Impact of the 14th Finance Commission and CSS Sharing Pattern on Health Expenditures

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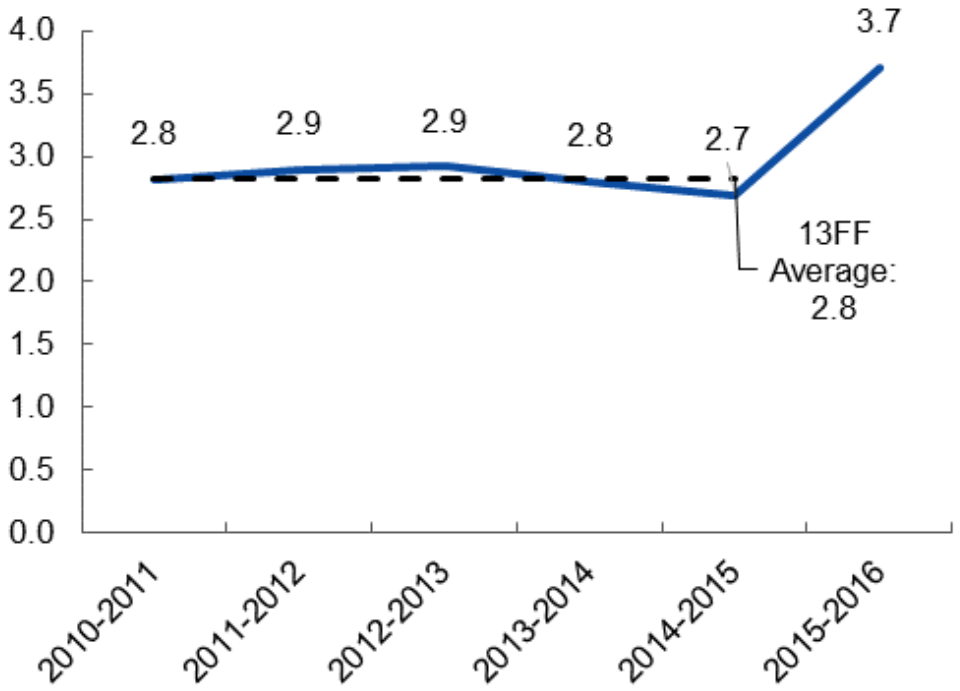
Motivation

- Two major changes have happened
  - Increase in untied transfers and a reduction in grants as a result of the Fourteenth Finance Commission (FFC) recommendations
  - Increase in the contribution of states in central health schemes following the recommendations of the sub-group of Chief Ministers on Centrally Sponsored Schemes (CSS)
- A priori it is expected that health expenditures will reduce
  - The total pie of grants has reduced leading to overall lower spending by the centre
  - Political economy suggests that states are likely to increase expenditure on relatively more visible sectors such as infrastructure, populist state schemes than on health – outcomes of which are slow to change and relatively less visible
- So what has been the impact of these changes on health expenditures
  - How has total government spending on health changed?
  - How has the total expenditure on central health schemes changed?
  - How has state government expenditure on health changed?
  - Are states prioritizing health expenditures by spending more untied funds on health?

Changes: The FFC recommended a significant increase in tax devolution…

- Tax devolution increased from 32 to 42 percent representing an increase in devolution from an average of 2.8 percent of GDP in the XIII FC period to 3.7 percent of GDP in FY15-16



..and rationalized the channels of inter-government transfers

Non Plan Grants

- Statutory Grants
  - Non-plan revenue deficit grants
  - Local body grants
  - Disaster relief grants
  - Sector-specific grants
  - State-specific grants
- Other non-plan grants

Plan grants

- Normal central assistance – untied for annual plans of states (Gadgil-Mukherjee formula)
- Additional Central Assistance for specific purpose schemes and transfers
- Special Central Assistance – untied assistance to NE and hilly states
- Special Plan Assistance

- Centrally Sponsored Schemes

- Statutory Grants
  - Revenue deficit grants
  - Local body grants
  - Disaster relief grants
- Centrally Sponsored Schemes

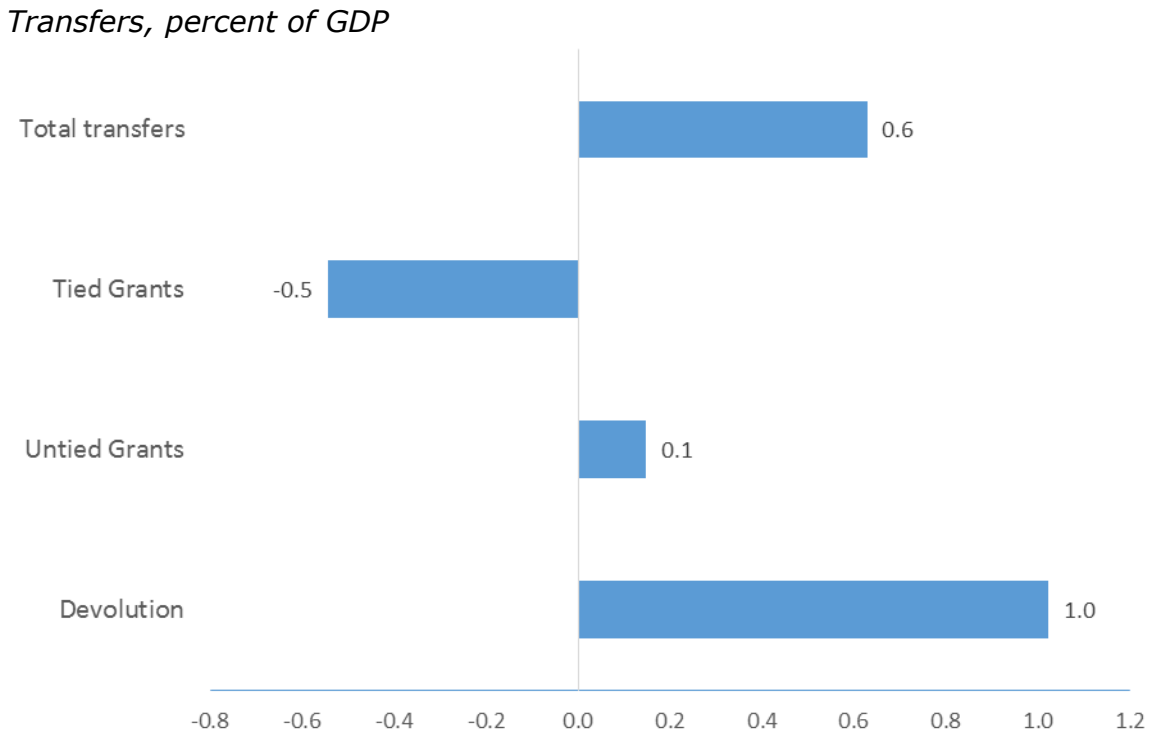
Sharing Pattern has been revised

- For Core Schemes
  - a) For 8 NE and 3 Himalayan States: Centre: State: 90:10
  - b) For other States: Centre: State: 60:40
  - c) For Union Territories: Centre: 100%

- For Optional Schemes
  - a) For 8 NE and 3 Himalayan States: Centre: State: 80:20
  - b) For other States: Centre: State: 50:50
  - c) For Union Territories: Centre: 100%

