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Fiscal Federalism and Intergovernmental Transfers for Financing Health in India

Background paper prepared for the

Working Group on Intergovernmental Transfers
for Health in Populous, Federal Countries

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Abstract

India's system of intergovernmental fiscal transfer is complex and fragmented, characterized by multiple institutions and modes of delivery. The total intergovernmental fiscal transfers are estimated to be around 14 per cent of GDP. Tax devolution and block grants to states under the constitutionally mandated Finance Commission transfers constitute 6.74 and 1.21 per cent of GDP respectively. In addition, plan grants devolved to the states on the recommendation of the Planning Commission constitute 5.89 per cent of GDP in 2014-15. Direct expenditure by Central government through ministries for large Centrally Sponsored Schemes in health, education, energy, water and sanitation, agriculture, rural employment and other sectors is estimated to be around 2.5 per cent of GDP, which is part of the Planning Commission transfers. Public expenditure on health constitutes 1.1 per cent of GDP or about $16 per capita per year. There is considerable variation among states – poorer states with high population and disease burden spend only half of the more advanced states. Moreover, in spite of equalization grants from the Finance Commission, there is increased dependence on fiscal transfers from the Center vis-à-vis increase in health expenditure in poorer states. The intergovernmental fiscal transfer system therefore needs to (i) augment the resource base of less developed states, (ii) incentivize them to prioritize expenditure on health, (iii) increase the equalization component of Finance Commission transfers to reduce the gap in per capita health expenditure and finally, (iv) improve the efficiency of resource utilization especially for funds from the Union ministry of health for the National Health Mission.

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1. Introduction

Many populous and federal developing countries are rapidly devolving more responsibility in terms of service delivery to their subnational governments. The move towards greater devolution is taking place at a time as countries gradually transition from low to middle-income status. With continued economic growth and better tax systems, low- and middle-income countries (LMICs) are generating greater levels of revenue which needs to be invested wisely. This is especially critical in the context of stagnant or declining levels of international donor assistance and a renewed focus on equity, efficiency and accountability in the use of resources.

The most important priority for increased public expenditure in developing countries is to provide universal and quality social services, especially in education and health. Devolution of responsibility for delivering these services, however, is often not complemented by a rational and transparent system of transfer of resources between the national government and subnational units. In countries like India which have a three-tier system of governance (national, state or provincial, and local), the issue is further complicated by the mismatch of revenue-raising capacity of lower tiers. Transfers are often fragmented, made in an ad-hoc fashion, and often lacking a normative basis for allocation. This exacerbates inequality among regions, induces governance failures, creates policy discord and administrative uncertainty, leading to poor outcomes (Buchanan and Musgrave, 1999).

Analysis of intergovernmental transfers from different contexts shows that these transfers, when designed well, can increase the accountability and the effectiveness of public service delivery, both of which can lead to better outcomes, especially in health. One primary motivation of the Center for Global Development's Working Group on Intergovernmental Transfers for Health in Populous and Federal Countries, therefore, is to understand the mechanisms for effective and efficient fiscal transfers that can lead to better health outcomes in low- and middle-income countries. This study examines the case of India in particular, given its large population and lagging by several measures of health outcomes. The study is organized as follows. We begin by briefly reviewing the basic principles of intergovernmental fiscal transfers. Next, we examine the general system of intergovernmental fiscal transfers in India and the different channels of funding from central to state governments. Then we turn to the system of intergovernmental fiscal transfers insofar as they are specific to health, supported with a review the literature on intergovernmental transfers for health in India. Based on this background paper, the study concludes with proposed areas for further policy research and potential areas of policy recommendations.

2. Basic principles of intergovernmental fiscal transfers

In this section we provide an overview of the basic principles of intergovernmental fiscal transfers, followed by a literature review of intergovernmental fiscal transfers in India.

The objective of a system of intergovernmental fiscal transfers is to correct two basic imbalances that arise in a federation: (1) vertical imbalance which arises between national and sub-national governments due to asymmetric assignment of functional responsibilities (especially with regard to the provision of social and economic services such as health and education) and taxation powers; and (2) horizontal imbalance among constituent units of the federation in the existing disparities in the revenue capacity and the distribution of federal resources. The extent of these imbalances is different across different federations and so also the design of the intergovernmental transfer mechanism to correct them.

As an example of such imbalances, recent research in India showed that the share of central government in total revenue expenditure of both central and state governments increased from 54.7% to 57.3% between 2005-06 and 2009-10, indicating higher vertical imbalance. During the same period, the variance of state's own revenues declined from 0.51 to 0.41. On the other hand, there was an increase in variance of both center-to-state transfers (0.18 to 0.26) and state-level development expenditures (0.28 to 0.30) between 2005-06 and 2009-10. (Chakraborty and Dash, 2013). This would indicate a trend towards centralization in resource mobilization and expenditure and an increase in disparity in intergovernmental fiscal transfers as well as developmental expenditure across states. We shall discuss these issues in detail below.

A standard guiding principle in allocating financial resources in a federal system is to enable the states or provinces (henceforth 'states') to provide 'comparable' levels of public services by taking into account the economic, social and geographical disparities that exist among the federal units, i.e. 'comparable' to other states. Further, in allocating resources to states so that 'comparable' levels of services are provided, there is an implicit expectation that such public services lead to improved outcomes, however defined. In most large, populous and federal countries, states are at different levels of 'fiscal capacity', i.e. the level of economic activity that can generate revenues for the government in the form of taxes and duties levied on goods and services. There are two possible outcomes: states are unable to raise the requisite revenue for provision of services, or they incur higher administrative cost in order to raise the resources as per their needs. In almost all federations, the central government collects taxes that yield higher revenues as the economy grows. This implies that states with low capacity to raise their own revenues will only be able to adequately spend on social and physical infrastructure when federal transfers supplement their own revenues. This makes the issue of designing a transfer system critically important.

Transfers from federal to sub-national governments are broadly of two types: (1) general purpose or unconditional transfers, and (2) specific purpose or conditional transfers. General purpose transfers (which include both tax devolution and unconditional 'block grants') can address both vertical and horizontal imbalance – vertical imbalance through progressive distribution of tax revenues to subnational units on the basis of a formula that accounts for the divergent tax and fiscal capacity of the subnational units, and horizontal imbalance on the basis of a set of objective criteria which

generally include economic indicators such as per capita income, infrastructure and tax effort. General purpose transfers, therefore, increase the capacity of states to determine their expenditure priorities and allocate budgetary resources accordingly.

Specific purpose transfers, on the other hand, are mostly grants that are tied to particular activities undertaken by sub-national entities. In most cases, 'equalization grants' seek to redress the divergence in per capita expenditure in social and economic services such as health, education, and infrastructure. Specific-purpose transfers are also designed to address 'cost disabilities' – the higher unit cost that sub-national governments face in delivering services such as health in particular regions of the country, such as mountainous terrain and nomadic communities spread over a large geographical area. If they are not designed properly, specific purpose transfers can be arbitrary, discretionary, and ad hoc, and thus lead to a dilution of the core principles of intergovernmental fiscal transfers.

3. Intergovernmental fiscal transfers in India

In this section we provide an overview of the constitutional provisions for intergovernmental fiscal transfers, and then turn to understand the multiple channels of fiscal transfers in India.

