Centre for Multilevel Federalism
Institute of Social Sciences
New Delhi

IFP - 2

INDIAN FEDERALISM PERSPECTIVES

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The CMF has two underlying aims. First, to provide an intellectually stimulating environment for more effective collaboration, discussion, and research on federalism in India. Second, to bring about more informed public opinion on issues of federalism and also contribute, through our international partners and networks, to placing India more firmly in the development of comparative federalism. The Centre aims to position itself as a primary resource for issues relating to the sharing of powers and responsibilities between different levels of government in India's federal system. It has sought to develop and propagate an interdisciplinary study of Indian federalism in a comparative perspective.

Through this series titled "Indian Federalism Perspectives", the CMF aims to share research, teaching, and policy insights on how India's multilevel federal system has engaged with a crisis that has multiple dimensions. The COVID 19 pandemic continues to impact our lives and throw up unusual demands and challenges. At the same time, it also provides us an opportunity to improve and fix dysfunctional elements in our federation. In this second issue, Prof. Indira Rajaraman underlines the need for a continuous communication system between and across different levels of the federation and how lessons gleaned from varied experiences could have beneficial outcomes.

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K K Kailash
01 September, 2020

Centre-state lessons from the Corona Virus pandemic
Indira Rajaraman*

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Dr. Indira Rajaraman was a Member of the Thirteenth Finance Commission. From 1994 until her retirement in 2007 she held the Reserve Bank of India Chair at the National Institute of Public Finance and Policy, Delhi, and from 1976 to 1994 she was on the Economics faculty of the Indian Institute of Management, Bangalore. She was a Visiting Scholar at Harvard and Stanford Universities (1984-85), and at the Fiscal Affairs Department of the International Monetary Fund (2004).

Dr. Rajaraman's research papers have appeared in journals and books published by Elsevier, Springer Verlag, John Wiley, the Brookings Institution and Oxford University Press, on a wide range of development issues. She writes regularly in the financial press.

Kerala state went well beyond the national advisories on the corona virus in January 2020, to track asymptomatic arriving air passengers and arrange for their treatment if found infected. Kerala used the structure of the Integrated Disease Surveillance Programme (IDSP), a national initiative of the Ministry of Health and Family Welfare at the Centre, a structure available in principle in all states. A Centre-State health portal on which the Kerala initiative could have been exhibited would have facilitated its possible adoption by other states, on the yardstick competition model which is one of the proclaimed advantages of the federal structure of governance. The paper also examines the larger underlying process of fund transfer under the National Health Mission, of which the IDSP is a small component, to implementing agencies at the last mile. Without a massive administrative re-organisation of processes for release of funds at the level of both Centre and states, no enhancement of fiscal allocations will improve health outcomes in India, nor enhance the capability of states to respond nimbly to sudden crises of the covid variety. The health and economic costs of the pandemic are a direct consequence of the lack of attention to these numbingly complex administrative processes governing fund flow.

Introduction

The points of entry into India of the novel corona virus were limited in the first instance to a small number of international airports, and at the time of the first communication from the World Health Organisation (WHO) dated 11 January 2020, potential entry of the virus was further limited to travellers entering the country from China. Kerala alone, among the states in India, was quick and effective in meeting the threat. There was no standing Centre-state communication channel, whereby other states could have adopted the steps taken by Kerala to contain the spread of the virus. Such a channel could function as a continual multi-nodal public policy learning framework whereby states in a federal entity can learn from one another.

