TAKSHASHILA INSTITUTION

Takshashila Working Paper

The Regressive Nature of Central Transfers for Health

Takshashila Working Paper 2018-03

December 2018

By Pranay Kotasthane | Devika Kher | Pavan Srinath | Aashish Chajjer

Advisor: Dr. M Govinda Rao, Member, Fourteenth Finance Commission, and former Director, National Institute of Public Finance and Policy.

This paper can be cited as "Kotasthane, et al, "*The Regressive Nature of Central Transfers for Health*, Takshashila Working Paper, 2018-03."

Abstract

Financing public health in India is a vital challenge. As a response, the Union government transfers funds to the lower tiers of government, specifically meant to improve the public health services. The stated goal of specific transfers is to ensure that at least certain minimum standards of healthcare are achieved all across the country. However, our analysis of this category of funds in the period 2005 to 2015 highlights several problems that make this goal difficult to achieve.

First, the transfers are poorly targeted, as these are not linked to health indicators. Instead, such transfers by and large tend to be incremental. Second, the specific purpose transfer system has not been very helpful in offsetting the fiscal disabilities of the poorer states. Third, there is evidence to suggest that States substitute grants received from the Union government for their own spending with the result that there has not been a commensurate increase in overall spending on healthcare.

Introduction

In a country with a predominant proportion of working age population, reaping demographic dividends critically depends on human development and health policy is an essential determinant of this. Given the high degree of externality and asymmetric information in healthcare provision, the State has a significant role to play. Unfortunately, available evidence shows that in India, the public spending on healthcare is low and out-of-pocket spending is more than four times the government spending (NHA Estimates 2013-14).

Not only is the public expenditure on health in India abysmally low, but it is also unevenly distributed. The Constitution has assigned "public health and sanitation, hospitals, and dispensaries" in the States' domain (Seventh Schedule, The Indian Constitution). But the high degree of vertical imbalance and competing claims from other functions makes it difficult for States to make adequate resource allocations to providing healthcare. Their revenue raising capacity is inadequate to meet expenditure requirements on the functions assigned in the Constitution and they have to depend on central transfers (Rao, 2017).

Wide inter-state differences in revenue capacities make the problem even more serious. Among the large States, the State with lowest per capita GSDP (Bihar) has one-fifth per capita GSDP as compared to the State with the highest per capita GSDP (Haryana). With such large differences in per capita taxable capacity, the low-income States are unable to provide even basic healthcare services to their populations. The proportion of young population in these States is large and the proportion of working age population will continue to increase even as the working age population in more affluent States starts declining.

Hence, reaping demographic dividend will critically depend on providing education and healthcare to the young population. In a world where there are no hindrances to mobility, people could walk on their feet to States where opportunities are more, and public service provision is better. However, low education levels, lack of information, and wide diversities including linguistic diversities, restrict population mobility. Therefore, reaping demographic dividend in the country depends on ensuring that the States with fiscal disabilities are given adequate resources to provide minimum standards of social services such as education and healthcare. At the same time, giving them transfers could soften their budget constraints by weakening the link between revenue and expenditure

decisions (Rao, 2010). Therefore, a careful approach to designing and implementing intergovernmental transfers is necessary.

In order to ensure minimum standards of healthcare across the country, the Union government has to intervene through intergovernmental transfers. The transfers could be unconditional or purpose specific. Unconditional transfers are given to enable the States to provide comparable levels of public services at comparable tax rates by offsetting their revenue and cost disabilities (Report of the Fourteenth Finance Commission, 2014). However, given the huge horizontal imbalances between States, it becomes virtually impossible to offset the revenue and cost disabilities completely. While these transfers offset the disabilities to the extent politically feasible, the role of specific purpose transfers assumes significance. The objective of such transfers is to ensure minimum standards of public services which are considered meritorious and have significant externalities. Specific purpose transfers to elementary education and basic healthcare are therefore extremely important to augment human development in disadvantaged States, ensure a balanced development, and reap demographic dividends in the country.

The Constitution recognises the fact that revenue powers and expenditure responsibilities to the State assigned in the Seventh Schedule would result in both vertical and horizontal imbalances (Rao and Singh, 2000). To resolve this, it has provided for the appointment of the Finance Commission every five years to make recommendations on the devolution of taxes and for providing grants in aid to the States. In addition, the central ministries have been introducing various schemes for specified purposes for which grants are given where the States are required to make matching contributions. There were as many as 176 such schemes, which were consolidated into 66 by 2013. In the aftermath of the recommendations of the 14th Finance Commission, the schemes were further rationalised and consolidated into 28 (Rao, 2017). For the health sector, the specific purpose transfer is given under the Centrally Sponsored Scheme called the National Health Mission.

The National Health Mission (NHM) was started as a National Rural Health Mission, a Centrally Sponsored Scheme in 2005. The scheme has expanded over the years and it has now come to constitute an important element of health expenditure in Indian States. In fact, almost two-thirds of central spending on health sector is under this scheme. Considering the importance of the health sector, the NHM has been a focus of discussions on health sector policies of the

country. Apart from NHM, specific purpose transfers are given also for some smaller schemes such as National Rural Drinking Water Programme (NRDWP) and National Nutrition Mission (NNP).

In this paper, we analyse the effectiveness of these specific purpose transfers meant for improving public health services across the country. In the second section, we describe the data and methodology used in the study. The third section analyses the design of specific purpose transfers in terms of equalising expenditures in fiscally disadvantaged States. The section also undertakes an econometric analysis to examine whether the specific purpose transfer for health has led to additional spending on the health sector or has merely led to substitution of spending from own resources by the States. Section four summarises the major findings of the study.