3.1. An overview of constitutional provisions

The Indian federal system was formally established in 1919 under colonial rule by the British government. The Government of India Act formally separated the fiscal powers and responsibilities of the central (or 'union') and state governments. The present Indian fiscal structure flows from the Government of India Act of 1935, which was the basis of the provisions of the Constitution of India enacted in 1950. These have more or less remained the same in India's post-independence period.

India's fiscal federalism clearly demarcates the revenue and expenditure powers among the various tiers of the government. Starting from 14 states in 1960, the country is now divided into 29 states, six union territories and the national capital region of Delhi (which has its own legislature as well). The 7th Schedule of the Constitution demarcates the legislative, executive, judicial and financial powers of the central and state governments. These are included in three separate 'Lists' – the Union, State and Concurrent – which provide the constitutional separation of functions undertaken by the union and the subnational units (i.e. states and union territories) with some overlap in the items included in the Concurrent list.

The mechanism of separation and assignment of fiscal powers between the different tiers of government is one of the most significant challenges faced by a federal polity. The delineation of taxation powers and distribution of revenues between the central and state governments is described

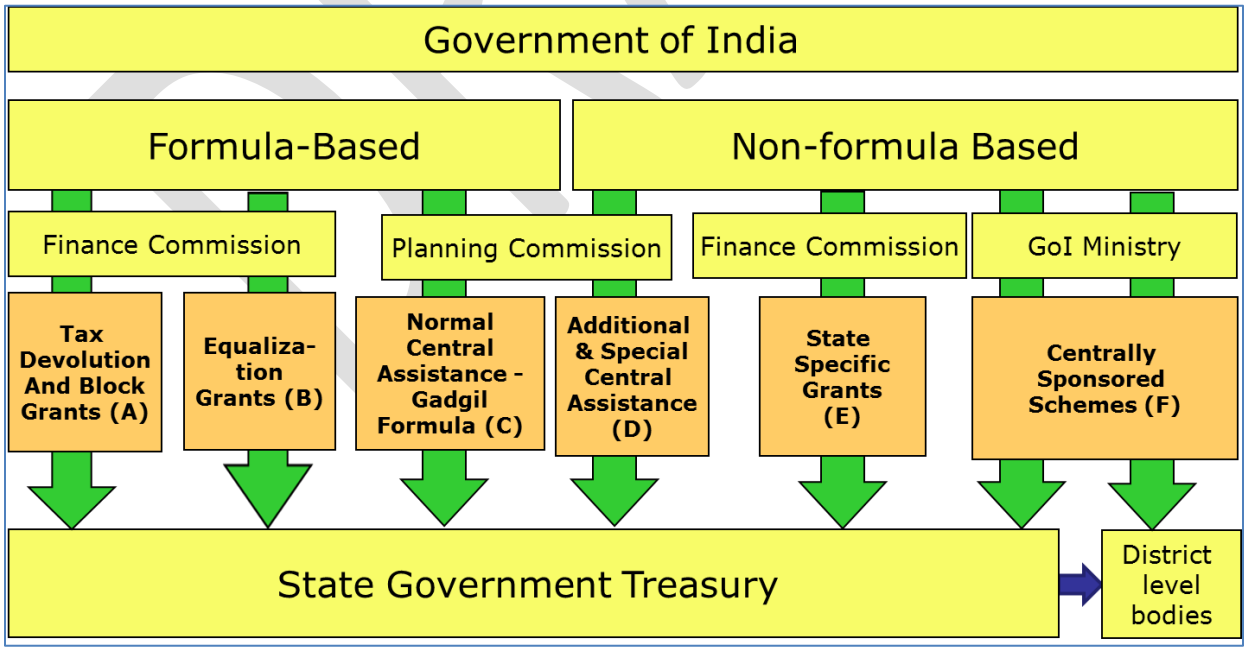
in Part XII of the Constitution. Specific taxation powers are provided in the respective Union and State Lists. Taxes on personal and corporate income, for example, are in the Union List, whereas taxes on professions, property and motor vehicles are levied and collected by the States. There are no taxable items in the Concurrent list, which implies that the taxes of the Centre and the States are completely separable and mutually exclusive.

As with most federations, the central government has most of the elastic taxes under its ambit which generates a significant degree of vertical imbalance within the fiscal federalism framework in India. In order to mitigate this imbalance, the Constitution has also prescribed certain obligations of the central government. These include obligatory sharing of union taxes on income (Article 270), sharing of union excise duties (Article 272), assignment of certain union taxes and duties entirely to the states (Article 269) and providing financial assistance to the States in the form of loans and grants (Article 275).

3.2. An overview of fiscal transfer channels in India

The multiple channels of fiscal transfers in India can be categorized by their channel or whether they are based on formulae. The main channels are the Finance Commission, Planning Commission, and off-Budget specific purpose transfers. In addition, individual transfers can also be classified by whether they are based on a formula or not.

Figure 1. Intergovernmental fiscal transfers in India



Source: Author's representation

Transfers directly to state treasuries via the Finance Commission

To execute these Constitutional provisions, Article 280 stipulates that the President of India on the advice of the Central government appoint a Finance Commission every five years[1] to (a) make recommendations regarding the distribution of net proceeds of taxes and their allocation among states, (b) determine the 'grants-in-aid' to be provided to the states, and (c) any other matter referred to the Commission in the interest of sound finance. The omnibus clause has been used by successive governments to include issues of fiscal capacity, debt obligations and service delivery in the Terms of Reference of the Finance Commissions, thereby making the recommendations more wide ranging than its core obligations of taxes and grants.

Finance Commissions therefore play a key role in India's system of intergovernmental fiscal transfers by determining the proportional amounts of general purpose transfers to the States. Finance Commission grants are constitutionally mandated and are therefore known as 'statutory transfers'. These consist of devolution of taxes and block grants, labeled (A) in Figure 1, equalization transfers especially for education and health, labeled (B), and State-specific grants to offset special needs, labeled (E).

Tax devolution and block grants are general purpose transfers distributed among states according to a normative framework and a formula. This formula takes into account the following four categories of state-level indicators: (1) population in 1971, (2) area, (3) fiscal capacity distance (capacity to raise own revenues compared to the benchmark state), and (4) fiscal discipline (adherence to fiscal rules, reduction in revenue and fiscal deficits). Historically, the variables for each of these four factors have been combined in a linear fashion, with each Finance Commission deciding on the weights for these indicators and thus calibrating the proportional amount of transfers, measured in shares, going to the States. The Thirteenth Finance Commission (2010-15), for example, used the following weights: Population – 25%; Area – 10%; Fiscal Capacity Distance – 47.5% and Fiscal Discipline – 17.5%.

Equalization grant are specific purpose transfers and based on a formula that differs from that used for tax devolution and block grants. They were mandated by the Twelfth Finance Commission (FC12) and the Thirteenth Finance Commission (FC13) to partially offset the differences in per capita expenditure on social sectors, especially education and health, across states. An analysis of these two formulae with respect to health is presented later in this paper. State-specific grants are not formula based and mandated solely at the discretion of the Commission. FC 13 provided twelve categories of State-specific grants in areas such as environment, forest, renewable energy, water resources, maintenance of infrastructure etc. These come with conditionalities and utilization may therefore depend on the capacity of the States to absorb these grants.

[1] The Fourteenth Finance Commission is currently in effect which will provide recommendations for 2015-20.

