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Health Provisioning Under Panchayati Raj: An Introduction to Decentralized Health Governance in India

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Abstract:

Since, decentralization has gained widespread recognition as one of the crucial determinants for development, hence, India like many other countries in the world has adopted decentralization as a key development strategy through the 73rd Constitutional Amendment Act of 1992. This act provides constitutional status to the village panchayats and recognised their role in rural development with 29 functional items including health, family welfare. Later, the principle of decentralized planning and implementation was further embedded through National Rural Health Mission in 2005, particularly in primary health care. The present study traces the evolution of decentralized governance in health sector, and examines the role of village panchayat in primary health care in India. The paper is mainly grounded on secondary data, collected from the sources like scholarly books, journal articles, government reports, and policy documents etc. It has been concluded that the panchayats are playing a central role in health governance at local level, but their contribution often remains ineffective due to low capacity and their constrained approach. Hence, the need of the hour is to establish a robust mechanism for monitoring and supervising PRI leadership in order to enable them mitigating the community needs more effectively.

Keywords: Decentralization, Health Governance, Panchayati Raj Institutions (PRIs), National Rural Health Mission (NRHM), India.

Introduction

As decentralization expected to improve governance outcomes in almost every sector, most of the countries in the world has adopted decentralization as a key national strategy in order to secure development. Likewise, Manor (1999) highlighted that decentralization, by the end of 1990s, has been already subscribed by more than 80 percent of the global nations. Perhaps, decentralization is the one and only strategy that mostly approached by the several countries around the world, especially the developing ones to secure development. Such recognition for decentralization is not something unexpected. Amongst the diverse set of justification for decentralizing the central authorities and holdings to the local bodies, the strongest one lies in the fact that it can hold the public representatives accountable in their busyness, and that in turn

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foster the responsiveness of services towards the actual needs of the community. (Channa and Faguet, 2016). Especially in India, it has been conceived as the key policy reform to secure healthy status (SGD 3) for all – which (public health) itself is crucial for national development in all terms and nothing holds much significance as compared to public well-being (Planning Commission, 1951, as cited in Roy, 2026a).

Hence, the Government of India has successfully initiated a landmark constitutional reform in 1992 to institutionalize decentralization in the country i.e., 73rd Amendment Act. This amendment has constitutionally recognized the role of Panchayati Raj Institutions (PRIs) in rural development by devolving them 29 functional responsibilities including health and sanitation under 11th schedule. However, the real push towards decentralized health governance in India was marked by the proclamation of National Rural Health Mission (NRHM), with an aim to make health services accessible for all citizens, in the year of 2005 – which later subsumed under NHM in 2013. The provisioning for the integration of panchayats in health governance is one of the most distinctive features of NRHM. The mission has come up with several measures for decentralized health governance such as the creation of Village Health Sanitation and Nutrition Committees (VHSNCs) and Rogi Kalyan Samitis (RKS); provision of local level health planning and untied funds etc (Bossert et al., 2010). However, significant variation exists when it comes to implementation, despite these formal platforms has been placed for decentralization all over the country. As Seshadri et al (2016) highlighted that the challenges like political and bureaucratic obstruction, paucity of funds, and limited awareness on their roles– forced the local self-government institutions to operate merely as an administrative unit of the higher authorities (Seshadri et al., 2016). In this backdrop, the present study seeks to trace the evolution of decentralized governance in health sector, and examines the actual role of panchayats in health provisioning at the Indian grassroots.

Methodology

This paper exclusively relies on secondary data collected from several sources like journal articles, scholarly books, policy documents, government reports, and newspapers etc.

Decentralization and its meaning

Conceptually decentralization is hard one to understand, as it has been viewed differently by the several scholars across the world. Hence, the uniformity in terms of defining decentralization is yet to be achieved, however the term is mostly understood as "the transfer of some managerial, technical or fiscal responsibilities from the central level to the periphery" (Cobos Muñoz et al., 2017, pp. 220). Thus, the term can be defined as the sharing of powers and responsibilities by the national authorities to local ones – that can be political, administrative, financial, judicial, and so on (Roy, 2026b). Similarly, Channa and Faguet (2016) has perceived the notion as the transfer of - command on physical resources and personnels engaged in the delivery of public services; responsibility for upholding the standard of public services; and sufficient fiscal authority to operate these functions (Channa and Faguet, 2016) – from central to local bodies of government.

