund flow norms, leading to bottlenecks to fund releases.

G. Best Practices in States

1. Proactive and Pragmatic Planning and Execution

Odisha and Telangana, the two best performing states in the context of the XVth FC health grants ensured that hindrances or challenges were promptly addressed with swift course corrections. Faced with ground-level implementation challenges and rigidities in centrally determined components, these states responded with adaptive strategies. Instead of allowing funds to remain unutilised—risking lapsing after the grant period—they pursued timely re-appropriations and institutional innovations while adhering to grant guidelines and securing necessary approvals from the National Level Committee (NLC).

Timely course correction expedited execution in Odisha. The state faced bottlenecks in executing civil works under the XV-FC grants through the PR & DW department in the first year. It was quick to revert the decision and hand over the charge of execution to H&FW department from 2022-23 onwards. Funds were also routed from PR&DW to H&FW at the district level, who then engaged agencies like the Rural Works Department or PSEs for construction. This ensured smooth execution through the established machinery under H&FW. Additionally, the state promptly engaged and deployed additional Public-Sector Units (PSUs) to deal with the heavy deluge of construction activities that had to be undertaken simultaneously under PM-ABHIM, XVth FC Health grants and ECRP II.

Importantly, both the states of Odisha and Telangana were also prompt in re-appropriating allocations from components where utilization was low, towards other uses. In Odisha, with limited UHWCs in place and recurring costs (like rent) overestimated for Odisha's context, funds under FU2 were underutilized in the first year. Demonstrating foresight, the state re-appropriated a major portion of the allocation in 2022-23 towards this component towards civil works for SHCs and UPHCs. Similar was the case of Telangana, where the utilization of the same Urban HWC component was low in the first year. Funds saved from this component due to underutilization of the allocation in 2021-22, were re-appropriated to cover non-recurring expenses for establishment of 38 new UPHCs in 2022-23.

Such a proactive approach is essential to maximize utilization of funds in time-bound grants like the XV-FC Grants and the PM-ABHIM.

Proactive Measures in Odisha

State	Challenge Faced	Pragmatic Action Taken	Consequences
Odisha	Civil works bottleneck with PR&DW; FU2 underutilisation	Shifted civil works to H&FW but adhered to the fund flow guidelines by using PR&DW as conduits; reallocated FU2 to prefab UHWCs, UPHCs, SHCs	Boosted execution & aligned funds with ground needs
Telangana	Unspent funds under FR4 and FU2 due to delays & overestimation	Re-appropriated funds across/within components (FR4→FR1, FU2 for new UPHCs)	Maximised fund utilisation, infrastructure expansion

Pragmatic Re-appropriation in Telangana

Component	Approval FY 21–22	Savings FY 21–22	Allocation FY 22–23	Revised Allocation FY 22–23
FR4: SHC to HWC Conversion	8,505	8,287	8,505.09	217.8
FR1: Construction of Building-less SHC/PHC	280.98	—	280.98	8,568

2. Ensuring Convergence and Alignment with Other Initiatives for Better Outputs

Odisha, Gujarat, Telangana and Meghalaya exemplify a common best practice in effectively leveraging multiple funding sources—from both central and state schemes—to advance health service delivery. Rather than treating schemes in isolation, these states adopted a comprehensive, outcome-oriented planning approach that maximized synergies across initiatives. The table below presents state-wise case studies of convergence.

State	Schemes/ Sources of Funds Converged	Example/Highlight	Impact
Odisha	XV-FC + NIDAAN (State) + NHM	PHC AAM in Baranga: XV-FC (equipment) + NIDAAN (HR) + NHM (renovation)	Enabled full diagnostic functionality and testing facilities through convergence
		BPHU + new CHC built simultaneously in Subarnapur	Unified infrastructure for health services and diagnostics
		NIDAAN funding plan split across XV-FC, NHM, and State Budget (2022–27)	Ensures sustainability post-grant
Gujarat	PM-ABHIM + ECRP-II + State funds	Devbhumi Dwarka: CCB + IPHL under PMABHIM, ICU + Pediatric Ward+ Field Hospital under ECRP-II tendered together	Cost-efficiency + integrated service delivery
		Similar convergence like Devbhumi Dwarka replicated across 20+ districts	Holistic planning model for construction and health service delivery
Telangana	NHM + XV-FC + PM-ABHIM	Telangana Diagnostics Hub: NHM (HR), XV-FC (Opex and equipment), PM-ABHIM (equipment & IPHL upgradation)	Strengthened diagnostics, expanded test range, ensured continuity via multiple funding sources
Meghalaya	PM-ABHIM + Hans Foundation (NGO) + MGNREGS	PM-ABHIM (construction of SHC) + Hans Foundation Manpower/HR +MGNREGS (Approach road to the facility)	Ensured the establishment of a well-functioning accessible facility at the grass-root level.

In Odisha, the XVth FC health grants were used in complementarity with the state scheme Nidaan – a state government initiative which aims at providing diagnostic services free of cost to all patients, and NHM funds. An example of this was visible at the laboratory at PHC AAM in Baranga, Cuttack. The Lab Technician (LT) was employed under the Nidaan scheme, while diagnostic equipment was being procured using the XV-FC grants. The renovation work for the same laboratory room was undertaken using the NHM funds. Thus, all the three sources together, enabled the operationalization of the laboratory unit in this facility.

Another interesting instance of convergence was also visible in the state of Meghalaya, where a new sub centre (SHC) built by the Village Health Council using the PM-ABHIM funds, was being operated in partnership with an NGO called the Hans Foundation. This collaboration allowed the SHC to engage a higher number of personnel including a Lab Technician and a Data Entry Operator and to also obtain equipment such as a neonatal intensive care warmer. Additionally, the approach road to this facility had been built by the villagers under the MGNREGS scheme. This

provided a unique example of how a convergence of community engagement with government efforts, supported by private partners can steer health sector initiatives towards desired results.

In Telangana, the state adapted the XVth FC health grants to strengthen state-level initiatives. In FR2 component, the state decided not to construct fresh BPHUs, but to use the allocation for strengthening and expanding the capacity of District Pathology and Radiology Hubs (DPRH) existing under the Telangana Diagnostics initiative. In fact, all funds for support of diagnostic infrastructure in the state (both rural and urban) were utilized for reinforcing Telangana Diagnostics. Additionally, in the urban component FU2, funds were used to expand the existing urban health facilities Basti Dawa Khanas in the state. Thus, the state modified the FC grants to suit its own context.

In Gujarat, the Health Department undertook a comprehensive planning exercise to converge the activities pertaining to ECRP II, PM-ABHIM and state-level initiatives. An example of this was evident in the District Hospital in Devbhumi Dwarka – the 50 bedded CCB and IPHL under the PM-ABHIM was combined with 20 bedded ICU, 42 bedded Pediatric unit and 100 bedded Field Hospital, and a single tender was issued to a construction agency. Such convergence ensures that facilities are situated in locations with comprehensive delivery of services apart from potential cost efficiencies.

3. Medium-term Planning on Human Resource and Funding

The returns from the investments undertaken using XVth FC grants and PM-ABHIM critically hinges on the ability of states to ensure adequate human resources in the newly constructed facilities. Of the six states taken up for study, Odisha stands out as the only one which has been planning HR expenses simultaneously with the construction activities. The table below shows how the recurring expenditure for the facilities is budgeted for in Odisha.

Recurring cost of PM-ABHIM components for 2024-25 (Amount in Rs. lakhs)

Component	No. of units	Fund required for 2024-25	Budget under PM-ABHIM in 2024-25 PIP	Fund already available under XV-FC	Fund to be met from NIDAN
IPHL	30	1020.00	612.00	-	408.00
CCB (only non-HR)	30	798.00	266.00	-	532.00
BPHU	314	2304.76	1504.70	722.08	800.06

The state has also prepared plans to address funding shortfalls that will emerge once the XV-FC Health Grants period concludes. The state's efforts toward such convergence are exemplified in the table below which shows how the total budget of its NIDAAN Scheme is being met by different sources including the state's own budgetary resources. The table also illustrates the potential increase in the state's fiscal commitment from FY 2026–27, when XV-FC support ceases. Thus, the state has also prepared plans to address for financial sustainability beyond the XV-FC period and PM-ABHIM timelines, to ensure continuity of these interventions and derive an understanding of long-term resource needs and synergies across schemes.

Odisha- Convergence across schemes NIDAAN Budget (2022-2027)

Sl. No.	Financial Year	Amount (In Crs)			
		Total	**State**	**XV-FC**	**NHM**
1	2022-23	**387.98**	179.82*	145.39	62.77
2	2023-24	**408.86**	164.88*	152.87	91.11
3	2024-25	**568.15**	277.26	160.7	130.19
4	2025-26	**596.19**	291.26	168.54	136.39
5	2026-27	**498.33**	355.54		142.79
	Total (2022-27)	**2459.51**	**1268.76**	**627.5**	**563.25**

Chapter 1: Background

A. Introduction:

The Union government has been extending financial support to states for strengthening state health systems for long now, through a number of Centrally Sponsored and Central Sector Schemes (CSS and CS). In addition, Finance Commissions, appointed every five years, have periodically recommended sector-specific grants to augment state capacities in key areas, including health. Over the past two decades, only two Finance Commissions have extended support for the health sector: first by the XIIth Finance Commission (2005–06 to 2009–10), and more recently by the XVth Finance Commission (2021–22 to 2025–26).

The XVth Finance Commission Health Grants were recommended in the backdrop of the COVID-19 pandemic. The pandemic had exposed vulnerabilities in India's public health infrastructure at various levels. In response, two major initiatives were launched in 2021 to address the systemic gaps and strengthen the healthcare infrastructure of the country —the XVth FC Health Grants and the Pradhan Mantri – Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). While distinct in design, both schemes shared a common goal: to build resilient, accessible, and well-equipped primary healthcare systems capable of responding to future public health emergencies.

In the backdrop of the pandemic, the XVth Finance Commission recommended one of the largest health sector grants totalling Rs. 70,051 crores, to be distributed over five years (FY 2021-22 to FY 2025-26). On an average, this amounted to about Rs. 14000 crores per year, which equals almost 40 per cent of the Union budget allocation on National Health Mission (NHM) in 2021-22. This makes the XV-FC health sector grant perhaps the largest grant allocated by any Finance Commission to the health sector. To put the unprecedented magnitude of these funds into perspective, the XIIth FC (2005-10) had recommended a grant of Rs. 5887 crores to states for the health sector, which is less than 10 per cent of the XVth FC health.

The second major intervention following the pandemic was the launch of PM-ABHIM in October 2021. PM-ABHIM extended support to the National Centre for Disease Control, and regional centres to boost pandemic preparedness and surveillance capabilities. Additionally, it aimed at building critical care hospital blocks (CCBs) in districts, establishing integrated public health laboratories (IPHLs), bolstering HWCs in urban and rural areas and establishing Block Public Health Units (BPHUs). Three of the components, i.e., HWCs in urban areas, HWCs in rural areas and BPHUs are common to both PM-ABHIM and the XVth FC Health Grant (Table 1 and Table 2).

Given the common focus of the two interventions, significant portions of PM-ABHIM were planned to be supported by the FC grants. Of the total allocation of PM-ABHIM, more than a third was to be financed through the XVth FC health grants. The integration between these two initiatives is evident in the financing of key components (Table 2). The XVth FC Health Grants were expected to cover around 59 per cent of the allocation for rural HWCs and 61 per cent for urban HWCs under PM-ABHIM (Table 2). Similarly, the FC grants were set to fund more than a

third of the component of BPHUs. Not only does this demonstrate a shared focus between the XVth FC Health Grants and PM-ABHIM, but also a strong interdependence in their financial structures.

B. Characteristics of the XVth FC Grants and PM-ABHIM Scheme

A unique feature of the XVth FC health grants was that the grants had to be executed through local bodies, with a view to enhance their engagement in health service delivery. This feature gave rise to a complicated execution structure (Figure 1 and Figure 2). Although the state health department was appointed as the nodal department for implementation, funds had to be released to the Panchayat Raj or the Urban Development Departments as local bodies lay under the purview of these departments. This implied that the implementation of these grants required close coordination across multiple departments at various levels of administrative machinery at the state-level. The implementation also entailed setting up a unique institutional structure consisting of a National Level Committee(NLC) at the country level, a State Level Committee(SLC) at the state level and a District Level Committees (DLC) for administering the grant.

In contrast to the execution frameworks of the XV-FC Health Grants, the operational architecture of the PM-ABHIM scheme was aligned with the established mechanisms of the National Health Mission (NHM). The Centrally Sponsored Scheme (CSS) components of the PM Ayushman Bharat Health Infrastructure Mission were to be implemented through the existing frameworks, institutions, and processes of the NHM. This approach was intended to avoid duplication—particularly in relation to the overlapping support provided under the XV-FC Health Grants and NHM—for similar activities. Accordingly, the PM-ABHIM leveraged NHM's structures at both central and state levels for appraisal, approval, implementation, and monitoring. As a result, in the case of PM-ABHIM, states were afforded the administrative flexibility typical of CSS, including inter-component re-appropriation and the use of existing institutional frameworks for implementation.

The XVth FC health grants were also tied in nature targeting five specific areas of State health systems. These include Urban Health and Wellness Centres (UHWCs), Building-less sub centres, PHCs, CHCs, Block level public health units (BPHUs), support for diagnostic infrastructure to the primary healthcare facilities and conversion of rural sub centres and PHCs to HWCs, as shown in Table 1. Bulk of the grants were focused on construction and other capital works, while also extending some support towards recurring expenditures. While financial support for Human Resources was made available under the grant for the first two years of its implementation, i.e., FY 2021-22 and FY 2022-23, but was subsequently withdrawn from FY 2023-24 onwards. Similarly, the PM-ABHIM scheme was also heavily focused on construction works with a view to augment physical infrastructure in health. Support for recurring expenditure under the PM-ABHIM was also only available for the duration of the scheme until FY 2025-26.

C. Objectives

This study was undertaken to evaluate the performance of the XVth FC Health Grants in the light of its unique design, and derive insights on the factors that affected its performance. Specifically, it intends to:

(a) identify the enablers, barriers and states' critical challenges in effectively utilizing the grants

(b) document field-level observations on health sector outputs and best practices associated with the grant

(c) assess states' plans for maintaining the newly created assets.

(d) provide recommendations for improving the effectiveness of such grants in future.

D. Data Sources and Methodology

The analysis was carried out in two stages. In the first stage, a broad assessment of the performance of the XVth FC health grant and PM-ABHIM across all states was carried out for the first three years of the grant 2021-22 to 2023-24. In PM-ABHIM, the focus of the assessment was exclusively on the overlapping components with the XVth FC health grant. Additionally, an attempt was made to understand the policy developments in the context of the two grants. This was based on information sourced from the Ministry of Health and Family Welfare (MoHFW) and data extracted from the NHM-PMS portal. Some information was also compiled from data placed in the public domain by the Ministry of Finance.

In the second stage, an in-depth analysis was conducted in six selected states to gain insights into ground-level implementation challenges. These included Odisha, Madhya Pradesh, Uttar Pradesh, Gujarat, Telangana and Meghalaya. The states were chosen based on their performance under the XV-FC grant. Odisha and Telangana were chosen from the ranks of top performing states, which had secured grant releases for each of the three years between 2021-22 and 2022-23. Gujarat and Madhya Pradesh were selected as they exhibited decent utilization rates, yet could not secure funds for the third year 2023-24 (as on November 2024). Uttar Pradesh and Meghalaya ranked low on the performance ladder as they could not secure releases of the XVth FC health grants after the first year.

States chosen for State-level Analysis

States receiving funds for three years	States receiving funds for two years	States receiving funds for only one year
1. Odisha	1. Madhya Pradesh	1. Uttar Pradesh
2. Telangana	2. Gujarat	2. Meghalaya

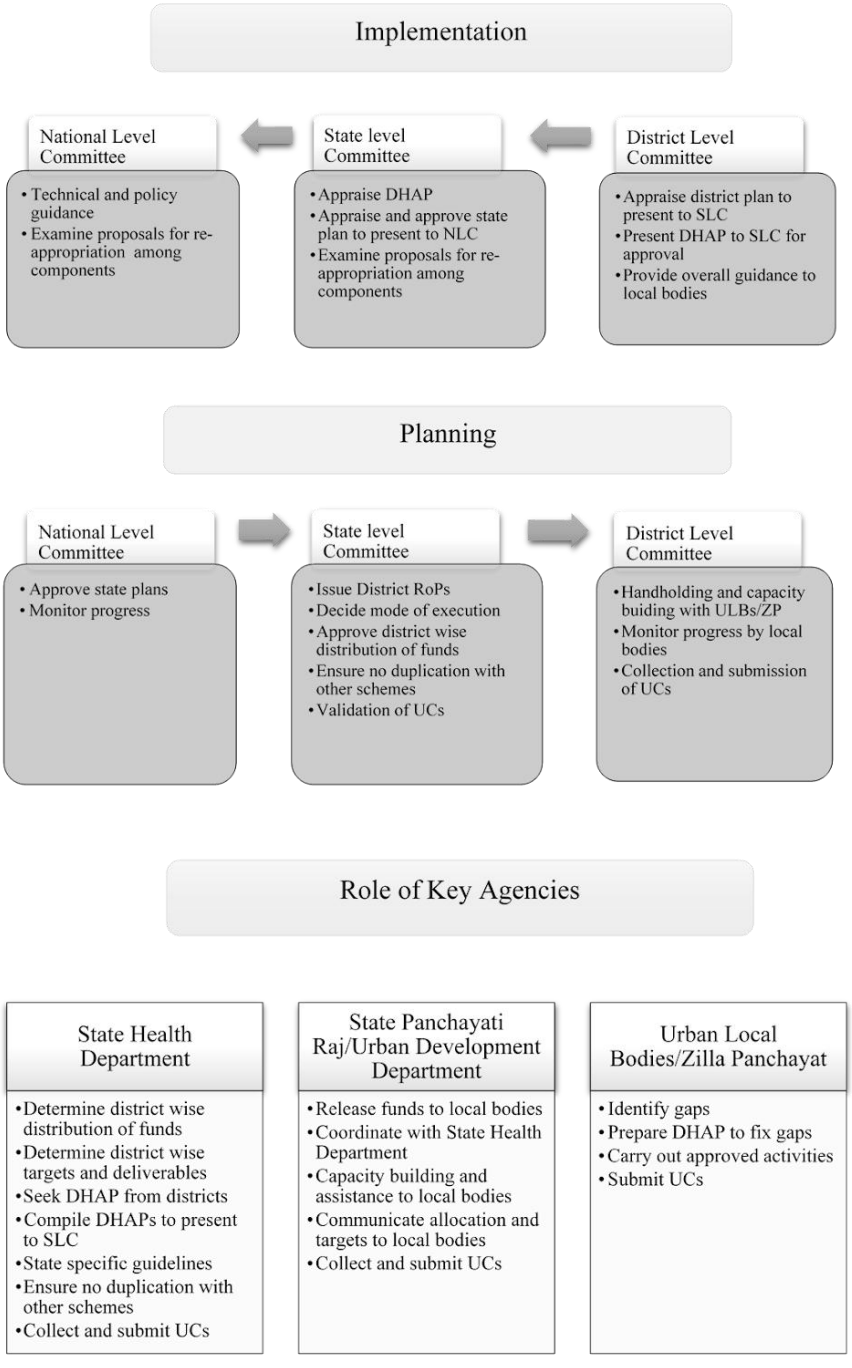
In every state, the study team engaged in two sets of interactions– the first set of interactions were held with key stakeholders involved in the implementation of the XV-FC Health Grants and the PM-ABHIM. This included detailed interactions with officials from the State Health Department including the State Health Society, representatives of the Panchayati Raj and Urban Development Departments (in states where they were involved in the execution), personnel from the civil/construction wings of departments responsible for capital works, and officials from local bodies and procurement agencies (wherever applicable). Discussions were also carried out with the State Finance Department to understand fund-flow issues in the states of Uttar Pradesh, Madhya Pradesh and Gujarat.

The second set of interactions were held at the district-level; two districts in each state. Districts were chosen in consultation with state-level officials. Within each district, field visits were conducted to selected facilities, which either received significant infrastructure/diagnostic support or were operationalised (or were in the process of being operationalised) either under the XV-FC Health Grant or the PM-ABHIM. These facility visits focused on trying to assess the tangible, ground-level developments that were or could be brought about by these initiatives. Data was collected on OPD footfalls and number of diagnostic tests wherever applicable and available. Interactions with the facility staff brought to the fore challenges being faced in service delivery. Discussions with the district- and block-level officials, on the other hand, provided insights into the administrative issues faced in implementing the grant.

Findings from both Stage I and Stage II were synthesized to build a comprehensive understanding of the implementation landscape, offering valuable insights into the challenges encountered, state-level best practices for cross-learning, and potential inputs for shaping the design of a prospective 16th Finance Commission Health Grant.

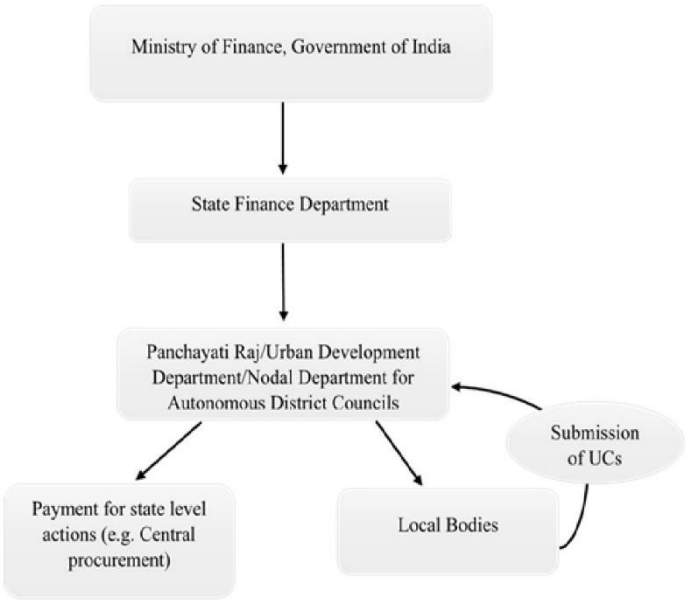
Appendix to Chapter 1

Figure 1: Governance and execution structure of the XV-FC Health Grants



Source: Technical and Operational Guidelines, Ministry of Health and Family Welfare, 2021

Figure 2: Mandated Fund flows for the XV-FC Health Grants



Source: Technical and Operational Guidelines, Ministry of Health and Family Welfare, 2021

Table 1: Year wise and Component wise Distribution of XV-FC Health Grant Allocations (in Rs. Crores)

Component	2021-22	2022-23	2023-24	2024-25	2025-26	Total
FR1 Building less SHCs, PHCs and CHCs	1350	1350	1417	1488	1562	7167
FR2 Block Public Health Units (BPHU)	994	994	1044	1096	1151	5279
FR3 Support for diagnostic infrastructure to primary healthcare facilities	3084	3084	3238	3400	3571	16377
FR3 a) SHCs	1457	1457	1530	1607	1687	7738
FR3 b) PHCs	1627	1627	1708	1793	1884	8639
FR4 Conversion of	2845	2845	2986	3136	3293	15105

Component	2021-22	2022-23	2023-24	2024-25	2025-26	Total
rural SHCs and PHCs to HWCs						
Total Grants for primary health sector in rural areas	**8273**	**8273**	**8685**	**9120**	**9577**	**43928**
FU1 Support for diagnostic infrastructure to primary healthcare facilities- Urban PHCs	394	394	415	435	457	2095
FU2 Urban Health and Wellness Centres (HWCs)	4525	4525	4751	4989	5238	24028
Total Grants for primary health sector in urban areas	**4919**	**4919**	**5166**	**5424**	**5695**	**26123**
Grand total	**13192**	**13192**	**13851**	**14544**	**15272**	**70051**

Source- Technical and Operational Guidelines, Ministry of Health and Family Welfare, 2021

Table 2: Component wise Distribution of PM-ABHIM Allocations (in Rs. Crores)

Component	Central Share	State Share	15th FC Share	Grand Total
AB-HWCs in rural areas in seven High Focus States and three NE States - Infrastructure of 17788 rural AB-HWCs*	2608.89	1479.8	5783.97	9872.66
AB-HWCs in urban areas (11,024 urban HWCs)	4863.41	2945.55	12146.25	19955.2
Block Public Health Units (BPHUs) in 11 High Focus States/UTs – 3382 BPHUs**	1712.27	775.04	1342.21	3829.52
Integrated Public Health Labs (IPHLs)	990.4	492.2	0	1482.6
Critical Care Hospital Blocks (CCB)	11952.4	7112.37	0	19064.8
Total	**22127.4**	**12805**	**19272.43**	**54204.8**

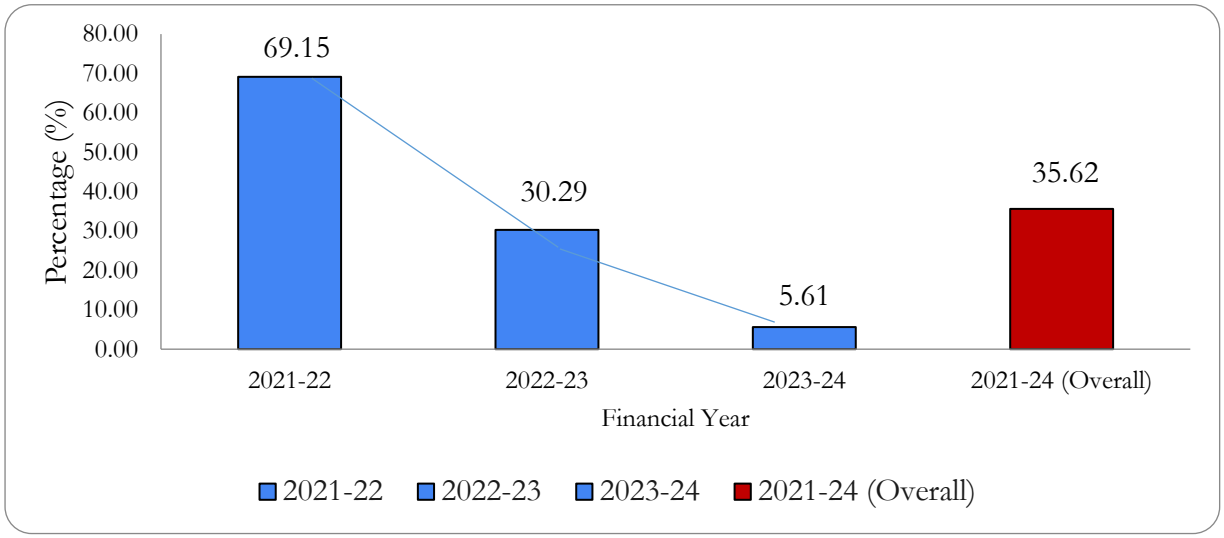
Source: Operational Guidelines for PM-ABHIM, Ministry of Health and Family Welfare, 2021

Chapter 2: Financial and Physical Performance – An Aggregate Analysis

A. Aggregate Trends in Performance of XVth FC Grant

The absorption of the health grants recommended by the XV[th] FC has been poor in States. Between 2021-22 and 2023-24, only about 36 per cent of the funds approved for all the 28 States could be utilized (Figure 3, Appendix Table 15).[10] Strikingly, the utilization rate has declined sharply over the years. In the first year 2021-22, the utilization rate stood at almost 70 per cent, which then fell to 30 per cent in the subsequent year 2022-23, before dwindling to an abysmal low of about 5 per cent in 2023-24 (Figure 3).

Figure 3: Utilization (Expenditure as a percentage of allocation) in XVth FC Health Grant, 2021-22 to 2023-24 (All States)



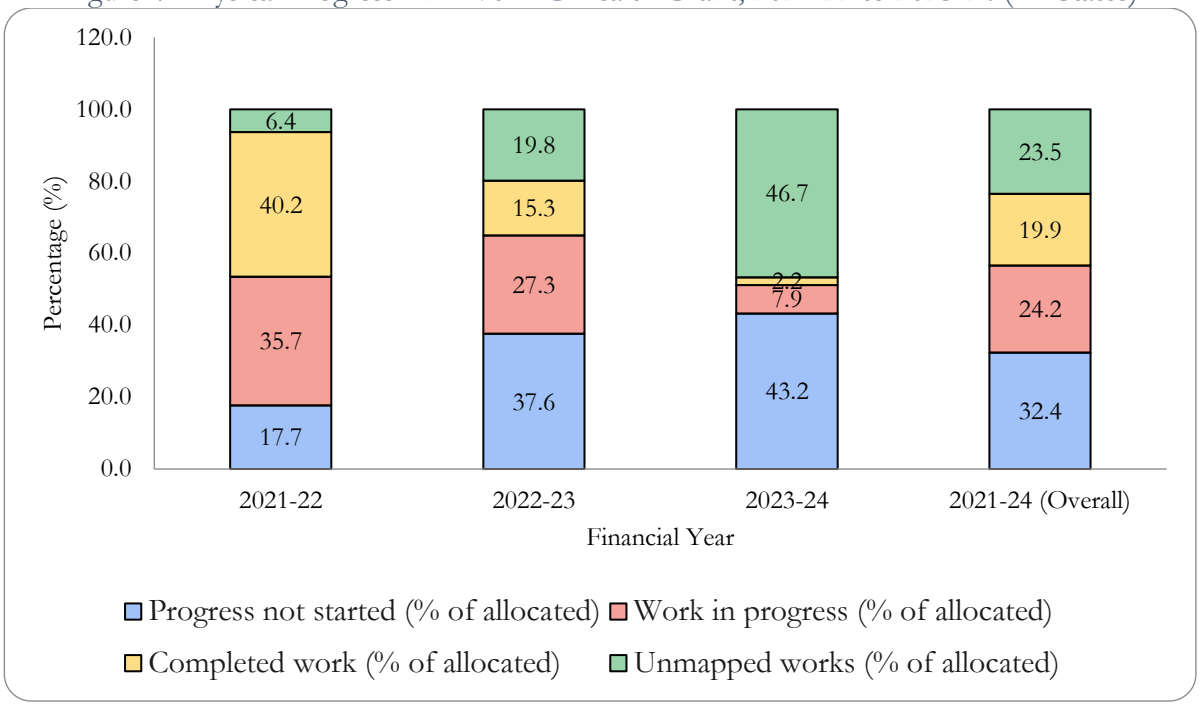
Source- Allocation (budget approvals) were based on figures provided by the Ministry of Health and Family Welfare and expenditure figures were sourced from the NHM-PMS portal.

The poor performance is also mirrored in the physical achievements under the grant. Between 2021-22 and 2023-24, work was yet to start in more than half (56 per cent) of the physical units targeted in States through the FC grants in those years (Figure 4). In only 20 per cent of the physical units, the work could be completed (Figure 4). The physical progress also slowed down over time.[11] In the first year 2021-22, work was yet to start in around 18 per cent of the total physical units targeted under the grant. In the subsequent year 2022-23, this proportion increased to 38 per cent, which then further increased to 43 per cent in 2023-24 (Figure 4). Similarly, unmapped physical units as a percentage of the total targeted units rose from 6.4 per cent in 2021-22 to a staggering 46.7 per cent in 2023-24. On the whole, of the total targets allocated, the number of physical units that could be mapped and some work started declined steadily each year (Figure 4, Appendix Table 16)

[10] Utilization is measured as the ratio of expenditure to allocation.

[11] Physical Progress is measured in terms of the proportion of units where work was either completed or in progress against the allocated/target quantity of works. This definition of physical progress has been followed throughout.

Figure 4: Physical Progress* in XVth FC Health Grant, 2021-22 to 2023-24 (All States)

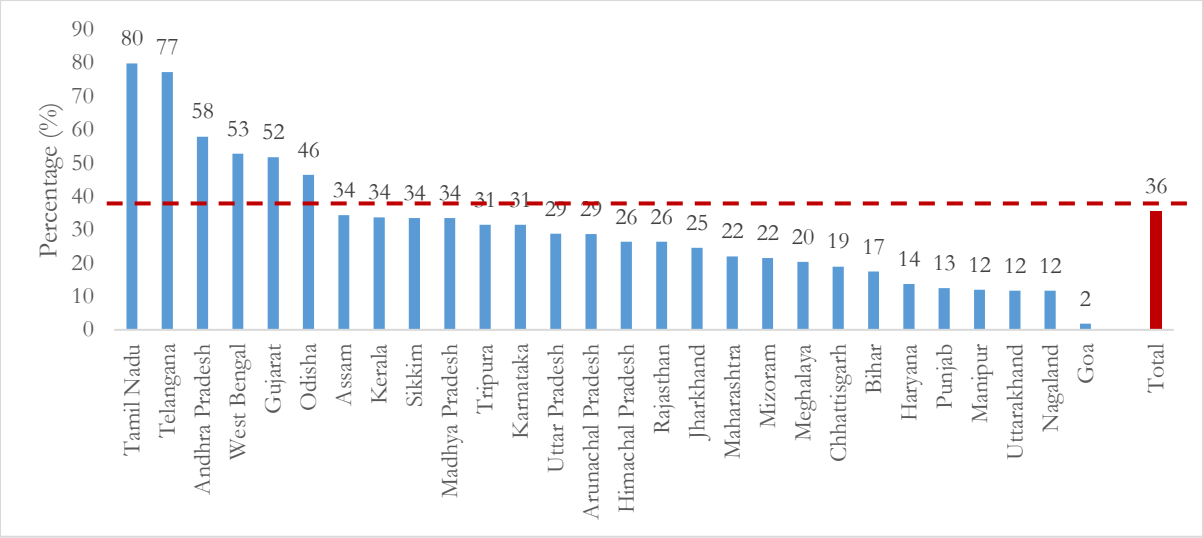


**target units where was work was either completed or in progress as a percentage of total number of target physical units*
Source- NHM-PMS portal, maintained by the Ministry of Health and Family Welfare

A comparison of state-wise fund absorption shows that only six states, viz. Tamil Nadu, Telangana, Andhra Pradesh, Gujarat, West Bengal and Odisha had a utilization rate higher than the all-state average (Figure 5, Appendix Table 17). The two States of Tamil Nadu and Telangana stood ahead of the rest with a utilization rate of 80 and 77 per cent respectively. Similarly, in terms of physical progress, only 9 out of the 28 states had progress better than the all-state average. Again, Telangana, Tamil Nadu and Odisha were significantly ahead of the rest with 96, 90 and 81 per cent progress in physical achievement (Figure 6, Appendix Table 17). **The correlation coefficient between utilization rate and physical progress across States is about 0.8., which indicates that the two dimensions mirror each other**[12]**.**

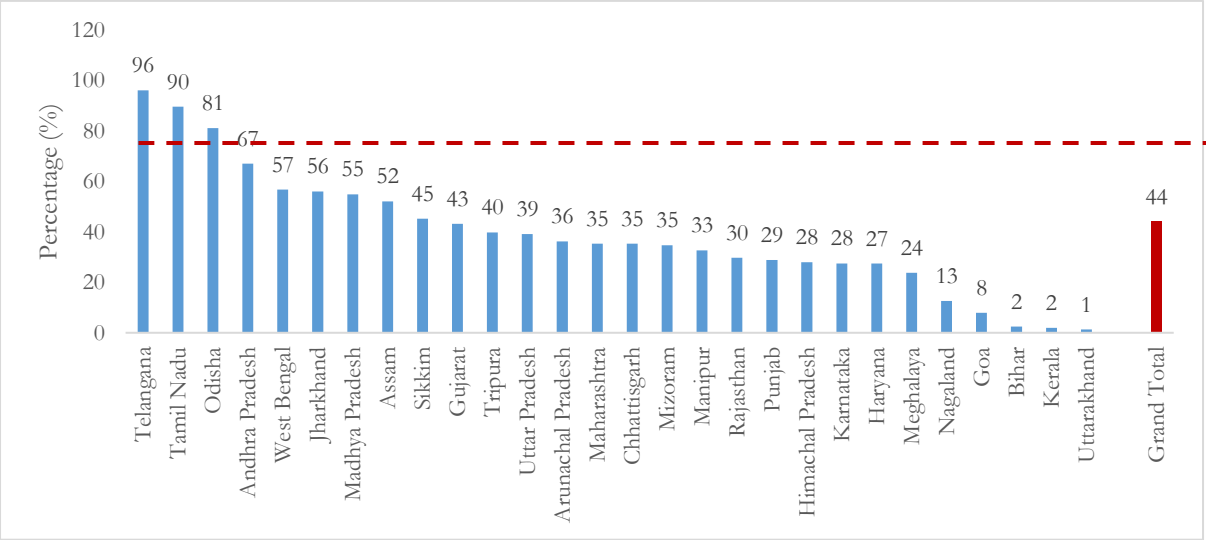
[12] Even when measuring physical progress by the proportion of the total allocated works which stand completed, the correlation coefficient between utilisation rate and physical progress stands at 0.56, again indicating a moderate degree of positive correlation.

Figure 5: State-wise Utilization (Expenditure as a percentage of allocation) in XVth FC Health grant, 2021-22 to 2023-24



Source- Allocation (budget approvals) were based on figures provided by the Ministry of Health and Family Welfare and expenditure figures were sourced from the NHM-PMS portal.

Figure 6: State-wise Physical Progress* in XVth FC Health grant, 2021-22 to 2023-24

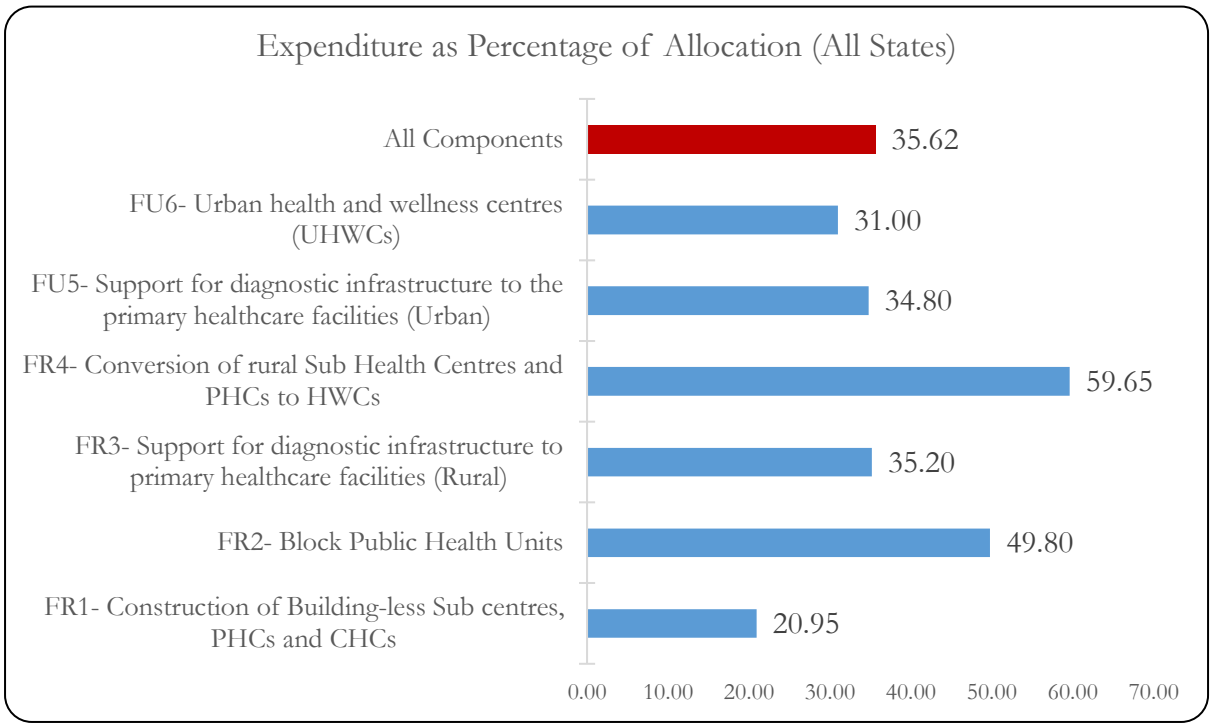


**target units where was work was either completed or in progress as a percentage of total number of target physical units*
Source- NHM-PMS portal, maintained by the Ministry of Health and Family Welfare

A look into the utilization rates of individual components suggests that the absorption of funds was substantially high (60 per cent) in FR4, which provided funds for conversion of Health Sub Centers (SHCs) and Primary Healthcare Centers (PHCs) in rural areas to Health and Wellness Centers (HWCs) (Figure 7). This component mostly involved recurring expenditure in the first two years, which are often better absorbed than capital expenditures. In contrast, the components extending the support for diagnostic infrastructure for primary health care facilities in rural (FR3) and urban (FU5) areas recorded utilization of only around 35 per cent (Figure 7). This could stem from the fact that these components involved some procurement, which entail more complex

processes. The lowest utilization of 21 per cent was in the component of FR1, which provided funds for upgrading building-less SHCs, PHCs and CHCs through construction activities (Figure 5). This is consistent with earlier studies on NHM, which had shown that components involving construction activities have a relatively low utilization rate.[13] The interventions through FR2, FU6 were relatively new and possibly needed more time to pick up pace.