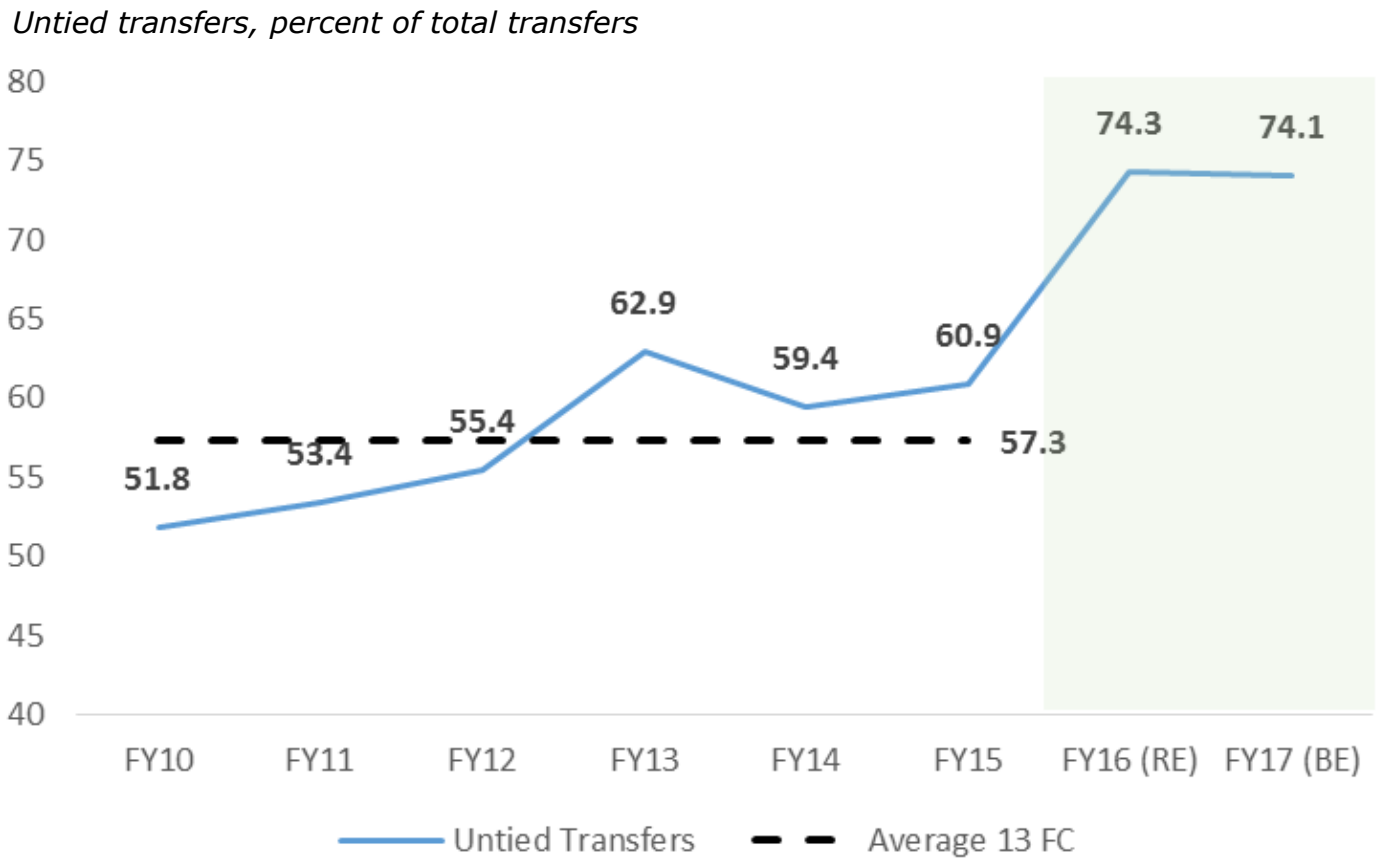
- Existing funding pattern for Core of the Core schemes to continue
- New funding pattern to be implemented from FY2015-16 onwards
- NHM shares revised from 75:25 to 60:40 in general category states. The NE and Himalayan states continue with a 90:10 sharing pattern

As a result total transfers increased and became more untied in nature



Grants given by Ministry of Finance and predominantly consisting of transfers under Art. 275(1) of the Constitution are classified as untied grants. The rest have been classified as tied grants. (source: Statement 10, Expenditure Budget Vol I, Union Budget)

…and the share of untied transfers in total transfers from Centre to the states increased substantially



