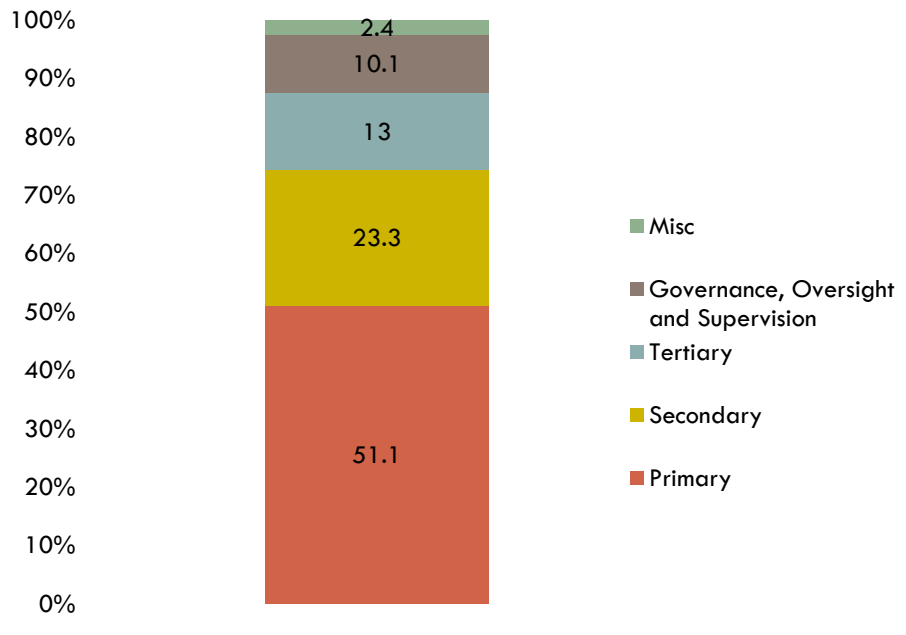
Power to the States: New pathways to Inter-governmental fiscal transfers for health

ACCOUNTABILITY INITIATIVE

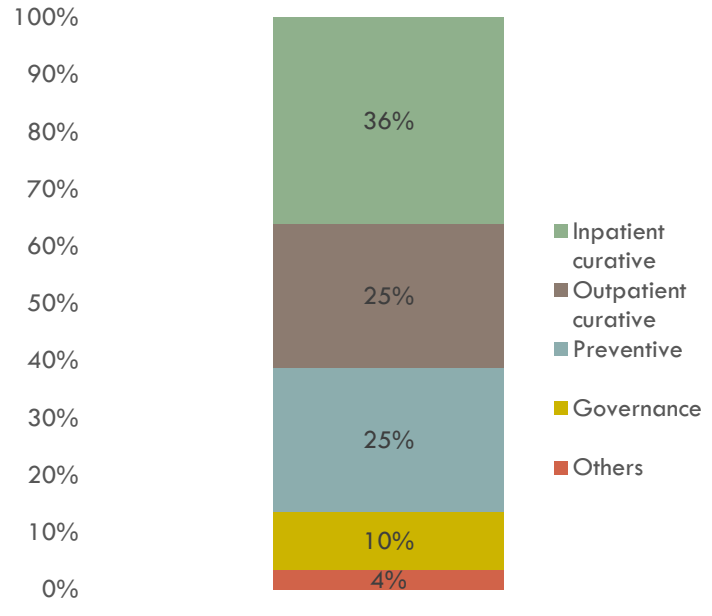
CENTRE FOR POLICY RESEARCH

What do government investment prioritize?

