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Utilization of Health Cess From Local Self-Governance to Support Community Health Initiatives in Rural Areas: An Explorative Study From Karnataka

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Abstract

Background: In India, the Panchayat Raj system is a local self-government system responsible for the economic, educational, and social development of villages. It represents weaker sections of society, including Scheduled Tribes, Scheduled Castes, Other Backward Classes, and Women. Karnataka is the first state in India to implement the Panchayat Raj Act and make Gram Panchayats (GPs) address local grassroots needs through decentralized governance. Under Section 4A of the Karnataka Health Cess Act, 1962, GPs collect 15% health cess to finance healthcare development.

Methodology: The Karnataka Health Promotion Trust (KHPT) and the Department of Rural Development and Panchayat Raj (RDPR), Government of Karnataka (GoK), collaborated to explore the collection and utilization of health cess across GPs for the financial period 2022-2023. This study adopts a purposive sampling approach.

Results: The study found that approximately 68 PDOs from an equal number of Gram Panchayats participated in the discussion across Karnataka, India. Twenty-one PDOs from the Mysuru Division participated in the study. All PDOs who participated in the study informed that their respective GPs collected land and built taxes from households annually. The study revealed that for the fiscal year 2022-

2023, 48.53% of the GPs collected health cess tax of less than ₹0.5lakh. Most respondents (60.29%) believed that health cess had been utilized. More than half of the PDOs (54.41%) mentioned that guidelines for utilizing health cess are available.

Discussion: The study recommends utilizing health cess in critical areas such as non-communicable disease management, maternal and child health, mental health awareness, and improving healthcare infrastructure. Health cess is a prime example of how fiscal policies can improve healthcare equality and accessibility by empowering GPs to lead community-based solutions and showcasing the transformative potential of localized governance in improving public health outcomes.

Keywords: Gram Panchayats, Health Cess, Community Health, Decentralized Governance, Healthcare access

Introduction

India is primarily a village land, and according to the Census of India (2011), around 69% of its total population resides in rural areas. India has a unique village-level governance system. The governance of such a small unit in India is called the Panchayati Raj Institutions (PRIs). Gram Panchayats (GPs) are local self-governing bodies and one of the important three-tier systems that play a crucial role in developing communities. The Karnataka state government has devolved the necessary executive powers and responsibilities to the GPs to enable them to operate as self-governing authorities. Aligned with the 11th schedule of the Indian Constitution, PRIs, with specific emphasis on GPs, are tasked with devising and executing schemes that connect local resources and grants to advance economic and social development programs, which include 29 functional items.[1] Karnataka pioneered the implementation of the Panchayat Raj Act in India, making it the first state to do so.[2]

It is no exaggeration to say that achieving Gandhi's idea of Gram Swaraj depends to a great extent on making Panchayats self-reliant and less dependent on higher tiers of government. To become self-reliant, the panchayats need to work to mobilize their funds as per the powers given to them by Article 243-H of the Indian Constitution, which authorizes the panchayats to levy, collect, and appropriate taxes, duties, tolls, and fees apart from receiving grant-in-aid from central and state government funds.[3] The Own Source Revenue (OSR) generation provides greater autonomy to the Panchayats and makes them self-reliant; thus, making the idea of gram-swaraj a reality remains crucial. GPs have more responsibilities and fewer financial resources.[4] Therefore, requiring them to mobilize their "own" revenues is important for efficiency and accountability. Thus, a critical factor necessary for strengthening Panchayats is enabling and empowering them to enhance their revenue. Improving own revenues strengthens the link between the revenue and expenditure decisions of rural local bodies at the margin, which is extremely important for promoting efficiency and accountability in providing services.

In the quest for advancement, GPs possess various resources, including health cess. 'Health Cess' refers to the funds collected by the GP to allocate resources toward developing and improving healthcare infrastructure and services and to spend on programs that directly benefit the village community under Section 4A of the Karnataka Health Cess Act 1962, which empowers GPs to levy and collect Health Cess of about 15 percent (Comptroller and Auditor General of India, 2018).[5] The collected funds can be used to upgrade existing healthcare centers, establish new clinics or hospitals, and provide essential medical equipment and medicines.

