The regressive nature of central transfers on health

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1. Transfers are not linked to health indicators. Instead, such transfers by and large tend to be incremental.
2. The specific purpose transfer system for health has not been very helpful in offsetting the fiscal disabilities of the poorer states.
3. States tend to substitute grants received from the union for their own spending. Hence no commensurate increase in overall spending.

Key Arguments

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Existing datasets on public health expenditures broadly have 3 issues:

1. direct transfers to implementing agencies dominates union-to-state transfers
2. challenge of decentralisation
3. substantial volume of health expenditures is incurred outside the Ministry of Health and Family Welfare (MoHFW) at the Union level and health departments at State levels

So, we constructed a comprehensive and comparable dataset for public health expenditures between 2004-05 and 2015-16

Methodology

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Outside our consideration

Fees collected by government hospitals, Social Health Insurance, Government Employee Schemes for Healthcare, Government Based Voluntary Health Insurance Schemes, Public Enterprises and parastatals' Financing Schemes

Public "Health and Allied" Expenditure

Includes in addition, revenue and capital expenditures on the budget major heads "Water Supply and Sanitation" and "Nutrition".

Public Health Expenditure

Revenue and Capital expenditures of all levels of governments on the budget major heads "Medical and Public Health" and "Family Welfare"

What constitutes public health expenditure on health?