Expenditure by type



Expenditure by function

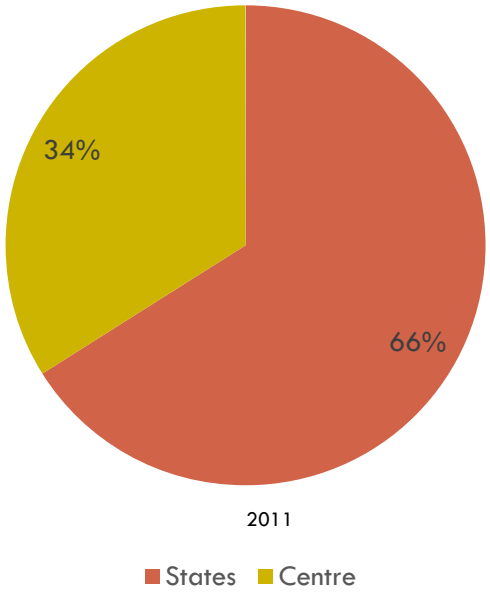


Source: Calculated from National Health Accounts 2013

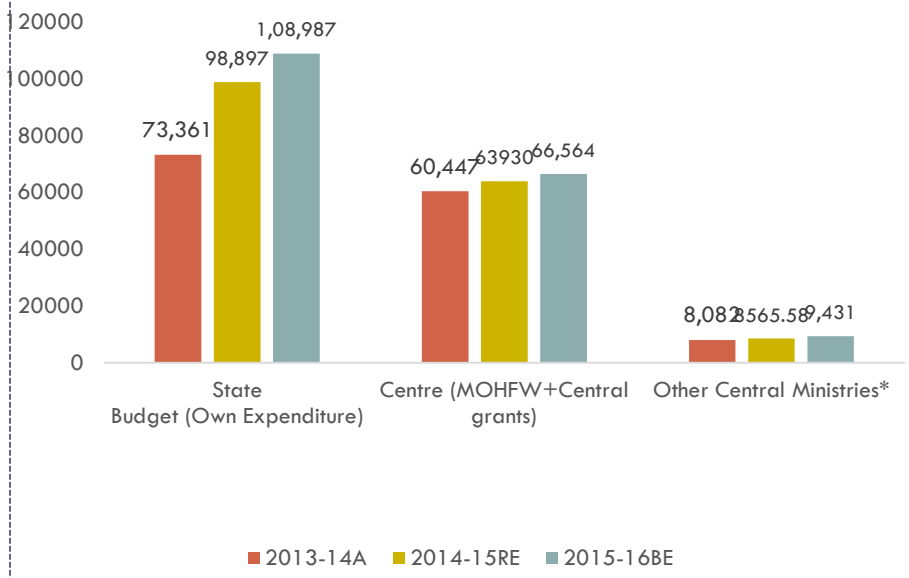
Who finances health? Centre Vs. State

50%-75% of state expenditure is tied to wages

States provide a bulk of the resources



States share rising post devolution



Source: Draft National Health Policy 2015

*Source: MoHFW Note: *Other Central ministries includes RSBY*

Lessons from existing IGFT

India's recent experiments with IGFT for Health

Type of Transfer	Rationale	Approach
Centrally Sponsored Schemes: National Health Mission (NHM)	To give additional resources to states to focus on primary healthcare.	Set of high focus states chosen. Designed by Centre and implemented by states on a co-sharing basis
13th Finance Commission- Performance Incentive for Health	Incentivising States to reduce IMR	Performance incentive after 2 years based on movement in IMR