The purpose of collecting health cess is to address the healthcare needs of rural families. According to Article 21 of the Constitution of India, its establishment is rooted in recognition, which guarantees a fundamental right to life and personal liberty. The right to health is inherent in a life with dignity that should be accessible to every citizen. However, some challenges make this difficult to implement successfully. Healthcare delivery in rural areas faces many challenges, including lack of awareness, limited healthcare infrastructure, insufficient funding, and geographical barriers. Closely related, and an issue that drew attention, is inequality in healthcare and how it continues to manifest in marginalized communities. In such cases, people should not forget that settling these issues through health cess collection could lead to meeting health conditions for some community members. Additionally, a steady and predictable revenue stream provides governments and local authorities with a reason to fund and thus make healthcare available as a service.

Methodology

The Karnataka Health Promotion Trust (KHPT), a non-government organization that focuses on initiatives to improve the health and well-being of communities in India, conducted an explorative study in Karnataka in collaboration with the Department of Rural Development and Panchayat Raj (RDPR), Government of Karnataka (GoK). During the study, the researchers interacted with Panchayat Development Officers (PDOs) from across the state, who are responsible for the administrative duties of GPs, to understand the collection of tax and use of health cess by the GPs in their respective villages for the community or to support community health initiatives. The study adopted a purposive sampling approach in which participants were selected based on their characteristics, in-depth knowledge, and experience working with GPs. There are 5759 GPs across Karnataka state from 31 districts, and a minimum of two PDOs participated in the study from each district.

A structured questionnaire was developed with input from RDPR personnel and validated through pretesting with PDOs. The study questions covered key components such as demographic details, village information, financial data such as annual collection figures for land and building tax, the status of health cess collection, the amount of health cess collected during the preceding fiscal year, the utilization of the collected amount, and study participants' suggestions on using health cess for specific purposes.

Data were collected through a combination of in-person and telephonic interactions. Due to the non-availability of PDOs during data collection and limited time, data were collected via telephone. Responses were documented in the hardcopy and entered into a Google Sheet, and the data were subjected to cleaning and verification processes before being analyzed using Microsoft Excel.

During the study, no individual information was collected, and ethics approval was not obtained, but consent was obtained to ensure data confidentiality. In addition, necessary approvals were obtained from the RDPR department before interacting with the PDOs. The taluka-level field staff from KHPT collected data from PDOs. These staff members have experience working with the Gram Panchayat intervention program. The respective district staff of KHPT were responsible for monitoring and following up on the process, and all staff received training on a data collection tool.

Results

The key findings regarding the collection and utilization of health cess by Gram Panchayats are depicted in **Table 1**. 68 PDOs from an equal number of Gram Panchayats participated in the discussion across Karnataka, India. Twenty-one PDOs from the Mysuru Division participated in the study (30.88%),

followed by the Belagavi Division (25%) and the Bengaluru Division (25%). All PDOs who participated in the study informed that their respective GPs collected land and building taxes from households annually. Of the 68 GPs, 29.41% collected land and a building tax of ₹1-3 lakh, followed by 20.59% of GPs between ₹3-5 and 20.59% of GPs between ₹5-10 lakhs. The average and median amount of land and building taxes reported were ₹8.55 lakhs and ₹4.27 lakhs, respectively with a range of ₹0.13 lakhs-₹100 lakhs.

The study revealed that for the fiscal year 2022-2023, 48.53% of the GPs collected a health cess tax of less than ₹0.5 lakh, followed by 27.94% between 0.5-1 lakh. The average and median amount of health cess reported were ₹1.99 lakhs and ₹0.54 lakhs, respectively with a range of ₹0.09 lakhs-₹65.63 lakhs. The majority of the GPs (76.47%) did not pay part of the health cess collected to the health department after spending part of the health cess amount for various purposes. Most respondents (60.29%) believed that health cess had been utilized. More than half of the PDOs (54.41%) mentioned that guidelines for utilizing health cess are available.