Figure 7: Component-wise utilization in XVth FC Health Grant, 2021-22 to 2023-24



Source- Allocation (budget approvals) were based on figures provided by the Ministry of Health and Family Welfare, and expenditure figures were sourced from the NHM-PMS portal.

A.1 Factors Affecting Aggregate Performance

The utilization of funds is a result of two contributing factors:

A) the extent of releases that could be obtained out of the allocation given to States
B) the volume of funds that could be spent out of the releases made.

Mathematically, the utilization rate can be decomposed into two components:

$$\frac{Expenditure}{Allocation} = \frac{Releases}{Allocation} \times \frac{Expenditure}{Releases}$$

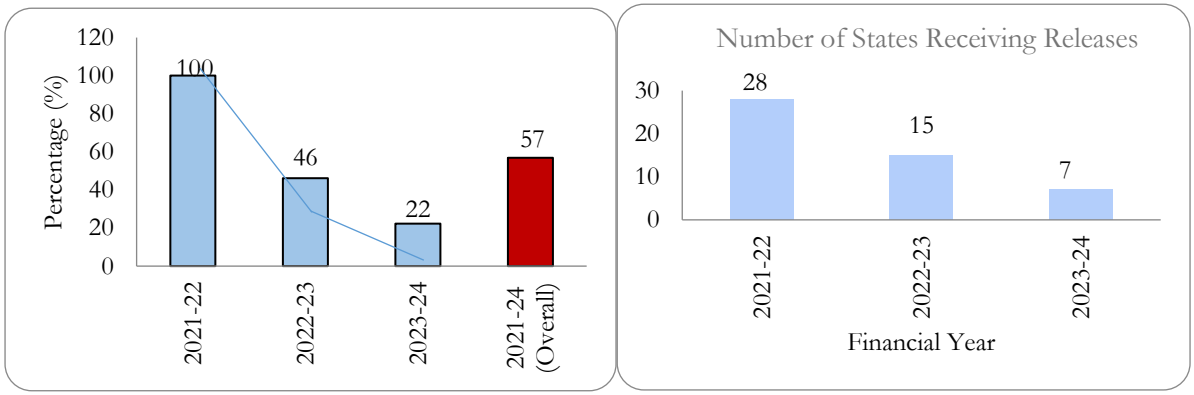
36 %	57 %	63 %

[13] Choudhury and Mohanty (2020), "Role of National Health Mission in Health Spending of States: Achievement and Issues"

A.1.1 Performance in Terms of Releases *vis-a-vis* Allocation

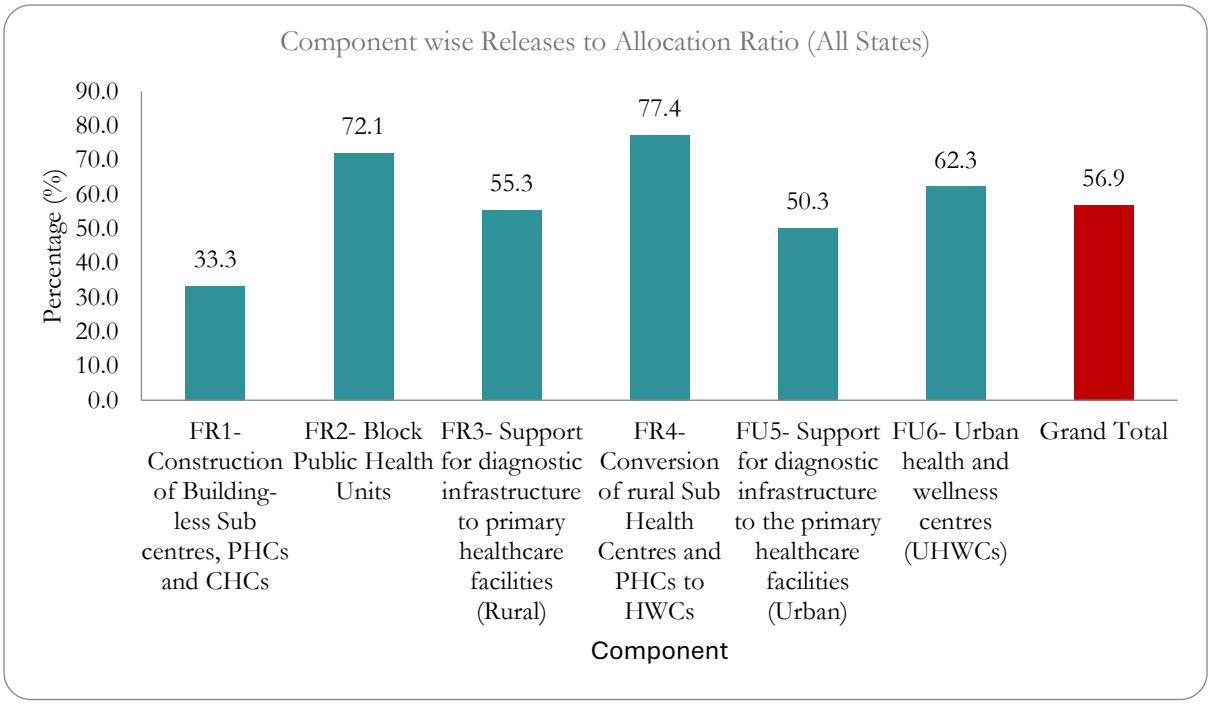
The major factor affecting utilization has been the low share of releases *vis-à-vis* the allocation (approvals) to States. Between 2021-22 and 2023-24, only around 57 per cent of the total allocation of funds to States could be released (Figure 8). Importantly, the share of releases to allocation fell sharply over the years as the number of States that could available releases fell drastically (Figure 8). In the first year 2021-22, releases were unconditional and as such all 28 States received the entire allocation of the year. In subsequent years, releases were conditional on the extent of utilization in the previous year(s) and subject to adherence to guidelines issued by the Ministry of Finance on the mode of transfer of grants in states. These conditions created a situation where the number of States that could obtain releases fell sharply after the first year (Figure 8). In 2022-23, only 15 out of the 28 states could avail releases under the grant. In 2023-24, this figure reduced even further to 7 States. Also, not all States receiving releases could obtain the full allocation for that year (Table 5). In 2022-23, only 8 out of the 15 States receiving releases could avail the full allocation for that year. In 2023-24, only 3 out of the 7 States receiving releases could obtain the full allocation. A component-wise examination indicates relatively low releases in FR1 and FU5, which involved construction activities and support for diagnostic infrastructure (Figure 9).

Figure 8: Releases as a Percentage of Allocation and Number of States Receiving Funds, 2021-22 to 2023-24 (All States)



Source: Figures on approved funds (allocation) and releases of funds were obtained from the Ministry of Health and Family Welfare

Figure 9: Component-wise Releases as a Percentage of Allocation, All States, 2021-22 to 2023-24



Source: Figures on approved funds (allocation) and releases of funds were obtained from the Ministry of Health and Family Welfare

A.1.1.1 Understanding Inter-temporal and Inter-State Variations

Conditionalities for Release of FC Grants

Releases of FC grants after the first year were conditional on two grounds: the utilization of released funds in the past year(s) and adherence to guidelines issued by the Ministry of Finance on the mode of release of funds to nodal departments at the State-level. In 2022-23, the utilization condition for release of grants stated that a minimum of 50 per cent of the funds released in the previous year had to be utilized. In 2023-24, a minimum of 50 per cent of the funds released in 2022-23, and 75 per cent of funds released in 2021-22 had to be utilized to qualify for further releases. These utilization criteria were applicable to each component of the grant separately.[14] The fulfillment of this condition was ascertained based on the expenditure figures reported by States in the NHM-PMS portal.

The second conditionality on the mode of release of funds directed states to transfer funds from the Department of Finance to the Department of Panchayati Raj/Urban Development Department, as local bodies were under the purview of these Departments. An exception was made for FR3, in which the guidelines allowed states to undertake centralized procurement at the state level, and release funds to agencies on the basis of the decision made by the State-level Committee. States were required to submit Grant Transfer Certificate (GTC) for future releases,

[14] Applicability to individual components meant that if a state had less than the required utilization in the previous year in any component due to which it could not receive releases in the current year, it would still be eligible to receive releases in the current year for other components in which it achieved the utilization target.

stating details of past releases. These GTCs were used as the basis of eligibility on the second criterion of release. Additionally, states are also required to transfer the grant to the nodal departments within ten working days of receipt from the Union Government. In case of any delay in transfer of grant to the nodal departments, the concerned State Finance Department was required to transfer the grant amount along with the penal interest for the period of delay.[15] Any violation of these guidelines/directives could result in ineligibility of states to receive further funds under the XV-FC Health Grants.

Releases to Allocation Ratio

A review of the status of current releases and utilization in previous years shows that several states did not receive the grant releases despite meeting the utilization criterion. In 2022-23, of the 13 states with no releases, 7 states had an overall utilization of over 50 per cent in 2021-22 (Table 4, Figure 8). These include Uttar Pradesh, Himachal Pradesh, Assam, Mizoram, Meghalaya, Chhattisgarh and Rajasthan. Similarly, in 2023-24, Sikkim and Gujarat could not obtain any release despite meeting the overall utilization level of 50 per cent in 2022-23 and 75 per cent in 2021-22 (Table 4, Figure 8). In these states, non-adherence to guidelines on mode of transfer of funds at the state-level possibly held back release of funds.

In principle, low utilization and non-adherence to guidelines on mode of transfer of funds on certain components, could still render a state eligible for release in other components in the subsequent year. Notably, in the five states of Maharashtra, Haryana, Manipur, Nagaland and Bihar who had an overall utilization of less than 50 per cent in 2021-22 and did not receive funds in 2022-23, there were components which had utilization above the 50 per cent benchmark in those years (Figure 8 and Table 4). The fact that these states did not receive releases even on those components, point towards the fact that releases were possibly not made due to violation of the transfer guidelines in those States.

In 2022-23, seven states could avail only partial releases (releases less than allocation) (Table 3). These include Jharkhand, Madhya Pradesh, Arunachal Pradesh, Karnataka, Punjab, Sikkim, and Uttarakhand. Of these, Arunachal Pradesh, Karnataka, Punjab, Sikkim and Uttarakhand could obtain less than 50 per cent of their allocations (Table 3). Similarly, in 2023-24, the three states of Karnataka, Kerala, and West Bengal received less than 50 per cent of their allocated grants (Table 3).

[15] This was to be done based on the procedure outlined in circular dated 4 August 2023 issued by the MoH&FW

Table 3: State-wise Releases versus Allocation, All States

State	2021-22		2022-23		2023-24	
	Releases	Releases as percentage of approval (%)	Releases	Releases as percentage of approval (%)	Releases	Releases as percentage of approval (%)
Andhra Pradesh	Yes	100	Yes	100	Yes	100
Arunachal Pradesh	Yes	100	Yes	42	No	0
Assam	Yes	100	No	0	No	0
Bihar	Yes	100	No	0	No	0
Chhattisgarh	Yes	100	No	0	No	0
Goa	Yes	100	No	0	No	0
Gujarat	Yes	100	Yes	100	No	0
Haryana	Yes	100	No	0	No	0
Himachal Pradesh	Yes	100	No	0	No	0
Jharkhand	Yes	100	Yes	98	No	0
Karnataka	Yes	100	Yes	43	Yes	12
Kerala	Yes	100	Yes	100	Yes	31
Madhya Pradesh	Yes	100	Yes	97	No	0
Maharashtra	Yes	100	No	0	No	0
Manipur	Yes	100	No	0	No	0
Meghalaya	Yes	100	No	0	No	0
Mizoram	Yes	100	No	0	No	0
Nagaland	Yes	100	No	0	No	0
Odisha	Yes	100	Yes	100	Yes	100
Punjab	Yes	100	Yes	24	No	0

State	2021-22		2022-23		2023-24	
	Releases	Releases as percentage of approval (%)	Releases	Releases as percentage of approval (%)	Releases	Releases as percentage of approval (%)
Rajasthan	Yes	100	No	0	No	0
Sikkim	Yes	100	Yes	14	No	0
Tamil Nadu	Yes	100	Yes	100	Yes	100
Telangana	Yes	100	Yes	100	Yes	84
Tripura	Yes	100	Yes	100	No	0
Uttar Pradesh	Yes	100	No	0	No	0
Uttarakhand	Yes	100	Yes	22	No	0
West Bengal	Yes	100	Yes	100	Yes	42
Grand Total		**100**		**46**		**22**

Source: Data on approved (allocated) funds and releases of funds were obtained from the Ministry of Health and Family Welfare

Table 4: Utilization of Released Funds in States 2021-22, 2022-23 and 2023-24 and Status of Releases in 2021-22 and 2022-23

State	Utilization of Released Funds in 2021-22 (%)	Received releases in 2022-23	Utilization of Released Funds in 2022-23 (%)	Received releases in 2023-24	Utilization of Released Funds in 2023-24 (%)
Andhra Pradesh	99.7	Yes	76.9	Yes	0.0
Arunachal Pradesh	88.8	Yes	0	No	-
Assam	73.1	No	-	No	-
Bihar	24.5	No	-	No	-
Chhattisgarh	57.5	No	-	No	-
Goa	5.1	No	-	No	-
Gujarat	94.3	Yes	63.3	No	-
Haryana	42.0	No	-	No	-
Himachal Pradesh	79.4	No	-	No	-
Jharkhand	72.4	Yes	2.8	No	-
Karnataka	62.7	Yes	65.9	Yes	39.1

State	Utilization of Released Funds in 2021-22 (%)	Received releases in 2022-23	Utilization of Released Funds in 2022-23 (%)	Received releases in 2023-24	Utilization of Released Funds in 2023-24 (%)
Kerala	71.1	Yes	31	Yes	0.0
Madhya Pradesh	73.6	Yes	29.4	No	-
Maharashtra	42.9	No	-	No	-
Manipur	35.9	No	-	No	-
Meghalaya	62.0	No	-	No	-
Mizoram	65.1	No	-	No	-
Nagaland	31.9	No	-	No	-
Odisha	86.2	Yes	55.2	Yes	0.0
Punjab	38.3	Yes	0	No	-
Rajasthan	55.1	No	-	No	-
Sikkim	81.9	Yes	100	No	-
Tamil Nadu	100	Yes	86	Yes	54.6
Telangana	95.8	Yes	95.1	Yes	45.3
Tripura	74.1	Yes	22	No	-
Uttar Pradesh	87.3	No	-	No	-
Uttarakhand	32.3	Yes	0	No	-
West Bengal	90.3	Yes	65.6	Yes	0.0
All States	**69.1**		**65.6**		**25.2**

Source- Data on releases obtained from the Ministry of Health and Family Welfare and expenditure was sourced from the NHM PMS portal

Figure 10: Past utilization in States, which could not avail releases in 2022-23 or 2023-24

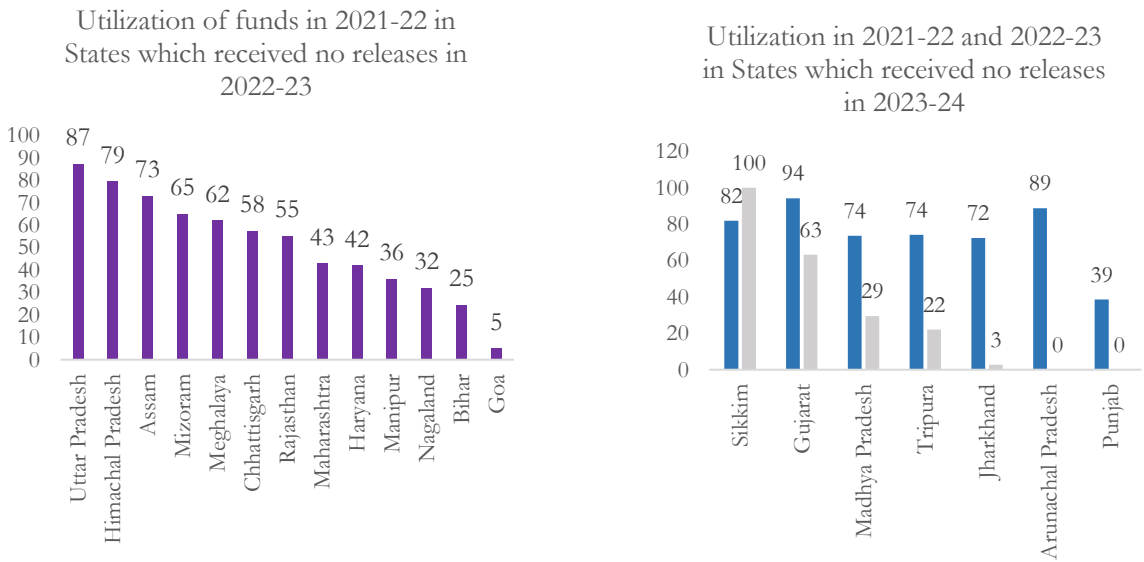


Table 5: Component-wise utilization in 2021-22 in States with no releases in 2022-23

(States with no releases despite meeting utilization target in more than one component)

State	Component	Utilisation (Expend/Releases) (in %) 2021-22	Whether any releases in 2022-23
Maharashtra	FR1	79	No
Maharashtra	FR2	68	No
Maharashtra	FR3	68	No
Maharashtra	FR4	89	No
Maharashtra	FU5	100	No
Maharashtra	FU6	18	No
Manipur	FR1	75	No
Manipur	FR2	39	No
Manipur	FR3	10	No
Manipur	FR4	56	No
Manipur	FU5	0	No
Manipur	FU6	32	No
Haryana	FR1	100	No
Haryana	FR2	61	No
Haryana	FR3	54	No
Haryana	FR4	54	No
Haryana	FU5	96	No
Haryana	FU6	15	No
Nagaland	FR1	0	No
Nagaland	FR2	0	No
Nagaland	FR3	100	No
Nagaland	FR4	97	No
Nagaland	FU5	92	No
Nagaland	FU6	0	No

Note: Highlighted cells indicate those cases where no releases were made despite meeting utilization criterion

Partial releases (less than 50 per cent of approval) seem to arise from three grounds. States like Punjab (in 2022-23), Kerala (in 2023-24) and Karnataka (in both 2022-23 and 2023-24) could avail releases only on those components in which they could meet the utilization criterion and this resulted in partial releases (Table 6). In contrast, possibly due to violation of guidelines, states like Sikkim (in 2022-23) and West Bengal (in 2023-24) could not receive releases on a number of components despite the utilization in those components above 50 per cent (Table 6). In other states like Arunachal Pradesh and Uttarakhand in 2022-23, it was a likely combination of both the facts: less than 50 per cent utilization in some components, and violation of transfer guidelines in some other components (Table 6). This is apparent from the fact that they did not receive releases not only in those components with low utilization, but also in components with good utilization.

Table 6: Component-wise utilization in States with partial releases*

State	Component	Utilisation (Expend/ Releases) (in %) 2021-22	Whether any releases in 2022-23	State	Component	Utilisation (Expend/ Releases) (in %) 2022-23	Whether any releases in 2023-24
Category 1: Partial Releases Due to Low Utilization in Specific Components							
PB	FR1	82	Yes	KL	FR1	0	No
PB	FR2	62	Yes	KL	FR2	68	Yes
PB	FR3	30	No	KL	FR3	60	Yes
PB	FR4	96	Yes	KL	FR4	68	Yes
PB	FU5	18	No	KL	FU5	40	No
PB	FU6	23	Yes	KL	FU6	7	No
KA	FR1	59.9	Yes	KA	FR1	24.6	No
KA	FR2	50.2	Yes	KA	FR2	30.9	No
KA	FR3	45.5	No	KA	FR3	NA	No
KA	FR4	100	Yes	KA	FR4	75.2	Yes
KA	FU5	10.8	No	KA	FU5	NA	No
KA	FU6	40.6	No	KA	FU6	NA	No
Category 2: Partial releases possibly due to non-adherence to guidelines (Non-receipt of Funds in Specific Components Despite Achieving Target Utilization)							
SK	FR1	100	No	WB	FR1	67.7	No
SK	FR2	98.8	No	WB	FR2	88.1	No
SK	FR3	100	Yes	WB	FR3	57.5	Yes
SK	FR4	100.6	No	WB	FR4	72.3	Yes
SK	FU5	101.4	Yes	WB	FU5	52.3	No
SK	FU6	54.2	No	WB	FU6	62.2	No
Category 3: Partial releases possibly due to combination of both low utilization in specific components and non-adherence to guidelines in others							
AR	FR1	100	Yes	UK	FR1	100	Yes
AR	FR2	100	No	UK	FR2	100	Yes
AR	FR3	100	Yes	UK	FR3	83.8	Yes
AR	FR4	100	Yes	UK	FR4	57.1	No
AR	FU5	100	Yes	UK	FU5	81.6	Yes
AR	FU6	0	No	UK	FU6	0	No

**Partial releases are those where the entire allocation could not be released @ Pertain to the year 2022-23;*

Note: PB is Punjab, KA is Karnataka, KL is Kerala, SK is Sikkim, WB is West Bengal, AR is Arunachal Pradesh, UK is Uttarakhand

The entire amount of approval could be obtained as releases by only 8 states in 2022-23 (Table 3). These include Andhra Pradesh, Gujarat, Kerala, Odisha, Tamil Nadu, Telangana, Tripura and West Bengal. Jharkhand and Madhya Pradesh also received close to the full approved amount. In 2023-24, only three states (Tamil Nadu, Andhra Pradesh and Odisha) could avail the entire

approval as releases (Table 3). Telangana was also close with about 84 per cent of the approval received in 2023-24.

Importantly, eight states which received the grants in both the first and second years could not secure grants in the third year (Table 3). Infact, the states of Gujarat, Madhya Pradesh, Jharkhand and Tripura had managed to obtain almost 100 per cent of the allocated grant in the second year (implying they could meet utilization criteria for all the components in the previous year), but could not secure any releases in the third year[16]. In both Jharkhand and Tripura, utilization fell sharply in the second year (2022-23) which led to non-receipt of releases in the third year (2023-24) (Table 4). Even in Madhya Pradesh utilization rates fell sharply in the second year (Table 4). Arunachal Pradesh, Punjab and Uttarakhand have not reported any utilization of funds in 2022-23, which led to no releases in 2023-24 (Table 4).

States that have managed to secure fund releases across the three years under review, the proportion of allocation actually disbursed has declined significantly in Karnataka, Kerala, West Bengal pointing towards a sluggishness in uptake. In Telangana too, there has been a decline in releases in the third year, albeit small.

Table 7: Component-wise utilization in 2021-22 in States with no releases in 2022-23
(States with no releases despite meeting utilization target in more than one component)

State	Component	Utilisation (Expend/ Releases) (in %) 2021-22	Whether any releases in 2022-23	State	Component	Utilisation (Expend/ Releases) (in %) 2022-23	Whether any releases in 2023-24
MH	FR1	79	No	HR	FR1	100	No
MH	FR2	68	No	HR	FR2	61	No
MH	FR3	68	No	HR	FR3	54	No
MH	FR4	89	No	HR	FR4	54	No
MH	FU5	100	No	HR	FU5	96	No
MH	FU6	18	No	HR	FU6	15	No
MN	FR1	75	No	NL	FR1	0	No
MN	FR2	39	No	NL	FR2	0	No
MN	FR3	10	No	NL	FR3	100	No
MN	FR4	56	No	NL	FR4	97	No
MN	FU5	0	No	NL	FU5	92	No
MN	FU6	32	No	NL	FU6	0	No

Note: MH is Maharashtra, HR is Haryana, NL is Nagaland, MN is Manipur

[16] Gujarat later received the instalment for FY 2023-24 in December 2024 and January 2025.

Table 8: Categorisation of states by XV-FC Health Sector grant releases status

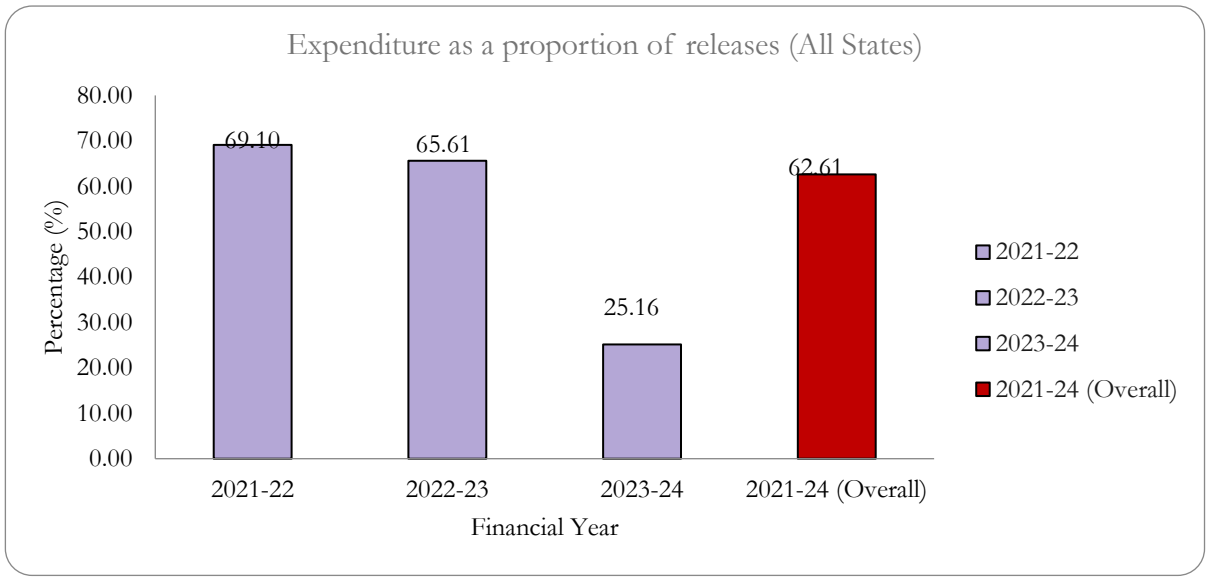
Sr. No.	States which received grant funding only in 2021-22	States which received grant funding only in 2021-22 and 2022-23	States which received grant funding in 2021-22, 2022-23, 2023-24
1.	Assam	Arunachal Pradesh	Andhra Pradesh
2.	Bihar	Gujarat	Karnataka
3.	Chhattisgarh	Jharkhand	Kerala
4.	Goa	Madhya Pradesh	Odisha
5.	Haryana	Punjab	Tamil Nadu
6.	Himachal Pradesh	Sikkim	Telangana
7.	Maharashtra	Tripura	West Bengal
8.	Manipur	Uttarakhand	
9.	Meghalaya		
10.	Mizoram		
11.	Nagaland		
12.	Rajasthan		
13.	Uttar Pradesh		

A.1.2 Performance in Terms of Expenditure *vis-a-vis* Releases

The absorption of funds out of the releases made to States was better than the proportion of releases *vis-à-vis* allocations. On average, between 2021-2024, about 63 per cent of the grant released to States was utilized (Figure 11). A component-wise breakup suggests that utilization was the highest in FR4, which deal with conversion of sub-health centers and PHCs into HWCs in rural areas (Figure 12). The relatively good performance of this component could be partially attributed to the fact that it largely involved recurrent spending. This is unlike other components, which included elements of capital spending and involved more complex processes for execution. The corresponding component in the urban areas FU6, which also included elements of capital spending had lower utilization than this.

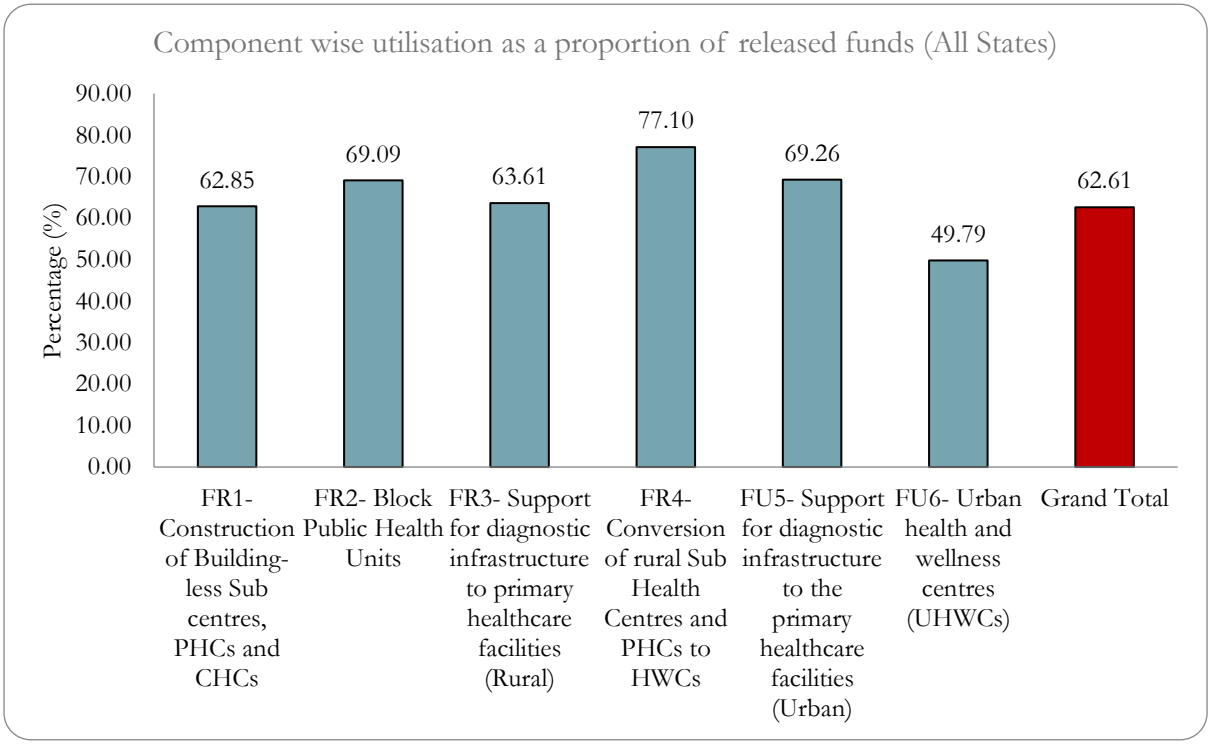
Notably, in the first two years, the aggregate utilization ratios were relatively stable at around 65-69 per cent, but fell sharply to 25 percent in the third year (Figure 11). A further exploration through a component-wise examination of the trend in absorption of releases in the first two years indicates that expenditure to releases ratio was relatively steady in FR1, FR4 and FU5 with each year of progress, but declined steadily in the other three components (Figure 13). The sharp fall in the third year was significant in all the rural components, the steepest fall being in the two components of FR4 and FR1 (Figure 12).

Figure 11: Expenditure as a Proportion of Releases, 2021-22 to 2023-24, All States



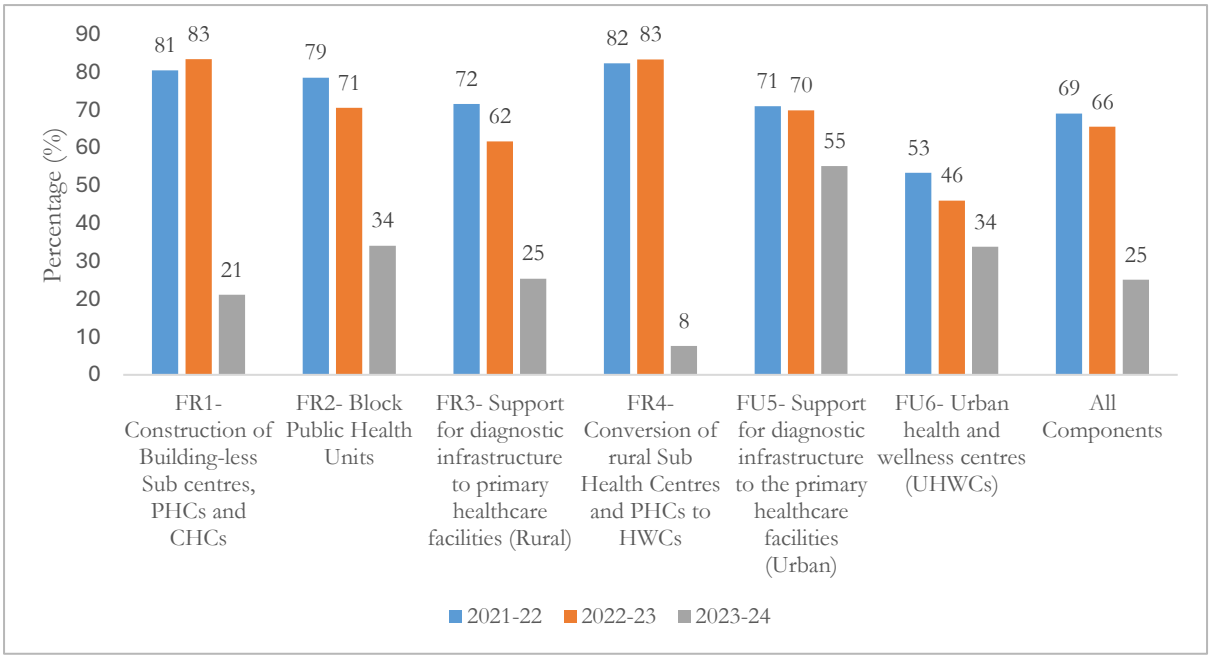
Source: Figures on releases were obtained from the Ministry of Health and Family Welfare. Expenditure figures were extracted from the NHM-PMS portal

Figure 12: Component-wise expenditure as a proportion of released funds, 2021-22 to 2023-24, All States



Source: Figures on releases were obtained from the Ministry of Health and Family Welfare. Expenditure figures were extracted from the NHM-PMS portal

Figure 13: Component-wise Expenditure as a Percentage of Releases, 2021-22 to 2023-24, All States



Source: Figures on releases were obtained from the Ministry of Health and Family Welfare. Expenditure figures were extracted from the NHM-PMS portal

A.1.2.1 Factors Contributing to the Slowing Down of Momentum in Expenditure vis-à-vis Releases

Effect of Directive prohibiting HR expenses on Absorption of Releases

A mid-way policy shift in terms of funding of Human Resources (HR) through the FC grant had a bearing on the sharp fall in utilization of releases in the third year. In the first two years, HR support was being provided through the FC grants in almost all components except FR1 (Table 9). The HR support was particularly prominent in FR4, where more than 90 per cent of use of the grant for PHCs and 73 per cent for SHCs was dedicated to this element. (Table 9). Even in FR2, the recurring expenditure (more than 90 per cent of which was towards HR) had to be charged first before planning for establishing new BPHUs after the first year.[17] This support for provisioning of human resources (remuneration/honorarium/incentives) using the grant funds was disallowed by the National Level Committee since 2023-24.

[17] As per the Operation and Technical guidelines issued by the Ministry of Health and Family Welfare in August 2021.

Table 9: Component wise unit costs from the Technical and Operational Guidelines issued by the Ministry of Health and Family Welfare

Component	Recurring/capital	Unit costs	Break-up of Recurring
FR1- Construction of Building-less Sub Centres, PHCs, CHCs	Only capital	SHC- Rs. 55.5 lakhs PHC- Rs. 1.43 Cr CHC- Rs. 5.75 Cr	Only capital expenditure
FR2- Block Public Health Units	Both capital and recurring	Capital cost- Rs. 80.96 lakhs Recurring cost- Rs. 20.14 lakhs	HR- Rs.18.36 lakhs Non-HR- Rs. 1.78 lakhs
FR3- Support for diagnostic infrastructure to primary healthcare facilities (Rural)	Both capital and recurring	SHC- Rs. 3.91 lakhs PHC- Rs.25.86 lakhs	No break down available
FR4- Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre	Only recurring	SHC- Rs. 7.81 lakhs PHC- Rs. 4.29 lakhs	SHC HR- Rs. 6.7 lakhs SHC non-HR- Rs. 1.1 lakhs PHC HR- Rs. 3.15 lakhs PHC non-HR- Rs. 1.14 lakhs
FU5- Support for diagnostic infrastructure to primary healthcare facilities (Urban)	Both capital and recurring	UPHC- Rs.25.86 lakhs	No break down given
FU6- Urban Health and Wellness Centres (UHWCs)	Both capital and recurring	70 lakhs Polyclinic services- Rs 5 lakhs Capital cost- Rs. 28 lakhs Recurring cost- Rs. 47 lakhs	HR- Rs. 22 lakhs Non-HR- Rs. 53 lakhs

Source: Technical and Operational Guidelines issued by the Ministry of Health and Family Welfare in 2021

The withdrawal for support of HR after the second year led to a significant re-appropriation of funds across different components in the third year. Allocation for the HR intensive component FR4 (which dealt with HWCs in rural areas) was slashed drastically, from about 21 per cent in 2021-22 and 2022-23 to a meagre 4 per cent in 2023-24 (Figure 10). Allocation was also reduced

in the component FU6 which dealt with HWCs in the urban areas: from 31-34 per cent in the first two years to about 21 per cent in 2023-24 (Figure 14). Correspondingly, allocation was enhanced for FR1 (which involved no HR support): from 10-13 per cent in the first two years to a staggering 45 per cent in 2023-24 (Figure 14). The re-appropriation led to a significant deviation of the approvals from those laid out initially in the Technical and Operational guidelines issued by the Ministry of Health and Family Welfare early in 2021 (Table 10).

The re-appropriation and corresponding deviation of 2023-24 approvals from the original allocation structure led to a major disruption. The component FR1 witnessed a fourfold increase in allocation between 2021-22 and 2023-24: from Rs. 1350 Crore to Rs. 5500 Crore. With FR1 primarily intended for construction of building-less sub-centers and PHCs, absorbing such a massive enhancement in allocation was likely to be difficult, particularly as construction expenditures tend to be sticky. This possibly led to the sharp decline in the utilization of releases in this component: from more than 80 per cent in the first two years to around 21 per cent in the third year. Even in some of the best performing states like Tamil Nadu and Telangana, the utilization of this component fell steeply. Interestingly, in FR4, in spite of a substantially lower allocation in 2023-24, the utilization of releases was remarkably low: from more than 80 per cent utilization in the first two years, it fell to less than 10 per cent in 2023-24. Similarly, in components FR2 and FU6, the utilization fell significantly in spite of a contraction in allocation. These are likely to be outcomes of the unexpected changes in the composition of allocation.

