INTRODUCTION

Public sector decentralization has been a priority of many countries during the last two decades and has been accepted by the groups and regimes from opposite ends of the political spectrum (Collins and Green, 1994). In health, decentralization is about improving responsiveness and incentive structure by transferring ownership, responsibility and accountability to States, districts, local communities or individuals (WHO, 2000, Vaughan et al., 1984). It can assume different forms depending on the level, personnel, and the kind of power decentralized and can be administrative, fiscal or political. Its actual shape, however, depends on the government, political and administrative structures and objectives and Organization of the healthcare system (Mills et al., 1990).

The significance of political decentralization is the transfer of planning and control of resources to the elected civil bodies. People are expected to be participants in, not simply the beneficiaries of, development programmes (Datta, 2000). Hence, it cannot be expected to be different from the centralized planning process unless there is an inherent mechanism for people’s participation. To be both effective and long lasting, people’s participation must not remain as a structure imposed from outside (Zakus and Lysac, 1998). It must be rooted in their expectations and supported by needed and usable information, material resources and significant stakeholder commitment. The real challenge is to achieve the optimum people’s participation, which is determined by the complex political and social milieu, tradition and culture (Tailor and Reinke, 1997).

Kerala’s political decentralization in 1996 followed the 73rd Constitutional Amendment Act of India, 1992, which
recognized elected Panchayat Raj (local self-government) Institutions (PRI) as constitutional bodies below the State level. The Act also recognized devolution of power to PRIs concerning 29 sectors including health, allowing them to control government healthcare units within their jurisdiction. Kerala has a three-tier – district, block and village – local self-governance. The state favours people’s participation in planning and programme implementation right at the village level. It devolved 28.6 percent of its Ninth Five Year Plan funds to the projects proposed by the PRIs (Kerala State Planning Board, 2005). Although Panchayats (as the PRIs are called) depend on the fiscal transfers from the State government to a greater extent, they do have their own powers of taxation. An important feature that makes Kerala’s decentralized planning (called People’s Plan Campaign) unique in the country is the people’s active role in planning and implementation (Reghuram, 2000). One of the major efforts has been to mobilize ‘the common public’ who otherwise remain passive objects of the development process. About 10.0 percent or 3.0 million of the State’s population took part in the first year itself (Franke and Chasin, 1997).

People’s Plan Campaign assumed importance in the light of the crisis faced by the widely acclaimed ‘Kerala model of development,’ a paradoxical phenomenon involving high levels of human development indices in health and literacy amidst low economic growth (Panikar, 1999, Kutty et al., 1993). Fiscal crisis, following the continuous low growth of the economy, posed challenges to health and education sectors (Franke and Chasin, 1992). Kerala is also passing through health crisis as morbidity rates are reportedly the highest among the major Indian States prompting experts to term it as ‘a low-mortality-high-morbidity syndrome’ (Panikar and Soman, 1984). Simultaneous presence of diseases of poverty and affluence further adds to the burden. Inefficiency of the government healthcare system, uncontrolled growth of private sector and lesser spending on preventive care are the other ills of Kerala’s health sector (Ekbal, 1997). Political decentralization, which has its implications for the health sector, should be viewed in this context.

Despite high expectations, Panchayats were new to the task of decentralized planning, introducing certain fresh challenges. Concerns were that the decentralized planning might be a mirage due to paucity of local reliable data, lack of experience and expertise, and widely prevalent cynicism of people towards developmental activities (Isaac and Harilal, 1997). Since decisions were to be taken at the periphery, State and national priorities might not be reflected in it. There could also be contradictions between felt and real needs of the people. Moreover, sudden flooding of Panchayats with funds to be spent within a short span of time and guidelines for rigid
sectoral allocation thrust on them might result in misuse and wastage of Plan funds (Gopinathan Nair, 2000).

This paper presents the results of a study on the resource-allocation decisions of 32 Grama (village) Panchayats (local self governments) in Kerala under the decentralized planning process initiated in 1996. More specifically, it analyses the link, if any, between the people's participation in grama sabhas (village assemblies) and the size of resources allocated to health.

