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# Federal Financing of Health

## Implications for Health System Capacity and Priority

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# Federal Financing of Health

## Implications for Health System Capacity and Priority

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## List of Abbreviations

<b>ASHA</b>	Accredited Social Health Activist
<b>BJP</b>	Bhartiya Janata Party
<b>CMO</b>	Chief Medical Officer
<b>CSS</b>	Centrally Sponsored Schemes
<b>FC</b>	Finance Commission
<b>FLWs</b>	Front Line Workers
<b>GDP</b>	Gross Domestic Product
<b>GIA</b>	Grant in Aid
<b>GST</b>	Goods and Services Tax
<b>HLEGs</b>	High-Level Expert Groups
<b>HMIS</b>	Health Management and Information System
<b>HPV</b>	Human Papillomavirus Vaccine
<b>MoHFW</b>	Ministry of Health and Family Welfare
<b>MoLE</b>	Ministry of Labour and Employment
<b>NCDs</b>	Non-Communicable Diseases
<b>NFHS</b>	National Family Health Survey
<b>NHM</b>	National Health Mission
<b>NPCC</b>	National Programme Coordination Committee
<b>NRHM</b>	National Rural Health Mission
<b>OOE</b>	Out-of-pocket Expenses
<b>OSR</b>	Own Source Revenues
<b>PIPs</b>	Project Implementation Plans
<b>PM-JAY</b>	Pradhan Mantri Jan Arogya Yojana
<b>RBSK</b>	Rashtriya Bal Swasthya Karyakram
<b>RCH</b>	Reproductive and Child Health
<b>RMNCH</b>	Reproductive, Maternal, Newborn, Child and Adolescent Health
<b>RoPs</b>	Record of Proceedings
<b>SBGF</b>	State Balanced Growth Fund
<b>SHA</b>	State Health Authority
<b>SHSs</b>	State Health Societies
<b>VHSNC</b>	Village Health Sanitation and Nutrition Committee

## Abstract

The paper seeks to understand (i) the role of National Health Mission (NHM) in defining/resetting health priorities in States and addressing horizontal inequalities; (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. The NHM helped reverse the declining trend in health spending by States by providing them with non-wage resources in the context of their low own revenues. However, health continues to be a low priority in state budgets, with the share of health spending in the total expenditure of State budgets remaining broadly unchanged over the past 30 years. Political leadership

often plays a key role in determining health as a priority. Post-NHM, horizontal inequalities have reduced to a small extent. Generally, States feel constrained by the Union government taking the lead in designing health schemes and setting priorities, with their role being reduced to mere delivery and implementation bodies. They also face uncertainty in fund flows, and there are no clearly defined platforms for communication. States address these constraints by exercising flexibility within the broader NHM framework, relying on their own funds using different platforms for communication. This, however, often occurs in an *ad hoc* manner, based on needs and issues faced.

## Executive Summary

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, (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 constraints 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.



## 1. Introduction

Fundamental to any federal structure is a clear framework for engagement that demarcates areas of responsibility, delegates work, and ensures accountability and autonomy between different levels of governance. Although health is a State subject in India, the roles and responsibilities in health and healthcare are spread across all the three levels of governance—the Union, States, and local bodies. Thus, while the Union government is responsible for family planning, health policymaking, and research (Union list), States are primarily responsible for creating, maintaining, and managing health institutions (State list). At the same time, the Union and States are jointly engaged in providing public health services, preventing the inter-state spread of infectious diseases, and overseeing medical education (Concurrent list). Local bodies play critical roles in the provision of preventive and public health services.

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) (refer to Appendix 1 for details) and the *Pradhan Mantri Jan Arogya Yojana* (PM-JAY), the erstwhile *Rashtriya Swasthya Bima Yojana*, and Central Sector Schemes such as the *Pradhan Mantri Swasthya Suraksha Yojana*.

Falling within the purview of Article 282 of the Constitution, the role of CSSs was initially envisaged to fulfil national objectives and ensure minimum levels of service delivery across all States (Saxena, 2011; Rao 2012). Designed centrally but funded by both the Union government and States, CSS allocations to different States are guided by their needs, ability to absorb grants, and spend them efficiently for the intended purpose, as well as the States' capacity and willingness to make matching contributions. Given that a significant portion of State funds are tied to salaries and wages, CSSs thus provide State governments access to much-needed funds and help develop their capacities in delivering healthcare services.

Over time, however, the number and quantum of CSSs have increased significantly and have become a predominant mechanism through which the Union government directs social policy in States. In 2021-22, for instance, CSSs comprised 23% of the total transfers to States.

Moreover, CSSs have also been increasingly formed on issues that are the prime responsibility of States, such as rural development, health, family welfare, etc. (Bagchi, 2003; Singh, 2022). The Fourteenth Finance Commission (FC XIV) observed that the expenditure of the Union government on subjects from the 'state list' increased from 14% to 20% between 2002-2005 and 2005-2011. This was also true for the 'concurrent list,' where the Union government's spending increased from 13% in 2002 to 17% in 2011 (Dahiya *et al.*, 2022).

This has led to an increasing tendency for the Union government to direct States in setting priorities. For a long time, States have expressed their discontentment with CSSs. They argue that such schemes undermine their autonomy and curb their ability to implement their own plans (Patnaik, 2015). The centralised nature of CSS design, coupled with the requirement for States to contribute matching funds for Union-directed priorities, impinges on the States' ability to allocate resources for state-specific health needs.

The Union Ministries, however, have argued that States need assistance to implement schemes of national importance (Saxena, 2012). Furthermore, the significance of these schemes can be gauged by the fact that States have never refused to avail grants from the Union government (CM steering group committee, 2015). As further evidenced by Aiyar (2019), States too have demanded and utilised more resources through CSSs, with the real conflict occurring when the Union government attempts to monitor and claim credit for a CSS's success (Ghosh, 2020).

The COVID-19 pandemic has further intensified the debate over which level of government should bear primary responsibility for public health. The Supreme Court of India asked the Union government about the response to the COVID-19 pandemic, and the Union government categorically stated that health is a state subject. As a senior official in Meghalaya stated, "*Basically, what they said was that it was States who have to manage this. The way that our federal structure works is that there is an assumption that there is a greater role of the Centre in every aspect, even if those are subjects at the state-level. When the accountability issue comes up, then the Centre or ministry in their affidavit said that States are responsible.*"

The need to unpack the role played by the Union and States in healthcare financing is critical, given that public spending on health in India has been one among the lowest, both in terms of share in GDP and per capita spending. In comparison to India, which spends around 1-2% of its GDP on health, its BRICS counterparts—Brazil, China, South Africa, and Russia—allocate between 3-4% of their GDP to healthcare. A lack of public spending on health has resulted in heavy dependence of households on out-of-pocket (OOP) expenses, leading to various hardships and sacrifices, including impoverishment and indebtedness (Garg and Karan 2008; Ghosh 2011; NCMH 2005; Selvaraj and Karan 2009). OOP expenditure as a percentage of the current health expenditure at 62.7 is one of the highest in the world, with India ranking 176 out of 196 countries (GOI, 2022). Several High-Level Expert Groups (HLEGs), Parliamentary Standing Committees, and even the Government's own health policies from time to time have advocated for raising public investment in health to 2.5-3% of the GDP, but this target has remained elusive.

Currently, States spend more than two-thirds of the total public spending on health, though there remain considerable variations in levels of public spending amongst States on health. For instance, per capita spending by State governments in Tamil Nadu, Uttarakhand, Kerala, and Himachal Pradesh was around ₹2,000-₹4,000, but it was less than ₹1,000 in Bihar and Uttar Pradesh (NHA, 2022). Yet, States are challenged by their institutional capacities, historical levels of investment, structural rigidities, and budgetary constraints set by the Fiscal Responsibility and Budget Management (FRBM) Act, along with a host of political economy factors.

The 'political economy of health' plays an important role in shaping health outcomes by influencing health priorities—balancing the diverse, often conflicting interests of the different stakeholders—and ensuring effective implementation of policy decisions (Goddard *et al.*, 2006). Understanding these processes and their underlying drivers is critical for assessing the feasibility of any health reforms, as well as ensuring their success and sustainability.

Against the above backdrop, this paper explores the evolving nature of federal financing for health, including the increase in union transfers through CSSs, and its implications on state-level health prioritisation and capacities. Specifically, the paper

seeks to understand (i) the role of CSSs, particularly the NHM, in defining/resetting health priorities in States and bringing down 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.

The study uses an embedded mixed-method approach combining quantitative data on health finances with detailed qualitative interviews from six states—Haryana, Madhya Pradesh, Meghalaya, Rajasthan, West Bengal, and Tamil Nadu. The selection of States was done purposely to capture different health trajectories, regional diversities, fiscal strength, and dependencies on Union government transfers, as well as differences in political orientation of the ruling dispensation.

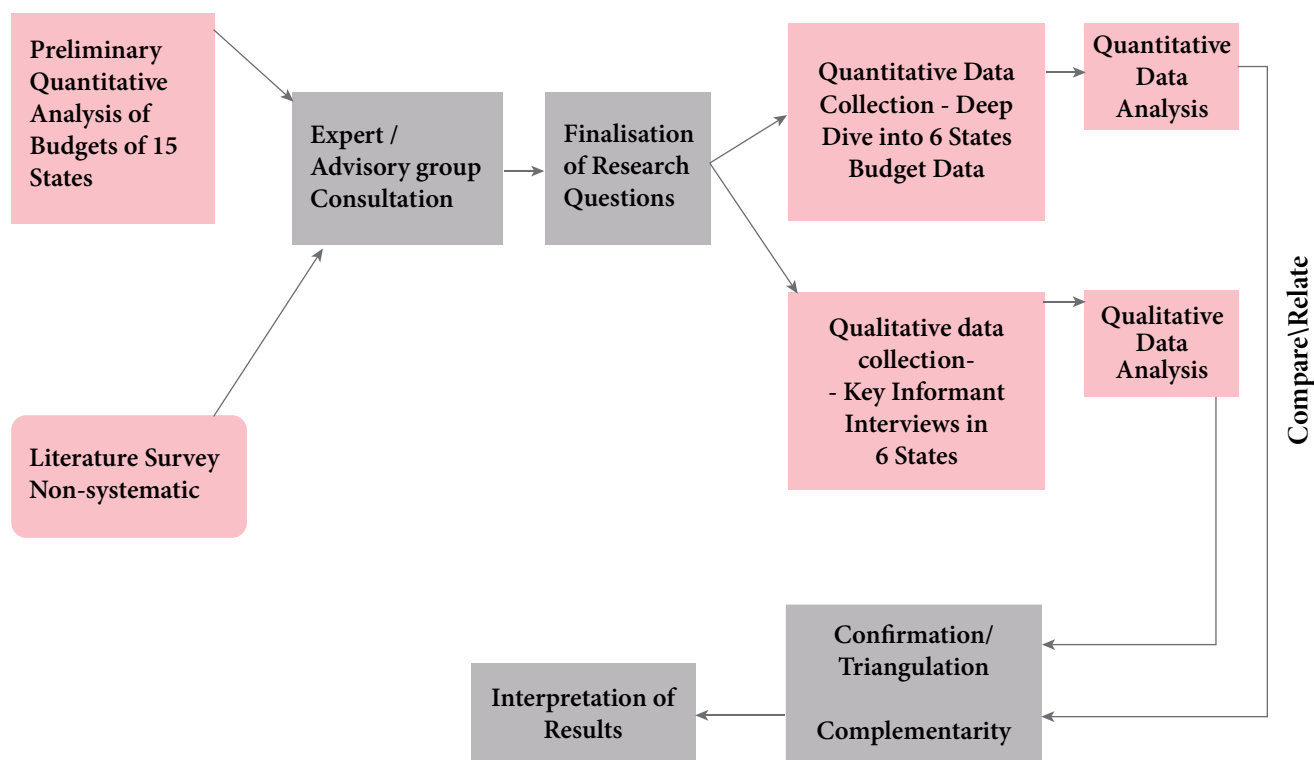
The study is organised in eight sections. Section 2 presents the design of the research paper. Section 3 tracks the rise in Union government financing for health and the changes in fiscal architecture, especially after the establishment of NITI Aayog and post the recommendations of the XIV and the XV Finance Commissions. Section 4 provides an overview of public finances for health for the sample states in this study. Section 5 delves deep into some of the constraints faced by the States in current fiscal design, particularly with respect to NHM. Section 6 looks at some of the underlying processes through which States cope with these constraints. This is followed by Section 7, which discusses the key issues emerging from the study, synthesises the main points, and spells out the policy implications. The paper concludes with the key findings in Section 8.

## 2. Study Design

### 2.1 Material and Methods

*Embedded Mixed Methods Study Design:* This study employs a mixed-methods approach, utilising a combination of quantitative budgetary analysis and qualitative methods through detailed Key Informant Interviews (KIIs) in sample states. During the formulation stage, the paper leverages textual analysis from a review of literature and preliminary budget data to develop research questions. These questions were then refined in consultation with an advisory group comprising public finance and health sector experts.

**Figure 2.1: An Embedded Mixed-Method Study Design**



Source: Authors representation.

Both qualitative and quantitative techniques were subsequently employed for data collection and analysis. The evidence generated was synthesised, with both techniques used to triangulate and complement each other (Figure 2.1).

### State Selection

To build a deeper understanding of fiscal federal dynamics in health financing effectively, six States with different health trajectories were identified. Of these, Tamil Nadu, West Bengal, and Haryana are non-high focus states under the NHM, while Rajasthan, Meghalaya, and Madhya Pradesh are high focus states. Meghalaya is a north-eastern State and geographically located away from the heartland, which makes its inclusion crucial. Since the political economy context may be driven by political party preferences, State selection considered different ruling dispensations. For instance, Madhya Pradesh and Haryana are ruled by the party in power at the Centre, *i.e.*, the BJP. Tamil Nadu and West Bengal are governed by the regional parties, while Meghalaya is also governed by a regional party with support from the BJP. Conversely, Rajasthan at the time of writing this paper was ruled by the main opposition party at the Centre, *i.e.*, the Indian National Congress.

### Qualitative Methods

KIIs were conducted with State and Union government officials to understand their perspectives on several issues, including the role of CSSs in health financing and the factors affecting prioritisation towards health. The respondents include serving and former Finance Secretaries, officials responsible for the budget-making process, Principal Secretary (Health), Union government officials who served in the sample states earlier, representatives from NITI Aayog, MD NHM, MD State Health Authority (SHA), and directors of line departments, as well as officials involved in the State budget-making process.

### Quantitative Methods

The quantitative analysis focused on the drivers of health financing by studying the change in prioritisation of health across both the Union government and States, the level of dependence of States on Union government financing, and trends in the composition of health expenditure. Several data sources have been utilised for state-wise analysis, including State budget documents such as the Annual Financial Statement and detailed estimates of

Revenue Receipts (1601-GIA from Central Government) and the RBI database.<sup>1</sup>

Data from the following budget heads has been used: (i) Medical and Public Health (2210, 4210, 6210); and (ii) Family Welfare (2211, 4211 and 6211).

It is important to note that beginning 2004-05, funds under the NHM were transferred directly by the Union government to autonomous implementing bodies known in the health sector as State Health Societies (SHSs). These funds thus bypassed State budgets. This practice of transferring funds directly to SHSs was discontinued from 2014-15. Instead, NHM funds are now devolved directly to State treasuries, which, in turn, transfer funds to SHSs. As a result, NHM expenditures in State budgets prior to 2014-15 and post-2014-15 are not directly comparable, and the GoI NHM funds need to be adjusted to ensure comparability. To account for these changes, analysis, wherever possible, was done in two phases: first from 2004-05 to 2013-14, and second from 2014-15 to 2020-21.