Methodology and sources

We have constructed a comprehensive and comparable dataset of public health expenditure in India from 2005 to 2015 for this study. This dataset is important because existing research on public health in India that relies on data provided in budget documents, suffers from major shortcomings listed below.

First is the issue of direct transfers to implementing agencies, bypassing the State budget. Prior to 2004-05 the grants for various Central schemes were given to the States and formed a part of the States' consolidated funds. With substantial increase in central grants for NRHM and other central schemes and scaling up of donor funded projects, several agencies and autonomous implementing agencies got set up at the State level for implementing programmes. In order to reduce delays in the transfer of funds at the level of implementation the Union government started giving grants to these agencies directly bypassing the State treasury route (Rao and Choudhury, 2012). The States were, however required to include their matching portions in their budgets as these are shared cost programmes. However, based on the recommendation of the High Level Expert Committee on Efficient Management of Public Expenditures, the practice was changed and the grants for the central schemes were routed though the States from 2014-15 budget (Planning Commission, 2011). This change in accounting practice means that studies relying on State budget documents alone do not provide the correct picture of health care expenditure in India.

Second, substantial volume of health expenditures is incurred by agencies other than the Ministry of Health and Family Welfare (MoHFW) at the Union level health departments at State levels. For example, public expenditure on drinking water, sanitation, and nutrition occurs outside the Ministry of Health. Moreover, Ministry of Defence and Ministry of Railways also finance and run institutions that deal with healthcare. Thus, relying on budget major heads for public health (2210) and family welfare (2211) alone does not give a holistic picture of public health expenditure.

Third, there is a fiscal decentralisation challenge. Some of the States such as Kerala and Karnataka, in keeping with the spirit of the 73rd and 74th amendment of the Constitution, have substantially devolved the implementation functions in regard to some of the developmental activities, including healthcare, to the urban and rural local governments. Since expenditure through this route is not shown under the relevant budget head but is clubbed under "Compensation and Assignment to Local Bodies", the data from State budgets do not accurately reflect spending on healthcare. In order to get accurate information, it is necessary to get access to the details of the transfers from the State governments to local governments.

The three issues listed above vitiate comparability of public health expenditures spatially (between States) and inter-temporally (between years). In the dataset we have constructed, we have tried to address these comparability issues by adding the central grants given directly to implementing agencies in different States and compiling and adding the local level data in Karnataka and Kerala, the two States with significant devolution of funds from the State governments to the local level. Thus, the analysis is based on more comprehensive and comparable data set.

The various sources of data used are given in Table 1 below.

Table 1. Data Sources for the figures used in this study

#	Item	Data Source	Details
1.1	**Union Government Expenditure**		
1.1.1	2210 - Medical and Public Health	Finance Accounts, CAG, Government of India	Obtained from statement No. 9, Detailed Account of Revenue Expenditure by Minor Heads and Capital Expenditure by Major Heads
1.1.2	2211 - Family Welfare		
1.1.3	2215 - Water Supply and Sanitation		
1.1.4	2236 - Nutrition		
1.1.5	4210 - Capital Outlay on Medical and Public Health		
1.1.6	4211 - Capital Outlay on Family Welfare		
1.1.7	4215 - Capital Outlay on Water Supply and Sanitation		
1.1.8	4236 - Capital Outlay on Nutrition		
1.2	**Combined Budgetary Expenditure of State Governments (Including 3601 Grants)**		
1.2.1	Health & Family Welfare	State Finance Accounts, CAG	Budget heads 2210 to 6236 were collected for each state, and then state totals were calculated in the Raw Dataset, and then summed up for all states. Data excludes all Union Territories
1.2.2	Water Supply and Sanitation		
1.2.3	Nutrition		
1.3	**Direct Transfers of Central Plan to Autonomous Agencies**		
1.3.1	2210 - Medical and Public Health	Expenditure Budget Volume I, Union Budget	
1.3.2	2211 - Family Welfare		
1.3.3	2215 - Water Supply and Sanitation		
1.3.4	2236 - Nutrition		
1.4	**Grants-in-aid to states under state/Central Plan**		
1.4.1	Medical and Public Health	Expenditure Budget Volume II, Government of India	Collated from departmental 'Demand for Grants' in Expenditure Budget Volume II
1.4.2	Family Welfare		
1.4.3	Water Supply and Sanitation		
1.4.4	Nutrition		
1.5	**Infant Mortality Rate (per 1000 live births)**	NFHS 3 and 4	NFHS 3 provides data from 2005-06, coinciding with the start year of the study period. NFHS 4 provides data from 2015-16.

According to our framework of functional classification of health expenditure, we define our public health expenditure categories as follows:

Expenditure on "Health" includes revenue and capital expenditures on the budget major heads "Medical and Public Health" and "Family Welfare".

Expenditure on "Health and Allied Fields" includes all expenditures listed in (1) in addition to revenue and capital expenditures on the budget major heads "Water Supply and Sanitation" and "Nutrition".

Based on this dataset constructed from government sources, we investigate the impact of central transfers in the next section.