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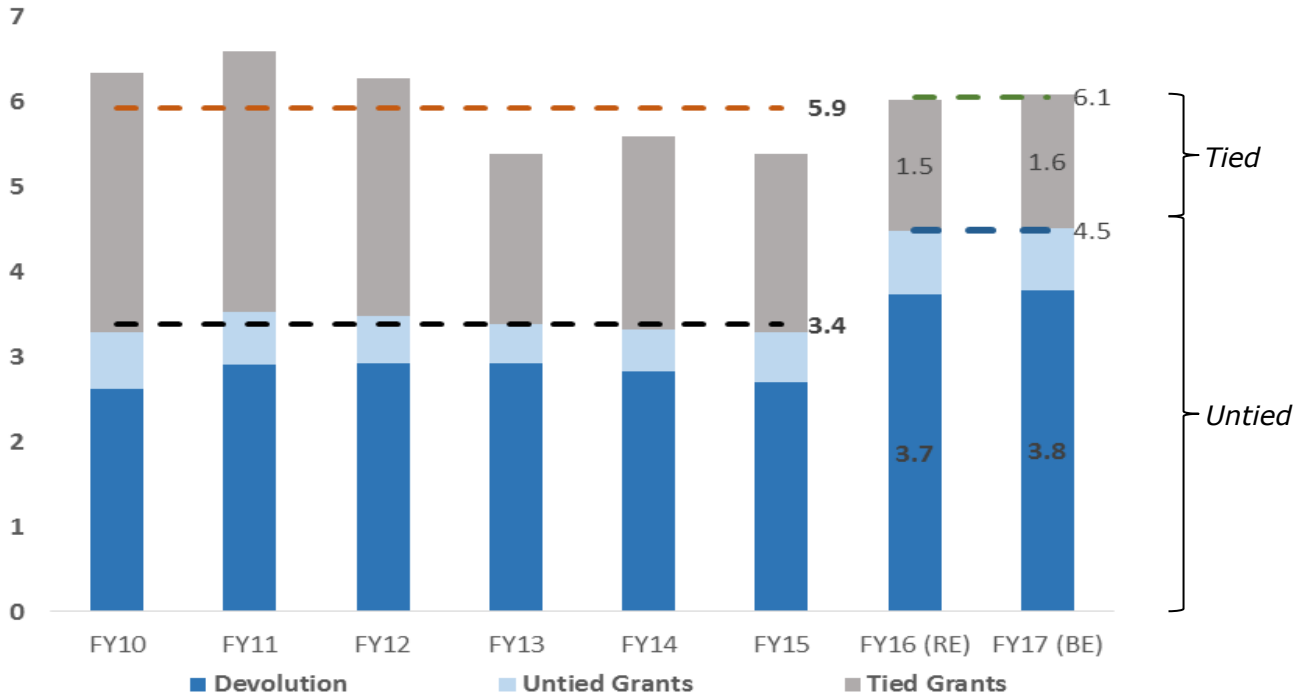
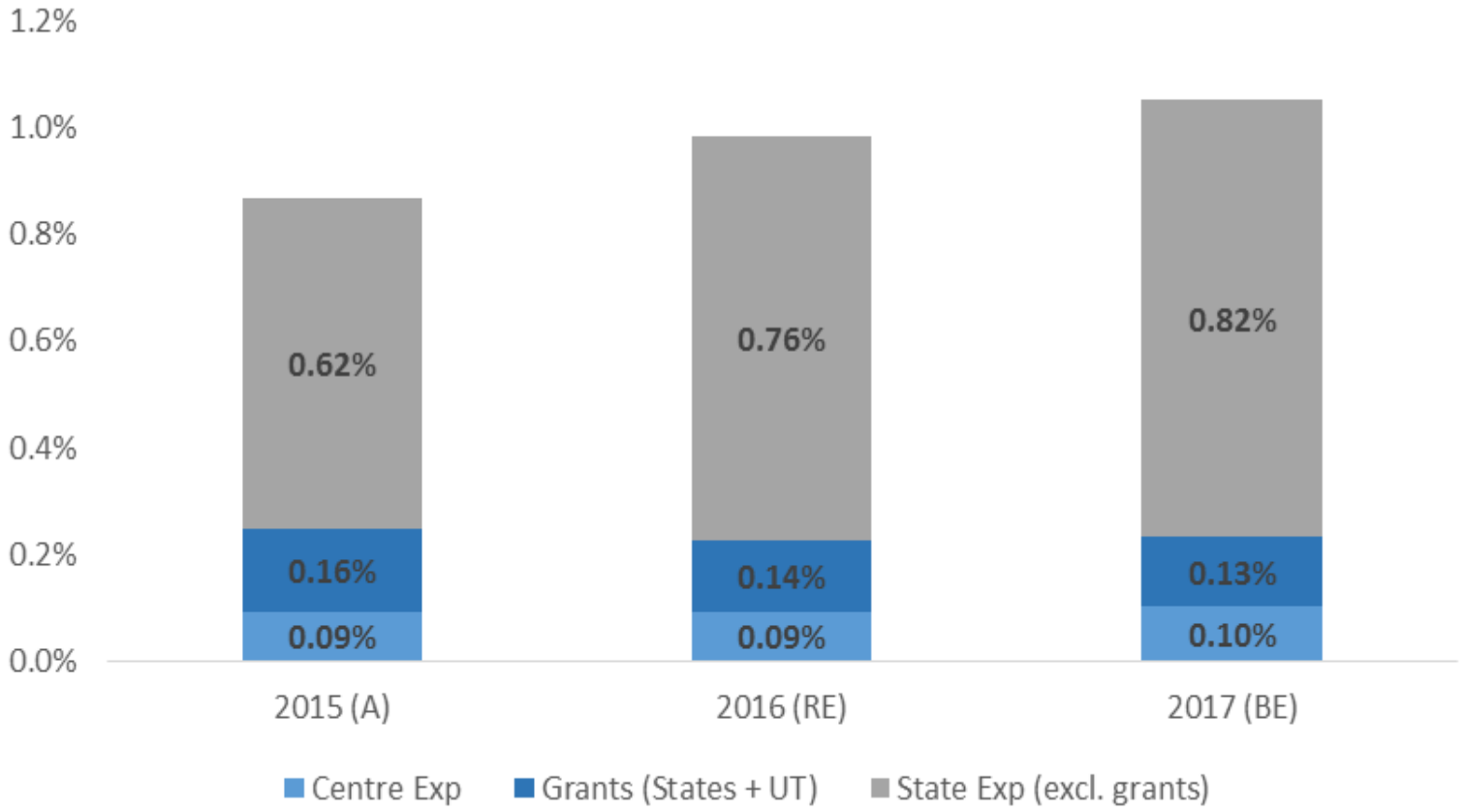
Average total transfers have remained largely unchanged from the 13 FC period, but the relative shares of tied and untied has shifted significantly in favor of untied transfers.

Total transfers, percent of GDP



Aggregate government expenditure on health has increased from 0.9 percent in FY15 to almost 1 percent of GDP in FY16, due to 0.14 percent of GDP increase in state expenditures

Aggregate health expenditures, percent of GDP



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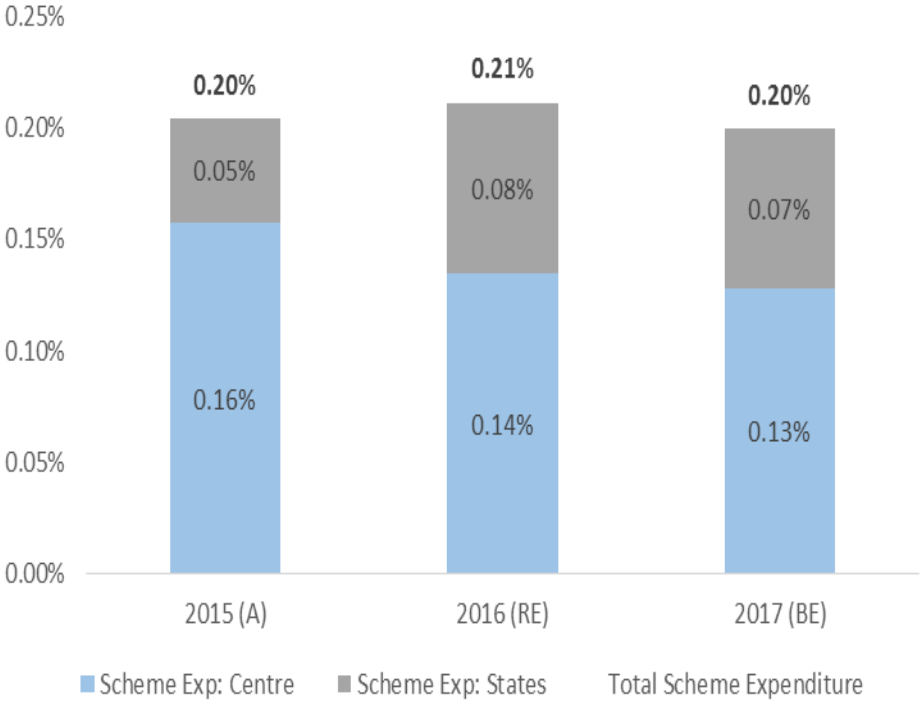
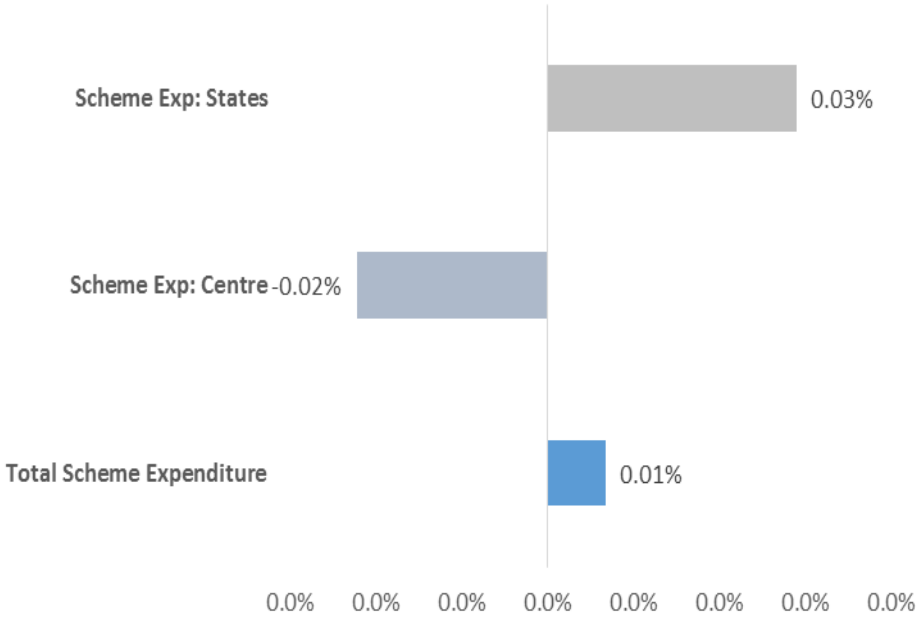
Total expenditure on health schemes improved as states contribution to the schemes surpassed the reduction in total central health grants