For detailed component-wise information on expenditures of NHM, Finance Management Reports were used. These reports provide approved budgets and expenditure for a state, line-item wise.

## 2.2 Limitations

It is important to highlight two limitations of the study.

First, while local governments play an important role in health delivery, the study is limited only to the relationship between the Union government and States in health fiscal delivery.

Second, there are challenges regarding the quality of publicly available data on health finances. For example, there are differences across different data sources concerning the quantum of expenditure incurred on CSSs. For most States, there are significant mismatches across different sources, which include data from Finance Accounts, State Budgets, and NHM

Financial Management Report (FMR) (audited). Moreover, data presentation is inconsistent across States. In some States, the share of Union funds for PM-JAY are transferred directly to escrow accounts, bypassing the State treasury. Conversely, in states like Madhya Pradesh, they are reflected under revenue receipts. While we have attempted to ensure consistency in analysis, in some cases, our analysis may not account for all Union transfers to States in the form of Grant-in-aid (GIA).

## 3. Health Financing in India: An Overview

### 3.1 Public Health Spending Trends

Public health spending in India has been characterised by its low quantum and significant inter-state variations. It is among the lowest in the world, measured either as a share of GDP or in per capita terms. Only a few countries in the world spent a lower proportion of GDP on health in 2014 than India (WHO 2016). Total health expenditure in India has remained less than 1% of GDP over the last 30 years, falling well below targets (2.5% of GDP) set in the National Health Policy (2017). Further, there remain significant variations across States in per capita health spending, ranging from as high as ₹7,353 in Arunachal Pradesh to as low as ₹608 in Bihar in 2018-19.

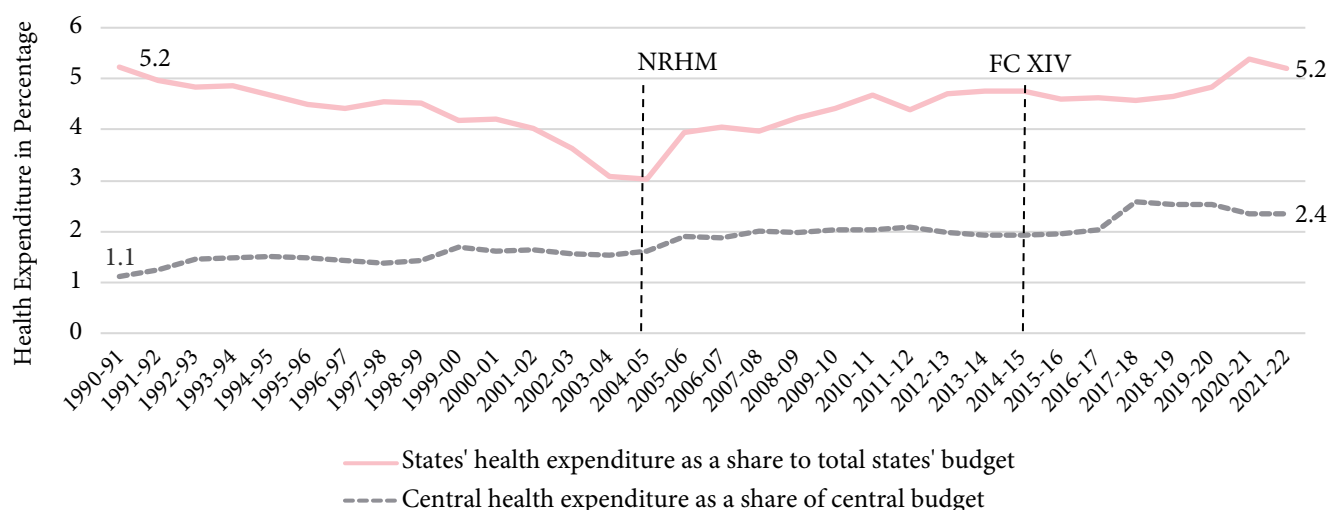
Despite the prevailing low health expenditures as a share of GDP, the period from 1994-95 to 2004-05 saw further decreases. However, with the launch of the NHM in 2005-06, there has been a marginal reversal of this trend. Expenditure as a proportion of GDP rose from 0.7% in 2004-05 to 1% in 2019-20.

Given that States are the major health spenders, accounting for as much as 77% of health expenditure in 1991-92, the launch of NHM saw an increase in health expenditure of states. The share of health in total expenditures of State rose from 3.04% in 2004-05 to 3.96% in 2005-06, and further to 5.3% in 2020-21 (Figure 3.1)

<sup>1</sup> A data validation exercise was conducted comparing health expenditure as reported in State budgets and those reported in the RBI study of State finances. Since both were found to be the same for the years 2014-15 to 2019-20, in order to cover a longer period, RBI data have been used.



**Figure 3.1: Union and State Health Expenditure as a Share of Total Budgets**



Source: Compiled using data from RBI State Finances, A Study of Budget; Union budgets.

Note: Centre's transfers to States have been included in the Centre's expenditure and deducted from State budgets to avoid double counting.

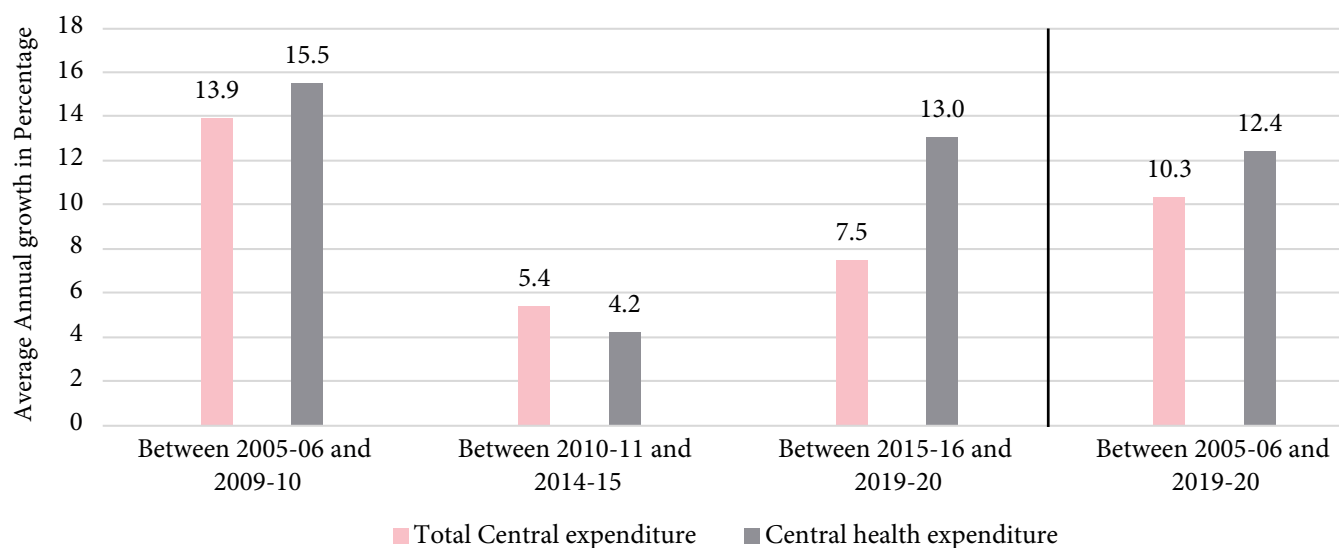
### 3.2 The Increasing Role of the Union Government in Health via NHM

The launch of the NHM was accompanied by an increasing role played by the Union government in health financing, evident from the fact that Union health expenditure per capita in the initial years of the NHM grew at a faster rate annually vis-à-vis overall expenditure. The growth of health expenditures per capita relative to total expenditure slowed down

during 2010-11 to 2014-15, but significantly outperformed overall expenditure in the next five years.

Overall, Union government health spending per capita grew by 12% annually between 2005-06 (the year of the launch of NHM) and 2019-20, compared with its overall spending, which grew by 10% (Figure 3.2). This is largely due to the launch and subsequent expansion of spending on NHM in first eight years.

**Figure 3.2: Average Annual Growth in per Capita Expenditure**



Source: Compiled using data from RBI State Finances, A Study of Budgets.

Reflecting the higher pace of health spending vis-à-vis overall spending, the share of health spending in the total spending of the Union government also increased post-NHM, reaching a peak of 2.6% in 2017 (refer Figure 3.1).

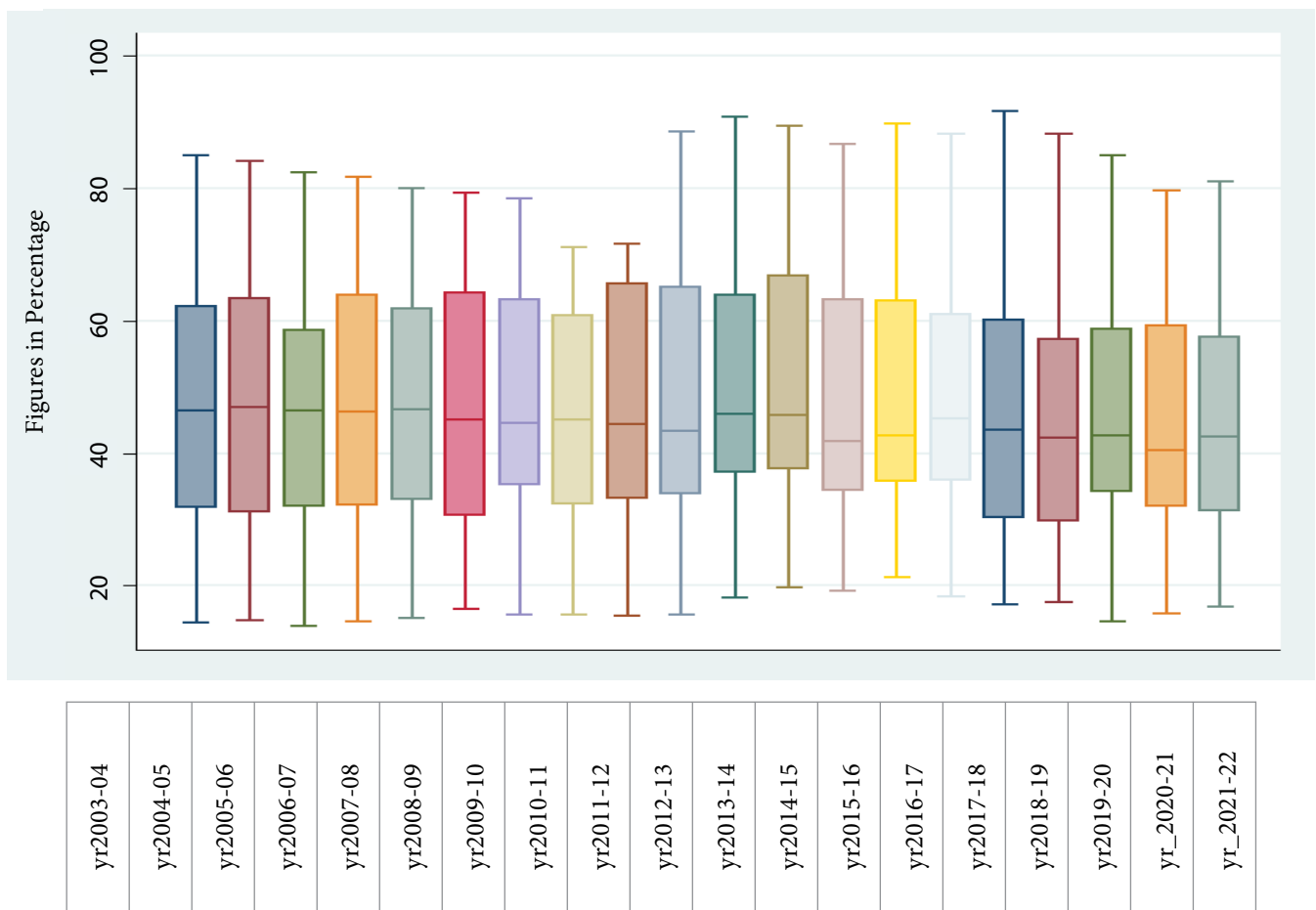
### 3.3 NHM in the Context of Limited Fiscal Space

For States, the NHM has provided access to non-wage resources and expanded the ability of States to deliver health services in the context of limited fiscal space.

A significant portion of revenue expenditure is frequently spent on committed liabilities comprising salaries, wages, and pension costs, as well as loan interest payments. State governments are required to make these payments even if they are short of funds. The greater the proportion of committed liabilities, the less budgetary flexibility there is for other expenditures.

This is even more relevant in the context of low Own Source Revenues (OSR), which have further declined recently (Figure 3.3). Revenue-raising capacities have thus failed to keep pace with expenditure needs, resulting in a dependence on Union funds.

Figure 3.3: Share of Own-Tax Revenue in Total Revenue of States: All States (%)



Source: Authors' estimates based on State Finances: A study of budgets, various rounds, RBI.

Note: Each colour represents a different state. For an explanation of box plot chart, refer to Appendix 2.

### 3.4 Recent Changes and Dependence on the Union Government

There have been two recent changes in the fiscal architecture which have relevance for State financing, including health.

First, the FC-XIV recommended significant changes in the way tax resources were to be shared between the Union and the State governments. Taking a comprehensive view on the aggregate transfers from the Union to the States and emphasising that tax devolution should be the primary route for the transfer of resources to States, the FC-XIV increased the share of tax devolution to States to 42% of the divisible pool (as against 32% recommended by the FC-XIII). This move was intended to increase fiscal space available to States.

However, this was accompanied by a change in the fund-sharing pattern for several CSSs on the ground that States could assume a higher fiscal responsibility for their implementation. In the case of NHM, the sharing pattern between the Union and States was changed from 75:25 to 60:40 for larger States and UTs with legislatures.

For States, while the recommendations of the FC-XIV increased States' share in the divisible pool in the first three years of implementation, thereby providing States with more untied resources, the share from tax devolutions has been declining since 2018-19. In 2020-21, the share of total receipts of States from tax devolution stood at 21%, similar to the levels in

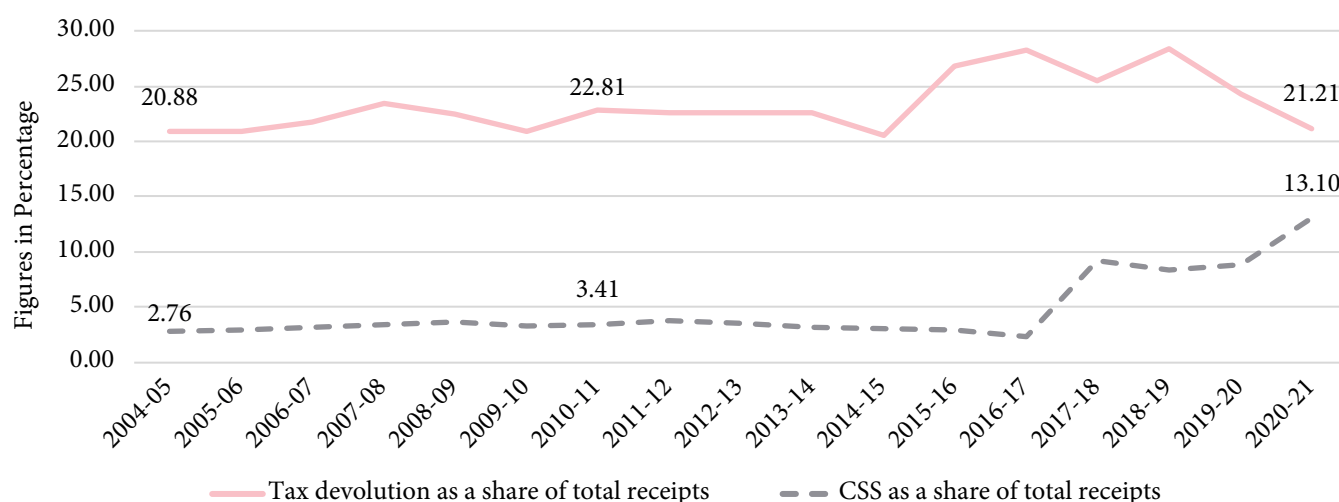
2004-05, and less than in 2010-11. This was partly due to declining gross tax revenues, coupled with the rise of cesses and surcharges imposed by the Union government, which were not included in the divisible pool. Moreover, the increase in States' shares for CSSs has meant that some of the untied funds received through increased tax devolution were once again ring-fenced into CSSs.

