Guidance Note to States for the implementation of Fifteenth Finance Commission (FC-XV)– Health Grants through Local Governments / Rural Components (from FY 21-22 to FY 25-26)

Section-I: Introduction

1. The Fifteenth Finance Commission (FC-XV), constituted by the President on November 2017 was, inter-alia, mandated to recommend measures needed to augment the Consolidated Funds of the States, for the period spanning FY 2020-25. The FC-XV had submitted two reports, one for the year 2020-21 and the Final Report for the period 2021-22 to 2025-26. The Commission has recommended that health spending by States should be increased to more than 8 per cent of their budget by 2022. The Commission has also recommended that Primary healthcare expenditure should be two-thirds of the total health expenditure by 2022 and that Centrally sponsored schemes (CSS) in health should be flexible enough to allow states to adapt and innovate, with the focus shifting from inputs to outcomes.
2. The commission recommended grants for the health sector as follows: (i) grants aggregating to Rs. 70,051 Crores through local governments and (ii) sectoral grants aggregating to Rs. 31,755 Crores to States. The XV-FC had also recommended State-specific grants for health amounting to Rs. 4,800 Crore. The total grants-in-aid support to the health sector over the award period works out to be Rs. 1,06,606 Crore.

3. The Union Government on 30-01-2021 vide Explanatory Memorandum as to the Action Taken on the Recommendations made by the Fifteenth Finance Commission in its Final Report for the years 2021-22 to 2025-26 inter-alia accepted the recommendations of the FC-XV **only in respect of the Local Bodies.** On the recommendations for the sectoral grants of various ministries including of Health Ministry, the Union Government had clarified that due consideration to sectors identified by the Commission will be given while formulating and implementing existing and new Centrally Sponsored and Central Sector Schemes.
4. Accordingly, the accepted recommendation of FC-XV through *Health Grants through Local Governments* (grants of Rs 70,051 Crore for the period to 2021 – 22 to 2025-2026)

to strengthen the health care system at the primary health care level are provided for the following: urban health and wellness centres (HWCs), building-less sub centres, PHCs, CHCs, block level public health units, support for diagnostic infrastructure for the primary healthcare activities and conversion of rural sub centres and PHCs to HWCs.

5. **Rs 43,928 Crores is allocated for healthcare facilities in rural areas to be coordinated by Rural Local Bodies (RLBs).**

6. This note lays out key principles for enabling Rural Local Bodies in the preparation of plans, resource allocations, fund transfers, and provides guidance on the role and functioning of the institutional mechanisms at District, State and National Levels.

7. It also provides details on operationalizing four key components approved under the grants including unit costs, to aid the RLBs in formulating their plans. They are:

   a. **Support for diagnostic infrastructure to the primary healthcare facilities** : The FC-XV provides support for diagnostic infrastructure in Sub Health Centres (SCHs) and Primary Health Centres (PHCs) under the vision of comprehensive primary health care. Diagnostic services are critical for the delivery of health services, and these grants are intended to fully equip the primary health care facilities so that they can provide some necessary diagnostic services.
   b. **Block Level Public Health Units**: Block public health units (BPHU) would integrate the functions of service delivery, public health action, strengthened laboratory services for disease surveillance, diagnosis and public health and serve as the hub for health-related reporting. The BPHUs will also improve decentralised planning and the preparation of block plans that feed into district plans. In addition, they will improve accountability for health outcomes. Given that the block health facility is co-terminus with the Block Panchayat /Panchayat Samiti/Taluka Panchayat, this has the potential to facilitate convergence with the panchayati raj institutions and the child development project officer of the Integrated Child Development Scheme (ICDS) programme. The FC-XV proposes to provide support to BPHUs in all the 28 States.
   c. **Building-less Sub centres, PHCs, CHCs**: An assessment of infrastructure gaps in rural PHCs/Sub centres based on Rural Health Statistics shows that number PHCs and

SHCs do not have the necessary infrastructure to meet the targets of the National Health Policy, 2017. The Commission proposes to provide support for necessary infrastructure for Sub Health Centre - HWCs and Primary Health Centre - HWCs in rural areas in close collaboration with rural local bodies.

d. **Conversion of Rural PHCs and Sub Centres into Health and Wellness Centre:** The Union Government has envisaged the creation of 1,50,000 HWCs by transforming existing SHCs and PHCs as the basic pillar of Ayushman Bharat to deliver comprehensive primary health care. It is proposed to provide support for necessary infrastructure for the conversion of rural PHCs and SHCs into HWCs so that they are equipped and staffed by an appropriately trained primary health care team, comprising of multi-purpose workers (male and female) and ASHAs and led by a mid-level health provider. PHCs linked to a cluster of HWCs would serve as the first point of referral for many disease conditions.

8. Flexibility for the States to re-appropriate among the components: Para 9.65 of the XV-FC report states that "It may be noted that all the above grants will be administered by the MoHFW. Though various components have been earmarked, we are cognizant of the fact that some inter-component adjustments within each State's overall share may be required in future years, as per the emerging ground realities. Hence, within each State's respective share, inter-component flexibility is allowed in consultation with the MoHFW".

Section-II: Salient points to be factored-in while implementing Rural Local Body components of FC Health Grants

Health is a technical subject, and the FC-XV grant is a **tied grant**, meant to be used for only specific initiatives, which involve several elements that are largely technical in nature. The capacity of Rural Local bodies, to manage public health functions directly *including the above four components of tied grants of FC-XV – Health Grants through Local Governments*, is likely to be variable. Collaboration with the State Health Departments, and close handholding with the Local Bodies in the form of technical guidance would enable effective and efficient utilization of the FC-XV Funds. Certain other factors that will have a bearing on the

implementation by the RLBs include:

- The implementation of the components of the FC-XV involves functions such as engaging competent human resources for health, procurement of medicines, equipment, diagnostics & consumables, contracting agencies to provide diagnostic services (as in the Hub and Spokes model), etc. Efficient use of funds for these activities, are dependent on economies of scale, standardized processes, including quality assurance, and require complex technical expertise.
- Most 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 agencies 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.
- The structure of rural local bodies differs from state to state. There are also differences between states in the powers which have been allocated to Local Bodies, which also accounts for variations in the capacities of the RLBs in the State/District to undertake health activities including mechanisms for such procurement processes.