The first press release on the novel corona virus (17 Jan 2020, 1599665)[1] from the Ministry of Health and Family Welfare (MOHFW), cites the 11 January 2020 WHO communication as having said that "keeping in view the limited human to human transmission the risk at global level is perceived to be low." The WHO clearly failed to perceive the high risk posed by the new pathogen. However, "as a matter of abundant

precaution the Ministry of Health has instructed screening of international travellers from China at designated airports namely, Delhi, Mumbai and Kolkata through thermal scanners". Another press release the same day (17 January 2020,1599666) issues a travel advisory for visitors returning to India from China, in spite of the WHO's risk assessment that "the mode of transmission is unclear", and "there is little evidence of significant human-to-human transmission". The advisory is for travellers returning from China to voluntarily self-declare at the airport if they feel sick upon arrival, or within a month of their return. A later press release (20 January 2020, 1599901) extends thermal screening to four additional airports at Chennai, Bangalore, Hyderabad and Kochi. This is the earliest date on which an airport falling in Kerala state was included within the ambit of the MOHFW warning system. Subsequent MOHFW press releases dated 22 January 2020 (1600137) and 23 January (1600329) merely report the number of flights and passengers screened, and report no cases detected; another dated 25 January (1600517) announces extension of thermal screening to 12 additional airports in addition to the previous seven.The important point to note is that even by 25 January, there is no advice from the MOHFW going beyond thermal screening at designated airports, and advising voluntary self-reporting by passengers a month after return.

The Kerala Guidelines

It was at that point that Kerala went beyond the national advisory to issue guidelines applicable within the state jurisdiction, of which an updated version dated 26 January is available in the public domain.[2] Running into 27 pages of impressive detail, it has the following provisions for asymptomatic arriving passengers from notified countries, where the list was to be continually updated.

Section 3, Page 5:
"(4) Names of asymptomatic passengers from said origins will be forwarded by Airport Health Officer/ Ports Health Officer to SSO IDSP (State Surveillance Officer of the Integrated Disease Surveillance Programme)- ADHS PH (Additional Director of Health Services, Primary Health) Kerala and State Nodal Officer Dr.Amar.S.Fettle which will also be shared to the DSO/DSU (District Surveillance Officer/District Surveillance Unit) of the concerned district.

(5) These passengers will have to be kept under close surveillance under home quarantine by the concerned DSO/PHC Medical officer (MO) for 28 days from the time of departure from the affected country or from the time of contact with a suspected/confirmed patient."

(7) Provision for passengers arriving by land transport from other airports like Bangalore, to be identified at community level through the same network.

Section 8, Page 11:
"Daily monitoring coordinated by PHC MO on information received from DMO/DSO, and by the designated area field staff."

"Referral and transportation management if indicated by development of symptoms, under direct liaison between DSO and MO PHC."

The Kerala provisions for surveillance, quarantining and daily monitoring of asymptomatic arriving passengers went well beyond the national instructions for voluntary self-reporting as issued by the MOHFW.

The formal instructions were to forward names of asymptomatic passengers to the State Surveillance Officer of the Integrated Disease Surveillance Programme (IDSP), a nationwide MOHFW initiative, and to the District Surveillance Unit of the concerned district where the destination of the arriving passenger lay. Here is a clear example of how a subnational state in a federal structure was activating a nationally instituted decentralised reporting structure which was being completely disregarded in the national instructions issued by MOHFW to all states. Surveillance was also extended, using the same network, to identify passengers having arrived from infected countries at airports outside Kerala from the notified points of origin, and arriving in

the state by land transportation.

There is clear evidence of integration within Kerala state between the surveillance structure of the nationwide IDSP, and the state-level primary health vertical, since responsibility for daily monitoring of home quarantine was placed under the direct supervision of the medical officer of the primary health centre, using designated area field staff.

The final and most noteworthy feature is the provision for referral and transportation of those under surveillance who developed symptoms, to care facilities.

Altogether, these instructions are outstanding in terms of last-mile coverage, closing all loopholes, and ensuring no possible avenue of infection was left uncovered, and that those infected were cared for towards full recovery.

Although the Kerala guidelines document was displayed online and therefore accessible to all, it seems not to have been noticed by the MOHFW, not even by the Integrated Disease Surveillance Programme (IDSP), which as a national programme is housed within the MOHFW. Cognisance of such state initiatives would have been facilitated if there had been a Centre-state portal, where Kerala could have posted its guidelines, and further reported infection rates among asymptomatic passengers quarantined and followed up after arrival.