Further, despite an initial rationalisation and decrease in the number of CSSs, over time the Union government continued to increase funding to States *via* CSSs. Thus, during both years when tax devolutions declined, the share of CSS transfers increased in the total receipts of States (Figure 3.4).

At an aggregate level, fiscal transfers by the Union government in States' revenue receipts are now at 48.3%, which is very close to States' own revenue at 52.2%, as against 37% in 2004-05.

Second, the introduction of Goods and Services Tax (GST) has brought about considerable changes in the union-state fiscal relationship. States no longer have the power to set tax rates or levy taxes, except on petroleum products and liquor. When GST was introduced, States' revenues subsumed under GST were protected by law for a transition period of five years (2017-18 to 2021-22). This period has since been further extended until 2026. Any shortfall in revenue during this time is to be covered by a compensation cess. The lack of taxation powers for States has further weakened their ability to generate resources, shrinking the fiscal space available to them.

**Figure 3.4: Tax Devolution and CSS as a Share of Total Receipts of States**



Source: Compiled from data as presented in *State Finances, A Study of Budgets*.

Both of these changes led to two important implications for State finances, which have resulted in greater dependence on the Union government. First, the proportion of States' own revenue in their total revenue receipts has declined, making them more reliant on funds from the Union. Second, the proportion of fiscal transfers in the total revenue receipts of States has increased sharply, reaffirming the fact that States depend on the Union for their financial needs.

Regarding health specifically, the period following the FC-XIV shows that between 2014-15 and 2020-21, while the total expenditure of the Union government grew at 12% on average, spending on health grew at a higher rate of 17%. The prioritisation of health was particularly evident in the period between 2016-17 and 2017-18, when Union health expenditure grew at 36% compared to the total expenditure, which grew at 9%.

Increases apart, there have also been shifts in the nature of health spending by the Union government. From 2014-15, GIA to States for health relative to other health spending by the Union government began to decline, reaching a low of 50% in 2019-20 (Figure 3.5). This decrease was despite the quantum of health transfers/GIA increasing during this period. This suggests that instead of transferring funds to States via CSSs such as NHM, the Union government increased its own direct funding through Central Sector Schemes and increased expenditure on medical hospitals such as

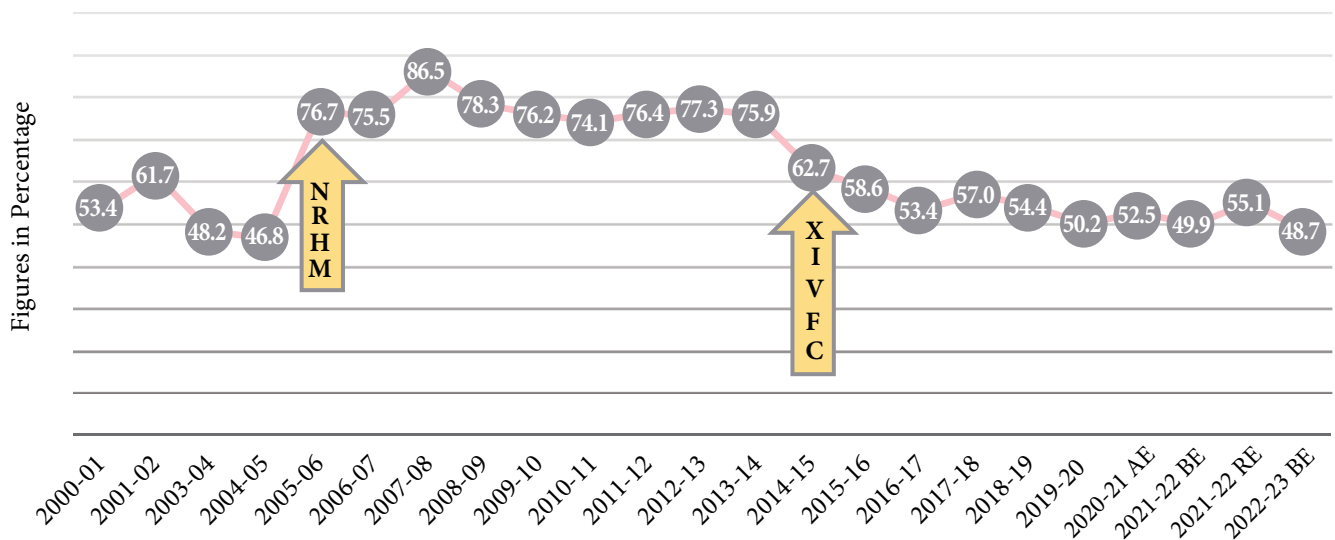
AIIMS. The decline in the share of health transfers to States vis-à-vis the Union's spending on health does not bode well for States' role on a subject which is in their domain. States may also need to source funds from a constrained fiscal environment to meet their health spending needs.

The following key points emerge from the above analysis: Post-NHM, health spending by States increased sharply, thereby reversing the declining trend that was witnessed from the early 1990s up to the launch of NHM. The NHM has certainly helped reverse the declining trend of spending on health. However, overall spending by States on health out of their overall spending has remained marginally above 5% in the last 30 years (between 1990 and 2021). As such, health, in general, remains a low priority in State budgets, and States in the past tended to spend less on health even when they had some fiscal space.

Further, a decrease in own-source revenues and a large share of committed liabilities for States, coupled with the increase in Union government spending on State subjects, has in effect increased the dependence of certain States on Union government spending. In fact, the role of the Union government has further increased, evidenced by an increase in its direct spending on health, as opposed to providing States with fiscal transfers.

Recent changes, such as those that occurred post the FC-XIV recommendations and the implementation of GST, have further impacted State finances and led

**Figure 3.5: Share of Health Transfers to States in Union Government Spending on Health – (%)**



Source: Union Budgets and State Budgets.



to limited fiscal space. Revenue constraints due to the COVID-induced economic slowdown and lower tax devolutions from the Union government could have a negative impact on health spending, given higher dependency of some States on Union government financing. The study also found that in case of economically weaker states only unconditional transfers (based on the award of the Finance Commission) mattered for health spending, with no impact on the own revenues (Raj *et al.*, 2024).. A recent study has found that the impact of unconditional transfers was greater than that of states' own revenue on health spending, unlike the period prior to the award period of the FC XIV, when states' own revenue was more important than conditional transfers for health spending (Raj *et al.*, 2024).

## 4. Public Spending on Health: Sample States

This section looks at trends with respect to health expenditure in six states in order to gauge how states prioritize health spending, availability of fiscal space, and the dependence on Union government transfers.

The priority accorded towards healthcare has been assessed in three ways. First, expenditure on health as a proportion of total expenditure has been analysed to see the relative priority given to the sector. Second, since proportions may mask the quantum changes in expenditure, annual growth rates of total expenditure and health expenditure have been compared. Finally, real per-capita spending on health has been analysed to observe differences across States as well as trends over time.

The analysis has been undertaken separately for the period before 2014 and the one after, due to changes in the fund transfer system from the State Health Society to the State treasury in 2014-15.

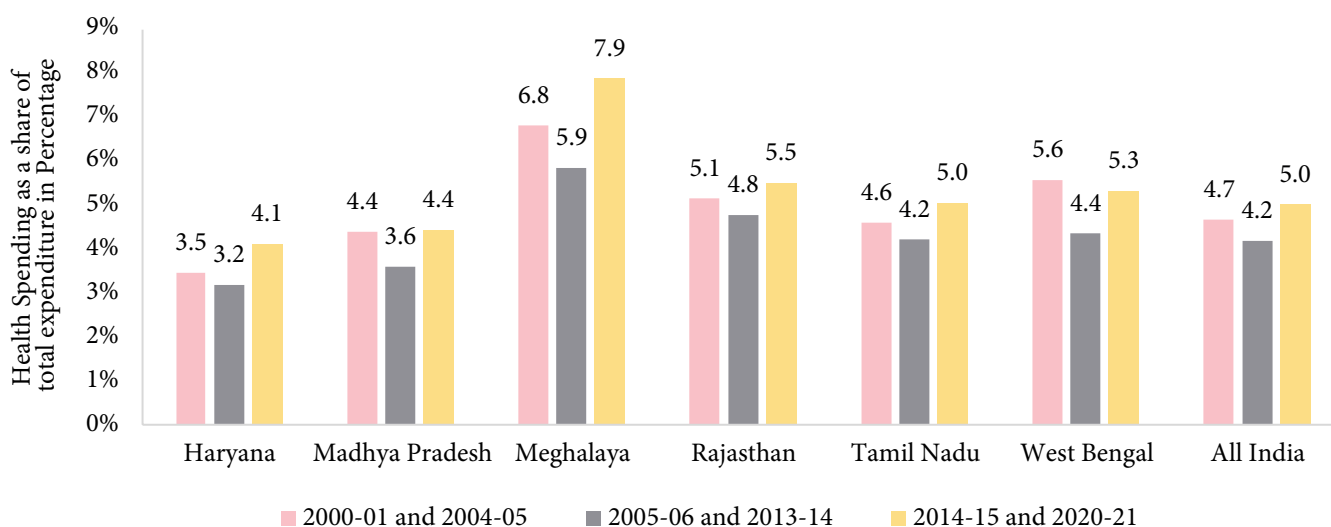
### 4.1 Share of Health in Total Expenditure

Unlike the overall trends, which saw an increase in health spending relative to total expenditure post-NHM, for all the sample states, health expenditure (state share + CSS) as a share of total expenditure decreased in the first phase, the period which saw the launch of NHM when compared to the previous period (Figure 4.1). The most severe decline was in West Bengal, with a 1.2% decrease, and Meghalaya (0.9%).

However, in the next phase from 2014-15 till 2020-21, all States saw an increase in healthcare spending as a share of their total health spending. For Meghalaya, it increased by 2%, followed by Haryana and West Bengal, which each increased by 0.9%.

The decline in the share of health expenditure of States relative to their total expenditure is in line with other studies that have seen a substitution effect when it comes to health financing through CSSs. In their analysis of the impact of unconditional transfers and specific-purpose transfers on States' priority-setting of health across 14 states from 1991-92 to 2007-08, Rao and Choudhury (2012) found that general purpose transfers were substituted for specific-purpose grants. That is, States substituted their own health expenditure with additional central government health grants. Another recent study confirmed that states substitute their non-NHM health spending with that of NHM spending (Raj *et al.*, 2023). Similarly, the yearly review of NHM conducted in 2013 and 2014 of select states in India, which included high-focus states such as Bihar, Jharkhand, Madhya Pradesh, Uttar Pradesh, Uttarakhand, West Bengal, etc., found evidence of some States diverting NHM funds to other pools or programmes (MoHFW, 2013; 2014). The trend continued in 2017 as well, with States such as Andhra Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Telangana, and Tripura diverting NHM funds to other schemes (CAG, 2017).

**Figure 4.1: Health Spending as a Share of Total Expenditure: Study States**



Source: RBI.

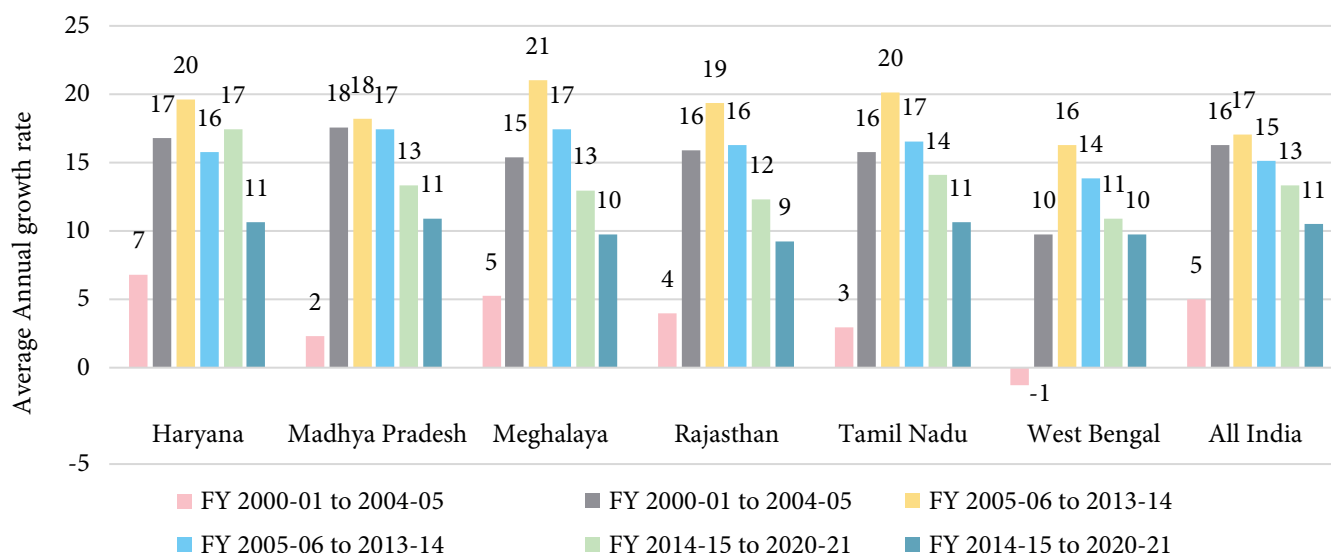
## 4.2 Annual Growth Rates in Health Expenditure

A closer look at the annual growth rates of health expenditure and total expenditure also mirrors similar trends. While the period between 2000-01 to 2004-05 saw the rate of health expenditure growth slower relative to total expenditure, this was reversed in the subsequent period after the launch of NHM.

Between 2005-06 and 2013-14, the average annual growth rate of health expenditure was faster at 17% compared to that of total expenditure, which grew at 15% (Figure 4.2).