Aggregate health scheme expenditures, percent of GDP



Changes in health scheme expenditures, percent of GDP



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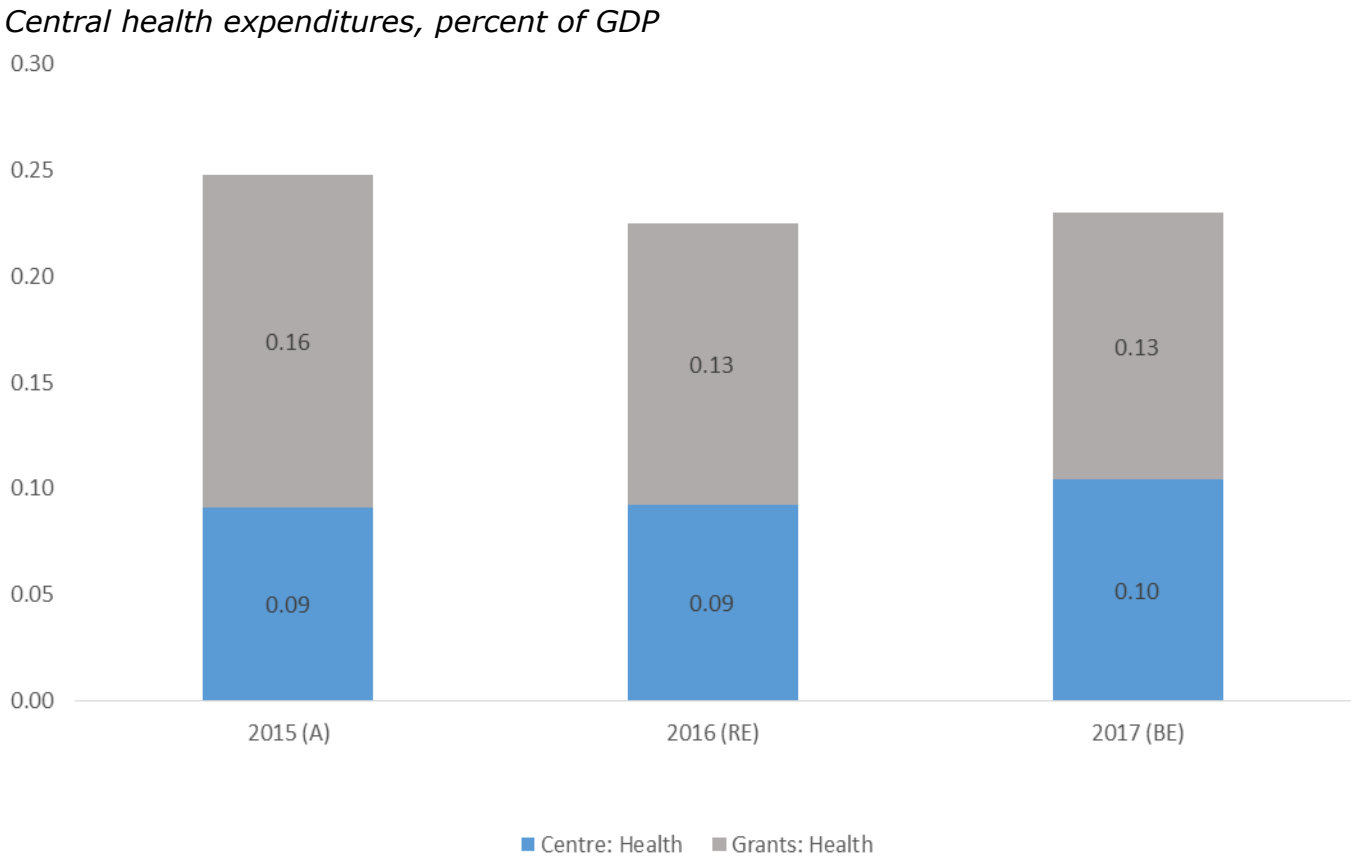
Central expenditures: Direct health expenditures by the Centre have remained unchanged but central health grants reduced by 0.03 percent of GDP, a 15 percent drop in grants between FY15 and FY16



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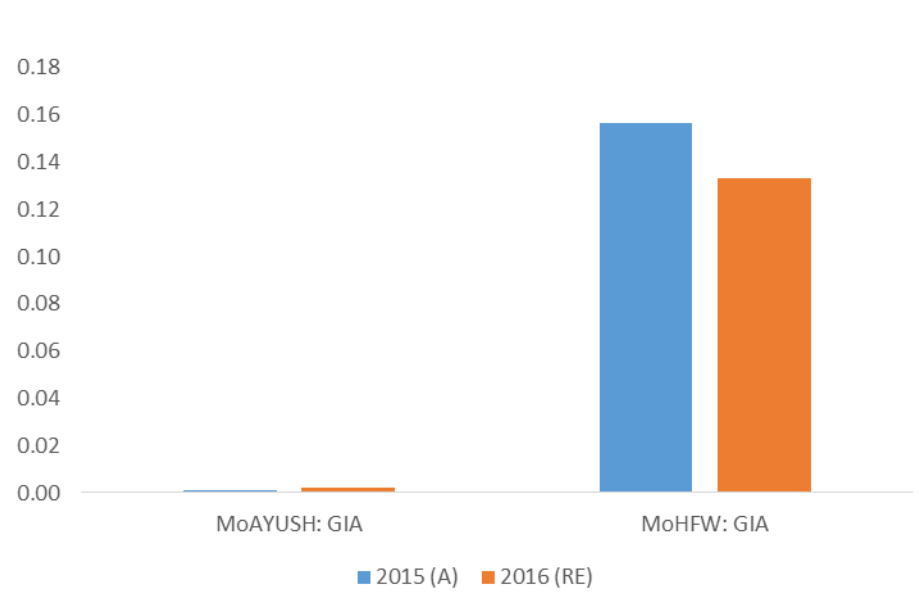
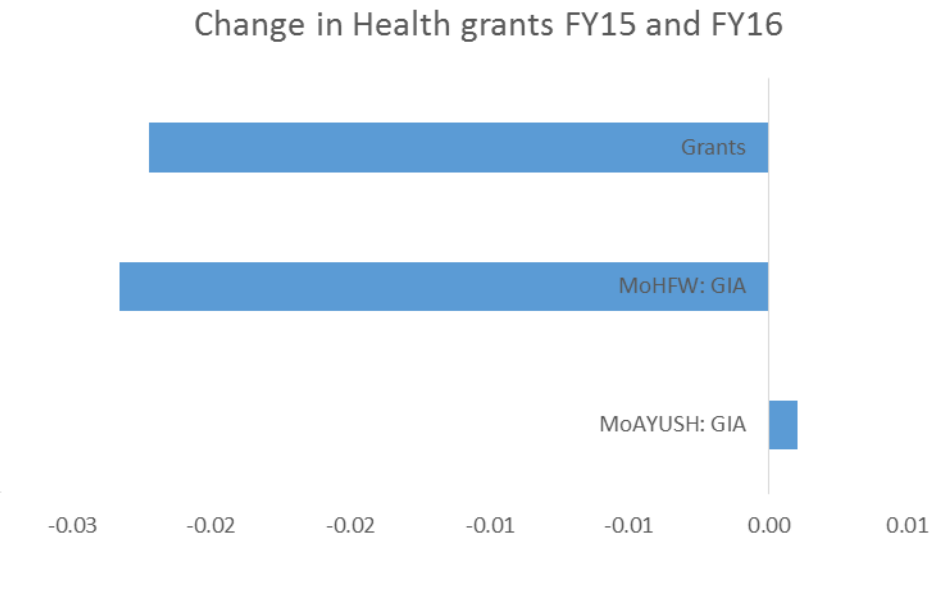
The aggregate reduction in health grants (15 %) has been predominantly due to reduction in grants for health and family welfare. There is steep increase in grants for AYUSH, but from a very low base

