

Center-State Fiscal Transfers to Promote Universal Health Coverage in India
Some Lessons from International Experience
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Overall Findings

As India seeks to achieve universal healthcare coverage and aims to boost central government funding for health from 1.1% of GDP to 3% in the next few years, one of the major health financing choices involves center-state fiscal transfers. How should the central government allocate monies to the states so that: health poor states catch up to rich states in health spending and outcomes or at least reach a minimum threshold and close the current gap; states give adequate priority to health using their own budgets, as well as transfers from the center; and central government fiscal measures help to stimulate improved performance within states, in terms of better health outcomes and greater efficiency?

At the request of Public Health Foundation of India (PHFI), the Results for Development Institute (R4D) prepared this preliminary technical note drawing on the experiences and lessons from a number of large federal countries, including Brazil, Canada, Germany, Mexico, and the United States. While a deeper review of this topic is likely to follow in the coming weeks, R4D rapidly created this brief over a short period of time as timely background material for PHFI and the High Level Expert Group.

Our research and analysis uncovered several findings:

- *Fiscal transfers from central government to sub-national governments (states/provinces and districts/municipalities) can have significant effects, positive and negative, on health spending levels and system performance.* The impact of these transfers is far from being straightforward and automatic. When carefully designed, they can make a big positive difference. When poorly constructed, they accomplish little and can even backfire. The “devil is in the details”. While learning from others, each country must design and implement fiscal transfer programs that build on existing practices and traditions, which vary widely from country to country.
- *General purpose equalization grants generally do not have a large redistributive impact on health system development.* Many countries redistribute wealth as a matter of constitutional mandate, giving sub-national governments autonomy in the use of these funds. India has also employed such general transfer policies. Because such general purpose grants allow states to shift and substitute central and local funds among programs, it is hard to use them to expand spending in a particular area such as health. If the goal is more equitable distribution and expenditure of resources for health, conditional grants may be more appropriate.
- *Conditional grants from central government, including non-matching, output-based transfers and matching grants using differential formulas across states are widely used in other federal countries to boost sub-national spending for health and target certain high priority programs and interventions.* India has

started to adopt this approach already. It could be expanded in pursuit of UHC, to help achieve national minimum standards and influence spending levels and patterns at state level. Non-matching output-based grants (e.g., Canada Health Transfer) can give sub-national governments latitude in approach but keep them focused on health sector results. Matching grants (e.g., US Medicaid, Mexico's Seguro Popular) can expand and equalize health spending at state level, forging stronger center-state partnerships.

- *Effective fiscal transfer programs are ones that encourage local commitment and accountability while maintaining a degree of autonomy for state officials.* To do so, transfers need to be carefully designed and aligned with institutional capacities at all levels. They must be stable and predictable so that state and local levels of government know what to expect from the center. At the same time, fiscal transfer programs must evolve over time as economic and political conditions change. It takes time to implement such programs fully, as the decades of experience with transfers in Brazil and Canada show. In that regard, India may wish to set a long-term vision of its fiscal transfer system and policies for health that move the country toward its overall UHC vision, and at the same time design a series of feasible incremental steps so that fiscal transfers evolve in the desired direction.

Why are fiscal transfers for health needed in India?

Historically, the central government in India has played only a modest role in health financing and provision. While health care consumed 4.1% of the GDP in 2008-2009, only 1.1% of that was public expenditure, and only about a third of public spending for health came from the center, with the states assuming most of the financial burden. Public spending will have to increase at a very high rate over the next few years if the government is to meet its pledge of having public outlays for health amount to 3% of GDP by 2020. It also suggests that the central government only has modest financial leverage with the states in health under current conditions, since Delhi currently covers a modest share of all public expenditures for health.

There are strong arguments for a central government role in helping to equalize government spending for health across states. There is a sevenfold difference across the states in public expenditure per person in 2004—from a high of INR630 in Himachal Pradesh to a low of INR93 in Bihar. Within their means, it appears that state government commitment to health also varies widely, with public spending as a proportion of total state budgets ranging from 4.4% in Karnataka to 10.6% in Kerala. There is no clear correlation between wealth (state GDP per capita) and state commitment to health (the share of state budgets devoted to the health sector), further complicating the situation.

Variations in health spending within states (across districts and between urban and rural areas) are also large (The World Bank, 1999). While 70% of Indians live in rural areas, there is a funding bias towards urban areas and private sector curative services (Selvaraj, 2009).