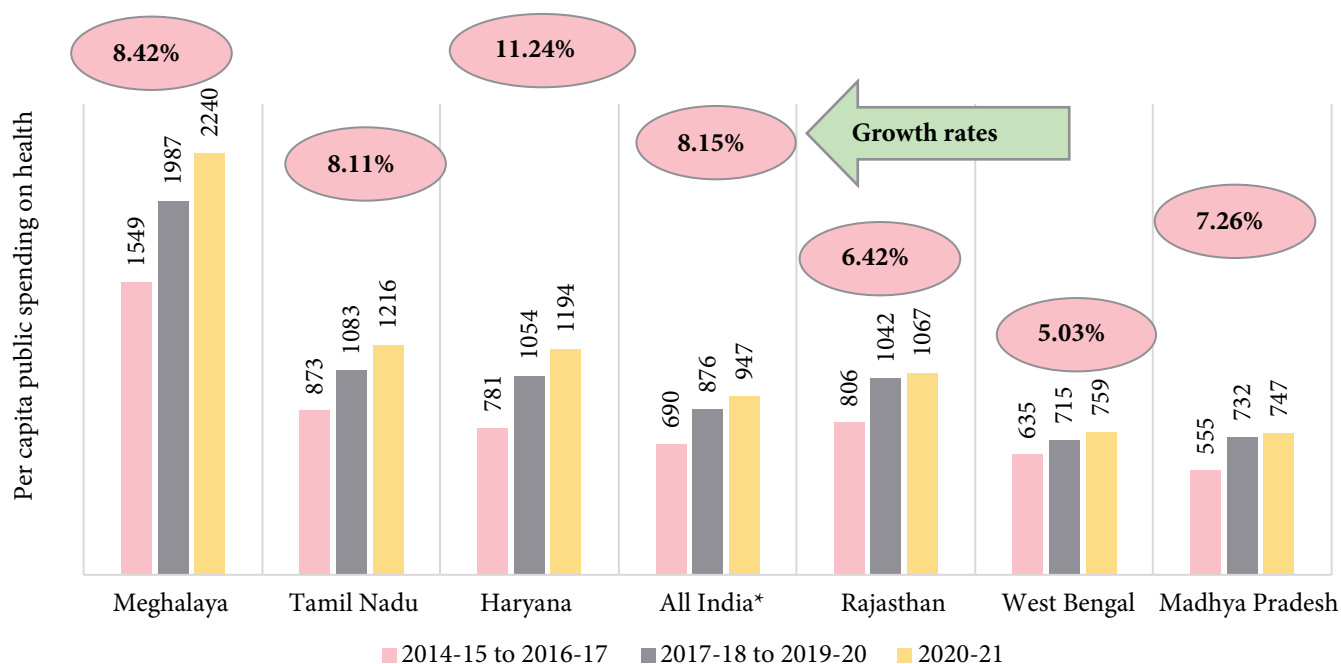
In the last phase, from 2014-15 to 2020-21, growth in health spending declined in all other sample states, while total expenditure grew at a much slower rate compared to the earlier phase.

**Figure 4.2: Growth in Total Government Expenditure (TE) and Government Expenditure on Health (HE)**



Source: State Budget.

Figure 4.3: Per Capita Public Spending on Health at Constant Prices



Source: State Budgets and Population Projection Report 2011-2036 and Inflation Data: [http://164.100.34.62:8080/TimeSeries\\_2012.aspx](http://164.100.34.62:8080/TimeSeries_2012.aspx).

### 4.3 Per Capita Health Expenditure

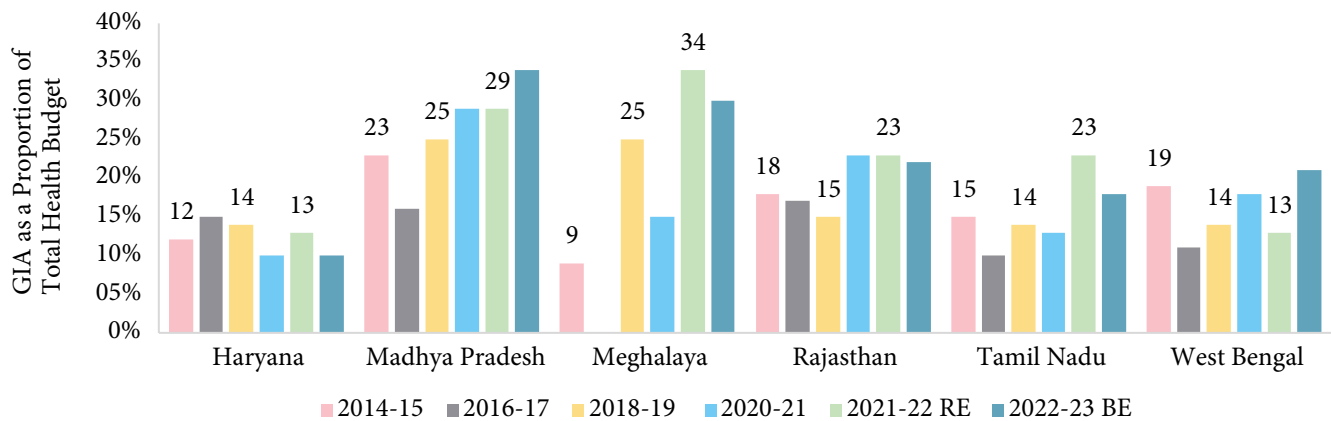
Per capita health expenditure in recent years has been calculated for the six sample states and the all-India level using population estimates and total health expenditure (Registrar General of India, 2020). The general price index has been used to convert the nominal figures into constant prices.

As depicted in Figure 4.3, there are considerable variations in per-capita spending across the sample states, ranging from ₹2,421 in Meghalaya to ₹860 in Madhya Pradesh in 2021. While per capita expenditure increased in real terms across all study states at an average of 8.3%, a look at individual States suggests significant variations in the pace of increase. For instance, the average annual growth rate of 12.2% in the case of Haryana was more than twice that of West Bengal, which grew at 6.3%.

From the above discussion, it is clear that there are considerable variations in public spending on health across the study states. After the introduction of NRHM, public spending on health grew at a faster pace across the board, relative to overall spending of states. However, in the recent period, there has been slowdown in health spending relative to overall spending by States.

In line with overall trends, GIA from the Union government also constituted an important source of health expenditure in some of the sample states. Of the six sample states, GIA constituted 30% or more of total health spending in Madhya Pradesh and Meghalaya. In contrast, it was less than 10% in Haryana. Additionally, while the share of GIA in total health spending increased in the case of Madhya Pradesh and West Bengal, it declined for all other sample states (Figure 4.4).

**Figure 4.4: Grants-in-aid on Health as a Proportion of Total Health Budget of Select States (%)**

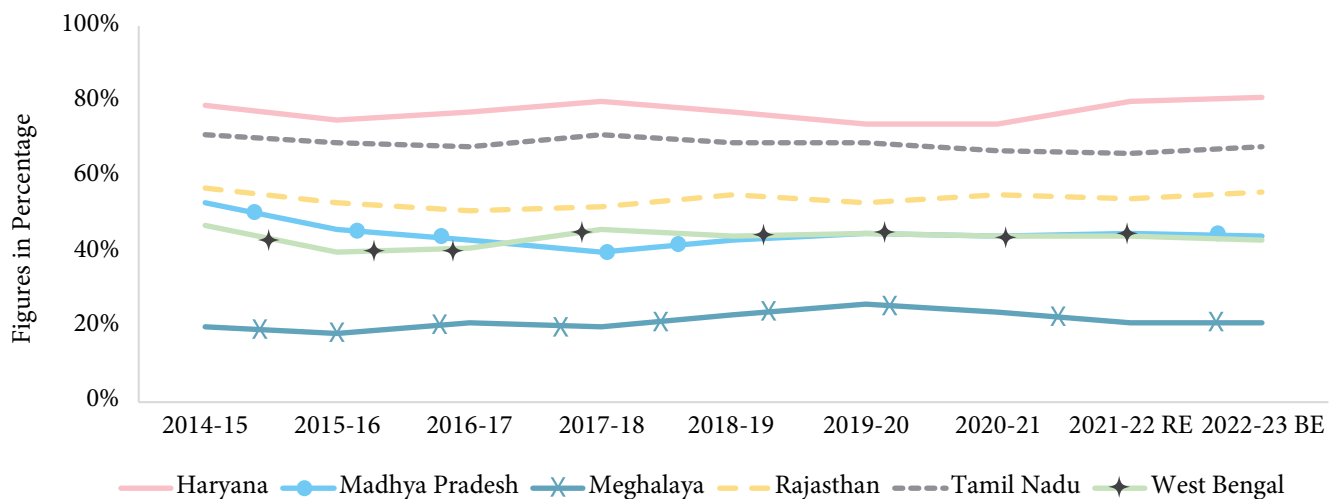


Source: State Budget.

Note: i) A breakup between 2016-17 A, department-wise or scheme-wise for Meghalaya, is not available.

ii) For Uttar Pradesh, the 2016-17 revenue receipts document was not available.

**Figure 4.5: Proportion of Own Source Revenue to Total Revenue Receipts of Select States**



Source: State Budget documents.

The share of own sources of revenue—OSR (tax and non-tax) in total revenue receipts varies sharply from State to State. The OSR constituted less than half for Madhya Pradesh (44%), West Bengal (43%), and Meghalaya (21%) in 2022-23 (BE). In fact, the proportion of OSR in revenue receipts declined significantly in Madhya Pradesh and West Bengal in 2022-23 (BE) compared to 2014-15. In contrast, OSR constituted a higher proportion in Haryana and Tamil Nadu (Figure 4.5).

To sum up, fiscally weaker states such as Madhya Pradesh and West Bengal are more dependent on transfers from the Union government, which make them vulnerable as they face greater risk and

uncertainty in their fund flows. Conversely, States with better fiscal parameters such as Haryana and Tamil Nadu can raise higher own revenues, providing these States with more autonomy and stability in expenditure decisions. Other studies on the fiscal status of States have indicated that richer states in India are able to mobilise their own tax revenues and raise funds for health (Berman, Bhawalkar and Jha, 2017; Choudhary and Mohanty, 2020). Findings from the sample states reflect these trends to an extent. Haryana and Tamil Nadu, which are the least dependent on Union government financing, have seen a greater increase in per capita health spending in recent years.



However, as the next section will demonstrate, fiscal independence does not solely explain the significant differences across States in the prioritisation given to the sector. For instance, despite being significantly dependent on Union government funds, Meghalaya's per capita expenditure on health and the share of total budget on health is the highest among the sample states.

Similarly, despite no real increase in OSR in Rajasthan and less than 25% of health expenditure coming from GIA, the State has seen substantial momentum towards health, including spending caused by the Rajasthan Right to Health Act, 2023.

What drives health prioritisation in a State? Does the increasing role of the Union government through NHM represent a constraint or an opportunity? The next section examines in greater detail the role of NHM in health financing in the six sample states.

## 5. The Role of NHM

### 5.1 Standard Setting and Prioritisation for Health

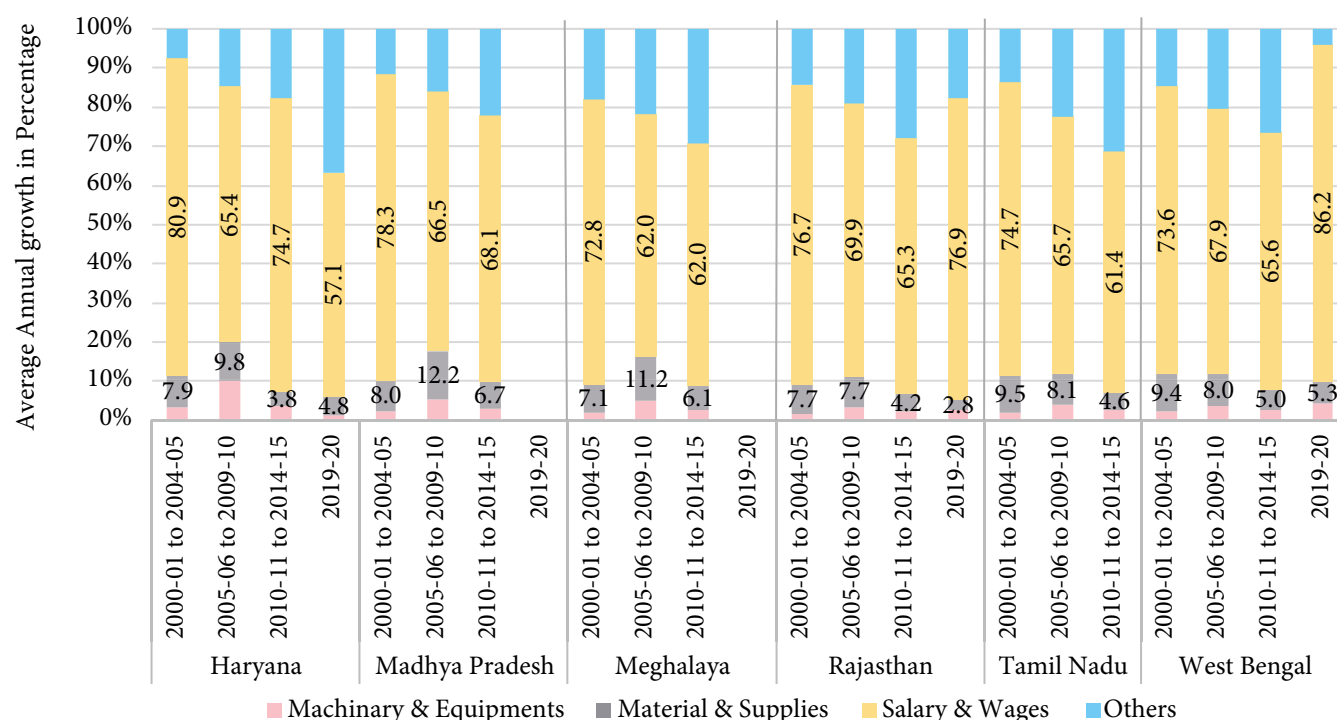
Even though what constitutes health system capacity remains debatable, it can be safely argued that a functioning health system needs a comprehensive combination of various inputs. Along with spending

on human resources such as salaries and wages, it is crucial to ensure that medicines and supplies are put in place, machinery and equipment are regularly maintained and upgraded, regular training of health personnel is conducted, and information education and communication (IEC) activities are emphasised. Figures 5.1 and 5.2 show the spending priorities in the State budget as well as the State Health Society.

As can be seen from Figure 5.1, a major part of the State budget is allocated to the salaries of permanent doctors, nurses, and other staff. In fact, prior to the introduction of the NHM between 2000-01 to 2004-05, as much as 81% of State budget in Haryana, 79% in Madhya Pradesh, and 77% in Rajasthan was spent on salaries and wages.