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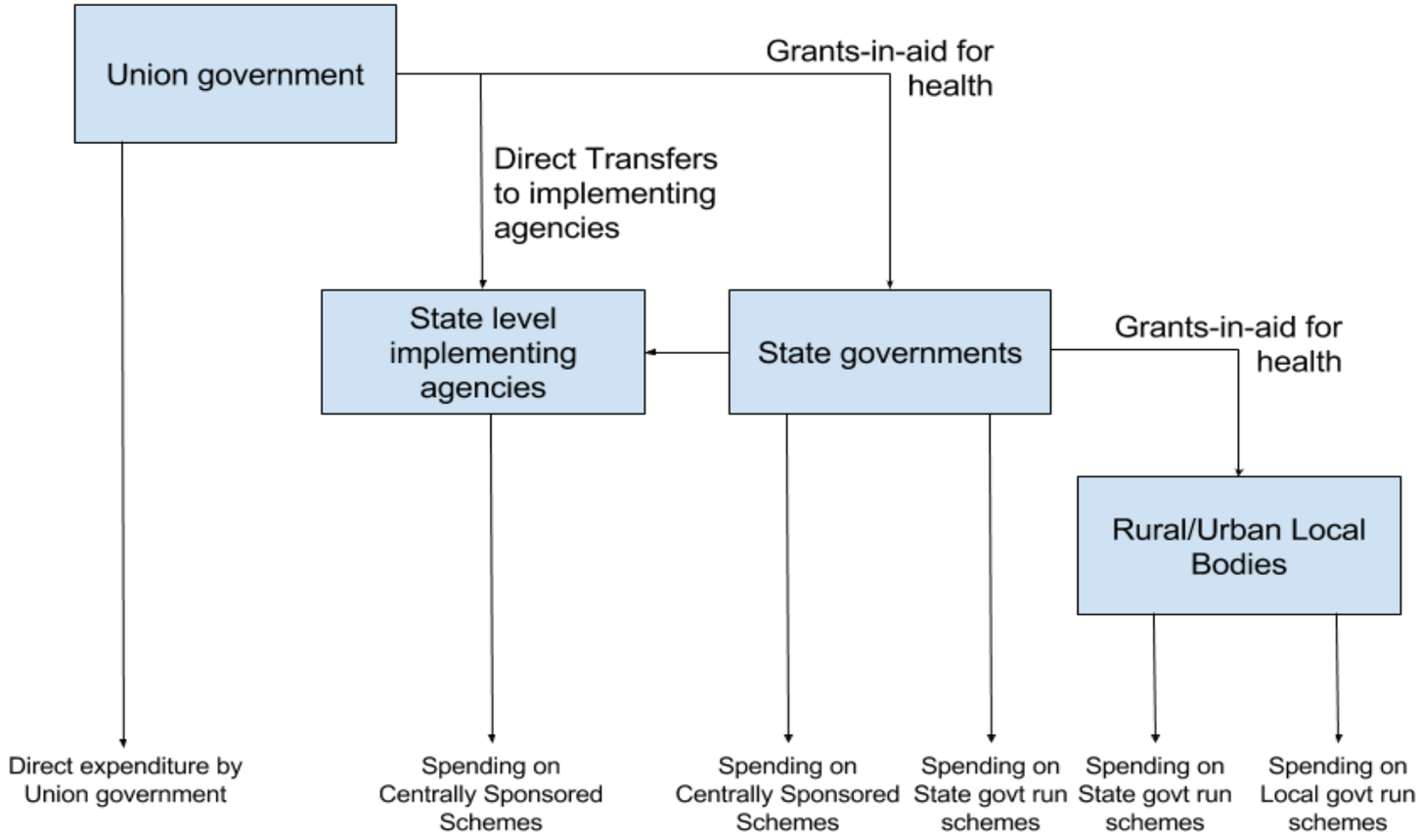
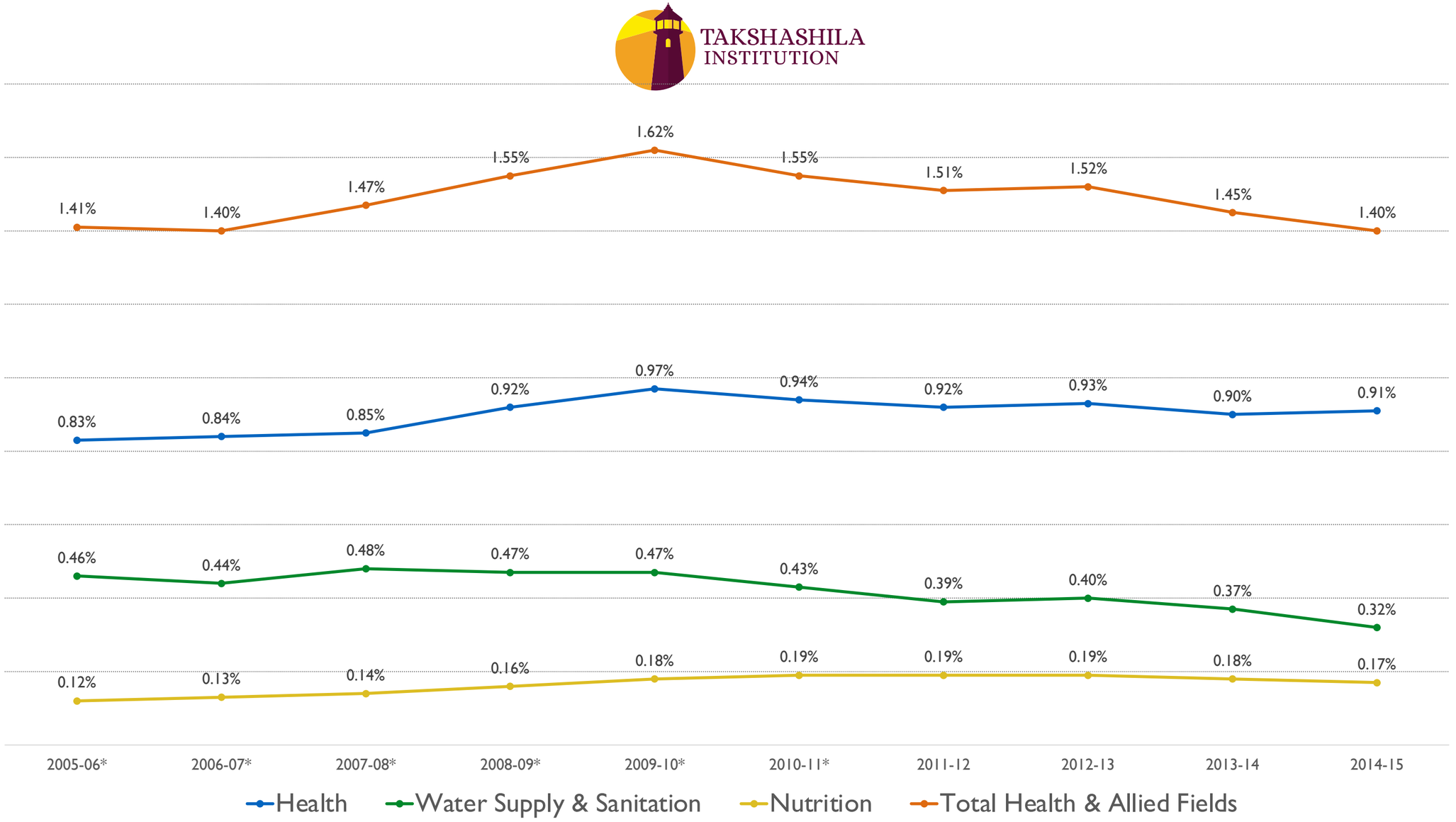