Until recently, central government funding for health was been earmarked for certain programmatic purposes, rather than being allocated to states specifically to reduce disparities

across them. Central government grants could be used for the improvement of government health facilities and for priority programs (e.g., specific diseases and family planning), leaving the states to cover other costs including staff salaries, facility maintenance, prevention, and primary care services.

In the last few years, two new programs—the National Rural Health Mission and Janani Suraksha Yojana have introduced more flexible funding (Balarajan, Selvaraj, & Subramanian, 2011). Both programs have targeted rural preventive and primary care delivery, and have charted a new path for financing. Central government funds are routed to newly formed state health societies, which have autonomy and decision-making authority to spend these resources. States can use central resources to fill gaps in human resources, health infrastructure and equipment, and operations and maintenance costs of government health facilities in order to comply with the Indian Public Health Standards.

Further changes are being considered in overall center-state fiscal transfers, and these could have important implications for revenue sharing and expenditures for health care (Shiva Kumar, et al., 2011). While central funds account for only a third of health spending in India, inter-governmental fiscal transfers finance about 60% of overall sub-national expenditures in India, a figure comparable to the situation in other transition economies and developing countries (Shah, 2006). As India seeks to boost public spending on health, reduce disparities across and within states, and reward performance according to select indicators, the volume and structure of center-state transfers will be vitally important.

Key Considerations for Center-State Transfers

The theory behind intergovernmental transfers derives from fiscal federalism, which states that the central government has the basic responsibility for fiscal stabilization and income redistribution within a country; while sub-national and local governments are best placed to determine the most appropriate services for those in their territory and to spend public funds and execute programs accordingly. (Bowser, Bossert, & Mitchell, 2006).

What objectives are being pursued through transfers? Based on the international experience and the literature on fiscal transfers that we studied, there are three main objectives behind such transfers for health:

- a. Promote fiscal equalization. Central transfers that advance fiscal equalization can reduce disparities in health care spending generally and on priority activities within health, such as preventive medicine and primary care. It is important to lower these disparities, which have an impact on health outcomes, cause fiscally-induced internal migration, and in some extreme cases, can lead to political unrest (Stark, 2010).
- b. Set a national minimum benchmark for all (sub-national) units of government to pursue, such as lower infant mortality rate or a higher ratio of primary care nurses per capita). Transfers may be targeted at the health services required to achieve those benchmarks, or states may be

rewarded for progress toward them. Minimum standards raise performance on key health indicators and can help to achieve interstate parity without the more politically contentious use of fiscal transfers explicitly to equalize wealth.

- c. Influence areas of high national priority (e.g., safe pregnancy and deliveries, HIV prevention). While health is constitutionally a sub-national responsibility in many large countries like India, the central government can use fiscal transfers as a lever to increase focus on the sector or on specific health programs.

What principles and practices matter in designing fiscal transfers for health? International experience suggests that there are a series of principles and features for fiscal transfer programs (Table 1). Other countries have followed these principles and practices in setting up fiscal transfers for health. These include: accountability, autonomy for sub-national government, clarity of objectives, efficiency, equity, incentives, predictability, responsiveness, revenue adequacy, simplicity, and transparency.

Table 1: Best Practices in Fiscal Transfer Design

<i>Grant Dimension</i>	<i>Description</i>
Accountability	Demand accountability from both the grantor for the design and operation of the program and from the recipient for financial integrity and results
Autonomy	Offer as much flexibility and independence as possible to sub-national governments in accomplishing goals. Encourage local, data-driven decision-making
Clarity of objectives	Use simple, clear language to specify grant objectives
Efficiency	Maintain neutrality with respect to recipients' choices of resource allocation for different types of activity
Equity (fairness)	Allocate funds based on fiscal need and inversely with the tax capacity of each jurisdiction. Give preference to governments that prioritize healthcare
Incentive	Provide incentives for sound fiscal management and discourage inefficient practices. Avoid specific transfers to finance sub-national government deficits.
Predictability	Publish five-year projections (with ceilings and floors) of funding to demonstrate predictability to recipients. Accompany hold harmless provisions for major changes in the formula
Responsiveness	Plan to accommodate unforeseen changes in the fiscal situation of the recipients
Revenue adequacy	Give state governments sufficient revenues to fulfill programmatic

	expectations
Safeguarding grantor’s objectives	Employ output-based grants and give recipients flexibility in the use of funds
Simplicity	Insist on simple, easy to understand formulas
Transparency	Disseminate widely formula and the allocations in order to achieve as broad a consensus as possible on the objectives and operation of the program

Source: Shah, 2006

What kind of transfers work best? There are two main types of transfers—general purpose (non-conditional) grants and specific-purpose (conditional) grants. General purpose transfers come with few or no strings attached. Conditional grants have restrictions on their use and allow the central government to influence spending patterns by lower levels of government, such as giving priority to health versus other sectors, or to certain types of services within the area of health.

