REVIEW OF INTER-GOVERNMENTAL FISCAL TRANSFERS FOR HEALTH: LESSONS LEARNED AND LOOKING AHEAD

VICTORIA Y. FAN, SMRITI IYER, AVANI KAPUR,
RIFAIYAT MAHBUB AND, ANIT MUKHERJEE

CENTRE FOR POLICY RESEARCH

ACCOUNTABILITY INITIATIVE
research and innovation for governance accountability

Center for Global Development

Accountability Initiative, Centre for Policy Research, Dharam Marg, Chanakyapuri, New Delhi 110021
w: www .accountabilityindia.in | f: www .facebook.com/ accountabilityindia | t: @AccInitiative

ACKNOWLEDGEMENTS

We would like to thank Àmanda Glassman and Yamini Aiyar for their support and advice without which this study would not have been possible. In addition, we are extremely grateful to Dr H.K. Amarnath of the National Institute of Public Finance and Policy (NIPFP), Delhi, who advised us on many tricky aspects of public finance and to Yuna Sakuma, Lauren Post and Vikram Srinivas for their research assistance. Finally, we would like to thank Bill and Melinda Gates Foundation and the Centre for Policy Research, whose support enabled us to write this report.

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1. MOTIVATION AND RATIONALE

In large, federal countries such as India, fiscal transfers from central to state governments are an important source of funds for the delivery of public services. When designed well, such intergovernmental fiscal transfers can increase the accountability and the effectiveness of public service delivery. But although there is extensive theoretical knowledge about different fiscal transfer mechanisms, there is limited empirical evidence about the effectiveness and efficiency of these mechanisms, especially with regard to improving health outcomes in low- and middle-income countries.

A cross-country survey of the literature on fiscal transfers for health (Glassman and Sakuma 2014) identifies gaps in evidence on effective design and implementation of such transfers in large federal countries. Moreover, although most health expenditure is sub-national, policymakers and donors continue to focus mainly on national level policies and institutions. In spite of these gaps in knowledge, the efficiency and effectiveness of health spending at the sub-national level will become increasingly important as many federal countries are projected to increase health spending significantly to achieve Universal Health Coverage (UHC) in the framework of greater fiscal devolution. A review of the literature on the various methodologies adopted for fiscal allocations for health is presented in Box 1.

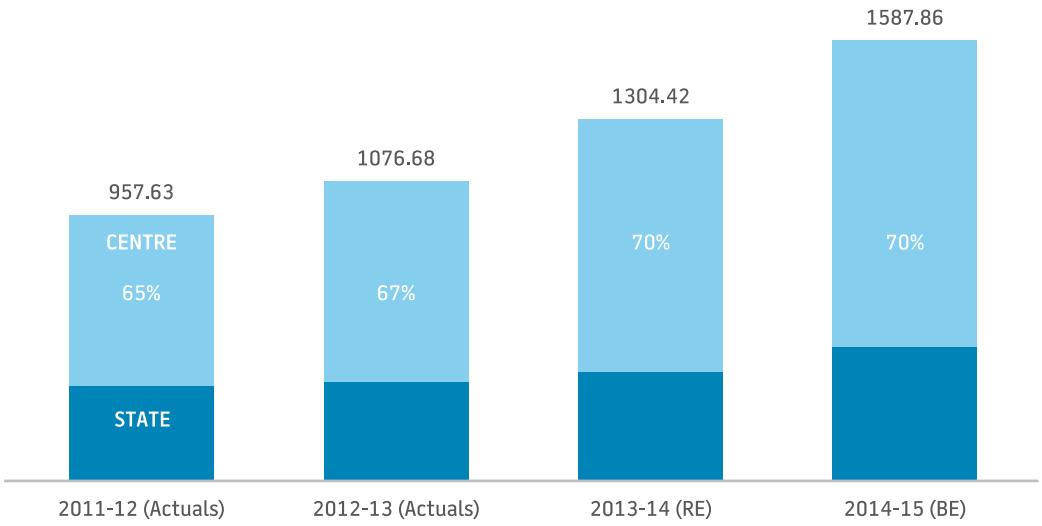
Evidence from around the world suggests that in many countries the majority of public spending on health is now executed by sub-national governments (Table 1). India is a case in point with 70 percent of all public spending on health executed through subnational governments. (Figure 1). As

TABLE 1: Expenditure on Health in Decentralized Middle-Income Countries

	Total Health Expend. Per Capita (current US$)	Govt Health Expend. (% of GDP)	Share of Govt in Total Health Expend. (%)	Share of Govt Health Expend. at Sub-National Level	Year	Source for Sub-National Data
Argentina	1074	4.9	67.7	57	2004	World Bank, 2012
Brazil	1083	4.7	48.2	54	2011	Langevin, 2012
China	367	3.1	55.8	98	2008	World Bank, 2012
Ethiopia	25	3.1	61.0	67	2005	Garcia & Rajkumar 2008
India	61	1.3	32.2	70	2014	MoH, 2015
Indonesia	107	1.2	39.0	67	2008	World Bank, 2008
Mexico	664	3.2	51.7	44	2011	Ministry of Finance 2011
Nigeria	115	1.1	27.6	64	2005	Olaniyan & Lawanson, 2010
South Africa	593	4.3	48.4	81	2005	World Bank, 2012

Source: Glassman and Sakuma (2014)

FIGURE 1: CENTER & STATE IN TOTAL HEALTH EXPENDITURE (RS. BILLION)



Source: Ministry of Health and Family Welfare (2015)

a result, state governments are the main drivers of the adequacy, efficiency and effectiveness of health expenditure and outcomes. The remaining 30 percent of funding is executed by the Center, and the question is how well the design and mechanisms of federal monies from Center to state create incentives for greater priority to health and better performance on outcomes.