Transfers directly to state treasuries via the Planning Commission

The Constitution lists 'economic and social planning' in the Concurrent List, which provided the basis for the formation of the Planning Commission in keeping with the centralized planning model adopted after Indian independence. The Planning Commission is tasked with preparing 'Five Year Plans' and distributes 'plan grants' to states in order to offset residual horizontal imbalance as well as providing incentives for long-term investment in infrastructure as well as social and economic services. States are divided into two categories: special and non-special, with the former being mainly hilly and northeastern states which have low population, revenue capacity and 'cost disability' in provision of social services due to locational and topological factors.[2]

Plan grants refer to grants to States determined by the Planning Commission and transferred to the State government treasury from the Ministry of Finance. The main channel of plan grants is the 'Normal Central Assistance' are distributed on the basis of the Gadgil formula[3] – labeled as (C) in Figure 1. The formula was originally designed in 1969 for providing a normative basis for allocation of 5th Five Year Plan grants to States. It was revised in 1991 to give more weightage (from 10 to 25 per cent) to States which were below the national average per capita income. The formula also stipulates that 30 per cent of total plan transfers would be provided to special category states, 90 per cent of which would be in the form of grants and 10 per cent loan component. The grant-loan ratio composition is 30:70 for general category states.

The current formula used by the Planning Commission has four components: (1) population in 1971 (60% weight), (2) per capita income (25% weight), (3) performance in terms of tax effort, fiscal management and 'progress in achieving national objectives' such as population control, literacy etc. (7.5% weight) and (4) 'special problems' defined at the discretion of the Planning Commission (7.5% weight). Although the formula has been critiqued over the years, it still forms the basis of the grants to States by the Planning Commission. In addition, 'Additional Central Plan Assistance' and 'Special Plan Assistance' also provide plan grants to States for particular sectors determined by the Planning Commission on the basis of state-specific demand for grants routed through the state treasuries – refer to (D) in Figure 1.

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[2] Eleven special category states are: Arunachal Pradesh, Assam, Himachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura and Uttarakhand. Himachal Pradesh, Jammu and Kashmir, and Uttarakhand are 'hill states'.

[3] For details on the calculation of the Gadgil Formula, please see pbplanning.gov.in/pdf/gadgil.pdf

Brief comparison of transfers by Finance and Planning Commissions

Both Finance and Planning Commission grants go towards augmenting the resource base of the state governments and are in the form of general or specific purpose budgetary transfers from the central government to the states. The FC block grants are intended to enable states to meet their recurrent ('non-plan revenue') expenditure needs, in contrast to grants from the Planning Commission. Whereas all transfers from the Finance Commission are formula based, in contrast, from the Planning Commission some transfers are based on formula and some are not. Moreover, unlike the Finance Commission, the Planning Commission does not have constitutional validity, therefore making the Planning Commission less accountable to the Parliament as far as fiscal transfers are concerned.

Whereas Finance Commission formula are updated every five years, the Planning Commission's Gadgil formula has remained essentially remained the same from 1991 onwards. The formula leaves room for discretion and political bargaining especially with respect to interpretation of the 'performance' and 'special problems' categories. The only ostensibly common factor used in both Finance and Planning Commission transfers is population. See Table 1 for a comparison of the formulae of the Finance and Planning Commissions. The table also makes clear that the largest weight for FC13 was for 'fiscal capacity distance' (47.5%), whereas the largest weight for the Planning Commission is population (60%).

Table 1. Factor Weights for Transfers by the Finance and Planning Commissions

State-Level Factor	Thirteenth Finance Commission (FC13) (2010-15)	Planning Commission's Gadgil Formula (1991-present)
Population in 1971	25%	60%
Land Area	10%	..
'Fiscal Capacity Distance'	47.5%	..
'Fiscal Discipline'	17.5%	..
Per Capita Income	..	25%
'Performance'	..	7.5%
'Special problems'	..	7.5%

Notes: 'Fiscal capacity distance' includes capacity to raise own revenues compared to the benchmark state. 'Fiscal discipline' includes adherence to fiscal rules, reduction in revenue and fiscal deficits. 'Performance' includes several areas including tax effort, fiscal management and 'progress in achieving national objectives' such as population control, literacy, etc. 'Special problems' are defined at the discretion of the Planning Commission.

Fiscal transfer mechanism through Finance and Planning Commission has been subject to critical examination in the recent past. The Working Group Report on States' Financial Resources for the 12th Plan notes that "the two main bodies follow approaches in a segmented way without any

effective coordination" (Planning Commission, 2012). Specifically, the Report notes that there is no explicit basis for 30 per cent earmarking for special category states, apart from the fact that the resources are distributed without any objective criterion. There is a propensity to increase Plan size on the part of the States. As a consequence, they accumulate debt burden and therefore interest liabilities, as well as recurring revenue expenditure for human resources and maintenance of capital stock. States then depend on the Finance Commission to fill their gap in revenue expenditure and increase their resource base through higher tax devolution.

Since the Gadgil formula ties grants received from the Planning Commission to higher borrowing through loans (with a ratio of 30:70) even for economically weaker states, it is difficult for the Finance Commission to devolve sufficient funds to substantially reduce horizontal inequality in per capita expenditure especially in revenue expenditure intensive sectors such as health and education. The Report recommends greater coordination between Finance and Planning Commissions by rationalizing Plan grants and harmonizing FC devolution to address horizontal inequality as a core outcome of the fiscal transfer system in India.

Other transfers including Centrally Sponsored Schemes

Apart from these two traditional streams of fiscal transfers from the Finance and Planning Commissions which have operated from the early 1950s, a third stream has emerged. This stream includes various Centrally Sponsored Schemes (CSS), labeled E in Figure 1. These schemes are designed and implemented by ministries of the Central government often with the help of donor agencies to support State-level expenditure in areas such as education, health, energy, water resources, agricultural and rural development, rural employment, skill development etc. These became important due to the compression of the states' social sector expenditure in the 1990s in the aftermath of the 1991 fiscal crisis and the ensuing economic reforms during the decade (Mooij and Dev, 2002). These are channeled through ministries of the Government of India, and are determined by scheme-specific budgetary requests rather than formula.

The largest schemes – which include universal elementary education, school meals, rural health, rural employment and urban development – are designed such that the funds flow from the central government to implementing societies at the state, district and local levels. Until 2013-14, these funds passed through an individual central government ministry, such as the Ministry of Health and Family Welfare, which in turn can choose to transfer funds to the state treasury's State Plan or other subnational implementation agencies units. From financial year 2014-15, however, the CSS transfers will be routed through the Planning Commission as Central government's support to the State plan, although the individual ministries will decide on the amount to be transferred to each state on the

basis of established procedures[4]. Such transfers, although designated 'plan grants', will not be under the purview of the Gadgil formula.

The importance of CSS has grown substantially over the last decade and now stands at nearly 2 per cent of GDP or approximately US$40 billion annually.[5] Most CSS also stipulate co-financing by state governments on the basis of a sharing formula determined by the executing central government ministry. This ad hoc structure of resource allocation and co-financing has led to fragmentation of the fiscal transfer mechanism, as explained below.