The Integrated Disease Surveillance Programme (IDSP)

The IDSP website (idsp.nic.in), states its mission as the establishment of "a decentralised State-based surveillance system for epidemic prone diseases to detect the early warning signals so that timely and effective public health actions can be initiated in response". The IDSP proudly reports that 90% of districts are directly reporting weekly disease surveillance data on the portal. These figures would have been routinely reported from Kerala in the weeks following the guidelines, but in the absence of any underlying information on the initiatives undertaken in that state towards better identification, would have merely been taken as evidence of the rapid spread of the disease in Kerala (as indeed did happen).

The reporting structure presupposes that decision making and initiatives will be confined to the Centre, with states merely assigned the role of reporters from the field in prescribed formats. There is no provision for reporting of state-level initiatives and their outcomes, so that information can be laterally disseminated, for direct emulation by states without having to wait for national directives.

The IDSP was started with World Bank assistance in 2004, but shifted later to domestic funding and at some point folded into the National Health Mission (NHM),[3] a national scheme with co-funding by states in prescribed shares. Starting from the horizon of the Fourteenth Finance Commission in FY 16, the state share was raised from the previous level of 25% to 40%, and the Central share correspondingly reduced from 75% to 60%.[4]

The IDSP is part of an NHM component called "flexible pool for communicable diseases (FPCD)". Far from enabling flexible or rapid responses in the field, the rigid structure governing NHM fund flows seems designed to ensure failure to respond. The deficiencies of that structure were exposed in the only detailed study of the flow of NHM funds (Chaudhury and Mohanty, 2019).[5] The paper has an in-depth focus on three states, Bihar, Maharashtra and Odisha, for two years FY 16 and FY 17, yielding six data points in all.

NHM funds are segregated by component. Even within the FPCD, there are separate components for each disease like tuberculosis or leprosy, and funds for each component are released separately at times not known in advance.[6] Separate accounts by component have to be maintained by the ultimate receiving agency in the states, the state health societies (SHS), and by the further downstream district-level sub-offices of the SHS. This deflects attention towards maintenance of records rather than towards addressing the burden

of communicable diseases. Issue of sanction orders at the Centre for fund transfer varies in timing by NHM component. The data points in the Chaudhury-Mohanty paper show that sanctions were issued well beyond the start of the fiscal year, although the delays might have become shorter since then.[7]

The IDSP, in five of the six data points in the Choudhury-Mohanty paper, was sanctioned for release at the Centre between November and February, a few months before the end of the fiscal year. This was for a programme to enable public health responses to the early warning signals of an epidemic.

Clearly, a system of this kind pre-supposes that the funds issued in a fiscal year will be partially unutilised and be available for use in the early months of the next fiscal year.[8] Unutilised funds with the SHS are formally included in the budgetary allocation for the next fiscal year.[9] However, the further problem with calling this unutilised is that the budgetary allocation may not have been fully released. This may be particularly true of the state contribution of 40%, which may be only fractionally fulfilled, and in proportions varying across components.

A further delay in fund transmission was added at the start of FY 15, when NHM funds had to be routed through state treasuries, instead of being directly released to the State Health Societies as in previous years,[10] a change paradoxically recommended by a committee appointed in 2010 to improve accountability.[11] The number of approvals required, and thus the time taken, for fund release from state treasury to SHS, varied widely between the three states studied in the Choudhury-Mohanty paper, from three months or more (Bihar), a little over two months (Maharashtra), to a month or less (Odisha).