National Rural Health Mission

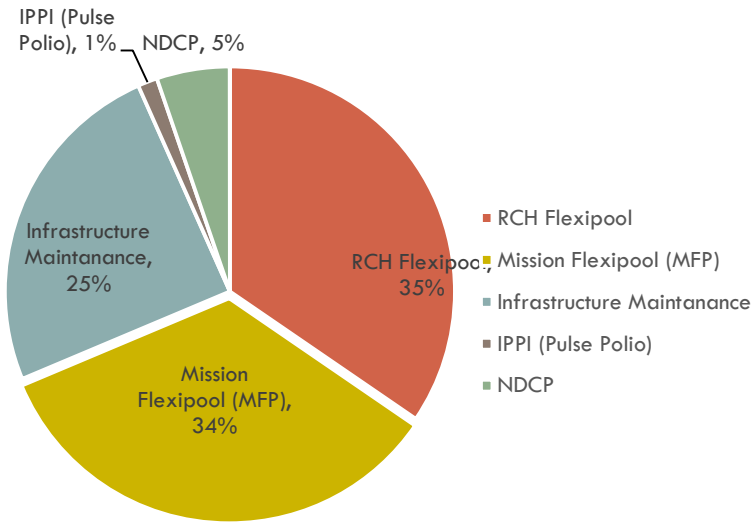
- NHM (rural and urban) expenditure constitutes around 15% of total public expenditure on health and 51% of GOI expenditure on health
- In FY 2016-17, Rs. 19473 allocated to NHM

Key Design Features

- Flexible and bottom up approach with states creating Project Implementation Plans (PIPs)
- Central flows consolidated by creating "flexible pools" – Reproductive and Child Health Care
- Small cash transfers to pregnant women and health workers to increase health service use. Example: Janani Suraksha Yojana (JSY)

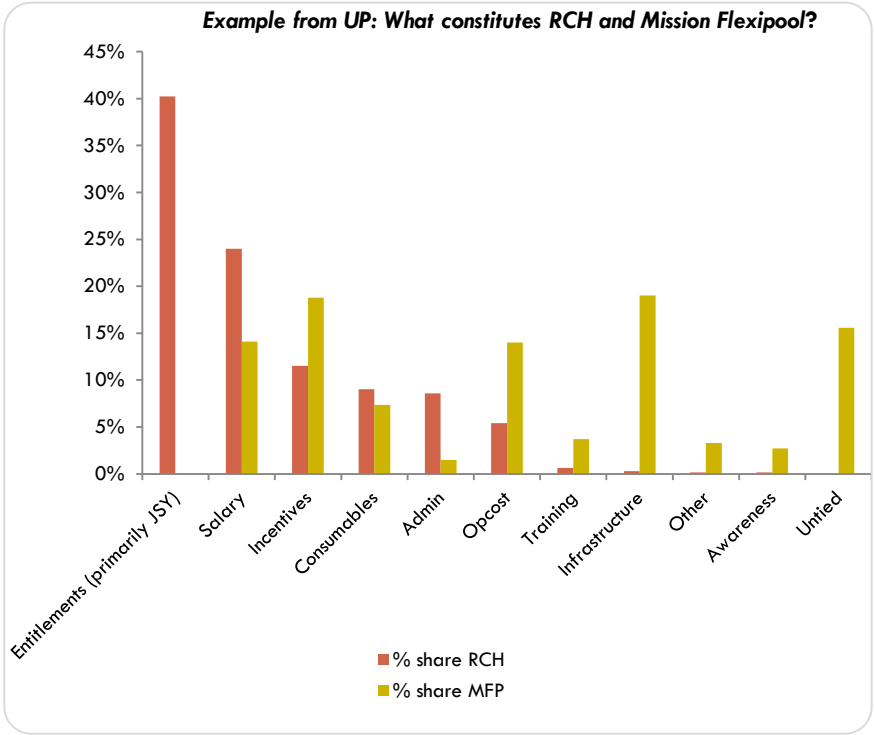
What does NHM Prioritise (Expenditure Trends)