In addition to CSS, which can provide grants to the state treasury or to other subnational units, quasi-fiscal transfers (QFT) which includes expenditure incurred by the central government on provision of goods and services which are provided at the state level can also be considered as one other channel of intergovernmental fiscal transfers. Examples include the cost of distribution of food grains through the Public Distribution System (PDS), fertilizer and petroleum subsidy, expenditure by central government ministries of education and health on educational and medical institutions run by the central government in the states (e.g. central government universities and tertiary care provided by medical research institutions for example).

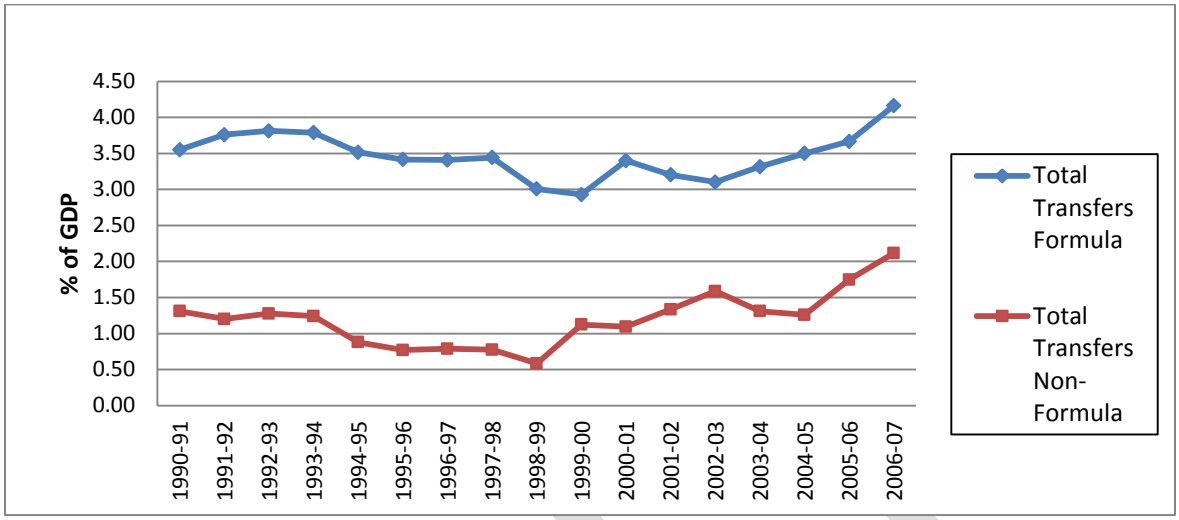
3.3. Patterns in intergovernmental transfers in India

Given the multiple channels of intergovernmental transfers in India, we next turn to understanding the absolute and relative sizes of each of these transfers for all sectors. The trend analysis of intergovernmental fiscal transfers from 1990-91 to 2006-07 indicates that the majority of transfers from the Finance and Planning Commissions are disbursed on a normative basis, i.e. using formula – see Figure 2 (Chakraborty, Mukherjee and Amarnath, 2010). As indicated earlier, formula-based transfers include statutory transfers (tax devolution and block grants) from Finance Commission as well as some plan grants ('Normal Central Assistance') from the Planning Commission. In terms of per capita expenditure, more than two-thirds of total transfers were based on a formula in 2006-07 (see Table 2).

[4] Government of India, Interim Budget, 2014-15, February 2014

[5] Chakraborty and Dash (2013), ibid

Figure 2: Fiscal Transfers, Formula and Non-formula, 1990-91 to 2006-07



Source: Chakraborty, Mukherjee and Amarnath, 2010

Table 2. Statewise Per Capita Formula and Non-formula based Transfers, 2006-07

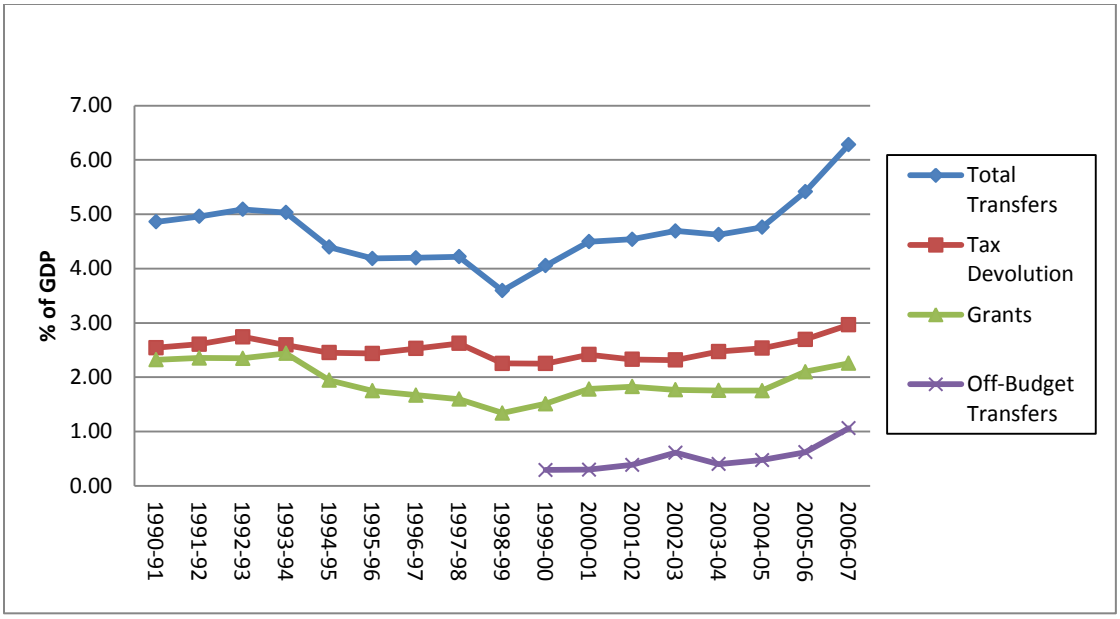
State	Formula Based Transfers		Non-Formula Based Transfers								
	Tax Devolution	Formula Based Grants	Plan Grants Outside Normal Central Assistance	Centrally Sponsored Schemes	Other Non-Plan Grants	Direct Transfers to Districts	Total Transfer	Aggregate formula based transfer	Aggregate non formula based transfer	Share of non formula based transfer (%)	Ratio of formula to non formula transfer
General Category States	**1071**	**285**	**44**	**141**	**135**	**290**	**1966**	**1355**	**610**	**31.0**	**2.2**
Andhra Pradesh	1092	333	21	161	96	306	2009	1425	584	29.1	2.4
Bihar	1451	243	41	106	183	324	2347	1693	654	27.9	2.6
Chattisgarh	1403	283	179	173	136	662	2836	1687	1149	40.5	1.5
Goa	1963	201	141	92	123	95	2615	2164	451	17.2	4.8
Gujarat	798	275	42	108	146	159	1527	1073	455	29.8	2.4
Haryana	550	235	35	158	55	221	1253	785	468	37.4	1.7
Jharkhand	1370	189	143	164	18	451	2335	1559	776	33.2	2.0
Karnataka	949	200	39	223	388	298	2096	1149	947	45.2	1.2
Kerala	951	343	22	104	152	116	1688	1294	394	23.4	3.3
Madhya Pradesh	1206	341	69	216	41	569	2441	1547	894	36.6	1.7
Maharashtra	570	365	16	100	328	178	1557	935	622	39.9	1.5
Orissa	1585	314	59	185	247	454	2845	1899	945	33.2	2.0
Punjab	580	160	34	124	512	123	1533	741	793	51.7	0.9
Rajasthan	1074	256	48	222	78	433	2109	1329	780	37.0	1.7
Tamil Nadu	977	317	74	96	22	190	1675	1294	381	22.7	3.4
Uttar Pradesh	1253	253	35	117	19	250	1926	1506	420	21.8	3.6
West Bengal	992	317	20	128	45	211	1713	1309	405	23.6	3.2
Special Category	**1376**	**2861**	**169**	**421**	**896**	**617**	**6340**	**4237**	**2103**	**33.2**	**2.0**
Arunachal Pradesh	2947	10886	1236	2718	1030	2599	21417	13833	7584	35.4	1.8
Assam	1349	1115	128	249	39	621	3502	2464	1038	29.6	2.4
Himachal Pradesh	933	2067	133	471	3578	549	7731	3000	4731	61.2	0.6
Jammu & Kashmir	1213	5129	4	458	395	517	7716	6342	1374	17.8	4.6
Manipur	1698	7328	224	579	135	397	10362	9026	1336	12.9	6.8
Meghalaya	1797	2227	293	429	1899	732	7376	4024	3352	45.4	1.2
Mizoram	2813	11246	780	1650	777	1486	18751	14059	4693	25.0	3.0
Nagaland	1219	3095	644	807	4094	453	10311	4314	5997	58.2	0.7
Sikkim	4596	7402	607	1740	1097	984	16425	11997	4428	27.0	2.7
Tripura	1503	5988	257	551	142	677	9118	7491	1627	17.8	4.6
Uttaranchal	1216	1513	87	164	1548	461	4989	2730	2259	45.3	1.2