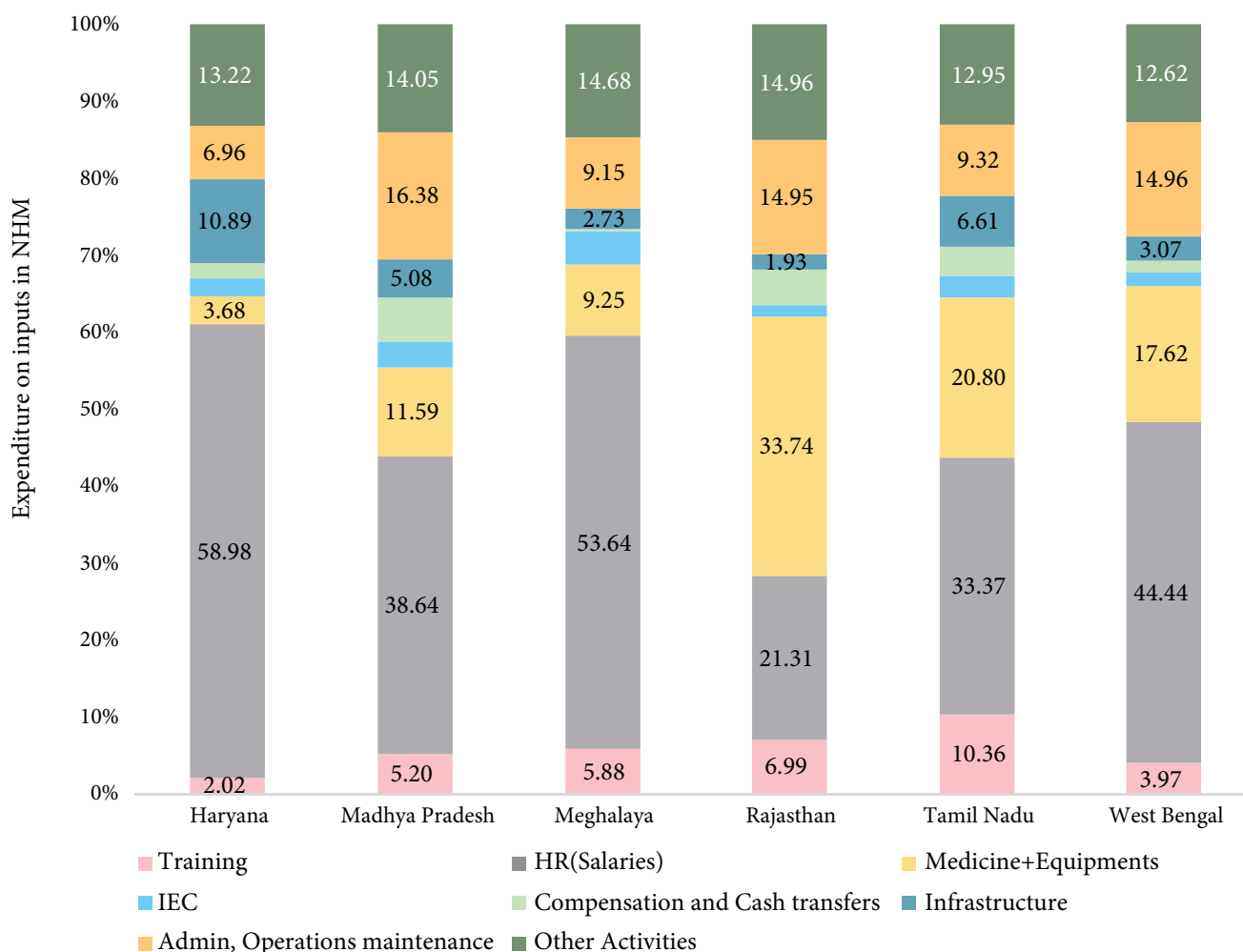
One of the key objectives of the NHM was to strengthen system capacities in States and bring health into the mainstream of high-focus states. The introduction of the NHM thus allowed for spending on other components such as training, medicines and supplies, equipment, and infrastructure, which help develop system capacities and enable States to deliver services better. Moreover, given that NHM primarily funds contractual staff, we see a reduction in the proportion of wages and salaries even in State budgets in the period after the introduction of the NHM after 2005-06.

**Figure 5.1: Share of Various Inputs in Health Budget of States: Five Year Moving Average**



Source: Detailed Demand for Grants, State Budgets, various years.

**Figure 5.2: Spending on Various Inputs under National Health Mission: 2019-20**



Source: Financial Management Reports in NHM.

A deeper dive into the various inputs under the NHM reflects the diverse nature of spending under the scheme compared to the State budgets. For instance, while States like Haryana and Meghalaya spent more than half of the NHM funds on Human Resources, others such as Tamil Nadu, Rajasthan, and West Bengal, known for their advanced medicine procurement and distribution systems, have effectively used NHM funds for medicine procurement (Figure 5.2). Tamil Nadu has a system of bringing NHM contractual staff gradually into their permanent structure and bears the salary expenses through the State budget; hence, the share of human resources in Tamil Nadu is only a third of the total budget.

The important role of NHM in freeing up funding to innovate and build technical and fiscal capacity for health, including fiscal management and reporting systems, was recognised by several States even in qualitative interviews. For instance, an official in Haryana spoke about the fact that “before NHM,

States were not focusing on health. The consciousness to improve health was low.” Similarly, an ex-official in West Bengal stated that, “NHM emerged with the idea of [an] integrated health system with focus on RCH, focus on PHC and integrating vertical programmes together. It helped create efficient affordable quality of care and reduced duplication of human resources used in different programmes.” Additionally, NHM also helped in reducing the workloads of doctors. “Pre-2005, government doctors had many different roles—IT, administration, awareness, and treatment. What NHM did is it created paraphernalia around the doctor like accountants, IT staff, etc., so the doctor could focus on being a doctor,” observed a Rajasthan health official.

This is particularly true for States that were not very proactive in envisioning and planning for health and lacked the financial, planning, and technical capacity for public health. In this view, since States are often in firefighting mode and focus more on

immediate challenges, they can miss the big picture. A common framework thus drives focus towards other less immediate issues as well, which are also important. As an official from Madhya Pradesh shared, *“In a way it’s good because it’s broader, wider. What would instinctively happen in States like MP is we would always be in firefighting mode. We will talk about MCH, sickle cell anaemia, but GoI also forces us to devote time, energy, space to discuss things like mental health, cancer care, and other hidden illnesses.”* Similarly, an official from Haryana shared, *“Since NHM provided policy, strategy, goals, finances, health infrastructure, States could progress, else it would have not happened.”*

Moreover, while States technically had the *“capacity at the State government level to analyse the needs of the people and then to actually allocate adequate funds as [they] think were necessary. That, unfortunately, [was] not really happening,”* said an official from Madhya Pradesh. Thus, programmes like NHM have been useful in ensuring some level of prioritisation.

However, while there has been an acknowledgement of the important role played by CSSs such as NHM, 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 on designing schemes and setting priorities. This view sees States as recipients of an agenda set by the Union government. Interestingly, this view was shared by Meghalaya which is highly dependent on Union transfers for health, as well as Tamil Nadu, which is less dependent.<sup>1</sup>

As an official from Meghalaya noted, *“States have taken the role of delivery systems. We are instruments for delivery. We are not actually exercising agency... Maybe States need to focus on subjects where they are expected to play an important role, and the Centre should play more of a supporting and facilitating role, and not a driving role.”* These sentiments were echoed by an official in Tamil Nadu who shared, *“Many of the health and education related decisions are taken at the*

*Centre, this is the choice we need to make [as a] State, as [the] State is providing resources.”*

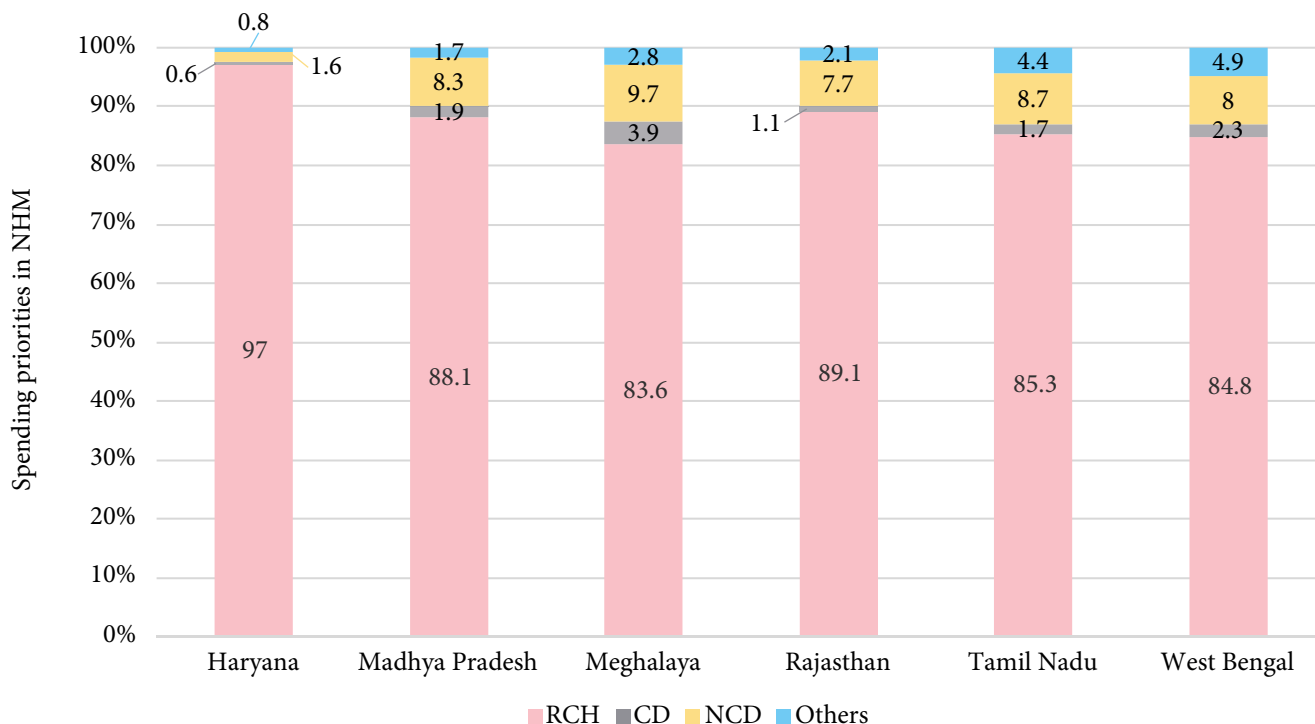
On the other hand, respondents who had experience of working with NHM at the Union government expressed that the Centre’s intervention in States is appropriate as they (i) need support for developing technical capacities; (ii) may not possess financial resources to raise funds; and (iii) ensure better utilisation of allocated funds. Some researchers have felt that lack of a state’s health capacity is a pretext used to justify centralisation, and they have argued that the Union government could invest in building State capacities rather than penalising them financially for underperforming (T. Sundararaman & Krishnamurthy, 2023).

A part of the problem with the Union government’s financing for health was with respect to the design of NHM. Discussions with States revealed two critical design issues. First was the one-size-fits-all approach, in which local conditions are not well reflected within the national, centralised design. Second, the fund flow process of NHM, with multiple conditionalities, results in delays and inequities. Both of these are discussed below.

## 5.2 One-Size-Fits-All Model

Though NHM started with the agenda of Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCH), and gradually disease control programmes got integrated into the NHM, the overall emphasis continues to be safe motherhood and child survival. Issues of Non-Communicable Diseases (NCDs) get very little emphasis under NHM. Even though there exists the notion of flexibility in preparing Project Implementation Plans (PIPs) and identifying State priorities, flexibilities remain mostly confined to changes within the broad items, while the scope of reallocating funds across areas remains limited. Essentially this meant that the overall kitty available for NCDs cannot be expanded significantly, even when a particular State feels the need to prioritise NCDs. In 2019-20, across the study states, more than 83% of funds are spent on RMNCH, while less than a tenth on NCDs.

**Figure 5.3: Spending Priorities Within NHM: 2019-20**



Source: NHM Financial Management Report 2019-20.

The lack of focus on NCDs within NHM is particularly worrying for some States. For instance, officials from Tamil Nadu mentioned that both Kerala and Tamil Nadu have a higher proportion of elderly population, and these States are trying to address the healthcare needs of the ageing populations. However, there remains limited scope within the NHM to address such issues. It should be noted further that these States are also going through demographic transitions, and the size of the working population is shrinking. As experienced in countries like Japan, over time, with a decrease in the working population and a corresponding shrinking of resource potential, the need for greater allocation of funds towards NCDs would increase.

Across States, there were examples of the Union government pushing for certain reforms without adapting them to the local context. In one instance, an official claimed that there were several examples of Union government officials insisting on particular components of the scheme being implemented in the state, with the State government officials having to

carry out those plans “as a formality.” In Meghalaya, the push for institutional delivery *via* the Janani Suraksha Yojana under the NHM as the only safe delivery method meant that the training of traditional birth attendants and the provision of delivery kits stopped. This, in fact, led to an increase in maternal mortality, given the local conditions and terrain, where having skilled birth attendants would have been a better option, according to an official. The State later had to create a policy once again focusing on training birth attendants (see Box 5.1 for more details).

Retired officials who have worked at the Union level provided a strong rationale for having a uniform approach: “From the administrator’s [end], it is convenient and efficient to have a uniform set of health plans, uniform health system goals, and a common set of indicators to track...” While such a uniform approach could be convenient and provides States additional financial resources, the question is whether States will choose efficiency over their autonomy.



### Box 5.1: Institutional and Non-institutional Deliveries in Meghalaya

When NHM was launched in 2005-06, there were some challenges with delivery mechanisms in Meghalaya. Meghalaya has approximately 7,000 localities, of which 6,400 are rural. Out of these, about 2,000 are in hard-to-reach areas. In this geography, the proportion of home deliveries was high. Prior to the launch of NHM, the State used to train traditional birth attendants and provide some delivery kits for safe delivery. According to officials, traditional methods existed due to local conditions.

NHM, instead, pushed for institutional delivery as the only safe delivery method. One way of doing this was through a new scheme, Janani Suraksha Yojana, which was launched under the NHM ambit. It provides financial incentives for institutional delivery. Consequently, with the launch of NHM, the training of traditional birth attendants and the provision of delivery kits stopped. This move resulted in an increase in maternal deaths in the State.

As the official shared, given local conditions and the distancing of the programme from traditional attendants, several people would have died. Cases arrive late, labour pains are extended, and delivery may have occurred in unsafe conditions.

Even now, several deliveries happen with the help of traditional birth attendants who are untrained. Therefore, Meghalaya now has a policy that allows pregnant women to bring a traditional birth attendant with them. The policy also includes compensation for traditional birth attendants in lieu of the loss of work.

*Source: Official, Health Department, Meghalaya.*

An official from Madhya Pradesh sums up the challenge of the 'one-size-fits-all' model: *"While [the] CSS has given a framework. At the same time, it has lost its flexibility...A cookie cutter approach has led to a lack of flexibility and lack of initiative at the state-level."* This sentiment was echoed by an official from another State who shared, *"Definitely NHM has helped. However some components may be helpful for some States, whereas not for other states."*

Acknowledging the concerns of reduced flexibility in NHM, an official from West Bengal said, *"The flexi pool in NHM has shrunk, and therefore the space for innovation has reduced. For instance, studies conducted to assess burden of diseases, implication of [the] use of pesticide[s] and fertiliser[s] on health, pollution-related health issues receive no support anymore."*

### 5.3 Fund Flow Challenges

Unlike tax devolution (where information on state-wise anticipated shares is available in the Union budget), for CSSs, States do not receive state-wise budget estimates. For fiscally weaker states, which are more dependent on Union transfers, this results in unpredictability in financing and fund flows.

States had varied experience with respect to 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. Speaking on the release of funds, an official from Tamil Nadu stated, *"There is always an uncertainty that if, at the end of the year, the Central government's money doesn't come, the States will have to fulfil the gap in resources."*

These experiences differ across both States and schemes. For instance, while Madhya Pradesh spoke about an increase in fund flow delays in recent years, Meghalaya felt that the release of funds had become timelier. Delays differ by scheme as well. In Rajasthan, officials reported NHM funds were timely, but PMJAY funds were not. Meanwhile, in Madhya Pradesh, according to consultants, the introduction of escrow accounts reduced delays in PMJAY, but funds were delayed in NHM.