In the context of India, until the mid-2000s, central transfers for health were primarily intended to reimburse states for expenditure on disease control and family planning programs. The mechanism of transfers changed significantly with the equalization grants introduced by the 12th and 13th Finance Commissions and the launch of the National Rural Health Mission (NRHM) in 2005. The mix of allocation instruments shifted towards a need-based formula determined by the Finance Commission and annual bids by state governments to access NRHM funding.[1]

The launch of the Centrally Sponsored Scheme (CSS) under NRHM in 2005 (now integrated into the National Health Mission (NHM)), was designed to provide additional resources to states to upgrade infrastructure and quality of service delivery given that the states' expenditure commitments were tied to salaries and administration[2]. Allocations for NRHM are based on Project Implementation Plans (PIPs), prepared by state governments. The PIPs are finalized after negotiations with the Center and funds shared between Center and states in a 75:25 ratio. To address regional imbalances in health outcomes, a set of 18 'high focus' (HF) states with the poorest health indicators were identified and

1. Mukherjee, A. (2014)
2. Accountability Initiative (2013)

provided additional resources. In 2013-14, 60 percent of total Center allocations for NRHM were for these states.

The 12th Finance Commission provided health specific grants to seven states on the basis of an equalization formula, which accounted for fiscal effort and expenditure need. The 13th Finance Commission created a trust fund, which was to be distributed among states on a formula based on performance in reducing the infant mortality rate (IMR).

This system which has been in place over the last decade is set to change again following the recommendations of the 14th Finance Commission report submitted in March 2015 and the proposed restructuring of the CSS, especially the National Health Mission (NHM). The Commission discontinued equalization grants in favor of greater unconditional devolution of tax revenues to states. This switch in approach puts even greater onus on state governments to decide on: (i) the priority to give to the health sector as a share of total state spending, (ii) the allocation of resources within the health sector and beyond for the achievement of goals, and (iii) the appropriate delivery mechanisms to meet state goals, which may or may not be related to improvement of health outcomes.

States will also have to factor in the restructuring of the NHM and reform agenda of the new National Health Policy, which proposes a move towards a single-payer system with multiple purchasing options (insurance, fee-for-service from private sector, free care in public facilities etc.) for health financing.[3] The role and mechanism, and cumulative effects, of Center-state fiscal transfers assume critical importance in this new financing environment and will have significant implications for performance and public expenditure management in the years to come.

The objective of this paper is to carry out a detailed analysis of the different modes of inter-governmental fund transfer for health to draw lessons on appropriate design and implementation mechanisms for fiscal transfers to improve health outcomes at the sub-national level. This paper reviews past policies related to fiscal transfers for health from the NHM to India's 12th and 13th Finance Commissions to begin to understand how well federal monies have helped to incentivize equity among states, own spending and performance, and looks ahead to the implications of its 14th Finance Commission report vis-à-vis health financing at the state level.

3. Mukherjee, A. (2015)

BOX 1: FISCAL ALLOCATION METHODS FOR HEALTH

Retrospective (de facto) transfers

Actual spending: Allocations are made based on how much sub-national entities actually spend. Although this approach is likely to incentivize greater than necessary levels of spending, it forms a basis for matching transfers, which encourage spending where sub-national entities would otherwise spend below efficient levels. (Smith 2008)

Prospective (ex ante) transfers

Need-based mathematical formula: Funding may be determined through a predetermined formula based on subjective or objective mathematical rules and reflecting perceived health needs (Pearson 2002; Smith 2008). The rules can be simple and incorporate a few factors—such as in Norway, where the formula includes age, gender, mortality, low birth weight —or very complex—such as in Brazil and South Africa, where the formulas incorporate 10 or more factors (Rice and Smith 2002; Shah 2007; Smith 2008).

Local government bids: Funding for health can be allocated by bids placed by local governments that reflect national health priorities and local disease burdens. In some cases, the transfers can be partially tied to improvement of health indicators. If successful, this mechanism can ensure that government funds are spent cost-effectively and in line with central or local government goals. Transfers based on local performance require greater scrutiny from the central government and technical capacity by the local entity, which may lead to large geographical inequality. (Rice and Smith 2002; Smith 2008)

Historical precedent: Central governments can allocate health funds based on historical precedent. Sub-national governments may receive adjustments based on changes to the overall budget (Pearson 2002). Allocation through historical spending can minimize disruptions to existing systems, but it also leaves local entities reliant on historical funding levels (Smith 2008). In some cases, this allocation mechanism could perpetuate inequity and inefficiencies in localities (Pearson 2002; Rice and Smith 2002).