Source: Financial Accounts, Various States

In contrast, non-formula based transfers refer to Additional Central Assistance, Special Central Assistance, CSS and QFT. Though a smaller proportion of total center-to-state transfers, non-formula-based transfers represent an increasing proportion of transfers, increasing from 27% in 1990-91 to 33% in 2006-07 (Figure 2). Non-formula based transfers are largely based on budgeting guidelines and not on a set of fixed norms, include grants from the Planning Commission that are outside the State Plan, expenditure through CSS, and quasi-fiscal transfers.

In Figure 3, non-formula-based transfers are further disaggregated into two categories from 2000-01: (i) grants (plan and non-plan) not mandated by Finance or Planning Commission formulae (second to bottom lower bold line) and (ii) off-budget grants (bottom line). By 2006-07, off-budget transfers to implementation societies, as in the case of the National Rural Health Mission (NRHM), constituted half of total non-formula transfers. Estimates show that QFT constitutes nearly 0.5 to 1 per cent of GDP, which has remained nearly the same over the last decade (Chakraborty, Mukherjee and Amarnath, 2010).[6]

Figure 3: Fiscal Transfers to States, 1990-91 to 2006-07



Source: Chakraborty, Mukherjee and Amarnath, 2010

Table 2 also shows that transfers from tax devolution (A) were more progressive than other kinds of transfers (including formula-based grants). Bihar, one of the poorest states in terms of per capita income, receives nearly three times the amount of per capita tax devolution than Maharashtra, one of the richer states. However, the per capita *non*-formula based transfer is nearly the same for these

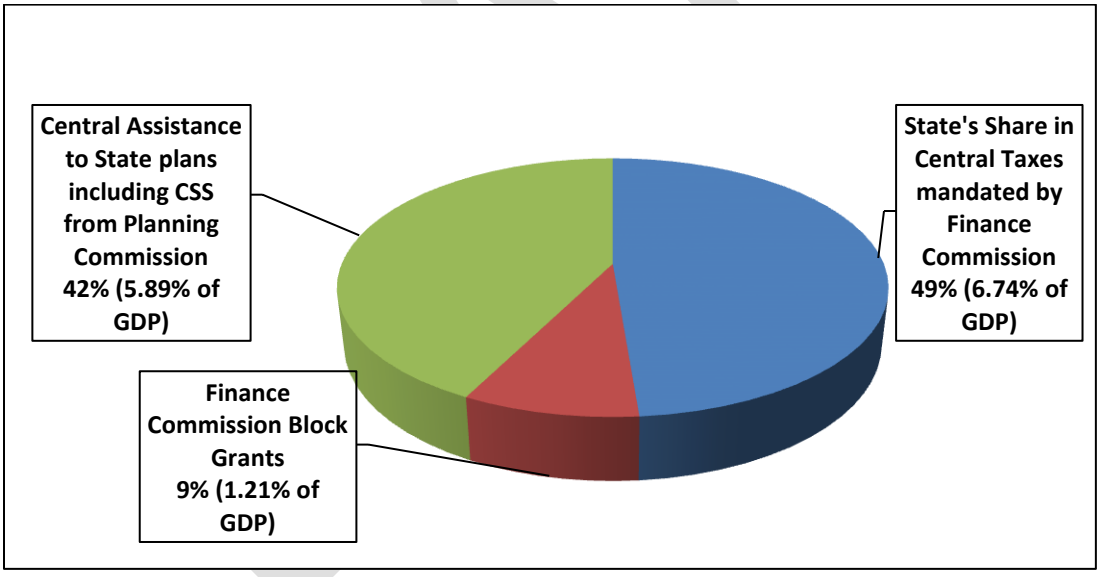
[6] Please see Chakraborty et.al.(2010) for details on methodology and calculation.

two states. Furthermore, Punjab, the state with the highest per capita income, receives nearly twice the amount of non-formula based transfer as Uttar Pradesh, which has one of the lowest per capita incomes.

This disparity between formula and non-formula based transfers has important implications in achieving the objective of a progressive system of intergovernmental transfers in India. This is further illustrated by Figure 3, which shows that the share of tax devolution as a percentage of GDP has remained more or less stagnant over the last two decades. On the other hand, the share of grants has increased substantially from 2000-01 onwards. This is mainly due to the rising share of 'off-budget' grants through CSS in total expenditure as well as the increase in plan grants.

In short, both Figures 2 and 3 show the rising importance of CSS transfers as a share of total intergovernmental transfers from the central government to states and subnational units. Indeed, the share of 'grants' in total fiscal devolution became greater than tax devolution for the first time in 2006-07. Recent figures indicate that this trend has continued over the last half a decade as well (Accountability Initiative, 2013).

Figure 4: Share of Major Fiscal Transfers, Budget Estimates for 2014/15



Source: Budget Documents, Government of India, 2014-15

The estimated shares of Finance and Planning Commission transfers are given in Figure 4 for the current fiscal year. Intergovernmental fiscal transfers constitute 13.84 percent of GDP according to the latest available figures from the budget of the Government of India. Of this, statutory transfers mandated by the Finance Commission constitute around 60 percent (7.95 percent of GDP), while the rest is comprised of transfers from the Planning Commission (5.89 percent of GDP).

From 2014-15, CSS transfers will be routed through the Planning Commission as well, which is a major departure from the erstwhile method of off-budget transfers directly from central government ministries to state and district level implementing agencies. The modalities of determining the actual amount to be transferred through the CSS remains the same. It remains to be seen whether the upward trend in CSS expenditure continues over the medium term under the new government.

