How effective has the Central Government been in nudging the states for financing Primary Health Care?

An analysis of fiscal federal relations in India

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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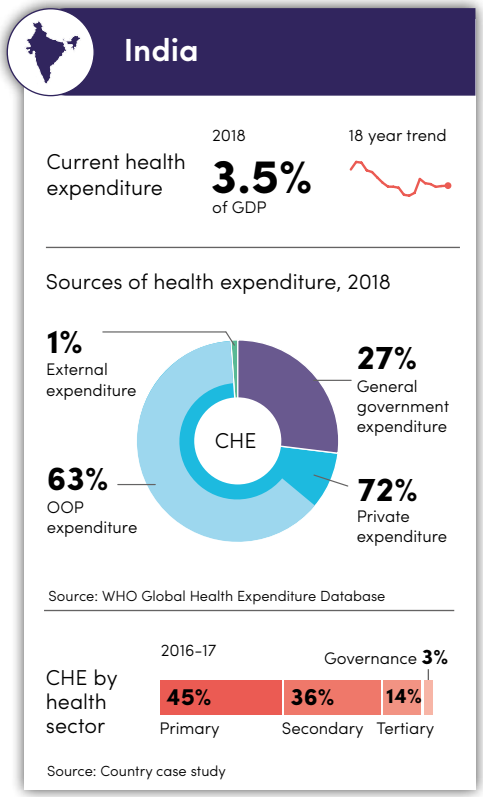
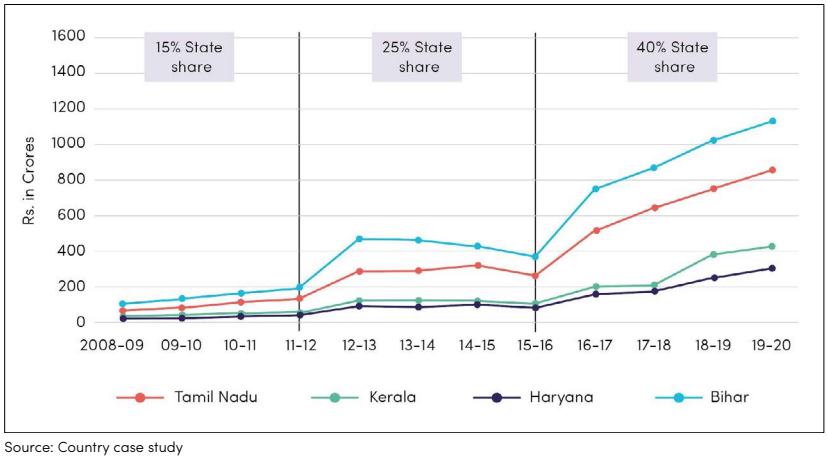
India's public health expenditure is amongst the lowest in the world at just 1% of gross domestic product (GDP). Consequently, a significant share of primary health care (PHC) is delivered by the private sector and paid for directly by households at the point of use. Constitutionally, States are responsible for mobilising and allocating resources for health; however, some specific programs, termed Centrally Sponsored Schemes (CSS), also receive funding from the Central government. One such program is the National Health Mission (NHM), set up to achieve universal access to health services through increased funding for PHC and improved coverage of services. With this central funding, the government introduced a set of conditions for States to comply with, obliging them to spend more on PHC and to follow government priorities. This report assesses the extent to which the central government was able to use different fiscal tools to influence the overall levels and patterns of PHC financing by State Governments. 4 states – Kerala, Bihar, Haryana and Tamil Nadu, were used in the analysis due to differences in the amount of NHM funds they received from the Centre.



POLICY INSTRUMENTS USED TO INFLUENCE PHC FINANCING

Since the NHM (formerly the National Rural Health Mission) was first implemented in 2005, the Central Government has used several fiscal tools to influence States' spending on PHC. Most significant is the policy of matching budgets, whereby States are required to match Central government contributions by a set ratio. This funding ratio has changed over time, with States' share increasing from 15% in 2011/12, to 40% in 2016/17. Other fiscal tools include conditionalities for States to adhere to that favour budget allocations for primary care, and new governance frameworks placing greater importance on the health sector and PHC. Finally, in 2013/14 the government introduced a performance-based incentive for releasing a proportion of the approved NHM budget to States.

Figure 1: States' contributions to the NHM, 2008-2019



Source: Country case study

TRENDS IN PHC FINANCING

The research shows that allocations for PHC have increased over the last 10 years, much of which can be attributed to an increase in States' contributions to the NHM (see figure 1). Despite increases in funding, the average State health expenditure was only 5.2% of their total budget in 2018/19, below the goal of 8% as set out in the 2017 National Health Policy. States spending is constrained by their ability to raise resources and to contribute to the conditional matching grant required under the NHM.

Much of the increase in NHM funds has been allocated to "Mission Flexipool", which offers States greater discretion for utilisation compared to other health areas, with funds spent on maintenance grants, Accredited Social Health Activists, and infrastructure

improvements. Despite increases in spending, the actual budgets for many health programmes and activities, including Mission Flexipool, were less than the amounts proposed by states following negotiations with the Centre.

CENTRAL GOVERNMENT'S ROLE IN SHAPING PRIORITIES AND SETTING THE AGENDA FOR PHC

The Central Government has exercised significant influence on States' health agendas, in particular through the National Programme Coordination Committee (NPCC) which appraises state plans. The creation of Health and Wellness Centres is one such programme that has been encouraged by the NPCC. On the other hand, State programmes that didn't align with the Central government's priorities, did not received funding.

The Centre has also brought about several other fundamental changes in primary care, for example by increasing emphasis on achieving health equity and improving performance. States with relatively poor health indicators and outcomes receive additional funding beyond the per-capita standard allocations, and strategies for improving health care have been created for more than 180 High Priority Districts across the country. In terms of performance, performance-based incentives now comprise 20% of the approved NHM budget and are awarded to States for meeting various criteria, although the disbursement of incentives has not been applied since 2019 due to COVID-19. There is a risk that states with poorly functioning health systems and low capacity to spend funds will be penalised further by the system of performance-based financing, and it is important that they are supported in building capacity to allocate and utilise resources for PHC.

The experience from the four states suggests that the NHM created a context in which the Central Government became a primary agenda-setter for PHC within States. With the proliferation of CSS over time, conditionalities set by the Centre are likely to play a larger role in the future.

LESSONS LEARNED

The study findings may have value for LMIC settings with federal systems of government, or where reforms aim to decentralise or devolve the financing and provision of PHC.

1. Policy levers and power dynamics between the central and state (or provincial level) can be used to encourage states towards a common goal of increasing spending on primary health care through a model of cooperative fiscal federalism.
2. The institutional arrangements of matching funds, as well as conditionalities for receiving contributions from the centre, are instrumental in nudging the decentralized institutions towards a common agreed program of work.
3. Governance frameworks influence the eventual outcomes of such fiscal instruments. In the Indian context, the creation of society structures and its linked accountability frameworks led to the health sector and primary health care gaining higher priority by States.
4. Performance-based financing may enhance inequalities between states unless it is backed up with a systematic attempt towards building capacity of the lower institutions for planning, performing, and absorbing the increased funding at their disposal.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

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