Political patronage: The allocation of health funding can be influenced by political patronage or factors such as ethnicity, where funds to local entities are allocated based on past support or importance for future government. While governments would be reluctant to admit to this funding mechanism, it has been found in many supposed "non-partisan" funding systems. (Pearson 2002; Rice and Smith 2002; Smith 2008)

From: Glassman and Sakuma (2014)

2. CENTRALLY SPONSORED SCHEMES: A BRIEF REVIEW OF NRHM

The NRHM constitutes a significant share of central funding (57 percent of total MOHFW allocations were for NHM in 2015-16). However, despite 10 years since its launch, problems in design and implementation have resulted in slow progress on outcomes. Some of these are outlined below:-

1) Lack of Flexibility with Rigid Central Guidelines

As mentioned, total approvals under NRHM are based on PIPs, submitted by state governments and the total resource envelope available with Center. The design of the current financial system is often driven by a one-size fits all approach with the Central government playing a significant role in determining priorities. Funds are tied to particular line items resulting in limited flexibility amongst states and states are forced to buy into conditions that may have limited innovation or create unnecessary structures – a health center had to look a certain way, a norm had to be followed to hire an "accredited social health activist" or ASHA (Glassman et al 2015). With the Center dominating both guidelines and finances, the PIP negotiation process often results in modifications and cuts in state proposals. An analysis of the total funding proposals submitted by states and the final approval indicate that in 2014-15, the Center approved only 69 percent of the total funds proposed by states under NRHM. Further, only 59 percent of funds under the NRHM Mission Flexipool (funds meant for strengthening health resource systems, innovations and Information, Education and Communication (IEC)) were approved by the Center.[4]

2) Process related bottlenecks in release of funds and spending

While NRHM has done relatively better than other CSS in the release of funds with nearly 90 percent of Central allocations being released, there are delays in the release of funds and slow release of state shares. For instance, in FY 2013-14, 46 percent of allocations were released in the first quarter and 66 percent in the first half of the year. This has decreased to 29 percent in the first quarter and 61 percent in the first half of FY 2014-15.[5] The lack of predictability in fund flows can result in low spending. This is evident in the fact that during the 11th Five Year Plan (2007-2012), of the total Rs 169,408 crores allocated by MOHFW, only 69 percent of funds were spent. For NRHM specifically, only 79 percent of funds were spent. The inefficiencies in release of funds and utilization has meant that many states have high unspent balances lying with them. For instance, at the start of financial year 2013-14, Uttar Pradesh had Rs. 819 crores unspent from the previous year. Similarly, Rajasthan had Rs. 300 crores.[6]

4. Accountability Initiative (2015)
5. Ibid
6. Calculations made from the 12th Five Year Plan Document, the Union Budget and State NRHM PIPs.

3) Inequalities in Health Financing and Outcomes

While the NRHM provided for additional funds for states with the lowest health indicators, as a consequence of the one-size-fits-all approach little regard was given to the socio-economic diversity across states. Past research by Rao and Chaudhury (2012) found that allocations have done little to respond to state needs and over the years, inequality in per-capita health expenditure across states has been increasing. The Draft Health Policy Note 2015 also points to a high degree of health inequity in health outcomes and access to health care services. For instance, in 2012, there was a 63 percent differential in IMR between rural and urban areas.

While the NRHM has led to a significant strengthening of public health systems by increasing infrastructure and human resources, these developments have been uneven. The lack of data on the years preceding the NRHM make it difficult to rigorously evaluate impact. However, according to the Draft National Health Policy 2015, "states with better capacity at the baseline were able to take advantage of NRHM financing sooner". In contrast, "larger gaps in baselines and more time taken to develop capacity to absorb funds meant that gaps between the desired norms and actual levels of achievement were worse in high focus states". (MoHFW 2015). Consequently, there are significant variations across states in the quality of care. Moreover, this approach has done little to relate financing to gains in healthcare. While the NRHM did provide for a small performance based incentive, preliminary analysis by CGD suggests that the rewards formula as currently designed does not in fact reward performance.[7]

3. FINANCE COMMISSION: MOVING TOWARDS A STATE-FOCUSED REGIME OF FISCAL TRANSFERS

Weak public sector delivery and low expenditures on health in India have been widely discussed issues in recent times. A number of research studies, as well as Government of India's own policy documents, highlight the need to increase public spending (particularly as a proportion of GDP) across the country[8]. India's public expenditure on health is estimated to be 1.3 percent of GDP, lower than most of the lower and middle income countries such as Brazil, China, and South Africa. Further, out-of-pocket spending as a share of total health expenditure is 67.7 percent, one of the highest in G-20 countries, and 63 million people fall into poverty each year due to cost of healthcare[9].

Careful design of intergovernmental fiscal transfers (IGFT) is crucial in making sure government funding enables local service provision in an efficient and equitable way. Based on a global review of

7. Glassman et al (2015)
8. Rao and Choudhury (2012); Approach Paper to the Twelfth Five Year Plan (2012-2017)
9. Draft National Health Policy 2015

the literature, we can propose a set of guiding principles that distinguishes a 'better' system from one that is not. These 'better practices' are listed and summarized in Table 2.