In light of these factors, States will need to take a decision, as per the local context, for implementation of the rural components of the FC-XV Health Grants. **The RLBs at all levels** would be required to be involved fully to identify the gaps in their districts, based on the technical guidance, select locations for establishing Building less SHCs / PHCs, and undertake monitoring for the effective implementation of the activities under these tied-grants. The technicalities involved in the implementation of these specific components and the benefits of economies of scale and the use of standardized procedures, may require the implementation of certain elements at the State / District level. Hence, it is suggested to the States that they could exercise flexibility regarding undertaking some of these activities (i.e

those that are specialized in nature, and which are not feasible and economical to be executed at District /RLB level) at state level through institutions already created for this purpose like State Health Society, Medical Service Corporations, etc. The RLBs would be encouraged to establish a Procurement Cell at each District, with a nodal officer to coordinate procurement functions with the State Health Society/Medical Service Corporation, to ensure timely and efficient procurement. Such a strategy would eventually create capacities within the RLBs to handle these responsibilities independently.

Other activities under these four components may be handled and implemented by the RLBs in close coordination of the District Health Department under the overall supervision of the District Collector, who is also the chairperson of the District Health Society.

In addition, taking into consideration, the structure of the rural local bodies across the States and technical nature of the components of FC-XV Health Grants, it is suggested that States may nominate District level Rural Local Body / Zilla Parishad as the implementing Local Body for these components. The district level RLB/ZP is better capacitated in terms of having a Health Division, a Public Health Engineering Division, etc, that could undertake the functions entailed. However, it must be emphasized that Rural Local Bodies below the District level such as Block Level Panchayats and Gram Panchayats (in some States, intermediary ones as well) are to be involved in planning and monitoring of these components for the health facilities located in their jurisdiction. However, this arrangement will depend on State specific delegation of powers to RLBs.

For the States which do not have typical three tier structures of Local Bodies in rural areas or in urban areas (States such as Nagaland, Mizoram, etc), guidance on this aspect will be given by DoE.

Section-III: Institutional Structures, composition and Roles

1. <u>National Committee (NC-FC-XV)</u>

(i) Composition: The FC-XV mandates that a committee headed by the Secretary, MoHFW comprising the Principal Secretaries of Health of all States should be set up to draw a time-line of deliverables and outcomes for each of the five years along with

a definite mechanism for flow and utilization of these grants. This mechanism needs to be in place for the first instalment of funds to start flowing by July 2021. Accordingly, MoHFW had constituted the National level committee chaired by Secretary, HFW and comprising of Secretaries of MoPR, MoHUA, DoE and Principal Secretaries of Health of all the 28 States with AS&MD as Vice-Chairperson and JS Policy as convener of the Committee and shared with the States (copy attached at Annexure-I)

(ii) Roles of NC-FC-XV:

1. The NC-FC-XV would provide the policy and operational guidelines on the implementation of FC-XV - *Health Grants through Local Governments*, including unit costs, technical specifications of equipment, and other details.
2. The NC would create mechanism for capacity building of RLB representatives in collaboration with MOFHW, MoPRI, and MORD for effective implementation of FC-XV grants
3. The NC-FC-XV would appraise the proposals received from the States for re-appropriation of budgets between components that exceed 20% of the allocation in each of these components and accord approval.
4. The NC-FC-XV would also provide necessary technical guidance to ensure that State Level Committees (SLCs) develop appropriate capacity building strategies for the District Level Committee (DLC) and RLBs.
5. The NC-FC-XV would conduct bi-annual progress review meetings to take stock of progress and challenges.
6. The NC would also use the monitoring mechanisms created under NHM to review progress in the states, including the Independent Monitoring mechanisms.
7. The NC will get component wise annual action plans from State Level Committees.

2. <u>State Committee (SLC-FC-XV)</u>

(i) **Composition:** The FC-XV mandates that at the State level, a State Level Committee under the Chief Secretary and comprising officials of the State Departments of

Health, Panchayat Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies should be in place and this SLC should be ready with plans for implementation by July 2021. Accordingly, a communication is sent to all the States to constitute the SLC, chaired by Chief Secretary comprising officials of the State departments of Finance, Health, Panchayat Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies, with Principal Secretary, Health of the State Government as the convener of the Committee (copy attached at Annexure-II). State is free to co-opt the experts in the field of Governance and Reforms of PRI / ULBs in the SLC. FC-XV also recommended that representatives of the ULBs and all three levels of PRIs should be involved by entrusting them, in a phased manner, with the responsibility of supervising and managing the delivery of health services. **Option is given to the States to utilize existing institutional arrangement of State Health Society (SHS) under National Health Mission (NHM) for performing the functions of SLC under 15th FC with the condition that all the mandatory required members, as mandated by 15th FC are to be added to the existing SHS.**

(ii) Roles of SLC –FC-XV:

1. Major responsibility of the SLC is to decide the mode of execution of the activities under these tied-grants of the FC-XV. Depending on the local context of the States, as per the reasons explained above, **the SLC will decide on the implementation agency/agencies** to execute the activities under each component. The activities could be executed
   a. by the Zilla Parishad /RLB or
   b. by the District Health Society or
   c. by existing agency / corporation for those activities to be undertaken through centralized processes at state/district levels.
2. According to the above decision, SLC may also decide the mechanism of payment to the agencies executing the select-activities centrally. This is further explained in Section IV.
3. The State Health Department and State Panchayat Raj (PR) Department will be informed about the SLC's decisions on those activities to be executed

centrally at the state level, and those that would need to be executed by ZPs / RLBs.