Maintenance of continuity in any component of health delivery is seriously challenged in the face of a funding process with the kinds of uncertainties and delays detailed above. Despite the availability of the unutilised overhang at the start of the fiscal year, there would be funding shortages for particular components at various points in time during the year, co-existing with underutilisation in other components. At such times, they are reported to prioritise disbursement not by programme so much as by budget head, with salaries given first priority. It is not clear whether the State and District Surveillance Officer posts under the IDSP are fully funded under the NHM, or are functions grafted onto State and District officers in the state's own health vertical. If the latter, the surveillance programme is likely to run more smoothly than if they are posts funded from the NHM, whose funding can be best described as fitful. Much of the IDSP funding probably goes towards training of data entry operators and computer equipment within the state. Since these elements of non-salary expenditure are low priority items, the functioning of the reporting system cannot possibly be very effective.

The final element in this numbingly defeatist structure is the further delay in release of funds from the SHS to the district-level end-use point, which is where health expenditures actually need to happen.

This is where the Kerala system of integrating the state's own health vertical, primed by the state's own fiscal resources, with the externally funded surveillance overlay enabled it to prove so effective.

Corona outcomes in Kerala state

As already mentioned, the Kerala initiative would have shown a higher case load count in the months before the lockdown, since it was far ahead of the rest of the country in identifying cases arriving through international airports. Chart 1 below shows the daily growth rate in Kerala (black line) and the rest of the country (black dotted) from the beginning of the first lockdown on 25 March 2020, upto 15 July 2020, which was a month and a half after the end of the successive lockdowns. The first lockdown brought the Kerala rate down to near zero since prior case arrivals were already identified, unlike the rest of the country which continued to record new cases transmitted by prior case arrivals.

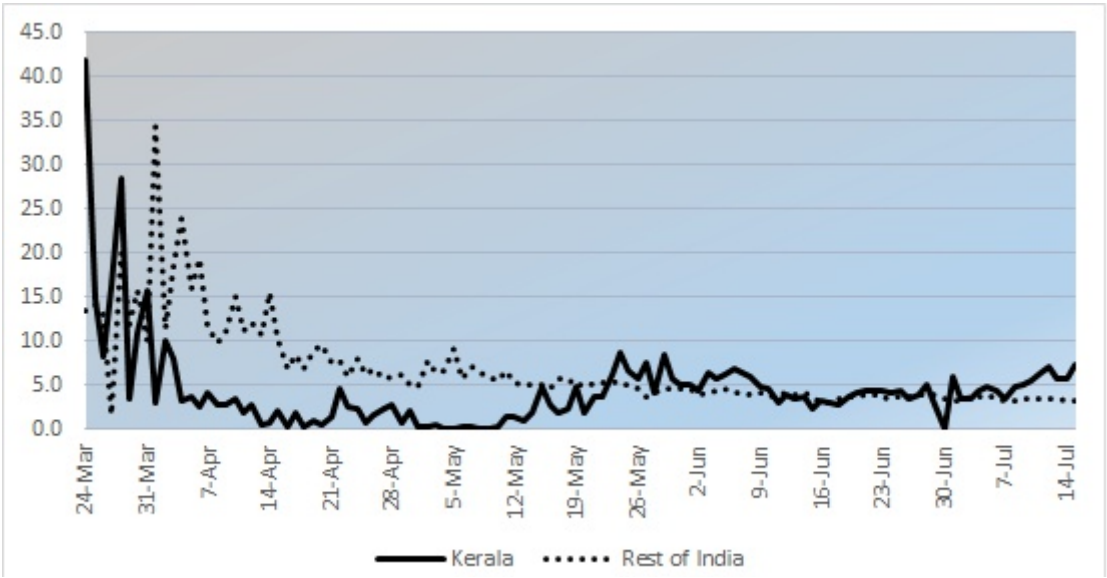
The Kerala daily growth rate ramped up in mid-May to equivalence with the national rate at around the 5% mark. The reason for this was the huge influx of returning non-resident Indians (NRIs) into Kerala, principally from the Gulf, starting with the first flight on 7 May under Phase I of the Vande Bharat Mission. Under Phase 1 which went until 17 May, 17 out of a total of 84 flights were destined for Kerala airports alone (Kochi, Kozhikode, Kannur and Trivandrum) carrying a total of nearly 4000 passengers. The pressure of passengers arriving from overseas got stepped up rapidly with Phase 2 running from 19 May to 23 June, with a total of 578 flights landing in Indian airports.[12] Aggregating across the five phases, there were a total of 3305 flights into India. For states like Kerala, these incoming flights marked an abrupt end starting 7 May to the domestic lockdowns, with a daily influx of passengers from some of the most afflicted countries in the world.