Structure



*GDP data for 2005-06 to 2010-11 from the 2004-05 series, and for subsequent years from the 2011-12 series.

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What has been the role of central transfers on health?

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Federal systems have mismatches between expenditure mandates & revenue-raising abilities. Hence: intergovernmental transfers.

The rationale for general purpose, untied transfers is to **enable** all states to provide comparable levels of public services at comparable tax rates.

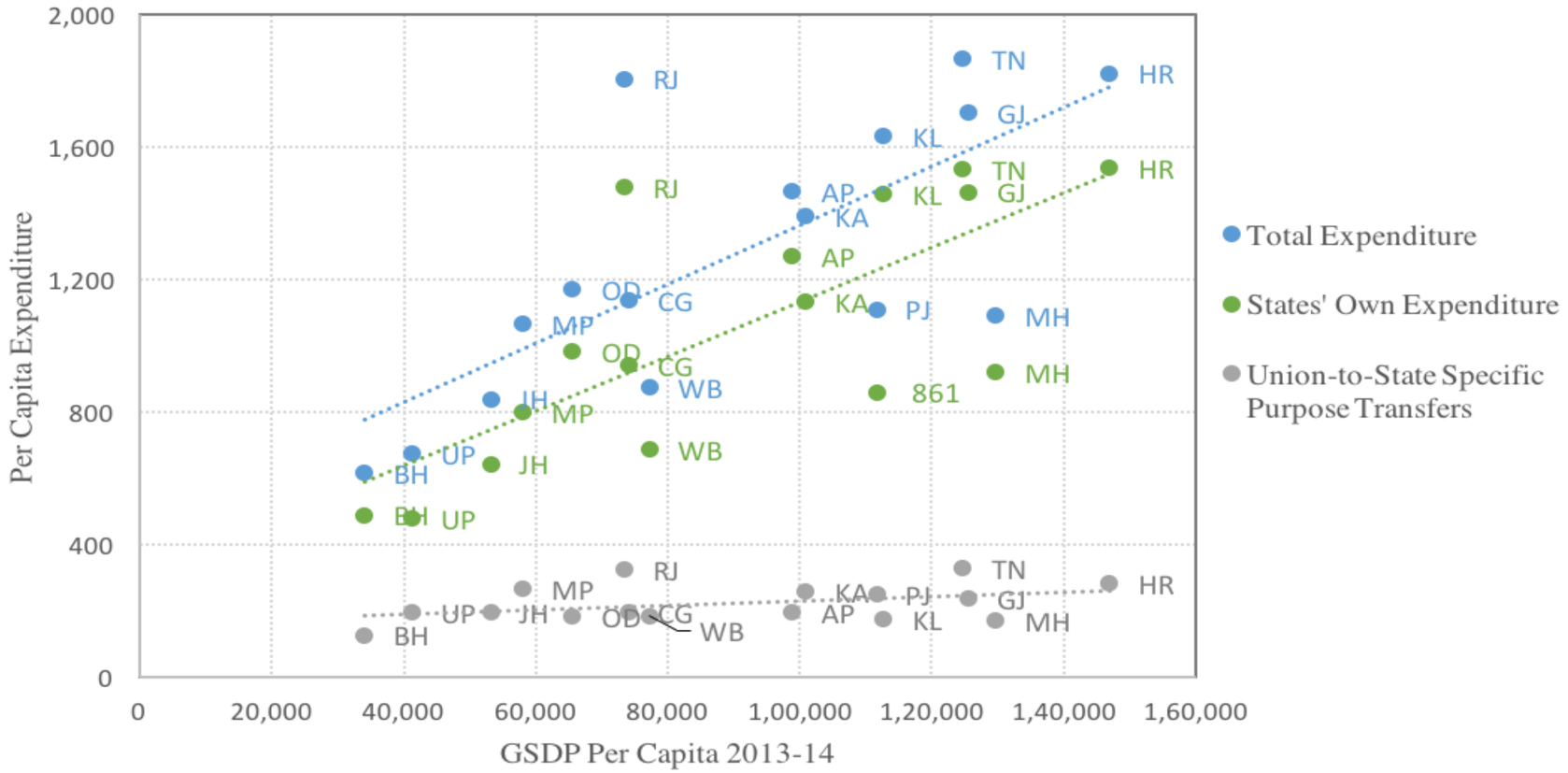
The rationale for specific purpose transfers is to **ensure** minimum standards of public services.