For fiscally weaker states, delays by the Union government could potentially impact scheme implementation and delivery. As a consultant from Madhya Pradesh put it, *"CSS is working well, but when NHA doesn't send money on time, then it is a mental hindrance. This directly impacts the quality of services by private hospitals. If these challenges persist, we don't know if private hospitals will want to get empanelled. We can't run this scheme without private hospitals. And fund delays means that working and operating capital of the hospitals is affected. It's an economy of scale issue for the hospitals."*

## 5.4 Addressing Horizontal Inequalities in Health Spending

These fund flow challenges and conditionalities associated with the release of funds have also impacted an important goal of the programme, namely that of increasing equity. As previously mentioned, addressing horizontal inequity in public spending on health between States has been one of the key objectives of the NHM. The concept of ‘high focus’ states was introduced specifically to provide additional financial support to backward states that had limited State resources and performed poorly on health indicators.

Of the total allocations under NHM, about 60% are transferred to 18 high focus states (such as Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, erstwhile Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Tripura, Uttarakhand, Uttar Pradesh), and 40% to the non-high focus states.

Horizontal inequality has been assessed in terms of whether per capita public spending on health by States through the NHM mechanism has been converging. The method involves calculating the mean per capita spending across States for a particular time period and generating a ratio of per capita spending of a particular State to the all-state mean. The ratio is divided into four categories: less than 0.5 (category 1); 0.5 or more but less than one (category 2); 1 or more but less than 1.5 (category 3); 1.5 or more (category 4). For instance, in Table 5.1, the columns represent the number of States with a per capita public spending ratio falling into the four categories for the pre-NHM period (2000-01 to 2004-05). The rows represent the number of States that fall into the four categories for the period 2014-15 to 2018-19. The lower the ratio, the higher the horizontal inequality, and *vice versa*. The two time periods are then compared. If more States have moved from the lower category to a higher category, it would suggest a decline in horizontal inequality, and *vice versa*.

Table 5.1 allows us to observe the transition over almost two decades. Of the 29 States covered, 23 States showed no change (shaded yellow), *i.e.*, they remained in the same category before and after the NRHM/NHM. Of the remaining six States, horizontal inequalities declined in 5 States (shaded green), but they increased in one State (shaded red). Thus, overall, there was some decline in horizontal

inequalities post-NHM. This essentially means that some expenditure equalisation took place during the NHM period. However, most of these transitions occurred during the first phase and not in the later period. This may be linked to reductions in the central share under the NHM, going from full Union funding to a shared arrangement of 85%, which was then progressively reduced to 75% and subsequently to 60%, disproportionately affecting laggard states.

The issue of horizontal inequality under NHM must be discussed in the context of fund flow mechanism under NHM. If a State can spend a higher proportion of funds early, they are likely to get the subsequent instalments, thus increasing their overall share in total spending. States like Tamil Nadu can leverage these aspects, while high-focus states have been on the receiving end. An official from Madhya Pradesh shared, “*When poor States are penalised, they lose out on more funds. I do not agree with the way the policy was designed. Also, States which are already suffering in capacity to give outlays of funds to these schemes, are losing out on both fronts.*”

These findings align with other studies, which reported that the NHM failed to bring the inter-state parity and provide health equity within the States of Uttar Pradesh, Bihar, Rajasthan, and Madhya Pradesh (Husain, 2011; Jeffery, 2021), defeating its basic assumption that people in all states would receive at least basic meritorious public services (Rao, 2018). States with better capacity at the baseline have been able to take advantage of NRHM financing sooner, while high-focus states had to first revive or expand their health institutions and revitalise their management systems. High-focus states lagged far behind from the other States, and the time taken to build capacity for absorbing funds signifies their low level of achievement despite NRHM’s intervention (Berman and Ahuja, 2008; Berman *et al.*, 2010; NHP draft, 2015). The average growth rate of allocations through NRHM was 22% for the period 2005-2009; however, the capacity of States to absorb the funds was neither considered nor improved when releasing funds (Berman *et al.*, 2010).

Another related challenge facing States are inter-district inequalities and horizontal equity within districts. One challenge of a universal scheme has been adapting to local context and needs. As per one official, “*NHM has not solved district inequalities. It is a universal programme primarily, and there is not much district-specific innovation.*” Another pointed out that

**Table 5.1: Per capita public spending by states: pre- and post-NHM**

		Pre-NHM 2000-01 to 2004-05				Total
		Below 0.5	Greater than or equal to 0.5 and less than 1	Greater than or equal to 1 and less than 1.5	Greater than or equal to 1.5	
Post-NHM 2014-15 to 2018- 19	Below 0.5	BHR, UP, JHK, MP (4)	WB (1)			5
	Greater than or equal to 0.5 and less than 1	ASM, ODI, CHG (3)	TK, AP, MH, KAR, TN, KER, PUN, TRI (11)			14
	Greater than or equal to 1 and less than 1.5	0		MEG, MAN, J&K, DEL (4)		4
	Greater than or equal to 1.5	0		HP, NAG (2)	GOA, MIZ, SKM, ARU (4)	6
<b>Total</b>		<b>7</b>	<b>12</b>	<b>6</b>	<b>4</b>	<b>29</b>

Source: Authors' calculations using RBI data and other central and State budgets to address transfer from the Union government.

Note: Figures within parentheses represent the total number of States in the category.

“one challenge with resolving district-specific inequalities is understanding districts in a deeper way. Currently, NHM is universal and relies on indicators from the HMIS, NFHS, etc. However, a detailed and in-depth understanding can only come from State and local officials.”

However, there were some contrasting views as well. Officials in Madhya Pradesh, for instance, believed that NHM played an important role in addressing district inequities, and it was more a question of how to tailor the scheme for the needs of the district. As an official stated, “In Madhya Pradesh, NHM has

definitely helped. Whenever we plan an intervention, we plan for hard-to-reach areas, difficult areas, home delivery pockets, etc. Accordingly, we tailor interventions.” Another official added, “In Madhya Pradesh, intra/inter district equalities are not because of scheme per se but because of intrinsic capacities and people themselves.”

The question of tailoring schemes such as the NHM to meet State needs was a recurring theme that came up in the discussions. Some of the ways in which States are able to cope with the constraints of the NHM design are discussed in the next section.

### Box 5.2: Addressing Horizontal Inequalities across Districts: The Case of State Balanced Growth Fund in Tamil Nadu

Beyond NHM, an innovative approach in addressing inter-district parity was adopted by Tamil Nadu in the form of State Balanced Growth Fund (SBGF) created in 2013. Under SBGF, 100 most backward blocks and backward urban local bodies have been identified based on indicators such as health, education, poverty, income etc. An official working closely on it reflected, “SBGF reduced regional imbalance and improved growth indicators. The Fund covered two components: (i) Numeracy and literacy in schools for grade IV to grade VIII students; and (ii) special focus on the first 1000 days of a child's growth, improving nutritional status of children, with convergence of ICDS and health.”

Such innovative efforts from State governments need to be complemented by fund devolution mechanisms under CSS like NHM.

## 6. Coping With Constraints: Dynamics and Strategies

### 6.1 Claiming Flexibility

Despite the standardised nature of the programmes, to a large degree, States 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, demonstrating ability, and possessing strong negotiation skills and interpersonal dynamics—were some of the ways in which this can be achieved. As a State official shared, *“We try and bring in new programmes and initiatives that fit the NHM agenda broadly, and if required, [we] request funds for smaller versions of programmes and then scale up after demonstrating success.”* Another official from Meghalaya shared, *“What we understood is that, given the aggressive central sector scheme approach, what states have to figure out how to channelise and utilise these resources.”*

A case in point was a pilot programme Madhya Pradesh wanted to conduct for the HPV vaccine for cervical cancer, which was not undertaken by the Union government. As the official shared, *“We asked, and they agreed. So, it is not that they don’t give funds at all. If we bring it on as a pilot, show results, and want to scale, [they will support us.]”*

Another official from Madhya Pradesh gave examples of being supported by the Union government to run programmes for sickle cell anaemia, despite it not being commonplace elsewhere. Similarly, an official in Rajasthan also shared innovations that the State was able to implement within the budget head for *Rashtriya Bal Swasthya Karyakram* (RBSK), wherein mobile dental vans were procured to tackle the problem of poor children’s dental health without incurring high transportation costs.

A common platform that emerged for States to ‘negotiate’ and ‘convince’ Union officials was the National Programme Coordination Committee (NPCC) meetings. Planning for NHM involves States creating plans, called Programme Implementation Plans (PIPs). These PIPs are then submitted to the MoHFW for appraisal and approval. They are appraised during the NPCC meetings, which involve discussions between officials from the Union and State governments. Once approved, these are known as Record of Proceedings (RoPs).

Discussions with officials revealed two important trends. First, with the abolition of the Planning Commission, the importance of platforms such as NPCCs to discuss centre-state issues (at least concerning health) has gained primacy.

The ability to do this, however, largely depends on the personality and interpersonal dynamics between individuals. An official shared, the NPCC can be a confrontational space, which then means that final NHM approved budgets for a State depend on the personalities of the officials involved and their relationship with each other. As he stated, *“It becomes a confrontation, and then it depends on my personality. It’s diplomacy but should be a consultative thing.”* Similar sentiments were echoed across States.

The importance of this platform was also recognised by a Union government official, though with a slightly different take on the nature of the meetings. They stated, *“The decision to approve or disapprove certain demands is mutually decided at NPCC, based on [the] States’ ability to defend the demands.”*

Second, the detailed PIP process has, in some cases, increased States’ capacity in needs assessment, fiscal management, and reporting systems. For instance, States like Tamil Nadu have developed a systematic approach to PIP preparation, where every new plan and programme are discussed with sectoral experts, and proper planning processes are undertaken. This puts the State in a better position to defend its plan, and as a result, the likelihood of the State getting the PIP sanctioned improves considerably.

At times, the nature of interaction is further influenced by the political dynamic between the Union government and the State government in question. An instance of this was a general reluctance to share data. As an official said, *“There is a lack of interest from the State to share data especially when indicators are not favourable. Data sharing stopped to safeguard political mileage.”* This trust deficit has intensified with the rise of centralised Management Information Systems, State rankings through indices, and the Union government’s decision to directly initiate the aspirational district programme.

### 6.2 Adapting to NHM Fund Flow Challenges

Recognising the uncertainty in fund flows within the NHM design, most States use their own funds as a stop gap to ensure that implementation of programmes is not stalled in case of delays by the Union



government. As an official in Meghalaya noted, “For quite a number of CCS schemes, the state government has created corpus funds. [The] state government provides funds initially [at] the beginning of the year, [and] when funds are released by [the] GoI, [they] are adjusted.”

### 6.3 Using Different Platforms for Coordination

As previously stated, apart from the NPCC, with the abolishment of the Planning Commission, there is limited formal fora for coordination and priority setting between the Union and State governments. Although there is a health body meant to meet every year or two—which includes bureaucrats and ministers from States and the Union government—this body last met before the COVID-19 pandemic, according to an official from Meghalaya. The absence of technical bodies like State Health Resources Centres also means that States at times lack technical capacity. As an official from Meghalaya noted, “In terms of operations and implementation, there are still many challenges. There is no uniform set of idea or data exchange. Coordination is needed and does happen between departments. When we need something, we write to the NHM and vice versa. But this exchange is not practised regularly or something that is uniform, so that gap is still there.”

In the absence of clearly defined platforms and structures apart from the NPCC, communication often occurs in an *ad hoc* manner. Based on needs and issues faced, officials at the state-level contact Union government officials. While online modes of communication such as video conferencing and WhatsApp messaging have made communication more direct and faster, it does mean that the nature of the discussion depends on the personalities and relationships of the officials involved.

For example, in Madhya Pradesh, officials were able to reach out to Union government officials and procure COVID-19 vaccines for Front Line Workers (FLWs) for local body elections, who didn’t qualify under the eligibility criteria at that time.

“...video conferencing is an important tool. So whatever issues we have during execution, we are free to flag them. Every week we have a video call with the secretary or the Minister or the JS. The team at the Centre is quite

responsive. They are a phone call away. People are just a WhatsApp away! They respond to them,” said an official from Madhya Pradesh

States have occasionally dealt with some of this by assigning multiple responsibilities to the same official. For instance, in Meghalaya, Madhya Pradesh, and Rajasthan, officials working on NHM often have responsibilities for PMJAY as well. This allows officials to have a wider view of proceedings. However, challenges persist, such as data sharing and creating regular platforms for communication and coordination.

A positive step in improving coordination was the creation of a separate authority outside a ministry *i.e.*, the National Health Authority, which has also helped communication and coordination, especially for regular PMJAY functioning. The main factor in this has been the continued presence of various “back-end” officials working on health insurance schemes—first RSBY and now PMJAY.

“A few core RSBY people moved from MoLE to health then to the National Health Authority (NHA). For many States, this was helpful, as they understood what States wanted. So that was a good thing. There was no separate authority [earlier], which is now there, so things are easier for States,” an official from Meghalaya explained.

There are several ways in which the NHA coordinates and communicates with States. According to consultants at the state-level, this communication happens on a daily basis, with designated coordinators, an IT-based support system with tickets, and through seminars, workshops, monthly, quarterly, annual reviews, as well as visits to States by NHA officials and functionaries.

### 6.4 State Prioritisation and Innovations for Health: Role of Political Will

Given that a large part of the state budget on health goes into bearing committed expenditure such as salaries and office expenses, the ability of States to allocate resources on state-specific priorities and innovations remains limited. However, some States have demonstrated their willingness to bring in additional resources and launched ambitious schemes and programmes. Examples such as *Swasthya Sathi*<sup>2</sup> in West Bengal, *Mukhya Mantri Nishulk Nirogi*

<sup>2</sup> A health insurance scheme, covering up to ₹5 lakh per annum per family.



*Yojana*<sup>3</sup>, and *Mukhya Mantri Nishulk Jaach Yojana*<sup>4</sup> in Rajasthan, and the recently introduced door-to-door medicine supply for NCDs in Tamil Nadu are examples of state-funded initiatives to respond to the health challenges faced by people. Some of these initiatives become politically more relevant when the political party in power at the state is different from the one in power at the Union level.

States have often adopted interesting financing mechanisms to fund such innovations. For instance, in the case of Rajasthan's free medicine scheme, additional allocations remained limited, while large gains were made through exercising economies of scale under a centralised procurement system (Sakthivel *et al.*, 2015). Tamil Nadu used a special innovation fund under the Department of Planning to initiate the door-to-door medicine delivery scheme, while the background research had been done in collaboration with external research agencies. In West Bengal also, reliance on external agencies for meeting some of the requirements of infrastructure, equipment, and machinery has been highlighted.

Interviews with State officials across study States pointed to two key factors that played a role in determining which sectors to prioritise or whether health was a major priority in the state. The first was the role played by political leadership, and the second were factors related to state-specific and historical context.

Nearly all States emphasised the role played by political leadership in setting the vision and goal. For instance, in Rajasthan, the political leadership provided the vision for the Right to Health Act, 2022 and they were supported by bureaucrats in creating a legal framework. Similarly, officials in West Bengal shared the pivotal role played by the Chief Minister in setting priorities for health.

In other instances, even when the line departments took the initiative to propose new schemes, the role of the political leadership in generating buy-in and finding ways to channel resources was said to be key. As an official in Meghalaya stated, *"Everyone is involved in setting priorities; the department*

*will initiate the proposal, then get the views of all the concerned departments. If policy changes are required, the approval of the cabinet is also required, or if a scheme is very important, then the approval of concerned Ministers and, at times, the legislature is needed."*

Sensitising political leaders is thus a strategy used by bureaucrats to generate support for various schemes and programmes. Officials in Meghalaya explained that one way of doing this is to involve the CM in review meetings to help them understand challenges faced and discuss what is feasible for government programmes. Most States believed that as long as political will was present, resources could be garnered and were not a challenge. States like Tamil Nadu and Meghalaya, for instance, have been successfully able to even leverage resources from external organisations.