Moreover, decentralization can be of several types, as it has been argued that the impact of decentralization on governance depend on the nature and forms of decentralization involved in

the respective country (Rondinelli, 1999). Hence, as per the nature of the recipient to whom the power and responsibilities are being devolved, it can mainly be divided into three major types (Boex et al., 2023), namely these are, as follows –

- **Deconcentration** – the transfer of administrative duties from national authorities to the bodies at subnational levels through setting up field offices and granting some decision-making power to regional personnels (Cheema and Rondinelli, 2007).
- **Delegation** – the shifting of powers, duties, and funds/assets from the national level bodies to the semi-independent local bodies or NGOs that supposedly remain under the control of central authority (Boex et al., 2023)
- **Devolution** – the true sense of decentralization involves strengthening of government organs at the local levels with complete authority to enable them taking full responsibility without central interference. In this framework, the local level bodies are permitted to operate as independent units, whereas the central authorities are confined to play a monitoring role instead of direct control (Kumar and Mishra, 2016).

Apart from these, decentralization can also be categorized as privatization and deregulation etc (Rondinelli, 1999). The notable point here is that, all the forms are necessary to be established firmly in order to secure democratic decentralization in any country (Rajasekhar, 2021).

Decentralization Drive in India

In India, instantly after independence, the policy makers realized that there is a need for decentralized system of governance. And hence, following the suggestion of B. R. Mehta Committee, Community Development Program (CDP) was launched in 1952, which marked the initial move towards decentralized governance in independent India (Alagh, 1999). Subsequently, a three-tiered structure of decentralization was endorsed by the National Development Council in 1958. But it has been evidenced that the development for decentralization in this country had never get the momentum due to several factors like missing of political and bureaucratic intension to decentralize the central power at local levels, shortage of funds, and limited knowledge, capacity, and clarity on the responsibility of local bodies. Hence, Ashok Mehta Committee has made several recommendations for the revival of the moribund panchayati raj system in the late 1970s, and the positive experiences of decentralized governance in the states like Karnataka and West Bengal gradually led to a growing demand for granting PRIs constitutional status. Finally, the panchayats were recognised as the third tier of Indian federation through the 73rd Amendment of the Constitution of 1992, that authorize them to act on 29 functional items enumerated under the 11th Schedule, including crucial areas such as rural health and sanitation. In other words, this amendment has mandated the village panchayats as the key player in the governance rural health.

Panchayats and Primary Health care in India

As already mentioned, that most countries (80 percent) of the world took the path of decentralization by the end of last century (Channa and Faguet, 2016). But the notable point here is that, the motivating factors behind adopting decentralized system of governance differs as per the necessity of the respective nations such as to foster economic development, eliminate

poverty, reinforce civil society, and consolidate democracy etc (Abimbola et al., 2019). On the other hand, its adoption also has been justified on several grounds e.g., political, technical, and financial (Raut and Sekhar, 2013). Firstly, in terms of political ground, decentralization is justified as it is expected to improve community involvement and autonomy, balance power relations, and mitigate local issues. Secondly on technical grounds, it is largely advocated as a policy reform that can enhance administrative efficiency and improve the standard of service delivery. And lastly on the fiscal ground, the application of decentralization is justified as the pathway for strengthening of cost-efficiency, granting sufficient authority over resources and revenues to the local governmental bodies, and reinforcing accountability mechanisms (Raut and Sekhar, 2013).

However, the rationality of decentralized from of governance in health sector lies with the fact that it often leads to improvement in health system functioning and results (Asfaw et al., 2004). It is worth noting that the decentralization movement of 1980s in health sector was mainly driven by WHO guidelines and stimulated by the 1978 Declaration of Alma Ata to resolve the issues of health systems, so that the marginalized rural inhabitants can be served better (Abimbola et al., 2019). In fact, it was only after Alma Ata conference of 1978, India along with many other countries in the world, has created health committees at the village-level that enabled decentralized health governance with community participation. However, neither the experience with decentralization and nor the existence of village level health committees in health sector is something new to India (Srivastava et al., 2016). At the earliest, the Bhore Committee report of 1946 recommended the establishment of health committees at the village level in order to foster collaboration between communities and rural health officials and to resolve rural health concerns. Subsequently, during the 1980s the committees were made operationalized in India as part of strengthening of primary health care through the declaration of first National Health Policy (NHP) of 1983 (Srivastava et al., 2016).

Thereafter, the National Population Policy of 2000 as well as the National Health Policy of 2002 laid huge emphasis on the execution of health schemes by grassroot level institutions (Kumar and Mishra, 2016). However, the real attempt towards decentralized governance of rural heath was marked by the introduction of National Rural Health Mission (NRHM) in 2005, that is now continuing as a submission under the National Health Mission (NHM) since 2013. The NRHM was launched to undertake the long required structural reforms in the primary health care system so that the quality, availability, and accessibility of basic health care can be strengthened, particularly for the vulnerable and marginalized section of our society (MoHFW, 2005).