Specific purpose transfers on health

Rao, M. Govinda.
"Central transfers to states in India: Rewarding performance while ensuring equity"
NITI Aayog Report, September 2017

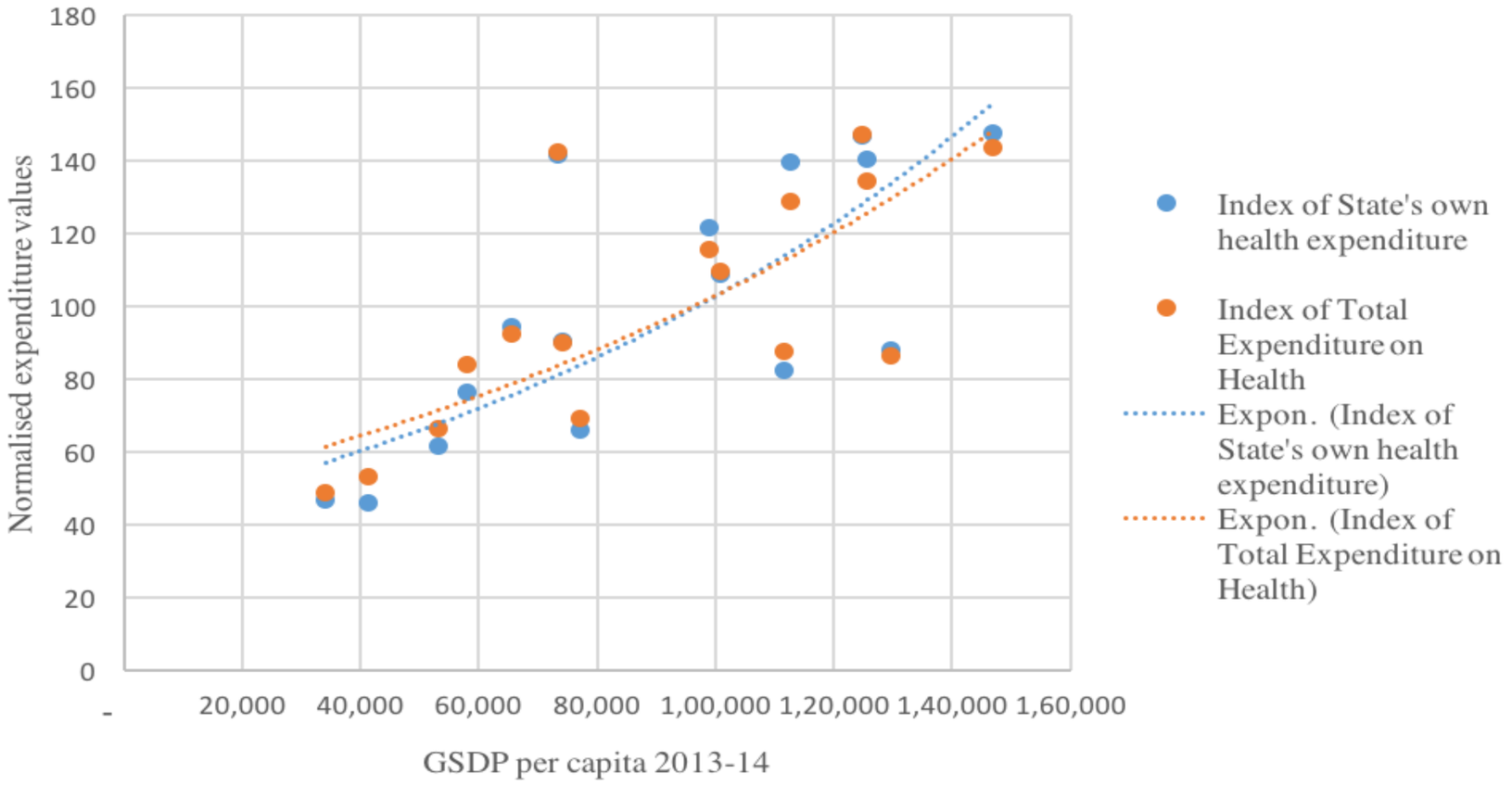
Central transfers' distribution does not help the poorer states enough