However, because of the initial advantage, the share of Kerala in total national cases remained low all through the period (chart 2).

If the rest of the country had followed the Kerala approach in the initial pre-lockdown months, when the virus entry points were confined to passengers arriving at international airports, and at least in January, to passengers arriving from China, the lockdown would (as it did in Kerala) have brought the growth rate down to near-zero, and post-lockdown, have grown again only with the fresh influx starting 7 May with the Vande Bharat flights, but from a lower base.

Since with free borders, no single state can keep its case growth rate appreciably below the national level, it is only the case fatality rate that can truly test the effectiveness of the Kerala model, which was not about case identification alone, but about arranging for referral and transportation to care centres for those identified.

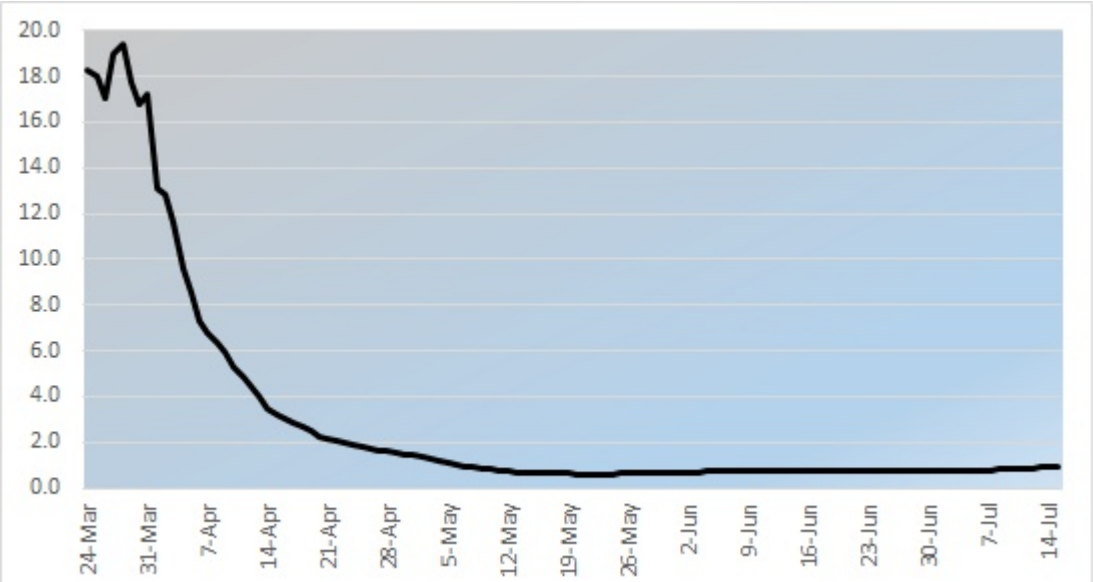
Chart 1: Daily % growth rate of corona cases 24 March to 15 July 2020



Source: Credit Suisse daily state-wise data series, assembled from daily data provided by Ministry of Health and Family https://www.mohfw.gov.in/