KERALA’S DECENTRALIZED PLANNING PROCESS

The Decentralized Planning process in Kerala involves five phases (as described in Figure-1). In the first phase, people’s needs are identified in Gramasabha (village assembly consisting of all voters in a Panchayat ward – a ward in 1991 had about 2,000 population and about 15 such wards form a Panchayat). Gramasabhas are convened on holidays to ensure maximum participation of women and backward population. Participants are encouraged to identify, discuss and prioritize developmental issues in each sector such as health through various subject groups. Trained resource persons and the elected representative of the respective ward facilitate each group discussion analysing the problems and suggesting possible solutions based on prior experiences. Deliberations of the groups are summed up and documented in the plenary session of the gramasabhas. One or two representatives from each group participate in next stages of planning too.

The key event of the second phase is Panchayat-level development seminars where ‘development report’ is prepared, presented and debated by gramasabha representatives, local experts, government officials and Panchayat leaders. Each Panchayat’s development report consists of brief history, natural resources available, ‘development gaps’ in each sector and possible solutions to

![Figure 1: Decentralized Planning: Programme and Activity](image-url)
bridge them; solutions are listed as ‘proposed projects’ in the report. Development seminars aim to match identified needs with natural and human resources in the locality.

The third phase is the formulation of different schemes corresponding to development problems identified by people with the help of Panchayat-level task forces. Task forces, consisting of officials and activists of each development sector, take into consideration available resources, technical requirements, cost, benefit and timeframe of each project proposed by grama sabhas.

The fourth phase is the actual preparation of Panchayat plan by the Panchayat committee. Projects are finalized based on the schemes prepared by task forces, grama sabha priorities, various guidelines of higher authorities and an assessment of resource needs and availability. Financial resources received from the State government in the form of grants constitute a major chunk of Panchayat resources. Grants are provided on the basis of total population and presence of disadvantaged communities. Panchayats received Rs.600 billion (12.5 billion US Dollars) as grants during 1996–2001. In the fifth phase, Panchayat-level plans are integrated at the higher (block or district) level.

Besides training the Panchayat leaders on community and resource mobilization, needs assessment and planning, the State Planning Board had suggested few guidelines for resource allocation. The Board identified 6 broad sub-sectors in health and desired the following order of priority in allocation of resources to health (Kerala State Planning Board, 1998). They are (1) drinking water, (2) environment & sanitation (3) control of communicable diseases, (4) other diseases prevention, (5) nutrition, and (6) health facilities & curative care. Implicit here is the order of priority expressed by the State Planning Board as given in the training modules (Kerala State Planning Board, 1998).

**METHODOLOGY**

The focal point of the analysis in this paper was provided by the process of and decisions concerning resource allocation of the chosen Panchayats during the three years of 1998–99, 1999–2000, and 2000–01. The paper specifically looks at the link between the socio-economic status of the Panchayats, people’s participation rate in the planning process and the share of resources allocated to health. Socio-economic status was assessed on the basis of the indicators mentioned in Panchayat development reports. Socio-economic variables used here are literacy, employment, population share of non-SC/ST (Scheduled Caste/Scheduled Tribe) people and the share of families above poverty line. The socio-economic status of a Panchayat was assessed using a
simple average of indicators (expressed in percentages) pertaining to all these variables. Participation rate is given as the total number of voters who participated in gram sabhas divided by the 1991 Panchayat population.

In addition to the link between health resources and Panchayats’ socio economic status and grama sabha participation, Panchayats’ resource priorities were also compared with that of the State’s. This was done to find whether or not priorities of Panchayats and the State matched. This is crucial if the state desires to achieve public health goals through its third-tier governments. State’s priority was listed from the State Planning Board documents.

Thirty two Panchayats were identified through a random two-stage sampling involving all the 990 Panchayats in the State. They came from three districts selected randomly from northern, middle and southern parts of the State. The chosen Panchayats were ranked according to their per capita allocation to health and people’s participation rate in gram sabhas. A 3×3 matrix was formed using the per capita resource allocation to health and Grama Sabha participation rates. Three grades of allocation and participation – high, medium and low – were considered to form the matrix. The chosen 32 Panchayats were placed in one of the nine cells of the matrix as per the participation rate and resource allocation to health. One Panchayat from each of the 9 cells in the matrix was randomly chosen for detailed analysis.