TABLE 2: Better practices for fiscal transfer design – key principles

Better practices for allocating IGFT	
Simple	Allocation for health is based on an objective, simple, and easy to understand formula
Predictable	Future health transfers are predictable and stable; a government may publish five-year projections (with ceilings and floors) and accompany major changes to the formula withhold-harmless provisions
Promotes equity	Allocation varies directly with health-related fiscal need factors and inversely with the tax capacity of sub-national entities
Promotes revenue adequacy	Give state governments sufficient revenues to fulfill programmatic expectations
Betters practices for using incentives in IGFT	
Fulfills grantor's objectives	In order to fulfilling grantor's objectives, transfer conditions specify health results to be achieved (such as through output-based transfers)
Promotes efficiency	Transfer system provides incentives for sound fiscal management and encourages efficient practices; does not make specific transfers to finance sub-national government deficits
Autonomous use of grants	Sub-national governments have independence and flexibility in setting health priorities for health
Better practices to account for IGFT	
Ensure financial and performance accountability	Grantors are held accountable for transfer system design and operations; grantees are held accountable to the grantors and its citizens for financial integrity and results
Promotes transparency	Allocation formula and allocations are disseminated widely in order to achieve as broad a consensus as possible on the objectives and operation of the program

Source: Adapted mainly from Shah 2007 and also draws from Bird and Smart 2002; Pearson 2002; and Steffensen 2010

In the Indian context, the sub-national situation is characterized by wide inter-state differences in per-capita spending and health outcomes (Table 3). These are driven by differences in fiscal capacity, revenue efforts, implementation capacity, and priorities accorded to the sector by the state. There is a consensus that structural reforms are needed to increase the share of public expenditure on health, reduce out-of-pocket and catastrophic health expenditure, and also reduce inter-state disparity in health spending and outcomes.

Therefore, the role of fiscal transfers in creating an enabling environment for more efficient allocation of resources and outcomes in health at the sub-national level in India is a key area of policy analysis.

TABLE 3: Public Expenditure on Health and Health Indicators in Indian states

Major States	Per Capita Government Health Expenditure (Rs.) 2009-10	Expenditure from State Budget (%)	Health Indicators			Full Immunization (children 12-23 mos.)
			IMR	U5MR	MMR	
Kerala	443.93	83.71	12.3	13.8	96.4	81.5
Tamil Nadu	430.43	77.82	26.4	28.8	116.7	77.3
Gujarat	371.89	73.70	45.2	55.2	158.6	56.6
Karnataka	343.26	78.94	39.3	44.9	201.4	78.0
Andhra Pradesh	329.76	75.91	47.3	48.9	157.7	68.0
Haryana	329.36	84.58	48.8	55.5	164.0	71.7
Maharashtra	327.33	79.23	29.1	32.8	124.3	78.6
Rajasthan	320.19	65.69	56.9	68.8	370.9	53.8
West Bengal	300.09	77.87	33.3	39.0	158.9	64.9
Orissa	287.95	60.27	62.3	77.8	308.4	59.5
Punjab	281.48	76.26	35.2	41.6	174.4	83.6
Chattisgarh	272.84	63.39	52.5	61.9	316.9	57.3
Uttar Pradesh	261.14	72.62	61.4	78.8	418.6	40.9
Madhya Pradesh	229.99	59.85	64.1	82.3	316.9	42.9
Jharkhand	202.66	70.06	42.7	57.7	305.2	59.7
Bihar	145.97	61.64	49.8	64.7	305.2	49.0

Source: Choudhury and Amarnath (2012); Gupta, Choudhury and Patra (2014); MoHFW (2013)

Our hypothesis is that an allocation design that is simple and predictable, and promotes equity with the objective of enhancing fiscal space at the sub-national level will enable them to prioritize expenditure. However, just focusing on allocation is not enough – outcomes are also a function of the design of incentives and accountability for state-level performance. A 'better' fiscal transfer design is one where allocations, incentives and accountability are aligned and carefully coordinated. We use this framework to review the Finance Commission transfers for health, outline some lessons learned for future work in this area of research.

2.1 Review of 12th Finance Commission Equalization Grants

Keeping in mind the level of disparity in per-capita expenditures across states, the 12th Finance Commission (12th FC) provided so-called "equalization grants" for health and education for the period 2005-2010. The underlying principle guiding this approach was "not only to improve the average levels of provisions of these services, which can be justified on grounds of nationwide

positive externalities, but also reduce disparities across states"[10]. Fiscal equalization thus provided "a mechanism for ensuring, with the help of inter-governmental transfers, that all states can provide comparable levels of services if they had comparable revenue availability" (Ibid). Consequently, the 12th FC recommended a total of Rs.5887.08 crore (around US$1 billion) of equalization grants for health (EGH) to be distributed across seven states whose per-capita expenditure was below the national average.

Fan et al. (2014) evaluated the methodology adopted by the 12th FC to assess the actual impact on health expenditure for the seven states that were awarded the equalization grants.[11] The key findings of the exercise are summarized below:

The lack of a clear methodology regarding the adjustments to revenue expenditure makes it difficult to replicate the calculations. The opaque selection process prevents states from understanding the reason for their eligibility, or in many cases their ineligibility. It also prevents subsequent Finance Commissions from learning from the methodology of the previous FC.

Many of the inter-governmental fiscal transfers come with conditionality. The EGH for the seven states had a number of conditionalities attached in terms of the revenue expenditure that states would have to undertake. Consequently, not all grants in aid were actually released. On average a total of 81 percent of the total amount allocated was released. There were, however, state-wise differences. While Madhya Pradesh got its entire allocation, Odisha only received 67 percent of its allocation (Table 4).