Notably, as the mission has set high importance for decentralized level planning, it has mandated the creation of a village health sanitation and nutrition committees (VHSNCs) for every villages – which is a straightforward but efficient mechanism – in order to secure greater involvement from the general public in the health governing process. The members of such committee include frontline health worriers such as Accredited Social Health Activists (ASHA), Anganwadi Workers (AWW), and Auxiliary Nurse Midwives (ANM); coupled with members from panchayati raj institutions, self-help groups (SHG), Non-Governmental Organizations, teachers' associations, beneficiaries, and socially marginalized sections etc. And

to facilitate their functioning an untied grant of 10k per year allocated to each and every committee in order to enable decentralized governance of health issues at the village level (Mohapatra, 2023). Most significantly, the mission has entitled PRIs a solid foundation to involve in health governance at the periphery, through the creation of several decentralized measures like VHSNC, RKS, ASHA, United Funds, and so on. Moreover, these village-level health committees often chaired by the Gram Panchayats were meant to enable decentralize/bottom-up health planning – as the plans of these committees are expected to integrate into higher level plans later (village>block>district>state>national) – and also designed to foster active engagement from the common public in the decision-making and execution process of health care services. In essence, today, panchayats are acting as the main body for planning, executing, and supervising the NRHM programmes in India – which ranges from flu to cancer. (Nanjunda, 2024).

Even the latest NHP of 2017, also held that the panchayats are to be reinforced so that they can assume a more active role in health service provisioning, especially in mitigating the broader social determinants of health. It has been argued that the mechanism of Community Based Monitoring and Planning (CBMP) should be made compulsory to provide citizen a central position in both the health system and the development process. This in turn would enable effective oversight of service quality and strengthen accountability in the management and delivery of healthcare (MoHFW, 2017).

Primary Health Care System in India

India's health care system has been built as a three-layered comprehensive structure, comprised of primary, secondary, and tertiary level of health care (Kumar and Mishra, 2016). The primary level health care is provided through an extensive and integrated arrangement of Sub-Centres (SCs) along with Primary Health Centres (PHCs) in India, as discussed in the following section.

Box 1. Primary Health Care Infrastructure in India

Sub-Centres: Sub-centres form the most peripheral units of the primary healthcare system; and being the closest institution to the community, it serves as the initial point of contact with health care. The SCs are primarily concerned with interpersonal communication in order to foster behavioural change. And contribute to a wide range of health initiatives such as maternal and child care, immunization, family welfare, nutrition, diarrheal disease management, and the control of both communicable and non-communicable diseases and so on. All the SCs should be staffed with at least one auxiliary nurse midwife (ANM) or female health worker, along with a male health worker. While the functioning of every six sub-centres to be monitored by a designated Lady Health Visitor (LHV), as per National Health Mission (NHM).

Primary Health Centres: Primary Health Centre i.e., a 4-6 bedded hospital, serve as most initial point of contact between the population and doctors. The PHCs delivers a blend of preventive and curative healthcare services with a strong emphasis on promotive measures. And to do so, there should be at least at least one medical officer coupled with paramedical

and other health personnel. Moreover, it also acts as the designated referral hub for six sub-centres, as enumerated under NHM.

Source: MoHFW (2021).

As per the latest statistics dated on 31st March 2021, total 156101 Sub Centres and 25140 PHCs are functioning in rural India, that marked an increase of 10075 SCs and 1904 PHCs in terms of their total number at the national level compared to the year of 2005 (MoHFW, 2021).

The Role of Panchayats in Primary Health Care

It has been widely argued that decentralization enhances accountability and transparency through community participation in the governing processes, and hence, it leads to improvement in quality, especially in health sector (Ghuman and Singh, 2013). Similarly, in India, the ownership and control of PRIs in health sector would enable effective utilization resources and fair distribution of benefits in health service delivery (Kumar and Mishra, 2016). Hence, India marched towards decentralization through the 73rd Constitutional Amendment Act of 1992, which transformed the traditional Panchayati Raj system as a constitutional body for local self-governance with three tier structure uniformly. Where, Gram Panchayat is the lowest tier of local self-government in India, that derives its power from state governments and responsible for several developmental activities at their respective villages.

In the Constitution of India, particularly under the 11th Schedule, panchayats are entrusted with the following health related responsibilities that ranges from provisioning of safe and adequate drinking water; maintaining public health and sanitation works, initiatives in relation to family welfare, programs regarding women and child development, and involvement in social welfare especially extending help to the disabled ones etc. In a nutshell, these provisions altogether reflect the constitutional basis for decentralized health governance through PRIs in India (GoI, 1992).