4. The State Health Department, will work out the district wise distribution of funds and physical targets for the above four components of FC-XV Health Grants accordingly.

5. The SLC would approve the District-wise distribution of funds / resources, including physical deliverables and targets - for the four components of *FC-XV – Health Grants through Local Governments in Rural Areas*.

6. The SLC will appraise and approve the **Annual** District Health Action Plan of the FC-XV grants, (DHAP-FC-XV), which would have details for each district with the physical deliverables and output-outcome indicators for the components under the FC-XV. **District Health Action Plan should be received in the specific format as mentioned in the Operational Guidelines.**

7. The annual DHAP has to be submitted by February 15th of each year. The State Level Committee would approve the DHAP by March 31, so that implementation could be started from the beginning of the financial year.

8. The State Level Committee would also consider any proposal from the districts for re-appropriation among the four rural components (exceeding 10% and less than 20%) and communicate the final approved proposal.

9. The State Level Committee would also examine any proposal from the Districts or propose the proposal for re-appropriation among the four rural components (exceeding 20%) and recommend to NC-FC-XV for consideration.

10. The SLC would meet **quarterly** to review progress of the various districts, on the physical and financial progress, besides conducting regular meetings for consideration of the proposals received from the States.

11. The SLC would also leverage required resources from other departments for the effective implementation of these components.

12. The SLC will ensure that the PFMS system is used by all the implementing agencies of the Grants or the present financial system of the executing agency is in conformity with PFMS.

(iii) Responsibilities of State Health Department – Convener of the SLC

1. State Health Department (SHD) will work out the District-wise distribution of funds / resources, including physical deliverables and targets - for the four components of *FC-XV – Health Grants through Local Governments* as per the public healthcare facilities available in the districts, based on the technical guidance provided by the National Committee and submit to SLC.
2. After approval by SLC, the SHD would communicate the resource allocation, physical deliverables and targets on a year wise basis, to all the districts and ULBs – district wise and ULB wise, seeking their **Annual proposals** in the form of District Health Action Plan (DHAP-FC-XV). For this exercise, it will work in close coordination with the State PR Department to arrive at the ZP / RLB wise financial allocation.
3. State Health Department will prepare the State Specific guidelines, supplementing the National Guidelines on the implementation of *FC-XV – Health Grants through Local Governments,* especially to clarify processes related to procurement, infrastructure and engagement of HR and with the approval of SLC, will communicate the same to the Districts and RLBs.
4. State Health Department will issue necessary instructions to the District Health Department to provide necessary support to the Rural Local Bodies at all levels in the district to do the gap analysis and provide the required data so as to prepare the District Health Action Plan effectively.
5. SHD will compile the Annual DHAP-FC-XV received from the District Level Committee (DLC) in accordance with the guidelines, unit costs, and the resource allocation communicated to the districts and will place before SLC for consideration. It is the responsibility of SHD to ensure, before forwarding the FC-XV proposals to SLC that there is **no duplication between the proposals**

submitted to the SLC under FC-XV and proposals proposed for funding under NHM or any other schemes of the GoI/State Government.

6. After approval, the SHD would communicate the approved DHAPs-FC-XV in the form of Record of Proceedings (RoPs) for further implementation as per the guidelines. Depending upon the decision of the State Level Committee at Section III (ii) (1) above, the RoPs will mention the activities decided to be executed by ZPs/ RLBs and other activities to be executed by other identified agencies, as explained above.
7. The SHD would also compile and forward the approved DHAP-FC-XV from all districts to the National Committee for information, duly hosting the same in the public domain within 2 weeks of approval by SLC.
8. The SHD will get monthly progress (physical and financial) from all DLCs-FC-XV and submit the progress bi-annually / quarterly to the SLC for review and directions.
9. The State Health Department will ensure that there is no duplication between the activities proposed under FC-XV and those of NHM and other centrally/state funded activities.
10. State Health Department in close coordination with State Panchayat Raj Department will collect the UCs of the instalments of FC-XV from all the executing agencies and local bodies and submit a single UC Statement for the State **with their joint signatures** through the State Finance Department to the DoE, Ministry of Finance and DoHFW. Based on recommendations of MoHFW only, the second and subsequent instalments of FC-XV will be released to the States.

(iv) Responsibilities of State Panchayat Raj Department

1. State PR Department will work in close coordination with SHD and provide all the assistance for implementation of FC-XV – Health Grants through Local Governments ear-marked for RLBs.
2. State PR Department will pursue with all the RLBs for the proper implementation of the approved DHAPs.

3. State PR department, in active collaboration with the SHD, will take actions for capacity building of the RLBs (elected members) for effective implementation and will utilize all their available resources and institutions.
4. For capacity building of officials, funds allocated by MoPRI would be utilized.
5. State Rural Development (RD)/Panchayati Raj (PR) department would converge their ongoing interventions from existing CSS schemes for capacity building of the officials of the district and sub-district Rural Local Bodies.
6. Further, the State RD/PR department would also converge existing management support mechanisms to ensure harmonization with existing instruments, such as Panchayati Raj Institutions Accounting Software (PRIA Soft) which is used for financial and inventory management of the department upto the Gram Panchayat Level, duly confirming to PFMS system.
7. State PR Department will collect the UCs of the amount released to ZPs / RLBs. It has the responsibility to submit the UCs of FC-XV-Health Grants, with the joint signature of the State Health Department to the State Finance Department, which will be subsequently submitted to the DoE, Ministry of Finance and DoHFW. Based on recommendations of MoHFW only, the second and subsequent instalments of FC-XV will be released to the States.