TABLE 4: Equalization Grants for Health Released to States, 2005-10 (as % of Allocation)

State	Allocation (Rs. Crore)	Releases (Rs. Crore)	Proportion of Allocations Released
Madhya Pradesh	181.64	181.64	100%
Assam	966.02	870.55	90%
Uttarakhand	50	40	80%
Bihar	1819.69	1439.35	79%
Uttar Pradesh	2312.38	1829.06	79%
Jharkhand	360.98	276.85	77%
Odisha	196.37	131.2	67%
Total	**5887.08**	**4768.66**	**81%**

Source: Planning Commission (2012); 1 crore=10 million

10. Srivastava (2006)
11. Detailed methodological note is available on request

The impact of EGH on eliminating the horizontal imbalance among states was fairly limited. The extent of contribution of the 12th FC EGH grant to the projected revenue expenditure on health varied between 4.5 percent in Madhya Pradesh to 43.8 percent in Assam. When compared with the actual expenditure incurred in 2009-10, Bihar and Assam were the only states where the EGH constituted more than one-third of their health expenditure. The grant design was also iniquitous – Madhya Pradesh hardly benefitted from the transfers even though its health indicators were comparable to Bihar (Table 5).

TABLE 5: Grants projected and received as a proportion of health expenditure (%)

State	Projected	Actual (2005-10)
Assam	43.8	32.9
Bihar	36.6	37.5
Jharkhand	20.7	19.5
Madhya Pradesh	4.5	4.0
Odisha	6.7	6.6
Uttar Pradesh	18.6	18.8
Uttarakhand	4.7	4.2

Source: AI-CGD calculations from Finance Accounts, various years

Finally, multiple sources of funds with their independent criteria and release mechanisms can at times lead to a fragmentation of transfers. With the exception of Uttarakhand, all the states that received the EGH also received equalization grants for education with their own set of conditionalities. New fiscal rules came into force through the Fiscal Responsibility and Budget Management (FRBM) Act, 2004. In addition, there are general purpose transfers to states by both the FC and the Planning Commission and the initiation of the NRHM. Although empirically difficult to verify, states would have found it difficult to adjust to the new fiscal transfer mechanisms, and EGH expenditure performance may have suffered as a consequence.

2.2. Review of 13th FC Performance-based Grants for Health

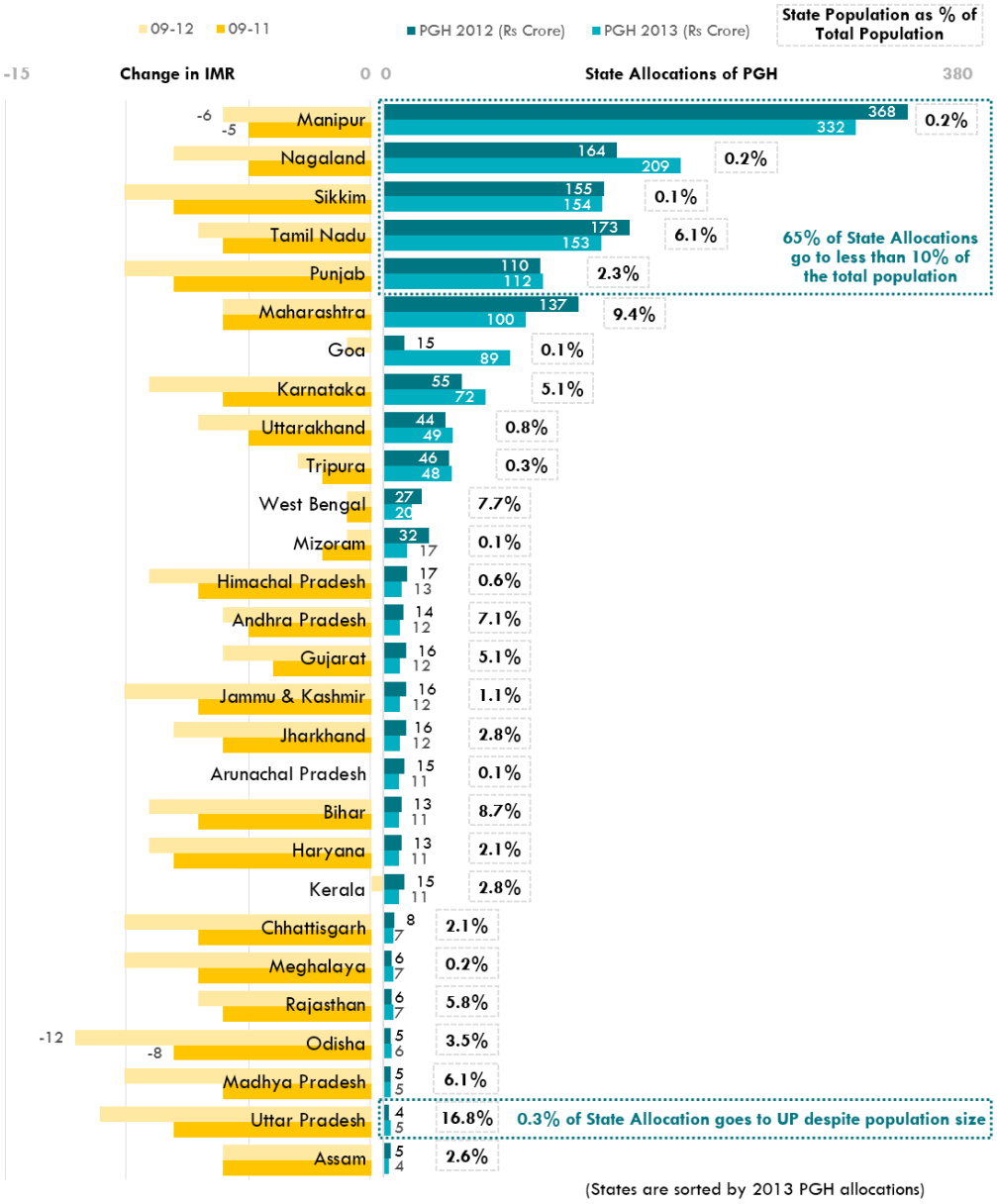
The 13th FC moved from a resource need-based equalization grant to a formula-based approach intended to incentivize states to improve outcomes in health. The methodology for the performance-based grants for health (PGH) recognized that each state had a different starting point as far as the IMR is concerned. The multi-component formula depends on two factors: (1) whether there was progress reducing the IMR, regardless of population weight, and (2) whether the reduction in IMR was better than the median IMR for all states. The intention of these components was to encourage movement towards reducing IMR in general and to incentivize improvement below the median level of IMR.[12]