Figure 14: Composition of Approved Funds Across Grant Components

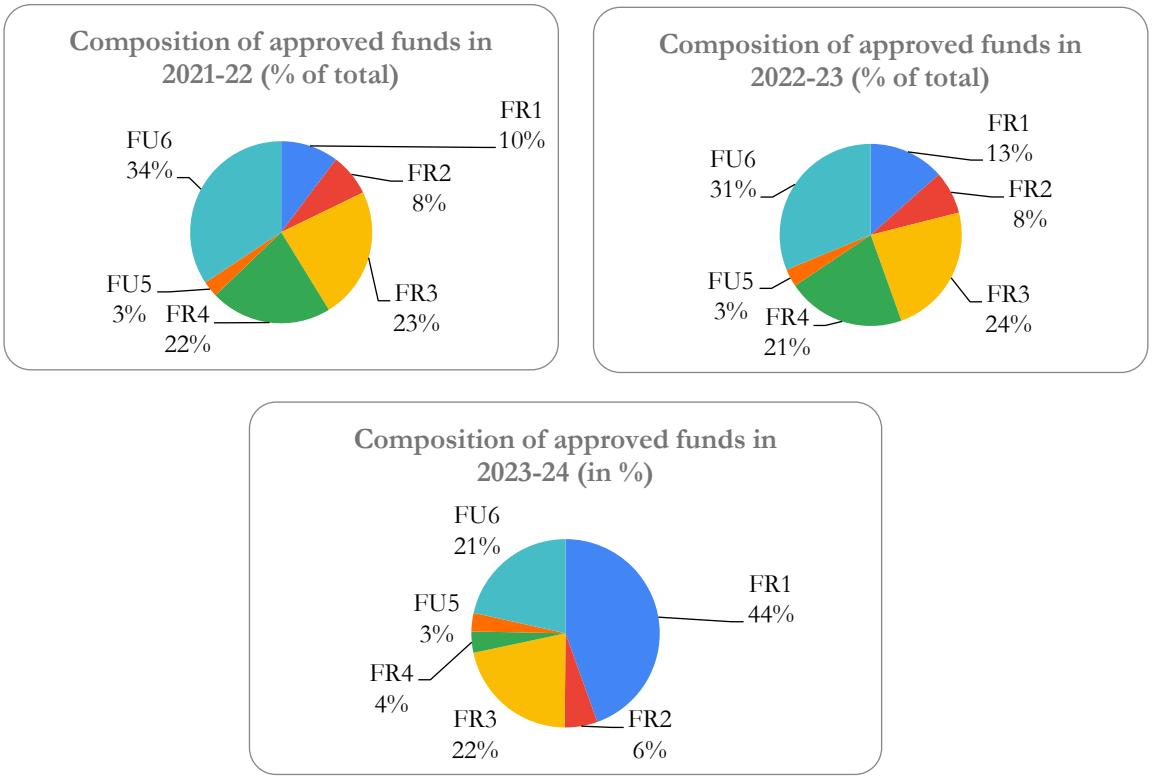


Table 10: Percentage deviation of grant approvals from initial allocation from Technical and Operational Guidelines (TOG) issued by MoH&FW (in crores)

	2021-22			2022-23			2023-24		
Component	**Allocation as per TOG**	**Approval by Ministry**	**Percent deviation**	**Allocation as per TOG**	**Approval by Ministry**	**Percent deviation**	**Allocation as per TOG**	**Approval by Ministry**	**Percent deviation**
FR1	1350	1350	0	1350	1742	29	1417	5516	289
FR2	994	990	0	994	986	-1	1044	696	-33
FR3	3084	3080	0	3084	3045	-1	3238	2668	-18
FR4	2845	2842	0	2845	2729	-4	2986	451	-85
FU5	394	375	-5	394	411	4	415	394	-5
FU6	4525	4510	0	4525	4050	-10	4751	2665	-44

Lag in Releases Due to Complex Grant Design led to Trailing Expenditures

The complex institutional structure for implementation of the grant led to significant lags in fund releases. As per the recommendations of the Finance Commission, an institutional structure had to be put in place before operationalizing the grant, which included constituting a National-level Committee, State-level committees and district-level committees. Also, detailed technical and operational guidelines had to be issued by both the Ministry of Finance and the Ministry of Health and Family Welfare as it involved local bodies and multiple components of spending coordinated across several departments in states. Setting up the operational architecture consumed time, which resulted in a situation where the grants for 2021-22 could be released only in November 2021 (Figure 15).[18] In fact, for six states (Maharashtra, Haryana, Andhra Pradesh, Rajasthan, Kerala, Jharkhand) supplementary proposals for the year 2021-22 were approved in March 2022 and July 2022 (next year) by the NLC.[19] Revised proposals for 2021-22 were also received from four other states (Assam, Gujarat, Maharashtra and Uttar Pradesh) and approved in July 2022 by the NLC. [20] The lag in approvals and releases for 2021-22 combined with the initial inertia of utilization probably induced a lag in fund releases in the next year 2022-23. For the year 2022-23, although the approval of state proposals of seventeen states came about in March 2022 and another nine states in July 2022, no funds were released till September 2022 (Figure 15). About 77 per cent of the releases could be made only in March 2023: 7-11 months after the approvals were made (Figure 15). Releases in 2022-23 were conditional on 50 per cent utilization of the grants released in the previous year 2021-22, and this is likely to have affected the timeline of fund releases. Additionally, as in the first year, revised/re-appropriation/supplementary proposals for 2022-23 for five states (Jharkhand, Odisha, Uttar Pradesh, Telangana and West Bengal) could be approved only in March 2023.[21] For 2023-24, although 20 states received approval of their proposals as early as March 2023, only about 34 per cent of the combined approval for 20 states could be released till January

[18] Approvals for these were accorded in the First and Second meeting of the National Level Committee (NLC) held on 8th October and 2nd November 2021

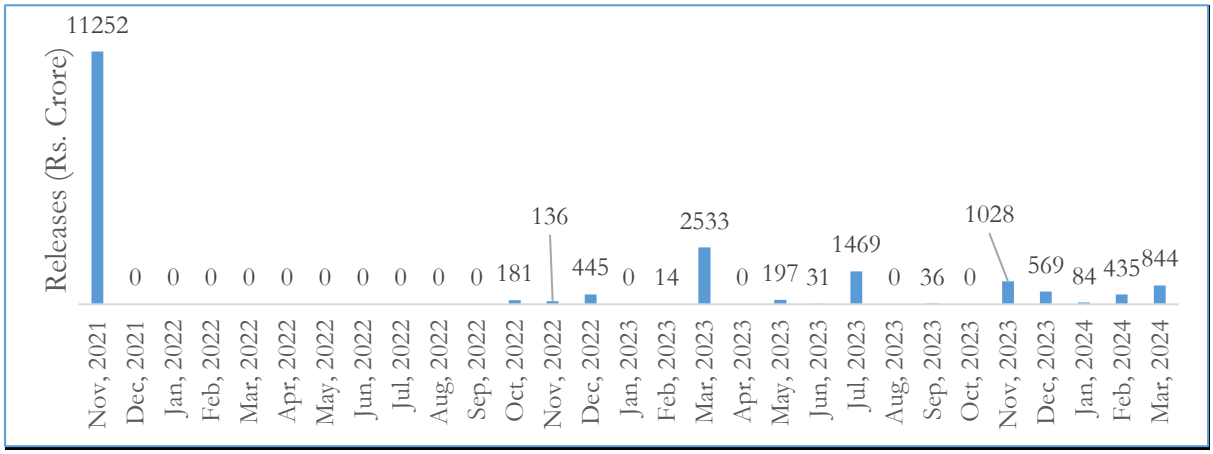
[19] Record of Deliberations of the Third and Fourth meetings of the National Level Committee (NLC) held on 16th March and 11th July 2022

[20] Record of Deliberations of the Fourth meeting of the National Level Committee (NLC) held on 11th July

[21] Record of Deliberations of the Fifth meeting of the National Level Committee (NLC) held on 29th March 2023

2024. This again could be partially driven by the lag in releases in previous years leading to trailing utilization and pending achievement of the utilization benchmark required to be eligible for further releases.

Figure 15: Month-wise Releases of the XVth FC Health grant, 2021-22 to 2023-24



Source: Ministry of Finance, available at https://doe.gov.in/monthly-summary-report

An important factor affecting the drag in utilization was also the tied nature of the XVth FC grants. A review of the record of deliberations of NLC meetings indicates that several states faced difficulties in aligning the tied grant components to their health sector needs, and this is reflected in repeated submissions and requests by the states for allowing flexibility in re-appropriation of funds across components.[22] States like Kerala and Andhra Pradesh, which have relatively better health systems requested for reducing funds for constructing building-less SHCs and PHCs, and allow re-appropriation of funds to other components. Similarly, States like Rajasthan, Odisha, Bihar and Tamil Nadu did not have adequate SHCs and PHCs for utilizing funds under the component Conversion of SHCs and PHCs to HWCs.[23] Special provisions had to be made by NLC for use of the funds in these components. Also, the mismatch between the tied grant components and the state-level needs led to revisions of proposals and re-appropriations, which contributed to the drag in approvals, releases and subsequent utilization.

B. Performance of PM-ABHIM and the Role of XVth FC Grants

The Operational Guidelines of PM-ABHIM suggests that three specific target areas were overlapping between the FC grants and the PM-ABHIM: infrastructure support to building-less SHCs to HWCs in rural areas, HWCs in urban areas and BPHUs. Considering this overlap, the FC grants were used as a supplementary source of funds for these components under PM-ABHIM (Table 11). In the first two components related to HWCs, the FC grants were expected to cover around 60 per cent of the resource envelope. In the remaining States, a combination of the FC grants and NHM resources was to be used to fund this component. In the third overlapping component dealing with BPHUs, the FC grants were meant to cover about a third (35 per cent) of the resource envelope in 11 High-focus States[24], and the entire financial requirement in the

[22] Documented in the Record of Deliberations (RoDs) in these meetings
[23] Record of Deliberations of the First meeting of National Level Committee (NLC) held on 8^{h} October 2021
[24] Table 9

remaining states. Thus, the FC grants had a significant role in implementation of certain components in PM-ABHIM, and to that extent, the performance of the FC grants for these components were critical for realizing the success of PM-ABHIM.

Table 11: Resource envelope for CSS components of PM-ABHIM

S. No.	Component	Central Share	State Share	15th FC Share	Grand Total (Rs. Crore)
1	AB-HWCs in rural areas in seven High Focus States and three NE States - Infrastructure of 17788 rural AB-HWCs*	26	15	59	9872.7
2	AB-HWCs in urban areas (11,024 urban HWCs)	24	15	61	19955.2
3	Block Public Health Units (BPHUs) in 11 High Focus States/UTs – 3382 BPHUs**	45	20	35	3829.52
4	Integrated Public Health Labs (IPHLs) in all the Districts	67	33	0	1482.6
5	Critical Care Hospital Blocks (CCB) in the districts	63	37	0	19064.8
Total		41	24	36	54204.8

*Ten States covered under Infrastructure support to Building-less SHCs are Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal and three NE States viz. Assam, Manipur and Meghalaya

** 11 High Focus States/UTs covered under BPHUs are Assam, Bihar, Chhattisgarh, Himachal Pradesh, UT-Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand.

Source- Operational Guidelines for PM-ABHIM

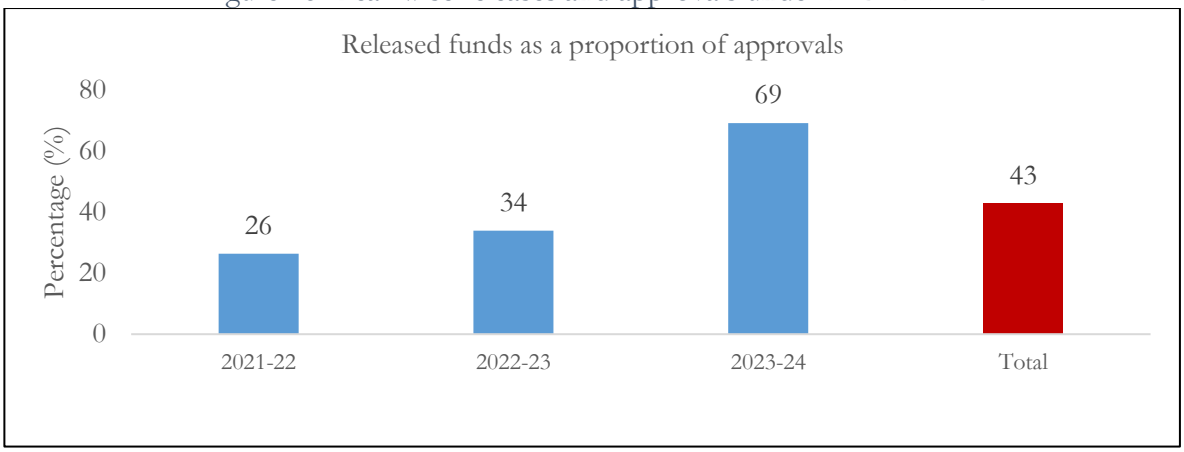
B.1 Aggregate Trends in Performance of PM-ABHIM

B.1.1 Financial Progress

The scheme-level performance of PM-ABHIM has been better than the XVth FC grants. Over the three-year period 2021-22 to 2023-24, performance of PM-ABHIM in terms of releases as a proportion of approvals (allocation) has been around 45 percent, which is higher than the corresponding figures of FC grants (Figure 16).[25] The proportion has also been increasing (improving) each year: from about 26 per cent in 2021-22 to about 69 per cent in 2023-24 (Figure 16). This is unlike the FC grants, where the ratio has steadily declined (worsened) in the same period.

[25] The total release for a state is imputed by assuming that that given central share constitutes 60% (90% in case of hilly and north-eastern states and 100% for Union Territories) of the total releases for that state.

Figure 16: Year-wise releases and approvals under PM-ABHIM



Source: Ministry of Health and Family Welfare (MoHFW)

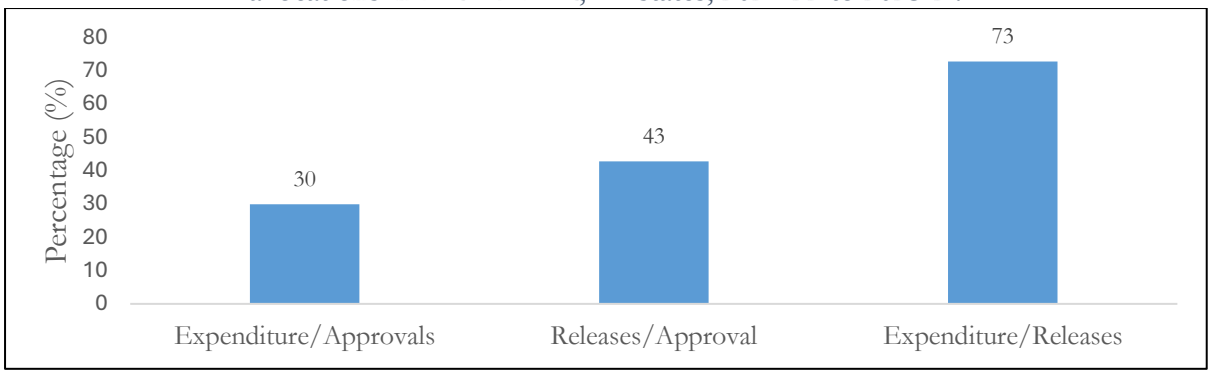
The performance of PM-ABHIM in terms of utilization (expenditures as a proportion of approvals) has been relatively low (around 30 per cent) over the 3-year period 2021-22 to 2023-24. The utilization has been dragged down more strongly by low releases than expenditures. Figure 17 indicates that less than half the approved allocations (43 per cent) could actually be released to states. However, once released to states, about 73 per cent of the releases were spent.[2627]

A comparison of the financial performance of specific components funded through the FC grants as compared to other sources of funding in PM-ABHIM can throw interesting insights on the effectiveness of the implementation of the FC grants. However, these call for information on disaggregated component-wise expenditures, which are unavailable.

A state-wise examination of the proportion of releases to approvals indicate that Tamil Nadu and Odisha are among the forerunners followed by Madhya Pradesh and Jharkhand (Figure 18). Among the north-eastern states, Tripura is ahead of the rest followed by Meghalaya, Manipur and Nagaland (Figure 18). In terms of the proportion of releases spent, Jharkhand and Odisha have been the top performers followed by West Bengal, Kerala, Telangana and Tamil Nadu (Figure 19). Overall, the states of Tamil Nadu and Odisha seem to be the best performers followed by Jharkhand and Madhya Pradesh in terms of fund absorption (expenditure as a proportion of approvals) (Figure 20). Among the north-eastern and hilly states, Manipur and Tripura stand ahead of others.[28]

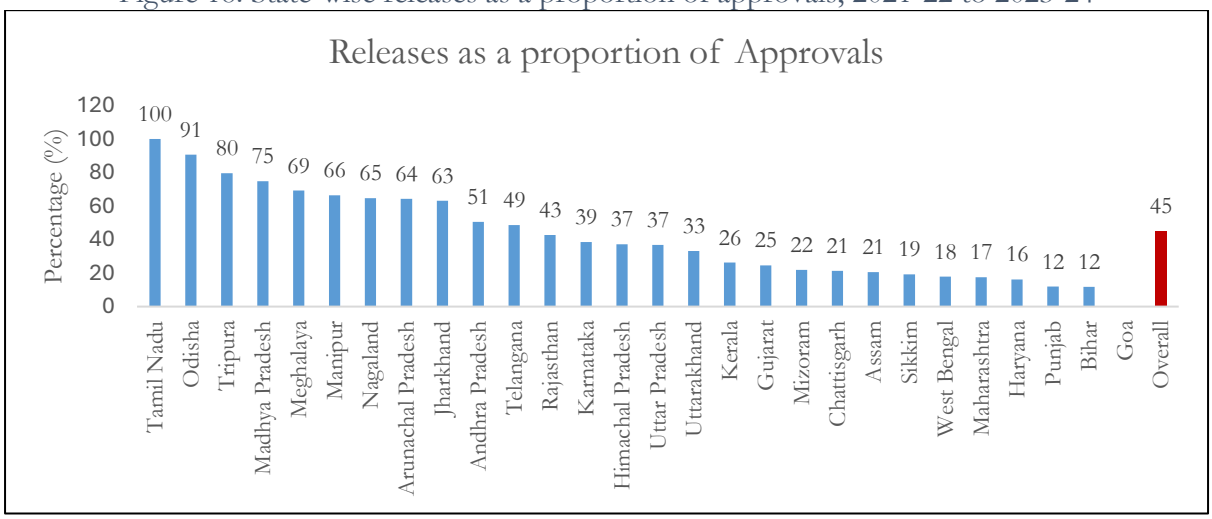
[26] Releases to approval ratio is likely to be biased upwards as the figures for Tamil Nadu and Manipur for the year 2023-24 turn out to be more than 200 per cent as per the figures of Central releases reported by MoHFW.
[27] We refrain from using year-wise comparison of expenditure figures for now as there are some inconsistencies in the data. In states like Jharkhand Odisha and Meghalaya, the reported expenditures exceed both the imputed releases and approvals in 2023-24.
[28] In Figure 14 and Figure 16, the ratio for Tamil Nadu exceeded 100. It has been pegged to 100 for now. Data inconsistencies need to be checked. Same was the case for Jharkhand in Figure 15.

Figure 17: Share of releases made out of allocations, expenditures incurred out of releases and allocations in PM-ABHIM, All states, 2021-22 to 2023-24



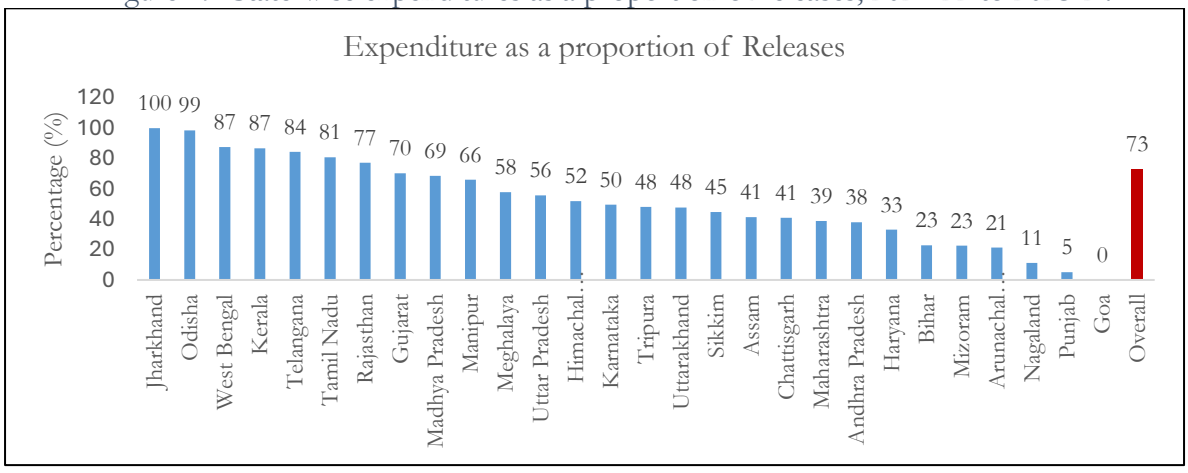
Source: Ministry of Health and Family Welfare (MoHFW)

Figure 18: State-wise releases as a proportion of approvals, 2021-22 to 2023-24



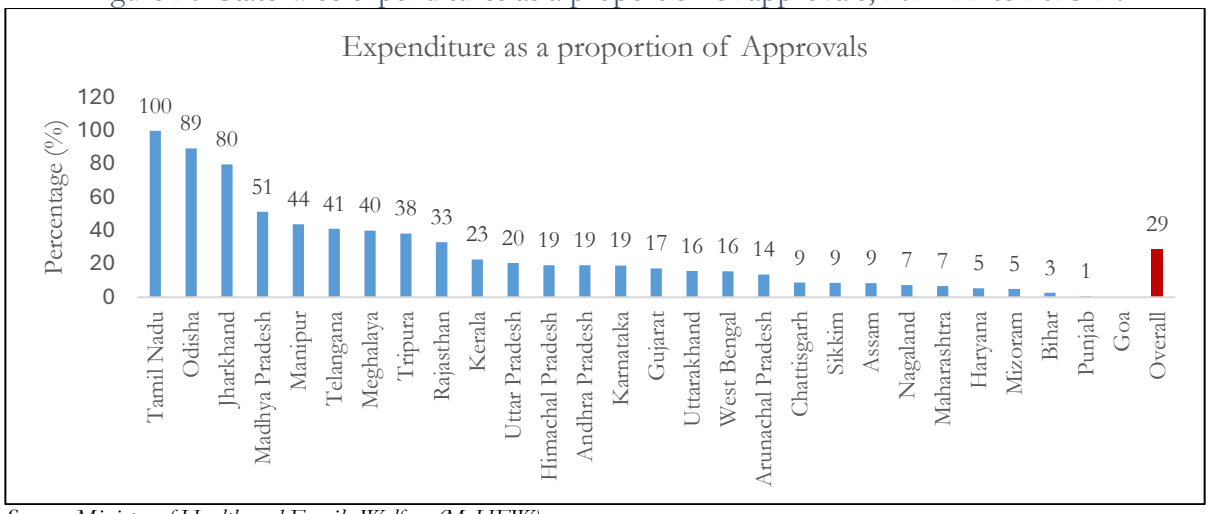
Source: Ministry of Health and Family Welfare (MoHFW)

Figure 19: State-wise expenditures as a proportion of releases, 2021-22 to 2023-24



Source: Ministry of Health and Family Welfare (MoHFW)

Figure 20: State-wise expenditures as a proportion of approvals, 2021-22 to 2023-24



Source: Ministry of Health and Family Welfare (MoHFW)

B.1.2 Physical Progress

The relative progress in physical units targeted under PM-ABHIM and the FC grants in common target areas can provide some understanding of the comparative performance of the two. However, such a comparison need to be treated and read with caution as there are marked differences in the nature of funding of the two. First, in components like rural HWCs, and BPHUs, only a few states received funding under PM-ABHIM, unlike the FC grants, which were available to all states. Secondly, financial support for certain components like rural HWCs was available only for the first two years 2021-22 and 2022-23 under PM-ABHIM, whereas the FC grants provided funds to all states. Thirdly, in components like urban HWCs, different states received allocation under PM-ABHIM in different years, while in contrast, all states received approvals under the FC grants in each year. Fourthly, support for human resources was provided under the FC grants only in the first two years, while in PM-ABHIM this support was extended for the entire duration of the scheme. Lastly, information on physical progress under the XVth FC grants have been sourced from the NHM-PMS portal, which shows no progress for components in certain states and years. This could be a consequence of non-updating of data as opposed to the actual progress.

Component 1: Infrastructure support to Rural HWCs

In the HWC component for rural areas, a comparison of physical progress in the units targeted under the XVth FC grants and through other sources under PM-ABHIM is possible in only the set of common states and the common years. In the first year, physical progress in units funded through the XVth FC grants was better, as work was started in most of the units (Table 12). In the 2nd year, as certain states could not avail the XVth FC grants, the progress in the units funded by other sources under PM-ABHIM was better.[29][30]

[29] Rajasthan and Bihar did not receive the FC grants in 2022-23. The physical progress is likely to be erroneously reported.

[30] As earlier, physical progress is measured by the number if physical units where work has either started or completed as a percentage of the total target (allocated) units in that year.

Table 12: State-wise Physical Progress in the component of Rural HWCs in the targeted units funded from XVth FC grants and other source of funds in PM-ABHIM

	2021-22				2022-23			
	XV-FC Health Grants		PM-ABHIM		XV-FC Health Grants		PM-ABHIM	
State	**Proportion of allocated units where work started (%)**	**Proportion of allocated units where work is completed (%)**	**Proportion of approved units where work started (%)**	**Proportion of total approved where work is completed (%)**	**Proportion of allocated units where work started (%)**	**Proportion of allocated units where work is completed (%)**	**Proportion of approved units where work started (%)**	**Proportion of total approved where work is completed (%)**
Assam	83	28	72	8	100	0	68	8
Bihar	76	47	18	6	32	15	0	0
Jharkhand	99	57	34	65	27	0	54	41
Manipur	100	25	34	66			100	0
Meghalaya	0	0	33	67			68	0
Odisha	92	1	79	11	81	17	69	15
Rajasthan	82	71	10	69	87	52	11	63
Uttar P	100	0	22	71			20	73
All	**91**		**68**		**22**		**57**	

Source: Ministry of Health and Family Welfare (MoHFW)

Component 2: Infrastructure support to Urban HWCs

In the component of Urban HWCs, the only metric available to measure physical progress under PM-ABHIM is the number of operationalized units. For the purpose of comparison with the XVth FC grants, we use the corresponding number of completed units using these grants as reported in the NHM-PMS portal (Table 13). Table 13 illustrates the issues in deriving a comparative picture between the PM-ABHIM and the XV-FC Health Grant. In 2021-22, only a single state received funds under PM-ABHIM. In subsequent years, while Himachal Pradesh, Mizoram, Rajasthan and Uttar Pradesh did not receive funds under the XVth FC, states like Odisha, Tamil Nadu and Telangana did not have any allocations from PM-ABHIM. The only instances of valid comparison emerge from the states of Karnataka and Andhra Pradesh, which received funding from both sources for this component in FY 2022-23. The two states, however, depict a divergent scenario.

Table 13: State-wise Physical Progress in the targeted units in the component of Urban HWCs funded from XVth FC grants and other source of funds in PM-ABHIM

	2021-22		2022-23		2023-24	
	XV-FC Health Grant	PM-ABHIM	XV-FC Health Grant	PM-ABHIM	XV-FC Health Grant	PM-ABHIM
State	Proportion of total units where work is completed (%)	Proportion of operationalised units (%)	Proportion of total units where work is completed (%)	Proportion of operationalised units (%)	Proportion of total units where work is completed (%)	Proportion of operationalised units (%)
Andhra P	100		50.00	100		100
Gujarat	100		51.98			
Himachal	0	100		100		81
Karnataka	100		97.55	63		91
Mizoram	0					
Odisha	0		0.00			
Rajasthan	64		39.68	51		38
Tamil N	100		68.04		0	
Telangana	100		90.89			92
Uttar P	0					
West B	0		0.00			

Note- Blank cells under PMABHIM indicate no allocations to the state for that year. Blank cells under XV-FC Health Grant correspond to no allocations/releases or no physical progress reported for that state in that particular year.

Component 3: Physical Progress under BPHUs

Table 14: State-wise Physical Progress in the targeted units in the component of Block Public Health Units (BPHUs) funded from XVth FC grants and other source of funds in PM-ABHIM

	2021-22				2022-23			
	XV-FC Health Grants		PM-ABHIM		XV-FC Health Grants		PM-ABHIM	
State	Proportion of allocated units where work started (%)	Proportion of allocated units where work is completed (%)	Proportion of approved units where work started (%)	Proportion of total approved where work is completed (%)	Proportion of allocated units where work started (%)	Proportion of allocated units where work is completed (%)	Proportion of approved units where work started (%)	Proportion of total approved where work is completed (%)
Assam	71	29	100	63	43	0	100	59
Bihar	0	0					0	0
Chhattisgh	100	76			7	0	94	50
Himachal	100	0	100	0			100	0
Jharkhand	100	0			162*	0	97	48
Madhya P	49	1			50	0	100	89
Odisha	100	3			43	0	91	20
Rajasthan	91	54			29	16	100	79
Uttar Pr	100	0					93	79
Uttarakhand	100	100	100	71			88	76

** Data need to be corrected.*

Note- Blank cells under PMABHIM indicate no allocations to the state for that year. Blank cells under XV-FC Health Grant correspond to no allocations/releases or no physical progress reported for that state in that particular year.

Table 14 shows the comparison of physical progress for the component of BPHU, under the XV-FC Health Grants vis-a-vis PMABHIM.[31] As different states receive funding under PM-ABHIM in different years, only a few states are actually available for comparison. There are indications that units targeted under PM-ABHIM had a better progress than the target units under XVth FC health grants.[32]

[31] 2023-24 has not been considered since the physical progress data are missing for all these states allocations towards BPHU under the XV-FC Health Grant.

[32] Rajasthan and Chhattisgarh did not receive any XV-FC Health grant releases in FY 2022-23, yet they reported physical progress. This is likely to due to error in reporting.

Appendix to Chapter 2

Data Notes

Regarding the XV-FC Health Grants- While the data for the utilisation and physical progress under the XV-FC Health Grants is sourced from the NHM PMS portal, releases and allocations for the same have been sourced from the MoH&FW. Analysis of the data from the PMS portal has brought forth some aspects of this data which might potentially impact the interpretation of the given analyses. The following section highlights some of these issues which warrant clarification-

Utilisation of funds sourced from the NHM PMS portal

- It was found that the utilisation of funds for certain states for components where they actually received releases in that particular year was missing. This was particularly the case, where the state had not received the next years' funding. For instance, the states of Uttarakhand, Arunachal Pradesh and Punjab have not reported utilization or physical progress for funds released in 2022-23. West Bengal, Odisha, Andhra Pradesh and Kerala have not reported the utilization of funds released during 2023-24.

- It should be noted that these missing values impact both the reported state level and all India utilisation ratios. Consequently, since the pattern of these missing values differs not just across states but even over time for a particular state, this also impacts the observed time trend in the utilisation rate.

- At the same time, instances of non-zero utilisation and physical progress was also noted in the case of states which had not received any releases in that particular year. For example, the data shows positive fund utilisation and physical progress for all components for the state of Rajasthan for the year 2022-23, when it actually did not receive any releases. If this is attributable to states booking expenditures for funds released in the previous year to the current year and if such practice is widespread, then it has implications for the interpretation of year wise reported utilisation ratios.

2. *Interpretation of physical progress (sourced from the NHM PMS portal) aggregated across components*

- The measure of physical progress essentially aggregates the units where work is in progress across different components of the Health Grant. Implicit in this aggregation is the notion of equal weightage to physical achievement for units across all components, which is likely to not hold in actuality. For instance, the physical progress in a component requiring capital expenditure is likely to be lower than in a component that is mostly recurring expenditure. Therefore, it should be borne in mind that it is a composite of units that are not exactly the same.

- Even considering the above point, such an aggregation of physical progress might have been acceptable for comparison had the weightage of each component in all states' allocation been the same. This, however, is not the case. For instance, while Bihar was allocated almost 29% of the first three years funding towards construction of

buildingless SHCs, PHCs and CHCs, the corresponding allocation to Tamil Nadu was only 18%. This potentially makes comparisons of aggregate physical progress untenable across states.

- One might argue that, in this case we can compare component wise physical progress across states. However, this would be fraught with two issues-

  (a) Potential inconsistencies in reports of physical progress- Example is the state of Kerala which reports zero physical progress for components FR4, FU5 and FU6 in 2021-22 in spite of robust utilization of allocated funds.

  (b) As shown in the main analysis, there is a smaller set of states that received releases in every subsequent year after FY 2021-22. Aggregating physical progress over years for a component would assume that the marginal efficiency of additional rupee of spending stays constant, which might be inaccurate. To understand this, consider two states A and B, each allocated Rs. 1 crore for construction of buildingless SHCs in the first year, where they were required to set up 100 units and could achieve that target. Now in the second year, only state A got releases for this component whereas B did not. State A was to target another 100 units in the second year, however due to stickiness in further capital works, it could only meet 70% of the target. Now, if we measure the rate of physical progress, it would be higher for state B, however for all purposes, we would like state A to show up as the better performer.

Regarding the PM-ABHIM- The data on the releases, expenditures and physical progress is sourced from the MoH&FW. The following concerns came to the fore with extended analysis of the data-

1. *Imputed total releases exceeding approvals-*

   - The total release for a state was imputed by assuming that that given central share constitutes 60% (90% in case of hilly and north-eastern states and 100% for Union Territories) of the total releases for that state. The resulting total releases exceeded 100% of the total approvals by a significant margin for certain states in certain years. For instance, the imputed total releases for the state of Tamil Nadu for FY 2023-24 came out at a staggering 215% of the total approvals for that year.

2. *Expenditures exceeding total imputed releases-*

   - The reported expenditures include the central share, the state share as well as unspent balances at the beginning of the year. In this case, if the reported approvals are inclusive of unspent balances, along with the releases, then this poses no issues to the analysis

   - However, if the given approvals are not inclusive of the unspent balances, this creates issues with ascribing the reported expenditures in a year to the releases or

approvals for that year, since there exists a possibility that the expenses pertain to previous year releases.

- It was found that for states like Jharkhand, Odisha and Meghalaya in FY 2023-24, the reported expenditure exceeds both the imputed total releases and approvals, by a significant amount. This raises concerns as to whether the reported expenditures in a particular year are being accurately attributed to the releases for that year and therefore, needs to be borne in mind while examining the observed aggregate and state wise trends in utilization.

Data Tables

Table 15: Aggregate Analysis: Financial Approvals, Releases and Utilisation

Financial Year	Fund utilisation (in lakhs)	Approved funds (in lakhs)	Released funds (in lakhs)	Utilisation as proportion of allocation (in %)	Releases as a proportion of allocation (in %)	Utilisation as a proportion of releases (in %)
2021-22	909030.38	1314637.13	1315434.13	69.15	100.06	69.10
2022-23	392678.81	1296491.63	598520.06	30.29	46.16	65.61
2023-24	69523.23	1239020.25	276329.19	5.61	22.30	25.16
Total	1371232.42	3850149.00	2190283.38	35.62	56.89	62.61

Source- Data on approved funds and release funds provided by the Ministry of Health and Family Welfare. Utilisation figures were sourced from the NHM-PMS portal.

Table 16: Aggregate Analysis: Physical Progress

Financial Year	Allocated Quantity	MappedQuantity	ProgressNot Started	ProgressWiP	ProgressCompleted	Progress not started (% of allocated)	Work in progress (% of allocated)	Completed work (% of allocated)	Unmapped works (% of allocated)
2021-22	303573	284287	53735	108418	122134	17.7	35.7	40.2	6.4
2022-23	294510	236110	110724	80381	45005	37.6	27.3	15.3	19.8
2023-24	270458	144206	116917	21326	5963	43.2	7.9	2.2	46.7
Total	868541	664603	281376	210125	173102	32.4	24.2	19.9	23.5

Source NHM PMS portal

Table 17: Aggregate Analysis – State Wise Financial and Physical Progress

State	Fund utilisation (in lakhs)	Approved/Allocated funds (in lakhs)	Utilisation as a proportion of allocated funds (in %)	Total allocated works quantity	Total works completed or in progress	Physical progress as percentage of allocated works (in %)
Andhra Pradesh	86417	149322	57.87	46364	31107	67.09
Arunachal Pradesh	4170	14510	28.74	2905	1052	36.21
Assam	28413	82766	34.33	29982	15612	52.07
Bihar	38949	223427	17.43	31508	782	2.48
Chhattisgarh	19482	102764	18.96	24734	8734	35.31
Goa	159	8782	1.81	351	28	7.98
Gujarat	99153	191848	51.68	64775	27983	43.20
Haryana	12782	92890	13.76	15938	4377	27.46
Himachal Pradesh	7787	29518	26.38	4313	1206	27.96
Jharkhand	33374	135562	24.62	17766	9964	56.08
Karnataka	52862	168188	31.43	48755	13422	27.53
Kerala	57016	169474	33.64	47455	938	1.98
Madhya Pradesh	93981	280487	33.51	46786	25689	54.91
Maharashtra	85389	387900	22.01	91903	32471	35.33
Manipur	1541	12869	11.98	1006	329	32.70
Meghalaya	3638	17866	20.36	2102	500	23.79
Mizoram	2031	9444	21.50	1659	576	34.72
Nagaland	1818	15548	11.69	1688	214	12.68
Odisha	65251	140640	46.40	48208	39130	81.17
Punjab	15292	122234	12.51	19995	5777	28.89
Rajasthan	66035	250491	26.36	78624	23388	29.75
Sikkim	2089	6232	33.52	720	326	45.28
Tamil Nadu	195291	244609	79.84	55735	49998	89.71
Telangana	95973	124233	77.25	15369	14787	96.21
Tripura	8102	25762	31.45	7542	3002	39.80
Uttar Pradesh	160313	556840	28.79	99353	38875	39.13
Uttarakhand	4848	41349	11.73	5108	65	1.27
West Bengal	129078	244593	52.77	57897	32895	56.82
Grand Total	**1371232**	**3850149**	**35.62**	**868541**	**383227**	**44.12**

Table 18: Intertemporal variation in component wise utilisation of released funds

	2021-22			2022-23			2023-24		
Components	**Fund utilisation (in lakhs)**	**Released funds (in lakhs)**	**Utilisation as a proportion of released funds (in %)**	**Fund utilisation (in lakhs)**	**Released funds (in lakhs)**	**Utilisation as a proportion of released funds (in %)**	**Fund utilisation (in lakhs)**	**Released funds (in lakhs)**	**Utilisation as a proportion of released funds (in %)**
FR1	108663	134977	**80.50**	52948	63464	**83.43**	18703	88475	**21.14**
FR2	77802	99014	**78.58**	45180	64006	**70.59**	10122	29627	**34.16**
FR3	220513	307990	**71.60**	74131	120111	**61.72**	14878	58466	**25.45**
FR4	234037	284150	**82.36**	122487	146860	**83.40**	2664	34833	**7.65**
FU5	26611	37483	**71.00**	11464	16394	**69.93**	2995	5423	**55.23**
FU6	241405	451820	**53.43**	86469	187685	**46.07**	20162	59506	**33.88**
Grand Total	**909030**	**1315434**	**69.10**	**392679**	**598520**	**65.61**	**69523**	**276329**	**25.16**

Figure 21: State-wise Expenditure as a Proportion of Releases, 2021-22 to 2023-24

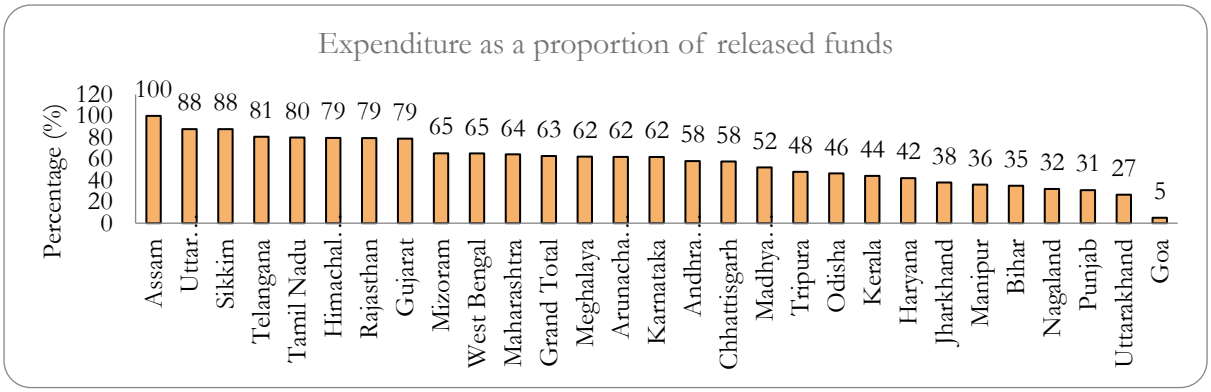


Figure 22: State-wise Releases as a Proportion of Allocation, 2021-22 to 2023-24

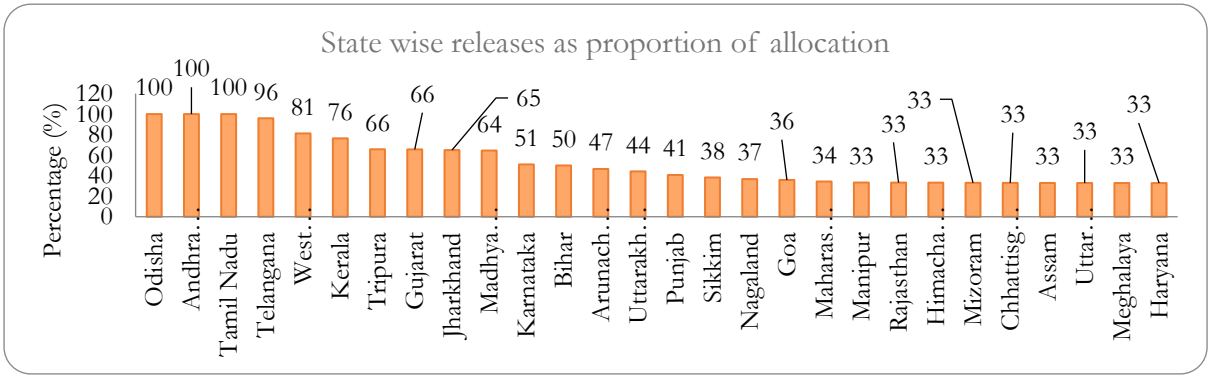


Table 19: State wise releases under PM-ABHIM (FY 2021-22 to FY 2023-24)