3. District Level Committee (DLC-FC-XV)

(v) **Composition:** The FC-XV mandates that a district level committee needs to be constituted in the district level under the District Collector / Deputy Commissioner comprising officials of Health, Panchayat Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies in the District. Accordingly, a communication is sent to all the States to constitute the District Level Committee (DLC), chaired by chaired by the District Collector/Deputy Commissioner comprising officials of the District Health, Panchayat Raj and Urban Affairs and select representatives from all three tiers of rural and urban local bodies in the District with Chief Medical Officer of the District as the convener of the

Committee (copy attached at Annexure-II). District is free to co-opt the experts in the field of Governance and Reforms of PRIs / ULBs in the DLC. **Option is given to the States to utilize existing institutional arrangement of District Health Society (SHS) under National Health Mission (NHM) for performing the functions of DLC under 15th FC with the condition that all the mandatory required members, as mandated by 15th FC are to be added to the existing DHS.**

(i) Roles of DLC-FC-XV:

1. District Level Committee (DLC) is responsible for providing overall guidance to the Zilla Panchayats /RLBs on the implementation of the FC-XV – *Health Grants through Local Governments*, including preparation of the proposals, component wise as per the Guidelines
2. The DLC would appraise the proposals received from the Zilla Panchayats, as per the technical guidance and recommend to the SLC for consideration. DLCs will be required to ensure that the negative list is adhered to by the RLBs as detailed in the technical guidelines.
3. The DLC is also empowered to re-appropriate the budget between line item components upto 10%. Proposals from the Zilla Panchayats / RLBs for re-appropriation between the line item components exceeding 10% would be submitted to SLC for consideration.
4. After receipt of approval of final approved DHAP-FC-XV from SLC through State Health Department, the District Level Committee will guide the concerned Zilla Panchayats / RLBs, in close coordination with the Health Department and monitor the implementation of the of the approved activity of various components of DHAP-FC-XV.
5. Necessary activities to guide and handhold the Zilla Panchayats including capacity building of Zilla Panchayat and the lower tiers of the RLBs in the district would be undertaken by the DLC so as to ensure smooth and effective implementation of the FC Rural components.
6. The DLC would mobilize the district health team, (and the state health department if required) to support Zilla Panchayat and the lower tiers of the

RLBs for planning, support, implementation and monitoring.

7. The District team identified will ensure that the RLBs under their mandate are provided with the technical assistance for developing and implementation of the approved proposals in their respective jurisdictions. The DLCs will organize workshops and provide handholding support for filling up the DHAP templates at the RLB level. Compilation and finalization of these templates for the DHAP will be done by the DLCs as per the stipulated timelines provided in the guidelines.
8. The DLC would leverage existing programmes and funds to ensure convergence with these activities for optimal utilization of funds.
9. The DLC would meet on a monthly basis to review progress and identify barriers to implementation and take appropriate action.
10. The DLC would collect the utilization Certificates from Zilla Panchayats for the amount released to them and forward the UCs to the SLC.

4. Rural Local Body (Zilla Panchayats / District Council / District Panchayat)

(i) Roles and Responsibilities:

1. Rural Local Body (RLB), depending on the physical targets and financial budget indicated by the State Health Department as explained at para II (2) (iii) (1), supported by the District Health Department, will undertake a gap analysis of the public health facilities in order to prepare action plan **for the five years** for the four components under the FC-XV. A template for the same will be provided by the DLCs in alignment with the DHAP and the timelines as provided in the guidelines.
2. RLB will prepare the proposal in the format of **Annual** *District Health Action Plan (DHAP)- FC-XV, given by the State Health Department* in respect of the four components specified above. This would be based on:
   (i) the resource allocation communicated by the state,
   (ii) gap identification exercise,

(iii) the unit costs for each activity (as per the technical guidelines).

The proposal would also project an annual requirement and phasing of the activities over the five-year period.

3. While preparing the action plan for the above components, all the concerned stakeholders (Zilla Panchayat and the lower tiers of the RLBs) will be involved in the planning process (as per the technical guidelines) to arrive at the requirements. The lower tiers of the rural local bodies such as Gram Panchayats etc. would also be involved in gap analysis and proposal preparation. **Existing Committees such as Village Health Sanitation Committees (VHSNC), Rogi Kalyan Samiites (RKS), Jan Arogya Samities (JAS) JAS, etc. which include representation from the elected representatives, and are actively involved in health prevention and promotion would also be involved as appropriate.**

4. The RLBs are to ensure land availability and other required provisions while ear-marking the funds for the five year plan wherever new health institutions are planned to be built.

5. In case, re-appropriation from one component to other component is required, the same will be included in the proposal and same will be submitted to the DLC. RLBs should keep in mind that proposal of more than 20% re-appropriation requires approval from National Committee with the recommendation of SLC.

6. Once approval is received, depending upon the decision of the State Level Committee at Para III (ii) (1) above, the Zilla Panchayats will implement the activities ear-marked for RLBs and pursue with the selected agency for the other activities of the components under the supervision of the DLC.

7. RLBs would regularly monitor, in close coordination with the District Health Department, the progress of work, the achievement of physical deliverables and programmatic outcomes. The checklists and templates for this will be communicated by the SLC.