4. Intergovernmental fiscal transfers for health in India

Public health expenditure in India is low. Depending on the source of the data, estimates vary between 1.4 per cent of GDP (Planning Commission, 2011) to 0.9 per cent (National Health Accounts, 2004-05). This variation in estimates is mainly due to different modes of classification, which include water supply and sanitation, as well as nutrition in some of the estimates. Correcting for these misclassifications and eliminating double counting of intergovernmental fiscal transfers, public expenditure on health is 1.1 per cent of GDP (Chowdhury and Amarnath, 2012). In addition, water supply and sanitation and nutrition constitute an additional 0.4 and 0.2 per cent of GDP respectively. Therefore the total public expenditure on health, water supply and sanitation, and nutrition constitutes 1.7 per cent of GDP in 2010-11 and an expenditure of Rs. 712 per capita ($15.8 per capita, in current US dollars).

The current policy objective is to increase public expenditure on health to 3 per cent of GDP by 2017, which would imply an additional 1.3 to 2 per cent increase in allocation for health, depending on whether we include water, sanitation and nutrition in the target. This total public health expenditure in India can be disaggregated by expenditures incurred by the three tiers of government: central, state, and local bodies e.g. district and village, for which there are multiple bodies at each tier.

In general, health is generally regarded as a 'State subject' under the Constitution, i.e. the responsibility of the state government. In its original form, entry 6 of the State list gave states the jurisdiction over 'public health and sanitation; hospitals and dispensaries'. However, the 42nd Amendment of the Constitution in 1976 inserted 'population control and family planning' as Item 20A in the Concurrent List under 'Social and Economic Planning' (Item 20). The present composition of financing for the National Rural Health Mission (NRHM) which includes reproductive and child health (RCH) services as well as 'upgradation' of the public health delivery system can be traced back to the concurrent jurisdiction over health following the 42nd amendment. In other words, it is not obvious from the current constitution that the central government necessarily hold major responsibilities in providing health-care services beyond the remit of 'population control and family planning'.

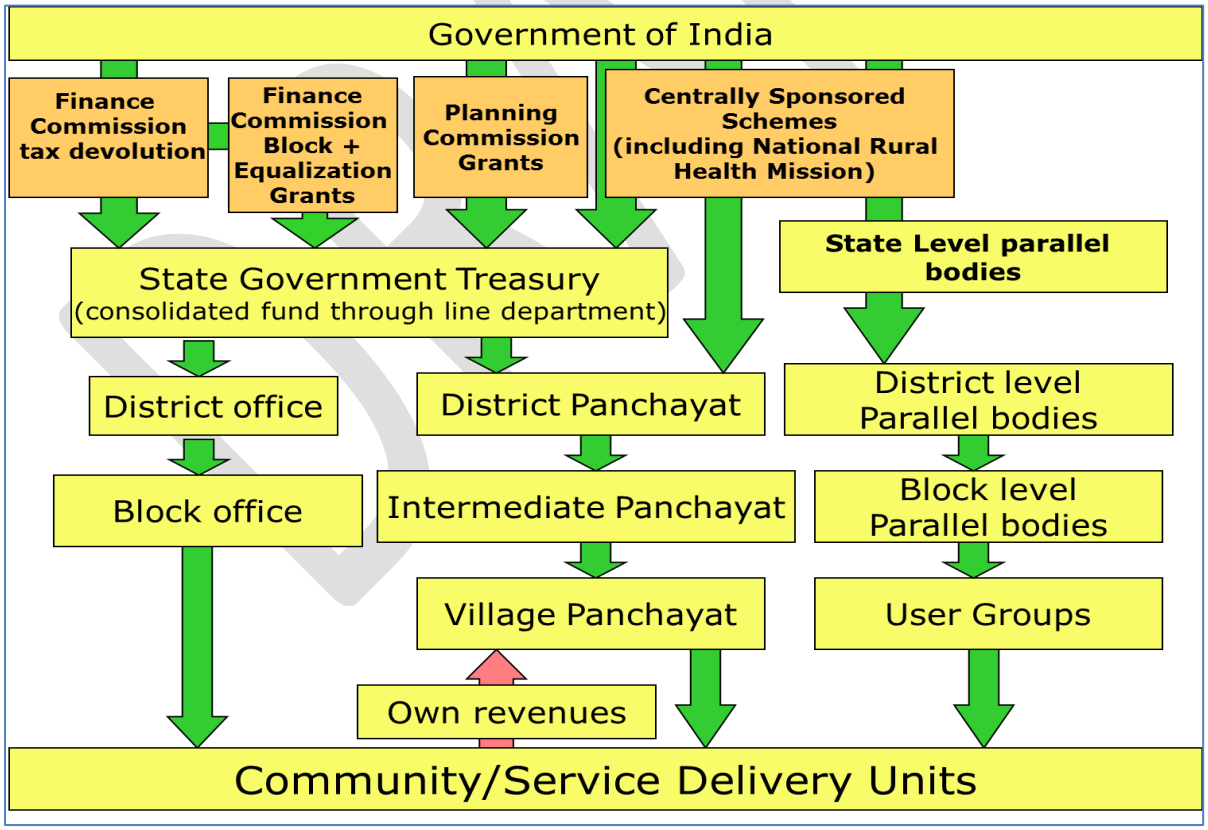
As described in the previous section, there are several channels by which agencies at each of the three tiers of government (central, state, local) can spend on health-care (Figure 5). The central government spends directly on health mainly through funds allocated for specialty hospitals and

medical colleges across the country and public goods such as medical research and collection of vital and epidemiological data.

States receive funds from the central government through three general categories: through the State Treasury, through state-level parallel bodies, or directly to districts (Figure 5). State treasuries receive transfers from Finance and Planning Commissions in addition to Central grants. These transfers impact health expenditure either indirectly through greater tax devolution, FC block grants and PC state plan grants ((A) and (C) in Figure 1), or directly through equalization grants mandated by the Finance Commission ((B) in Figure 1). Therefore, the state government treasury comprises own resources, FC and PC transfers, and central grants-in-aid through CSS, which may require minimum state financing from own revenues. State treasuries in turn transfer some of the expenditure responsibilities to rural and urban local bodies.

Notably, CSS transfer funds to three different bodies – state government treasuries, state-level parallel bodies, and district governments. These may be augmented by contribution from revenue collection by local bodies themselves, usually monitored by user groups at the facility level.

Figure 5: Fiscal Transfers and Fund Flows Across Different Levels of Government



Source: Author's representation

4.1. Patterns in per capita health expenditure in India

Annex Table 1 provides a summary of state-wise information of per capita expenditure on health in India between 2006-07 and 2009-10. This coincides with the period of the award of FC12 transfers. The states are grouped under general category and others, including special category, North-eastern states and the National Capital Territory. Per capita expenditure is further disaggregated into expenditure from State resources and from the Centre through both budgetary and off-budget channels.

State-wise data in Annex Table 1 shows that States in the south and west of the country (Andhra Pradesh, Gujarat, Karnataka, Kerala, Maharashtra and Tamil Nadu) have higher levels of per capita expenditure than others in the general category states. With the exception of Rajasthan, states with low per capita income spend less than Rs.200 per capita on health from own revenues. In per capita terms, in Goa total expenditure on health is 9 times that of Bihar, and expenditure from own revenues is nearly 14 times that of Bihar.