*"This year the medical and health budget is ₹16,000 crore (plus, medical education is separate)...Government buy-in is there, as health is a priority sector. All requirements we have, we get from finance,"* said an official from Rajasthan.

The involvement of political leadership also means that they can be susceptible to changing priorities depending on which political party is in power. Each party, when in power, tries to improve on existing schemes, including those created by previous governments, and adds schemes of their own choices. However, most felt that positive competition among political parties was useful. Balabanova *et al.*, (2013) observed that political commitment to health, unaffected by the party in power, has resulted in effective health service delivery in Tamil Nadu.

*"Certainly, some bit of positive competition on which party does better does persist and has been useful,"* an official from Tamil Nadu remarked.

Lack of political buy-in, however, can on occasion prevent the implementation of schemes. Some CSSs may not be launched in States where there are serious political differences between the political leadership at Union and State levels. Such differences have led to West Bengal and Delhi not adopting PMJAY.

<sup>3</sup> A scheme that aims to provide free medicines.

<sup>4</sup> A scheme that aims to provide free screening and diagnostic services.

Priority setting is also partly driven by historical and local factors. This is particularly true in the case of Tamil Nadu, which has a long history of focusing on public health. In fact, the first hospital was set up in the region as early as 1655, and a medical college was opened in 1835. An important milestone for the state was the passing of the Madras Public Health Act, 1939, later called the Tamil Nadu Public Health Act.

Similarly, Chief Ministers in Meghalaya too have a history of prioritising the social sector, including health and education. The high cost of service for providing basic necessities has further meant more budgets are required and thus spent on sectors such as health. This is reflected in the budget analysis as shown in the previous section, with Meghalaya spending the highest per capita on health among the six states studied.

## 7. Discussion

The central aim of this study is to assess the role of union-state fiscal relationship, and particularly Union transfer to States, on public financing of healthcare in the States of India. Using the case of the NHM, the paper seeks to determine whether the scheme has been able to bring more public resources for health.

It must also be noted that since 2013-14, a series of policy and institutional changes have been introduced in the country, which have consequences for the financing of public services like health. Specifically, these changes include the introduction of GST, the abolition of plan and non-plan distinctions in central transfers, along with replacement of the Planning Commission with NITI Aayog; a greater share of the divisible pool of resources devolving on States through the Fourteenth Finance Commission recommendation, and the routing of central funds through State budgets rather than direct transfers to autonomous societies.

Interestingly, despite an initial rationalisation and decrease in CSSs, over time the Union government continued to increase spending to States via CSSs. Fiscal transfers from the Union government now are almost half the level of States' own revenues, which make them highly dependent on the Union. This dependency does not augur well for social sector spending by States, including health, especially because a large portion of their receipts goes into financing their committed liabilities.

Given the increasing role of the Union government, this study sought to understand the perspectives of States on CSSs, including the implications of NHM design, in addressing state-specific needs; the type of innovations and coping mechanisms that exist at the state-level; and the factors that shape prioritisation for health.

Some key points emerge from the analysis of public spending on health. Overall, public spending on health has increased, thus reversing the declining trend that was witnessed from the early 1990s up to the launch of the NRHM. However, overall spending by States on health has remained broadly stagnant at 5% in the last 30 years. Health, in general, is a low priority in State budgets, and in the past, States tended to spend less on health even when they had some fiscal space. Now that their fiscal space is constrained due to the COVID-19 induced expenditure and lower tax devolution from the Centre, their spending on health could suffer.

The Union has rapidly expanded its footprints in health post NRHM\NHM, as reflected in a sharp rise in its health spending. Consequently, the proportion of untied resources to the States in the form of tax devolutions and grants in relation to the Union's spending on health has declined. GIA for health, which could be both tied or untied, have also declined in relation to overall health spending by the Union. There are mixed feelings about the expanding role of the Union in health through NHM. While officials in some States were concerned with reducing the role of States to mere implementing bodies, others acknowledged that the NHM helped improve the focus on health and provided States with additional resources.

Specifically, States reflected on the challenges with the common framework and norms that are applied across States and the unpredictability of finances. This has had an impact on the ability of NHM to promote horizontal equity between States in public spending on health.

The evidence in this paper shows that even though overall spending has increased, inter-state variations continue. However, it should be recognised that some States, which were spending much less compared to the all-state average, have now moved closer to the mean—these States largely belong to the high-focus states. This is a positive development and corroborates the fact that States perceive the role of NHM as pivotal in prioritising health.

Yet, in none of the study states, there were calls to completely abolish CSSs such as NHM. Instead, the focus was on means of how to cope with and manage the distortions in the scheme design, coupled with calls for greater flexibility and formal platforms for centre-state negotiation.

States in India are also at diverse stages of demographic transition and thus have different disease profiles. NRHM (now NHM), which began on the principles of decentralised planning and flexi pools to enable States to prioritise their needs, developed rigidities in flexi pool allocations (Rao, 2017). The NHM prescribes flexi pools to facilitate States in tailoring the scheme as per their local needs. However, over time the scope of flexibility has been conditional and limited, though it still exists. For instance, as long as States are asking for something new within the specific ambit of NHM and the demand is based on some form of evidence, the Union government is willing to fund it. However, if a particular state needs something radically different from what is mandated by the Union, such demands are likely to be turned down. In such circumstances, States like Tamil Nadu or Haryana, which have greater resource availability and technical skills, are able to fund innovative programmes from their own resources. Poorer states have limited fiscal and technical capacity to finance and implement such innovations.

While schemes like NHM have brought the focus back to health, it is probably high time to consider allowing greater flexibility within the design of CSS. As a senior health official shared, this flexibility “should not only be in funds but also in choosing policy too.” There is a need to shift the focus of inter-governmental fiscal health financing from inputs to outputs/outcomes, while advancing the measurement agenda as an accountability tool. Complementary to the flexibility noted above, the Union government could shift the focus of CSS transfers away from line items and activities towards outputs and outcomes, with States being empowered to choose their own pathways to achieve results (FC-XV).

Union government initiatives should also focus on strengthening decentralised institutions, building research capacity, state-level production capacities, and managerial capacities. The NHM experience of

implementing decentralised planning and the PIP and budget preparation process has been a great learning experience for States. However, the spirit of decentralisation has been compromised. Recently, the planning cycle under NHM has changed to a biennial from an annual process. This should be used as an opportunity to reinstate and strengthen the practice of bottom-up planning, greater community participation, and ownership of the programme.

It would be crucial to augment public spending on health quite significantly. However, given the constitutional division of responsibilities, the onus of increasing public spending rests with the States. There remain large variations in the capacity of States to spend, and the level of actual investment on health by States. The issue of whether healthcare should continue to feature in the state list and the Union government should continue to play a supporting role has been debated extensively. The “High Level Group on Health Sector” of the XV Finance Commission recommended that public health and hospitals should be a part of the Concurrent list so that the Union government can play a greater role in bringing horizontal equity across States (Finance Commission 2019). Such a recommendation needs to be seen in light of the overall attitude of the Union Government towards centralisation of health policy space, even though there are many examples that demonstrate the value of leaving health policy to the state-level, given the diversity of context.

Thomas Jefferson once said in a letter that the only way States can guard against over-centralisation of power in the national government is “to strengthen the State governments: and as this cannot be done by any change in the federal Constitution, . . . it must be done by the states themselves” (Letter from Thomas Jefferson to Archibald Stuart, Dec. 23, 1791). The Constitution of India, which is more flexible than that of the US, might allow more powers to the states, provided that states demand it, develop their capacity and, as stated by Jefferson, the key remains in States asserting for more power. We have argued that States cannot altogether veto CSSs, yet they can demand more flexibility and perhaps the evidence-based scheme formulations.

## 8. Concluding Remarks

The introduction of the NHM marks a major landmark in health policy development in India. This initiative addressed the previous neglect of public healthcare delivery systems and the low public spending in the social sector. The NHM represented a marked departure from the limited focus on family planning and vertical disease control programs, characterised by a top-down, target-driven approach, to an integrated strategy emphasising conditional flexibility and bottom-up planning. Notably, the NHM has achieved remarkable improvements in maternal and child health outcomes. Despite shifts in political priorities at the Union level, the NHM continues to be a key vehicle for Union health interventions. Its sustained relevance, even with a decrease in political prioritisation, underscores its importance among States.

Post-NHM, health spending by the Union increased at a faster pace than its overall spending, while States have also been able to moderately augment their spending. However, as expected, the issue of horizontal inequity in public spending and the goal of achieving some sort of convergence of per capita spending was not realised, though some improvement was observed. In recent years, owing to changes in the union-state fiscal relationship, the share of tax devolutions in States' total receipts has declined, and that of funding to States *via* CSSs by the Union government has increased. As a result, the share of CSS transfers in total receipts of States has risen. However, the Union has increased its own direct funding through Central Sector Schemes, while the funding through CSS such as NHM has declined. This has led to diverse implications across States. Some continue to depend heavily on Union resources for health, while others have been able to contribute a significant share of their own resources.

The NHM has brought in some important reforms in the health system—improved planning processes, better financial management, and filling key human resource gaps with the introduction of new cadres for management, finances, and service delivery. There has also been concerted efforts to improve health systems capacities at the state-level. In principle, the NHM was supposed to provide flexibility in identi-

fying State priorities executed through a bottom-up planning process. Over time, in-built flexibilities became limited and states depend heavily on their capacity to articulate and negotiate with the Union to get their proposals approved. Consequently, better-off states can leverage opportunities more effectively, than States with limited fiscal space. Health system capacities continue to depend on Union funding and techno-managerial guidance to implement the programme. The notion of bottom-up planning was reduced to routine activities with limited scope for innovation, and the potential of community engagement remained largely unexplored. Union directives and guidelines continue to evolve over time, creating their own set of implementation challenges and delays. The scope of joint fora of dialogue between the Union and the States has remained limited and hierarchical. In fact, the only existing platforms are based on inter-personal relationships. There is a need to establish a more institutionalised mechanism, not just through the NPCC meetings, within the NHM.

The study brings some critical questions about centre-state fiscal relationships in health to the fore. Given the diversity of the country and ensuing demographic and epidemiological changes, does a 'one-size-fits-all' approach remain relevant? Do we continue to focus largely on RMNCH across the country, or recognise the diverse needs of the country and create conditions for States to choose their own priorities, particularly for NCDs? If discussions with State officials are to be taken seriously, the limited and conditional flexibility provided under the NHM has played an important role at a critical juncture. However, it is high time to better recognise the diverse capacities of States. States should be provided with greater flexibility to identify locally relevant priorities in health and accorded greater financial resources to plan and implement them. Nonetheless, we also recognise that drawing some concrete policy recommendations on these serious issues requires further enquiry, including issues related to the ideal division of responsibilities between the Union and States on health, the impact of greater transfers of untied resources to States on health outcomes, and the capacity of States to prioritise health.



## References

- Aiyar, Yamini. (2021, March 15). *Flagship Seminar Series on India's Public Finances Part 2: Federalism and Human Capital*. <https://csep.org/wpcontent/uploads/2021/03/Federalism-and-Human-Capital.pdf>
- Bagchi, Amaresh. (2003). Fifty years of fiscal federalism in India: An appraisal. *Working Papers 03/2*.
- Balabanova, D., Mills, A., Conteh, L., Akkaziya, B., Banteyerga, H., Dash, U., Gilson, L., Harmer. (2013). Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. *Lancet (London, England)*, 381(9883), 2118–2133. [https://doi.org/10.1016/S0140-6736\(12\)62000-5](https://doi.org/10.1016/S0140-6736(12)62000-5)
- Berman, P., & Ahuja, Rajeev. (2008). Government Health Spending in India. *Economic and Political Weekly*, 43(26–27). <https://www.epw.in/journal/2008/26-27/special-articles/government-health-spending-india.html>
- Berman, P., Ahuja, Rajeev, Tandon, Ajay, Sparkes, Susan, & Gottret, Pablo. (2010). *Government health financing in India: Challenges in achieving ambitious goals*. World Bank. <https://www.jstor.org/stable/pdf/resrep26269.4.pdf>
- Berman, Peter, Bhawalkar, Manjiri, & Jha, Rajesh. (2017). *Government Financing of Health Care in India since 2005: What was achieved, what was not, and why?* Project Harvard T.H. Chan School of Public Health Boston. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2031/2017/01/Government-financing-of-health-care-in-India-since-2005.pdf>
- CAG. (2017). *Reproductive and Child Health under National Rural Health Mission Report (Performance Audit 25 of 2017)*. Ministry of Health and Family Welfare. <https://cag.gov.in/en/audit-report/details/31333>
- Choudhary, Mita, & Mohanty, Ranjan Kumar. (2017). Utilisation, Fund Flows and Public Financial Management under the National Health Mission: A Study of Selected States. *NIPFP*.
- Dahiya, S., James, K., Patel, K., Pathak, A., & Singh, A. (2021). India's Human Capital: The Regulatory Context for Leveraging Federalism. *Indian Public Policy Review*, 2(5 (Sep-Oct)), 1–33. <https://doi.org/10.55763/ippr.2021.02.05.001>
- Finance Commission (2019). High Level Expert Group on Health Sector, XV Finance Commission, Government of India.
- Garg, C. C., & Karan, A. K. (2009). Reducing out-of-pocket expenditures to reduce poverty: A disaggregated analysis at rural-urban and state level in India. *Health Policy and Planning*, 24(2), 116–128. <https://doi.org/10.1093/heapol/czn046>
- Ghosh, A. K. (2020). *The Paradox of 'Centralised Federalism': An Analysis of the Challenges to India's Federal Design*.
- Ghosh, S. (2011). Catastrophic payments and impoverishment due to out-of-pocket health spending. *Economic and Political Weekly*, 46(47), 63–70.
- Goddard, M., Hauck, K., & Smith, P. C. (2006). Priority setting in health—A political economy perspective. *Health Economics, Policy, and Law*, 1(Pt 1), 79–90. <https://doi.org/10.1017/S1744133105001040>
- Husain, Zakir. (2011). Health of National Rural Health Mission. *Economic and Political Weekly*, 46(4). <https://www.epw.in/journal/2011/04/special-articles/health-national-rural-health-mission.html>
- Jeffery, R. (2021). Health policy and federalism in India. *Territory, Politics, Governance*, 10(1), 67–85. <https://doi.org/10.1080/21622671.2021.1899976>
- Ministry of Finance. (2014). *XIV Finance Commission Report*. [https://fincomindia.nic.in/writereaddata/html\\_en\\_files/oldcommission\\_html/fincom14/others/14thFCReport.pdf](https://fincomindia.nic.in/writereaddata/html_en_files/oldcommission_html/fincom14/others/14thFCReport.pdf)
- Ministry of Finance. (2022). *Economic Survey 2021-22*.
- Ministry of Health and Family Welfare. (2005). *National Commission on Macroeconomics and Health (NCMH)*.
- Ministry of Health and Family Welfare. (2013). *7th Common Review Mission Report (No. 7)*. <https://nhsrcindia.org/sites/default/files/202103/7th%20CRM%20Main%20Report%202013.pdf>
- MoHFW. (2014). *8th Common Review Mission Report*. [https://nhsrcindia.org/sites/default/files/2021-06/8th\\_CRM\\_Main\\_Report.pdf](https://nhsrcindia.org/sites/default/files/2021-06/8th_CRM_Main_Report.pdf)