Conditional transfers. Conditional transfers provide incentives for state governments to undertake specific programs or activities. These transfers come in a variety of types -- each with its trade-offs in control, efficiency, and effectiveness. There are three main types of conditional transfers: non-matching, matching open-ended and matching close-ended (Table 2).

Non-matching or block grants combine multiple grants into one “block” within a functional area (such as health care) and come with few restrictions or monitoring activities (Bowser, Bossert, & Mitchell, 2006). Central governments often impose conditionalities on these block grants, specifying certain inputs (capital or operating expenditures) or output targets (e.g., achieving a certain level of service delivery). Input-based conditionality is sometimes considered intrusive. Output-based conditionality can advance grantors’ objectives while preserving local autonomy (Shah, 2006). A maternal voucher scheme is a classic example of output-based financing. Providers are paid based on the babies they deliver, not on the hours they work or their seniority.

Matching provisions are often incorporated into conditional transfers, requiring grantees to finance a specified portion of expenditures using their own resources. Proponents contend that matching grants reinforce joint responsibility between center and state. They incentivize states to participate in programs without the heavy-handedness of a federal mandate. Matching grants have been shown to increase spending on appropriate cost-effective activities (Bowser, Bossert, & Mitchell, 2006).

Care must be taken to set matching rates at a level that allows poorer states to participate in the program. For example, the U.S. government-financed health insurance program for the low income families, Medicaid, uses a formula to calculate federal and state shares, ranging from a 50%:50% federal state contribution for better off states to a 75%:25% ratio for poorer states (Kaiser Commission on Medicaid and the Uninsured, 2011). The National Rural Health Mission is similar, with the state contribution varying from 13% to 36% (Shiva Kumar, et al., 2011).

Another challenge for fiscal transfers is substitution: rather than augmenting state funds with central resources, the latter could replace the former. In order to discourage such behavior,

Medicaid has “maintenance of effort” stipulations to ensure that states provide at least the same level of financial support to the program as they did in the previous year.

Matching requirements can be either open-ended, with the central government matching whatever level of resources the state provides, or closed-ended, with the central government matching state contributions up to a ceiling. The US Congress designed Medicaid to be open-ended in order to quickly fill the void of a health care safety net (Weil, 2003). Closed-ended matching helps prevent cost overruns for the central government, by setting a pre-determined maximum expenditure. While limiting financial exposure to the grantor, this grant design can constrain the growth and reach of health programs.

Table 2: Types of Conditional Transfers

	<i>Matching Open-ended</i>	<i>Matching Close-ended</i>	<i>Non-matching</i>
<i>Benefits</i>	Incentivize grantees to ramp up funding for programs which might not be state priorities	Central government financial obligations are known from the outset	If output-based, ideal for results accountability while maintaining local autonomy
<i>Drawbacks</i>	Unexpected central government obligations	Signals limited commitment to the program; slows ramp up	Output-based monitoring requires more oversight, consequences for poor performance by states
<i>Examples</i>	US Medicaid	National Rural Health Mission	Canada Health Transfer

International experience with transfers to reduce disparities across states

Central governments in some large federal countries such as Canada and Germany employ general purpose transfers to reduce fiscal disparities between states. These equalization grants are not confined to the health sector. Creating the systems, formulas, and institutions for these transfers is complex, highly political, and takes time to refine. Countries that have been successful with some degree of fiscal equalization have had to compute—or provide a proxy for—the costs and benefits of providing public services. Shah (2006) concedes that estimating fiscal capacity -- the ability of governmental units to raise revenues from their own sources -- is conceptually and empirically difficult. Even more complex to measure are expenditure needs such as health burden and cost of care per region. Countries have a hard time agreeing to an explicit standard of equalization -- the transfer amount to which each state is entitled in order to provide public sector benefits per household that are comparable to other states.