Results and Discussion

3.1 Equalisation impact of Central Health Transfers

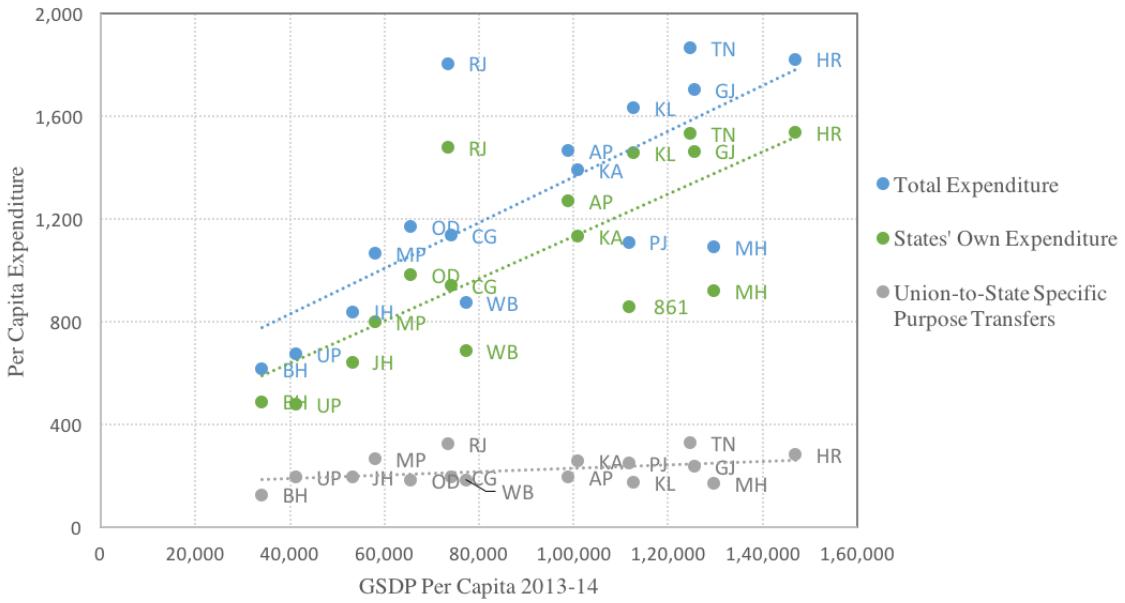
As noted above, the Union government transfers must ideally ensure that a basic standard of health is met across all States. In fiscal terms, this means that central transfers should be inversely proportional to the revenue raising capacity of the States. However, our analysis shows that specific purpose transfers on health and allied fields (including expenditure on nutrition and drinking water supply) appear to have little relation to a State's level of income.

Figure 1 is a snapshot of a sample year in our study period, for which the governmental components of expenditure on health and allied fields have been broken down. Both total per capita public expenditure, and per capita State's own expenditure vary positively with increases in per capita GSDP. But, per capita transfers on health and allied fields appears to stay the same across income. This clearly indicates the inability of Union government towards improving the health conditions in States that need external help.

As the Figure 1 shows, even the poorest States have own expenditures on health and allied fields being three to four times as much as the transfers they receive. In order to ensure minimum levels of services, it might be necessary to redistribute the transfers more heavily in the favour of poorer States – to the extent that the transfers to poorer States doubles or triples. This will remain a

difficult bargain in a federal system like India's where each State is a self-governing unit.

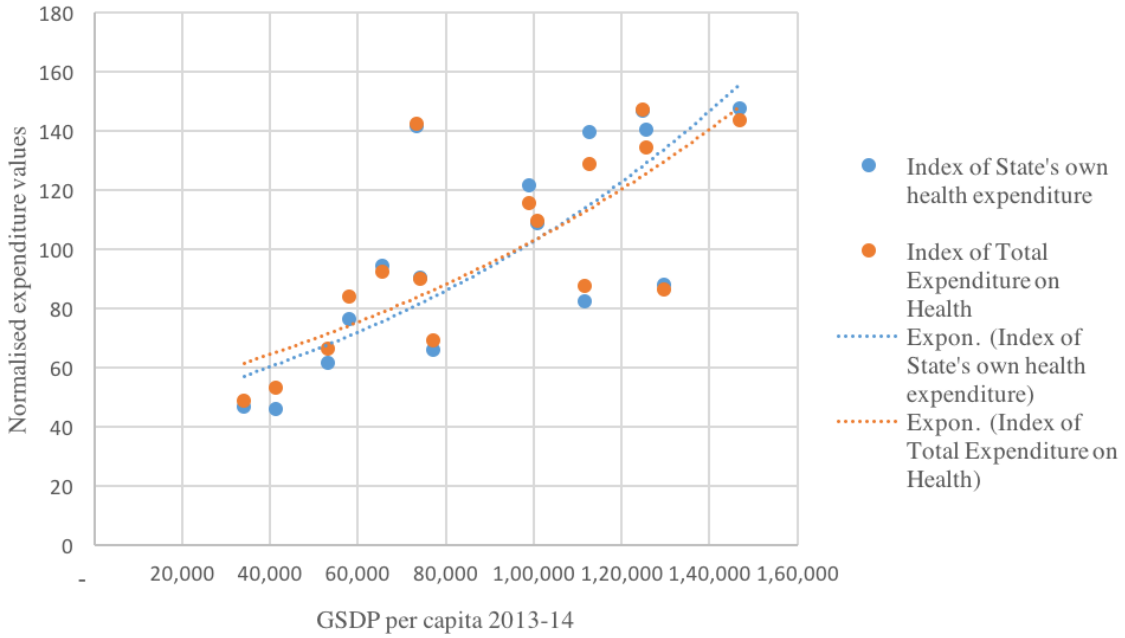
Figure 1. Per Capita Public Expenditure on Health and Allied Fields at the state Level for 2013-14



To analyse the extent of equalisation achieved through central transfers, we constructed an index that juxtaposes State government's own expenditures on health with total expenditures on health. The total expenditure on health also includes transfers given to the State government and direct transfers to State implementing agencies (Figure 2).

The index of States' own health expenditure (with all-state average specified at 100) increases steeply with per capita incomes. The index of total health expenditures (including transfers) too shows a steep slope with per capita incomes, but is only slightly flatter than the former reflecting the extent of equalization. Thus, it is seen that (i) The Central transfers on health are not equalising at all, and (ii) Even after the fiscal transfers are considered, per capita health expenditures are positively correlated with per capita incomes of the States. The lack of revenue resources in low income States enable them to incur much lower levels of spending than their richer counterparts. This has a direct impact on the health standards in low income States and exposes a large population susceptible to larger number of health issues.