Year	2021-22				2022-23				2023-24				Total			
State	Total Approval (in Rs. lakhs)	Central govt releases (in Rs. lakhs) (1)	Expected central govt releases @60% of approval (2)	Actual releases as proportion of approved (in %) (1)/(2)	Total Approval (in Rs. lakhs)	Central govt releases (in Rs. lakhs) (1)	Expected central govt releases @60% of approval (2)	Actual releases as proportion of approved (in %) (1)/(2)	Total Approval (in Rs. lakhs)	Central govt releases (in Rs. lakhs) (1)	Expected central govt releases @60% of approval (2)	Actual releases as proportion of approved (in %) (1)/(2)	Total Approval (in Rs. lakhs)	Central govt releases (in Rs. lakhs) (1)	Expected central govt releases @60% of approval (2)	Actual releases as proportion of approved (in %) (1)/(2)
Andhra P	2500	375	1500	25	8549	1576	5129	31	7146	3578	4287	83	18195	5529	10917	51
Bihar	83912	12586	50347	25	103799	717	62279	1	0	0	0		187711	13303	112627	12
Chattisgarh	7500	1125	4500	25	12611	134	7566	2	14766	3223	8860	36	34877	4483	20926	21
Goa	0	0	0		0	6	0		0	375	0		0	381	0	
Gujarat	11505	0	6903	0	18611	2954	11167	26	21122	4604	12673	36	51238	7558	30743	25
Haryana	7375	1106	4425	25	8641	131	5185	3	14964	1767	8978	20	30980	3004	18588	16
Jharkhand	29808	4470	17885	25	41676	18304	25006	73	15642	10227	9385	109	87126	33001	52276	63
Karnataka	7500	1125	4500	25	21232	3710	12739	29	35732	10057	21439	47	64464	14892	38679	39
Kerala	2500	375	1500	25	7549	2489	4529	55	8155	0	4893	0	18204	2864	10923	26
Madhya Pradesh	12625	2285	7575	30	30442	9870	18265	54	34953	22852	20972	109	78020	35007	46812	75
Maharashtra	11630	1745	6978	25	19130	407	11478	4	20115	3176	12069	26	50875	5328	30525	17
Odisha	21407	3215	12844	25	32806	21146	19684	107	22139	17158	13283	**129**	76352	41519	45811	91
Punjab	2625	0	1575	0	14562	2416	8737	28	16557	0	9934	0	33744	2416	20246	12
Rajasthan	30255	4537	18153	25	49203	8359	29522	28	38238	17306	22943	75	117696	30202	70618	43
Tamil Nadu	11630	1745	6978	25	23077	15042	13846	109	21633	27936	12980	**215**	56339	44723	33804	132
Telangana	7500	1125	4500	25	16190	5388	9714	55	31221	9521	18733	51	54911	16034	32947	49
Uttar Pradesh	68858	12463	41315	30	109546	17371	65728	26	68913	24796	41348	60	247317	54630	148390	37

West Bengal	6630	995	3978	25	15019	0	9011	0	16514	3091	9908	31	38163	4086	22898	18
NE and Hilly																
States	**Total Approval (in Rs. lakhs)**	**Central govt releases (in Rs. lakhs)**	**Expected central govt releases @90% of approval**	**Actual releases as proportion of approved (in %)**	**Total Approval (in Rs. lakhs)**	**Central govt releases (in Rs. lakhs)**	**Expected central govt releases @90% of approval**	**Actual releases as proportion of approved (in %)**	**Total Approval (in Rs. lakhs)**	**Central govt releases (in Rs. lakhs)**	**Expected central govt releases @90% of approval**	**Actual releases as proportion of approved (in %)**	**Total Approval (in Rs. lakhs)**	**Central govt releases (in Rs. lakhs)**	**Expected central govt releases @90% of approval**	**Actual releases as proportion of approved (in %)**
Arunachal Pradesh	250	56	225	25	598	10	538	2	794	883	715	124	1642	949	1478	64
Assam	26399	5790	23759	24	37437	226	33693	1	17788	9145	16009	57	81624	15161	73462	21
Himachal Pradesh	3136	0	2822	0	4358	2805	3923	72	5589	1569	5031	31	13084	4374	11776	37
Manipur	2026	456	1823	25	2249	1092	2024	54	620	1378	558	**247**	4895	2926	4406	66
Meghalaya	4287	965	3858	25	4517	4328	4065	106	397	442	357	124	9201	5735	8281	69
Mizoram	125	28	113	25	2674	152	2407	6	397	452	357	127	3196	632	2876	22
Nagaland	125	28	113	25	299	8	269	3	397	442	357	124	821	478	739	65
Sikkim	0	0	0		125	75	113	67	2549	388	2294	17	2674	463	2407	19
Tripura	125	0	113	0	157	90	141	64	190	248	171	145	472	338	425	80
Uttarakhand	692	156	623	25	6501	3231	5851	55	4126	0	3714	0	11319	3387	10187	33

Table 20: Total state wise expenditures under PMABHIM (FY 2021-22 to FY 2023-24)

State	Approval (in Rs. lakhs)	Central govt release (in Rs. lakhs)	Imputed state govt contribution @40% (in Rs. lakhs)	Expenditure (in Rs. lakhs)	Expenditure as proportion of approval (%)	Expenditure as proportion of total imputed release (%)
Andhra Pradesh	18195	5529	3686	3510	19.3	38.1
Bihar	187711	13303	8869	5069	2.7	22.9
Chattisgarh	34877	4483	2989	3064	8.8	41.0
Goa	0	381	254	0		0.0
Gujarat	51238	7558	5039	8837	17.2	70.2
Haryana	30980	3004	2002	1663	5.4	33.2
Jharkhand	87126	33001	22001	69492	79.8	126.3
Karnataka	64464	14892	9928	12322	19.1	49.6
Kerala	18204	2864	1910	4137	22.7	86.7
Madhya Pradesh	78020	35007	23338	40036	51.3	68.6
Maharashtra	50875	5328	3552	3446	6.8	38.8
Odisha	76352	41519	27679	68198	89.3	98.6
Punjab	33744	2416	1611	207	0.6	5.1
Rajasthan	117696	30202	20135	38893	33.0	77.3
Tamil Nadu	56339	44723	29815	60180	106.8	80.7
Telangana	54911	16034	10690	22548	41.1	84.4
Uttar Pradesh	247317	54630	36420	50673	20.5	55.7
West Bengal	38163	4086	2724	5954	15.6	87.4
Special category states						
State	**Approval (in Rs. lakhs)**	**Central govt release (in Rs. lakhs)**	**Imputed state govt contribution @10% (in Rs. lakhs)**	**Expenditure (in Rs. lakhs)**	**Expenditure as proportion of approval (%)**	**Expenditure as proportion of total imputed release (%)**
Arunachal Pradesh	1642	949	105	225	13.7	21.3
Assam	81624	15161	1685	6961	8.5	41.3
Himachal Pradesh	13084	4374	486	2525	19.3	51.9
Manipur	4895	2926	325	2145	43.8	66.0
Meghalaya	9201	5735	637	3682	40.0	57.8
Mizoram	3196	632	70	159	5.0	22.6
Nagaland	821	478	53	60	7.3	11.3
Sikkim	2674	463	51	230	8.6	44.8

Tripura	472	338	38	181	38.3	48.1
Uttarakhand	11319	3387	376	1795	15.9	47.7
Union territories						
State	**Approval (in Rs. lakhs)**	**Central govt release (in Rs. lakhs)**	**Imputed state govt contribution @0% (in Rs. lakhs)**	**Expenditure (in Rs. lakhs)**	**Expenditure as proportion of approval (%)**	**Expenditure as proportion of total imputed release (%)**
Andaman & Nicobar Islands	0	111	0	0		0.0
Chandigarh	2100	1517	0	756	36.0	49.8
Dadra & Nagar Haveli and Daman & Diu	225	52	0	21	9.1	39.8
Delhi	0	0	0	0		
Jammu & Kashmir	27966	6112	0	3667	13.1	60.0
Ladakh	250	62	0	31	12.4	49.8
Lakshadweep	125	63	0	7	5.3	10.6
Puducherry	2174	328	0	351	16.1	106.8
Total	**1407980**	**361650**	**216469**	**421025**	**29.9**	**72.8**

Table 21: Physical progress Rural HWC

Year	2021-22					2022-23					Total				
State	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**
Assam	384	306	29	80	8	384	291	31	76	8	768	597	60	78	8
Bihar	1273	300	82	24	6	1273	0	0	0	0	2546	300	82	12	3
Jharkhand	447	441	291	99	65	446	423	183	95	41	893	864	474	97	53
Manipur	32	32	21	100	66	32	32	0	100	0	64	64	21	100	33
Meghalaya	75	75	50	100	67	76	52	0	68	0	151	127	50	84	33
Odisha	302	271	34	90	11	302	254	46	84	15	604	525	80	87	13
Rajasthan	555	436	385	79	69	557	411	350	74	63	1112	847	735	76	66
Uttar Pradesh	835	779	590	93	71	835	774	606	93	73	1670	1553	1196	93	72
TOTAL	**3903**	**2640**	**1482**	**68**	**38**	**3905**	**2237**	**1216**	**57**	**31**	**7808**	**4877**	**2698**	**62**	**35**

Table 22: Physical progress Urban HWC

State	Units approved (#) 2021-22	Units operationalised (#) 2021-22	Proportion of operationalised units (%) 2021-22	Units approved (#) 2022-23	Units operationalised (#) 2022-23	Proportion of operationalised units (%) 2022-23	Units approved (#) 2023-24	Units operationalised (#) 2023-24	Proportion of operationalised units (%) 2023-24	Units approved (#) Total	Units operationalised (#) Total	Proportion of operationalised units (%) Total
Andaman & Nicobar Islands	0	0		0	0		0	0		0	0	
Andhra Pradesh	0	0		45	45	100	45	45	100	90	90	100
Chandigarh	9	0	0	16	14	88	19	15	79	44	29	66
Dadra & Nagar Haveli and Daman & Diu	0	0		1	1	100	2	2	100	3	3	100
Gujarat	0	0		0	0		0	0		0	0	
Himachal Pradesh	2	2	100	8	8	100	16	13	81	26	23	88
Jammu & Kashmir	10	10	100	25	25	100	44	30	68	79	65	82
Karnataka	0	0		114	72	63	563	510	91	677	582	86
Mizoram	0	0		0	0		0	0		0	0	
Odisha	0	0		0	0		0	0		0	0	
Puducherry	3	3	100	8	5	63	14	11	79	25	19	76
Rajasthan	0	0		47	24	51	190	72	38	237	96	41
TamilNadu	0	0		0	0		0	0		0	0	
Telangana	0	0		0	0		500	462	92	500	462	92
Uttar Pradesh	0	0		0	0		0	0		0	0	
West Bengal	0	0		0	0		0	0		0	0	
Total	**24**	**15**	**63**	**264**	**194**	**73**	**1393**	**1160**	**83**	**1681**	**1369**	**81**

Note- For states like Assam, Odisha, Gujarat, Manipur, Mizoram,Tamil Nadu and West Bengal the allocations under this component have been made for later years, i.e., FY 2024-25 and FY 2025-26, which are not a part of this analysis.

Table 23: Physical Progress BPHU

Year	2021-22					2022-23					2023-24					Total				
State	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**	**Units approved (#)**	**Units where work started (#)**	**Units where work completed (#)**	**Proportion of approved units where work started (%)**	**Proportion of total units where work is completed (%)**
Assam	16	16	10	**100**	**63**	41	41	24	**100**	**59**	42	8	0	**19**	**0**	99	65	34	66	34
Bihar	0	0	0			59	0	0	**0**	**0**	0	0	0			59	0	0	0	0
Chhattisgarh	0	0	0			16	15	8	**94**	**50**	18	16	1	**89**	**6**	34	31	9	91	26
Himachal	6	6	0	**100**	**0**	14	14	0	**100**	**0**	15	0	0	**0**	**0**	35	20	0	57	0
J & K	29	19	3	**66**	**10**	57	0	0	**0**	**0**	57	0	0	**0**	**0**	143	19	3	13	2
Jharkhand	0	0	0			29	28	14	**97**	**48**	34	27	3	**79**	**9**	63	55	17	87	27
Madhya Pradesh	0	0	0			35	35	31	**100**	**89**	40	33	10	**83**	**25**	75	68	41	91	55
Odisha	0	0	0			35	32	7	**91**	**20**	40	39	15	**98**	**38**	75	71	22	95	29
Rajas	0	0	0			33	33	26	**100**	**79**	37	28	2	**76**	**5**	70	61	28	87	40
Uttar P	0	0	0			91	85	72	**93**	**79**	105	90	16	**86**	**15**	196	175	88	89	45
Uttarakhand	7	7	5	**100**	**71**	17	15	13	**88**	**76**	17	6	0	**35**	**0**	41	28	18	68	44
TOTAL	**58**	**48**	**18**	**83**	**31**	**427**	**298**	**195**	**70**	**46**	**405**	**247**	**47**	**61**	**12**	**890**	**593**	**260**	**67**	**29**

STATE LEVEL INSIGHTS

Chapter 3: State-Level Insights from Odisha

A. The Context

Odisha has been among the top performers in the country in the context of the XVth FC health grant (Refer Figures in Aggregate Analysis). It is one of the few states where the Finance Department has not only adhered to the DoE guidelines on release of funds to the nodal departments, but has also ensured that the releases were made within the prescribed time limit of 10 days. The state has been able to obtain the releases pertaining to the XVth FC health grants in each of the years between 2021-22 and 2023-24, and has recorded a relatively good rate of utilization (65 per cent) of the released FC grants as shown in Table 24 below.

Table 24: Odisha- Year-wise Financial Utilisation of XV-FC Health Grants as Percentage of Funds Released (%)

Component	2021-22	2022-23	2023-24 until 26.12.2024	Cumulative Total
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	76.64	54.51	51.39	56.16
FR2 Construction of Block Public Health Units (BPHUs)	83.18	50.58	53.35	63.56
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	87.01	55.97	53.81	65.41
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	98.69	80.93	-	89.80
Sub-Total of Rural Components	**88.69**	**62.50**	**52.25**	**66.69**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	94.23	53.71	53.17	66.81
FU2 Urban Health & Wellness Centres (HWCs)	79.40	52.23	6.45	53.88
Sub-Total of Urban Components	**81.93**	**52.94**	**19.97**	**57.29**
Grand Total	**87.12**	**61.71**	**47.80**	**65.27**

Data Source- Information provided by the Odisha Government

The initial outlay under the XV-FC Health Grants for the state of Odisha had a marked rural focus. In the period 2021-22 and 2023-24, nearly 77 per cent of the XV-FC allocation was directed towards the rural components, of which support for diagnostic services (FR3) and conversion of SHCs and PHCs to HWCs (FR4) accounted for about 27 per cent each. The rural focus was even higher after the first year. In the first year, the urban HWCs component (FU2) was underutilized and the unused funds of this component were re-appropriated to the rural component FR1 in

subsequent years. Additionally, when the support for HR was withdrawn in 2023-24, a substantial part of the allocation for operationalizing HWCs under FR 4 were re-appropriated towards FR 1. This increased the rural thrust in actual approvals, *vis-à-vis* the initial allocation. On average, between 2021-22 and 2023-24, around 85 per cent of the approval under the XVth FC in the state was towards the rural components as shown in Table 25 below.

Table 25: Initial Allocation vs. Financial Approvals

Financial Year	**Total Cumulative (2021-22 to 2023-24)**			
Component	**Allocation (Rs. Crores)**	**Approval (Rs. Crores)**	**Component as % of total allocation**	**Component as % of total approval**
FR1 Construction of Building- less Sub-Health Centres, PHCs & CHCs	222.09	478.81	15.8	34.0
FR2 Construction of Block Public Health Units (BPHUs)	88.69	77.09	6.3	5.5
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	388.03	387.87	27.5	27.6
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	382.26	250.42	27.1	17.8
Sub-Total of Rural Components	**1,081.07**	**1,194.20**	**76.7**	**84.9**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	56	56	4.0	4.0
FU2 Urban Health & Wellness Centres (HWCs)	272.03	156.21	19.3	11.1
Sub-Total of Urban Components	**328.03**	**212.21**	**23.3**	**15.1**
Grand Total	**1,409.10**	**1406.4**	**100.0**	**100.0**

Note- The approvals represent the amount approved after any re-appropriation among components. The allocations are the ones recommended by the XVth FC; Data Source- Information provided by the Odisha Government

B. The Approach and Execution

B.1 Fund Flow and Execution Agency

Figure 23 and Figure 24 below indicate the fund flow arrangement and execution agencies for each of the components of the XV-FC grants in Odisha. Funds for all components (excluding the diagnostic components) were transferred to the Panchayati Raj and Drinking Water (PR & DW) Department and the Housing and Urban Development (H & UD) Department. For the components involving diagnostic support, funds were transferred to the Health and Family Welfare department as State Health Society was the designated executing agency. Bulk of the procurement for both rural and urban components were decentralized to district-level offices of H&FW, through District Health Societies. For a small portion of procurement, funds were also transferred to Odisha Medical Services Corporation at the state-level. In terms of execution, PR & DW, H&UD and H&FW were required to carry out their respective works in the first year. However, due to issues in initiating works by the PR&DW and H&UD departments in the first year, all works were subsequently taken over by the H&FW department. Since 2022–23, although funds were initially released by the Finance Department to PR&DW and H&UD, they were later transferred to H&FW at the district level for actual execution.

Figure 23: Fund Flow Arrangement for the Rural Components in Odisha

Component	Budget Provision under	1st level Recipient	2nd Level Recipient/Executing Agency
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	PR & DW Department	District Offices under PR & DW Dept.	Block Development Officers (BDOs) in 2021-22 (District Offices under H&FW Dept. after 2021-22)
FR2 Construction of Block Public Health Units (BPHUs)			
FR2 Equipment of BPHUs			District Offices under H&FW Dept.
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	District Offices under H&FW Dept.
FR4 Conversion of Rural Sub-Health Centres to HWCs		District Offices under PR & DW Dept.	District Offices under H&FW Dept.

Data Source- Information provided by the Odisha Government

Figure 24: Fund Flow Arrangement for the Urban Components in Odisha

Component	Budget Provision under	1st level Recipient	2nd Level Recipient/Executing Agency	3rd Level Recipient/Executing Agency
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	H&UD Department	State Health Society under H&FW Dept.	District Offices under H&FW Dept.	NA
FU2 Urban Health & Wellness Centres (HWCs)		District Offices under H&UD Dept.	District Offices under H&FW Dept.	Public Works Department (PWD) (for capital works)

Data Source- Information provided by the Odisha Government

B.2 Adapting FC Grants to meet State-specific Context and Ensuring Synergies Across Multiple Sources of Funding

Odisha struck a fine balance between ensuring smooth fund flows and effective execution of works. Funds were routed timely through multiple nodal departments to ensure that there were no bottlenecks in obtaining releases. It also entrusted the actual execution of works to the nodal departments (PR&DW, H&UD and H&FW) in the first year. However, as noted earlier, substantial delays in initiating works by non-health departments prompted the State to ensure that all implementation was subsequently undertaken by the H&FW department. By altering the actual execution agency and handing over the charge to H&FW, the state was able to streamline the works within the existing set-up of the health department. This ensured departmental ownership and enabled the state to leverage the existing administrative machinery for execution of similar

works. The flipside of this however, was the fact that local bodies were not involved in the execution of the FC grant.

Figure *25*:Executing Agency in Odisha for XV FC Grant Components

	Executing Agency as per guideline	**Actual Executing Agencies in the State**	
		2021-22	**2022-23 onwards**
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	PR & DW Department	PR & DW Department	Works Department/PSUs as assigned by H&FW Department
FR2 Construction of Block Public Health Units (BPHUs)			
FR2 Equipments of BPHUs		H&FW Department	H&FW Department
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	H&FW Department	H&FW Department	H&FW Department
FR4 Conversion of Rural Sub-Health Centres to HWCs	PR & DW Department	H&FW Department	H&FW Department
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	H&FW Department	H&FW Department	H&FW Department
FU2 Urban Health & Wellness Centres (HWCs)	H&UD Department	H&FW Department	H&FW and PWD

Data Source- Information provided by the Odisha Government

The State also combined the FC grants effectively with other sources of funds to provide all-round support to health facilities. Officials forwarded several examples of this. To begin with, the State accorded priority to saturating SHCs. FR 1 was used to construct building-less SHCs. As recurring expenses for SHC-HWC were already built in under the NHM budget in 2021-22, funds from the conversion component FR4 were utilized for equipping the SHC-HWCs with necessary Equipment, Instruments and Furniture (EIF) in that year. In the next year, the recurring expenses of SHC-HWCs in 17 aspirational/tribal districts were shifted out of NHM budget and included in the FR4 component of the XVth FC grant. Even in PM-ABHIM, comprehensive planning was undertaken to ensure complementarity between different sources of funds. Table 26 below indicates typical planning by the state for various components under PM-ABHIM in 2024-25.

Table 26: Recurring Costs of PM-ABHIM Components for 2024-25 (in Rs. Lakhs)

Component	No. of units	Fund required for 2024-25	Budget under PM-ABHIM in 2024-25 PIP	Fund already available under XV-FC	Fund to be met from State Scheme NIDAN
IPHL	30	1020.00	612.00	-	408.00
CCB (only non-HR)	30	798.00	266.00	-	532.00
BPHU	314	2304.76	1504.70	722.08	800.06

Data Source- Information provided by the Odisha Government

Backward and economically weaker sections of the population were also prioritized in implementation. In FR1 and FR2, constructions in aspirational and tribal districts were taken up at first go.[33] Similarly, in the component FU2, funds were deployed towards operationalizing UHWCs that targeted the needs of slum and vulnerable population.

B.3 Utilization of Funds in XVth FC Health Grants and PM-ABHIM in Odisha

Utilization of funds in the rural components was higher than the urban components in the XV-FC grants. Between 2021-22 and 2023-24, about 67 per cent of the FC grants released to the state for the rural components were utilized, while in the urban areas, the utilization was about 57 per cent (Table 24). Interestingly, the utilization in component FR4 involving conversion of SHCs and PHCs into HWCs was significantly higher than the rest. This is possibly due to the fact that bulk of the funds in this component were spent on HR, which is easier to utilize than the components involving civil works.

Fund utilization under PM-ABHIM was significantly higher than the XV-FC grants. Between 2021-22 and 2024-25 (27.12.2024) the overall utilization of funds in PM-ABHIM was around 89 per cent (Refer Table 38).

In comparison, it was 65 per cent in XV- FC grants (till 2023-24). In the three overlapping components of the two grants: infrastructure support to rural SHCs, BHPUs and urban HWCs, the utilization of funds was consistently better in PM-ABHIM than XV-FC grants. Notably, the component of the UHWCs clocked the least utilisation rate at 64 per cent. It must however be noted that this component was only allocated in the year 2024-25 and is therefore, very recent.

[33] For BPHUs, 119 tribal blocks of the state were to be saturated.

Table 27: Odisha- Comparison of Physical Progress under PM-ABHIM and XV-FC (as of January 2025)

	XV-FC Health Grants			PM-ABHIM		
Component	**Total units (#)**	**Work started or completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started or completed (%)**	**Work completed (%)**
FR1- Construction of building less SHCs	966	*53.83*	*7.76*	604	*87.42*	*18.05*
FR2- Block Public Health Units (BPHU)	117	*55.56*	*7.69*	197	*68.53*	*12.18*

Data Source- Information provided by the Odisha Government

For overlapping components under the XV-FC and PM-ABHIM, the variation in performance may be partly attributed to the more complex fund flow architecture of the former, in contrast to the streamlined releases directly to a single health department under the latter. There is evidence that the time taken in releasing funds from PR&DW and H&UD to H&FW since 2022-23 was substantial in several districts. Table 28 below shows the dates on which the state treasury received release of funds from the GoI, the dates on which the funds were received by the PR & DW Department, and the dates on which these funds were received by the district level offices of the Health Department for utilisation– for the component FR1 pertaining to construction of building less SHCs. These variables are documented for six districts for which data could be obtained. The last column indicates the time lag (in number of days) between the receipt of funds by the PR & DW Department and its release to the district level Health (H&FW) Department offices.

Table 28 shows that in 2022–23, the release of funds from the PR Department to district-level H&FW offices (DHS) took between 1.5 months in districts like Cuttack to as long as 6.5 months in Khurda. In 2023–24, the delays were shorter but still significant—ranging from 1 to over 3 months depending on the district. These delays in fund transfer ultimately translate into delays in execution, creating a cascading effect on progress for all subsequent years.

Table 28: Time Taken in Transfer of Funds in Odisha

FY 2022-23					
FR1- Construction of Building less SHCs					
District	**Date received from GoI**	**Date of receipt from Treasury to PR Dept**	**Date of receipt from PR Dept to district H&FW office**	**Delay between receipt and transfer of funds to PR Dept (# days)**	**Delay between transfer of funds from PR Dept to district Health Offices (# days)**
Cuttack	14-Jul-23	26-Jul-23	11-Sep-23	12	47
Keonjhar	14-Jul-23	26-Jul-23	29-Sep-23	12	65
Khurda	14-Jul-23	26-Jul-23	17-Feb-24	12	206
Koraput	14-Jul-23	26-Jul-23	6-Oct-23	12	72
Mayurbhanj	14-Jul-23	26-Jul-23	6-Nov-23	12	103
Puri	14-Jul-23	26-Jul-23	14-Nov-23	12	111
FY 2023-24					
FR1- Construction of Building less SHCs					
District	**Date received from GoI**	**Date of receipt from Treasury to PR Dept**	**Date of receipt from PR Dept to district H&FW office**	**Delay between receipt and transfer of funds to PR Dept (# days)**	**Delay between transfer of funds from PR Dept to district Health Offices (# days)**
Cuttack	7-Jun-24	25-Jun-24	3-Sep-24	18	70
Keonjhar	7-Jun-24	25-Jun-24	21-Sep-24	18	88
Khurda	7-Jun-24	25-Jun-24	2-Aug-24	18	38
Koraput	7-Jun-24	25-Jun-24	8-Oct-24	18	105
Mayurbhanj	7-Jun-24	25-Jun-24	3-Oct-24	18	100
Puri	7-Jun-24	25-Jun-24	4-Oct-24	18	101

Data Source- Information provided by the Odisha Government

C. Challenges Faced by the State in Implementing the Grants

C.1 Issues in Carrying out Civil Works through PR & DW

The civil works required as a part of the XV-FC health grants came as an additional responsibility to the PR & DW Department, alongside its existing duties. At the time of initiation of this grant, the PR&DW was already overburdened with other sectoral responsibilities and could not prioritize and initiate this work for several months. According to the officials from the PR&DW Department, the unavailability of technical personnel to manage construction activities from the inception to handover stage due to existing commitments further contributed to these delays. Also, as per the officials of PR&DW, the administrative approval process for high value projects (above

Rs. 50 lakh) is centralized, requiring clearance from technical staff at the state level. Since all the construction activities under the XVth FC grants fell within this high-value category, substantial time was consumed in obtaining the necessary approvals. This should be seen in light of the fact that the process is more decentralized if civil works are undertaken by the health department. For instance, construction works undertaken by the State Health Society (SHS) under schemes like the NHM are approved at the district level itself.

The capacity constraint of PRIs is evident from another development in the state. In 2020, some of the functions of health and other departments in the state (including construction works) was devolved to local bodies. However, due to the difficulties faced in discharging the functions effectively, the 2020 order was partially withdrawn in 2022 and the construction and maintenance of higher-level facilities (CHCs and above) were handed back to the Works Department.

C.2 Hurdles in Absorption of Funds Allocated for UHWCs

The absorption of funds in the UHWC component was relatively low despite the fact that a substantial part of the allocation for this component was recurring in nature. UHWC was a new initiative in the State, and this induced a gestation lag in their operationalization. The limited number of operational UHWCs during the initial years severely constrained the absorption capacity of these funds. Officials pointed out that the allocation of funds per UHWC in some items like rents was disproportionately high for a state like Odisha. Additionally, the per-unit allocation for UHWCs was considered too high relative to the actual patient caseload. State officials pointed out that the Urban Primary Health Centers (UPHCs), which offer a similar range of services, were deemed sufficient to meet the healthcare needs of the population, raising questions about the rigidity of such pre-specified and fixed allocations towards components. Consequently, the FY 2021-22 allocation was found to be sufficient to meet even the next year's recurring expenditure under this component. In 2022-23, of the total allocation of 89.19 crores in this component, a meagre 5.4 crore was earmarked for UHWCs and 1.3 crores was utilized for construction of UPHCs operating in rented buildings. The remaining 69.3 crores (more than three-fourths of the total allocation) had to be re-appropriated towards FR1.

C.3 Sharp Midway Rise in Allocation in FR1 Hindered Utilization

Due to the withdrawal of HR support after the first two years, there was a de-facto discontinuation of FR4 component concerning the conversion of SHCs and PHCs into UHWCs, and a significant reduction in the per unit allocations of the BPHU (FR2) and UHWC (FU2) components. The consequent re-appropriation of this ceased support meant a massive increase in the approvals towards construction of building-less SHCs (FR1) since the entirety of the conversion component was directed towards this component, along with the HR allocations for other components like BPHUs (FR2) in FY 2023-24. The re-appropriation on account of both under-utilization of the UHWC component and withdrawal of HR support is reflected in Table 25, which lays out the initial allocations envisaged by the XV-FC Health Grants against the actual approvals received for each of the components. Figures in the last two columns indicate that while the rural component was initially designed to occupy a 77 per cent share in the first three years of the Health Grant, it ended up constituting about 85 per cent of the total releases in these years. Thus, the overall utilization of funds in the State was heavily dependent of the absorption capacity of the allocation in FR1.

C.4 Mismatch between Prescribed and Actual Unit Costs of Construction

Both PM-ABHIM and the XV-FC grants focused on the construction of physical infrastructure. However, a key challenge in implementation arises from the divergence between the prescribed normative unit costs and actual construction costs. Cost escalations potentially arise due to a number of reasons, one of which is delays in procurement of land. Besides, Odisha being a coastal state has several water-logged districts where construction requires further expenditure on appropriate strengthening of building foundations. Procurement of raw materials is also costlier in remote and tribal regions which further puts upward pressure on costs.

These funding gaps in the provided unit costs and the actual costs have to be filled by tapping into the state budget. Additional fund approval from the state budget adds to the administrative processes and delays the initiation of construction works. The following tables document the nature and extent of cost escalations encountered during the construction of IPHLs and SHCs, along with the corresponding financial contributions required from the state budget. Such cost escalations not only strain limited state resources but also risk disrupting timelines and compromising the pace of progress.

Table 29: Odisha- Cost Escalations and Requirement from State Budget for IPHL (in Rs. Lakhs)

Sno.	Name of Work	Location	Cost as per administrative approval	Funding from PM ABHIM	Funding from NHM	Balance Fund required from State Budget
1	IPHL	DHH, Kendrapara	43	43		0
2	IPHL	DHH, Sundargarh	61	61		0
3	IPHL	DHH, Raygada	103	103		0
4	IPHL	DHH, Deogarh	197	125		72
5	IPHL	DHH, Bolangir	198	125		73
6	IPHL	DHH, Dhenkanal	220	125		95
7	IPHL	DHH, Ganjam	203	125		78
8	IPHL	DHH, Kandhamal	216	125		91
9	IPHL	DHH, Mayurbhanj	219	125		94
10	IPHL	DHH, Bhadrak	227	125		102
11	IPHL	DHH, Balasore	230	125		105
12	IPHL	DHH, Sambhalpur	196	125		71
13	IPHL	DHH, Sonepur	67	67		0
14	IPHL	DHH, Jharsuguda	65	65		0
15	IPHL	DHH, Gajapati	196	125		71
16	IPHL & BB	DHH, Nawarangpur	416	125	186	105
17	IPHL	DHH, Bargarh	103	103		0
18	IPHL	DHH, Khurda	213	125		88
19	IPHL	DHH, Keonjhar	229	125		104
20	IPHL	DHH, Nuapada	81	81		0
21	IPHL	DHH, Malkangiri	10	10		0
22	IPHL	DHH, Kalahandi	181	125		56
		TOTAL	3678	2285	186	1207

Data Source- Information provided by the Odisha Government

Table 30: Odisha- District-wise Costs and Requirement from State Budget for SHCs (in Rs. Lakhs)

District	No. of units	Approved Cost	Estimated Cost	Additional requirement	Total Estimate Cost	Balance Fund required
Anugul	17	782	935	0	935	153
Balasore	47	2571	2756	0	2756	185
Bargarh	6	276	330	0	330	54
Bhadrak	19	867	967	0	967	100
Balangir	10	460	500	0	500	40
Boudh	2	54	109	0	109	55
Cuttack	54	2484	2951	350	3101	617
Deogarh	31	1534	1687	0	1687	153
Gajapati	14	711	781	0	781	69
Ganjam	96	4427	5062	94	5157	730
Jagatsinghapur	8	440	446	52	498	58
Kalahandi	80	4030	5062	0	5062	1032
tKandhamal	40	1840	1840	285	2125	285
Kendrapara	19	874	1211	0	1211	337
Kendujhar	8	440	552	104	656	216
Khordha	31	1588	1748	0	1748	160
Malkangiri	26	1268	1295	455	1750	482
Mayurbhanj	213	10005	13327	0	13327	3322
Nabarangpur	25	1375	1509	500	2009	634
Nayagarh	20	929	1078	0	1078	149
Nuapada	5	266	306	0	306	40
Rayagada	73	3132	3751	513	4264	1132
Sambalpur	8	386	422	0	422	36
Sonepur	19	919	1059	0	1059	140
Total	871	41658	49684	2153	51837	10178

Data Source- State Reports

C.5 Conditionality for Release of Funds under PM-ABHIM

Under PM-ABHIM, each component includes both capital and recurring expenses, and a 75 percent utilisation rate is required for the release of the next instalment of funds. Civil works progress at a slower rate and entail payments at different stages, whereas recurring expenses are periodic in nature and occur regularly. Bundling these two types of expenditures into a single component means that delays in civil works can lower the overall utilisation rate, which in turn may delay the release of funds needed for regular recurring payments. To address this issue, the state officials were of the view that funding towards civil works should be packaged as a separate component in itself.

D. Observations from Facility Visits in Districts

The team undertook field visits to health facilities in the districts of Cuttack and Puri. Both the visits also included discussions with the Chief District Medical Officer (CDMO) and other officials at the District Health Society. All the chosen facilities were beneficiaries of funding from either of these initiatives. The facilities visited by the study team are listed below:

Cuttack	Puri
1. PHC AAM at Baranga	1. UPHC Pentakatha
2. SHC AAM at Naraja, Baranga	2. PHC AAM Nagapur, Gop Block
3. BPHU (under construction) at Subarnapur CHC	3. SHC AAM Samasara, Pipili Block

D.1 Cuttack

1. PHC AAM at Baranga

The first facility visited was an NQAS certified rural PHC AAM in Baranga, which covered a catchment population of almost 26000. Staffed by both a medical officer (MBBS doctor) and AYUSH doctor, this PHC (designated as HWC in 2021-22) had an average daily footfall of about 150 OPDs attended to by the medical doctor and about 30 OPDs catered to by the AYUSH doctor.

The PHC AAM currently had an operational laboratory and received equipment under the diagnostic component (FR3) of the XV-FC Health Grants. Interestingly, this laboratory was made operational in May 2022 by using the XV-FC Health grants for purchase of equipment, NHM funds for renovation of room and the state sponsored Nidaan scheme for hiring a laboratory technician (LT), exhibiting an ideal model of convergence and alignment of different initiatives to achieve desired output. This enabled the facility to obtain the NQAS certification in 2022.

Data collected on OPD footfalls in recent months along with the same data for the same months in 2021 (before the laboratory was made functional) shows a substantial increase in OPD footfalls in recent months.

Table 31: OPD- PHC AAM at Baranga, Cuttack District, Odisha

Allopathy OPD	**2021**	**2024**
September	1429	3660
October	1322	3142
November	1153	3111
Ayush OPD	**2021**	**2024**
September	141	307
October	176	469
November	167	342

Data Source- Information provided by the Health Facility

While one can argue that the increasing trend in the OPD footfall could be attributable to multiple reasons including demand side factors such as change in health seeking behaviour, increasing awareness etc., the magnitude of the this observed increase (more than two-folds) and anecdotal evidence both suggest that the expansion of laboratory services played a significant role.

2. SHC AAM at Naraja, Baranga Block

The second facility was a Health Sub Centre located at Naraja in Baranga block, which was functional as an AAM (HWC) since 2021, with a catchment population of about 5879. Staffed with a CHO, 1 ANM and 1 Health worker (male) and attached with 6 ASHA workers, this SHC has an average daily OPD footfall of about 25 patients.

This facility benefited from two components under the XV-FC Health Grants-the first being FR3 which provides diagnostic support to SHCs and the second being FR4 for conversion of SHCs into HWCs. As highlighted above, in the first year of the grant, Odisha utilised the FR4 component towards purchases of EIF (Equipment, Instruments and Furniture) in Sub Centres. This facility received EIF worth about Rs. 3 lakhs including an observation table, wheel chair, crash trolley, autoclave etc. from the FR4 component of the XV-FC Health Grant, while the diagnostic component provided support for about 16 kit based diagnostic tests.

To gauge the impact of the enhancement of diagnostic services and expansion of equipment, data for OPD footfall was collected before (before October 2022 when EIF and diagnostics were received) and after the intervention (2024). The table below displays this data, which suggests a notable increase in the outpatient footfall.

Table 32: OPD- SHC AAM at Naraja, Baranga block, Cuttack District, Odisha

Month Year (Before)	OPD	Month Year (After)	OPD
May 2022	210	August 2024	298
June 2022	202	September 2024	302
July 2022	208	November 2024	330

Note: OPD footfalls for the same months in 2024 as in 2022 could not be obtained due to some discrepancies in the data records; Data Source- Information provided by the Health Facility

3. BPHU at Subarnapur CHC, Cuttack

This BPHU was under construction at Subarnapur Community Health Centre (CHC). While the BPHU construction is being funded by the PM-ABHIM, the Subarnapur CHC is also being upgraded to a 30-bedded new building from the existing one with only 6 beds, with the construction being funded by the NHM. Both the BPHU and new CHC building were planned to be completed by March 2025. The district-level officials shared the prescribed BPHU layout and described the adherence to the guidelines.

Only 3 of the 17 sanctioned positions for doctors at this CHC were currently filled. Being in the vicinity of a busy highway and accident-prone area, this CHC serves as a point of

care for injured victims. While not operational as a delivery centre currently, the upgraded CHC has a labour room and is being envisaged as a delivery point that would help reduce the load at the nearby Kala Pathar PHC, which is overburdened with deliveries. With the planned expansion in capacity and services at the CHC, the BPHU is expected to serve as a critical tool for enhancing diagnostics services.

D.2 Puri

1. Urban PHC at Pentakatha

This facility was operated out of a 2.5 years old building and had a catchment population of about 49000. Due to its proximity to a DH, the average OPD footfall of this UPHC is on the lower side and in the range of 70-80 per day.

With a total staff of 8 including a Medical Officer hired contractually under NHM in July 2024, this facility received diagnostic support and equipment under the Urban Diagnostics component FU2 of the XV-FC Health Grants. Most of this equipment such as microscope, test tube rack, table top centrifuge, digital Hb meter and biochemistry analyser was received in October 2022, with some additional equipment being received in November 2024. The OPD footfall and total in-house diagnostic tests carried out in this UPHC before and after the intervention is shown in the table below.

Table 33: OPD and Diagnostics- Urban PHC at Pentakatha, Puri District, Odisha

Month year	OPD	In-house Tests	Month year	OPD	In-house Tests
September 2021	2469	965	Sep 2024	2173	1560
October 2021	2317	850	Oct 2024	1877	1533
November 2021	2497	742	Nov 2024	1794	1523

Data Source- Information provided by the Health Facility

Figures indicate that the OPDs are lower in 2024 compared with 2021. This could be attributable to the current Medical Officer joining only in July 2024, prior to which the position was vacant for three months, thereby leading to diversion of patient load. Interestingly, in spite of the lower outpatient load, there is marked increase in the number of diagnostic tests that were carried in house, testifying to the augmented diagnostic capacity of the facility.

2. PHC AAM Nagapur, Gop Block

This facility was equipped with a staff of 8, including a Medical Officer (MBBS) and covering a catchment population of approximately 29000, this PHC receives an average outpatient load of about 50 patients per day.

An NQAS certified facility, the PHC AAM received diagnostic support under the FR3 component of the XV-FC Health Grants, which allowed it to expand the number of diagnostic tests being done in-house from a mere 16 previously to 43 currently. Using the

grant, this facility received equipment like microscope, test tube rack, table top centrifuge, HB meter, refrigerator, incubator, biochemistry analyser, which were received in July 2022. With the consistent presence of a Medical Officer for the last 2 years, the change in OPD footfalls and in house testing at this facility is captured in the table below. Figures in the table show that the expansion of test services has shown up in a remarkable increase in the number of tests being conducted in-house in this facility.

Table 34: OPD and Diagnostics- PHC AAM Nagapur, Gop Block, Puri District, Odisha

Month year	OPD	Inhouse Tests	Month year	OPD	Inhouse Tests
September 2021	920	324	September 2024	1727	575
October 2021	1193	87	October 2024	1703	720
November 2021	1003	100	November 2024	1805	460

Data Source- Information provided by the Health Facilityl

3. SHC AAM Samasara, Pipili Block

This facility was an NQAS certified SHC AAM in the Pipili Block. With a sanctioned staff of 1 CHO, 1 Health Worker (Male) and 1 ANM (currently vacant), about 9 ASHAs covering 10 villages were associated with this facility.