12. Detailed methodological note is available on request

The 13th FC PGH gave states a lead time in the first two years (2010 to 2011) to make improvements, and allocated the Rs.5000 crore (around US$1 billion in 2010 dollars) over the remaining three years (2012 to 2015). The annual payment was made only after publication of state-wise IMR from the preceding year in the Sample Registration System (SRS). Each state's eligibility was determined annually, based upon their improvement in the IMR relative to its 2009 baseline value.

Using state-level IMR values from SRS, the Working Group replicated the 13th FC's formula for PGH and calculated each state's expected share of total allocations for the first two years of implementation for which data is currently available (Figure 2).

FIGURE 2: STATEWISE DISTRIBUTION OF INCENTIVE GRANTS FOR HEALTH FROM 13TH FC, 2012-13



Note: Over the period of interest, IMR reduced or stayed the same in all states, except for Arunachal Pradesh, where it increased marginally. IMR 2011 data are used for 2012-13 PGH, and IMR 2012 data are used for 2013-14 PGH.
Source: Sample Registration System (2014); AI-CGD Calculations

Our analysis shows that one state alone, Manipur, received more than a quarter of the national allocation in 2012 and more than a fifth in 2013. Four states – Manipur, Sikkim, Nagaland and Tamil Nadu – taken together received more than half of the total allocations. States already below the median got a larger share in the distribution of the pool of resources, and states like Odisha with higher absolute reduction did not benefit to the same extent.

It is difficult to ascertain empirically whether the PGH was an effective tool in increasing state-level incentives for greater effort that would lead to reducing disparity in health outcomes and rewarding states for performance. Still, a few key lessons can be learned in terms of design of such transfers, including ways to make performance grants more broad-based taking into account a set of output and outcome indicators. These are summarized below:

The structure of the financing and payments in outcome-based fiscal transfers deserves careful attention. The 13th FC formula assumes that states already have upfront resources available to reduce infant mortality, and that the subsequent reward is sufficient to incentivize further reductions. It also assumes that the level of reward to each state will be commensurate with their effort. Our analysis shows that the distribution of resources was skewed towards states with already low IMR, therefore it is not clear whether the grant would have acted as a significant incentive to achieve better outcomes.

It is important to keep the outcome-based formula simple in designing fiscal transfer for indicators such as IMR which vary significantly across states. The complex formula adopted by the 13th FC presented several highly implausible counterfactual scenarios. For example, the scenario of providing no incentive to the better-performing states if their IMR increased is highly unlikely given they were already on a trajectory to reduce their IMR. The lack of a weight given to population or birth rate contributed to this severely unequal distribution of payments.

One alternative mechanism would be to provide incentive grants to states for 'bending the curve'. This design recognizes that most states are already on a trajectory of reducing infant mortality, even without any additional incentive. Therefore states should be rewarded for improving their IMR at a rate higher than their expected trajectory of IMR decrease. A state's IMR can be reasonably predicted by plotting a historical time series. The state can be compensated for each additional averted infant death beyond this expected trajectory that is verified independently, in the framework of a 'cash-on-delivery' transfer.[13]

13. Birdsall and Savedoff (2010)

2.3 Implications of the 14th FC Report on Fiscal Transfers for Health

The 14th FC submitted its report on fiscal devolution to states in February 2015. It did not recommend any equalization or outcome-based transfer for health. However, it significantly increased the share of taxes going to the States from 31.54 percent under the 13th FC to 42 percent. It also gives 10 percent weight to the 2011 population to account for demographic change to determine the share of individual states in total fiscal transfers.

This approach of the 14th FC has several significant implications.