Figure 2: Assessing the progressivity of Central Transfers on Health



The analysis shows that the equalising impact of specific transfers in health is extremely low. Public expenditures are higher in more developed States and this trend is offset only very slightly after taking into account specific transfers on health. Such a distribution leads to increasing inequalities in infrastructure levels and human development causing divergence of incomes across Indian States. These figures confirm the fact that the specific transfer system has not been very helpful in offsetting the fiscal disabilities of the poorer States and significant inequalities in the standards of public services continue to persist. To further examine the impact of specific transfers, in the next section we explore the impact of central transfers on health outcomes at the State level.

3.2 Targeting of Central Transfers to Deficient States

To study the impact of transfers on health across States, we have used Infant Mortality Rate (IMR)[1] as an indicator of health status. The IMR data is collected as part of the National Family Health Survey[2] (NFHS), a large-scale, multi-round survey conducted in a representative sample of households throughout India.

NFHS data is not collected on a yearly basis. The last two surveys were conducted in 2015-16 (hereafter referred to as NFHS-4) and 2005-06 (here after referred to as NFHS-3). These two surveys are largely coterminous with our study period. Thus, NFHS-3 data helps in taking stock of the state of public expenditures and

health outcomes at the start of the study period. By comparing the change in public health expenditures over the next decade with changes in health outcomes between NFHS-3 and NFHS-4 helps in establishing the impact of public health expenditures on changing health outcomes.

Figure 3. Per capita expenditure on Health and Allied Fields according to Infant Mortality Rate (2005-06)

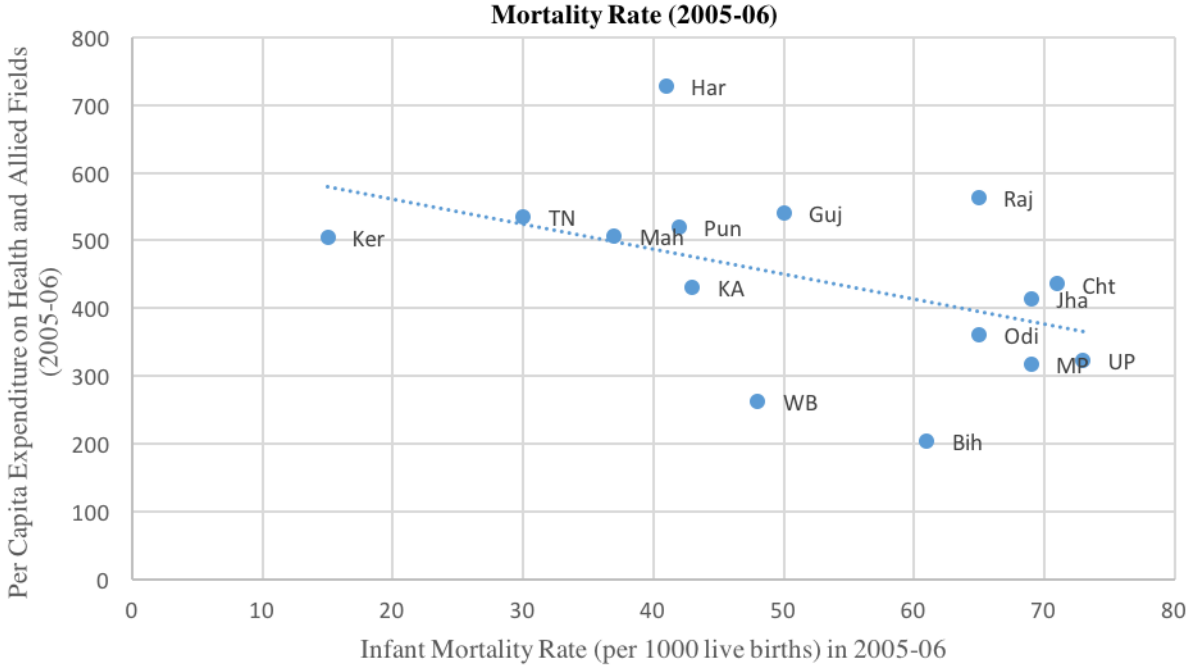
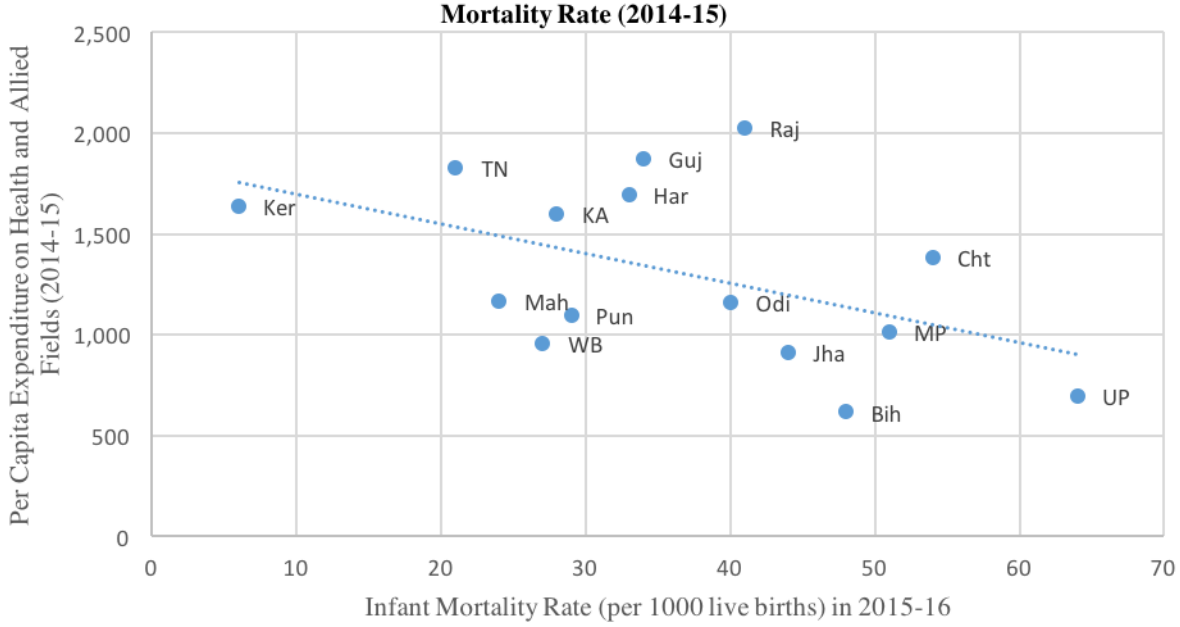