Table 1: Distribution of the Grama Panchayats according to various characteristics

Characteristics	***N=68***	***%***
Division wise participants (PDOs)		
Belagavi Division	17	25.00
Bengaluru Division	17	25.00
Kalaburagi Division	13	19.12
Mysuru Division	21	30.88
Annual Income from land and building tax		
<1 lakh	4	5.88
1-3 lakh	20	29.41
3-5 lakh	14	20.59
5-10 lakh	14	20.59
10-15 lakh	5	7.35
15-20 lakh	3	4.41
>20 lakh	5	7.35
No Response	3	4.41
Health Cess (Tax) Collection		
<0.5 lakh	32	47.06
0.5-1 lakh	19	27.94
1-1.5 lakh	4	5.88
1.5-2 lakh	4	5.88
2-3 lakh	4	5.88
4-5 lakh	1	1.47
>5 lakh	3	4.41
No Response	1	1.47
GPs paid a health cess amount to the Health Department		
No	52	76.47
Yes	16	23.53
Health Cess spent		
Yes	41	60.29
No	20	29.41
To some extent	1	1.47
No Response	6	8.82

Guidelines for utilization of Health Cess		
No	12	17.65
Yes	37	54.41
Do Not Know/No Response	19	27.94

During the study, PDOs were also asked about the common reasons for using health cess and other potential uses of health cess funds. The most frequently cited reasons for using health cess funds are sanitation and the procurement of cleaning equipment, followed by health awareness programs such as pulse polio and the purchase of consumables for organizing health camps. In addition, some amount was utilized to resolve electricity problems in the villages and primary health centre repairs.

In addition, the study also gathered PDOs' opinions on possible purposes for which health cess can be utilized. According to PDOs, the collected health access can be used for various purposes, such as supporting Anganwadi facilities, catering to the medical needs of physically challenged individuals, enhancing sewerage systems, promoting Asha workers' initiatives, fostering healthcare awareness and fogging in villages, directing funds toward education, aiding pregnant women, offering free treatment to senior citizens, organizing health camps, providing nutritional support, facilitating transportation for the elderly, disabled, and pregnant women during non-communicable diseases (NCDs), allocating funds for polio and pandemic or emergency programs, procuring medicines for economically disadvantaged seniors, improving sanitation infrastructure, holding special village meetings, aiding the residents of particular villages, assisting distressed animals, augmenting GP staff, covering medical expenses for the unwell within the GP, deploying funds during pandemics, utilizing vehicle allowances for Asha workers transporting pregnant women, and commemorating.

Discussion and Recommendations

Gram Panchayats are local governance bodies that address community health needs using the Health Cess collected locally in their villages.[6] Karnataka, the first state in India to put the Panchayat Raj Act into action, has set up a strong system for decentralized governance. This allows GPs to gather and distribute resources like the Health Cess to develop local areas. In line with a prior study that highlighted the varied fiscal capacities of local governance bodies owing to differences in economic development and population density, these results appear like a breath of fresh air.[7] GPs are often restricted by constraints on their available revenue streams, which tend to limit their ability to implement large-scale interventions and inevitably spark a debate about how best these might be funded if implemented equitably. Limited resources of GPs frequently make it challenging to carry out extensive health interventions, highlighting the need for approaches to boost income creation and equitable distribution. Most GPs used the collected health cess for primary health centre renovations, health awareness campaigns, cleaning supplies, and sanitation. A study showed similar results, identifying health awareness and sanitation initiatives as the main areas of spending in decentralized health finance schemes.[8]

The current study identified some challenges that prevent the efficient use of health cess, such as limited infrastructure, lack of awareness among PDOs or GP members, and socioeconomic inequities. According to a study in 2021, GPs in socio-economically disadvantaged regions face difficulties mobilizing and using financial resources because of insufficient capacity-building initiatives and limited technical expertise.[9] Although PDOs reported having access to guidelines or circulars for using health cess, some were unaware

of them, highlighting the need for enhanced training and information dissemination. According to an earlier study, enhancing resource usage and fostering accountability require capacity-building initiatives specific to the requirements of local government bodies.[10]

To address these challenges, this study proposes that leveraging health cess could be allocated to prevent and manage communicable diseases and organize activities for screening non-communicable diseases (NCD). These include conducting awareness campaigns, providing Information Education and Communication (IEC) materials, organizing health camps, providing necessary devices and supplies, purchasing screening supplies such as batteries, lancets, cotton swabs, screening strips, forms, and templates for data collection at the health camp, raising awareness of maternal deaths, child deaths, and infant mortality rates, and taking action to reduce these issues to national averages or below. Implement activities for HIV/AIDS prevention and provide support to infected individuals. Implement government-declared initiatives, such as TB Mukt Grama Panchayats and Anemia Mukt Grama Panchayats. Conduct cancer screening camps, provide financial aid to disadvantaged patients, and support children's education. Increase mental health awareness, identify needy individuals through house-to-house surveys, and provide counselling and support services. According to Section 58 (1A) (I,) (II) of the Karnataka Grama Swaraj and Panchayat Raj Act of 1993, funds can be used to build and maintain public toilets, implement the universal immunization program, and Section 58(6) III describes the residents ' health, safety, education, and medical needs.[6,11]