Central health grants, percent of GDP





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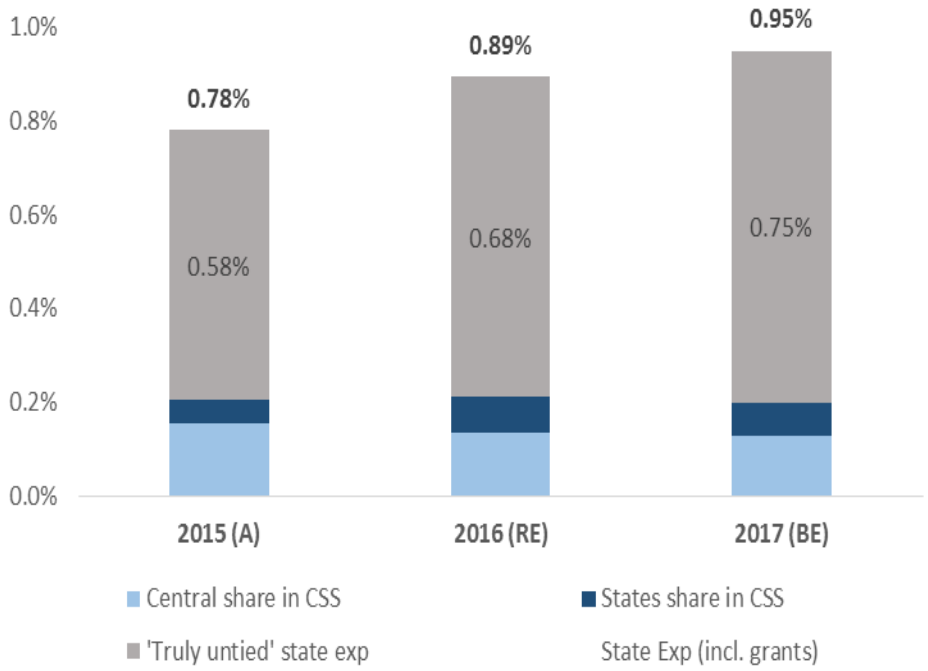
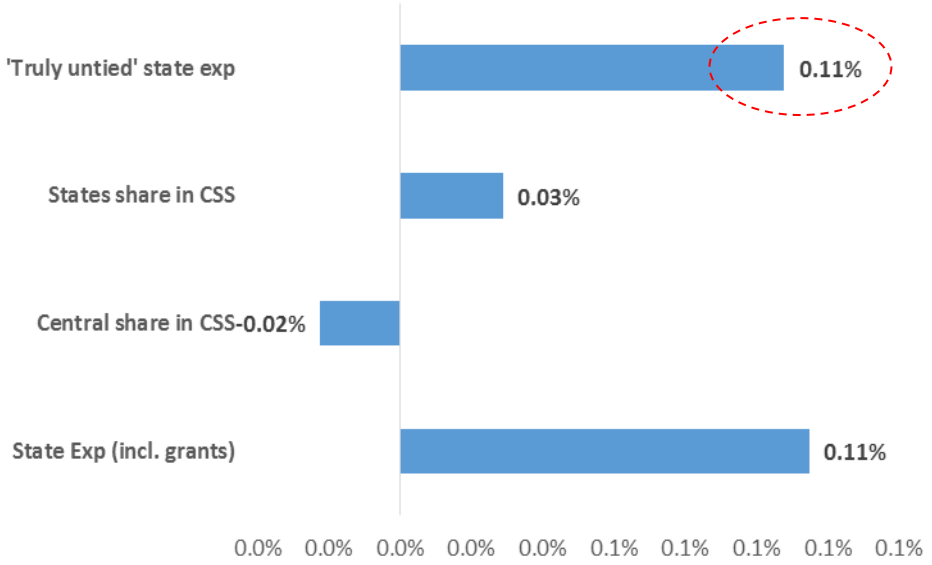
In aggregate, states prioritized health by increasing their 'truly untied' health expenditures. Reduction in total central health grants shares was more than offset by the increase in state share

Aggregate state health expenditures, percent of GDP



Aggregate state health expenditures, percent of GDP



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Methodology

- Total government expenditure on health – by the Centre, central health grants and state expenditures have been collected
- Total health grants among states has been apportioned based on the share of approved state wise expenditure on National Health Mission (NHM) scheme
- The contribution of the states to NHM from their untied funds have been calculated based on the sharing pattern of the scheme. These are considered to be tied expenditures even though they are from the untied pool of centrally transferred resources
- Health expenditures, over and above central health grants and state's mandatory contribution towards these grants are defined as ***'truly untied'*** and are taken as an indicator (% of GSDP) of the extent to which the states prioritize expenditures on health
- Finally health outcomes in states are compared against the extent to which each state has prioritized health expenditures, before and after the two major changes in fiscal transfers

Data: Public expenditure on health

- Incurred by 3 tiers of government
- Central government
  - Direct spending on health
  - Grants to states – Centre reports it separately in its budget but States includes it under their expenditures
- State government
  - Direct spending on health including resources transferred to local bodies
  - Grants received from Centre
- Local government
  - Own resources
  - Transfers / loans and advances received from the states