Germany and Canada have macro, whole-of-government level fiscal equalization mechanisms. The Germans have defined a fiscal capacity yardstick that is applied on a per capita basis across each Lander (state). Poor states obtain 95% of this yardstick from rich states in an elaborate

“fraternal” equalization policy. The federal government is the conduit and funds migrate from rich Lander to poor ones. There is also a second level of equalization that involves transfer of VAT revenues from the federal government to the poorer Lander. These solidarity measures are mandated by the German constitution.

Canada, too, has constitutional language that promotes solidarity: “provincial governments [must] have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.”¹ Canada compares the revenue capacity per capita at the national level to that of each province. In fiscal year 2008-2009, of Canada’s ten provinces, seven received additional funds from general federal revenues. As opposed to the German system, the Canadian central government in a “paternal” model transfers the funds to the poor provinces (Stark, 2010).

In both of these examples, the richer states directly (Germany) or indirectly (Canada) compensate poorer states. Despite the wide differences in state income across the US, there is no broad equalization protocol. Instead, reduction of disparities is targeted through specific programs in health, education, and other merit goods.

India’s 12th Finance Commission 2005-2010 recommended a general-purpose equalization scheme to redistribute national wealth to seven low-income, poor-health, and fiscally-constrained states—Assam, Bihar, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh, and Uttarakhand—to help them come closer to the INR268 average for state spending on health (Shiva Kumar, et al., 2011). These transfers, because they are disconnected from any state commitment to health spending objectives, may reduce some fiscal disparities but have not had a measurable impact on health outcomes (Tandon & Cashin, 2010). As unconditional grants, the new central funds are not ring-fenced and can be spent on non-health priorities.

Experience with fiscal transfers to set national standards

For the sake of simplicity and objectivity, some countries have opted to target health equity goals through output-based national minimum standards grants. Fund renewals are tied to performance.

Non-matching output-based block transfers with conditions on standards of service and access are used in Canada. The Canada Health Transfer (CHT) is a system of federal block grants to fund health care services at the provincial level. It consists of cash and tax transfer provisions. In FY09, cash transfers totaled nearly \$23 billion and tax transfers -- in which the federal government lowered its tax rate so that the provinces could hike theirs -- amounted to about \$14 billion. The CHT is allocated on an equal per capita basis, adjusting for differing wealth levels of the provinces, and the rate of growth of the transfers is tied to the GDP growth rate. There are no restrictions for spending, but there are strong conditions on access to health care. Provinces receiving federal funds must abide by five conditions: (1) universal coverage (2) portability of coverage across provinces (3) public insurance by public/private provision (4) option for private

¹ Constitution Act, 1982, 30 & 31 Vict. § 36 (U.K.), as reprinted in R.S.C., No. 5 (Appendix 1985).

providers to opt in/out² of public insurance (5) no extra billing³. If provinces breach these provisions, the federal government can revoke transfers and apply clawbacks (Shah, 2006).

To reduce health disparities, India could scale up its use of output-based non-matching grants. Because no match is required, these grants would serve as welcome cash infusions to fiscally-constrained states. The grant's output requirements would help ensure that funds actually deliver benefits.

At the same time, the central government could favor states demonstrating a commitment to health care, as shown through the share of state revenues allocated to health services. Quantifying state commitment towards health is not easy. Mandating that states and municipalities reserve 12% and 15% of their budgets, respectively, as does Brazil, is one approach. Alternatively, the central government could adjust its block grants in proportion to the share of state revenues allocated to health. India could also incorporate "maintenance of effort" provisions to ensure that state spending rises over time.

Bottom-line: India may want to scale up output-based non-matching grants tied to national minimum standards. These grants reinforce state right to health, give states considerable flexibility, and bind them to concrete goals. The transfers can be adjusted to favor more vulnerable states and since grants do not require matching, they should have broad political appeal.

Experience with transfers to shape local health priorities in line with national goals

Open-ended matching transfers have worked well to prompt state governments to prioritize health programs. In order to promote fiscal equity at the same time, some central governments have set matching rates that vary inversely with fiscal capacity -- the less able the state to invest in the program due to financial constraints, the higher the matching rate by the central government.