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



Low equalising impact

Figure 2: Assessing the progressivity of Central Transfers on Health



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Targeting of central transfers to deficient states

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The States that spend more on health continue to have lower IMR

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

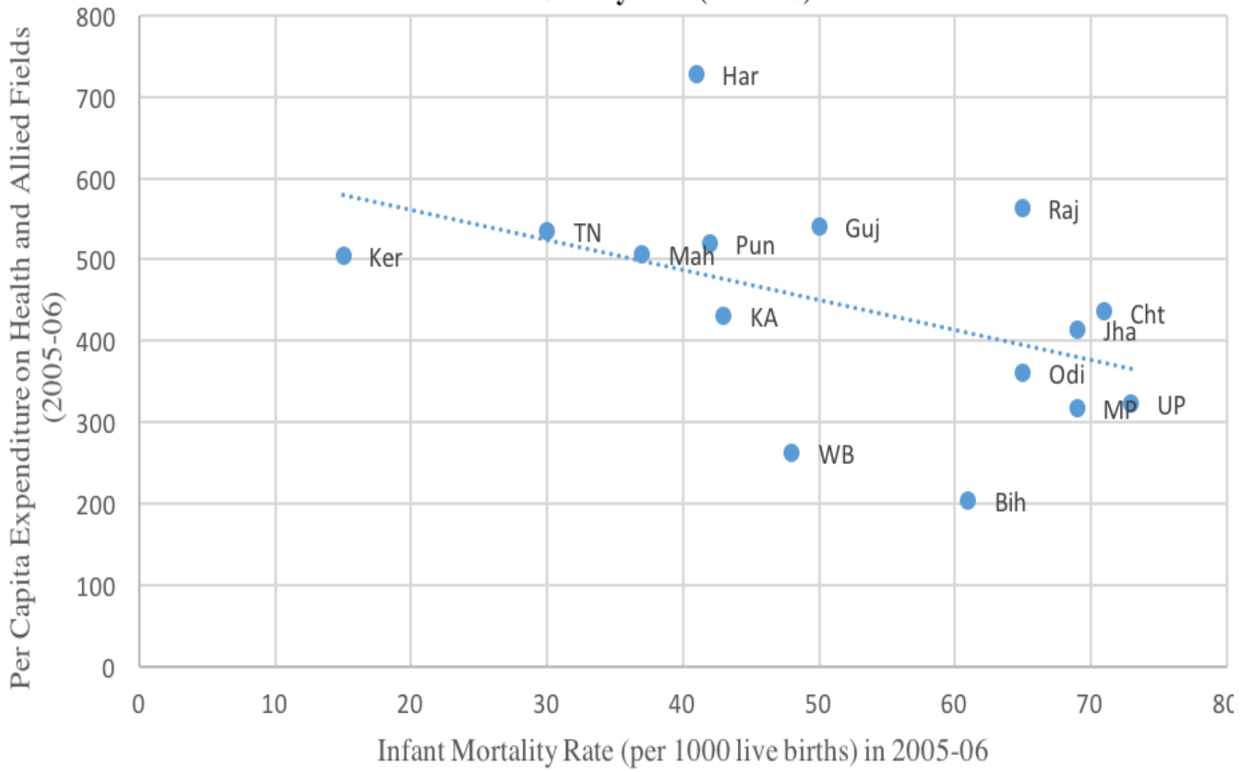
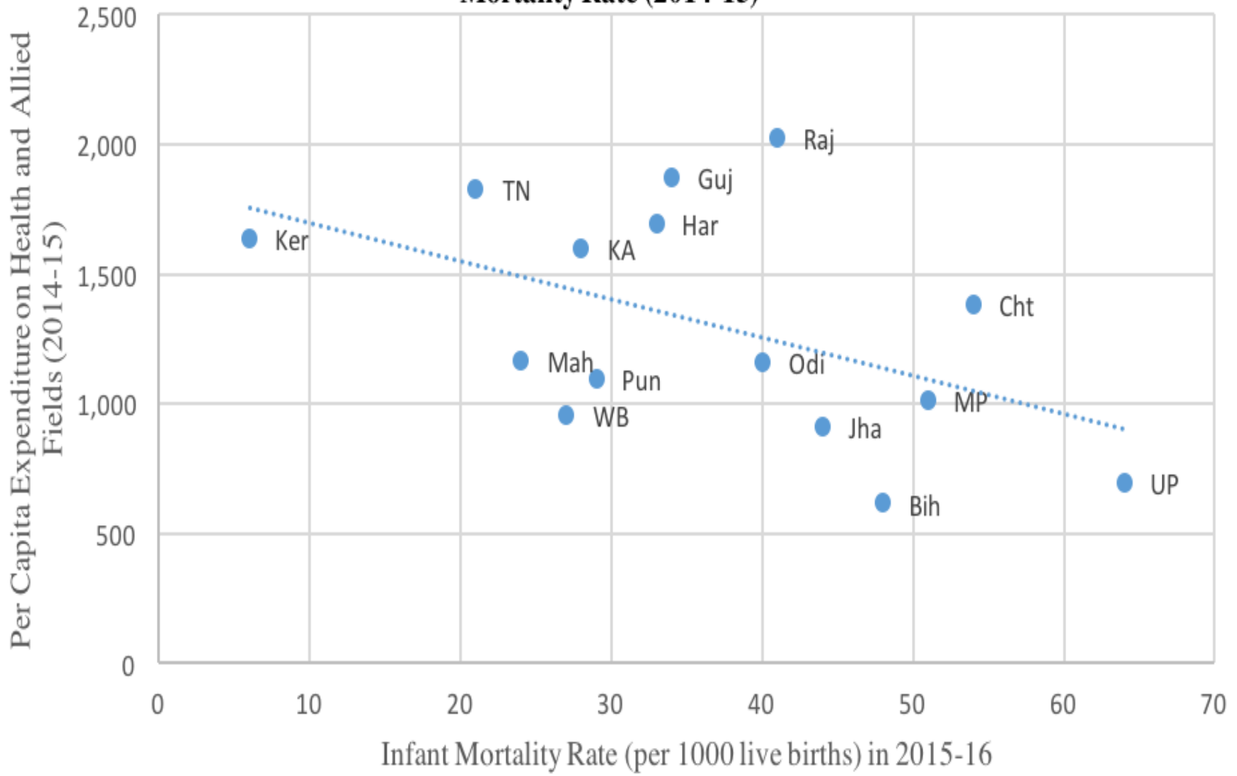