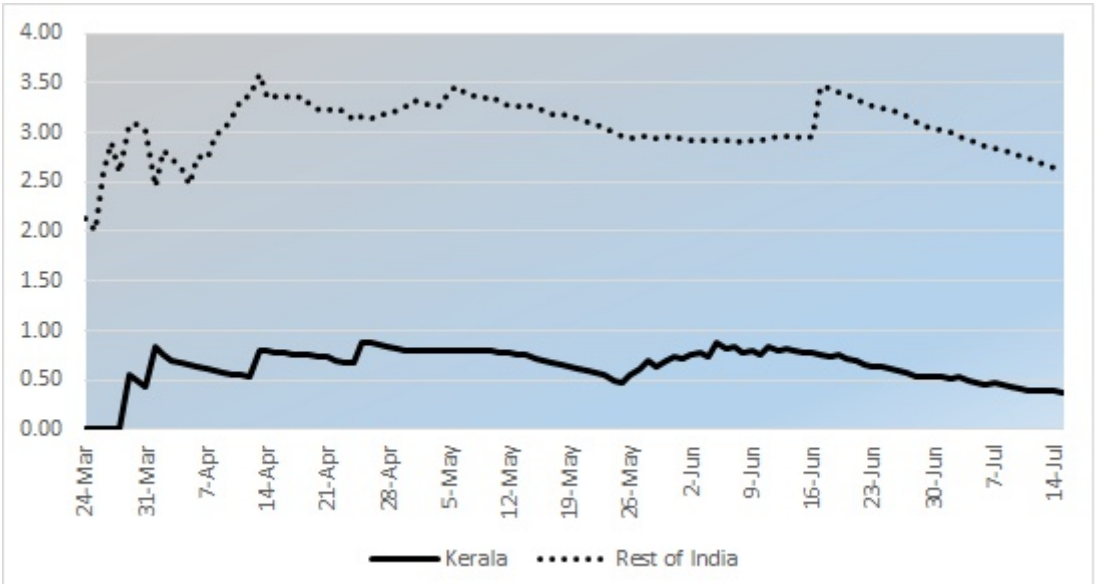
Notes: The national lockdown markers are (1:25 March to 14 April); (2: 14 April to 3 May); (3: 4-17 May); (4: 18-31 May). This was followed by three numbered unlock periods, covering the months of June, July and August respectively. The first influx of air passengers began during Lockdown 3 with the first Vande Bharat flight from UAE to Kerala on 7 May, and continued steadily thereafter (see text). The lagged impact in Kerala is visible from the middle of May, and was more pertinent than the end of the lockdowns on the case growth rates.

Chart 2: Kerala % share of national total cases 24 March to 15 July 2020



Source: See source to Chart 1.

Chart 3: Fatality rates as a % of concurrent cases 24 March to 15 July 2020



Source: See source to Chart 1.

Fatality rates as a percent of concurrent cases, are shown in chart 3. Deaths as a concurrent percent of cases when cases are growing in number will be lower than as a percent of cases at the point of diagnosis, but that bias affects both series shown in chart 3. The Kerala fatality rates are well below the 1% mark, the rest of India is at an average of 3%.

Conclusions

The response of Kerala to the initial entry of the covid pandemic in terms of immediate identification of those infected and arrangements for cure of the identified are shown in this paper, along with the outcomes in terms of case share and fatality rates relative to the rest of the country. The progress made by the state was set back starting mid-May from the opening up of airports to return migrants from the Gulf and other points of origin, which raised the case growth rate to equivalence with that in the rest of India.

Outbreaks of communicable diseases call for immediacy of response. There has to be an open portal for continuing communication across states whereby improved processes and responses can be adopted, along the lines of the yardstick model which is one of the proclaimed advantages of a federal structure of governance. Had that been in place, the pandemic could have been nipped in the bud when its entry points were limited to a few international airports.

The larger failure in health outcomes in India is embedded in structural problems with fund flows. The Centre's funding to states for health is transmitted across a huge trust divide, which has made the fund flow over time ever more segmented by end-use prescriptions. Since April 2014, further layers in the transfer structure have impeded fund flow and so have delayed fund transmission even more than previously.