- Ministry of Health and Family Welfare. (2014). National health policy-draft 2015. [https://www.nhp.gov.in/sites/default/files/pdf/draft\\_national\\_health\\_policy\\_2015.pdf](https://www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf)
- National Health Systems Resource Centre. (2022). *National Health Accounts Estimates for India 2018-19*. Ministry of Health and Family Welfare. [https://nhsrcindia.org/sites/default/files/2022-09/NHA%202018-19\\_07-09-2022\\_revised\\_0.pdf](https://nhsrcindia.org/sites/default/files/2022-09/NHA%202018-19_07-09-2022_revised_0.pdf)
- NITI Aayog. (2015). *Report of the sub-group of Chief Ministers on rationalisation of Centrally Sponsored Schemes*. NITI Aayog. <https://www.niti.gov.in/sites/default/files/2019-08/Final%20Report%20of%20the%20Sub-Group%20submitter%20to%20PM.pdf>
- Patnaik, P. (2015). From the Planning Commission to the NITI Aayog. *Economic and Political Weekly*, 50(4), 10–12.
- Raj, J., Ranjan, R., Shrawan, A., and Gupta, V. (2024). Fiscal Transfers from the Union to States and Healthcare in India (Forthcoming). Centre for Social and Economic Progress, New Delhi.
- Rao, Govinda M. (2018). Making federalism work for India's development. In *Challenges and Issues in Indian Fiscal Federalism* (pp. 9–13). Springer, Singapore.
- Rao, M. G., & Choudhury, M. (2012). *Health Care Financing Reforms in India*.
- Registrar General of India. (2020). *Population Projections for India And States 2011 – 2036, Report Of The Technical Group On Population Projections*.
- National Commission On Population Ministry Of Health & Family Welfare, New Delhi – 110011.
- Saxena, N.C. (2012). Central transfers to states and centrally sponsored schemes. *Esocialsciences. Com*, 195.
- Selvaraj, S., Mukhopadhyay, I., Kumar, P., Aisola, Malini, & Datta, Pritam, P. (2014). Universal access to medicines: Evidence from Rajasthan, India. *WHO South-East Asia Journal of Public Health*, 3(3–4), 289–299.
- Selvaraj, Sakthivel, & Karan, Anup K. (2009). Deepening Health Insecurity in India: Evidence from National Sample Surveys since 1980s. *Economic and Political Weekly*, XLIV (40). <https://www.epw.in/journal/2009/40/special-articles/deepening-health-insecurity-india-evidence-national-sample-surveys>
- Singh, M. P. (2022). *Federalism in India*. Sage Publications.
- T. Sundarraman, & Krishnamurthy, M., K. (2023). Redesigning and Revitalizing India's Public Health Governance: Addressing, Abiding & Antagonisms. In Ritupriya, & S. Hameed, *Dreams of a Healthy India: Democratic Healthcare in Post-Covid* Times. New Delhi: Vintage books.
- WHO. (2016). Global Health Expenditure Database. <https://apps.who.int/nha/database>

## Appendix 1: National Health Mission (NHM)

The National Rural Health Mission was launched in 2005 in all States and Union Territories of India with special focus on 18 states, namely, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh by the Ministry of Health and Family Welfare (MoHFW).

In 2013, the National Health Mission (NHM) was launched by merging the existing National Rural Health Mission (NRHM) (2005) with the National Urban Health Mission (NUHM)<sup>5</sup> by the Ministry of Health and Family Welfare (MoHFW). By merging NRHM and NUHM in NHM, the scope of mission was expanded to cover urban health services along with rural health services.

NHM is a flexible and dynamic mission intended to provide states with guidance to strengthen their health system capacities in attainment of Universal Health Coverage. Adding to the existing vision of providing affordable, accessible and quality healthcare, NHM envisions to provide for universal equitable healthcare that would respond to people's need as well as seek intersectoral convergence for effective health service delivery. The key elements of the NHM are set out below:

- Ensuring the well-being of the economically disadvantaged, vulnerable, and marginalized populations by adopting a rights-based approach to healthcare
- Enhancing public health systems to establish universal access to healthcare and safeguard individuals from the escalating expenses associated with medical care.
- Fostering a trustworthy environment between healthcare providers and the people they serve.
- Empowering communities to actively engage in efforts to achieve the highest attainable levels of health.

- Establishing transparency and accountability as integral components of all processes and mechanisms within the healthcare system.
- Enhancing efficiency to maximize the utilization of existing resources.

Programmatic components under NHM are similar to NRHM, with expanded scope of urban areas as well:

- (i) Health Systems Strengthening including infrastructure, human resource, drugs & equipment, ambulances, Mobile Medical Units (MMUs), Accredited Social Health Activists (ASHAs) etc.
- (ii) Reproductive, Maternal, Newborn, Child and Adolescent Health Services (RMNCH + A)
- (iii) Communicable Disease Control Programmes
- (iv) Non-Communicable Diseases Control Programme interventions up to District Hospital level
- (v) Infrastructure Maintenance

Additionally, NHM under National Quality Assurance Programme has set up State Quality Assurance Committee and Units in all states and union territories providing quality of health service and ensuring patient safety.

A major objective was to raise public spending on health from 0.9% GDP to 2-3% of GDP.

Centre and the states contribute 60:40 ratio in NHM as it is a Centrally Sponsored Scheme. For North Eastern Region (NER) states and Himalayan states, the ratio is 90:10, where 10% is contributed by states. Budgetary estimates of Funds allocated to NHM has incrementally increased from Rs 27,989 crore in 2020-21, Rs 31,100 crore in 2021-22 to Rs 36,960 crore in 2022-23.

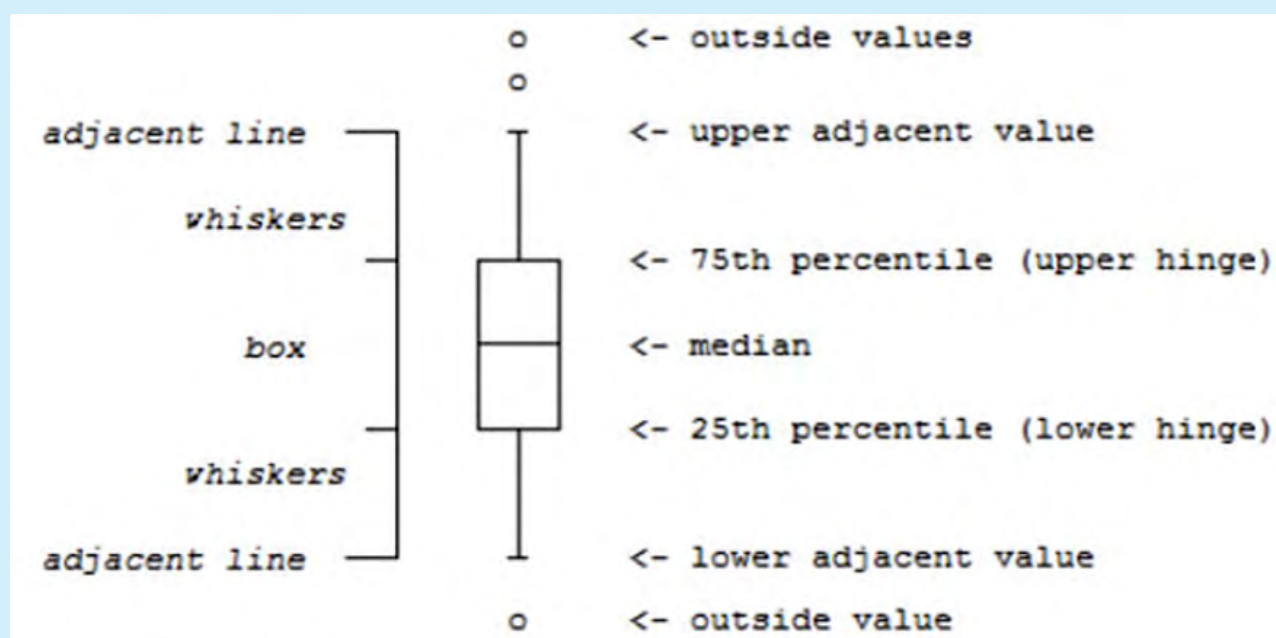
<sup>5</sup> NUHM which was also launched in 2013, consisting of one Urban Community Health Centre (UCHC) for a population of 5,00,000 in metro cities and 2,50,000 for smaller cities; and one Urban Primary Health Centre (UPHC) for every 50,000 residents. Similar to ASHA's under NRHM, ASHA's were appointed in Urban Areas too.

## Appendix 2: Explanatory Note on Box plot

**Figure 3.3: An Explanatory Note on Box Plot**

A box-whisker plot (also called as box plot) is a non-parametric approach for graphically representing the frequency distribution of a variable through their quartiles in the form of a box. The middle line in the box represents the median and the upper and lower hinges of the box represent the 3<sup>rd</sup> and 1<sup>st</sup> quartiles (or 75<sup>th</sup> and 25<sup>th</sup> percentile) respectively. The length of the box represents the interquartile range which is a measure of dispersion. The spacing between the upper hinge and median, and median and lower hinge of the box indicates the degree of skewness in the data. The values which are outside 1.5 times the length of the box on either side are considered as outside value (or outliers) and represented as dots in the plot. The box-whisker plot also has lines extending vertically from the boxes called whiskers indicating variability outside the upper and lower quartiles. The upper and lower adjacent values represent the maximum and minimum of the series excluding outliers.

Box-whisker plot can be represented as:



Source: STATA Graphics Reference Manual.

## Appendix 3: Per capita Spending of States between 2014-15 to 2021-22

Per capita spending	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22 RE
Meghalaya	1516	1478	1652	1646	2419	1895	2405	2421
Tamil Nadu	847	890	882	1010	1160	1078	1409	1540
Haryana	713	762	867	910	1035	1216	1330	1619
All India	641	688	742	828	896	905	1041	1130
Rajasthan	748	836	832	964	1103	1059	1040	1335
West Bengal	568	671	667	685	708	753	816	977
Madhya Pradesh	520	562	582	701	693	803	744	860

Source: Based on Author's calculation

## About the authors



**Avani Kapur** is a researcher and development practitioner and a leading public finance expert with nearly two decades of experience. She is a Senior Visiting Fellow at the Centre for Policy Research (CPR) and Founder, Director of Foundation for Responsive Governance (ResGov) which works on transforming lives by enabling responsive governance that is adaptive, accessible, and attentive to every vulnerable citizen's need. Prior to this, Avani was a Senior Fellow at CPR where she led the Accountability Initiative – the largest research group working towards strengthening accountability and transparency in governance. Avani has led several financing, and process tracking studies on implementation of key social sector programmes including in health, nutrition, water, sanitation, and education. She is a Tech4Good Fellow and part of the WICCI Council of Ethics. As part of her academic work, she is on the editorial board of the Journal of Development Policy and Practice and regular reviewer for Journals such as World Development Perspectives, Journal of Food Security amongst others. Avani is an alumnus of the London School of Economics and Political Science (LSE), in the United Kingdom and Smith College Massachusetts, USA amongst others.



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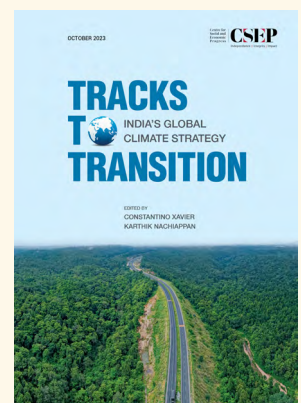
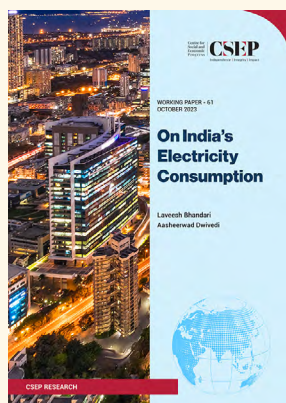
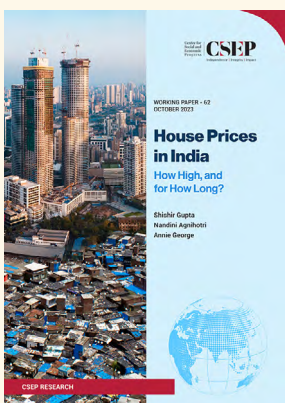
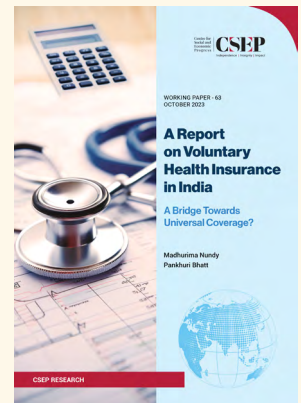
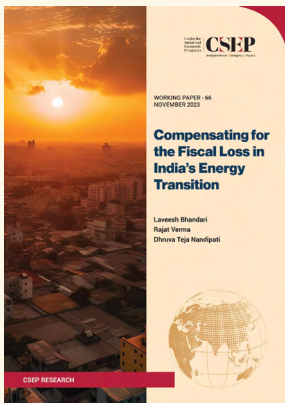
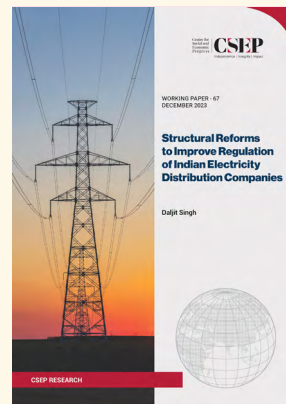
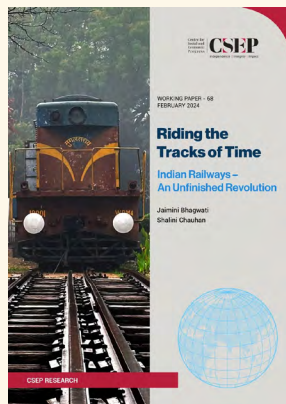
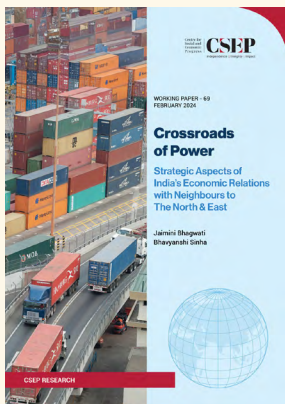
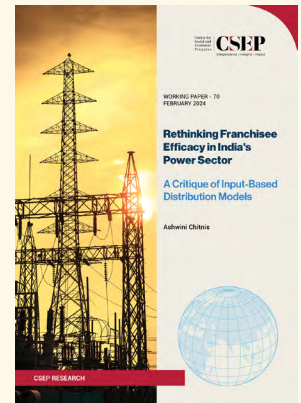
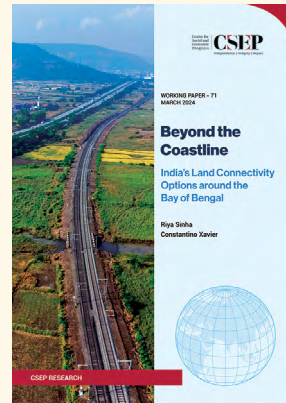
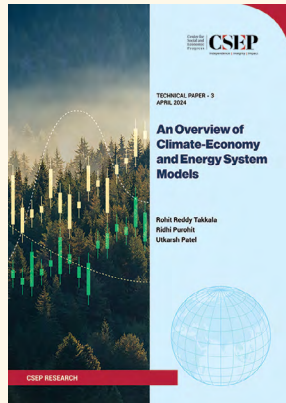
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