Extreme disparity in healthcare expenditure across states is therefore evident, suggesting the need for intervention by the Central government to reduce horizontal inequality in public expenditure, if not eliminate it completely. Contribution of Central transfers in total per capita health expenditure varies between 45 per cent in case of Assam to 6 per cent for Goa. Table 3 also shows that low-income and special category states are heavily dependent on Central expenditure, indicating the need for restructuring of the fiscal transfer framework and incentives for higher expenditure on health by states.

While all states have increased their public expenditure on health between 2006 and 2010, two critical elements deserve special consideration: (1) States such as Madhya Pradesh, Chattisgarh, Jharkhand, Bihar and Uttar Pradesh which have some of the worst health indicators in India do not show any significant change in their level of per capita expenditure, and (ii) on average one-third of this increase comes from greater fiscal transfers from the Centre for these states, compared to only 20 per cent on average for states with high per capita expenditure and better health indicators such as Maharashtra, Kerala and Tamil Nadu.

This implies that the scale of fiscal transfers for health is still inadequate to bridge the gap in per capita public expenditure on health in poorer states, in addition to the fact that there is increased dependence on fiscal transfers from the Centre. The data also shows that year-to-year variation in per capita health expenditure is higher for states with greater dependence on transfers from the Centre, suggesting volatility in allocations.

Table 3. Increase in per capita health expenditure, 2006-10 (%)

	Total	State's Share	Centre's Share
Andhra Pradesh	26.36	75.91	24.09
Bihar	10.28	61.64	38.32
Chattisgarh	5.20	63.39	36.45
Gujarat	67.21	73.70	26.30
Goa	34.09	93.57	6.41
Haryana	63.42	84.58	15.42
Jharkhand	18.06	70.06	29.84
Karnataka	43.62	78.94	21.13
Kerala	35.37	83.71	16.23
Madhya Pradesh	7.56	59.85	40.05
Maharashtra	49.73	79.23	20.69
Orissa	43.14	60.27	39.90
Punjab	13.10	76.26	23.90
Rajasthan	40.57	65.69	34.33
Tamil Nadu	55.47	77.82	22.30
Uttar Pradesh	12.51	72.62	27.54
West Bengal	49.30	77.87	22.13

Source: Basic Data Choudhury and Amarnath, 2012; Author's calculations

4.2. Equalization grants for health: discussion of FC12 and FC13 formulae

The level of disparity in per capita expenditure on health across states is evident from a review of the data in Table 3. This was the primary motivation for equalization grants provided by the Twelfth Finance Commission (FC12) during its award period (Srivastava, 2006). The underlying principle guiding this approach was that "an equalization principle in determining service-specific grants can play an important role in a situation where, while the average expenditure on health and education may grow covering all states, for some states where service provisions are below average, expenditure on these heads needs to grow faster than average if they are to catch up" (Srivastava, 2006).

Grants were given to seven states on the basis of a formula which calibrated tax effort and potential revenue expenditure on health. The grants bridged 30 per cent of the gap in per capita revenue expenditure which would have been needed for full equalization.

As shown in Table 4, the FC12 equalization grants vary greatly in importance depending on the state. For Assam, FC12 grants nearly doubled the total revenue expenditure on health, while for Madhya Pradesh it increased by less than 5 percent. The details of the grant amounts are provided in Table 3,

along with the proportional impact of the equalization grant in augmenting the state's own revenue expenditure for health.

The FC12 cited the examples of Canada and Australia which provide specific transfers for health to equalize quality of service delivery in addition to unconditional general purpose transfers. It also noted that the transfer mechanism had become fragmented and that there was a need to take a holistic view of equalization transfers which would require harmonization between statutory grants (A), plan grants (C) and CSS (F). The FC12 equalization grants, therefore, had limited impact on eliminating the horizontal imbalance among states as far as per capita public health expenditure is concerned.

The Thirteenth Finance Commission (FC13) recommended performance based incentive grants of Rs.5000 crore (nearly US$ 1 billion) for States to reduce their infant mortality rate (IMR) over period 2010-15. The grant was to be provided for three years (2012-13 to 2014-15) on the basis of the criteria provided in Table 5. The performance is assessed on the basis of official IMR for states published by the Registrar General of India in the Sample Registration System (SRS) bulletins. The reward for performance is based on a formula which has two components: improvement in the absolute value of the parameter and providing a premium if such change is above the median value of the parameter for all states. The formula calculates an incentive coefficient for each State and then uses them as weights to allocate the FC13 grant among states. Compared to the funds received by States from FC12, the amount of the IMR grant is much lower. While it has the advantage of being normative the pay-for-performance principle proposed by the FC13 needs a greater level of resources to be taken seriously by the States as an important component of the fiscal transfer mechanism.

These observations raise important issues for further examination of the fiscal transfer system in general and for health in particular. Specifically, there is a need to undertake detailed state-level budget analysis to estimate the prioritization and composition of health expenditure at the sub-national level. Further research is required to ascertain the extent to which fiscal transfers from the Union incentivizes spending on health in the States, whether they can improve efficiency of resource allocation and increase effectiveness of outcomes.

Table 4. Equalization Grants for Health by 12th Finance Commission

State	2005-06	2006-07	2007-08	2008-09	2009-10	2005-10	Grant as % of Revenue Expenditure in Health
Assam							
Normal Expenditure	196.94	219.58	244.84	272.99	304.39	1,238.74	
Grant	153.58	171.24	190.93	212.89	237.38	966.02	
Total Revenue Exp.	350.52	390.82	435.77	485.88	541.77	2,204.76	43.82
Bihar							
Normal Expenditure	500.82	558.41	622.63	694.23	774.07	3,150.16	
Grant	289.30	322.57	359.66	401.02	447.14	1,819.69	
Total Revenue Exp.	790.12	880.98	982.29	1,095.25	1,221.21	4,969.85	36.61
Jharkhand							
Normal Expenditure	219.74	245.01	273.19	304.60	339.63	1,382.17	
Grant	57.39	63.99	71.35	79.55	88.70	360.98	
Total Revenue Exp.	277.13	309.00	344.54	384.15	428.33	1,743.15	20.71
Madhya Pradesh							
Normal Expenditure	607.66	677.55	755.46	842.34	939.21	3,822.22	
Grant	28.88	32.20	35.90	40.03	44.63	181.64	
Total Revenue Exp.	636.54	709.75	791.36	882.37	983.84	4,003.86	4.54
Orissa							
Normal Expenditure	434.88	484.90	540.66	602.83	672.16	2,735.43	
Grant	31.22	34.81	38.81	43.28	48.25	196.37	
Total Revenue Exp.	466.10	519.71	579.47	646.11	720.41	2,931.80	6.70
Uttar Pradesh							
Normal Expenditure	1,610.74	1,795.97	2,002.51	2,232.80	2,489.57	10,131.59	
Grant	367.63	409.90	457.04	509.60	568.21	2,312.38	
Total Revenue Exp.	1,978.37	2,205.87	2,459.55	2,742.40	3,057.78	12,443.97	18.58
Uttaranchal							
Normal Expenditure	161.73	180.32	201.06	224.18	249.96	1,017.25	
Grant	10	10	10	10	10	50	
Total Revenue Exp.	171.73	190.32	211.06	234.18	259.96	1,067.25	4.68
Total Normal Expenditure	**3,732.51**	**4,161.74**	**4,640.35**	**5,173.97**	**5,768.99**	**23,477.56**	
Total Grant	**938.00**	**1,044.71**	**1,163.69**	**1,296.37**	**1,444.31**	**5,887.08**	
Grand Total Revenue Exp	**4,670.51**	**5,206.45**	**5,804.04**	**6,470.34**	**7,213.30**	**29,364.64**	20.05