This facility received EIF under the FR4 component supporting conversion of SHCs into HWCs from the XV-FC Health Grants as well as funding under the diagnostic support component FR3. It was observed that some of the EIF obtained included equipment to support physiotherapy and other items like inverter for electricity backup. While only about 10 tests were carried out in-house back in 2022, now the SHC AAM offers services for 16 kit-based diagnostic tests. The observable changes in OPD footfall and diagnostic services are documented in the table below.

Table 35: OPD and Diagnostics- SHC AAM Samasara, Pipili Block, Puri District, Odisha

Month year	OPD	Inhouse Tests	Month year	OPD	Inhouse Tests
September 2021	86	12	September 2024	316	145
October 2021	85	20	October 2024	317	191
November 2021	86	11	November 2024	301	504

Data Source- Information provided by the Health Facility

Figures indicate that both the OPD and in-house tests were abysmally low in the three months shown in 2021. This is attributed to the fact that the CHO only joined in 2022, therefore the services of the SHC were limited to outreach based activities in 2021. There is a robust increase in OPD and in-house testing in 2024. This highlights that the observed outputs such as number of tests and OPD footfall cannot be exclusively ascribed to a particular intervention, but rather it is a consequence of multiple inputs, including human resources and other infrastructure.

Appendix to Chapter 3

Table 36: Timeline of Actual Component-wise Expenditure (in Rs. Lakhs)

Component	Expenditure till 27.02.2023	Proportion of total expenditure incurred till 27.02.2023 (%)	Expenditure from 27.02.2023 and 14.03.2024	Proportion of total expenditure incurred from 27.02.2023 and 14.03.2024%	Expenditure from 14.03.2024 till 26.12.2024	Proportion of total expenditure incurred from 14.03.2024 till 26.12.2024	Total expenditure till 26.12.2024
FR1	*1,910.85*	*7.11*	*11,238.52*	*41.80*	*13,738.82*	*51.10*	*26,888.19*
FR2	*827.16*	*16.88*	*2,687.18*	*54.83*	*1,386.51*	*28.29*	*4,900.85*
FR3	*5,523.11*	*21.77*	*12,654.17*	*49.88*	*7,191.99*	*28.35*	*25,369.27*
FR4	*10,738.26*	*47.75*	*7,160.97*	*31.84*	*4,588.93*	*20.41*	*22,488.16*
Sub-Total of Rural Component	**18,999.38**	**23.85**	**33,740.84**	**42.36**	**26,906.25**	**33.78**	**79,646.47**
FU1	*453.92*	*12.13*	*2,262.11*	*60.46*	*1,025.22*	*27.40*	*3,741.25*
FU2	*3,995.86*	*47.48*	*3,752.88*	*44.59*	*666.93*	*7.92*	*8,415.67*
Sub-Total of Urban Component	**4,449.78**	**36.60**	**6,014.99**	**49.48**	**1,692.15**	**13.92**	**12,156.92**
Grand Total	**23,449.16**	**25.54**	**39,755.83**	**43.31**	**28,598.40**	**31.15**	**91,803.39**

Data Source- Information provided by the Odisha Government

Table 37: Odisha- Year-wise Physical Progress of Construction Related Components of XV-FC Health Grants

	2021-22			2022-23			2023-24			Total (2021-22 to 2023-24)		
Component	Total units (#)	Work started/ completed (%)	Work completed (%)	Total units (#)	Work started/ completed (%)	Work completed(%)	Total units (#)	Work started/ completed(%)	Work completed(%)	Total units (#)	Work started/ completed(%)	Work completed(%)
FR 1	202	90.1	31.19	284	58.1	3.52	480	36.04	0.42	966	53.83	7.76
FR 2	36	97.22	25	27	59.26	0	22	63.64	0	117	55.56	7.69

Data Source- Information provided by the Odisha Government

Table 38: Odisha- Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 as on 27.12.2024 (in Rs. Lakhs)

Component	**Approved Budget**	**Funds Received (Master Sanction)**	**Expenditure incurred**	**% of expenditure against budget**	**% of expenditure against available funds**
Infrastructure Support for Building-less Sub Health Centres	27,814.57	89,718.17	24,681.44	*89*	*89*
Urban health and wellness centres (HWCs)	3,220.00		2,059.50	*64*	
Block Public Health Units (BPHUs)	11,844.02		10,739.90	*91*	
Integrated Public Health Labs (IPHLs)	3,920.10		2,770.22	*71*	
Critical Care Hospital Blocks (CCBs)	58,140.20		39,390.19	*68*	
Total	104,938.89	89,718.17	79,641.25	*76*	*89*

Data Source- Information provided by the Odisha Government

Table 39: Odisha- Financial Utilisation under XV-FC Health Grants FY 2021-22 to FY 2023-24 (in Rs. Crores)

Component	Approved Budget 2021-24	Funds Received	Funds Released	Expenditure Incurred till 31.08.24	% of Expenditure against funds received
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	*478.81*	*478.81*	*478.81*	*268.88*	*56.16*
FR2 Construction of Block Public Health Units (BPHUs)	*77.09*	*77.09*	*77.09*	*49*	*63.56*
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*387.87*	*387.87*	*372.6*	*253.69*	*65.41*
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	*250.42*	*250.42*	*250.42*	*224.88*	*89.80*
Sub-Total of Rural Component	**1,194.19**	**1,194.19**	**1,178.93**	**796.45**	**66.69**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*56*	*56*	*56*	*37.41*	*66.81*
FU2 Urban Health & Wellness Centres (HWCs)	*156.21*	*156.21*	*156.21*	*84.16*	*53.88*
Sub-Total of Urban Component	**212.21**	**212.21**	**212.21**	**121.57**	**57.29**
Grand Total	**1,406.40**	**1,406.40**	**1,391.13**	**918.02**	**65.27**

Table 40: Odisha- Year-wise Initial Allocation vs. Approvals (in Rs. Crores)

Financial Year	**2021-22**		**2022-23**		**2023-24**	
Component	**Allocation**	**Approval**	**Allocation**	**Approval**	**Allocation**	**Approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	72.83	72.83	72.83	141.98	76.43	264
FR2 Construction of Block Public Health Units (BPHUs)	29.08	29.08	29.08	29.08	30.53	18.93
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	127.22	127.19	127.22	127.03	133.59	133.65
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	125.33	125.12	125.33	125.3	131.6	
Sub-Total of Rural Component	**354.46**	**354.22**	**354.46**	**423.39**	**372.15**	**416.59**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	18.36	18.36	18.36	18.36	19.28	19.28
FU2 Urban Health & Wellness Centres (HWCs)	89.19	89.19	89.19	19.7	93.65	47.32
Sub-Total of Urban Component	**107.55**	**107.55**	**107.55**	**38.06**	**112.93**	**66.6**
Grand Total	**462.01**	**461.77**	**462.01**	**461.45**	**485.08**	**483.18**

Data Source- Information provided by the Odisha Government

Table 41: Odisha- Year-wise Physical Progress for Construction related Components of PM-ABHIM

Component	Year	Total units (#)	Not started (#)	Work started (#)	Work completed (#)	Work started or completed (%)	Work completed (%)
CCB	2021-22	3	0	3	0	*100.00*	*0.00*
	2022-23	6	0	6	0	*100.00*	*0.00*
	2023-24	6	1	4	1	*83.33*	*16.67*
	2024-25	6	5	1	0	*16.67*	*0.00*
	2025-26	7	4	3	0	*42.86*	*0.00*
	TOTAL	**28**	**10**	**17**	**1**	***64.29***	***3.57***
IPHL	2021-22	3	0	1	2	*100.00*	*66.67*
	2022-23	6	0	3	3	*100.00*	*50.00*
	2023-24	6	1	4	1	*83.33*	*16.67*
	2024-25	6	5	1	0	*16.67*	*0.00*
	2025-26	9	6	2	1	*33.33*	*11.11*
	TOTAL	**30**	**12**	**11**	**7**	***60.00***	***23.33***
BPHU	2021-22	0	0	0	0		
	2022-23	35	2	25	8	*94.29*	*22.86*
	2023-24	40	1	25	14	*97.50*	*35.00*
	2024-25	44	42	2	0	*4.55*	*0.00*
	2025-26	78	17	59	2	*78.21*	*2.56*
	TOTAL	**197**	**62**	**111**	**24**	***68.53***	***12.18***
SC	2021-22	302	33	225	44	*89.07*	*14.57*
	2022-23	302	43	194	65	*85.76*	*21.52*
	TOTAL	**604**	**76**	**419**	**109**	***87.42***	***18.05***

Data Source- Information provided by the Odisha Government

Chapter 4: State-Level Insights from Telangana

A. The Context

Telangana has been one of the best performing states in the country with respect to the XVth FC health grants (Refer Figures in Aggregate analysis). The state adhered to the DoE guidelines on fund flows and managed to secure releases for all the three years 2021-22 to 2023-24. In the first two years of the grant, the state could utilize around 95 per cent of the releases of the grant to the state, and stood next only to Tamil Nadu in terms of the overall absorption of funds in the three-year period. Of the six states visited by the study team, Telangana stands out as the only state, which has engaged both rural and urban local bodies in the implementation of the FC grant.

The rural-urban distribution of allocation by the FC was broadly in accordance with the degree of urbanization in the state. About 66 per cent of the total grant amount for the first three years was allocated to the rural components; the remaining towards urban (Table 42). Among the rural components, BPHU (FR2) had the highest weight at 28 per cent of the total allocation for the first three years of the grant, while the construction of building-less SHCs, PHCs and CHCs (FR1) the lowest weight at 0.67 per cent. The single largest component of overall allocation was towards urban HWCs (FU2) standing at 32 per cent of the total grant.

Table 42: Telangana- Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	**Cumulative Total (2021-22 to 2023-24)**			
Component	**Allocation**	**Approval**	**Component as % of total allocation**	**Component as % of total Approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	858	25320.58	0.67%	20.15%
FR2 Construction of Block Public Health Units (BPHUs)	36149	31408.26	28.26%	24.99%
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	21523	21481.78	16.82%	17.09%
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	25952	10364.09	20.29%	8.25%
Sub-Total of Rural Component	**84482**	**88574.71**	**66.04%**	**70.49%**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	2703	2696.23	2.11%	2.15%
FU2 Urban Health & Wellness Centres (HWCs)	40748	34391.92	31.85%	27.37%
Sub-Total of Urban Component	43451	37088.15	33.96%	29.51%
Grand Total	**127933**	**125662.86**	**100.00%**	**100.00%**

Data Source- Information provided by the Telangana Government

B. The Approach and Execution

B.1 Fund Flow and Execution Agency

Releases of funds in the state conformed to the DoE guidelines. All construction activities in the rural components were assigned to the Zilla Parishads (RLB), and therefore, funds for these were released by the Finance Department to the Panchayati Raj and Rural Development (PR&RD)

Department. Similarly, for the urban components, funds were transferred by the Finance Department to the Department of Municipal Administration and Urban Development (MA & UD) Department for execution. All funds for procurement under FR2, FR3 and FU1 were transferred to the Health Department and subsequently released to Telangana Medical Services and Infrastructure Development Corporation (TGMSIDC). Table 43 below highlights the fund flow and execution arrangements for different components of the grant.

Table 43: Telangana- Fund flow under XV-FC Health Grants

Component	Budget Provision under	1st level recipient	2nd level recipient
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	PR & RD Department	PR & RD Department	Zila Parishad CEO
FR2 Block Public Health Units (BPHUs)	Health Department	Health Department	TGMSIDC (Procurement of kits, reagents, equipment)
	PR & RD Department	PR & RD Department	Zila Parishad CEO (Construction and repair of PHCs)
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Health Department	Health Department	TGMSIDC (Procurement)
			DM & HO (Transportation/runner costs under Hub and Spoke)
FR4 Conversion of Rural Sub-Health Centres to HWCs	PR & RD Department	PR & RD Department	DMHO (Salary, training)
			Zilla Parishad CEO (Part re-appropriated for construction of SHCs)
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Health Department	Health Department	TGMSIDC
FU2 Urban Health & Wellness Centres (HWCs)	MA & UD Department	MA & UD Department	Urban Local Bodies (UPHC construction)
			Urban Local Bodies →DMHO (For BDKs or UHWCs)

Data Source- Information provided by the Telangana Government

B.2 Adapting FC Grants to Meet State-specific Context

Telangana utilised the XV-FC health grants to strengthen two state-specific initiatives. First, components FR2, FR3, and FU1 were used to support 'Telangana Diagnostics'—a state government initiative aimed at providing free and high-quality diagnostic services. Secondly, the component FU2 was used to expand and reinforce Basti Dawa Khanas (BDKs), a variant of UHWCs operational in the state.

Under the FR2 component of the grant, the state decided not to construct fresh Block Public Health Units (BPHUs), but to use the funds to strengthen the existing infrastructure of District

Pathology and Radiology Hubs (DPRH) and for procurement of laboratory equipment in these hubs.

FR3 was used for procurement of diagnostic kits, reagents and equipment and used towards strengthening of the in-house capacity of Telangana Diagnostics, which has been operational through a Hub and Spoke model. A part of the funds in this component was also transferred to the District Medical & Health Officers (DMHO) to meet sample transportation costs for connection of hubs and spokes. Similarly, FU1 was used for procurement of reagents and equipment to strengthen the provision of diagnostic services in urban facilities under the Telangana Diagnostics initiative.

Interestingly, even prior to the recommendation of the XV-FC Health Grants, Telangana possessed a network of about 259 Basti Dawa Khanas, which are an analogue of the Urban HWCs envisaged under the XV-FC Health Grants and PM-ABHIM. Funds under the component FU2 UHWCs were used to operationalize additional BDKs, provisioning of drugs and consumables in BDKs and for construction of UPHCs.

In terms of costs, the state proposed SHC construction at 20 lakhs (lower than the provided cost norm of Rs. 55 lakhs) with a building area of 915 sq. ft. instead of the norm of 1500 sq. ft. due to lower land availability. However, with respect to CHCs, the state is pursuing construction of 50-bedded CHCs rather than the provided 30-bedded, which implies that costs incurred are higher than the amount being provided under the XV-FC Health Grants. According to State officials, this shortfall in funds is being met from the state budget.

Active engagement in re-appropriation of funds across components to suit the local context was a distinct feature in Telangana, (Refer Table 55 and Table 56 in the Appendix). The state had unspent balances or savings in a number of components from the FY 2021-22 funds, which it proposed to re-appropriate across components/ other uses within the same component. The re-appropriation proposal of the state pertaining to several components in FY 2022-23 was approved in the 5th NLC meeting held in March 2023. First, the approved budget in FY 2021-22 was Rs. 85.05 crore of which, Rs. 2.18 crore was incurred towards training of ASHAs & ANMs for 1,089 SC-HWCs. Due to paucity of time, HWCs could not be operationalized which resulted in savings of Rs. 82.87 crore from the FY 2021-22 funds. These savings were proposed to be used towards the recurring expenditure under the same component in FY 2022-23. Similarly, since the significant amount of savings (Rs. 82.87 crore) from 2021-22 were used to meet the expenditure under this component in 2022-23, Rs. 82.87 crores of the allocation intended for this component for 2022-23 was re-appropriated towards the construction of building-less SHCs and PHCs. Additionally, there were savings from the FY 2021-22 allocation to FU2 UHWC component amounting to Rs. 68.64 crore from the total budget of Rs. 133.09 crore for that year. In view of availability of unspent balance in FY 22-23, this Rs. 68.64 crore was converted to non-recurring budget for establishment of 38 new UPHCs @Rs.1.8 crore each of Rs. 68.64 crore. Moreover, as in most other states, due to the withdrawal of HR support since FY 2023-24, there were major re-appropriations. From the allocation pertaining to HR support for the components concerning conversion of SHCs to HWCs (FR4), BPHU (FR2), and Urban HWCs (FU2), an additional Rs. 161.75 crores were re-appropriated towards the construction of building less SHCs, PHCs, CHCs (FR1)

B.3 Achievements: Financial and Physical Progress

For the period 2021–22 to 2023–24, the expenditure reported on the PMS portal is significantly higher than the figures shared by state officials during the study team's visit. According to state-level data, only about 55 per cent of the released funds were spent during these years. The utilisation rate was notably lower for the rural components compared to the urban components.

A noticeable laggard in terms of utilization of releases was the component FR1 *Construction of Building-less SHCs, PHCs and CHCs* (Table 44). This could be attributed to two possible reasons. First, there was a manifold increase in the allocation of this component after the initial year, and this made it difficult to absorb the additional funds. A substantial amount of savings from FR4 *Conversion to HWCs* component in the first year was re-appropriated to this component in the second year.[34] In the subsequent year 2023-24, with the withdrawal of HR support, an even larger sum was re-appropriated to the FR1 component.[35] Since the re-appropriated funds were released to the implementing departments only in June and October 2024, the absorption rate was yet to pick up.[36] Secondly, the implementation of this component was carried out by rural local bodies under the PR & RD department, who are also burdened with other sectoral construction works. Also, as the construction works needed to be done by the local bodies in coordination with the H & FW department, there could be delays on account of transfer of funds to local bodies and inter-departmental coordination.

The physical progress in the construction components of both rural and urban components mirror the poor utilization of funds (Table 45). As on February 2025, no SHC, PHC or UPHC has been completed under FR1 or FU2. Since all construction activities were to be carried out by local bodies under PR&RD and MA&UD, the low utilisation could be attributed to challenges in execution by these local bodies.

The progress in the procurement related components (for strengthening Telangana Diagnostics), were executed by the H&FW department, and had significantly better performance (Table 44). For expansion of BDKs also, although funds were released to MA & UD Department for execution through urban local bodies, these were subsequently given to the DMHO under the

[34] This component constituted a very small proportion of the total grants in the first two years, with about Rs. 2.8 crores being allocated in 2021-22 and 2022-23 each. In the first year, this allocation was employed towards the construction of 14 building-less SHCs. An additional Rs. 82.87 crores, which constituted savings from the first year of the conversion to HWCs component (FR4) was re-appropriated to this component in 2022-23. This increased the total approval to this component to about Rs. 85.87 crores. The increased approval for this component was also transferred to the PR & RD Department towards the construction of an additional 414 SHCs.

[35] A substantial portion of the initial HR provisions under the components of conversion to HWCs (FR4), BPHU (FR2) and Urban HWCs (FU2) was re-appropriated to the construction of SHCs, PHCs and CHCs component. This increased the allocation towards this component to Rs. 164.7 crores from the initially allocated Rs. 2.96 crores. A part of these funds was to be used towards construction of about 200 SHCs and about 42 PHCs for which the PR & RD Department is the designated implementing agency.

[36] A portion of the funds was to be used towards construction of 11 CHCs for which the TGMSIDC (Telangana Medical Services and Infrastructure Development Corporation) under the Health Department would be the implementing agency.

Health Department for actual execution at the district level.[37] The fund utilization and physical progress in this component has also been decent (Table 44).

Table 44: Telangana- Year-wise Financial Utilisation of XV-FC Health Grants as a Percentage of Releases

Component	2021-22	2022-23	2023-24	Cum total
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	*15.66*	*9.46*	*18.73*	*15.56*
FR2 Construction of Block Public Health Units (BPHUs)	*55.56*	*39.72*	*0.00*	*35.89*
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*100.00*	*100.00*	*28.24*	*85.16*
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	*100.00*	*26.17*	*16.52*	*85.23*
Sub-Total of Rural Component	**80.13**	**45.59**	**14.88**	**46.15**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*100.00*	*100.00*	*67.11*	*76.12*
FU2 Urban Health & Wellness Centres (HWCs)	*86.08*	*93.90*	*0.00*	*72.82*
Sub-Total of Urban Component	**86.95**	**94.28**	**28.63**	**73.36**
Grand Total	**82.44**	**62.13%**	**18.60**	**54.78**

Data Source- Information provided by the Telangana Government

Table 45: Telangana- Year-wise Physical Progress for Construction related Components of XV-FC Health Grants

	Total Cumulative (2021-22 to 2023-24)		
Component	**Total units**	**Work started/completed (%)**	**Work completed (%)**
FR1 a) Construction of building less SHCs	657	*99.54%*	*0.00%*
FR1 b) Construction of building less PHCs	42	*100.00%*	*0.00%*
FR1 c) Construction of building less CHCs	11	*100.00%*	*9.09%*
FR2 BPHU (Partially allotted to construction of PHCs)	85	*97.65%*	*24.71%*
FU2 Urban HWCs (Partially allotted to construction of UPHCs)	92	*14.13%*	*0.00%*

Data Source- Information provided by the Telangana Government

In PM-ABHIM, the state could utilize 67 per cent of the total funds available to the state (up to February 2025) (Table 46). This was better than states like Gujarat and Uttar Pradesh, but worse than Odisha. As a proportion of total approvals, this share was only about 46 per cent.

[37] The FY 2021-22 funding under this component, was used to operationalize an additional 237 new BDKs. In FY 2022-23, this component was allocated towards construction of 55 UPHCs and towards drugs and consumables for 390 BDKs. In 2023-24, it has been allotted towards construction of 37 UPHCs and drugs for 500 BDKs and 251 UPHCs.

In PM-ABHIM, Telangana received funding for three components: Critical Care Blocks (CCBs), Integrated Public Health Laboratories (IPHLs) and Urban Health and Wellness Centres (UHWCs). The only component, which was common to both the XV-FC Health Grants and PM-ABHIM, was UHWCs or U-AAMs. This component received funding under PM-ABHIM only since 2023-24, and hence only has a single overlapping year with the XVth FC grant.

In terms of physical progress, as shown in Table 47, both the components of CCB and IPHL exhibit good progress with over 93 per cent of units allocated to each component being either in progress or completed. About 5 CCBs of the total 31 target units of the state stand completed – a completion rate of 16 per cent and another 8 are scheduled to be completed by 31st March 2025. Similarly, an impressive 60 per cent of all target IPHL units have been completed in the state, reflecting strong physical progress under PM-ABHIM in the state.

Table 46: Telangana- Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 as on 20.02.2025 (in Rs. Crores)

Year	Approved Budget	Funds Received (State+Central share)	Expenditure incurred	% of expenditure against approved budget	% of expenditure against available funds
2021-22	75	18.75	0	*0.00%*	*0.00%*
2022-23	161.90	85.76	83.75	*51.73%*	*97.66%*
2023-24	312.21	120.96	141.72	*45.39%*	*117.16%*
2024-25 (up to 20.02.2025)	334.01	374.5	178.31	*53.38%*	*47.61%*
Grand Total	**883.12**	**599.97**	**403.78**	***45.72%***	***67.30%***

Data Source- Information provided by the Telangana Government

Table 47: Telangana- Component-wise Physical Progress for Components of PM-ABHIM (Total Units from FY 2021-22 to FY 2025-26)

Component	Year	Total Units (#)	Work in Progress (#)	Completed(#)	Not Started(#)	Work started or completed (%)	Work completed (%)
CCB	2021-22	3	**24**	**5**	**2**	**93.55**	**16.13**
	2022-23	6					
	2023-24	6					
	2024-25	6					
	2025-26	10					
	Total	**31**					
IPHL	2021-22	3	**11**	**20**	**2**	**93.94**	**60.61**
	2022-23	7					
	2023-24	7					
	2024-25	7					
	2025-26	9					
	Total	**33**					

Data Source- Information provided by the Telangana Government

C. Challenges Faced by the State

Telangana faced two distinct challenges in the implementation of the XVth FC grants; the first being the delay in transfer of funds to the implementing/nodal departments, and second being issues specific to execution of health-related construction by the local bodies.

C. 1 Delay in transfer of Funds from Finance Department and Ensuing Penal Interest

There was a delay in transfer of funds from the state's Finance Department to the Health, PR & RD and MA & UD Departments to begin with. In 2021-22, the delay amounted to about 20 days, which led to a penal interest liability of over Rs. 73 lakhs for the Finance Department. This penal interest could be paid by the Finance Department to the Health Department only in March 2023. In 2022-23, the delay was even more pronounced: around 10 months for large proportion of funds (Table 48). This resulted in a penal interest liability of approximately ₹15 crores for the State Finance Department, which was paid to the Health Department only in July 2024. As fund disbursement for the next instalment depends on prior utilization, any initial setback creates a cascading effect, impacting utilization in all subsequent years.

Table 48: Telangana- Delay in Transfer of FY 2022-23 XV-FC Health Grants from the State Finance Department

Component	Amount received from GoI (in lakhs)	Date of receipt	Amount transferred (in lakhs)	Date of transfer	Delay (no. of days)
FR3 Support for Diagnostic Infrastructure to the Sub Centres in rural areas	3492.5	29/03/2023	3337	17/01/2024	**294**
			144.5	19/01/2024	**296**
			11	23/01/2024	**300**
FR3 Support for Diagnostic Infrastructure to the PHCs in rural areas	3555	29/03/2023	2400	05/10/2023	**190**
			1155	19/01/2024	**296**
FR2 Construction of Block Public Health Units (BPHUs)	11846.04	29/03/2023	2646.04	23/01/2024	**300**
			4200	26/02/2024	**334**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	8508.09	29/03/2023	4020.98	11/04/2023	**13**
			2814.93	19/01/2024	**296**
			1651.55	23/01/2024	**300**
			20.63	26/02/2024	**334**
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	280.98	29/03/2023	6.57	19/01/2024	**296**
			274.41	23/01/2024	**300**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	879	29/03/2023	879	19/01/2024	**296**
FU2 Urban Health & Wellness Centres (HWCs)	13360	29/03/2023	2600	05/10/2023	**190**
			1663	17/01/2024	**294**
			417	23/01/2024	**300**
			8680	11/04/2023	**13**

Source- Grant Transfer Certificate submitted to DoE for 2022-23

C.2 Issues Specific to Execution by Local Bodies

The involvement of local bodies in the construction related components of the grant posed several challenges. While urban local bodies were to be involved in construction of UPHCs from FY 2023-24 onwards, rural local bodies were involved in the construction of SHCs and PHCs from the first year of the grant itself. Both these components were noticeable laggards in terms of physical progress.

According to State officials, initially, the State Health Department requested the PR & RD Department to transfer the FC funds to the District Health Society under the Health Department for implementation. However, this was met with opposition by some Zilla Parishad CEOs, and consequently, PRI representatives decided to execute the construction of SHCs and PHCs themselves. These deliberations delayed the initiation of works by six months to a year.

The constructions associated with the FC grants also came as an addition to the existing responsibilities of the PR&RD department. Being occupied with other sectoral assignments, the PR Department at one point returned the proceeding for construction of 200 Sub Health Centres to the Health Department. This was subsequently transferred to the DMHO under the Health Department, who could then coordinate with the District Collector to make the decision about allocation of works to agencies. Additionally, due to the administrative dichotomy in the implementation of the FC grant, the Health Department—being outside the direct fund flow mechanism—is not immediately informed of fund transfers from the state treasury to the PR Department, further complicating coordination efforts.

Officials also highlighted the challenges that arise when health sector-related activities are executed by agencies outside the Health Department. This arrangement often results in a lack of ownership, as the implementing local bodies tend to feel accountable to their parent departments rather than the Health Department. Consequently, the primary stakeholder—the Health Department—is excluded from a position of control, while the executing agency may prioritise its own core responsibilities over health-related tasks.

D. Observations from Facility Visits in Districts

Field visits to selected facilities in the districts of Hyderabad and Yadadri were undertaken to assess the on-ground impact of the XV-FC Health Grants and the PM-ABHIM. The diagnostics and UHWCs components have exhibited the most significant uptake, and therefore, the facility visits primarily focused on BDKs established under the urban HWCs component of the XV-FC Health Grants, and diagnostics enhancement under both XV-FC Health grants and the PM-ABHIM. Notably, most primary health facilities were still under construction in the state.

Hyderabad	Yadadri
1. Telangana Diagnostics IPHL 2. Basti Dawa Khana (BDK) Urban AAM Ratnanagar	1. Under construction CCB at district Hospital (recently converted to General Government Hospital, Yadadri) 2. Telangana Diagnostics Hub (IPHL) next

	to the District Hospital 3. Basti Dawa Khana (BDK) Urban AAM Jagdevpurgadda 4. Under construction UPHC at Bhongir 5. Basti Dawa Khana (BDK) Urban AAM-Hanumanvada 6. Under construction SHC at Wadaparthi

D.1 Hyderabad

1. Telangana Diagnostics (TD) IPHL

This TD Hub was upgraded to an IPHL in 2023-24. It was originally set up under the Free Diagnostics Service Initiative of the NHM in 2018. Employing 26 Laboratory Technicians (LTs), 6 consultants,1 Lab Manager, 1 Quality Manager and 6 Data Entry Operators (DEOs) and 6 category four staff, this was a vibrant facility receiving as many as 8000-9000 testing samples a day from 467 spokes.

Housing a pathology, microbiology and a biochemistry lab, this facility received diagnostic equipment from both the XV-FC Health Grant and the PM-ABHIM, which allowed it to expand its testing range and capacity from the previously offered 57 tests to about 134 tests.

The facility exhibited a case where multiple sources of funding could be combined to run a vibrant facility. The operating expenses of this facility were covered under the NHM until 2020. From 2020–21 to 2022–23, they were funded through the XV-FC Health Grants, after which the facility was upgraded to an IPHL and brought under the coverage of PM-ABHIM. However, the operating expenses of this IPHL are to the tune of Rs. 10 crores per annum as opposed to Rs.49 lakhs provided under the PM-ABHIM, therefore the shortfall in operating expenses is being met through the XV-FC Health Grants. HR support continues to be covered under the NHM.

This IPHL illustrates the challenges in attributing outputs or outcomes to specific initiatives, as its performance reflects the combined impact of various components under PM-ABHIM and XV-FC, along with complementary human resource support provided through schemes such as the NHM.

2. Basti Dawa Khana (BDK) Urban AAM Ratnanagar

This BDK was operationalised using the XV-FC Health Grants. Started around 1.5 years ago, this BDK was situated in a government building in a populated residential area. Staffed by 1 MBBS Medical Officer (MO) who had been in position for about 5 months at the time of our visit, 1 staff nurse and 1 supporting staff, this BDK covered a catchment population of about 4500 people. Witnessing an average daily OPD footfall of about 60-70 patients, this facility offered about 3 kit-based tests which could be conducted in-house. This BDK was under the Kingkoti UPHC which was located at a distance of about 1.5 km from this facility.

The operationalization of this BDK improved access for people in the vicinity and reduced patient overload on the nearby UPHC. This BDK witnessed robust OPD footfall in recent months as shown in the table below.

Table 49: OPD at BDK Ratnanagar, Hyderabad District, Telangana

Month	November 2024	December 2024	January 2025	February 2025
OPD	1400	1700	1850	1560
ANC	50	60	47	30
NCD	132	147	160	176
Immunization	50	58	60	60
OP Referral	10	14	30	14
Lab Referral to Telangana Diagnostics	180	280	350	230

Data Source- Information provided by the Health Facility

D.2 Yadadri

3. Office of DMHO

Conversations with district-level Health Department officials at the DMHO office revealed that the district was allocated approximately 25 SHC-AAMs, of which 5-6 have been made operational. The officials emphasized that Rs. 20 lakhs of budget allocated per SHC was insufficient to meet the costs. The discussion also brought to the fore the issues faced in coordinating with the PR & RD as well as the MA & UD Departments, along with the political interference faced in location and land identification.

In terms of the urban components, about 4 BDKs had been operationalised under this district using the XV-FC Health Grants. The outputs generated by these 4 BDKs can be gleaned from the data on their OPD footfall for the last few months shown in the table below.

Table 50: OPD Footfall at BDKs in Yadadri District, Telangana

	Total footfall		
Facility Name	**November 2024**	**December 2024**	**January 2025**
Choutuppal(Basthi Dawakana)	1828	1988	1935
Hanumanwada (Basti Dawakhana)	1875	2032	1883
Jagdevpur gadda (Basti Dawakhana)	1938	2114	1963
Samad chowrasta (Basti Dawakhana)	1820	2098	1928
Total	**7461**	**8232**	**7709**

Data Source- Information provided by the Health Facility

The table shows that these four new BDKs cumulatively witnessed a significant footfall of about 7500-8000 OPDs in a month.

4. Under construction CCB at district Hospital, Yadadri)

The district hospital, which had been recently converted into a General Government Hospital, was a 150-bedded facility (capacity of over 200), offering all major specialities and witnessing an OPD footfall of 500-700 per day.

A 50-bedded CCB unit was being constructed by the TGMSIDC at this facility, along with 4 new Operation Theatres (OTs). The CCB equipment had already been sanctioned at the time of our visit, and the CCB was expected to become operational within 3-4 months.

Interestingly, while the hospital had its own lab, this lab was now being used as a sample collection centre from where samples were transferred to the Telangana Diagnostics (TD) Hub IPHL, set up in the vicinity from the PM-ABHIM. The construction of this IPHL helped in reducing the crowding at the existing hospital lab, streamlining the patient flow and also allowing for a wider range of tests.

5. Telangana Diagnostics Hub (IPHL) next to the District Hospital

This TD District Hub was established as an IPHL under the PM-ABHIM initiative in July 2023. Located next to the district hospital and constructed by the TGMSIDC, this facility served as a diagnostic hub to 30 spokes including the adjacent DH/GGM. Staffed by 7 Laboratory Technicians (LTs), 1 Lab Manager, 1 Pharmacists, 1 DEO, 2 consultants and 2 radiographers, this IPHL offers pathology, biochemistry and microbiology services.

This facility served as a hub to 30 spokes and currently offered 78 out of the 134 tests that are planned to be provided. The IPHL receives about 400-600 samples a day on an average, which are used to conduct about 1000-1200 tests.

The facility was set up using funds from both the diagnostic component of the XV-FC Health grant as well as the IPHL component under PM-ABHIM. The officials mentioned that with the discontinuation of the XV FC Grant support and of the PMABHIM scheme, it will be a huge fiscal challenge to sustain this costly initiative.

6. Basti Dawa Khana (BDK) Urban AAM Jagdevpur Gadda

This facility was operationalised from the XV-FC Health Grants in March 2023. Operating from a municipality owned community hall, this BDK covers a catchment population of about 8651 and is located at a distance of 2-3 km from the nearest UPHC. With one staff nurse (SN) and one multipurpose worker (MPW), this BDK had a Medical Officer (MO) in place until the month before our visit.

With an average daily OPD footfall of about 80-85 patients, the operationalisation of this BDK helped in reducing the patient pressure on the UPHC. It offered about 8 tests in-house and was also an assigned spoke for sample collection. While the initial capital and

operational expenses of this BDK were covered under the XV-FC, the HR costs are now being covered under the PM-ABHIM.

The table below records the facility's outputs in terms of OPD footfall over the past few months, demonstrating that it serves approximately 2,000 patients per month.

Table 51: OPD Footfall at BDK Jagdevpur Gadda, Yadadri District, Telangana

	December 2024	January 2025	February 2025
Total footfall	2114	1963	1834
No. of patients who received medicines	2060	1963	1834
No. of patients availed diagnostic tests	264	231	303
No. of patients availed tele-consultation services	126	131	97

Data Source- Information provided by the Health Facility

7. UPHC- Bhongir

This facility was under construction. The UPHC is currently operating out of a rented building. This unit being an urban facility, is being constructed by the MA & UD Department. Covering a population of about 58000 and staffed by 1 Medical Officer (MO), 1 Staff Nurse, 5 ANM, 1 pharmacist, 1 LT, 1 DEO/Accountant and 1 support staff, this facility faces space and work flow constraints operating within the current premises.

Constructed using funds from the XV-FC Health Grants, this new building, featuring 6 beds and 2 floors, is expected to address the challenges in functioning and accommodate the daily OPD footfall of 100 patients.

8. Basti Dawa Khana (BDK) Urban AAM- Hanumanwada

This facility was operationalised using the XV-FC Health Grant. Covering a catchment population of 11600, this BDK was made functional in March 2023, and is situated in a municipal owned community hall.

Staffed by 1 Medical Officer who had recently resigned, 1 staff nurse and 1 supporting staff, this BDK witnesses a load of 80-90 OPDs patients per day and offers 8 tests in house, with samples for another 67 tests being sent to the hub.

The patient footfall and other outputs from this facility in recent months are documented in the table below.

Table 52: OPD Footfall at BDK Hanumanwada, Yadadri District, Telangana

	December 2024	January 2025	February 2025
Total footfall	2032	1883	1633
No. of patients who received medicines	1994	1877	1592
No. of patients availed diagnostic tests	73	55	91
No. of patients availed tele-consulation services	143	111	80

Data Source- Information provided by the Health Facility

9. SHC Wadaparthi

This facility is being constructed using the XV-FC Health Grants. The SHC is currently operating out of a Gram Panchayat premises, while the new building is being constructed by the PR & RD Department.

At the time of the team's visit, construction had come to a halt due to costs exceeding the allocated budget of ₹20 lakh. Additional funds were being sought from the Health and Family Welfare Department to complete the construction.

Appendix to Chapter 4

Table 53: Telangana- Financial Utilisation under XV-FC Health Grants FY 2021-22 to FY 2022-23 (as of February 2025)

Component	Approved Budget 2021-24	Funds Received	Expenditure Incurred as of February 2025	% of Expenditure against funds received
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	*25320.58*	*25318.98*	*3939.85*	*15.56%*
FR2 Construction of Block Public Health Units (BPHUs)	*31408.26*	*31408.26*	*11271.61*	*35.89%*
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*21481.78*	*21481.6*	*15101*	*85.16%*
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	*10364.09*	*10364.09*	*8833.2*	*85.23%*
Sub-Total of Rural Component	**88574.71**	**88572.93**	**39145.66**	**46.15%**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	*2696.23*	*2695.96*	*4905.77*	*76.12%*
FU2 Urban Health & Wellness Centres (HWCs)	*34391.92*	*32961.47*	*24001.9*	*72.82%*
Sub-Total of Urban Component	**37088.15**	**35657.43**	**28907.67**	**73.36%**
Grand Total	**125662.86**	**124230.36**	**68053.33**	**54.78%**

Data Source- Information provided by the Telangana Government

Table 54: Telangana- Year-wise Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	2021-22		2022-23			2023-24	
Component	Allocation	Approval	Allocation	Approval	Approval after reappropriation	Allocation	Approval
FR1 Construction of Buildin- less Sub-Health Centres, PHCs & CHCs	281	280.98	281	280.98	8568	296	16471.6
FR2 Construction of Block Public Health Units (BPHUs)	11852	11820.16	11852	11846.04	11846.02	12445	7742.08
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	7053	7018	7053	7047.5	7047	7417	7416.78
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	8509	8505.09	8509	8505.09	217.8	8934	1641.2
Sub-Total of Rural Component	**27695**	**27624.23**	**27695**	**27679.61**	**27678.82**	**29092**	**33271.66**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	886	886	886	879	879	931	931.23

FU2 Urban Health & Wellness Centres (HWCs)	13360	13309.92	13360	13360	13360	14028	7722
Sub-Total of Urban Component	**14246**	**14195.92**	**14246**	**14239**	**14239**	**14959**	**8653.23**
Grand Total	**41941**	**41820.15**	**41941**	**41918.61**	**41917.82**	**44051**	**41924.89**

Data Source- Information provided by the Telangana Government

Table 55: Telangana- Reappropriation Across Components in FY 2022-23 (in Rs. Lakhs)

Component	Approval in 2021-22	Savings in 2021-22	Allocation in 2022-23	Revised allocation after reappropriation in 2022-23
FR4 Conversion of Rural Sub-Health Centres to HWCs	8505	8287	8505.09	217.8
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	280.98	0	280.98	8568

Data Source- Information provided by the Telangana Government

Table 56: Telangana- Reappropriation Across Components in FY 2023-24 (in Rs. Lakhs)

Component	Initial Allocation 2023-24	HR costs=Amount available for reappropriation	Approval after reappropriation 2023-24	Savings proposed for
FR2 BPHU	12445	4700.16	7742.08	FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs
FR4 Conversion of SHCs to HWCs	8934	7161.6	1641.2	
FU2 Urban HWCs	14028	5768.48	7722	
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	296		16471.6	

Data Source- Information provided by the Telangana Government

Table 57: Telangana- Penal Interest for XV-FC Health Grants

Financial Year	Date of adjustment	Penal interest amount (in Rs.)
2021-22	29/03/2023	73,91,000
2022-23	27/07/2024	14,89,46,000

Data Source- Information provided by the Telangana Government

Table 58: Telangana- Fund Flow to Rural Local Bodies

Date of receipt from GoI	Date of transfer from Finance Department to PR & RD Department	Date of transfer from PR & RD Department to Zila Parishads	Amount of transfer (in Rs.)	Allocated for
30/11/2021	30/12/2021	30/04/2022	671,992,000.00	14 SHC construction and 206 PHC repair and renovation
30/11/2021	30/12/2021	30/08/2022	670,800,000.00	43 new PHCs

Data Source- Information provided by the Telangana Government

Chapter 5: State-Level Insights from Madhya Pradesh

A. The Context

Madhya Pradesh has been an average performer among Indian states in terms of the XV- FC health grants. Between 2021-22 and 2023-24, the fund utilization rate in the state has been around the all-India average with physical progress marginally better than the country-average (Refer Table in Aggregate Analysis). The State was able to obtain bulk of the releases in the first two years of the grant period 2021-22 and 2022-23, but was unable to do so thereafter. In terms of utilization of funds, the state managed to score over 50 per cent in most of the components in the first two years, making it eligible in terms of the utilization criterion to secure subsequent releases. Yet, till the time of visit by the study team, the state could not avail releases for the third year due to violation of the DoE guidelines on releases of funds.