Figure 3 shows the relationship between overall public health expenditures and IMR. The downward sloping trend line that indicates that the States having lower IMR also appear to be those that spend more, as of 2005-06. The poorer States were unable to reduce the IMR due to their fiscal constraints and therefore, needed fiscal support from the Union government.

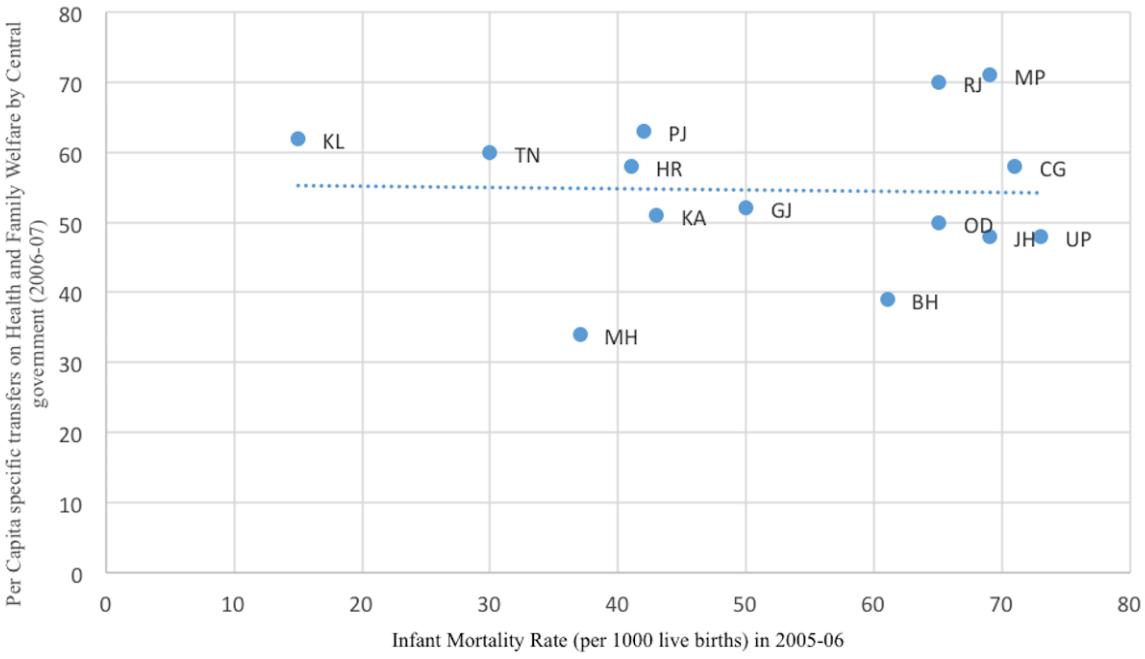
In order to ascertain the change in health outcomes over the decade, we repeated the same plot with the NFHS-4 data and overall public health expenditure in the year 2014-15[3]. The result shows that, even though the public health expenditure and the IMR number both show improvement, the States that spend more on health expenditure continue to have lower IMR (Figure 4). This indicates that specific transfers made by the Union government have been unable to ensure minimum standards of IMR across the country.

Figure 4. Per capita expenditure on Health and Allied Fields according to Infant Mortality Rate (2014-15)



To further understand the impact of the specific transfer by the Union government on changing health outcomes, Figure 5 places State wise IMR data against per capita central transfers on health[4] at the start of the study period i.e. 2006-07. Figure 6 repeats the same plot albeit with IMR numbers from NFHS-4 and central transfers in the year 2014-15[5].

Figure 5. Per capita specific transfers on Health and Family Welfare (2006-07) according to Infant Mortality Rate (2005-06)