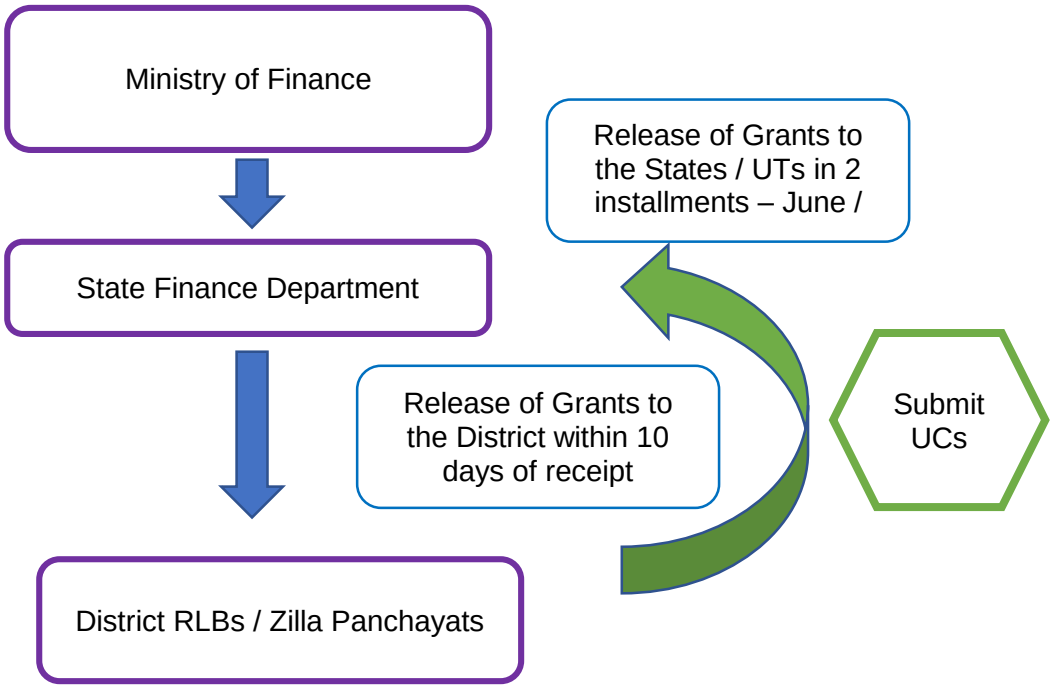
8. RLBs will bring the issues requiring resolution at the State level, to the State Health Department / PR department through DLC and share with the DLC on a quarterly basis.

9. RLBs can supplement the resources available with them, for better and effective

implementation of the these tied-grants of the FC-XV Health Grants of rural sector.

Section-IV: Proposed Fund Release mechanism including submitting UCs

1. Funds, as per the guidelines of DoE of the Ministry of Finance, funds will be released to the concerned State Treasury, based on the distribution of the rural components arrived RLB-wise by the SLCL as explained supra.
2. State Finance Department will release funds to the concerned ZP/ RLBs based on approved proposals of the SLC as per the distribution of funds between various districts.
3. Depending upon the decision of the State Level Committee at Section III (ii) (1) & (2) above, the States may decide modality for the payment of specific state/district level executed activities such as HR engagement, Procurement of medicines, equipment, diagnostics & consumables, contracting agencies to provide diagnostic services (as in the Hub and Spokes model), etc as per local context. This could be done by pooling the corresponding budgets from the Zilla Panchayats and transferring them to the District Health Society/State level agencies identified for implementation of selected components.
4. Separate guidelines will be issued by DoE on settling the UCs. In general, UCs have to be settled by the RLBs and based on the UCs received, a joint statement of UCs will be submitted by the State Health Department and State Panchayat Raj Department, to the State Finance Department, which will be subsequently submitted to the DoE, Ministry of Finance and DoHFW. Based on the recommendations of MoHFW only, the second and subsequent instalments of FC-XV will be released to the States.
5. **The Single Nodal Account (SNA) mode of fund release and payments may be followed for these health grants as is being done for the Centrally Sponsored Schemes (CSSs) under the new mechanism. This will also enable in simplification of the processes and ensure no duplication happens with NHM or PMASBY. This single nodal account mechanism will also simplify the collection of the UCs and fund flow mechanism will be streamlined.**


Ministry of Finance
State Finance Department
District RLBs / Zilla Panchayats
Release of Grants to the States / UTs in 2 installments – June /
Release of Grants to the District within 10 days of receipt
Submit UCs

Section-V: Main Factors to be considered for the four Rural Local Bodies Components of FC-XV Health Grants

Below Table has the year wise break up for the four components :

(Rs In Crore)

Sr. No	Total Health Grants	2021-22	2022-23	2023-24	2024-25	2025-26	Total
1	Building-less Sub Centres, PHCs, CHCs	1350	1350	1417	1488	1562	7167
2	Block level Public Health Units	994	994	1044	1096	1151	5279
3	Support for diagnostic infrastructure to the primary healthcare facilities	3084	3084	3238	3400	3571	16377
3.a	Sub-Centres	1457	1457	1530	1607	1687	7738
3.b	PHCs	1627	1627	1708	1793	1884	8639
4	Conversion of rural PHCs and Sub Centres into health and wellness centre	2845	2845	2986	3136	3293	15105
	Total Grants for primary health sector in rural areas	**8273**	**8273**	**8685**	**9120**	**9577**	**43928**

The details of the components are :

1. **Building-less Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs)**:
    - To meet the infrastructure gap and ensure availability of comprehensive primary healthcare close to the community, a health grant of **Rs 7176 Cr for the construction of Building less SHCs, PHCs and CHCs.** This would apply to the Sub Health Centre and PHC facilities that do not currently operate out of their own buildings or are operating from dilapidated buildings / rented buildings (refer to Rural Health Statistics 2019).
    - **The fund allocation for this component would be contingent upon availability of land for the health facility**. **State may consider allotting these funds to the districts in challenge mode, i.e this component would be**

sanctioned only on availability of land, by the district or local body for this component. The choice of prioritizing a 'buildingless' SHC or PHC and their location, would rest with the District Level Committee. However certain broad principles are to be followed:

- Priority to be given to building PHC/SHC in remote areas, to ensure thirty minutes time to care approach and reduce geographic barriers.
- Selection of sites should be such that the benefits reach larger segments of vulnerable populations such as SC / ST population dominated blocks/areas
- Selection and posting of HR should be done, commensurate with the building process, so that there is no lag between completion of the building and its functioning.
- State should make arrangements for the operational costs, well in advance so that the facility is utilized immediately on completion.