RCH & Mission Flexipool key priority



Source: NRHM MIS

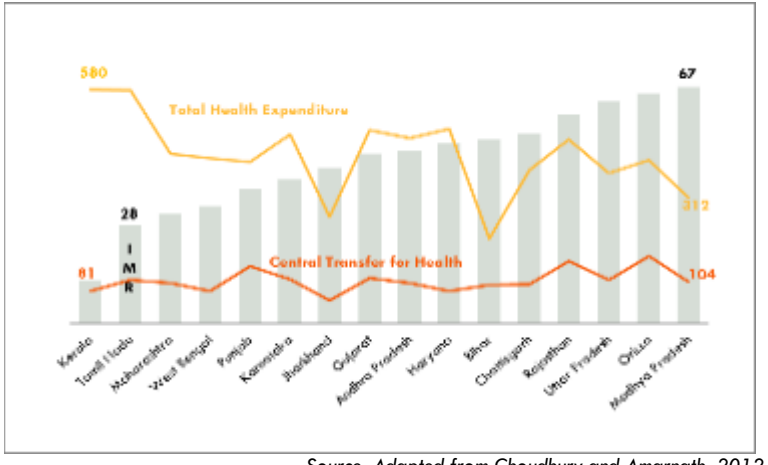
Entitlements get spent; untied funds don't



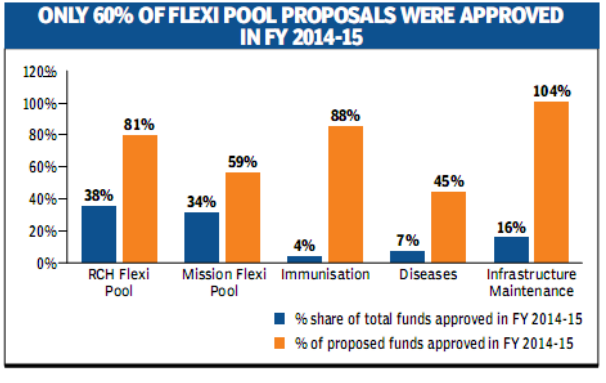
Source: Uttar Pradesh ROP

Lessons learnt from NHM

- Despite focus states: the additional central transfers have not been able to respond adequately to needs
  - Minimal variation in per capita NRHM transfers across states
- Disincentives comprehensive planning at state level
  - Limited flexibility: Uniform norms across the country
  - Significant difference between proposed allocations and approved allocations: only 69% of total state proposals approved in 2014-15
  - Delays in PIP approval process



Source: Adapted from Choudhury and Amarnath, 2012



Source: Accountability Initiative, Budget Briefs, 2015

Lessons learnt from NHM

- Lack of predictability in fund flows: low releases and delays in release of funds
  - Example in 2014-15 in Uttar Pradesh only 54% of funds approved released to the State
  - Only 10% of this released till November 2015.
  - But, state guidelines enable usage of unspent balances for "routine activities" such as salary payments, JSY and routine immunization
- Salaries and Entitlements such as JSY get spent: Limited expenditure on other components

Performance incentives under13th Finance Commission (FC)