Figure 4. Per capita expenditure on Health and Allied Fields according to Infant Mortality Rate (2014-15)



1. States that already had a head-start received more per capita specific transfers on health
2. by 2015-16, the specific transfers had become even more regressive

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

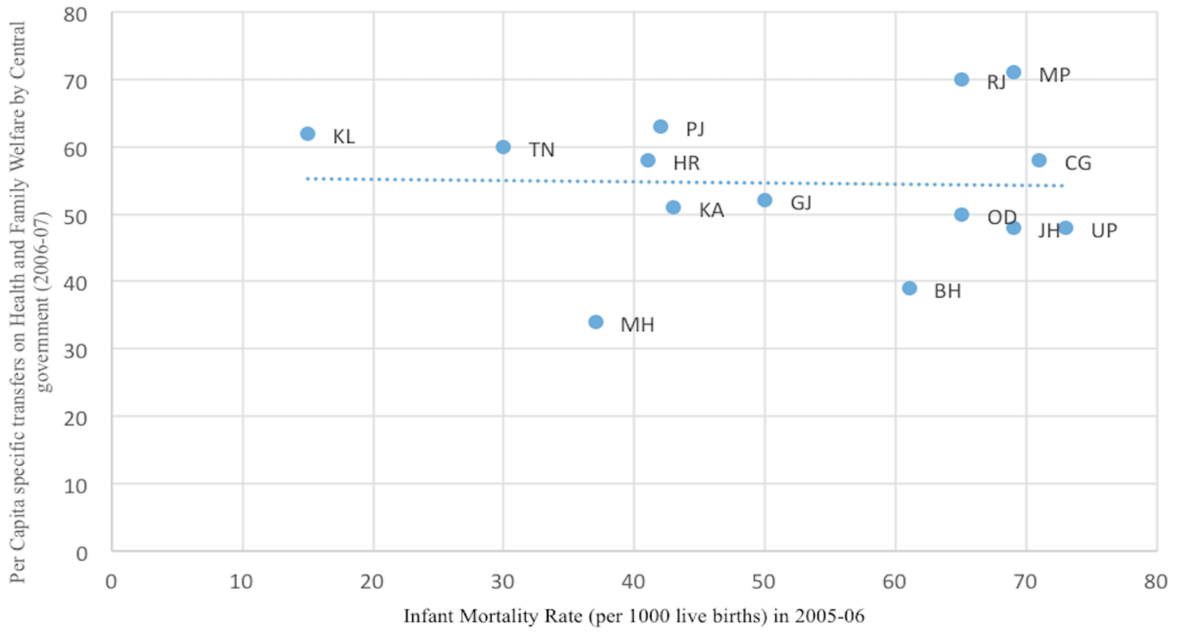
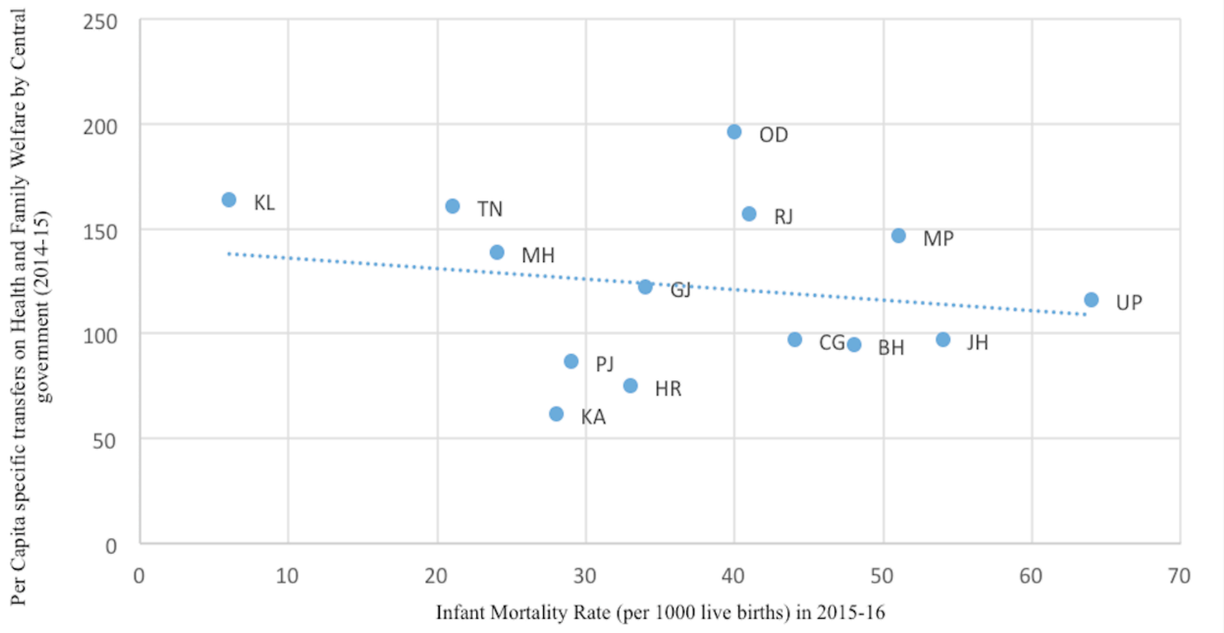