- The districts should plan for such up-gradation ensuring that all the blocks are covered and based on the local capacities available, these new buildings will be completed over the stipulated duration.
- **Unit Cost** : Construction of a new building is Rs 55.5 lakhs for a SHC (maximum), Rs.1.43 Cr for a PHC is (maximum) and Rs.5.75 Cr for a CHC (maximum). The details with the layout and costing will be provided in the *Operational Guidelines for implementation of FC-XV Health Grants through Local Governments (FY 21-22 to 25-26)* and are also available on the NHM website[1]. The Local bodies are free to supplement their resources to provide further improved infrastructure taking into consideration, local demands and needs.

2. Block Level Public Health Units:

- To enable the integrated delivery of public health, clinical and laboratory services, and a hub for data compilation for sub block facilities, a health grant of Rs 5279 Cr has been approved to be set up across 28 states. The BPHUs would have the following components:

[1] (https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1215&lid=481)

1. Public Health Unit for providing clinical and public health functions such as surveillance and detection of outbreaks.
2. Block Public Health Lab for providing diagnostics services.
3. HMIS Unit for data compilation and monitoring, which would be linked to the Integrated Health Information Platform (IHIP), with the responsibility to update IHIP on regular basis.

- **Unit Cost** : A maximum of Rs 80.96 lakhs of Capital expenditure per BPHU and a a maximum of Rs.20.14 lakhs of recurring / operational expenditure per BPHU (applicable once they are functional in the subsequent year after establishment of BPHUs) is prescribed and further details will be provided in the *Operational Guidelines for implementation of FC-XV Health Grants through Local Governments (FY 21-22 to 25-26)*

3. Support for diagnostic infrastructure to the primary healthcare facilities:

- To support diagnostic infrastructure at SHCs and PHCs in rural areas, a health grant of Rs 16,377 Cr has been provided by the XV-FC and will enable strengthening diagnostic services in the Sub Health Centres and the PHCs.
- The range of diagnostic tests has been expanded in alignment with the guidelines of comprehensive primary healthcare services under Ayushman Bharat[2]. The guidelines have to be followed by the states for utilizing the FC-XV grant.
- Under FC-XV Health Grants, as the diagnostic infrastructure is being supported at SHC and PHC levels through this component and at Block level through the BPHU component explained above, the states should plan comprehensively to ensure that all the required clinical and public health diagnostic services are provided to the community through SHCs, PHCs and Block level public healthcare facilities either by strengthening in-house facilities or through Hub and Spoke model (although a fully equipped Hub at Block level) is recommended, duly pooling the resources. Some of the high-end tests may be done at the Hub and Spoke model. Outsourcing model for diagnostic services can also be considered by the states.

[2] vide GOI letter, D.O. No. Z-1595/7/2018-NHM-I dated 1st July 2019

- Further, it is observed that the budget indicated for this activity is sufficient, States may utilize the resources for developing an IT system (App / Portal based for each facility providing the services) to monitor the diagnostic services provided to the people effectively.
- **Unit Cost** : Ideally for equipping a new / greenfield SHC or PHC with the required diagnostic infrastructure, a maximum of Rs 3.91 lakhs for each SHC and a maximum of Rs 25.86 lakhs for each PHC may be required. Grants under this component of FC-XV would be utilized for the existing / brownfield SHCs and PHCs in rural areas depending on the gap analysis and comprehensive diagnostic plan of the district. Accordingly, the unit rate for each SHC / PHC will be varying as per the identified gaps in the facility.
- It is recommended that States may plan for improving diagnostic infrastructure in all the SHCs and PHCs in the State/District in the next five years period and may utilize the FC-XV grants effectively. In the process, Priority is to be given to SHCs and PHCs in remote areas, to ensure time to care approach and reduce geographic barriers. Details about the diagnostic services to be made available at the SHCs and PHCs will be provided in the ***Operational Guidelines for implementation of FC-XV Health Grants through Local Governments (FY 21-22 to 25-26)***

4. Conversion of rural PHCs and Sub-Centres to HWCs:

- Rs 15,105 Cr has been allocated for this component to achieve the vision of the 1.5 lakh Ayushman Bharat – HWCs, providing comprehensive primary health care services, closer to the public.
- As the unit rate per SHC or PHC are indicated by the FC-XV, the State is at liberty to utilize the budget for non-recurring expenditure of the newly identified SHCs or PHCs to transform into HWCs or for recurring expenditure of the already functional SHC-HWCs and PHC-HWCs.
- For making the CPHC services through HWCs by converting all eligible SHCs and PHCs into HWCs, State/District will be requiring more than resources that being

provided under FC-XV. States are requested to prepare a comprehensive plan for meeting the financial requirements of next five years, effectively using the FC-XV grants and supplemented by the resources of NHM and / or other State / GoI resources and States may exercise the flexibility as per the local context. However, States have to ensure that there is no duplication of resources for conversion of SHC or PHC into HWCs, between FC-XV, NHM and other GoI/State resources.