While the quantitative analysis was based on State Planning Board and Panchayat documents, the detailed analysis was based on 18 group discussions with the then elected Panchayat, other community leaders, Panchayat staff, and local resource persons and on the perusal of Panchayat development reports, and evaluation reports.

RESULTS

On an average 20.3 percent of Panchayat resources were allocated to health (range 8.6–31.1 percent). The average socio-economic score of the chosen 32 Panchayats was 63.8 percent (range 50.5–70.3 percent) – 80.0 percent literacy, 28.1 percent employed, 89.6 percent non-SC/ST population and 58 percent above poverty line.

Grama Sabha Participation

The participation of the registered voters in grama sabhas was 7.7 percent (range 4.0–15.5 percent) in the chosen Panchayats. Based on their participation rate, Panchayats were categorized into low (participation rate < 6.4 percent [less than the mean minus 16.67 percent of mean]), medium (participation rate between 6.4 percent and 8.8 percent [between the mean plus or
minus 16.67 percent of the mean] and high [participation rate > 8.8 percent (above the mean plus 16.67 percent of mean)]. As it can be seen from Table-1, higher the grama sabha participation higher was the allocation to health and vice versa. Regression results showed that every percentage decline in the participation rate resulted in 1.3 percent decline ($t = 3.1$, adjusted $R^2 = 0.21$) in resources allocated to health.

**Socio-economic Status of the Panchayats**

Socio-economic status of the Panchayats provided another dimension to the analysis. Table-1 indicates that higher allocation to health was associated with lower socio-economic status of the Panchayat and vice versa. The linear regression also confirmed such a resource allocation pattern. In fact, socio-economic status had both direct and indirect (through grama sabha participation) impact on resource allocation. For every one percent increase in the socio-economic status, there was 0.5 percent decline ($t$ value $= 2.3$, adjusted $R^2 = 0.12$) in resources allocated to health. Decomposition of the effect indicated that 40.4 percent of the decline was directly associated with the socio-economic status while the rest was associated with the participation rate. In other words, every percentage increase in socio-economic status was associated with a 0.25 percent decline ($t$ value $= 3.0$, adjusted $R^2 = 0.2$) in participation rate and as seen already, every percentage decline in the participation rate resulted in 1.3 percent decline ($t = 3.1$, adjusted $R^2 = 0.21$) in resources allocated to health.

**Other Local Factors Influencing Resource Allocation to Health**

Primary Health Centre (PHC) staff, capable of providing public health expertise, mostly stayed away from the planning process with PHC medical officers not even aware of health projects of Panchayats in their locality. PHC staff found the entire planning exercise burdensome and was reluctant to participate in it. Panchayats, as informed by discussants, were dissatisfied with PHCs for their lukewarm support.

Another limiting factor was the equality (not necessarily equity) considerations in reallocating resources across different geographic areas within a

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**Table 1** Grama Sabha Participation and Resource Allocation to Health

<table>
<thead>
<tr>
<th>Grama sabha participation</th>
<th>No. of Panchayats</th>
<th>Allocation to health (% of total Panchayat resources)</th>
<th>Average SES score</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (&gt; 8.8%)</td>
<td>7</td>
<td>25.2</td>
<td>61.0</td>
</tr>
<tr>
<td>Medium (6.4% - 8.8%)</td>
<td>18</td>
<td>19.6</td>
<td>62.9</td>
</tr>
<tr>
<td>Low (&lt; 6.4%)</td>
<td>9</td>
<td>17.8</td>
<td>67.4</td>
</tr>
</tbody>
</table>
Panchayat. Although a Panchayat is seen as a single unified territory, it is practically treated as a conglomeration of several small political sub-territories when it comes to resource allocation. Each Panchayat consists of several wards and elected members representing these wards treat ‘ward’ as a separate entity and demand due share in resources for their wards. This kind of behaviour among key decision-makers led to lack of consensus in identifying the projects for funding.

**State versus Local Priority**

Table-2 provides actual resource allocation of Panchayats to different items within the health sector during the years 1998–99, 1999–2000 and 2000–01. While the top two priorities of Panchayats and the State matched, others were jumbled. Resource allocation to the control of communicable diseases and other disease prevention were given the least priority by the chosen Panchayats. Detailed discussions with local stakeholders revealed that the deviation from expressed priorities of the State was due the lack of local technical expertise, not because people felt that way.