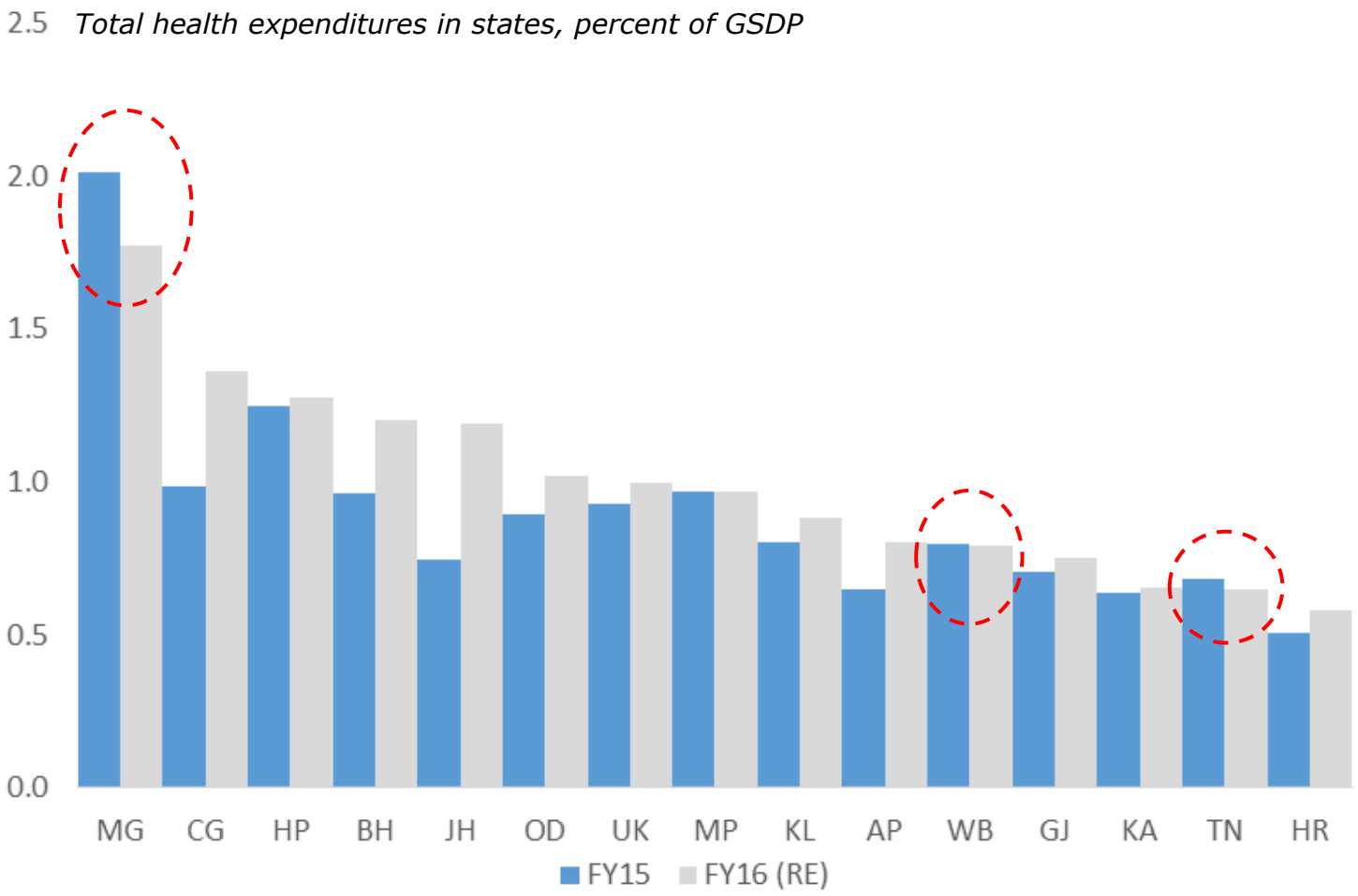
Data: Health Expenditures – Centre

- Expenditures under budget major heads related to health in MoHFW, MoAYUSH (health expenditure on central and state government employees (largely Defence and Railways) has not been considered)
  - Medical and Public health – Current and Capital – 2210 & 4210
  - Family welfare – Current and Capital – 2211 & 4211
- Grants – in – aid expenditures from MoHFW, MoAYUSH
  - GIA to States - 3601
  - GIA to Union Territories – 3602
- These have been compiled from Union Budget documents FY 2016-17

Data: Health Expenditures – States

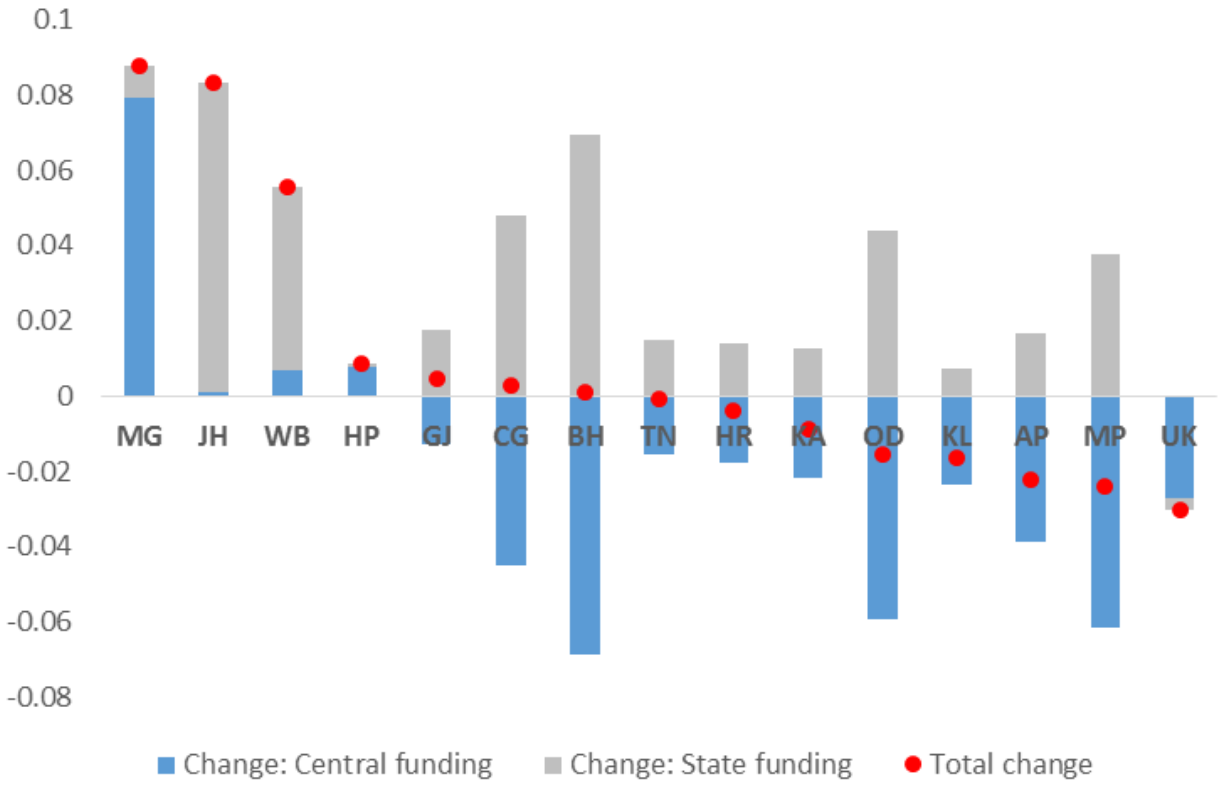
- Expenditures under budget major heads related to health collated from state budget documents and audited finance accounts (FY2014-15)
  - Medical and Public health – Current and Capital – 2210 & 4210
  - Family welfare – Current and Capital – 2211 & 4211
- Loans and advances to third tier of government is included
- Grants – in – aid received for major health schemes (Ideally revenue receipts under major head 1601 for state DoHFW and DoAYUSH). But in the absence of this data, approved expenditures on National Health Mission (NHM), that comprises the majority of central health grants, has been compiled from the Record of Procedings (RoPs) of the state Program Implementation Plans (PIPs). This data is used to apportion total central health grants among states.