- **Unit Cost** : As per the FC-XV, an amount of Rs.9.7 lakhs (maximum) is to be utilized for conversion of each SHC into HWC and an amount of Rs.5.6 lakhs is to be utilized for conversion of each PHC into HWC.

- The indicated activities that can be covered include infrastructure (physical and IT) upgradation as per the CPHC guidelines, Human Resources - Remuneration and performance-based incentive of CHOs, Team based incentives of primary healthcare team at the HWCs, ASHA incentives, Additional services such as Physiotherapy, Counseling and Yoga, Capacity building of ASHAs, ANM/ MPWs, CHOs, VHSNC/JAS/PRI/SHG, IEC, Data management, Office Support, and IT Support, Monitoring/Accountability: Independent monitoring cost, Support cost to JAS for Social Audi

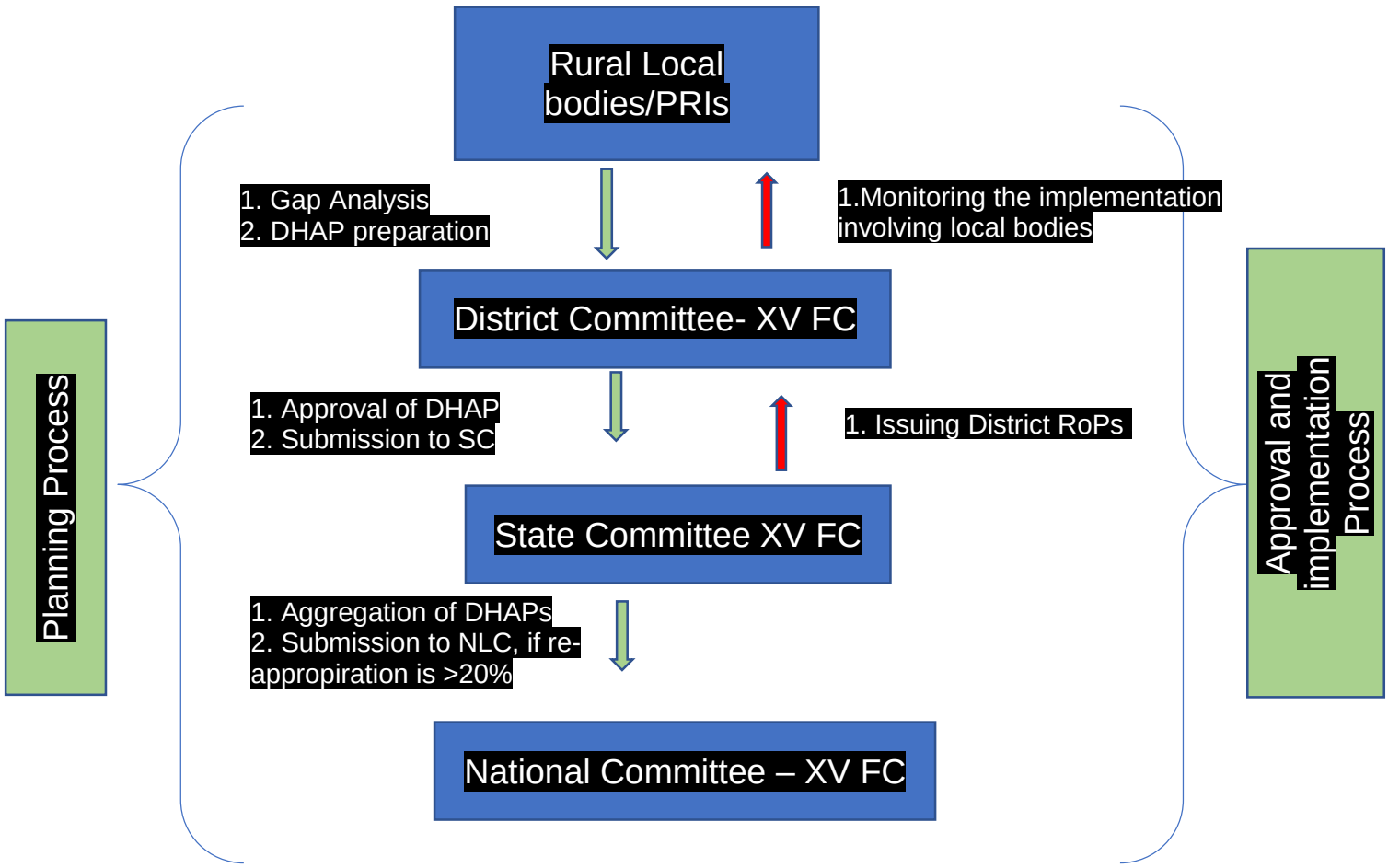
Section-VI: Miscellaneous Points

- The *Operational Guidelines for implementation of FC-XV Health Grants through Local Governments (FY 21-22 to 25-26)* of Ministry of Health and Family Welfare are to be followed for all the four rural components**. For the component of BPHUs, the guidelines are common for both PMASBY and 15th FC. For the component of conversion of SHCs / PHCs into HWCs, the funds should not be utilized for the negative list of activities mentioned in the GLs.**
- The existing Monitoring Framework of NHM will be upgraded to include the monitoring of these components of FC-XV, time bound deliverables and outcomes for all the four components for each of the five years.
- The Assets created out of XV FC Grants are mandatorily to be geo-photo tagged and uploaded in IT portal and app developed by MoPR and the MIS developed by the MoHFW.
- The Grants will be released by the Department of Expenditure (Finance Commission Division) of Ministry of Finance as per the rule provision in this regard subject to fulfilment of all stipulated guidelines / conditions and the State Government should transfer each installment of the LBs grants received to the RLBs without any deduction, within ten working days of receipt from the Union Government.
- The unit rate indicated in the *Operational Guidelines for implementation of FC-XV Health Grants through Local Governments (FY 21-22 to 25-26)* of Ministry of Health and Family Welfare are to be followed, while making district wise allocation. These allocations need to be made **keeping in view the rural population of the district, including where there are no urban local bodies**. Preferential allocation is to be made to aspirational districts including tribal (**Tribal districts as notified by MoTA**) and insurgency affected districts (**around 30 districts as finalized by MHA**). **Hilly districts apply to Hill states/UTs such as all NE States, Himachal Pradesh, Uttarakhand, Jammu & Kashmir and Ladakh.** The aim should be to ensure availability of health facilities as per the stipulated population norms.
- The above-mentioned allocation of money can be used for the activities specified