The 14th FC devolution increases States' fiscal space. A major constraint for low per capita expenditure on health can therefore be mitigated to a considerable extent. Comparing revised budget estimates for 2014-15 and budget estimates 2015-16, our calculations indicate that apart from the North-eastern states, the major beneficiary of this devolution would be poorer states like Chhattisgarh, Jharkhand, Madhya Pradesh, Uttar Pradesh and Bihar (Figure 3), with increases ranging from 2.5 to 1.8 percent of Gross State Domestic Product.[14]

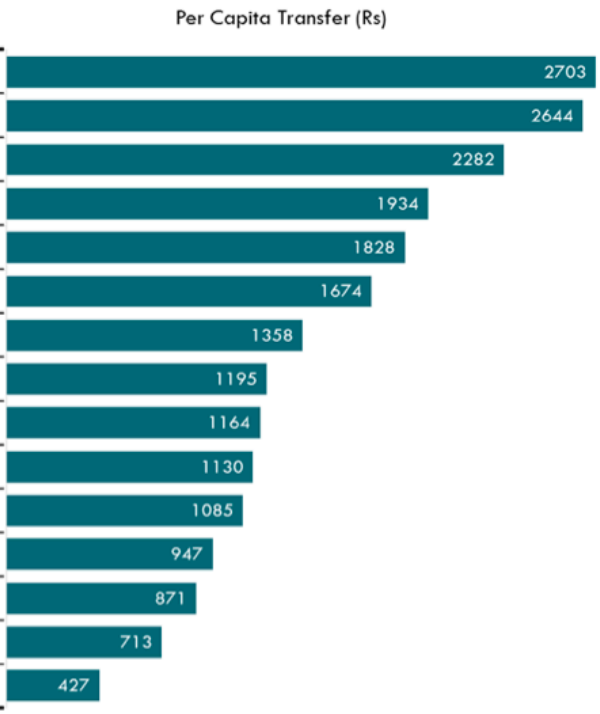
Greater transfers to the States also mean that fiscal space of the Center has reduced significantly. The Center's discretion in determining transfers through the centrally sponsored schemes is now down from nearly one-third to less than one-sixth of the total pool of shared tax revenue. Seen in the context of other major institutional reforms such as the restructuring of the Planning Commission, the leverage the Center had with the States in directing development policy will give way to a much broader array of policy choices driven by state needs and priorities.

Increased fiscal space, higher per capita fiscal devolution, and restructuring of the National Health Mission creates a policy environment for health that is both an opportunity and a challenge. Without a doubt, there is a move towards a more state-led approach to development policy. States now have more headroom to determine their priorities, without being directed by equalization and incentive grants of the FC, or by conditionalities imposed by the Center through instruments like the centrally sponsored schemes. However, the impact on health will depend on whether states decide to give priority to health in their own spending decisions and in the allocation of monies within health.

14. Complete list of states available in Figure 3a. Andhra Pradesh and Telengana have been left out of the calculations.

FIGURE 3: INCREASE IN FISCAL SPACE AND PER CAPITA DEVOTION POST 14TH FC REPORT

	Share in Total Devolution (taxes & grants in aid)	Increase as % of projected GSDP
Chhattisgarh	2.8%	2.9%
Kerala	3.1%	1.8%
WB	8.1%	2.5%
MP	6.9%	2.6%
Jharkhand	2.9%	2.8%
Odisha	4.3%	1.9%
Karnataka	4.3%	1.1%
UP	16.3%	2.2%
Rajasthan	5.2%	1.1%
Bihar	8.8%	2.6%
Punjab	1.5%	0.7%
Maharashtra	5.4%	0.6%
Gujarat	3.0%	0.6%
Haryana	1.1%	0.4%
TN	3.8%	0.3%



Source: 14th Finance Commission (2015); AI-CGD calculations

The discussion in this section indicates that India's experience with equalization and performance transfers for health through the FC route has been a mixed bag. Equalization grants were not large enough to shift the level of health expenditure in the states over the long term. The performance grant created few big winners while the remaining pool was too small to have any significant impact on incentives for improving outcomes over and above the trend. However, after the recommendations of the 14th FC, India is moving towards the next phase of experimentation vis-à-vis fiscal transfers. This is a world where states would take the lead in prioritizing health while the Center plays a less directive role in state-level decisions on health expenditure. There is an urgent need to think about structural reform of health financing and fiscal transfers that would create a health system that would put India at par with our peers in the developing world.

4. CONCLUSIONS AND WAY FORWARD

In the post-14th FC devolution environment, the key policy question is whether states be willing and able to increase expenditure on health to the extent that is necessary to improve outcomes. Over the last decade, the policy debate has centered around the role of CSS in directing funds through top-down fiduciary arrangements, thereby curtailing the flexibility of the states to undertake innovations on their own. Now that the Center has signaled an exit strategy by reducing expenditure on NHM in the 2014-15 budget, it is incumbent upon states to create new institutional structures for better health financing and delivery and adequately fill the space that the Center has ceded to them.

However, this is also an opportunity to undertake a 'pivot' in Center's role in health in general. Taking a cue from health reforms carried out in other middle-income Asian and Latin American countries such as Thailand, Philippines, China, Mexico, Colombia and Brazil, it could take upon itself the task of priority-setting and providing performance-based incentives that would crowd-in sub-national expenditure. Most of the countries that carried out successful reforms in health separated the payment functions from delivery functions. Fiscal transfers performed the task of paying for services or for performance-linked contracts based on an objective needs assessment and evaluation criteria. The recommendations of the 14th FC has opened up these structural reform possibilities and areas for further research.