However, some vulnerable districts collect very little tax, as they are socio-economically backward and drought-affected. To address the challenges faced by these vulnerable districts and Gram Panchayats, firstly, a comprehensive approach that integrates both short-term and long-term strategies is required, including engaging with local communities and involving them in decision-making processes, such as conducting regular community meetings and consultations to gather input and feedback, which could help identify local challenges and tailor strategies accordingly. Second, involving community members in the implementation of development projects can ensure ownership and commitment. Third, access to Basic Services such as healthcare, education, and water is crucial for improving the socioeconomic conditions of these districts. Investing in health care clinics and schools and improving water and sanitation facilities could help improve residents' quality of life and attract private investment. Fourth, investment in infrastructure development includes building and improving roads, bridges, and other essential infrastructure to facilitate commerce and trade. Building schools, hospitals, and other social amenities can also improve socioeconomic conditions, encouraging individuals and businesses to settle in these districts. Finally, tax incentives or exemptions should be offered to encourage investment and business growth in these districts.

Additionally, it provides capacity-building support to local government agencies for efficient tax collection and the utilization of funds for development projects. According to the study, capacity-building programs, public-private partnerships, and tax policy reforms can increase their Own Source Revenue.[12] Implementing such strategies can allow GPs to conduct more comprehensive community health programs and help bridge financial inequities.

The article highlights the need for policymakers to improve fiscal decentralization in socioeconomically backward areas by giving more power to the Gram Panchayats (GPs) to earn and control their revenue resources. It draws attention to revising tax policies to strengthen financial independence and form standard operating procedures for utilization of health cess funds in an efficient and transparent manner to reduce underutilization and mismanagement. The findings also call for targeted healthcare interventions

in specific sectors such as maternal and child health, non-communicable diseases (NCDs), and sanitation, along with adapting them to district and state health priorities in accordance with the type of diseases that dominate rural healthcare delivery.

Based on the findings, the study highlights the necessity for focused capacity-building initiatives to further bridge gap and dispense knowledge among PDOs while engaging with local stakeholders on issues like resource mobilization, expenditure, and respective developmental agendas. It also demonstrates the value of data-driven planning by challenging program managers to leverage demographic and financial data insights to develop evidence-based, community-specific health initiatives. Public-private partnerships (PPPs) are another important consideration to engage private sector knowledge and investment to improve rural healthcare development.

Donors and funders can focus on targeted investment in high-impact capacity-building and infrastructure provision in the health sector for under-resourced Gram Panchayats (GPs), specifically in areas of low tax collection or socioeconomic disadvantage. The study also suggests the possibility of unique mechanisms of health financing geared toward incentives for GPs on various healthcare performance parameters to enhance outcomes.

Grassroots-level participation can be stimulated by targeting community organizations and advocacy groups in attaining communities' healthcare needs to prioritizing spending on it. They can also be used to strengthen the health awareness centre, wherein existing health cess funds can be utilized to curb unsafe sanitary conditions as well as organize health campaigns which would include primarily the health conditions of rural communities.

Conclusion

The Panchayat Raj Institutions are vital mechanisms through which the government exercises its authority and functions. The utilization of health cess among Gram Panchayats in Karnataka is a testament to the power of localized decision-making in healthcare or for specific purposes, such as improving maternal and child health, preventing and managing communicable and non-communicable diseases, increasing public knowledge of important health issues, and carrying out government-promoted programs. These focused initiatives, which include mental health assistance, health camps, awareness campaigns, and improvements to infrastructure, can significantly improve community health outcomes and quality of life. Gram Panchayats could make development sustainable and equitable by involving local communities in decision-making processes, encouraging ownership of development projects, and providing tax incentives to attract private investments.

In conclusion, streamlined collection and effective utilization of health cess, coupled with capacity-building measures for local governance bodies, can go a long way toward bridging the healthcare divide, promoting health equity, and fostering a healthier and more resilient rural population. This comprehensive approach strengthens Gram Panchayats as an important focal point for rural health and socioeconomic development. GPs can improve public health outcomes, maximize resource use, and support the larger goals of equitable and sustainable rural development.

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