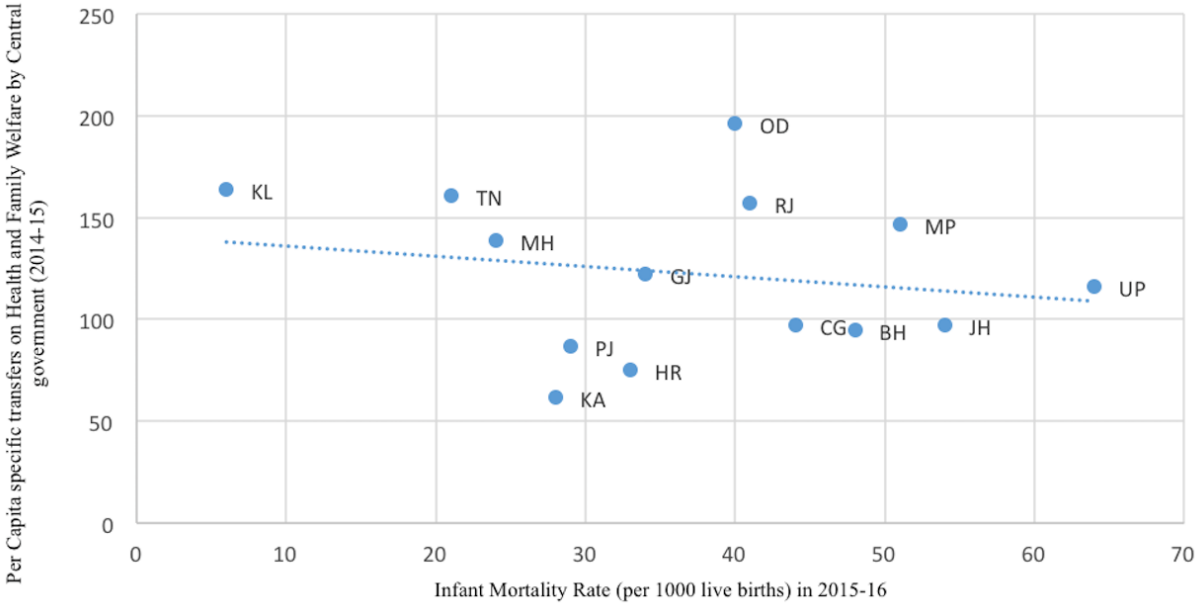


Two findings result from these figures. One, States that already had a head-start in terms of better IMR figures in 2005-06 received more per capita specific transfers on health in the next year (2006-07). Ideally, Centrally Sponsored Schemes such as NHM (earlier NRHM) that began around the same time should have addressed the wide disparity between States through progressive transfers. However, it is apparent that the specific transfers have been designed in such a way that they haven't been able to address the problem.

Two, by 2015-16, the specific transfers had become even more regressive (higher negative correlation). Even though both IMR numbers and specific health transfers have shown improvement, the inequity has increased. States that do better on IMR were still the ones that were receiving more specific transfers in per capita terms. In contrast, the States that continued to fare badly were receiving much lesser specific transfers in per capita terms.

Evidently, the specific transfers are not equalising. Rather, they are regressive in nature.

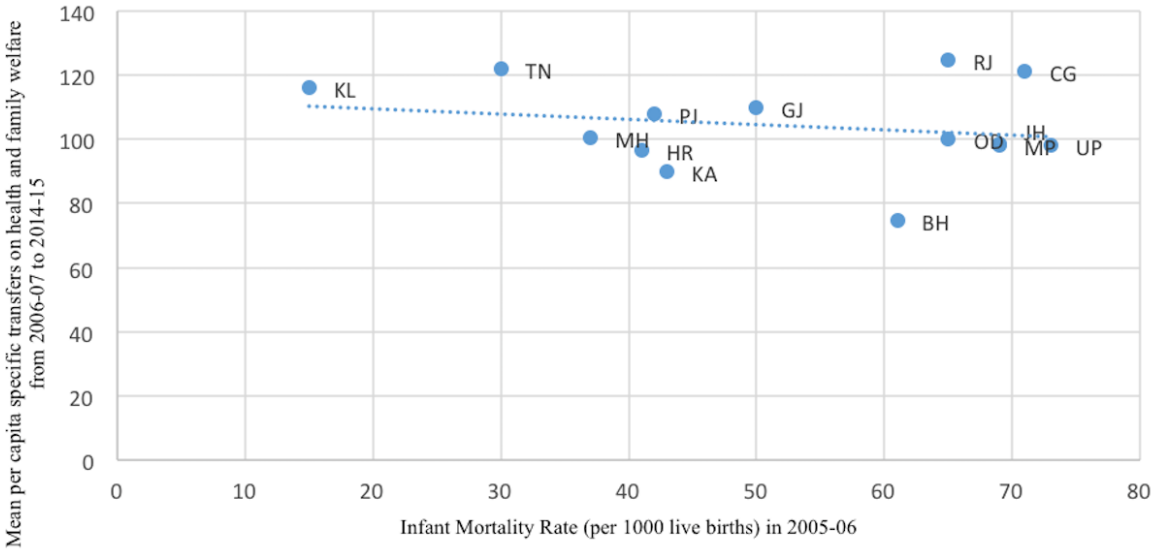
Figure 6. Per capita specific transfers on Health and Family Welfare (2014-15) according to Infant Mortality Rate (2015-16)



Specific transfers by the Union government often spill over into the succeeding financial years. In order to eliminate the effects of such spillovers, a more direct intertemporal comparison is done in Figure 7. Here, the mean of the specific

transfers on health and family welfare for the entire study period between 2006-07 and 2014-15 is plotted against the IMR data in NFHS-3.

Figure 7. Mean per capita specific transfers from 2006-07 to 2014-15 according to IMR (2005-06)



The result is the same. Throughout the study period, States with better health outcomes received more specific transfers per capita. These transfers were not equalising. States that were performing poorly on IMR needed a lot more fiscal support from the Union government in order to ensure that minimum standards of public health are met across the country. Even though the Union government started Centrally Sponsored Schemes such as NHM with this purpose, the negative relation between IMR and specific purpose transfers is a clear indicator that the States with low IMR receive the least focus from the Union government.

A reason for this regressive nature of specific transfers is because the grants for Centrally Sponsored Schemes are not determined on the basis of the deficiencies in the prescribed standard of services. State allocations are instead based on incremental plans prepared by the respective State governments (Rao, 2017). This inability to link the transfers with service levels makes it difficult to judge them based on achieving minimum standards. The focus then becomes spending money rather than ensuring that at least a minimum level of health services is achieved throughout the country.