There is considerable variation in total spending on health in states (incl. central grants), but in most of the 15 states considered, it has increased. Exceptions – MG, WB, TN



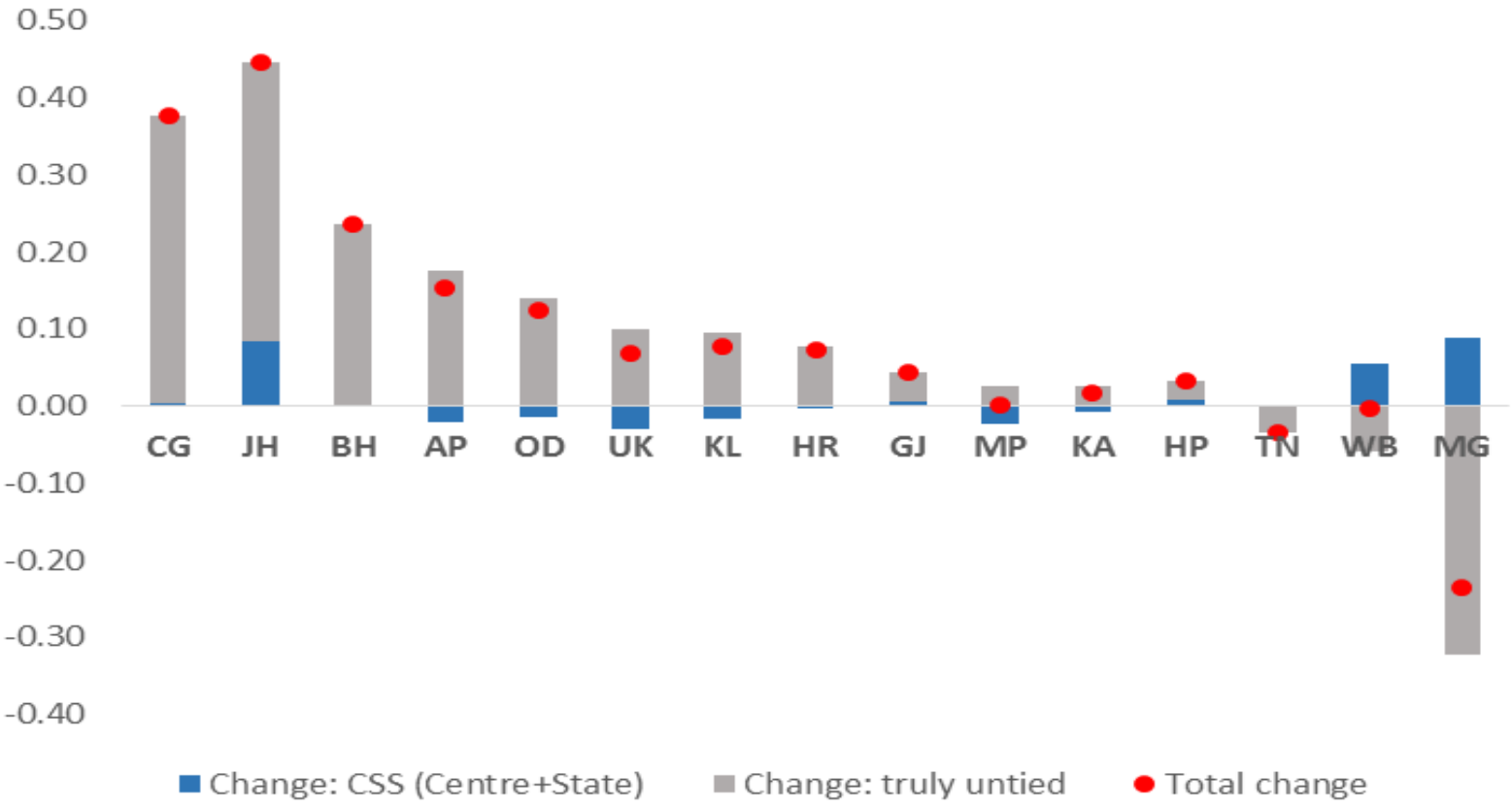
Central health scheme funding reduced in most states as a result of the reduction in grants

Change in central health scheme expenditures in states, percent of GSDP



Most large states, with the exception of TN and WB, prioritized the health sector by spending more from their 'truly untied' funds

Change in health expenditures in states, percent of GSDP



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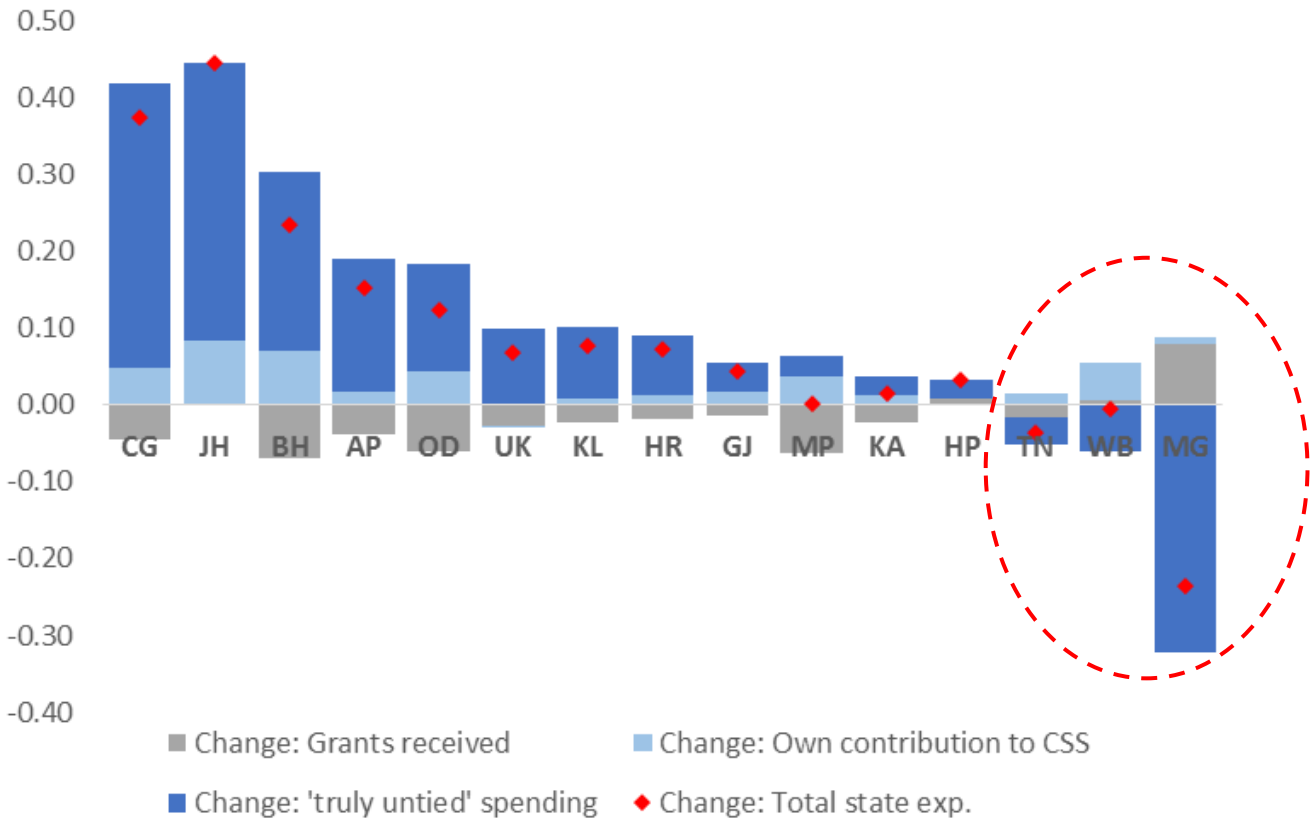
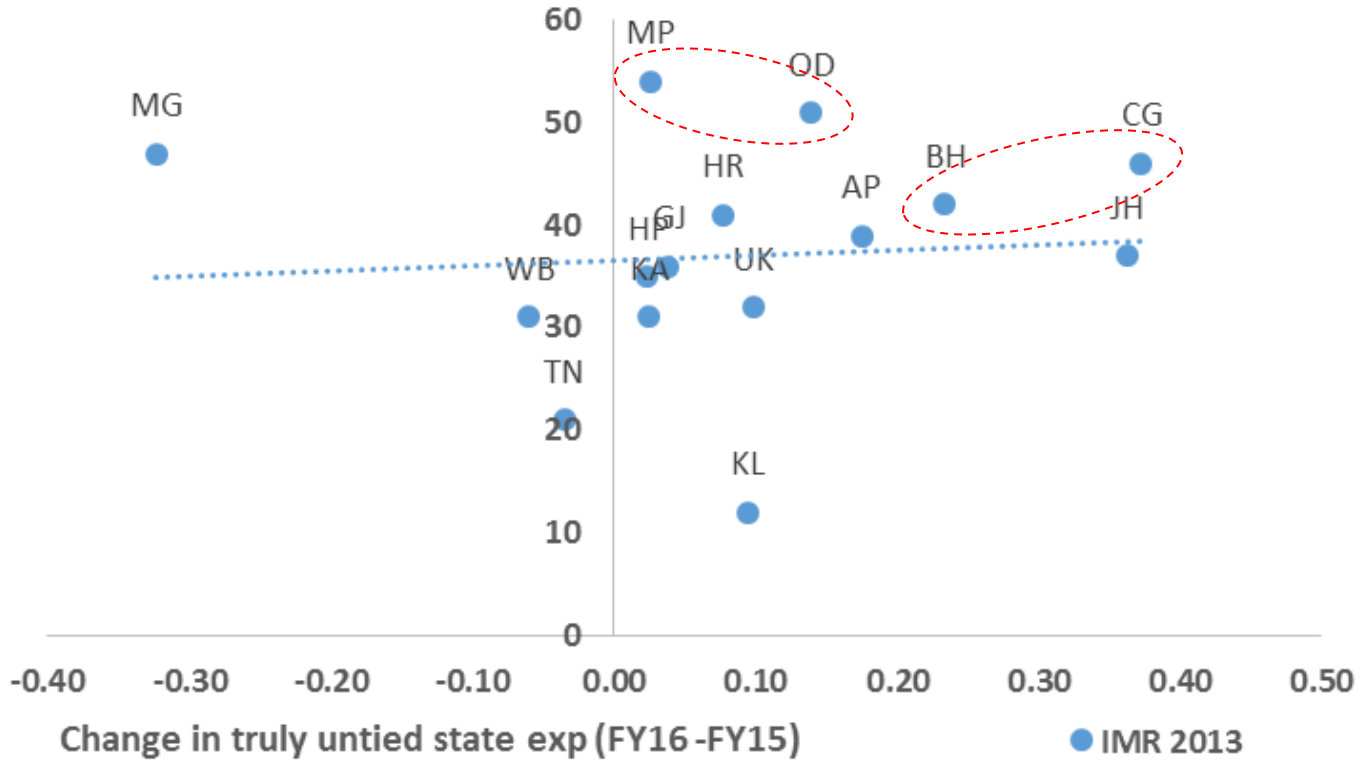
..But most states compensated by increasing their 'truly untied' spending. Expenditure reduced in 3 states predominantly because they reduced their 'truly untied' spending on health.