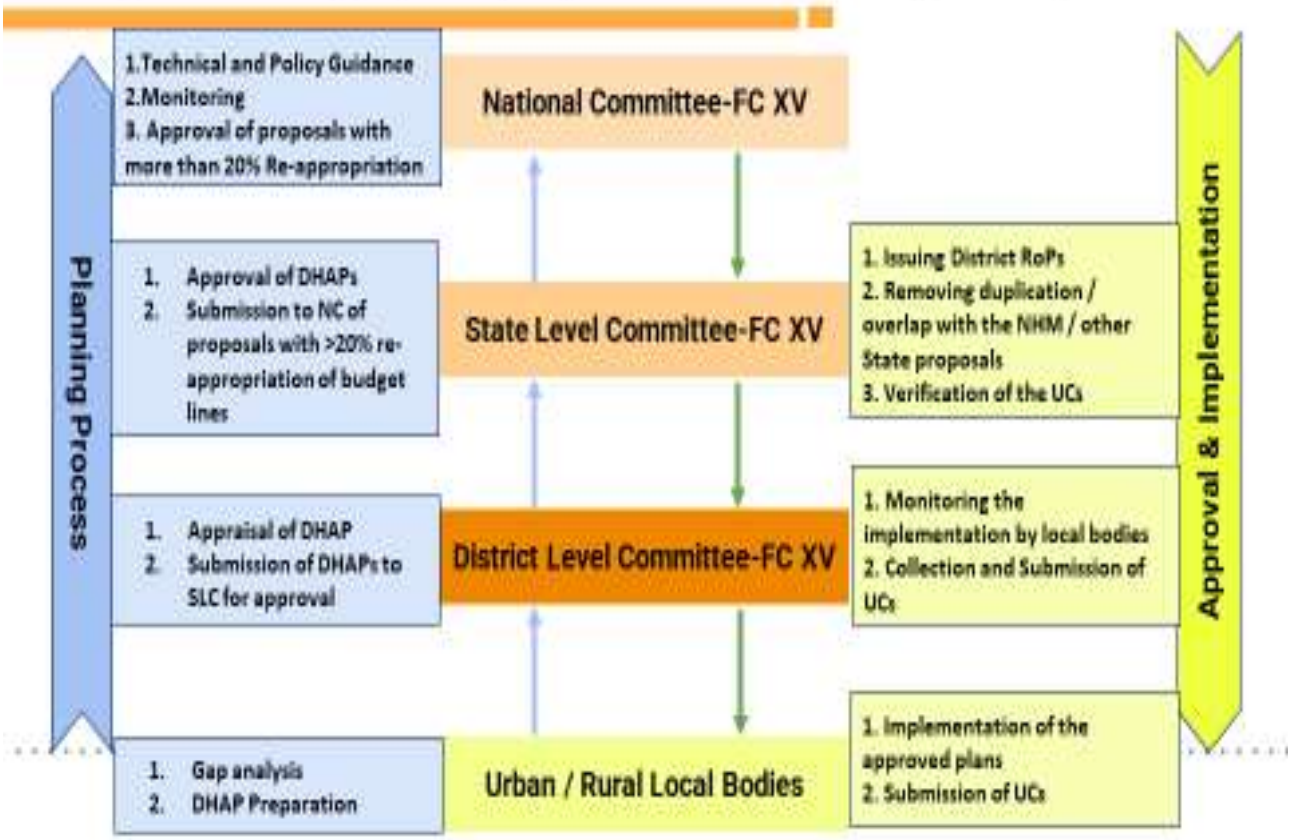
above and as per the recent guidelines issued by Government of India. The negative list provided in the guidelines have to be adhered to.

- The areas overlapping with the peri-urban / urban areas should be re-allocated to the urban areas, if all criteria are met and considered for fund allocation under the urban components of the XV-FC.

Planning, Preparation, Appraisal, implementation and monitoring of the Proposals under FC-XV Health Grants through Local Governments



Flow diagram of Planning, Preparation, implementation and monitoring of the Proposals



Roles and Responsibilities of various committees of FC-XV.

- Guidance to States for flow and utilization of grants, with a timeline of deliverables and outcomes
- Monitoring and Evaluation
- Approval of State proposals of more than 20% of re-appropriation of budget lines among the components.

- Approval of the District Level Plans as per fund allocation, including approval of re-appropriation proposals of < 20% and > 10% of budget lines among the components
- Issuing of District RoPs,
- Validation of UCs submitted by District Level Committee and submission of Joint UC to MoHFW
- Submission of re-appropriation proposals to the NLC (>20% of budget lines) among the components.

- Finalization of the District Level Plans including re-appropriation proposals of <10% of budget lines among the components, as per the fund allocation
- Submission of the District Plan to the State Level Committee, including re-appropriation proposals of <10% of budget lines among the components
- Cross-verification of the UCs

- Gap Analysis
- Preparation of the DHAP
- Reporting of the work completion / activities approved
- Obtaining and submitting the UCs to the DLCs