Table 59 below presents the initial allocations and financial approvals. The initial outlay of the XVth FC grants was broadly balanced between the rural and the urban components: 51 per cent in rural versus 49 per cent in urban areas. However, due to re-appropriation of funds from urban to rural components over the years, the share of rural components in actual approvals increased. By the end of 2023–24 (the first three years of the grant), the rural component accounted for 61 percent of the approved expenditure, while the urban component accounted for only 39 percent. Within the rural components, more than 70 per cent of the approvals was towards the two components – FR3 for the support for diagnostic infrastructure and FR1 for the construction of building-less SHCs, PHCs and CHCs. Among the two urban components, more than 92 per cent of the approval was towards the single component FU2 Urban Health and Wellness Centres (UHWCs).

Table 59: Madhya Pradesh- Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	**Cumulative Total (2021-22 to 2023-24)**			
Component	**Allocation**	**Approval**	**Component as % of total allocation**	**Component as % of total Approval**
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	9158	60312	3.25	21.50
FR2 Construction of Block Public Health Units (BPHUs)	8842	7660	3.14	2.73
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	64464	64452	22.90	22.98
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	60316	39549.84	21.42	14.10
Sub-Total of Rural Component	**142780**	**171974**	**50.71**	**61.31**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	8287	8287	2.94	2.95
FU2 Urban Health & Wellness Centres (HWCs)	130488	100226	46.35	35.73
Sub-Total of Urban Component	**138775**	**108513**	**49.29**	**38.69**
Grand Total	**281555**	**280487**	**100**	**100**

Data Source- Information provided by the Madhya Pradesh Government

B. The Approach and Execution

B.1 Fund Flow and Execution Modalities

The XV-FC health grants were intended to be implemented through Urban and Rural Local Bodies, with the exception of the diagnostic support components—FR3 and FU1, respectively. However, practical constraints limited the feasibility of this arrangement, and the state was unable to adhere to the prescribed setup. According to the state officials, due to the limited capacity, technical expertise, and experience of the Panchayati Raj and Rural Development (P&RD) Department in executing health-related construction, it was decided that the FR1 and FR2 components would be implemented through the existing arrangements within the Health Department.

It was also mentioned that the P&RD Department, already burdened with other responsibilities, was reluctant to take on a new function. Moreover, since construction of health facilities would require monitoring and planning to be done by the Health Department, it was deemed more practical for the Health Department to execute these components directly. Consequently, the Health Department assigned the construction works to designated agencies[38], while the recurring expenses under this component were managed by its district-level offices.

The component FR3 *Support for Diagnostic Infrastructure to the Primary Healthcare facilities* consisted of diagnostic support towards SHCs and PHCs. For the part that dealt with diagnostic support to SHCs in form of kit-based testing– the fund was transferred from the State Health Society to the District-level offices of the Health and Family Welfare Department, so that the procurement could be executed at the district level. For the other part of this component, in continuation of the existing model adopted by the state with respect to diagnostic testing, it was decided to execute this through the Public Private Partnership (PPP) mode for diagnostics. The state of Madhya Pradesh has operationalized the PPP diagnostics model via a Hub and Spoke Model, wherein private parties are contracted in to deliver diagnostic services. Adoption of this arrangement for utilisation of this component essentially implied that the XV-FC Health Grant would be used to reimburse the private partners for these tests and not for procurement of diagnostic equipment. The same holds true for FU1 component for urban primary healthcare facilities.

The FR4 *Conversion of Rural Sub-Health Centres & PHCs to HWCs* component was utilised to provide for the recurring expenditures of identified facilities that were earlier being covered through NHM. Since 2023-24, after the discontinuation of support for human resources, the expenses towards HR were shifted back to and provided for under the NHM budget.

For the urban component FU2 UHWCs, the state adopted the approach of utilising this component for the fresh construction of new UHWCs and decided to vest the execution assignment with the Directorate of Urban Administration and the Development under the Department of Urban Development and Housing (UD&H). As in the case of rural components,

[38]The construction of SHCs and PHCs was done by the agencies of the State-level healthDepartment/NHM Office, CHCs byPolice Housing Corporation and BPHUs by the Programme Implementation Unit (PIU) and PWD.

the recurring expenses under this component were incurred by district-level offices of the Health Department.

Table 60 below summarizes the fund flow and execution arrangement for each of the components.

Table 60: Madhya Pradesh- Fund flow under XV-FC Health Grants

Component	Budget Provision under	1st level recipient	2nd level recipient
FR1 Construction of Building- less Sub-Health Centres, PHCs & CHCs	H&FW Dept.	State Health Society under H&FW Dept.	Construction Agencies
FR2 Block Public Health Units (BPHUs)		State Health Society under H&FW Dept.	Construction Agencies (Civil work)
			District level offices under H&FW Dept (Recurring expenses)
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	Partially to District level offices under H&FW Dept. for SHC level kit based tests
			State Health Society (hub and spoke and some state level procurement)
FR4 Conversion of Rural Sub-Health Centres to HWCs		State Health Society under H&FW Dept.	District level offices under H&FW Dept.
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	State Health Society (Hub and spoke and some state level procurement)
FU2 Urban Health & Wellness Centres (HWCs)		State Health Society under H&FW Dept.	Directorate of Urban Administration & Development (UADD) (Civil works)
			District level offices under H&FW Dept. (Recurring expenses)

Data Source- Information provided by the Madhya Pradesh Government

B.2 Achievements: Financial and Physical

Madhya Pradesh managed to secure releases only in the first two years of the grant, 2021-22 and 2022-23. Year-wise and cumulative financial utilisation under the XV FC Components is presented in Table 61 below. In these years, the utilization of the released funds in the rural components was remarkably better than the urban components; 79 per cent in rural *versus* 35 per cent in urban. The state secured an impressive 90 per cent utilisation rate for the construction related FR1 component, while the utilisation for the other rural components ranged between 75 per cent to 82 per cent.

Among the urban components, the component on diagnostic infrastructure FU1 recorded 67 per cent, but this pertained only to 2021-22 funds, since no releases could be obtained for this component in 2022-23. The non-release of funds was on account of the fact that the stipulated 50 per cent utilization criterion for this component was not satisfied when the second tranche was received. The more glaring laggard is the second urban component relating to UHWCs, which

struck a utilisation rate of an abysmal 34 per cent. In 2022-23, the utilization of this component was as low as 10.28 per cent. Since this component accounts for almost half of the total allocation under the XV-FC Health Grants for Madhya Pradesh, the low utilization rate in this component has the effect of dragging down the aggregate utilisation for the first two years to about 58 per cent.

The component-wise physical progress mirrors the financial utilization performance. As shown in Table 62 below, in each of the components involving construction activities, more than 60% of the assigned units were completed. Also, in line with the financial utilisation, FR1 component displays the highest rates of completion. The only noticeable laggard again is UHWCs.

The aggregate utilization rate of funds in PM-ABHIM was better than the XVth FC health grants (Table 63). In the comparable years 2021-22 and 2022-23, the aggregate utilization of PM-ABHIM was around 80 per cent. A component-wise review suggests that the state received funding for three components- CCBs, BPHUs and IPHLs under PM-ABHIM. Of these, the component BPHU was overlapping with the XVth FC health grant and recorded the highest utilization of about 76 per cent. This was comparable with the utilization rate for this component under the XVth FC health grant.

The physical progress under the scheme has also been impressive. Table 43 shows that work has been initiated or completed in over 80 per cent of all the targeted works under the scheme. Notably, as in other states, the rate of physical progress is non-zero even for units allocated for FY 2025-26, for which funding has not yet been received. This is in line with guidelines which allowed for preponement of infrastructure works under PM-ABHIM, in order to achieve the targeted completion of units within the scheme period.

Table 61: Madhya Pradesh- Financial Utilisation under XV-FC Health Grants as Share of Releases 2021-22 to 2022-23 (per cent) (as of 14 January 2025)

Component	2021-22 (%)	2022-23 (%)	Cumulative total
FR1 Building less Sub Centers, PHCs, CHCs	100.00	81.61	90.80
FR2 Block Public Health Units	78.45	78.40	78.43
FR3.1 Diagnostic infrastructure- SCs	96.55	63.90	80.23
FR 3.2 Diagnostic infrastructure- PHCs	96.82	66.61	81.72
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	100.00	50.58	75.29
Sub-Total of Rural Component	**97.17**	**60.94**	**79.06**
FU1 Diagnostic infrastructure- Urban	67.18		67.18
FU2 Urban health and wellness centers (HWCs)	57.82	10.28	34.33
Sub-Total of Urban Component	**58.38**	**10.28**	**35.35**
Total (In Lakhs)	**78.06**	**35.95**	**57.12**

Data Source- Information provided by the Madhya Pradesh Government

Table 62: Madhya Pradesh- Year-wise Physical Progress for Construction Related Components of XV-FC Health Grants

	2021-22			2022-23			Total (2021-22 to 2022-23)		
Component	**Total units (#)**	**Work started/completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started/completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started/completed(%)**	**Work completed(%)**
FR1 A. Construction of Building-less Primary Health Centres	6	*100.00*	*100.00*	21	85.71	71.43	27	*88.89*	*77.78*
FR1 B. Construction of Building- less Sub-Health Centres	39	*97.44*	*89.74*	0			39	*97.44*	*89.74*
FR2 Construction of Block Public Health Units (BPHUs)	35	*100.00*	*85.71*	37	*97.30*	*94.59*	72	*98.61*	*90.28*
FU2 Construction of Urban HWCs	570	*92.98*	*72.63*	213	*82.16*	*32.86*	783	*90.04*	*61.81*

Data Source- Information provided by the Madhya Pradesh Government

Table 63: Madhya Pradesh- Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 as on 31.12.2024

Component	**Approved Budget (Rs. Lakhs)**	**Funds Received (State + Central share)**	**Expenditure incurred**	**% of expenditure against budget**	**% of expenditure against available funds**
Block Public Health Units (BPHUs)	10691.77	67790	8119.91	*75.95%*	*80.40%*
DH-Critical Care Hospital Blocks (CCBs)	66263		34855.19	*52.60%*	
Integrated Public Health Labs (IPHLs)	6003.15		2850.44	*47.48%*	
GMC-Critical Care Hospital Blocks (CCBs)	23750		8678.42	*36.54%*	
Grand Total	**106708**	**67790**	**54504**	***51.08%***	***80.40%***

Data Source- Information provided by the Madhya Pradesh Government

Table 64: Madhya Pradesh- Year-wise Physical Progress for Construction related Components of PM-ABHIM

Component	Year	Total units (#)	Work in Progress (#)	Completed(#)	Not Started(#)	Work started or completed (%)	Work completed (%)
BPHU	2021-22	-	-	-	-	-	-
	2022-23	35	4	31	0	*100.00*	*88.57*
	2023-24	40	23	10	7	*82.50*	*25.00*
	2024-25	44	29	9	6	*86.36*	*20.45*
	2025-26	77	52	13	12	*84.42*	*16.88*
	TOTAL	**196**	**108**	**63**	**25**	***87.24***	***32.14***
IPHL	2021-22	6	2	4	0	*100.00*	*66.67*
	2022-23	11	5	6	0	*100.00*	*54.55*
	2023-24	11	8	1	2	*81.82*	*9.09*
	2024-25	11	8	1	2	*81.82*	*9.09*
	2025-26	13	5	2	6	*53.85*	*15.38*
	TOTAL	**52**	**28**	**14**	**10**	***80.77***	***26.92***
CCB- District Hospital	2021-22	4	3	1	0	*100.00*	*25.00*
	2022-23	7	6	0	1	*85.71*	*0.00*
	2023-24	7	7	0	0	*100.00*	*0.00*
	2024-25	7	7	0	0	*100.00*	*0.00*
	2025-26	12	8	0	4	*66.67*	*0.00*
	TOTAL	**37**	**31**	**1**	**5**	***86.49***	***2.70***
CCB- Government College	2021-22	1	1	0	0	*100.00*	*0.00*
	2022-23	3	3	0	0	*100.00*	*0.00*
	2023-24	3	2	0	1	*66.67*	*0.00*
	2024-25	3	2	0	1	*66.67*	*0.00*
	2025-26	3	3	0	0	*100.00*	*0.00*
	TOTAL	**13**	**11**	**0**	**2**	***84.62***	***0.00***

Data Source- Information provided by the Madhya Pradesh Government

C. Challenges Faced by the State in Implementing the Grants

C.1 Delay in transfer of funds and accrued penal interest

Madhya Pradesh was unable to meet the mandated timeline of 10 days for the release of XV-FC health grants from the State Finance Department to the nodal departments. The Grant Transfer Certificate (GTC) submitted by the state to GoI shows that while the first instalment of the XV-FC Health Grant was received by the state treasury on 12 November 2021, the earliest partial transfer to the Health Department was made on 28 January 2022– a delay of more than two months. This first tranche constituted about 67 per cent of the total grant amount. The remaining 33 per cent was transferred in the months of September and October of 2022, constituting a delay of more than 10 months. Even when the second instalment of the grant pertaining to FY 2022-23 was released by the GoI, the time lag for transfer of funds by the State Finance Department exceeded 10 days (but was less than a month). These dates and amounts from the GTC are elucidated in Table 65 below.

Table 65: Madhya Pradesh- Delay in Transfer of First Instalment (in Rs. Lakhs)

Date of receipt from GoI	Amount received from GoI	Date of transfer from State Finance Dept to Nodal Dept	Amount of transfer from State Finance Dept to Nodal Dept	No. of days delayed (in excess of 10 days)
12 November 2021	92279.92	28 January 2022	62324.00	67
		9 September 2022	26400.00	291
		20 October 2022	3555.92	332

Source- Grant Transfer Certificates

The delay in release of funds implied that the state Finance Department had to pay penal interest to the nodal department to be eligible for the release of the second instalment of the grants for FY 2022-23. Consequently, the state Finance Department paid an amount of Rs. 22.17 crores to the State Health Department as penal interest. Similarly, for FY 2022-23, the State Finance Department paid a penal interest amounting to Rs. 29.43 lakhs to the Health Department. This penal interest for the year 2022-23 could be paid to the Health Department only in 2024. The process was further delayed on account of the fact that the penal interest was booked to the wrong budget head of the health department and needed time to rectify the error. These lags resulted in the delay of initiation of works under the grant.

C.2 Disruption in Work due to Cessation of further releases post the FY 2022-23

The release of funds to Madhya Pradesh was stalled after 2022-23 due to violation of DoE guidelines on fund flow mechanism. As per the DoE guidelines, funds from the State Finance Department had to be released to the departments overseeing local bodies (except the diagnostic components). However, all funds were released by the Finance Department to the H&FW department during the first two years, leading to a cessation of further releases by GoI.

The holding back of releases by the GoI posed a major challenge since the state had already initiated works pertaining to FY 2023-24 in various components based on approvals received from the NLC. This issue was exacerbated by the sheer volume of civil works that were planned since FY 2023-24. The increased volume of construction works since 2023–24, reflected in the increase in approved units shown in

Table 45 resulted from the significant re-appropriation of funds towards the FR1 component following the withdrawal of HR support.

Stalling of funding has implications for the continuity of work on these units, as state engineering personnel strongly emphasized the difficulty of retaining contractors amid payment disruptions. They also highlighted that cost escalations and the deterioration of partially constructed structures—due to theft and environmental exposure—could further increase construction costs when work resumes.

Table 66: Madhya Pradesh- Physical progress FR1- Building-less SHCs

Building less – SHCs						
SN	**Financial Year**	**Approved Units**	**Tender Floated**	**Work Awarded**	**Work In-progress**	**Work Completed**
1	FY 2021-22	39	38	38	3	35
2	FY 2022-23	0	0	0	0	0
3	FY 2023-24	1640	1640	1428	812	6
4	FY 2024-25	64	64	57	10	0
5	FY 2025-26	66	66	59	8	0
	Total	**1809**	**1808**	**1582**	**833**	**41**

Data Source- Information provided by the Madhya Pradesh Government

C.3 Difficulty in absorbing funds in diagnostic support components due to PPP model

The state faced significant hurdles in utilizing funds in the diagnostic infrastructure components as it used an outsourcing model in PPP mode for diagnostic services. It was decided that bulk of the allocation in these components will be used for reimbursing private agencies for diagnostic services. Using funds for reimbursement meant that the rate of absorption would be slower since it was not being used to procure diagnostic equipment that would typically entail higher expenditure. Additionally, the amount spent on reimbursement was contingent on the number of tests being performed and was therefore, demand-driven. Also, in the urban component, due to the limited existence of operational UPHCs and Sanjeevani clinics at the time of introduction of the XVth FC grant, the number of diagnostic tests that were carried out was not very high resulting in less expenditure in FU1. All these reasons led to a sluggish fund utilization rate.

C.4 Issues Due to Differences in the Prescribed Unit Cost of Construction and Actual Cost

Officials highlighted that the fixed cost norms of construction for different categories of facilities prescribed by the XV-FC Health Grant guidelines were inadequate to meet the cost of construction in the state. In a letter to the MoH&FW dated 12 May 2023, the state proposed a cost of Rs. 71.17 lakhs for construction of SHC, against the cost norm prevalent at the time of Rs. 55.5 lakhs. Later, the unit costs were revised to Rs. 65 lakhs per SHC for all states. However, for construction of PHCs, the provided cost of Rs. 143 lakhs (later revised to Rs. 159 lakhs) fell short of the state's estimated cost at Rs. 180 lakhs. The additional costs had to be supplemented from the state budget adding to further administrative processes and delays.

C.5. Issues with implementation of the component UHWCs (FU2)

The utilization of funds and physical progress in the UHWC (FU2) component was remarkably poor as discussed in Section B. Although a substantial part of this component was provided for recurring expenditure, due to a limited number of operational UPHCs and Sanjeevani clinics to

begin with, the absorption of funds in the recurring portion was difficult.39 The state chose to prioritise the construction of new UHWCs rather than operating them from existing government buildings or rented premises. The charge of constructing UHWCs was handed over to the Directorate of Urban Administration and Development (UADD) under the Department of Urban Development and Housing.

Discussions with officials of UADD revealed that urban local bodies (ULBs) were carrying out health related constructions for the first time (which involved its own nuances and technical details), and this called for adequate handholding and capacity building of local bodies. They also mentioned that there were difficulties in identifying encroachment-free land parcels in urban areas. There is also some evidence of delay in transfer of funds from UADD to ULBs, who were ultimately responsible for tendering of works to agencies. Table 67 and Table 68 below show that while bulk of the first instalment was released to UADD in the months of March and April 2022, the earliest release of funds to Urban Local Bodies was 16 November 2022, a lag of over 6 months. The delay in transfer of funds also holds for the second instalment.

The delay in construction amounted to a delay in operationalization of UHWCs, owing to which a substantial amount of funds provided for recurring expenses could not be utilised in the first two years of the grant. There was also a high degree of centralisation in recruitment. For instance, walk-in interviews for Medical Officer positions at UHWCs are conducted at the state level. Since it is not viable to do so for individual UHWCs, it is carried for multiple positions at a time. This whole recruitment process could take about three months from the time of handover of a unit, according to state officials, adding to the delay in making these units functional. It is also worth mentioning that due to similar challenges in this component, states like Uttar Pradesh and Gujarat have made efforts to decentralise the recruitment process for appointment of MOs to the district level.

Table 67: Madhya Pradesh- Dates and Amounts of Transfer from Health Department to the UADD

Date of Transfer from Health Department to UADD	**Date of receipt from Health Department by UADD**	**Amount Transferred (Cr.)**
30/03/2022	08/04/2022	64.25
25/04/2022	29/04/2022	68.75
09/11/2022	28/11/2022	9.5
08/06/2023	08/06/2023	53.25
Total		**195.75**

Data Source- Information provided by the Madhya Pradesh Government

[39] At the time of introduction of the XVth FC grant, only 172 Sanjeevani clinics were operational in the state in all. Under FU2 of the XV-FC Health Grants, 611 new Sanjeevani clinics were proposed.

C.6 Anticipated fiscal burden on account of human resources

It needs to be borne in mind that the bulk of XV-FC Health Grants and PM-ABHIM funds were geared towards construction, and the actual burden of recurring expenditure entailed by these units will only actualize in the years to come. In the case of the XV-FC Health Grants, the HR support stands withdrawn from 2023-24 onwards. In most states including Madhya Pradesh, this has amounted to a shifting of the HR funding from XV-FC Health Grants to the NHM. To illustrate the growing burden of HR funding, in July 2024, the Health Department of Madhya Pradesh issued a notification to sanction a total of 46,491 new positions (including regular, contractual and outsourced positions) for currently existing and sanctioned SHCs, PHCs, CHCs, Civil Hospitals, and District Hospitals. Nearly 60 per cent of these positions (27,838) are expected to be filled through the NHM. This reflects the dependence of the State on NHM funding to meet a substantial part of the anticipated expenditure on human resources in future.

Table 68: Madhya Pradesh- Dates and Amounts of Transfer from UADD

Date of transfer of first instalment	Total amount of transfer funds	No. of ULBs to whom transferred	Date of transfer of second installment	Total amount of transferred funds	No. of ULBs to whom transferred
16/11/2022	1,137,450,000.00	167	24/04/2023	1,250,000.00	1
09/05/2023	72,500,000.00	12	01/06/2023	6,250,000.00	2
Total	**1,209,950,000.00**	**179**	02/06/2023	11,250,000.00	2
			05/07/2023	17,500,000.00	6
			27/07/2023	27,500,000.00	6
			07/08/2023	1,250,000.00	1
			10/08/2023	3,750,000.00	2
			28/08/2023	3,750,000.00	3
			06/09/2023	2,500,000.00	2
			11/09/2023	12,500,000.00	3
			27/09/2023	2,500,000.00	1
			03/10/2023	2,500,000.00	2
			09/10/2023	6,250,000.00	2
			13/10/2023	2,500,000.00	2
			20/10/2023	1,250,000.00	1
			30/10/2023	11,250,000.00	3
			08/11/2023	5,000,000.00	4
			20/11/2023	1,250,000.00	1
			06/12/2023	2,500,000.00	2
			18/12/2023	21,250,000.00	5
			08/01/2024	1,250,000.00	1
			09/01/2024	7,500,000.00	4
			23/01/2024	7,500,000.00	3
			29/01/2024	6,250,000.00	3
			09/02/2024	5,000,000.00	3
			01/03/2024	2,500,000.00	2
			04/03/2024	12,500,000.00	5
			07/03/2024	72,650,000.00	1
			19/03/2024	10,000,000.00	1
			26/03/2024	2,000,000.00	1
			12/04/2024	2,500,000.00	1
			24/04/2024	5,000,000.00	3
			06/05/2024	2,500,000.00	2
			15/05/2024	1,250,000.00	1
			28/05/2024	7,500,000.00	2

Date of transfer of first instalment	Total amount of transfer funds	No. of ULBs to whom transferred	Date of transfer of second installment	Total amount of transferred funds	No. of ULBs to whom transferred
			30/05/2024	1,250,000.00	1
			07/06/2024	1,250,000.00	1
			24/06/2024	3,750,000.00	2
			28/06/2024	6,250,000.00	3
			15/07/2024	1,250,000.00	1
			26/07/2024	1,250,000.00	1
			30/07/2024	7,500,000.00	1
			20/08/2024	12,500,000.00	3
			13/09/2024	2,500,000.00	1
			23/09/2024	1,250,000.00	1
			25/09/2024	1,250,000.00	1
			04/10/2024	1,250,000.00	1
			23/10/2024	7,500,000.00	1
			11/11/2024	3,750,000.00	2
			23/12/2024	12,500,000.00	1
			03/01/2025	2,500,000.00	2
			09/01/2025	5,000,000.00	3
			28/01/2025	1,250,000.00	1
			Total	**363,400,000.00**	**111**

Data Source- Information provided by the Madhya Pradesh Government

D. Observations from Field Visits to Selected Facilities

Field visits were undertaken in the districts of Bhopal, Sehore and Rajgarh to gauge the on-ground impact of the grants. The chosen facilities were beneficiaries of either the XV-FC Health Grants or PM-ABHIM and are listed below. The facilities visited in Bhopal, being primarily urban, comprised mostly urban HWCs or Polyclinics. A specific focus was laid on visiting UHWCs, keeping in view the high weightage of the UHWC component in the total grants allocated to the state.

It is important to bear in mind that diagnostic outcomes are not expected to vary much on account of the XV-FC Health grants in this state, as the state policy of utilising these grants for reimbursement of tests was outsourced via PPP mode.

Bhopal	**Sehore**	**Rajgarh**
1. Polyclinic at Sevaniya Gond 2. Sanjeevani[40] Clinic at Neelbad 3. Sanjeevani Clinic at Piplani 4. AAM PHC at Kresher Basti	1. BPHU at CHC Shyampur	1. BPHU at CHC Narsinghgarh 2. SHC (under construction) Baiheda, Beora

[40] All UHWCs are branded as Sanjeevani clinics in Madhya Pradesh.

D.1 Bhopal

The first three urban facilities listed above in the district of Bhopal were all existing as functional UHWCs with Medical Officers even before the receipt of the XV-FC Health Grants, and benefited in terms of construction of new premises funded by these grants.

1. **Polyclinic at Sevaniya Gond**

   This facility was an NQAS certified Polyclinic. The facility was converted from a Civil Dispensary (CD) to a UHWC in 2021, and was one of the 32 planned UHWC polyclinics in the district of Bhopal. The facility covered a catchment population of about 18000 and offered three kinds of specialist services– paediatrics, gynaecology and physiotherapy with the plans to introduce a fourth speciality of internal medicine in the near future. The facility witnessed an average OPD footfall of about 60-70 patients daily, and offers 17 kit based diagnostic tests.

   The current premise of this Polyclinic was constructed using the infrastructure support for UHWC component (FU2) of the XV-FC Health Grants. A wellness centre including a Geriatric and Adolescent Clinic has also been constructed, however, the required HR specialists to make these functional is yet to be engaged.

   The major enhancement that this facility experienced on account of the XV-FC Health Grants is the new premises, which replaced the older civil dispensary structure.

2. **Sanjeevani Clinic UHWC at Neelbad**

   This facility was a UHWC whose premises were freshly constructed using the XV-FC Health Grants. Earlier operating out of a rented premise, this UHWC had a staff of 4 personnel including a Medical Officer, all funded under the NHM. Constructed as per the IPHS standards, this facility covers a catchment population of approximately 25000-27000, and witnessed an average daily OPD footfall of 40-50 patients.

   At the time of visit of the study team, the new premises had been handed over only 3-4 days ago. Therefore, it would be premature to expect immediate benefits in terms of improved patient load that would accrue due to certainty of timings and space. While the impact on OPDs would manifest in some time, the presence of the new premises to operate from, essentially is the most tangible output of the XV-FC Health Grants.

3. **Sanjeevani Clinic UHWC at Piplani**

   This facility was also a Civil Dispensary that had been converted into a Sanjeevani Clinic (UHWC). The facility had a total staff strength of 15, including a Medical Officer and AYUSH doctor. The XV-FC Health Grants were used for expansion and upgradation of this facility and a new portion encompassing OPD, NCD, ANC room, store, Autoclave, VIA Room, laboratory, toilets was constructed and completed about 5-6 months before the visit of the study team.

   With an average monthly OPD footfall of about 2000-2500 patients, this facility also provides ophthalmology and psychiatric/psychological services in partnership with two

different NGOs. As with the previous two facilities, it is difficult to ascertain the impact of the XV-FC Health Grants on patient related outcomes since this was already a well-functioning healthcare provider prior to the expansion of premises. As such, the most visible output of the grants is manifested in the upgraded premises.

4. AAM PHC at Kresher Basti

This facility was newly established but not yet functional unlike the previous three facilities which were already functioning out of older or smaller premises, this PHC was newly established where no other PHC existed before. Funded from the FR1 component of the XV-FC Health Grants, the construction of this PHC was completed in September-October 2023 and was handed over only recently.

Located in a slum area with a high demand for primary care, the PHC is expected to serve a population of approximately 30,000. Constructed as per IPHS standards and equipped with a labour room, it is envisaged to function as a delivery point. The PHC was constructed using the XV-FC Health Grants, while the adjoining staff quarters were constructed using the state's own funds.

Although the construction of the PHC had been completed over a year ago, the recruitment and handing over was delayed due to the state and general elections. Recently, a Medical Officer, Nursing Officer, Staff Nurse and peon were appointed from the regular cadre base of the state. In the meantime, with no security guard or maintenance personnel in place, there have been reports of thefts and vandalism, further adding to the costs of the project. With the recruitment of security guard, Lab Technician, Pharmacist, ANM and Data Entry Operator pending but underway, the operationalization of the facility is expected to happen in the near future.

The case of this facility establishes the case as to why it might be premature to look at outcomes (such as service delivery) of relatively recent capital expenditure initiatives, since outcomes are a product of a multitude of processes which can take time to come together into a cohesive whole.

D.2 Sehore

1. BPHU at CHC Shyampur

The facility was constructed using the XV-FC Health Grants, within the vicinity of CHC in Shyampur. The construction of the BPHU was completed in April 2023 and made functional in February 2024. The adjoining CHC has also been approved to be rebuilt under the XV-FC Health Grants.

Staffed with 2 Lab Technicians and 1 employee to handle registration, this BPHU offered a total of 65 types of diagnostic tests, out of which about 50 were outsourced and the rest were being conducted in-house. The BPHU acts as a Hub for other facilities in the block within the Hub and Spoke model, and witnesses a high load of diagnostic testing on that

account. The table below captures the number of diagnostic tests carried out at the CHC before and after the BPHU was made functional.

Table 69: Diagnostic Tests- BPHU at CHC Shyampur, Sehore, Madhya Pradesh

Month year (before)	Diagnostic tests	Month year (after)	Diagnostic tests
October 2023	16303	October 2024	9892
November 2023	6165	November 2024	15614
December 2023		December 2024	22305

Data Source- Information provided by the Health Facility

There was no dramatic increase in the number of diagnostic tests carried out within this facility after the establishment of the BPHU. This is so because in the absence of any procurement of in-house diagnostic equipment, the establishment of BPHU only amounted to the construction of a separate premise where samples could be collected and where the associated administrative works and registration could take place.

Rajgarh

1. **BPHU at CHC Narsinghgarh**

This was a freshly constructed BPHU in the vicinity of a CHC in Narsinghgarh. This 37-bedded CHC is being revamped and expanded into a 100-bedded sub-district/civil hospital. The BPHU construction was completed in December 2024 and it was expected to be operationalized by the end of January 2025.

The adjoining CHC is functioning as a delivery point and offers 4 specialist services including Gynecology, Pediatrics, General Surgery and Internal Medicine and also provides Radiology and Anesthetist services on an on-call basis. The BPHU, when functional, would house the equipment and works which are currently being operated from the laboratory in the old CHC building.

2. **SHC (under construction) Baiheda, Beora**

This SHC is being built under component FR1 'Construction of Building less SHC, PHCs and CHCs', and is supposed to house the SHC currently operating out of the neighbouring Anganwadi Centre.

This visit highlighted the challenges associated with the cessation of XV-FC Grant funding after 2022–23 in the state. The construction work was on the verge of stalling due to delayed payments, as no funds had been received since FY 2022–23. Engineering personnel from the Health Department expressed concern that contractors might withdraw from the project because of the prolonged payment delays.

Appendix to Chapter 5

Table 70: Madhya Pradesh- Financial Utilisation under XV-FC Health Grants FY 2021-22 to FY 2022-23 (as of 14 January 2025)

Component	Amount Approved	Amount Received	Amount Utilized
FR1 Building less Sub Centers, PHCs, CHCs	6006	6006	5453.65
FR2 Block Public Health Units	5798	5798	4547.1
FR3.1 Diagnostic infrastructure- SCs	20522	20522	16464.18
FR 3.2 Diagnostic infrastructure- PHCs	21738	21738	17764.1
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	39549.84	39549.84	29777.92
Sub-Total of Rural Component	**93613.84**	**93613.84**	**74006.95**
FU1 Diagnostic infrastructure- Urban	5434	2717	1825.25
FU2 Urban health and wellness centers (HWCs)	84512	84512	29012.04
Sub-Total of Urban Component	**89946**	**87229**	**30837.29**
Total (In Lakhs)	**183559.84**	**180842.84**	**104844.24**

Data Source- Information provided by the Madhya Pradesh Government

Table 71: Madhya Pradesh- Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	2021-22		2022-23		2023-24	
Component	Allocation	Approval	Allocation	Approval	Allocation	Approval
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	3003	3003	3003	3003	3152	54306
FR2 Construction of Block Public Health Units (BPHUs)	2899	2899	2899	2899	3044	1862
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	21136	21136	21136	21124	22192	22192
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	19776	19774.92	19776	19774.92	20764	0
Sub-Total of Rural Component	**46814**	**46812.92**	**46814**	**46800.92**	**49152**	**78360**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	2717	2717	2717	2717	2853	2853
FU2 Urban Health & Wellness Centres (HWCs)	42783	42750	42783	41762	44922	15714
Sub-Total of Urban Component	**45500**	**45467**	**45500**	**44479**	**47775**	**18567**
Grand Total	**92314**	**92279.92**	**92314**	**91279.92**	**96927**	**96927**

Data Source- Information provided by the Madhya Pradesh Government

Chapter 6: State-Level Insights from Gujarat

A. The Context

Gujarat was an interesting case in the context of the XVth FC health grant. The State had an impressive utilization rate in the first two years of the grant, but had not received releases subsequently (Refer Figure in Aggregate analysis). Also, despite the fact that the State's rate of fund absorption in the XVth FC health grant was significantly higher than the all-India average, the physical progress remained relatively poor and stood below the country average (Refer Figure in Aggregate analysis).

The initial distribution of allocation across rural and urban areas was broadly in accordance with the level of urbanization in the State. In the original allocation by FC, around 44 per cent was towards the urban components; the remaining 56 per cent towards rural (Table 72) below. The component FR1 *Construction of Building-less SHC, PHCs and CHCs* attracted a meagre 0.2 per cent of the allocation initially. However, due to the withdrawal of HR support in 2023-24, which led to large sum of funds being re-appropriated towards the component FR1, its share in total actual approvals increased to about 10 per cent. Of the rural components, FR3 *Support for Diagnostic Infrastructure* had the highest share of allocation (around 22 per cent). Among the urban components, more than 85 per cent of the allocation was towards FU2 *Urban Health and Wellness Centres (UHWCs).*

Table 72: Gujarat- Cumulative Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	**Cumulative Total (2021-22 to 2023-24)**			
Component	**Allocation**	**Approval**	**Component as % of total allocation**	**Component as % of total Approval**
FR1 Construction of Building-less Sub-Health Centres, PHCs & CHCs	358.00	19273.95	*0.19%*	*10.05%*
FR2 Construction of Block Public Health Units (BPHUs)	15344.00	13194.64	*8.00%*	*6.88%*
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	42509.01	42509.00	*22.15%*	*22.16%*
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	48803.00	32002.00	*25.43%*	*16.68%*
Sub-Total of Rural Component	**107014.01**	**106979.59**	***55.76%***	***55.76%***
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	5377.00	10919.29	*2.80%*	*5.69%*
FU2 Urban Health & Wellness Centres (HWCs)	79522.00	73949.00	*41.44%*	*38.55%*
Sub-Total of Urban Component	**84899.00**	**84868.29**	***44.24%***	***44.24%***
Grand Total	**191913.01**	**191847.88**	***100.00%***	***100.00%***

Data Source- Information provided by the Gujarat Government

B. The Approach and Execution

B.1 Fund Flow and Execution Agency

Gujarat did not follow the Department of Expenditure (DoE) guidelines regarding the release of funds to the nodal departments of local bodies. Instead, funds for all components, were routed to the Department of Health and Family Welfare (H&FW) (Table 73). This deviation may be attributed to the state's unique context—specifically, the presence of a Project Implementation Unit (PIU) within the H&FW Department, which is responsible for all health-related construction activities. The PIU was tasked with implementing all construction-related components under both the XV-FC Health Grants and PM-ABHIM. Although the XV-FC guidelines designated local bodies as implementing agencies (excluding diagnostic components), Gujarat's unique context, featuring a dedicated unit for health-related construction possibly necessitated the direct release of funds to the H&FW department. Despite the nonconformity to the DoE guidelines on fund flows however, the state faced no difficulty in securing fund releases from the Government of India.

Table 73: Gujarat- Fund flow under XV-FC Health Grants

Component	Budget Provision under	1st level recipient	2nd level recipient
FR1 Construction of Building- less Sub-Health Centres, PHCs & CHCs	H&FW Department	State Health Society under H&FW Dept.	Project Implementation Unit (PIU) under Health Department
FR2 Block Public Health Units (BPHUs)		State Health Society under H&FW Dept.	PIU (Capital expenses)- only from 2023-24 onwards
			District Health Society (Recurring expenses)
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept. (GMSCL in FY 2021-22)	Gujarat Medical Services Corporation (GMSCL)
			25% to District Health Society for kit based tests etc. (only from FY 2022-23)
FR4 Conversion of Rural Sub-Health Centres to HWCs		State Health Society under H&FW Dept.	District Health Society
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	Gujarat Medical Services Corporation (GMSCL)
			25% to District Health Society for kit based tests etc. (only from FY 2022-23)
			Ahmedabad, Vadodara and Surat Municipal Corporations
FU2 Urban Health & Wellness Centres (HWCs)		State Health Society under H&FW Dept.	District Health Societies in 33 districts
			8 Urban Health Societies (Municipal Corporations)

Data Source- Information provided by the Gujarat Government

Funds for support of diagnostic infrastructure in both rural and urban components (FR3 and FU1), were mostly handed over to the Gujarat Medical Services Corporation Limited (GMSCL) under H&FW Department. In the rural component FR3, the entire grant amount for FY 2021-22 was transferred to GMSCL. Subsequently, owing to the delays and time lags faced in centralised procurement, it was decided that 25 per cent of the allocated funds in FY 2022-23 for FR3 would be handed over to the District Health Societies (DHSs) of respective districts. DHSs could use these funds for procuring and supplying diagnostic kits, reagents, etc. to the SHCs and PHCs or to facilitate transport for any Hub and Spoke arrangement. The first phase of procurement focused on kit-based tests in SHCs, PHCs and CHCs, followed by procurement of diagnostic equipment. Under the urban diagnostic infrastructure component (FU1), the three major Municipal Corporations—Ahmedabad, Vadodara, and Surat—were entrusted with the procurement of both diagnostic kits and equipment for all facilities within their jurisdictions. Again, as in the case of rural diagnostics, about 25 per cent of the 2022-23 funds for this component were later given to the DHSs of respective districts as a policy experiment with the objective of expediting procurement.

B.2 Adapting FC grants to meet State-specific Context and Ensuring synergies across Multiple sources of Funding

The State adapted the component FR2 *Construction of Block Public Health Units (BPHUs)* to its own context. In the first two years of the grant, funds were not used for construction activities, but for conversion of existing Taluka Health Offices (THOs) into BPHUs. According to state officials, Gujarat already had the necessary structure and administrative workforce for BPHUs within its Taluka Health Offices. Converting THOs into BPHUs amounted to setting up the laboratory by procuring diagnostic equipment, hiring laboratory personnel and upgrading/renovating the existing structure. From the third year of the grant, i.e., FY 2023-24 onwards, the state had proposed to set up some BPHUs involving construction of fresh structures. The FU2 component was also used to reinforce the state's pre-existing Deen Dayal Upadhaya (DDU) clinics staffed with AYUSH doctors.

The State also undertook an integrated planning exercise for two components of PM-ABHIM, i.e., CCBs and IPHLs with existing and allied activities under the ECRP-II initiative. As per the state officials, CCBs essentially amounted to creation of ICUs, while the state was already planning the implementation of the ECRP II focussing on paediatric units and ICUs. Although this was conceptually welcomed as convergence of separate initiatives, it delayed the actual initiation of works. Notably, the integrated planning was possible owing to the existence of the single entity, the PIU, which oversaw all construction activities under various schemes.

Allocation in FR4 component was used to meet part of the HR expenses previously being covered under the NHM. With the withdrawal of the HR component since 2023-24, these expenses were again booked under NHM budget.[41]

[41] State officials mentioned that this led to issues since NHM norms for remuneration were lower as compared to that of XV FC Grant.

B.3 Achievements: Financial and Physical

Expenditure under the XVth FC health grant recorded in the PMS portal is significantly higher than the actual figures of expenditure provided by the state. This results in a reflection of high utilization of funds in the PMS portal *vis-à-vis* the actual figures recorded by the state Government. As per the PMS portal, around 79 per cent of the funds received by the state have been utilized, while actual figures provided by the state show a meagre utilization rate of 33 per cent. Table 77).