Another reason might be the uniform matching ratio for specific transfers across States. Figures 5, 6, and 7 clearly show that Kerala, which is the best State in terms of health outcomes measured by IMR, avails the largest per capita grants from the

Union government while UP which has the worst IMR numbers avails the least per capita grants. This is partly because under the current transfer system, the matching contributions required from both Kerala and UP are same. While Kerala as a richer State has the fiscal space to fulfil matching requirements, a State like Uttar Pradesh does not fulfil these requirements, in turn availing smaller grants in per capita terms. Thus, it has been proposed that introduction of varying matching ratios depending on the shortfall in services levels could improve the design of the grant system.

There is an urgent need to rethink the specific transfer mechanism: specifically, the factors that are used to decide horizontal distribution of specific transfers. The Union transfers need to be redirected keeping in mind the inequalities in revenue earning capacity of States such that poorer States are provided enough fiscal support to cater to the basic health needs of their residents. In order to attain universal access of basic, affordable healthcare Union government has to examine the role it is playing in creating that fiscal space for public expenditure on health. So, the next section looks at the effect of specific purpose transfers on State government's own expenditures.

3.3 Stimulation versus Substitution Effects

Does a unit increase in specific purpose transfers by the Union government on health lead to an increase in States' own expenditure on health (stimulation) or does it reduce State's own expenditure in these areas (substitution)? To investigate this relationship, we apply the econometric analysis conducted by Rao and Choudhury (2012). They examined health expenditures to 14 major States in India from the period 1991 to 2007, investigating the relationship between States' own expenditures on health, transfers from the Union government, overall revenues of the State's, and the States' priority for health. In order to test substitution or stimulation effect, we have recreated this econometric analysis.

Details of the econometric analysis methodology used are as follows:

In India, given that the States have a predominant role in the provision of health care, the possibility of additional fiscal space at the state level can be due to:

Increase in own revenues of the states;

Increase in general-purpose transfers from the Finance and Planning Commissions, which includes shared taxes, and plan and non-plan grants;

Increase in specific-purpose transfers for the health sector; and

Changes in prioritisation in favour of the health sector.

In India, foreign aid is not an important factor in determining the fiscal space nor are earmarked taxes important.[6]

A two-way fixed effects panel data model can be used to estimate the effects of health transfers from the Union government, as well as the other factors that influence health expenditure at the State level. The change in States' own per capita expenditures on health (PC_OHE) can be taken as the dependent variable. The independent variables are changes in per capita specific purpose transfers on health (PC_CGH), per capita state's own revenues (PC_SOR), per capita general purpose transfers received by the state (PC_GPGC), and States' priority on health spending in overall budgetary and extra-budgetary expenditures at the State level (SPH). Thus, the equation used is:

$$\Delta (PC\_OHE)_{it} = \alpha + \beta \Delta (PC\_CGH)_{it} + \gamma \Delta (PC\_SOR)_{it} + \psi \Delta (SPH)_{it} + \tau \Delta (PC\_GPGC)_{it} + \upsilon (state\ Dummies) + \sigma (Year\ Dummies) + \varepsilon_{it}$$

Where,

$\Delta (PC\_OHE)_{it} = \{(PC\_OHE)_{it} - (PC\_OHE)_{it-1}\}$ or changes in per capita own health expenditure (from the previous year) of state *i* in year *t*;

$\Delta (PC\_CGH)_{it} = \{(PC\_CGH)_{it} - (PC\_CGH)_{it-1}\}$ or changes in per capita central

Government's grant (from the previous year) for health to state *i* in year *t*;

$\Delta (PC\_SOR)_{it} = \{(PC\_SOR)_{it} - (PC\_SOR)_{it-1}\}$ or changes in per capita own revenues

(from the previous year) of state *i* in year *t*;

$\Delta (SPH)_{it} = \{(G_{hi} / G_{bi})_t - (G_{hi} / G_{bi})_{t-1}\}$ or changes in the ratio of public expenditure on

health to total budget expenditure of the i^{th} state in the year *t* over the previous year; and

Δ (PC_GPGC) $_{it}$ = changes in per capita general purpose grant by the central government

to state *i* in year *t* = (tax devolution + plan and non-plan grants).[7]

Based on this construction, Rao and Choudhury had concluded that for the entire period 1991-2007, and for sub-periods 1991-2000 and 2001-2007 – increases in health grants by the Union government had a significant substitution effect on States' own expenditures on health. For our study, the analysis conducted by Rao and Choudhury is repeated for a more recent period to investigate whether the same substitution effect has continued.

The panel data analysis was conducted for the years 2012-2015 on health expenditures excluding water supply, sanitation and nutrition. The equations have been estimated for a balanced data series.

The analysis was conducted for major states, of which only 11 states were used: Chhattisgarh, Gujarat, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, and Uttar Pradesh. All these are general category states, whose data are generally more robust, and the pattern of expenditure from general category states is more internally comparable than that of all states.

Of the general category states, Goa was dropped from the analysis because of its small state size. Andhra Pradesh, Bihar, Haryana, Punjab, and West Bengal are not included in the study because of several data gaps.

Data from the year 2011 was also removed for the analysis because of incompleteness. In cases where there were a few missing values, the values for the previous or succeeding years has been used to estimate the equation. The data for general purpose grants has been sourced from annual reports of the Reserve Bank of India on state finances.[8]

All other data used has been collected or generated based on the analysis conducted in the study, described in the methodology section.