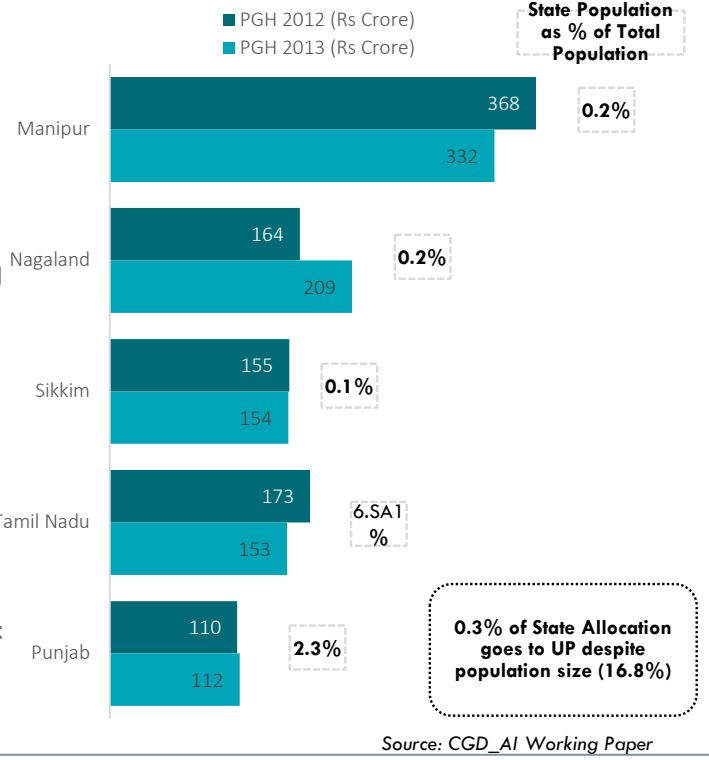
Overview

- 13th FC tasked with making recommendations that addressed "*the need to improve the quality of public expenditure to obtain better output and outcome.*"
- Rs 5,000 crore allocated for health over three years (2012–15)
- Amount distributed as a performance incentive to states that reduced their IMR.
- Allocation formula took into account the relative improvements from the median and used a weighted average to calculate the share of the funds going to each state. However, it did not consider population or state health expenditure

Performance incentives under 13th Finance Commission (FC)

Lessons learnt

- What worked
  - Predictable fund flows: Based on a formula
  - Flexible: States have freedom to decide what activities to prioritise: gives them lead time to design intervention.
  - Incentivises outcomes – release linked to progress in reducing IMR
  - Based on independently collected, regular data on IMR (*difficult to fudge*)
- Limitations
  - Assumption that States have upfront resources
  - Lack of weight to population, birth rate or even trajectory of IMR decline means incentive amount concentrated in a few states



Source: CGD_AI Working Paper

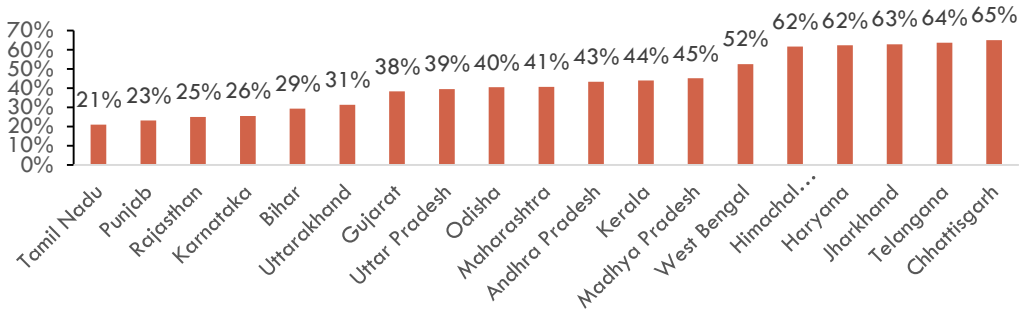
Where we stand today

Implications of acceptance of recommendations of14th FC fiscal transfers

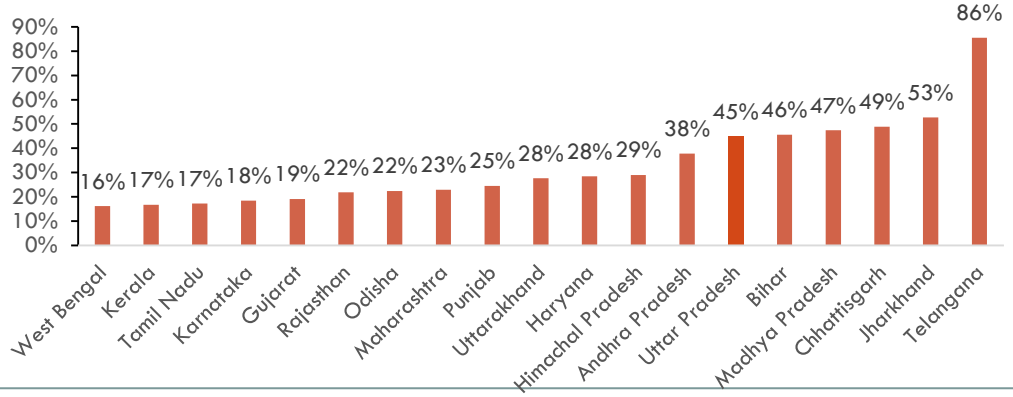
Opportunities: 14th Finance Commission

- Fiscal space has increased
- Most states have increased social sector spending
- Shifts within social sector spending
  - Bihar: Reports wanting to spend 83% more on health this year (compared to previous year)
  - UP: Consistently reporting 23% increase for public health; 46% for family welfare last year, but 9% this year.