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APPENDIX

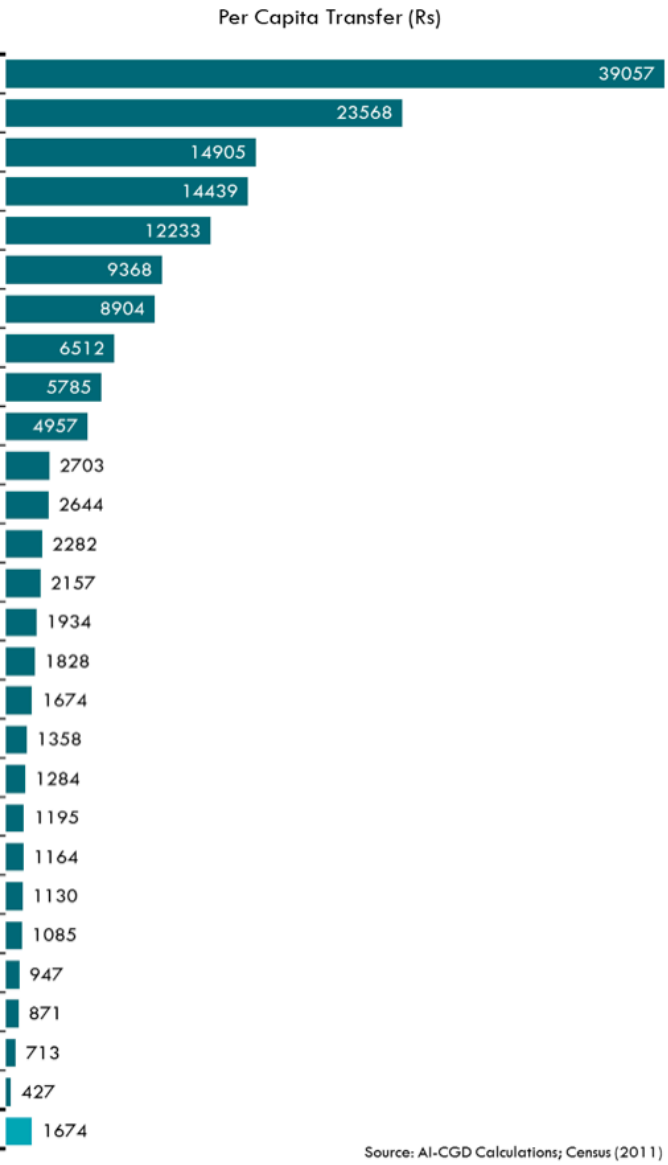
TABLE A1: Increase in Fiscal Space and Per Capita Devolution post 14th FC Report

States	Share in Total Devolution (taxes & grants in aid)	Increase in FC Transfers as % of Projected GSDP	Per Capita Increase in Fiscal Devolution (2011 population)
Arunachal Pradesh	1.20%	29.16%	39057
Assam	3.40%	3.67%	2157
Bihar	8.80%	2.58%	1130
Chhattisgarh	2.80%	2.86%	2703
Goa	0.30%	1.51%	6512
Gujarat	3.00%	0.56%	871
Haryana	1.10%	0.35%	713
HP	2.00%	6.98%	12233
J&K	3.10%	10.43%	8904
Jharkhand	2.90%	2.79%	1828
Karnataka	4.30%	1.14%	1358
Kerala	3.10%	1.80%	2644
MP	6.90%	2.60%	1934
Maharashtra	5.40%	0.58%	947
Manipur	0.90%	12.27%	9368
Meghalaya	0.70%	6.42%	5785
Mizoram	0.70%	20.76%	23568
Nagaland	1.00%	12.09%	14439
Odisha	4.30%	1.88%	1674
Punjab	1.50%	0.74%	1085
Rajasthan	5.20%	1.13%	1164
Sikkim	0.30%	4.41%	14905
TN	3.80%	0.29%	427
Tripura	0.70%	5.88%	4957
UP	16.30%	2.16%	1195
Uttarakhand	1.00%	0.77%	1284
WB	8.10%	2.46%	2282
All States	**100.00%**	**1.64%**	**1674**

Source: AI-CGD Calculations; Census 2011

FIGURE 3A: INCREASE IN FISCAL SPACE AND PER CAPITA DEVOLUTION POST 14TH FC REPORT

	Share in Total Devolution (taxes & grants in aid)	Increase as % of projected GSDP
Arunachal Pradesh	1.2%	29.2%
Mizoram	0.7%	20.8%
Sikkim	0.3%	4.4%
Nagaland	1.0%	12.1%
HP	2.0%	7.0%
Manipur	0.9%	12.3%
J&K	3.1%	10.4%
Goa	0.3%	1.5%
Meghalaya	0.7%	6.4%
Tripura	0.7%	5.9%
Chhattisgarh	2.8%	2.9%
Kerala	3.1%	1.8%
WB	8.1%	2.5%
Assam	3.4%	3.7%
MP	6.9%	2.6%
Jharkhand	2.9%	2.8%
Odisha	4.3%	1.9%
Karnataka	4.3%	1.1%
Uttarakhand	1.0%	0.8%
UP	16.3%	2.2%
Rajasthan	5.2%	1.1%
Bihar	8.8%	2.6%
Punjab	1.5%	0.7%
Maharashtra	5.4%	0.6%
Gujarat	3.0%	0.6%
Haryana	1.1%	0.4%
TN	3.8%	0.3%
All States	100%	1.6%



Source: AI-CGD Calculations; Census (2011)