Table 2. Regression Results – Dependent Variable: Changes in states' Own Expenditure on Health, from a two-way fixed effects panel data model

#	Independent Variable	Coefficient of Variation (and Standard Error)			
		Rao and Choudhury (2012)			New Analysis
		1991-2007 (Model I)	**1991-2000 (Model II)**	**2001-2007 (Model III)**	**2012-2015 (Model IV)**
1	Specific Purpose Transfers from Union Government on Health	-0.952*** (0.074)	-0.777*** (0.114)	-1.059*** (0.109)	-0.360*** (0.137)
2	State's Own Revenues	0.012*** (0.003)	0.015*** (0.004)	0.1545*** (0.006)	0.012 (0.020)
3	State's Priority for Health (as % of spending)	17.649*** (1.828)	15.03*** (2.038)	19.487*** (4.231)	38.644*** (12.069)
4	General Purpose Transfers (Unconditional) from Union Government	0.019*** (0.007)	0.014 (0.011)	0.013 (0.01)	0.017** (0.008)
5	Constant	18.252*** (3.561)	17.17*** (3.885)	3.552 (5.035)	58.204*** (17.542)
6	State Specific Fixed-effects	Yes	Yes	Yes	**Yes**
7	Time Specific Fixed-effects	Yes	Yes	Yes	**Yes**
8	Number of states	14	14	14	**11**
9	Number of Observations	224	126	84	**55**
10	R-square	0.69	0.62	0.77	**0.29**

The regression results are summarised in Table 2. In the analysis conducted for major states for 2012-2015 (Model IV), a significant and large negative sign is found in the correlation coefficient for specific health transfers from the Union government, with state's own expenditures on health. This means that all other things being equal, a unit increase in specific purpose transfers by the Union government on health will lead to a reduction in States' own expenditure on health. That is, there is a significant substitution effect that continues to happen with the National Health Mission and other centrally sponsored schemes in health. This re-confirms the findings of Rao and Choudhury (2012) for 2012-2015. The magnitude of the substitution effect (measured by the coefficient of correlation) appears to be much smaller than for previous periods. It is possible that better and improving accounting systems under the National Health Mission might have contribution to a smaller substitution effect, but with the available evidence, this is just conjecture.

In summary, intergovernmental transfers on health are not being directed at States with a lower taxable capacity. The transfers also fail at stimulating States' own expenditure on health and instead end up substituting States' own expenditures. The current design of intergovernmental transfers needs to change, in order to increase public expenditure on health in India.

Conclusion

Based on the results, we conclude that there are a number of problems with the design and implementation of specific purpose transfers for health. First, the transfers are poorly targeted, as these are not linked to indicators. The reason for this has to be found in the fact that the transfers are not given according to the deficiency in health standards. The transfers instead tend to be of an incremental nature. This suggests that the transfers are not designed to achieve the basic goal of ensuring at least a minimum standard of health across all States in India.

Second, the grants are not linked to improving service levels and the States with larger shortfall in services do not receive higher grants. Transfers are thus regressive in nature; States with better health outcomes received more specific transfers per capita.

Third, in some schemes like healthcare, States were able to substitute grants for their own spending with the result that there has not been a commensurate increase in spending on healthcare after the grants are received.

Finally, a redesign of the intergovernmental transfer system and a rapid increase in the revenue generation capacities of poorer States is imperative in order to ensure better health outcomes for every Indian.

References

Rao M G, Choudhury M. Inter-state equalization of Health Expenditures in Indian Union. *National Institute of Public Finance and Policy Report*. 2008

Rao M G, Choudhury M. Health Care Financing Reforms in India. *National Institute of Public Finance and Policy Working Paper 100*. 2012

Jain N and Bhat R. Analysis of Public and Private Healthcare Expenditures. *Economic and Political Weekly*. 2006

Rao M G. The Effect of Transfers to States on Public Services in India. *Working Paper submitted to OECD*. 2017

Report of the Fourteenth Finance Commission, Volume 1.

Rao M G and Singh N. The Political Economy of Centre-State Fiscal Transfers in India. *United Nations Public Administration Network Working Paper No 107*. 2000

Rao M G. A Review of Indian Fiscal Federalism. *Research Study of the Commission of Centre-State Relations*, 2010

Rath A. Growing Centralisation of Social Sector Policies in India. *Economic and Political Weekly*. 2013

Government of India. Report of the High Level Expert Committee on Efficient Management of Public Expenditures. *Planning Commission*. 2011

Panagariya A, Chakraborty P, Rao M G. Growth and Development of States in India. *Oxford University Press. New York*. 2015

Srinath P, Kotasthane P, Kher D, Chhajer A. Public Expenditure on Health in India 2005-06 to 2014-15. *Report Submitted to Public Health Foundation. New Delhi.* 2017

National Health Systems Resource Centre. National Health Accounts Estimates for India (2013-14). *New Delhi: Ministry of Health and Family Welfare*. 2016

Notes

[1] IMR: definition. It is the number of deaths per 1,000 live births of children under one year of age. The IMR is a strong indicator to study the basic medical resources available at the state level as factors affecting the health of entire populations can also impact the mortality rate of infants.

[2] NFHS is an initiative by the Ministry of Health and Family Welfare which has conducted four rounds of survey to collect information regarding population, health, and nutrition at state level

[3] NFHS-4 provides health indicators for the year 2015-16. Since 2015-16 actual expenditures are still not available completely, we have used data for the year 2014-15 for comparison.

[4] As described in the Methodology section, this refers to revenue and capital expenditures on the budget major heads "Medical and Public Health" and "Family Welfare".

[5] NFHS-4 provides health indicators for the year 2015-16. Since 2015-16 actual expenditures were not available completely, we have used data for the year 2014-15 for comparison. Similarly, NFHS-3 provides health indicators for 2005-06 but since we do not have the break-up of health expenditures for 2005-06, we have used data for 2006-07.

[6] Ibid

[7] Ibid

[8] RBI, "state Finances: A Study of state's Budgets", reports for the years 2010-11 to 2015-16.