Source: Report of the 12th Finance Commission, ANNEXURE 10.3 (Paragraph 10.19) Pages 461

Table 5. Schedule of the Thirteenth Finance commission IMR Grant

Year	Amount (Rs.billion)	Calendar Year of Measurement	Year of SRS Report
2010-11	Baseline	2009	2010
2012-13	15	2011	2012
2013-14	15	2012	2013
2014-15	20	2013	2014

5. Conclusions and future work

India's system of intergovernmental fiscal transfer is complex and fragmented, characterized by multiple institutions and modes of delivery. The Constitutional mandate for fiscal devolution rests with the Finance Commission which is constituted every five years to determine the share of resources between the Centre and State governments and its distribution among the federal units. Planning Commission, although not having Constitutional powers, has also played an important role in distribution of resources among States for over six decades through successive Five Year Plans. Tax devolution and grants to states under the Finance Commission mandate constitute 6.74 and 1.21 per cent of GDP respectively. In addition, plan grants devolved to the states on the recommendation of the Planning Commission constitute 5.89 per cent of GDP in 2014-15. More recently, the central government has directly allocated resources through ministries for large Centrally Sponsored Schemes in health, education, energy, water and sanitation, agriculture, rural employment and various other sectors. It is estimated to be in the range of 2-3 per cent of GDP in 2012-13. The total intergovernmental fiscal transfers are estimated to be around 15 per cent of GDP.

It is not surprising, therefore, that the fragmentation of the fiscal transfer mechanism has not been successful in reducing disparity in per capita expenditure in health across States in India. Economically weaker states spend roughly one-third of the richer states on health, with adverse consequences for health outcomes. The former are also the more populous with higher burden of disease, poor infrastructure and weak delivery capacity. Considering the urgent need to reduce such disparities, the 12th and 13th Finance Commissions mandated equalization grants for health. However, they followed two different approaches. FC12 provided grants to eight states on the basis of normative criteria but with variable impact on augmenting their revenue expenditure on health.

FC 13 on the other hand mandated formula-based grants to all states to be distributed on the basis of their relative improvement in infant mortality rate (IMR). The distribution of resources and comparison of impact of the two modes of transfer on health expenditure will have to be examined further.

The National Rural Health Mission has been one of the most important channels for Centre to State transfer of resources for health. The Mission has been extended nationally to cover urban centres as well from 2013-14 onwards. The design of NRHM is complex since it subsumed erstwhile health sector programs such as Reproductive and Child Health (RCH) and several disease control programs. Moreover, states are divided into three categories according to their health outcomes and resource needs. The resource allocation and utilization and program implementation through state and district level structures needs further data analysis and research.

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	Per Capita Total Public Exp on Health				Per Capita Public Exp on Health by States				Per Capita Public Exp on Health by Centre			
	2006-07	*2007-08*	*2008-09*	*2009-10*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2006-07*	*2007-08*	*2008-09*	*2009-10*
Andhra Pradesh	260.97	305.96	318.70	329.76	193.68	225.27	245.74	257.92	67.29	80.69	72.95	71.84
Bihar	132.37	155.88	135.94	145.97	93.01	98.89	79.61	79.94	38.46	56.99	56.33	66.73
Chattisgarh	259.36	219.67	210.56	272.84	143.70	130.85	133.74	201.76	114.79	88.82	76.83	70.36
Gujarat	222.41	254.55	285.72	371.89	164.35	178.53	208.17	285.11	58.06	76.02	77.55	86.77
Goa	905.82	884.42	1052.88	1214.65	868.49	831.68	975.91	1120.81	36.41	52.74	76.97	93.84
Haryana	201.54	212.23	248.25	329.36	163.58	184.77	215.35	274.81	37.96	27.47	32.90	54.55
Jharkhand	171.66	186.20	270.79	202.66	101.76	130.09	191.71	158.90	70.79	55.27	78.28	43.76
Karnataka	239.01	302.72	326.09	343.26	196.21	243.69	252.84	263.32	43.70	59.03	72.46	80.68
Kerala	327.95	388.00	429.14	443.93	287.41	307.94	352.94	381.93	40.53	79.18	76.20	62.00
Madhya Pradesh	213.83	236.64	210.88	229.99	127.58	124.63	127.92	153.33	85.35	112.00	82.96	76.66
Maharashtra	218.62	265.79	302.68	327.33	196.67	199.78	237.13	249.40	21.04	66.01	65.55	77.94
Orissa	201.17	208.44	218.65	287.95	118.34	116.15	147.76	169.92	82.83	93.08	70.89	118.73
Punjab	248.89	246.05	260.80	281.48	200.00	202.34	206.84	181.81	49.78	43.71	54.71	99.68
Rajasthan	227.78	263.65	313.67	320.19	154.82	162.63	210.12	211.59	73.85	101.03	102.79	108.60
Tamil Nadu	276.86	287.92	343.97	430.43	210.19	214.85	266.20	350.88	66.67	73.94	77.78	80.29
Uttar Pradesh	232.10	214.51	235.67	261.14	177.64	154.79	166.67	186.03	54.45	60.57	68.99	75.81
West Bengal	201.00	215.06	230.78	300.09	154.40	165.17	176.24	241.54	46.59	49.89	54.53	58.55
Arunachal Pradesh	1334.16	1234.71	1474.08	1379.97	854.85	711.82	1070.81	1002.26	478.39	522.00	404.08	377.70
Assam	285.82	396.25	405.96	519.96	163.46	162.76	216.41	335.97	122.37	234.34	189.55	183.98
Himachal Pradesh	756.38	755.56	810.98	1036.19	575.75	590.79	638.85	674.90	181.57	164.77	172.12	361.29
Jammu Kashmir	643.72	692.49	650.44	803.38	610.57	609.99	568.52	696.31	33.15	82.50	81.92	107.07
Manipur	437.31	766.31	712.06	803.57	308.48	457.53	441.00	566.65	128.83	308.79	271.06	236.10
Meghalaya	531.39	604.20	592.73	844.47	394.34	466.66	448.62	613.54	137.05	137.54	144.12	230.93
Mizoram	1168.59	1438.96	1765.35	2226.28	608.51	701.12	1233.35	1690.71	560.08	737.84	532.00	535.57
Nagaland	1025.83	1070.42	922.92	1009.74	606.13	698.86	599.06	670.48	419.70	371.56	323.86	339.26
Sikkim	1070.54	1282.81	1764.06	1792.55	873.85	997.74	1055.14	1362.71	196.69	285.07	708.92	430.56
Tripura	560.86	624.05	675.09	824.98	411.30	442.43	473.10	610.75	149.56	181.63	202.00	214.24
Uttarakhand	418.18	453.55	461.00	447.11	378.81	367.32	357.79	341.23	39.37	86.23	103.21	105.87
NCT Delhi	673.55	761.66	882.80	979.26	642.44	717.99	834.30	934.36	31.12	43.67	48.50	44.90

Source: Compiled from Chaudhury and Amarnath, 2012