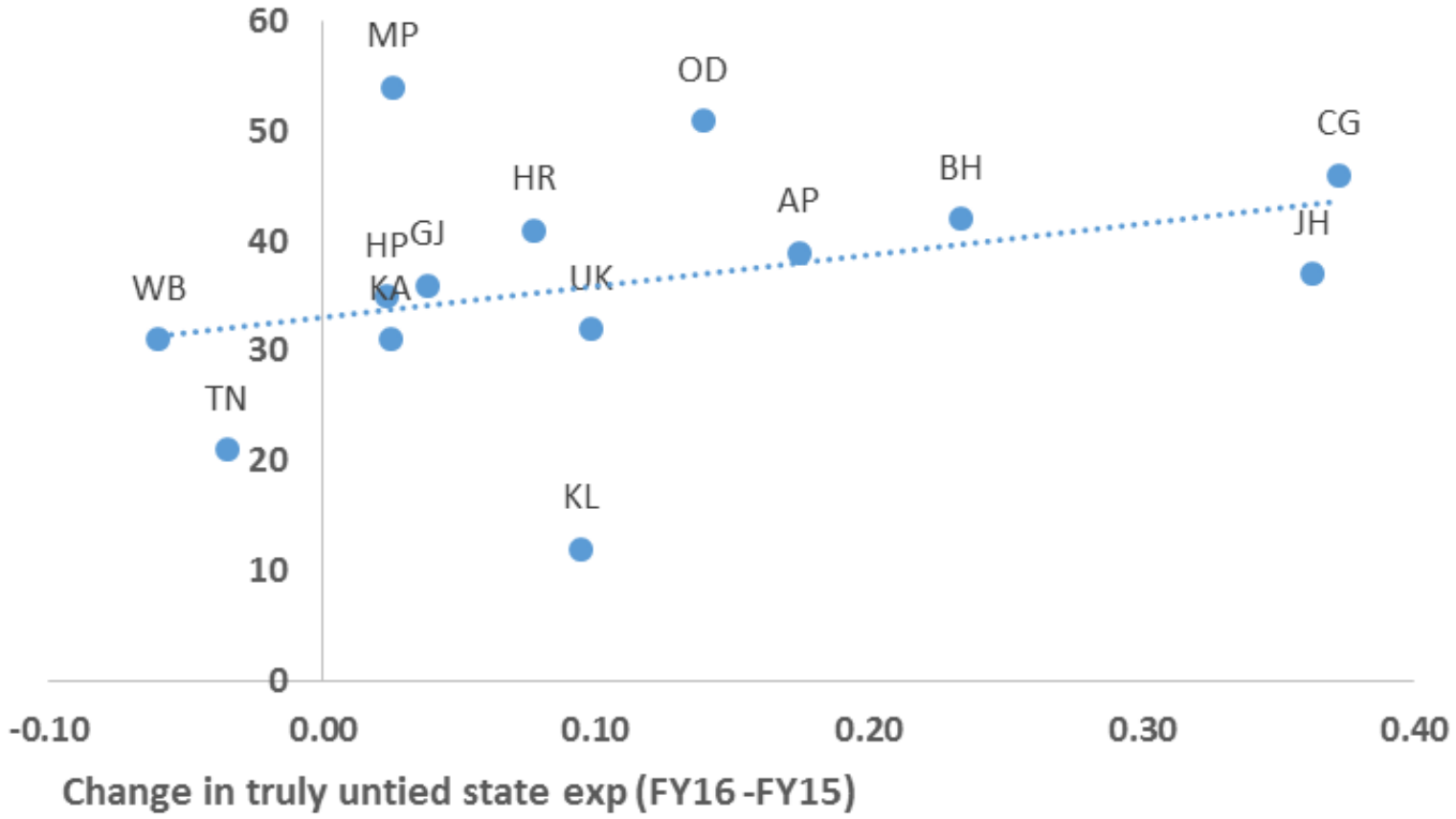
Change in health expenditures in states, percent of GSDP



No strong correlation between states health outcome (IMR/1000) and prioritization of health expenditures by states but some of the low income states, notably CG, BH and JH are prioritizing but others, especially MP and OD are not.



But if MG is taken out



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Scope for further analysis

- Final picture will emerge after FY16 actual figures are available
- Use of actual expenditure data on CSS will improve the analysis
- Including expenditure on water supply and sanitation, nutrition etc.
- Analyzing health outcomes against public expenditures

Thank you