WORKING PAPER | EXECUTIVE SUMMARY

Federal Financing of Health

Implications for Health System Capacity and Priority

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Though health is a state subject in India, responsibilities in health and healthcare are spread across all three levels of governance—the Union, States, and local bodies. These constitutional boundaries, however, have blurred over the years with the Union government playing an increasingly greater role in healthcare through Centrally Sponsored Schemes (CSSs) such as the National Health Mission (NHM). In this context, this paper explores the evolving nature of federal financing for health, including the increase in union transfers through CSSs and its implications for state-level health prioritisation and capacities. Essentially, this paper seeks to understand (i) the role of CSSs, particularly the NHM, in defining/resetting health priorities in States and reducing horizontal inequalities in health spending across States; (ii) the constraints faced by States within the federal structure for delivering effective healthcare services; and (iii) the mechanisms through which States manage these constraints.

This study uses a mixed-method approach, combining quantitative budgetary analysis with qualitative methods. The quantitative analysis focused on the drivers of health financing, while the qualitative aspect was based on Key Informant Interviews (KIIs) conducted with key State and Union government officials, both serving and former, in six States: Haryana, Madhya Pradesh, Meghalaya, Rajasthan, West Bengal, and Tamil Nadu.

Public health spending in India, as percentage of GDP, has been low compared to its peers, and exhibits significant inter-state variations. Public health spending by States as a share of GDP declined during the period from 1994-95 to 2004-05. This trend, however, was reversed post-NHM. Thus, NHM has helped reverse the declining trend of spending on health, though total spending on health by States in their overall spending has remained little above 5% in the last 30 years (between 1990 and 2021). As such, health in general remains a low priority in state budgets. The launch of NHM was accompanied by an increased role of the Union government in health financing. During this period, its per capita health spending grew at an annual rate of 12.4 % between 2005-06 (the year NHM was launched) and 2019-20, compared to 10.3 per cent annual growth rate in its overall spending.

NHM has provided States with access to non-wage resources, expanding their ability to deliver health services. This is particularly significant in the context of many States with their low own revenue. It is noteworthy that own revenue varies markedly across States, ranging from less than 20% to more than 80%. In recent years, the share of tax devolutions in the total receipts of States has declined, while that of CSS transfers has increased. Overall, the dependence of States on the Union government has increased.

NHM had a distinct impact on health spending in its initial phase. From 2000-01 to 2004-05, the rate of health expenditure grew more slowly compared to total expenditure (Centre plus States), a trend that reversed after the launch of NHM. Thus, between 2005-06 and 2013-14, the average annual health expenditure of six sample States increased at a faster rate of 17% compared to total expenditure, which grew by 15%. However, from 2014-15 to 2020-21, growth in health spending declined in these States. Significant variations were observed in per capita spending across the sample states, ranging from ₹2,421 in Meghalaya to ₹860 in Madhya Pradesh in 2021. Growth rates of per-capita spending differed across States as well. Of the six sample states, grant-in aid (GIA) by the Union government constituted 30% or more of the total health spending in Madhya Pradesh and Meghalaya, whereas it was less than 10% in Haryana. Fiscally poorer states such as Madhya Pradesh and West Bengal are more dependent on transfers from the Union government, which makes them vulnerable as they face greater risk and uncertainty in their fund flows. In recent years, the Union government's role in healthcare has increased, as reflected in an increase in its direct spending on health through Centre sector schemes, relative to its fiscal transfers to States.

The important role of NHM in freeing up funding to innovate and build technical and fiscal capacity for health was recognised by several States. However, there are mixed views on the implications of the Union government designing national programmes with standardised norms and guidelines. One view is that States have been relegated to the role of delivery and implementation, with the Union taking the lead in designing schemes and setting priorities. Across states, there were also examples of the Union government pushing for certain reforms, without adapting to the local context. On the other hand, some States felt that the NHM helped them focus on health, which otherwise had not been given adequate attention.

States had varied experiences with respect to varied fund flows through CSSs. While some State officials experienced uncertainty and inconsistency with fund receipts for health schemes from the Union government, others did not.

The evidence suggests that, the horizontal inequalities have reduced post-NHM, *albeit* modestly, as reflected in the increased per capita health spending in five states, but have increased in one State relative to their pre-NHM levels. However, some States felt that NHM has not helped address inter-district inequalities.

As States, in general, face many constrains in the design of NHM, they have devised various strategies to address them. These coping mechanisms include claiming flexibility within the broader NHM agenda, adapting to fund flow challenges by relying on own funds, using different platforms for coordination, and leveraging the role of political leadership in visioning and channelling resources. Despite the standardised nature of the programme, states to a large degree have been able to claim some level of operational flexibility. Our discussion with States revealed that tweaking State initiatives to align with the broader Union government agenda can be achieved through demonstrated ability, strong negotiation skills, and effective interpersonal dynamics. In the absence of clearly defined platforms and structures, apart from the National Programme Coordination Committee (NPCC), communication often occurs in an *ad-hoc* manner. State-level officials typically contact Union government officials based on the needs and issues faced.

Discussions with State officials across study states clearly suggested the key role of political leadership in determining health as a major priority. Nearly all States emphasised the role played by the political leadership in setting the vision and goal, as well as channelling resources. Sensitising political leaders is thus a strategy used by bureaucrats to generate support for various schemes and programmes.

It is high time that diverse capacities of States are recognised, and that they're provided with greater flexibility to identify locally relevant priorities in health, and accorded greater financial resources to implement them.

About the authors

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