Figure 6. Per capita specific transfers on Health and Family Welfare (2014-15) according to Infant Mortality Rate (2015-16)



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Result remains same even when we accounted for specific purpose transfers spilling into succeeding financial years

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

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Do centrally sponsored schemes stimulate (or substitute) health expenditure?

The possibility of additional fiscal space at the state level for health can be due to:

1. *Increase in own revenues of the states;*
2. *Increase in general-purpose transfers from the Finance and Planning Commissions, which includes shared taxes and plan and non-plan grants;*
3. *Increase in specific-purpose transfers for the health sector; and*
4. *Changes in prioritization in favour of the health sector.*

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

Where,

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

$\Delta (PC\_CGH)_{it} = \{ (PC\_CGH)_{it} - (PC\_CGH)_{it-1} \}$ or changes in per capita central government's specific purpose grant (from the previous year) for health to State *i* in year *t*;

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

$\Delta (SPH)_{it} = \{ (G_{hi}/G_{bi})_t - (G_{hi}/G_{bi})_{t-1} \}$ or changes in the ratio of public expenditure on health to total budget expenditure of the i^{th} State in the year *t* over the previous year; and

$\Delta (PC\_GPGC)_{it}$ = changes in per capita general purpose grant by the central government to State *i* in year *t* = (tax devolution + plan and non-plan grants).

Ref: Rao, M. Govinda, and Mita Choudhury. "Health care financing reforms in India." National Institute of Public finance and policy working paper 2012-100 (2012).

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

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

1. *transfers are poorly targeted*
2. *the grants are not linked to improving service levels and the states with larger shortfall in services do not receive higher grants*
3. *states were able to substitute grants for their own spending with the result that there has not been a commensurate increase in spending on healthcare after the grants are received*

Conclusion

- Don’t spread resources thin. Focus on a small set of service delivery standards & achieve them. Specify fewer objectives.
- Link transfers to service levels
- Don’t fiscally handicap poor states by mandating high matching contributions. Implement a varying matching ratio – by taxable capacity.

Agenda for reform

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Thank You.

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