Health facilities and curative care received 6.1 percent of the total plan resources available for health. This is contrary to the fear in the beginning of the reform that decentralization would result in over emphasis on construction of buildings and curative care. One possible reason for lesser emphasis in practice could be the repeated directives from the government to impart rationality in allocation decisions (Government of Kerala, 1997).

**DISCUSSION**

The paper brought out two issues in resource allocation under decentralized planning. The first is the forward and backward linkages between socio-

<table>
<thead>
<tr>
<th>Expenditure item</th>
<th>Proportion of resources allocated (%)</th>
<th>Priority accorded by Panchayats</th>
<th>Priority accorded by The State Planning Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking water</td>
<td>32.2</td>
<td>First</td>
<td>First</td>
</tr>
<tr>
<td>Environmental and sanitary conditions</td>
<td>31.4</td>
<td>Second</td>
<td>Second</td>
</tr>
<tr>
<td>Nutrition</td>
<td>26.3</td>
<td>Third</td>
<td>Fifth</td>
</tr>
<tr>
<td>Health facilities and curative care</td>
<td>6.1</td>
<td>Fourth</td>
<td>Sixth</td>
</tr>
<tr>
<td>Other diseases prevention</td>
<td>3.0</td>
<td>Fifth</td>
<td>Fourth</td>
</tr>
<tr>
<td>Control of communicable diseases</td>
<td>1.0</td>
<td>Sixth</td>
<td>Third</td>
</tr>
</tbody>
</table>
economic status of the Panchayats, people’s participation and resource allocation to health. Size of allocation to health was determined negatively by the socio-economic status of the Panchayats and positively by people’s participation. On the other hand, higher socioeconomic status itself was detrimental to grama sabha participation. In other words, people’s participation declined if their economic status increased. It is striking that those Panchayats which had poor socio-economic status showed more interest in health and vice versa.

One of the major factors determining the nature of resource flow to health, as brought out by the discussants, was the lack of technical expertise among those participating in the Planning process. Similar results were obtained by another study in Kerala (Elamon, 1998). Unlike other sectors such as agriculture, horticulture and rural infrastructure, prior experiences at the local level in dealing with health-related problems were generally minimal. The lack of coordination essentially stems from the fact that government healthcare system was not put into the reform process so as to enable its staff to deal with the new situation. Often, medical professionals lack expertise in finding practical solutions and in converting them into projects. Similar experiences were found in other countries which opted for decentralized planning for health (Collins and Green, 1994, Aranjo, 1997).

The lack of consensus in the choice of projects was found to be a reason for the selection of smaller projects that are spread across almost all wards of the Panchayats. This was observed by other studies too (Gopinathan Nair, 2000 and Varatharajan et al., 2004).

Second is the allocative inefficiency of the resource allocation within subsectors in health. Allocative efficiency suffered due to two reasons. First, resource allocation was based on local socio-political milieu rather than any objective criterion. Second, lack of technical expertise forced the Panchayats to allocate resources to tasks in which they had some knowledge. However, the resource allocation priority as expressed by the State may not suit all the Panchayats equally. Therefore, it is difficult to say whether the allocations were allocatively inefficient or not.

CONCLUSIONS

Results indicated that health is an important priority of the rural population in Kerala and allocation to health increased with people’s participation in grama sabhas and declined with higher socio-economic status. Health priorities of the State government and Panchayats did not match due to local ‘equality’ considerations and lack of technical expertise on certain aspects. For instance, the investment for control of communicable diseases
and prevention of other diseases received minimum attention from Panchayats.

After some years of limited People’s Plan campaign, Kerala is all set to implement it again in the Eleventh Five Year Plan, as stated in the draft approach paper (Kerala State Planning Board, 2006). Observations of this study may be of help when the State authorities strategize the decentralized planning process. In the light of the present results, two actions may be considered to improve the Panchayati raj vis-à-vis health – active campaign for higher grama sabha participation and education of the higher socio-economic groups on the power and benefits of people’s participation.

ACKNOWLEDGEMENT

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