Table 74 shows the difference of fund utilization in different components based on the two sources.

The divergence in expenditure figures reported in the PMS portal *vis-a-vis* the actuals is due to the accounting processes. It may be noted that the difference in expenditure figures is particularly pronounced in the diagnostics components (FR3 and FU1) and UHWCs (FU2). This stems from the fact that when releases are made to procurement agencies and implementing agencies by H&FW department, it is recorded as expenditure in the PMS portal, even if the final purchasing entity is yet to incur the expenditure.

The progress of actual utilization of funds in the diagnostic components and UHWCs has been particularly poor due to the unduly long time taken up in the administrative processes involved (Discussed in more details in the 'Challenges' section later). Year-wise financial utilisation is shown in Table 75. As expected, both the PMS reports and actual utilisation data show better progress in the first year of the grant, since reported expenditures reflect cumulative spending over the years. The utilization in FR1 was remarkably better than the rest (Table 77).

Table 74 However, it should be borne in mind that the allocated amount in this component was very meagre, and the construction of only two PHCs was targeted.

In PM-ABHIM, the actual rate of utilization of funds has been dragged down by the low availability of funds/releases to the State (Table 76). Between 2021-22 and 2024-25 (up to December), only about a fifth of the total approved budget could be spent. The total expenditure in this period was about 92 per cent of the releases/fund available, indicating that the primary bottleneck has been the releases/fund availability.

One possible reason for the low rate of fund receipts under PM-ABHIM was the concentration of allocations in the CCB component, which involves large-scale, capital-intensive works that typically progress more slowly. According to state officials, initiation of CCB works was delayed due to the adoption of an integrated planning approach, aimed at converging this component with works under ECRP-II and other state-led infrastructure initiatives, such as the construction of medical colleges. This approach involved bundling tenders across multiple schemes, which contributed to delays in commencement. Since subsequent PM-ABHIM releases are contingent on 75 per cent utilisation of the previous instalment, these initial delays likely constrained further fund releases relative to the total approved budget. However, expenditure data for FY 2024–25 suggests that spending has gained momentum as the state moved beyond the initial planning and convergence phase (Table 76).

In terms of physical progress as shown in Table 77, both the co mponents of CCB and IPHL exhibit comparable rates of progress with over 65 per cent of units in progress in each. Since CCBs involve not only large-scale civil works but also substantial planning for site selection and convergence with other infrastructure, the observed physical progress in Gujarat under this component is consistent with experiences in other states. 1 CCB and 2 IPHLs have already been completed in the state in December 2024, with another three CCBs and seven IPHLs slated for completion by March 2025. While the current completion rates of IPHL units in the state are lower compared to other states like Madhya Pradesh, Uttar Pradesh and Odisha (each of which had completed over 20% of their IPHL units by December–January 2025), the completion of the aforementioned seven units is likely to significantly raise the state's overall physical progress. As with other states, works pertaining to FY 2025-26 have been initiated in line with the PM-ABHIM guidelines permitting initiation of work on units allocated to future years in advance to achieve targets within the scheme period (Table 77).

Table 74: Gujarat- Financial Utilisation under XV-FC Health Grants FY 2021-22 to FY 2022-23 (as of 12 February 2025)

Component	Amount Approved (Rs. in Lakhs)	Amount Received (Rs. in Lakhs)	Grant Distributed to Imp. agency	Expenditure as per PMS portal	Actual Expenditure as per SoE/Tally	Utilisation rate as per PMS portal (%)	Actual utilisation rate as per SoE/Tally (%)
FR1 Building less Sub Centers, PHCs, CHCs	234.00	234.00	233.00	222.00	223.00	*94.87%*	*95.30%*
FR2 Block Public Health Units	10062.00	10062.00	4712.00	7705.07	3445.00	*76.58%*	*34.24%*
FR3.1 Diagnostic infrastructure- SCs	13498.00	13498.00	8410.00	5755.04	2044.00	*42.64%*	*6.51%*
FR 3.2 Diagnostic infrastructure- PHCs	14376.00	14376.00	8986.00	11621.72		*80.84%*	
FU1 Diagnostic infrastructure- Urban	3525.29	3526.00	1990.00	2660.03		*75.44%*	
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	32002.00	32002.00	32000.00	31253.00	23412.00	*97.66%*	*73.16%*
FU2 Urban health and wellness centers (HWCs)	52146.00	52146.00	46238.00	39931.00	12424.00	*76.58%*	*23.83%*
Total (In Lakhs)	**125843.29**	**125844.00**	**102569.00**	**99147.86**	**41548.00**	***78.79%***	***33.02%***

Data Source- Financial data shared by the state, the PMS portal values are as per data downloaded in October 2024

Table 75: Gujarat- Year wise Financial Utilisation of XV-FC Health Grants as a Percentage of Releases

	2021-22		2022-23	
Component	**Utilisation rate as per PMS portal (%)**	**Actual utilisation rate as per SoE/Tally (%)**	**Utilisation rate as per PMS portal (%)**	**Actual utilisation rate as per SoE/Tally (%)**
FR1 Building less Sub Centers, PHCs, CHCs	*94.02%*	*94.87%*	*95.73%*	*95.73%*
FR2 Block Public Health Units	*97.22%*	*68.48%*	*55.93%*	*0.00%*
FR3.1 Diagnostic infrastructure-SCs	*82.89%*	*30.29%*	*2.39%*	*0.00%*
FR 3.2 Diagnostic infrastructure-PHCs	*75.03%*		*86.65%*	*0.00%*
FU1 Diagnostic infrastructure-Urban	*99.94%*		*50.94%*	*0.00%*
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	*96.88%*	*72.48%*	*98.44%*	*73.83%*
FU2 Urban health and wellness centers (HWCs)	*100.00%*	*47.65%*	*53.15%*	*0.00%*
Total (In Lakhs)	***94.28%***	***47.08%***	***63.29%***	***18.95%***

Data Source- Information provided by the Gujarat Government

Table 76: Gujarat-Total Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 up to December 2024 (Figures in lakhs)

Year	**Approved Budget**	**Funds Received (State+Central share)**	**Expenditure incurred**	**% of expenditure against budget**	**% of expenditure against available funds**
2021-22	11505	0	0	*0.00%*	
2022-23	18611	4437	3224.12	*17.32%*	*72.66%*
2023-24	21122	7673.34	5613.25	*26.58%*	*73.15%*
2024-25	28033	6614.9	8574.78	*30.59%*	*129.63%*
Grand Total	**79271**	**18725.24**	**17412.15**	***21.97%***	***92.99%***

Data Source- Information provided by the Gujarat Government

Table 77: Gujarat- Year-wise Physical Progress for Construction related Components of PM-ABHIM

Component	Year	Total units (#)	Work in Progress (#)	Completed(#)	Not Started/ Tender floated(#)	Work started or completed (%)	Work completed (%)
CCB	2021-22	4	4	0	0	*100.00%*	*0.00%*
	2022-23	6	5	1	0	*100.00%*	*16.67%*
	2023-24	6	5	0	1	*83.33%*	*0.00%*
	2024-25	6	1	0	5	*16.67%*	*0.00%*
	2025-26	10	5	0	5	*50.00%*	*0.00%*
	TOTAL	**32**	**20**	**1**	**11**	***65.63%***	***3.13%***
IPHL	2021-22	3	2	1	0	*100.00%*	*33.33%*
	2022-23	7	6	1	0	*100.00%*	*14.29%*
	2023-24	7	7	0	0	*100.00%*	*0.00%*
	2024-25	7	1	0	6	*14.29%*	*0.00%*
	2025-26	9	5	0	4	*55.56%*	*0.00%*
	TOTAL	**33**	**21**	**2**	**10**	***69.70%***	***6.06%***

Data Source- Information provided by the Gujarat Government

Note- Works in progress exclude units where tender is floated/approved;

C. Challenges Faced by the State in Implementing the Grant

The most significant factor that has marked the implementation of the XV-FC health grants in Gujarat is the considerable time taken in the execution of the diagnostics component (FR3 and FU1), as well as for streamlining the UHWCs component (FU2). This delay assumes an even greater significance if we look at the weightage accorded to these components in the total funding approval under XV-FC Health Grants, with diagnostics amounting to over 25 per cent and UHWCs constituting 38 per cent of the total funds (more than 85 per cent of urban components) from 2021-22 to 2023-24 (Table 72).

C.1 Delay in implementation of diagnostic component due to administrative processes

Lengthy administrative processes contributed to the sluggish implementation of the diagnostics component in the state. Detailed discussions with officials in charge revealed that it took nearly one and a half years to issue the indents for kit-based tests to GMSCL after the first instalment of funds was received by the H&FW department in December 2021. The indents for procurement of rapid diagnostic kits had to be revised twice after the department received the charge for this component. The first indent issued in August 2022 was put on hold as it was thought that a larger committee should be constituted to decide on the allocation after seeking gap analysis. The committee subsequently decided on the allocation in December 2022 and indents were issued to GMSCL for procurement in January and February of 2023. Later, this indent had to be revised again as it included kits for dengue antigen testing for SHCs, which was not in accordance with

GoI norms. Consequently, a final revised indent could only be issued in July 2023 for procurement of kits leading to a time lag of nearly one and half years since the initiation of the process. Even after the indents were finalized, none of the diagnostic equipment and instruments that were to be procured centrally by GMSCL using the FC grants for FY 2021-22, could be procured till the time of visit of the study team. In a time-bound grant, such delays make it nearly impossible to absorb the grants.

Similar issues affected the implementation of the other part of the diagnostics components.. The indent for equipment for BPHUs was made in December 2023 and as late as July and October of 2024 for PHCs and non-BPHU CHCs. The indent for equipment for urban diagnostics (FU1) was still awaiting approval at the time of the visit of the study team. Representatives from GMSCL posited that it takes about 1-1.5 years to deliver equipment after the request is issued. There are also separate divisions responsible for procurement of reagents and equipment within the GMSCL, so indents for equipment and reagents cannot be placed simultaneously. Owing to these factors, no new diagnostic equipment (except Glucometers) had so far been made available to the health facilities at the time of our visit, even from the FY 2021-22 funds under the XV-FC Health Grants. Interestingly, the three urban municipal corporations of Ahmedabad, Vadodara and Surat were given the funds for procurement of both kits and equipment directly for the urban component, and have performed reasonably well, according to officials.

Similar delays in procurement of equipment by GMSCL has been pointed out in a recent report of audit of Public Health Infrastructure and Management of Health Services in Gujarat by the Comptroller and Auditor General (CAG) of India.[42] During the period 2016-2022, GMSCL received 456 indents for procurement of equipment, but could finalize the purchase procedure for only 67 indents. Similarly, GMSCL could not finalize the rate contracts for 10 to 25 per cent of the medicines in the Essential Drug List (EDL), resulting in lack of supply of these medicines to health facilities in the State. These delays call for attention and CAG has urged GMSCL to take up steps to ensure timely procurement in future.

Keeping the procedural hurdles and the corresponding delays in view, the Health Department has now transferred about 25 per cent of the FY 2022-23 funds for the diagnostics component to the District Health Society in a bid to expedite and decentralize the procurement process for kits.

C.2 Delay on account of streamlining processes for urban HWCs

In the case of UHWCs, there was considerable time spent in planning on the recruitment processes and other guidelines such as those related to rent. The initiation of this component too, happened with a lag of a year after the receipt of funds. The process of establishing Urban Health and Wellness Centres (UHWCs) began in 2021-22, where medical officers had to be recruited. Although recruitment of M.B.B.S. Medical officers in the state were usually conducted at the state level, discussions were held on whether the recruitment process for UHWCs should be managed at the state or district level. To address this, a committee was formed and it was decided to decentralise the recruitment process to the district level. On January 18, 2023, the committee issued

[42] Report of the Comptroller and Auditor General of India on Public Health Infrastructure and Management of Health Services, Government of Gujarat, Report no 05 of 2024 (Performance Audit –Civil)

detailed guidelines outlining the human resource recruitment policy and rental payments. Subsequently, guidelines for telemedicine services were developed and circulated. The committee is currently working on developing guidelines for the team-based incentive component and untied funds, for which no specific guidelines exist.

C.3 An integrated approach to ensure convergence across schemes led to delays

One of the factors that affected the initiation of the two components of the PM-ABHIM, i.e., CCBs and IPHLs, was the state's policy of planning to integrate these components with existing and allied activities under the ECRP-II initiative and the state initiative of conversion of district hospitals to medical colleges. Similarly, in the case of IPHL, the objective was to create a single unit integrating all equipment and laboratory testing functions. This required integrating these activities, for which combined tenders were issued, leading to delays in initiation.

C.4 Difference Between the Prescribed and the Actual Cost of Construction could compromise quality

Officials pointed out that actual costs often exceeded the prescribed cost norms as the building's foundation depended on factors like the soil type and earthquake zoning. It was emphasized that in the absence of adequate flexibility in cost norms, there is a risk of compromising construction quality.

D. Observations from Facility Visits in Districts

The state did not undertake any construction related activities in the first two years of the XV-FC Health grants, except for one PHC each in 2021-22 and 2022-23. Progress under the diagnostics component has been notably slow, with no equipment delivered to health facilities so far—except for a few glucometers and rapid diagnostic kits. The progress of the other component of UHWCs was also slow to begin with, but has now gathered pace with 662 UHWCs or UAAMs having been made operational. The case of the UHWCs therefore, provides the most compelling evidence in terms of assessing the impact of the XV-FC Health grants.

With this perspective, the team undertook field visits to urban facilities within the district of Ahmedabad under the Ahmedabad Municipal Corporation (AMC), the largest corporation in the state with a vibrant network of health facilities. The AMC received funding under the diagnostics (FU1) and UHWCs (FU2) components of the XV-FC Health Grants. The AMC procured diagnostic equipment and kits from the Central Medical Store (CMS) for UPHCs, UCHCs and tertiary care hospitals and a small portion from the GSMCL.

In the second district of Kheda, the facility visits focused on a BPHU functioning out of a converted Taluka Health Office (THO) and a newly established U-AAM from the XV-FC Health Grants. The list of visits is summarized below:

Ahmedabad (12 February 2025)	Kheda (13 February 2025)
1. UHWC Juna Vadaj -2 2. Chandkheda UCHC	1. BPHU, Taluka Health Office Nadiad 2. UPHC- Nadiad 2 3. UHWC- AAM 2 under UPHC Nadiad 2

D.1 Ahmedabad

1. *UHWC Juna Vadaj -2*

This UHWC established had been operationalised about a year ago using the XVth FC health grant. The facility catered to a population of about 4000 people, and was staffed by a Medical Officer, a staff nurse and a category 4 worker. This UHWC witnessed a daily average OPD footfall of about 35-40 patients and offered basic tests such as blood pressure, blood sugar, Hb and other kit-based tests.

The augmentation of services through UHWCs can be noted from the following table, which shows the average daily OPD footfall for 2023-24 and 2024-25 for all UHWCs located within the AMC area. The table shows that the average daily OPD footfall in 2023-24 when UHWCs were initially operationalized was about 25 patients per day. This has increased to an average of 42 patients per day in 2024-25, signifying a sizeable increase in service delivery.

Table 78: Ahmedabad Municipal Corporation (AMC), Gujarat- OPD Data for UHWCs

UHWC OPD DETAILS

SR NO	ZONE	2023-24			2024-25 (Up to Jan.25)		
		OPD	NO OF UHWC	AVG/DAY /UHWC	OPD	NO OF UHWC	AVG/DAY /UHWC
1	CENTRAL ZONE	48,674	9	**19**	92,388	11	**35**
2	EAST ZONE	112,433	16	**24**	196,724	17	**48**
3	NORTH WEST ZONE	73,206	10	**25**	97,609	12	**34**
4	NORTH ZONE	142,083	20	**25**	251,007	24	**44**
5	SOUTH WEST ZONE	47,592	9	**18**	76,281	9	**35**
6	SOUTH ZONE	225,758	24	**33**	322,181	27	**50**
7	WEST ZONE	98,965	17	**20**	169,261	20	**35**
AMC TOTAL		**748,711**	**105**	**25**	**1,205,451**	**120**	**42**

Data Source- Information provided by the Health Facility

2. *Chandkheda UCHC*

This facility was a 30-bedded UCHC which saw an average daily OPD footfall of about 500 during slack season, and as high as 700 patients per day during peak season. The facility was staffed with 11 consultants including paediatrician, gynaecologist, surgeon, anaesthetist, 4 Medical Officers, 11 GNM, 1 OT assistant, 1 NPM, 4 LTs, 1 X ray technician, 4 pharmacists and 14 category four workers.

Functioning as a delivery centre carrying out 30-35 deliveries in a month and offering general surgeries such as for hernia, appendix, cyst removal, cataract etc., this UCHC was the recipient of diagnostic equipment from the XV-FC Health Grants. It received an Immuno-analyser on April 2024 which enabled tests such as thyroid profile, ferritin, troponin, vitamin D3 and B12 to be carried out within the facility. Previously, such tests had to be referred to the civil hospital.

It also received a non-stress test (NST) machine in December 2024 which is important since it functions as a delivery centre, and a CBC three-part machine, which was used to replace an earlier non-functional machine. The additional tests which could be carried out within the facility using the immune-analyzer are documented in the table below–over 900 tests which would previously have to be referred outside, were carried out within the facility over a period of 8 months.

Table 79: Chandkheda CHC, Gujarat- No. of Diagnostic Tests Performed using New Equipment from XV-FC Health Grant

Month	T3	T4	TSH	Vitamin D3	Vitamin B12	Ferritin	Trop-I	HEV
January	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0
May	3	3	24	0	0	0	0	0
June	4	4	114	4	0	0	0	0
July	6	6	115	15	0	8	0	5
August	5	5	86	11	0	15	0	1
September	5	5	83	2	0	10	0	1
October	2	6	70	3	0	5	6	1
November	15	10	94	10	0	12	2	2
December	26	26	135	13	0	9	2	2
Total	**41**	**36**	**721**	**49**	**0**	**37**	**10**	**12**

Data Source- Information provided by the Health Facility

D.2 Kheda District

3. Office of CDMO

The district was allocated 25 per cent of the diagnostic component for FY 2022-23 in December 2024, for which the process of gap analysis was ongoing. This component would involve purchase of reagents, kits and small equipment whereas equipment such as biochemistry analysers and CBC counters would continue to be procured at the state level.

Regarding the UHWC component, the district received the first instalment of funds in 2022. However, guidelines were issued and recruitment powers were delegated to the CDMO only in January 2023, following which this work was initialized. The first UHWC in the district was subsequently made operational in October 2023. The OPD footfall

being witnessed in the 12 operationalised UHWCs was shared by the district and is documented in the table below-

Table 80: OPD Attendance in UHWCs, Kheda District, Gujarat

Facility Name	Facility Sub-Type	Allopathic- Outpatient attendance										
		24-Apr	24-May	24-Jun	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	Total
UHWC-12 Kapadwanj	**UAAM**	588	562	406	571	568	524	504	499	580	781	5583
UHWC- 6 Kapadwanj	**UAAM**	902	555	197	381	293	626	572	462	579	750	5317
UHWC-10 Santram	**UAAM**	0	456	893	631	696	686	847	726	794	994	6723
UHWC-11 SRP	**UAAM**	875	982	817	875	815	793	904	917	935	1295	9208
UHWC-1 Haridas	**UAAM**	712	0	830	0	850	0	777	725	772	863	5529
UHWC-2 LOP	**UAAM**	806	944	968	993	942	913	812	944	912	617	8851
UHWC-3 Mssion	**UAAM**	945	1140	950	850	733	715	721	1076	728	766	8624
UHWC-4 Santram	**UAAM**	0	0	893	568	808	839	840	868	882	1030	6728
UHWC-5 SRP	**UAAM**	866	897	837	856	800	725	818	867	912	1276	8854
UHWC-7 Haridas	**UAAM**	0	0	317	0	666	0	716	725	794	847	4065
UHWC-8 LOP	**UAAM**	232	464	464	402	468	650	760	811	860	913	6024
UHWC-9 Mission	**UAAM**	953	1054	953	991	819	832	886	825	887	935	9135
	Total	**6879**	**7054**	**8525**	**7118**	**8458**	**7303**	**9157**	**9445**	**9635**	**11067**	**84641**
	Average	**573**	**588**	**710**	**593**	**705**	**609**	**763**	**787**	**803**	**922**	**7053**

Data Source- Information provided by the Health Facility

The table shows that cumulatively the UHWCs in the district witness an output of over 6000 OPDs in a month on an average. Importantly, the data shows that the number of OPDs in these UHWCs were increasing over time.

4. *BPHU, Taluka Health Office Nadiad*

This was an erstwhile Taluka Health Office (THO), which had been converted into a BPHU. The state already had a program assistant and accounts assistant from the NHM at THO in every Taluka. Therefore, in the first two years of the XV-FC Health Grant, the state converted these existing THOs into BPHU by adding a laboratory unit (BPHL) to the existing HMIS unit. Since laboratory equipment is yet to be delivered to the BPHU, the actual change in services resulting from this component will only be observable in the future.

5. *UPHC- Nadiad 2 functioning as a polyclinic*

Staffed with 1 Medical Officer, one Pharmacist, two Staff Nurses, one peon, one Midwife, 1 Laboratory Technician and one clerk, this UPHC covers a population of about 50,000 and caters to 70-80 OPD in a day on an average.

While this UPHC was slated to receive diagnostic equipment under the XV-FC Health Grants, it had been established as a polyclinic using funding from the urban component of the grants. A paediatrician and gynaecologist had been appointed to visit the facility for 2 hours every Friday, at a remuneration of Rs. 1500 per two hours. As with the BPHU, the full effect of the funding from the XV-FC Health Grants could only be assessed after the receipt of the expected diagnostic equipment.

6. *UHWC- AAM 2 under UPHC Nadiad 2*

This was a new UHWC- AAM established under the XV-FC Health Grants in Nadiad. Operating out of a rented premise in a densely populated locality, this AAM catered to a population of about 25000 and had been operational since October 2023.

Staffed with 1 Medical Officer, 1 Staff Nurse, 1 Multi-Purpose Worker (MPW), 1 cleaning staff and 1 security guard, this facility witnessed approximately 40 OPD on average per day. The OPD footfall at this facility is shown in the table below– the monthly OPD ranged from 600 to almost 1000 patients, all of which constitutes a net addition to service delivery.

Table 81: OPD at UHWC-AAM 2 under UPHC Nadiad 2, Kheda District, Gujarat

Facility Name	Facility Sub-Type	Allopathic- Outpatient attendance										
		24-Apr	24-May	24-Jun	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	Total
UHWC-2 LOP	**UAAM**	806	944	968	993	942	913	812	944	912	617	8851

Data Source- Information provided by the Health Facility

Appendix to Chapter 6

Table 82: Examples to Demonstrate Convergence Between PM-ABHIM and ECRP-II in Gujarat

District	Components tendered together
Devbhumi Dwarka	(20 ICU+42 Pediatric Ward+100 Field Hospital+IPHL+CCB)
Panchmahal	(CCB) +IPHL +GMERS
Chhota Udepur	(20ICU+42 Pediatric Ward+100 Field Hospital+CCB)+IPHL
Patan	(only CCB)
Surendranagar	(10+IPHL+CCB)
Gir Somnath	(100 Field Hospital+IPHL+CCB)
Arvalli	(42 Pediatric Ward+100 Field Hospital+CCB+IPHL)
Kutch	(CCB) +IPHL
Junagadh	(CCB) +IPHL
Valsad	CCB+IPHL
Ahmedabad	CCB +IPHL
Kheda	100 bed CCB+IPHL
Gandhinagar	CCB+IPHL
Mahisagar	CCB + (IPHL)
Rajkot	CCB +IPHL New Construction
Morbi	CCB+IPHL +GMERS
Mehsana	CCB + DH
Sabarkantha	CCB + IPHL +GMERS
Vadodara	CCB + IPHL +GMERS
Narmada	CCB+IPHL +GMERS
Surat	CCB
Navsari	CCB+IPHL +GMERS
Amreli	CCB
Jamnagar	CCB + IPHL
Porbandar	CCB+IPHL +GMERS
Anand	CCB

Data Source- Information provided by the Gujarat Government

Table 83: Gujarat- Year-wise Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	2021-22		2022-23		2023-24	
Component	**Allocation**	**Approval**	**Allocation**	**Approval**	**Allocation**	**Approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	117.00	117.00	117.00	117.00	124.00	19039.95
FR2 Construction of Block Public Health Units (BPHUs)	5031.00	5031.00	5031.00	5031.00	5282.00	3132.64
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	13937.00	13936.99	13937.00	13937.00	14635.01	14635.01
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	16001.00	16001.00	16001.00	16001.00	16801.00	0
Sub-Total of Rural Component	**35086.00**	**35085.99**	**35086.00**	**35086.00**	**36842.01**	**36807.6**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	1763.00	1762.29	1763.00	1763.00	1851.00	7394.00
FU2 Urban Health & Wellness Centres (HWCs)	26073.00	26073.00	26073.00	26073.00	27376.00	21803.00
Sub-Total of Urban Component	**27836.00**	**27835.29**	**27836.00**	**27836.00**	**29227.00**	**29197.00**
Grand Total	**62922.00**	**62921.28**	**62922.00**	**62922.00**	**66069.01**	**66004.60**

Data Source- Information provided by the Gujarat Government

Chapter 7: State-Level Insights from Uttar Pradesh

A. The Context

Uttar Pradesh has been a relatively poor performing state in terms of the XVth FC health grants. Both the utilization of funds and the physical progress have been below the all-India average (Refer Figure in Aggregate Analysis). Additionally, the State could not avail releases of the XVth FC grants after the first year 2021-22. Even in the case of PM-ABHIM, the utilization of funds has been below the all-India average (Refer Figure in Aggregate analysis).

The XVth FC allocation had a pronounced rural focus in Uttar Pradesh, with about 73 per cent of the total grant value being assigned to the rural components, as shown in Table 84 below. Among the individual components, the support for diagnostic infrastructure to primary healthcare facilities in rural areas (FR3) held the maximum weightage at 30 per cent of the total allocation, followed by Urban Health and Wellness Centres (FU2) at 23 per cent and conversion of SHCs and PHCs to HWCs at about 21per cent. Among the urban components, the support for diagnostic infrastructure FU1 was relatively small. More than 80 per cent of the allocation was directed to FU2 for UHWCs.

Table 84: Uttar Pradesh- Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	**Cumulative Total (2021-22 to 2023-24)**			
Component	**Allocation**	**Approval (before re-appropriation)**	**Component as % of total allocation**	**Component as % of total approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	140710.2	154487.0	24.99	27.93
FR2 Construction of Block Public Health Units (BPHUs)	23342.0	27187.4	4.15	4.91
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	168855.0	165061.5	29.99	29.84
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	118142.0	77467.5	20.98	14.00
Sub-Total of Rural Component	**412097.0**	**424203.3**	**73.19**	**76.68**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	21463.0	22085.6	3.81	3.99
FU2 Urban Health & Wellness Centres (HWCs)	129493.0	106930.9	23.00	19.33
Sub-Total of Urban Component	**150956.0**	**129016.6**	**26.81**	**23.32**
Grand Total	**563053.0**	**553219.9**	**100.00**	**100.00**

Data Source- Information provided by the Uttar Pradesh Government

B. The Approach and Execution

B.1 Fund Flow and Execution Modalities

Uttar Pradesh did not follow the DoE mandated fund flow structure as in many other States. Although most components of the XV-FC Health Grants were intended to be executed through local bodies (excluding diagnostic components), funds for all components were implemented by the Health department in the state. As per the officials of the state, local bodies participated in the meeting of the state-level committee (SLC) and expressed reservations and unwillingness to undertake the designated activities. Keeping this in view, it was decided to implement the XV-FC Health Grant through the Health Department itself.

In the only year for which the state received FC grants, the state decided to focus on establishment of building less Sub-Health Centres in FR1. The construction of the SHCs was modelled on the structure of SHCs developed by the state (and not IPHS standards), which allowed them to carry out the constructions at a unit cost of Rs. 33 lakhs, lower than the prescribed unit cost of Rs. 55 lakhs. The state proposals for the later years FY 2024-25 and 2025-26 were however, based on IPHS standards at the prescribed unit cost of Rs. 65 lakhs per unit. The construction of these units was to be carried under the purview of the Department of Medical Health and Family Welfare through several public-sector construction agencies.

For the components related to Diagnostic Infrastructure to the Primary Healthcare facilities (both rural and urban), the procurement of high-value equipment was carried out centrally through the Uttar Pradesh Medical Supplies Corporation Limited (UPMSCL) (Table 85).

The procurement of lower value items such as reagents and rapid diagnostic kits was done by the District Health Societies (DHS). All diagnostic service procurement in the state was aimed at strengthening in-house diagnostic capacity. This is unlike Madhya Pradesh where the state used an outsourcing PPP model to deliver diagnostic services.

The FR4 component on Conversion of Rural Sub-Health Centres & PHCs to HWCs was utilised towards payment of CHO remuneration, incentives, IEC and IT support as per guidelines. Prior to the implementation of the FC grants, these expenditures were being borne through the NHM budget. With the withdrawal of HR support, it was proposed to shift it back to the NHM budget.

Under the FU2 Urban Health & Wellness Centres (HWCs) component, upgradation and renovation of UHWCs functioning from rented premises was carried out under the purview of the NHM Office under the Department of Health and Family Welfare. The actual execution was overseen by the District Health Societies (DHSs) of the respective districts.

Table 85 below shows the flow of funds for the XV-FC Health Grants in Madhya Pradesh.

Table 85: Uttar Pradesh- Fund flow under XV-FC Health Grants

Component	Budget Provision under	1st level recipient	2nd level recipient
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	H&FW Dept.	H&FW Dept. (DGFW)	Construction Agencies
FR2 Block Public Health Units (BPHUs)		H&FW Dept. (DGMH)	Construction Agencies
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	Partially to the District Health Society under H&FW Dept. for kit based tests, consumables etc.
			UPMSCL (state level procurement)
FR4 Conversion of Rural Sub-Health Centres to HWCs		State Health Society under H&FW Dept.	District level offices under H&FW Dept.
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities		State Health Society under H&FW Dept.	Partially to the District Health Society under H&FW Dept. for kit based tests, consumables etc.
			UPMSCL (state level procurement)
FU2 Urban Health & Wellness Centres (HWCs)		State Health Society under H&FW Dept.	District Health Society under H&FW Dept.

Data Source- Information provided by the Uttar Pradesh Government

B.2 Achievements: Financial and Physical

Financial utilisation under the XV FC Components is presented in Table 86 below. Uttar Pradesh has achieved a robust rate of utilization for the first year of the grant at almost 89 per cent of total funds received. However, this performance must be interpreted in the light of the fact that the state did not receive any funds under the XV-FC Health Grants subsequent to FY 2021-22. Therefore, not only does the stated expenditure represent cumulative progress since 2021-22, but it also relates to only a single year's allocation. Also, as in most other States, the utilization rate in the rural components has been higher than the urban components: 94 per cent vs. 76 per cent.

In terms of physical progress of works as shown in Table 87 below, about 68 per cent of all SHCs and 79 per cent of all BPHUs approved in FY 2021-22 have been completed as of January 2025. The state has also initiated works for about 37 per cent of SHCs sanctioned for the year FY 2022-23, for which funds are yet to be received.

In PM-ABHIM, a major impediment seems to have been securing releases of funds. In the period 2021-22 to 2024-25, only about 41 per cent of the total approved allocations under the scheme were available to the State (Table 88). Consequently, as while expenditure as a proportion of funds available under the scheme was about 69 per cent, it was only 28 per cent of the allocated budget (Table 88). The physical progress under PM-ABHIM has been robust in the context of BPHUs and building-less SHCs as shown in Table 90. Even in IPHL, about 32 per cent of the total IPHL target units from FY 2021-22 to 2024-25 have been completed. The only slow progress appears to be in the component of UHWCs, a mere 1.63 per cent. This should be interpreted in light of the fact that UHWCs were allocated in PM-ABHIM only from the 2024-25.

Table 86: Uttar Pradesh- Financial Utilisation under XV-FC Health Grants for FY 2021-22 (as of January 2025)

Component	Amount Approved (Rs in crores)	Amount Received (Rs. in crores)	Amount Utilized (Rs in crores)	Utilization as % of Amount received
FR1 Building less Sub Centers, PHCs, CHCs	333.55	333.55	333.55	100.00
FR2 Block Public Health Units	76.1	76.1	76.1	100.00
FR3.1 Diagnostic infrastructure- SCs	255.7	255.7	242.21	94.72
FR 3.2 Diagnostic infrastructure- PHCs	281.53	281.53	209.4	74.38
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	387.34	387.35	387.35	100.00
Sub-Total of Rural Component	**1334.22**	**1334.23**	**1248.61**	**93.58**
FU1 Diagnostic infrastructure- Urban	70.37	70.37	70.31	99.91
FU2 Urban health and wellness centers (HWCs)	416.54	424.55	303.9	71.58
Sub-Total of Urban Component	**486.91**	**494.92**	**374.21**	**75.61**
Total (In Lakhs)	**1821.13**	**1829.15**	**1622.82**	**88.72**

Data Source- Information provided by the Uttar Pradesh Government

Table 87: Uttar Pradesh- Year wise Physical Progress for Construction related Components of XV-FC Health Grants

		2021-22		2021-22 (fund not received yet)		
Component	**Total units (#)**	**Work started/completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started/completed (%)**	**Work completed (%)**
FR1 Construction of Building less Sub-Health Centres	1047	*100.00*	*67.72*	1264	*36.95*	*0.00*
FR2 Construction of Block Public Health Units (BPHUs)	94	*98.94*	*78.72*	74	*4.05*	*2.70*

Data Source- Information provided by the Uttar Pradesh Government

Table 88: Uttar Pradesh-Total financial utilisation under PM-ABHIM 2021-22 to 2024-25 as of January 2025 (in Rs. Lakhs)

Year	Approved Budget	Funds Received (State+ Central share)	Expenditure incurred	% of expenditure against budget	% of expenditure against available funds
2021-22	688.57	1337.38	923.02	*28.10*	*69.02*
2022-23	1023				
2023-24	689.13				
2024-25	884.08				
Grand Total	**3284.78**	**1337.38**	**923.02**	***28.10***	***69.02***

Data Source- Information provided by the Uttar Pradesh Government

Table 89: Uttar Pradesh-Component-wise Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 (in Rs. Lakhs)

Component	Approved Budget	Funds Received (State+Central share)	Expenditure incurred	% of expenditure against budget	% of expenditure against available funds
Construction of Building-less Sub-centres	92684.5	133738	43698.72	*47.15%*	*65.05%*
CCB- 50 bedded District Hospital	42434		21685.82	*11.91%*	
CCB- 50 bedded Medical College	23750				
CCB- 100 bedded District Hospital	115851				
BPHU	31876.778		18549.49	*58.19%*	
IPHL	10377.33		3061.3	*29.50%*	
Urban HWC (Rented Buildings)	18750				
Grand Total	**335723.608**	**133738**	**86995.33**	***25.91%***	***65.05%***

Source: Approved budget derived from RoPs shared by the state.

Table 90: Uttar Pradesh- Physical Progress for Construction related Components of PM-ABHIM

	Year wise number of works (#)							
	2021-22	**2022-23**	**2023-24**	**2024-25**	**2025-26**	**Total units (#)**	**Completed units (#)**	**Completed units as proportion of total FY 2021-22 to FY 2025-26 units**
BPHU	0	91	105	115	204	515	279	*54.17%*
IPHL	8	15	15	15	22	75	24	*32.00%*
CCB- 50 bedded District Hospital	2	4	4	4	8	22	0	*0.00%*
CCB- 50 bedded Medical College	2	4	4	4	8	22	0	*0.00%*
CCB- 100 bedded District Hospital	3	6	6	6	9	30	0	*0.00%*
Construction of buildingless sub-centres	835	835	0	0	0	1670	1287	*77.07%*
Urban HWC (Rented Buildings)	0	0	0	250	424	674	11	*1.63%*
Total	**850**	**955**	**134**	**394**	**675**	**3008**	**1601**	***53.22%***

Data Source- Information provided by the Uttar Pradesh Government

C. Challenges Faced by the State in Implementing the Grants

C.1 Cessation of XV-FC Health Grant Releases

The primary challenge faced by the state of Uttar Pradesh in the implementation of the XV-FC Health Grants was the fact of no releases could be obtained after FY 2021-22, i.e., beyond the first year of the grant. This stemmed from a) violation of the guidelines in terms of the implementation and fund flow through local bodies and the consequent need for payment of penal interest, and (b) miscommunication between the state officials, approvals by the National-level Committee (NLC) on revised proposals and DoE, Ministry of Finance leading to the need for returning funds to GoI.

1. *Delay in transfer of funds and consequent penal interest*

   Uttar Pradesh could not adhere to the mandated fund flow structure and the timeline for transferring funds from the Finance Department to the nodal departments. In contrast to the DoE mandate, the state decided to transfer all funds to the Health Department for execution of the grant, but no budget provision was made in the Demand for Grants of the Health Department for the financial year 2021-22. The budget provision was subsequently made in 2022-23, and the funds received by the Finance Department from

GoI remained unreleased to the Health Department until then. This delayed transfer of funds beyond the mandated 10 days and entailed the payment of penal interest. For the state to be eligible for release of the next tranche of funds, the Finance Department needed to pay the penal interest to the Health Department for the period of delay. While a penal interest amount of Rs. 9227.95 lakh was paid towards the end of 2023, this was booked to a wrong accounting head, leading to further delays in correction of the same.

2. *Miscommunication on the revision of FY 2021-22 approval and consequent penal interest*

There was a miscommunication between the State officials, NLC approvals and DoE Ministry of Finance on the revised proposals for the FY 2021-22,43. The state had requested revisions of allocations for only three specific components FR3, FU2 and FU1 (to be revised from Rs. 993.86 Crore to Rs. 1024.14 Crore) and the previously allocated budget for the other components were to remain the same (Rs. 796.98 crore). Thus, the total approval after revision was supposed to be Rs. 1821.12 Crore (1024.14+796.98) (Refer Table 97 in the Appendix. However, the DoE considered the total approvals for FY 2021-22 as amounting to the sum of revised proposals for the three components, (Rs. 1024.14) crores and consequently raised a demand for return/payment of interest for the releases pertaining to the excess of total approvals. This proved to be a major hindrance in securing the releases for subsequent years of the grant.

C.2 Utilisation Criterion Challenge for PM-ABHIM

The state officials emphatically stated that the 75 per cent utilization criterion for obtaining the next instalment of PM-ABHIM was stringent and hard to fulfil in the face of the kind of construction activities involved. This could potentially feed into the low rate of releases against budget approvals in the State discussed earlier (41 per cent)[44]. According to the Chief Engineer, all initiated units have varying degrees of progress, and the mandated utilisation criterion often amounts to stalling of funding for units in advanced stages of progress, due to presence of the laggard units.

C.3 Challenges with HR Recruitment and Availability

Officials also pointed out that a key challenge in operationalizing health facilities with adequate human resources (HR) is the process for procurement and staffing. Currently, the indent for procurement of equipment and HR recruitment is issued only when 75 per cent of the structure is completed. However, if only a few facilities reach this threshold while many others lag behind, procurement and hiring processes are delayed. This is because economies of scale in mass procurement and recruitment are not realized, making it cost-inefficient to proceed. As a result, even the first few completed facilities remain non-functional, as their operationalization becomes contingent on the completion of other health facilities.

[43] The revised proposal for 2021-22 was submitted and deliberated in the fourth meeting of the NLC held on 11 July 2022

[44] It should be borne in mind that this is only presented as one of the potential reasons for the low rate of releases.

D. Observations from Field Visits to Districts

The team undertook field visits to the districts of Barabanki and Lucknow with a view to survey different types of health facilities being supported by either the XV-FC Health Grants or the PM-ABHIM. The visits spanned over 7 facilities in the two districts, the details of which are listed below.

Barabanki (29 January 2025)	Lucknow (30 January 2025)
1. SHC Khaspariya 2. UPHC Manjhlepur 3. BPHU at CHC Dewa	1. UHWC AAM Chitwapur 2. BPHU at CHC Mohanlalganj 3. IPHL at Lok Bandhu Raj Narayan Hospital 4. CCB (under construction) at Ram Manohar Lohia Hospital

D.1 Barabanki

SHC Khaspariya, Barabanki

This facility was housed in a new building constructed using the XV- FC Health Grants (handed over in January 2024). It had also received miscellaneous equipment and furniture under the FC grant. The SHC was previously operating from a rented building located next to the Sarpanch's house in the village and faced operational constraints. The SHC catered to a catchment population of about 6000 and was staffed by a Community Health Officer (CHO), ANM and 4 ASHAs for outreach services. The average OPD footfall was about 15-16 patients per day.