Even if the present structure of Centre-state funding in the form of specific grants for health is retained, the process needs to be reformed along the following four lines:

- Merging components, so that the flexible pool for communicable diseases is truly flexible, and not segmented into separate components for specific diseases like tuberculosis. The total NHM flow should be divided into at most four components, with flexibility of use within each.

- The calendar for sanction orders at the Centre should be known in advance, and adhered to within a margin of +/- two working days.

- States should be required to streamline the administrative process for release of NHM funds (which after April 2014 flow to the state treasury in the first instance), such that the State Health Society, the agency charged with execution, receives funds no later than ten days after receipt at the state treasury. The time and attention of state government functionaries used up in shepherding the approval process for fund release from the state treasury is a deadweight loss that no state government can afford.

- The mandatory contribution of 40% by states is worked into the budgetary allocation, but not always fully released in practice. The low utilisation rates worked out on a denominator of allocations reflect this phenomenon in part. This can be rectified by requiring states to commit their contribution to the NHM budget in absolute terms rather than as a percent of the total, in amounts that they feel confident they can deliver.

In conclusion, it must be pointed out that the process failures which have crippled health outcomes in the country are not specific to any political formation or ideology. They are quite simply an outcome of the fact that processes underlying fund flow have not been paid the attention they deserve.

As the covid pandemic has shown, a failure on the health front is not only tragic in itself, but could defeat the larger economic ambitions of the country.

Notes

[1]These press releases from the Ministry of Health and Family Welfare (MOHFW) can be located by date on the website of the Press Information Bureau, www.pib.nic.in, PIB Delhi (English).

[2]https://dhs.kerala.gov.in/wp-content/uploads/2020/03/ncorona_26012020.pdf; accessed 14 July 2020.

[3]The IDSP is an insignificant component of the total flow, typically 0.2 to 0.3 % of total NHM funds.

[4]This was a consequence of the raising of the statutory unconditional share of states in the Centre's tax revenues from 32% to 42% starting with year FY 16, as recommended by the Fourteenth Finance Commission for the FY 16 to FY 20 quinquennium, further extended by the Fifteenth Finance Commission for years beyond.

[5]Choudhury, Mita and Ranjan Kumar Mohanty, 2019, "Utilisation, Fund Flows and Public

Financial Management under the National Health Mission" Economic and Political Weekly, LVI: 8 (23 February); 49-57.

[6]Nor even uniform across states.

[7]On account of the advancement of the date of presentation of the Central budget to two months before the start of the fiscal year starting with FY 19, these sanction delays might have become shorter. In the paper, for the six data points, the major component was sanctioned typically six months after the start of the fiscal year, towards end-September. The earliest for any component was end-June. Sanctions for other small components were dribbled out after September, and went into March, the last month of the fiscal year.

[8]The utilisation ratio of Central funds allocated for the "flexible pool for communicable disease" component, into which IDSP is folded, is not surprisingly a mere 55%, on average across all 29 states in the country.

[9]However there is a puzzle here. If that were the case, the quarterly pattern of expenditure should be evened out.That does not seem to be the case in the Choudhury-Mohanty study.

[10]Part of a general change across all Centrally Sponsored Schemes, which are co-funded with states.

[11]The committee was chaired by C. Rangarajan. The members were Nitin Desai, Ravinder Dholakia, M.G.Rao, and D.K.Srivastava.

[12]The source of data on Vande Bharat missions to fly home non-resident Indians from overseas locations is the website https://www.mea.gov.in/vande-bharat-mission-list-of-flights.htm, accessed on 12 August 2020. The flights were grouped into five phases, phase 1 (7-17 May, 84 flights); phase 2 (19 May – 23 June, 578 flights); phase 3 (23 June – 2 July, 553 flights); phase 4 (3 July – 1 August, 1082 flights); and phase 5 (1-30 August, 1008 flights).

Preferred citation for this contribution:
Rajaraman, I. (2020). Centre-state lessons from the Corona Virus pandemic *Indian Federalism Perspectives,*1(2) September.