At least 20% increase in central transfers+devolution



Increases in social sector spending



Challenges for Health Financing post 14th FC

- But, greater transfers to the States also mean that fiscal space of the Center has reduced significantly
  - No real increase in allocations for NHM: cuts in GOI allocation for NRHM
- Do states have flexibility?
  - Proportion of untied funds actually decreased in UP; unchanged in Bihar
  - Increase in fund sharing ratio between GOI and states from 75:25 to 60:40
  - Increasing burden on wages and salaries – 7th Pay Commission

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

How best should the Centre utilize its limited resources for improving health outcomes?

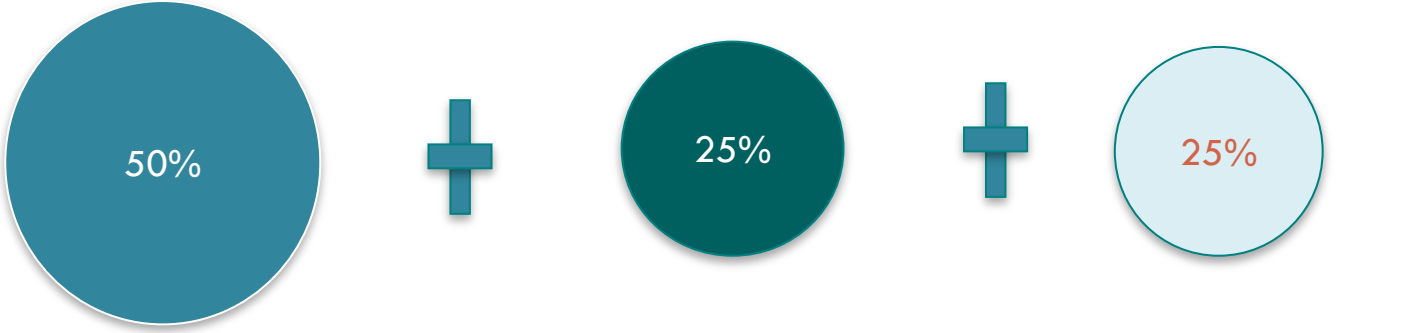
Looking Ahead: Potential Solutions

- Pay for health outcomes:
  - Choose a single, simple metric of health status and incentivise good performance. Metric could be IMR but benchmarked with population, birth rate etc. and GOI could pay for each averted infant death; alternately could be reduction in out of pocket expenditures
- Pay for performance:
  - A complementary payment mechanism could rely on an index of health indicators. Each additional percentage increase in the mean index, weighted by population, would be associated with a specific payment.

Example from Education

A performance based financing system to incentivize a focus on learning

Three window funding for SSA



Other important recommendations

- **Move money to the States:** combine incentives for performance based on health outcomes with block grants/untied funds
- **Predictability in fund flows:** Strengthen data based planning and ensure predictably in fund flows. Using IT for real time tracking? (example PFMS)
- **Improve accountability and data:** independent institution(s) should collect, manage and analyze health-related information, and measure state-level outcomes
- **Capacity Building:** Strengthen process of budget making at the state level and local government?
- **Learning and Sharing Platforms:** Regular tracking of state finances and building a platform for learning and sharing (increased coordination across depts.)

THANK YOU

FOR MORE INFORMATION VISIT: www.accountabilityindia.in

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