The newly constructed SHC helped in improving both the quantity and the quality of health service delivery. The current CHO, who had spent about six months working from the rented premises, pointed out a number of constraints that the staff faced while operating from that premise. These issues included limited space availability, premises being locked during working hours, displacement of records and registers by the owner, and a general sense of uncertainty that affected the functioning of the SHC. In contrast, the newly constructed buildings offered more planned space for improved service delivery and were free from the owner's interference. For example, the enlarged space now allowed better privacy for conducting ANC screenings. There is also evidence of some increase in OPD footfalls in recent months, as indicated in Table 91.

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Table 91: OPD footfall - SHC Khaspariya, Barabanki District, Uttar Pradesh

Month year (before building construction)	OPD	Month year (after building construction)	OPD
October 2023	330	October 2024	359
November 2023	132	November 2024	365
December 2023	67	December 2024	135

Data Source: Information received from the Health Facility

UPHC Manjhlepur, Barabanki

This was a new UPHC constructed by the Nagar Palika (Municipality) on their own land and operationalized in November 2024. Covering a catchment population of about 50,000, this UPHC was staffed by a Medical officer, a pharmacist, 1 LT (Laboratory Technician), 1 Staff Nurse and a security guard. It witnessed an average OPD footfall of about 50 patients per day.

This UPHC was slated to receive diagnostic equipment such as haematology analyser and biochemistry analyser from the XV-FC Health Grants. Currently, it was offering only 5-6 diagnostic tests, but the provisioning of diagnostic equipment would allow it to expand this range to about 50 tests. Currently, patients have to go to the nearby district hospital for most diagnostic tests. With the new equipment, the volume of diagnostic tests and OPD footfall is expected to increase further in the future.

BPHU at CHC, Dewa, Barabanki

The CHC functions as a First Referral Unit (FRU) and 24 by 7 delivery centre and covers a population of about 2,52,440. A 30-bedded unit staffed by 7 doctors and having an over 80 per cent bed occupancy rate, this CHC was a vibrant facility carrying out over 100 deliveries a month and witnessing a patient footfall of 150 OPDs per day on average (crossing 300 in peak season). The robust patient footfall made this CHC particularly well suited to the expansion of diagnostic facilities through creation of a BPHU.

The new BPHU adjoining this CHC was housed in a freshly constructed building and also received high-value diagnostic equipment, both funded by the XV-FC Health Grants. Made fully operational in September 2024, this BPHU had 3 Laboratory Technicians, 2 of whom were hired only after the construction of the BPHU. The establishment of the BPHU allowed the expansion of test services to cover about 47 tests, whereas earlier, the laboratory in the CHC could offer only about 20 tests. The staff also mentioned that with the upcoming use of the biochemistry analyser, this range would be expanded even further to cover around 65 tests.

The Table 92 below presents the number of diagnostic tests conducted in the CHC lab during the months prior to the establishment of the BPHU, and for the same months in the following year (to account for seasonality), after the BPHU was established. While there is some increase in the number of tests particularly in the month of December 2024, this needs to be read with

caution as the BPHU is relatively new, and the full impact would only manifest in the months to come when the expanded range of tests is offered and a longer time trend can be examined.

Table 92: Diagnostic Tests- BPHU CHC Dewa, Barabanki District, Uttar Pradesh

Month year (before BPHU)	Diagnostic tests	Month year (after BPHU)	Diagnostic tests
October 2023	7016	October 2024	5639
November 2023	3156	November 2024	5069
December 2023	1258	December 2024	5770

Data Source: Information received from the Health Facility

D.2 Lucknow

UHWC AAM Chitwapur (UFWC), Lucknow

This facility catered to a population of about 50000 and witnessed a daily OPD footfall of about 100-150 patients. It had a sanctioned strength of 13 staff, including 1 medical officer (MO), 1 pharmacist, 2 staff nurses, 1 Laboratory Technician (currently vacant), 4 ANM, 3 fourth category staff, 1 Health Visitor and 1 Assistant Research Officer (ARO).

An NQAS certified facility, this UFWC received high-value diagnostic equipment such as an automated analyser from the XV-FC Health Grants. Previously, a range of about 17 essential tests were being carried at this facility which should be expanded to 30 once the LT is hired. It is also slated to receive a biochemistry analyser from the XV-FC Health Grants, which would help expand this range even further. Since the new diagnostic equipment could not be operationalised in the absence of an LT, we do not document the outcomes in terms of the number of tests at this facility. At the same time, this highlights the importance of having the necessary human resources in place to ensure that any capital investment is productive.

BPHU at CHC Mohanlalganj, Lucknow

Operationalised in June 2024, this BPHU was built using the XV-FC Health Grants. With the adjoining CHC conducting over 250 deliveries in a month and offering specialities such as paediatrics, gynaecology, anaesthesia, dental eye surgery, this facility too was well-suited for the establishment of a Block Public Health Unit. This BPHU was staffed by a total of 7 Laboratory Technicians (LTs) with two positions lying vacant.

Apart from the construction, high-value equipment at the BPHU was also sourced from the XV-FC Health Grants. The automated analyser and biochemistry analyser so obtained have enabled a remarkable expansion of the range and number of diagnostic tests being offered at this CHC. For instance, prior to the availability of the automated analyser, blood count tests had to be performed manually and the number of tests offered were limited to about 10-12 tests. Attesting to the value added by the BPHU, local officials and CHC staff noted that even outside practitioners had begun referring people to this facility for diagnostic testing.

This BPHU is also scheduled to receive a Truenat machine further from the XV-FC Health Grants. In terms of the challenges, the staff highlighted that two additional LTs who were

slated to join the BPHU, did not join and hiring for the same would be conducted in the next cycle of recruitment. The Table 93 below illustrates the reported diagnostic tests in the CHC sourced from HMIS. While the number of in-house diagnostic tests does not show an increase following the establishment of the BPHU, it is important to note that no outsourced tests were recorded prior to its setup. This raises the possibility that outsourced tests were previously included under in-house diagnostics, rendering the 2024 figures not directly comparable to earlier data.

Table 93: Diagnostic Tests- BPHU CHC Mohanlalganj, Lucknow District, Uttar Pradesh

Month year (before BPHU)	Diagnostic Tests in house	Diagnostic Tests Outsourced	Month year (after BPHU)	Diagnostic Tests	Diagnostic Tests Outsourced
October 2023	5140	0	October 2024	3124	829
November 2023	3264	0	November 2024	2531	859
December 2023	4344	0	December 2024	3708	1856

Data Source: Information received from the Health Facility

IPHL at Lok Bandhu Raj Narayan Hospital, Luchnow

The Lok Bandhu hospital is a 300 bedded hospital and offers facilities equivalent to a district hospital. The addition of the IPHL allowed the hospital to expand its range of offered tests by nearly twofold; with about 120 types of tests being conducted now as opposed to 50-60 earlier. This IPHL was also designated as a Hub for the CHCs and PHCs under the hub and spoke diagnostic arrangement of the state around the time of its operationalisation.

The establishment of the IPHL has accorded numerous benefits to the facility, according to the staff, including but not limited to:

- Microbiology culture tests have been introduced after the coming up of the IPHL.
- The dedicated IPHL led to a streamlining of the collection and testing process where patients do not need to enter the laboratory area. The separation of the lab from the sample collection and report distribution area has significantly improved the efficiency and quality of services for patients.
- Microbiological surveillance of OTs and Labour Room can now be conducted in house with the expanded services of the IPHL.

About 5-6 LTs have been hired post the establishment of the IPHL, in addition to 7 LTs already in place before and a new Microbiologist has been appointed in the hospital; strengthening forward linkage with IPHL. The consequent expansion of services is mirrored in the significant increase in both OPD footfall and diagnostic testing shown in Table 94 below.

Table 94: Diagnostic Tests- IPHL at Lok Bandhu Hospital, Lucknow District, Uttar Pradesh

Month year (before BPHU)	Diagnostic tests in house	OPD	Month year (after BPHU)	Diagnostic tests	OPD
October 2023	230979	66915	October 2024	363991	66250
November 2023	264357	50923	November 2024	375779	60100
December 2023	209462	46369	December 2024	264874	53579

Data Source: Information received from the Health Facility

CCB (under construction) at Ram Manohar Lohia (RML) Hospital

This was a 100-bedded critical care block (CCB) coming up (under construction) in the Ram Manohar Lohia Hospital in Lucknow. The construction began in October 2024 and is slated to be completed by October 2025. The attached RML hospital houses a 200-bedded MCH wing constructed using NHM funds.

The execution of the CCB has been handed over to the UPRNN (Uttar Pradesh Rajkiya Nirman Nigam (a state-owned PSU), to oversee the tendering, monitoring, construction, and quality assessment. Since this CCB is not yet functional, there are no documented outcomes, but being co-located with a MCH referral hospital, it is expected to significantly enhance critical care services in the region.

Appendix to Chapter 7

Table 95: Uttar Pradesh- Revised Proposal for FY 2021-22 (in Rs. Crore)

Component	Initial Approval (2nd NLC)	Revised Approval (4th NLC)
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	498.97	537.23
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	70.31	70.37
FU2 Urban Health & Wellness Centres (HWCs)	424.58	416.54
Total amount	**993.86**	**1024.14**

Data Source- Information provided by the Uttar Pradesh Government

Table 96: Uttar Pradesh- Year-wise Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial Year	**2021-22**			**2022-23**			**2023-24**	
Component	**Allocation**	**Approval**	**Approval after revision**	**Allocation**	**Approval**	**Approval after reappropriation**	**Allocation**	**Approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	33368.0	33354.7		33368.0	33368.0	38952.2	35022.0	87764.3
FR2 Construction of Block Public Health Units (BPHUs)	7653.0	7610.2		7653.0	7653.0		8036.0	11924.1
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	53723.0	49897.0	53723.0	58723.0	58723.0		56409.0	56441.5
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	38735.0	38733.8		38735.0	38733.8	38733.8	40672.0	0.0
Sub-Total of Rural Component	**133479.0**	**129595.7**		**138479.0**	**138477.8**		**140139.0**	**156129.9**

Financial Year	2021-22			2022-23			2023-24	
Component	**Allocation**	**Approval**	**Approval after revision**	**Allocation**	**Approval**	**Approval after reappropriation**	**Allocation**	**Approval**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	7037.0	7031.3	7037.0	7037.0	7037.0		7389.0	8017.3
FU2 Urban Health & Wellness Centres (HWCs)	42455.0	42450.1	41654.1	42455.0	36872.0	36872.0	44583.0	27608.8
Sub-Total of Urban Component	**49492.0**	**49481.4**		**49492.0**	**43909.0**		**51972.0**	**35626.1**
Grand Total	**182971.0**	**179077.1**		**187971.0**	**182386.8**		**192111.0**	**191756.0**

Data Source- Information provided by the Uttar Pradesh Government

Table 97: Uttar Pradesh- Revised Proposal for FY 2021-22 (in Rs. Crores)

Component	Initial Approval (2nd NLC)	Revised Approval (4th NLC)
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Rs. 498.97 crores	Rs. 537.23 crores
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Rs. 70.31 crores	Rs. 70.37 crores
FU2 Urban Health & Wellness Centres (HWCs)	Rs. 424.58 crores	Rs. 416.54 crores
Total amount	**Rs. 993.86 crores**	**Rs. 1024.14 crores**

Data Source- Information provided by the Uttar Pradesh Government

Table 98: Uttar Pradesh- Land Availability issues for Components under PM-ABHIM

Component	No. of units	Financial approval issued	Work Start	Work Complete	Land problem/ unavailable (% of approved works)
Construction of Buildingless Sub-centers	1670	1670	1552	1287	118 (7%)
Block Public Health Unit (BPHU)	515	479	459	279	16 (3%)
Integrated Public Health Lab (IPHL)	75	64	56	24	8 (12.5%)
Critical Care Block (CCB)	74	60	56	0	12 (20%)

Data Source- Information provided by the Uttar Pradesh Government

Chapter 8: State-Level Insights from Meghalaya

A. The Context

Meghalaya's performance has been poor in the context of the XVth FC Health Grants. The state had received funds only for the first year (2021-2022) of the FC Health Grant as of October 2024. Of the allocation for 2022-23, only funds pertaining to the diagnostic components were received, that too as late as January 2025.

The state presents a unique case for implementation of the XVth Finance Commission Health Grants. As a hilly and predominantly tribal state governed under the Sixth Schedule of the Constitution, it operates without the usual Panchayati Raj Institutions (PRIs). Administrative powers in tribal areas rest with the Autonomous District Councils (ADCs), and keeping this in view, the Department of Expenditure (DoE), Ministry of Finance specified that the implementation of the rural components should be handled by the Autonomous District Councils (ADCs). ADCs were required to work in close coordination with the district health departments, as they had historically never been involved in health-related activities. It must be noted that much of the construction works under the H&FW Department in the state were being handled by the department's own engineering wing.

Table 99: Meghalaya- Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial year	**Cumulative Total (2021-22 to 2023-24)**			
Component	**Allocation**	**Approval**	**% of total allocation**	**% of total revised approval**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	979	1367	5.48	7.65
FR2 Construction of Block Public Health Units (BPHUs)	2822	2579	15.79	14.43
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	3675	4670	20.56	26.14
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	2833	2494	15.85	13.96
Sub-Total of Rural Component	**10309**	**11110**	**57.67**	**62.19**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	461	457	2.58	2.56
FU2 Urban Health & Wellness Centres (HWCs)	7107	6298	39.75	35.25
Sub-Total of Urban Component	**7568**	**6755**	**42.33**	**37.81**
Grand Total	**17877**	**17866**	**100.00**	**100.00**

Data Source- Information provided by the Meghalaya Government

There was a marked urban focus in the initial FC allocations for the state. In the period 2021-22 to 2023-24, about 42 per cent of the allocations were directed towards the urban components, and 58 per cent towards rural (Table 99). This was not in alignment with the context of the state, which was predominantly rural. The single largest allocation was towards the FU2 UHWCs, accounting for nearly 40 per cent of the total allocation. The allocation towards support for diagnostic infrastructure FR3 was also substantial at 21 per cent of the total allocation. Among the rural components, FR1 *Construction of building less SHCs, PHCs and CHCs* had the lowest allocation (5.5 per cent), while among the urban components, the allocation for FU1 stood the lowest at 2.6 per cent. Notably, Meghalaya also received funding for the rural component of construction of SHCs, PHCs and CHCs under the PM-ABHIM.

B. The Approach and Execution

B.1 Fund Flow and Execution Agency

The Table 100 shows the fund-flow arrangements adopted in the state of Meghalaya. Given the unique context of the state characterized by absence of local bodies, all funds were released by the Finance Department to the H&FW Department. Subsequently, these funds were transferred to the State Health Society for execution. Funds pertaining to the procurement components FR3 and FU1 were handed over to the Meghalayan Medical Drugs & Services Limited (MMDSL) for procurement. Similarly, funds for construction of SHCs and PHCs under FR1 were handed over to the Village Health Councils (VHCs). A VHC is a body of village-level community representatives, which was introduced in the state to support and mobilize various-health related activities at the grassroots level. In FU2 component for UHWCs, funds were passed on to District Health Societies for operationalizing UHWCs.

Table 100: Fund Flow Arrangements for the XV-FC Grant Components in Meghalaya

Component	Budget Provision under	1st level recipient	2nd level recipient
FR1 a) Construction of Building- less Sub-Health Centres	Health Department	State Health Society	Village Health Council
FR1 b) Construction of Building less PHCs	Health Department	State Health Society	Health Engineering Wing
FR2 Block Public Health Units (BPHUs)	Health Department	State Health Society	Health Engineering Wing
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Health Department	State Health Society	Meghalayan Medical Drugs & Services Limited (MMDSL)
FR4 Conversion of Rural Sub-Health Centres to HWCs	Health Department	State Health Society	NA
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	Health Department	State Health Society	Meghalayan Medical Drugs & Services Limited (MMDSL)

Component	Budget Provision under	1st level recipient	2nd level recipient
FU2 Urban Health & Wellness Centres (HWC)	Health Department	State Health Society	District Health Society

Data Source- Information provided by the Meghalaya Government

For FR2 *Construction of Block Public Health Units (BPHUs)*, the state adopted a mixed approach. Of the total allocation of 39 BPHUs for all the five years of the XV-FC Health Grant, funds for construction of 13 BPHUs was released to the Engineering Wing under the Health Department; the funds for the remaining 26 BPHUs was given to the Village Health Councils (VHC) for construction.

B.2 Adapting FC grants to meet State-specific Context and Ensuring Synergies across Multiple Sources of Funding

The assignment of construction responsibilities for SHCs and BPHUs to VHCs was an adaptation to the state's local context. Although the DoE guidelines recommended the involvement of ADCs in implementing the rural components, their involvement was contentious given their limited engagement in health-related activities in the past. As VHCs were already operational in the state at the grass-roots level since 2022, the state decided to assign the task of constructing SHCs and 26 BPHUs to VHCs. This adaption and decision to entrust construction works to VHCs took a substantial amount of time and could be finalized only by 2024.

The design of SHCs in the state was also modified to suit the local context. The state finalised two types of designs for SHCs and the choice of a particular location was based on the topography and requirements of the community. These designs took into account IPHS standards and made modifications to suit the local context. Provisions for staff quarters were made in all new SHCs, as it was a necessity given the terrain of the state and presence of hard-to-reach areas.

The FR3 *Support for Diagnostic Infrastructure to the Primary Healthcare facilities* component was exclusively used for meeting the requirements for diagnostic equipment/kits for the 155 existing Sub Centres in the state. In FU2 *Urban Health & Wellness Centres (UHWCs)*, the official population norms for UHWCs at one UHWC per 15000-20000 population had to be relaxed (for some locations) in view of the high degree of population dispersion in the state.

The State also used funding for the component FR4 *Conversion of Rural Sub-Health Centres & PHCs to HWCs* towards appointment and payments to MLHP (Mid-Level Health Provider[45])

[45] An MLHP refers to the Community Health Officer (CHO) recruited and appointed at a Health and Wellness Centre.

B.3 Achievements: Financial and Physical Progress

While assessing the progress of the states, it should be borne in mind that the state received funds for all components only in the first year 2021-22 and for the diagnostic components in 2022-23.

In 2021-22, although the aggregate utilization of funds was about 60 per cent, this was primarily driven by the utilization in the diagnostic components (Table 101). Even in 2022-23, all releases corresponding to the diagnostic components were utilized (Table 101). Importantly, the absorption of funds was nil in FR1, and a meagre 42 per cent in FR2. The delay in decision to handover construction of SHCs and BPHUs to VHCs possibly contributed to the low utilization of funds in these components. Even in FU2 component on UHWCs, the fund utilization rate was less than 50 per cent. In sum, although the state of Meghalaya has achieved robust utilisation of the diagnostic components, the other components continue to lag behind.

The physical progress mirrors the financial progress. The completion of target units has been very low (Table 102). None of the allocated SHCs, PHCs or BPHUs have been completed so far, and only about half of the total allocated units have seen some work in progress. For the FY 2022-23, although funds pertaining to these components had not been received by the state till the time of the team's visit, work on one of the two PHCs allocated for FY 2022-23 had already commenced.

Table 101: Meghalaya- Year-wise Financial Utilisation of XV-FC Health Grants as Percentage of Releases

Component	2021-22	2022-23	Cumulative total
FR1 Building less Sub Centers, PHCs, CHCs	*0.00%*		*0.00%*
FR2 Block Public Health Units	*41.47%*		*41.47%*
FR3.1 Diagnostic infrastructure- SCs	*94.96%*	*100.00%*	*97.48%*
FR 3.2 Diagnostic infrastructure- PHCs	*124.45%*	*100.00%*	*112.32%*
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	*58.75%*		*58.75%*
Sub-Total of Rural Component	***66.66%***	***100.00%***	***75.38%***
FU1 Diagnostic infrastructure- Urban	*100.66%*	*100.00%*	*100.33%*
FU2 Urban health and wellness centers (HWCs)	*48.01%*		*48.01%*
Sub-Total of Urban Component	***51.22%***	***100.00%***	***54.01%***
Total (In Lakhs)	**60.12%**	**100.00%**	**67.59%**

Data Source- State's Report; Blanks indicate no releases for that component

Table 102: Meghalaya- Year-wise Physical Progress for Construction related Components of XV-FC Health Grants

	2021-22			2022-23			Total (2021-22 & 2022-23)		
Component	**Total units (#)**	**Work started /Completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started /Completed (%)**	**Work completed (%)**	**Total units (#)**	**Work started /Completed (%)**	**Work completed (%)**
FR1 a) Construction of Building less Sub-Health Centres	6	*50.00%*	*0.00%*	1	*0.00%*	*0.00%*	7	*42.86%*	*0.00%*
FR1 b) Construction of Building less PHC	0			2	*50.00%*	*0.00%*	2	*50.00%*	*0.00%*
FR2 Construction of Block Public Health Units (BPHUs)	13	*100.00%*	*0.00%*	12	*0.00%*	*0.00%*	25	*52.00%*	*0.00%*

Data Source- State's Reports

In PM-ABHIM, the performance has been significantly better. Under the scheme, the state was allocated budget towards three components: Infrastructure support for building-less sub-centres, Integrated Public Health Laboratories (IPHLs) and Critical Care Blocks (CCBs). Only the first component was common with the XVth FC health grants.

The state achieved an expenditure to the tune of 64 per cent of the total available funds (state and central share combined), amounting to 46 per cent of the approved budget (Table 103). In terms of sheer proportions, this places its performance at par with that of a state like Telangana under the PM-ABHIM. In terms of releases, the state could avail 69.6 crores out of 96.9 crores of the approved budget, that is, about 72 per cent of the approved budget.

A review of component-wise utilization of funds under PM-ABHIM indicates that the component of Infrastructure support for building-less sub centres exhibits expenditure amounting to 83 per cent of the total budget under PM-ABHIM (Table 104). This is at odds with the abysmal rate of financial utilization of the same component under the XV-FC Health Grants. This reflects the challenges of the execution structure prescribed by the XV-FC Health Grants, which delayed the implementation of the construction related components in the state by a period of almost 2 to 3 years.

Even in terms of physical progress under PM-ABHIM, in the component for building-less SHCs, the state reports initiation of 96 per cent and completion of 42 per cent of the allocated units (Table 105). This is in stark contrast to the physical progress for the same component under the XV-FC Health Grants, where the rate of completion stands at 0, even with a small allocation of 6 SHCs. CCBs are only allocated for FY 2025-26 for Meghalaya, and therefore, only exhibit commencement of work. IPHLs, however, exhibit a lower rate of physical progress with only 1 out 10 allocated units being completed as of yet.

Table 103: Meghalaya- Year-wise Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 as of March 2025 (Figures in Rs. crores)

Year	Approved Budget	Funds Received (State+Central share)	Expenditure incurred	% of expenditure against approved budget	% of expenditure against available funds
2021-22	42.87	10.72	0	*0.00%*	*0.00%*
2022-23	45.17	47.86	1.50	*3.32%*	*3.13%*
2023-24	3.97	4.91	19.30	*486.15%*	*393.08%*
2024-25 (up to March 2025)	4.95	6.17	23.85	*481.82%*	*386.55%*
Grand Total	**96.96**	**69.66**	**44.65**	***46.05%***	***64.10%***

Data Source- Financial Management Report

Table 104: Meghalaya- Component-wise Financial Utilisation under PM-ABHIM FY 2021-22 to FY 2024-25 as of March 2025 (Figures in Rs. Crores)

Component	Approved Budget	Funds Received (Master Sanction)	Expenditure incurred	% of expenditure against budget	% of expenditure against available funds
Infrastructure Support for Buildingless Sub Health Centres	83.80	69.66	43.70	*83.13%*	*64.10%*
Integrated Public Health Labs (IPHLs)	13.16		0.65	*0.00%*	
Critical Care Hospital Blocks (CCBs)	0.00		0.30		
Total	**96.96**	**69.66**	**44.65**	***46.05%***	***64.10%***

Data Source- Financial Management Report

Table 105: Meghalaya- Component-wise Physical Progress for Components of PM-ABHIM (total units from FY 2021-22 to FY 2025-26)

Component	Year	Total units (#)	Work in Progress (#)	Completed(#)	Not Started(#)	Work started or completed (%)	Work completed (%)
Building less SHCs	2021-22	75	**81**	**64**	**6**	***96.03%***	***42.38%***
	2022-23	76					
	2023-24	0					
	2024-25	0					
	2025-26	0					
	Total	**151**					

Component	Year	Total units (#)	Work in Progress (#)	Completed(#)	Not Started(#)	Work started or completed (%)	Work completed (%)
IPHL	2021-22	1	**9**	**1**	**0**	***100.00%***	***10.00%***
	2022-23	2					
	2023-24	2					
	2024-25	2					
	2025-26	3					
	Total	**10**					
CCB	2021-22	0	**2**	**0**	**0**	***100.00%***	***0.00%***
	2022-23	0					
	2023-24	0					
	2024-25	0					
	2025-26	2					
	Total	**2**					

Data Source- Information provided by the Meghalaya Government

C. Challenges Faced by the State in Implementation of the Grant

C.1 Issues with Grant design in the State's Unique context and the Consequent Delay in Execution

One of the most strongly expressed views by the state's health officials was that the design of the grant which envisaged implementation of health-related construction through local bodies, was particularly ill-suited to a context like Meghalaya. Unlike other states where issues with grant design were in terms of establishing coordination and delays in fund transfer to implementing agencies, the challenge in Meghalaya was the absence of PRIs.

Conversations with state officials revealed a chequered history of execution of government schemes through the ADCs, marked by persistent challenges in the effective utilisation of funds. At the same time, the direction from the GoI to implement these grants through the ADCs made the decision about the executing agency a politically sensitive issue in a tribal state like Meghalaya. This meant that a significant amount of time was spent in arriving at the decision for assigning the execution of construction works under these grants. The construction activities could be handed over to Village Health Councils (VHC) for implementation only in 2024. This amounts to a lag of almost three years between the receipt of funds for this component from the GoI in 2021, to the final decision on its execution and consequent transfer of funds to the Health Department in 2024. Table 106 below captures the delay in transfer of funds for each of the XV-FC Components.

The confusion regarding the mode of execution was compounded by the initiation of the PM-ABHIM which shared similar components but no mandated mode of execution. As per the state officials, a sudden focus on decentralisation of health facilities' construction through XV-FC Health Grant, was inconsistent with the state's existing administrative and operational framework.

The delay in the decision about the executing agency at the state level resulted in a commensurate delay in transfer of funds by the Finance Department. This is illustrated by the Grant Transfer Certificate (GTC) issued by the state's Finance Department for the first year's funds (Table 106) There was a delay of over 2.5 years in FR1 *Building less SHCs and PHCs*, over 1.5 years in FR2 BPHUs, and about 6 months for the diagnostics and UHWCs component.

Table 106: Meghalaya- Delay in Transfer of FY 2021-22 Funds to Health Department

Components of Health Sector Grants	**Amount received from GOI (Rs. In Lakh)**	**Date of Receipt (00/00/00)**	**Date of Transfer by SFD to Local Body Nodal/Department**	**Amount Transferred (Rs. In Lakh)**	**Amount transferred by Nodal Depart to Local Bodies**
FR3.1 Support for diagnostic infrastructure to the Sub centres in rural areas	605	30-11-2021	9/6/2022	605	605
FR3.2 Support for diagnostic infrastructure to the PHCs in rural areas	604	30-11-2021	9/6/2022	604	604
FR2 Block level public health units in rural areas	925	30-11-2021	25/07/2023	925	925
FR1 Building-less Sub centres, PHCs,CHCs in rural areas	321	30-11-2021	7/8/2024	321	321
FR4 Conversion of rural PHCs andf sub centres into health and wellness centre in rural areas	928.84	30-11-2021	9/6/2022	928.84	928.84
FU1 Support for diagnostic infrastructure to the primary healthcare facilities in urban PHCs	151	30-11-2021	9/6/2022	151	151
FU2 Urban health and wellness centres (HWCs)	2330	30-11-2021	9/6/2022	2330	2330

Data Source- Grant Transfer Certificate issued by the state

C.2 Impediments in Obtaining Land for Construction in Meghalaya Due to Community Ownership

Another difficulty that is unique to a tribal Sixth Schedule state like Meghalaya is that the control and ownership of the land is with the community. This means that acquiring land for construction of health facilities is a particularly long-drawn and challenging process, involving negotiations and bargaining with the local community. The community control of land resources has been the genesis of the "Land for Jobs" policy of providing government jobs to people who donated land to the government for various development projects and to establish government offices. State and district officials confirmed that the provision of land for facilities like SHCs is often contingent on providing jobs to the members of the community.

D. Observations from Facility Visits in Districts

The team undertook visits to facilities in the two districts of East Khasi Hills and West Khasi Hills.

Since the construction works under XV-FC Health Grants were late to be executed, the set of functional facilities were limited to operationalised UHWCs under XV-FC Health Grants and those constructed under the PM-ABHIM. Two Urban HWCs were selected for visit in the relatively densely populated pockets of Shillong in the East Khasi Hills, while one newly constructed SHC in a remote area near Nongstoin, West Khasi Hills was in focus in terms of the rural components.

The following section describes the facility visits in detail.

East Khasi Hills	**West Khasi Hills**
1. UHWC Mawlai Mawdatbaki 2. UHWC Nehru State Dispensary	1. Sub Health Centre (SHC) Thiepkseh , Rambrai

D.1 East Khasi Hills

1. <u>UHWC Mawlai Mawdatbaki</u>

   This facility was operationalised in February 2024 from the XV-FC Health Grants. It was situated in a rented premise that was earlier functioning as a community hall for the locality. It had a total staff of 6 members including 1 Medical Officer, 1 Staff Nurse, 1 ANM, 1 Accountant, 1 Laboratory Technician and 1 Multi-trained staff. Catering to a population of about 11699 people in a relatively heavily populated area, this facility witnessed an average OPD footfall of 30-40 patients per day. Before this UHWC, the closest government facilities were the Mawroh PHC and the civil dispensary, both located at a distance of 1.5-2 kms. Offering about 14 types of kit-based rapid diagnostic tests in house, this UHWC also sends samples for other tests to the central laboratory at Pasteur Institute.

   The Medical Officer explained challenges faced in terms of vaccine hesitancy and refusal among population in certain pockets, non-registration of pregnancy and elaborated outreach efforts to mobilise health seeking behaviour in these sections of population. While expressing the need for a pharmacist and facing some shortages of drug deliveries from the MMDSL, the staff also explained that they interact and coordinate with the Village Health Councils in their health activities.

   The OPD footfall and number of ante-natal check-ups (ANC) conducted by this facility in the last few months is documented in the table below

Table 107: OPD and ANC at UHWC Mawlai Mawdatbaki, East Khasi Hills, Meghalaya

Month	OPD Footfall	ANC (in facility)	ANC (outreach)
October 2024	1282	44	8
November 2024	1110	51	6
December 2024	842	42	5
January 2024	787	42	2
February 2024	843	40	1

Data Source: Information provided by the Health Facility

The table shows that UHWC was receiving an OPD footfall of over a 1000 patients a month. There is some fall in footfall due to seasonal decline in winter months.

2. UHWC Nehru State Dispensary

This facility was a state dispensary converted into an Urban HWC in January 2024 using the XV-FC Health Grants. Catering to a population of about 21854, this facility was operating out of privately owned rented premises. Previously functioning as a state dispensary for about 20 years, this UHWC sees an average daily OPD footfall of 50-60 patients in winter months and an average of about 90 patients in summer. It was staffed by 2 Medical Officers, 4 ANM, 2 Staff Nurse, 3 Health Assistants, 1 Lab Technician, 1 Upper Divisional Assistant, 1 Data entry operator/Accountant, 1 sanitary inspector.

This facility saw an expansion in the range of services offered after conversion into a UHWC, which now includes oral, ENT screening, eye check-up, VIA screening for cervical cancer and screening for breast cancers. Wellness activities such as yoga have been introduced and the facility has also been inducted as a spoke for the Hub and Spoke model recently operationalised in urban areas.

The Medical Officer explained that the footfall has increased substantially since the introduction of testing facilities at the UHWC, where the LT had joined less than a year ago. The change in OPD prior to and post the conversion of the facility to a UHWC is illustrated in the table below.

Table 108: OPD at UHWC Nehru State Dispensary, East Khasi Hills, Meghalaya

Month Year (before)	OPD	Month Year (after)	OPD
September 2023	1184	September 2024	1436
October 2023	1240	October 2024	1523
November 2023	1020	November 2024	1457
December 2023	806	December 2024	901

Data Source: Information provided by the Health Facility

The table shows that the OPD at the facility observably increased even in the winter months. While having no complaints in terms of availability of medicines, the staff reported challenges in terms of water supply, space constraints and lack of proper washroom facilities.

D.2 West Khasi Hills

1. Sub Health Centre (SHC) Thiepkseh, Rambrai

   This was a newly constructed SHC built by a Village Health Council (VHC) under the PM-ABHIM initiative. Operationalised in December 2024 the facility witnessed an average OPD attendance of 10-12 patients per day. The facility was operational for only about two months at the time of the team visit, yet had an OPD footfall of 68 patients in the entire month of February 2025, increasing in March to 72 patients just up to 11 March, signalling an uptake in outpatient services. The SHC catered to a catchment population of about 2300, and was staffed by 1 Staff Nurse, 1 Lab Technician, 1 Data Entry Operator, 1 Multi-Training or Multi-Purpose Worker and 1 ANM[46]

   Discussions with members of the Village Health Council (VHC) provided an understanding of the coordination and monitoring role played by different agencies during the construction process. The actual construction process was preceded by a period of discussions with the VHC on their agreement to build the facility, followed by assessment of land and technical assistance and monitoring provided by block, district and state level team of PM-ABHIM.

   The facility served as an example of convergence of schemes and initiatives. While the building was constructed by VHC under PM-ABHIM, a part of the operating expenses and equipment for this facility was covered by Hans Foundation, an NGO partner that was running 2 out of 46 SHCs in the West Khasi District.[47] Interestingly, the approach road to the facility was built by the villagers under the MGNREGS scheme, exemplifying the idea of convergence of efforts to achieve one common goal.

[46] ANM was due to join from 1st of April 2025

[47] The support from Hans allowed this facility to recruit personnel over and above those mandated for SHCs. This also meant that the facility received relatively advanced equipment such as a neonatal intensive care warmer –also covered by the Hans Foundation

Appendix to Chapter 8

Table 109: Meghalaya- Financial Utilisation under XV-FC Health Grants for FY 2021-22 and FY 2022-23 (as of March 2025)

Component	Amount Approved (Rs in Lakhs)	Amount Received (Rs. in Lakhs)	Amount Utilized (Rs in Lakhs)	Utilization as % of Amount received
FR1 Building less Sub Centers, PHCs, CHCs	642	321	0	0.00%
FR2 Block Public Health Units	1850	925	383.63	41.47%
FR3.1 Diagnostic infrastructure-SCs	1210	1210	1179.51	97.48%
FR 3.2 Diagnostic infrastructure-PHCs	1198.78	1198.78	1346.45	112.32%
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	1857.68	928.84	545.73	58.75%
Sub-Total of Rural Component	**6758.46**	**4583.62**	**3455.32**	**75.38%**
FU1 Diagnostic infrastructure-Urban	302	302	303	100.33%
FU2 Urban health and wellness centers (HWCs)	4655	2330	1118.67	48.01%
Sub-Total of Urban Component	**4957**	**2632**	**1421.67**	**54.01%**
Total (In Lakhs)	**11715.46**	**7215.62**	**4876.99**	**67.59%**

Data Source- Information provided by the Meghalaya Government

Table 110: Meghalaya- Partial Releases for FY 2022-23

	2021-22		2022-23	
Component	**Amount Approved (Rs in Lakhs)**	**Amount Received (Rs. in Lakhs)**	**Amount Approved (Rs in Lakhs)**	**Amount Received (Rs. in Lakhs)**
FR1 Building less Sub Centers, PHCs, CHCs	321	321	321	0
FR2 Block Public Health Units	925	925	925	0
FR3.1 Diagnostic infrastructure-SCs	605	605	605	605
FR 3.2 Diagnostic infrastructure-PHCs	604	604	594.78	594.78
FR4 Conversion of rural Sub Health Centers and PHCs to HWCs	928.84	928.84	928.84	0
Sub-Total of Rural Component	**3383.84**	**3383.84**	**3374.62**	**1199.78**
FU1 Diagnostic infrastructure-	151	151	151	151

Component	2021-22		2022-23	
	Amount Approved (Rs in Lakhs)	Amount Received (Rs. in Lakhs)	Amount Approved (Rs in Lakhs)	Amount Received (Rs. in Lakhs)
Urban				
FU2 Urban health and wellness centers (HWCs)	2330	2330	2325	0
Sub-Total of Urban Component	**2481**	**2481**	**2476**	**151**
Total (In Lakhs)	**5864.84**	**5864.84**	**5850.62**	**1350.78**

Data Source- Information provided by the Meghalaya Government

Table 111: Meghalaya- Initial and Supplementary Proposal for FY 2023-24

Component	Allocation	Initial Approval	Shortfall of Approval from Allocation	Additional amount proposed in supplementary proposal	Revised approval after supplementary proposal
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	337	333	4	392	725
FR2 Construction of Block Public Health Units (BPHUs)	972	728.64	243.36		728.64
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	1257	1242.33	14.67	1018.92	2261.25
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	975	637.1	337.9		637.1
Sub-Total of Rural Component	**3541**	**2941.07**	**599.93**		**4351.99**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	159	155.16	3.84		155.16
FU2 Urban Health & Wellness Centres (HWCs)	2447	164	804		1643
Sub-Total of Urban Component	**2606**	**1798.16**	**807.84**		**1798.16**
Grand Total	**6147**	**4739.23**	**1407.77**		**6150.15**

Data Source- Information provided by the Meghalaya Government

Table 112: Meghalaya- Total Number of OPDs in UHWCs from April 2024 to February 2025

District	Name of the Facility	Total No. of OPDs from April 2024 to February 2025	Monthly average
EGH	**Kusimkolgre UHWC**	1199	109
	Warimagre UHWC	158	14
EJH	**Khliehriat UHWC**	3127	284
	Lad Rymbai UHWC	2166	197
EKH	**Laban state dispensary**	12354	1123
	LAITUMKHRAH UHWC	140	13
	Mawlai Mawdatbaki UHWC	11628	1057
	Nehru Memorial State Dispensary	14459	1314
	Shastri Memorial State Dispensary	17667	1606
NGH	**Babukona UHWC**	2187	199
	Bangalmura UHWC	2376	216
	Dilma UHWC	2221	202
RBD	**Iewmawlong.UHWC,**	2568	233
	Lower Narbong UHWC	1436	131
SGH	**Mahadeo UHWC**	1765	160
SWGH	**Ampati UHWC**	1815	165
	Balughat UHWC	2737	249
	Dorambok UHWC	1270	115
	Ghegapara UHWC	5262	478
	Kalaipara UHWC	1998	182
SWKH	**Mawten UHWC**	2410	219
	sakwang UHWC	2060	187
WGH	**Agillanggre UHWC**	1921	175
	Rongkhon UHWC	1871	170
	Shantinagar UHWC	1656	151
WJH	**Iawmusiang UHWC**	6706	610
	MIhmyntdu UHWC	9595	872
WKH	**MAIRANG UHWC**	9686	881
	Mawkhlam UHWC	3958	360
	Pyndengrei UHWC	4982	453

Source- State's reported data. (EGH- East Garo Hills, EJH- East Jaintia Hills, EKH- East Khasi Hills, NGH- North Garo Hills, RBD- Ri Bhoi District, SGH- South Garo Hills, SWGH- South West Garo Hills, SWKH- South West Khasi Hills, WGH- West Garo Hills, WJH- West Jaintia Hills, WKH- West Khasi Hills)

Table 113: Meghalaya- Year-wise Initial Allocation vs. Approvals (in Rs. Lakhs)

Financial year	**2021-22**		**2022-23**		**2023-24**		
Component	**Allocation**	**Approval**	**Allocation**	**Approval**	**Allocation**	**Approval**	**Revised approval after supplementary proposal**
FR1 Construction of Building less Sub-Health Centres, PHCs & CHCs	321	321	321	321	337	333	725
FR2 Construction of Block Public Health Units (BPHUs)	925	925	925	925	972	728.64	728.64
FR3 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	1209	1209	1209	1199.78	1257	1242.33	2261.25
FR4 Conversion of Rural Sub-Health Centres & PHCs to HWCs	929	928.84	929	928.84	975	637.1	637.1
Sub-Total of Rural Component	**3384**	**3383.84**	**3384**	**3374.62**	**3541**	**2941.07**	**4351.99**
FU1 Support for Diagnostic Infrastructure to the Primary Healthcare facilities	151	151	151	151	159	155.16	155.16
FU2 Urban Health & Wellness Centres (HWCs)	2330	2330	2330	2325	2447	1643	1643
Sub-Total of Urban Component	**2481**	**2481**	**2481**	**2476**	**2606**	**1798.16**	**1798.16**
Grand Total	**5865**	**5864.84**	**5865**	**5850.62**	**6147**	**4739.23**	**6150.15**

Data Source- Information provided by the Meghalaya Government

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