Subsequently, the 2005 NRHM - following the principles of decentralized governance as enumerated by the 73rd amendment act - has clarified and expanded the health-related duties of PRIs further. Under NRHM, each and every individual states in this country were expected to devolve required funds, human resources, and health programmes to the local bodies. The Zilla Parishads were made to lead the District Health Mission through managing, monitoring, and overseeing the primary healthcare facilitates (e.g., SCs and PHCs). Hence, Gram Panchayats support and supervise the functioning of ASHAs, facilitate health planning, enable effective utilization of untied funds and foster intersectoral cooperation by their active involvement in the VHSNCs at the community level. In add to these, PRIs were also made to play a strong role in the management of (RKS) healthcare facilities of secondary and tertiary level (MoHFW, 2005). Hence, active engagement of PRIs in health governance expected to improve quality, access, equity, availability, effectiveness, accountability, and transparency in the delivery of health services.

Thus, the framework for decentralized governance in India was laid by the 73rd constitutional amendment act of 1992, which was further developed and utilized by the NRHM of 2005 in order to enable community participation in the delivery of health care services. In fact, it was

only the NRHM, which truly integrates panchayati raj system with health sector in India, particularly in primary health care. The Panchayats plays central role in decentralized health governance at the grassroots, in the following ways –

- Decision Making: The Panchayats involves in the preparation of village level health plans, that incorporates into the higher-level health plans (block and district strategies).
- Supervision: They support and monitor the working of primary health care facilities such as ASHA program, SCs and PHCs etc.
- Allocation of Resource: The knowledge of local panchayats enables effective and timely utilization of health resources towards actual necessities.
- Accountability: Village level health officials including doctors and nurses working in the SCs and PHCs, and the frontline health workers such ASHAs, ANMs are made to remain answerable to the panchayats.

Empirical Evidences

Indian healthcare system often characterized with high rate of absenteeism, lower quality of clinical care, and rampant corruption lead to mistrust towards public healthcare (Hammer et al., 2006). Decentralization, through the 73rd amendment act of 1992, was one of the attempts to strengthen primary health care in India, especially in rural area. Since, decentralization bring governments closer to people, thus it was expected that PRIs would respond to local necessities more efficiently, and hence, lead to better planning, implementation and monitoring of health services at the local level. Moreover, the introduction of NRHM in 2005 marked a healthy push towards decentralized governance (Raut and Sekhar, 2013) – as it has promoted health engagement of PRIs further.

However, empirical studies on Indian decentralization continuously suggesting that the actual role of panchayats in health sector vary from one context to another. For example, Besley et al (2004) challenged the argument that decentralisation improves equitability and efficiency in service delivery automatically, and evidenced that identity and residential proximity of local representatives heavily impact the distribution of public goods under decentralisation. Varatharajan et al (2004) though agreed that decentralization can improve access and delivery of health services as per the international evidences, but it may fail as well, if poorly designed – particularly with financial imbalances and weak local institutions.

Anju et al. (2023) studied the impact of decentralisation on policy making, program execution and service delivery with regard to health at the grassroots in Kerala, which shows that decentralization generates mixed results. The positive outcomes of decentralisation include community-led creative interventions; improved infrastructure and service delivery etc. However, several challenges like resistance from higher authorities, elite dominance, poor institutional capacity of local bodies etc., have undermined the effectiveness of decentralized governance. Apart from these, heterogeneity is another problem for decentralization. In other words, as PRIs serves better in the prosperous regions compared to the other contexts, hence decentralization may exacerbate the existing inequalities in our society. Even, the post NRHM

evidences also reveal the same experiences. For instance, Nanjunda (2020; 2024) find that though the PRIs have been given more role clarity and autonomy in health governance, yet the factors like fiscal reliance, lack of technical expertise, bureaucratic and political control and weak intersectoral coordination etc., continue to limiting the potential of PRIs in health sector.

Conclusion

In this paper, an attempt has been made to trace the evolution of decentralization in Indian health sector and to examine the role of panchayats in basic health care. It can be said that the development of Indian decentralization highlights a conscious effort from the policy makers to make governance democratic, particularly through the panchayats – which emerging as the leader of decentralized health governance at the grassroot level. The review of available empirical studies suggests that the involvement of panchayats in health sector yields mixed outcomes in India. In conclusion, the study totally agree what Kumar and Mishra (2016) argued that the village panchayats assume a critical role in the provisioning of health services, but their contribution often remains short due to inadequate capacity and a constrained approach, which hampers the creation of a supportive environment. Since, health is one of the most vital needs for the humans; hence, it becomes necessary to establish robust mechanisms for monitoring and supervising PRI leadership, enabling them to refine their strategies and respond more effectively to community wants (Kumar and Mishra, 2016).

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