In the US, Medicaid is a system jointly financed by the federal government and the states, covering 60 million low-income families. Matching rates depend on a rolling three-year average of US national per capita income vs. state per capita income. The equation does not consider health burden or the cost of care. On average, the center-state split is 57% to 43%. The average state in the US spends 16% of its budget on Medicaid, which after education is the second costliest item on state budgets. Medicaid represents the single largest source of federal grant support to states. At 8% of the entire federal budget, Medicaid is the third-largest domestic spending program after Social Security and Medicare (Kaiser Commission on Medicaid and the Uninsured, 2011).

States that choose to participate (all do) must obey broad national guidelines. However, each state has flexibility in establishing its own eligibility standards, level of provider payment, and scope of services. For instance, New Jersey chooses to cover more individuals at the expense of paying providers relatively low rates, compared to what New York pays⁴. In order to receive the

² Patients can be reimbursed at government fee schedule rates for providers opting out

³ Providers opting in cannot bill patients extra

⁴ Interview Julie Hardman, former Medicaid Director of Washington, DC; March 2011

federal match there are certain basic services, such as family planning, which must be provided in each state.

Another federal country, Mexico, has recently launched a public insurance program that uses redistributive matching grants. Seguro Popular is funded 69%:31% center-state on average, and covers 20 million of the 50 million informal sector and indigent Mexicans. The federal government transfers funds (\$1.76 billion in 2007) in two components: the Cuota Social (CS) includes a fixed amount per family in every state and the Aportación Solidaria Federal (ASF) varies by state and represents the redistributive part of the formula. In 2007 the CS was roughly \$261 per family and the average ASF was \$391 per family (Secretaría de Salud 2007). The required matching contribution for states was \$130 per affiliated family in 2007. (Enrolled families also have a yearly premium that varies by income but averages \$113). States have the option to participate in the Seguro Popular, but if they do, they must offer an explicit benefit package of health interventions that comprise 90% of the national service demand (Frenk, Gomez-Dantes, & Knaul, 2009).

Prior to the introduction of the Seguro Popular, state ministries of health received funding through “no strings attached” block grants called FASSA. Funds for the Seguro Popular augment the FASSA and make the central transfers more progressively distributed across the states. Still, because FASSA funds are 70% of the total state MoH budgets, it will take time for the federal transfers to be significantly redistributive. By steadily phasing out FASSA and phasing in PHI, the federal government has infused substantial new resources into the health sector and gradually improved the progressivity of those resources without eliciting a political backlash from the states (Lakin, 2010).

India’s leading health sector matching transfer programs, Rashtriya Swasthya Bima Yojana (RSBY) and the National Rural Health Mission, are funded by an average 85%:15% center-state match⁵ (Shiva Kumar, et al., 2011). These programs are relatively new and their impact on health is encouraging but still inconclusive. While both have implemented progressive cost sharing between center and states, these initiatives have not required the states to increase their overall share of public spending on health. All states except Uttar Pradesh, Bihar, and Gujarat spent less proportionately on health in FY08 than they did in FY02. Maintenance of effort provisions could possibly solve this problem.

A continuation of matching fiscal transfers could also aid RSBY to expand state-based risk pools in breadth (to an above-the-poverty-line group) and/or in depth of coverage (e.g., by adding outpatient care and pharmacy).

Bottom-line: The US Medicaid program and Mexican Seguro Popular illustrate the influence of the federal government on states but also the importance of gradual shifts in health financing regimes. Changing priorities, especially in states with highly constrained budgets, requires time. The central government can help states by giving them a long range view of matching rates so that

⁵ For a few states, RSBY uses a 90:10 center-state split

states can plan ahead, strengthen their revenue collection efforts, and make the necessary investments health systems and management capacity.

Table 3: Principles in Designing Fiscal Transfers

<i>Grant Objective</i>	<i>Grant Design</i>	<i>Practices to Emulate</i>	<i>Practices to Avoid</i>
<i>Reduce regional fiscal disparities</i>	General non-matching equalization transfers	Fiscal equalization with explicit standard that determines total pool and allocation (Canada, and Germany)	Grants that fund state deficits tend to condone fiscal irresponsibility
<i>Set national minimum standards</i>	Conditional non-matching, output-based block transfers with conditions on standards of service and access	Health transfers (Canada)	Transfers with conditions on inputs alone
<i>Influence local priorities in areas of high national (but lower local priority)</i>	Open-ended matching transfers (preferably with matching rate varying inversely with fiscal capacity)	US Medicaid	Ad hoc grants that do not build local capacity and broad public support

Source: Shah, 2006

Conclusion

Center-state transfers can be expected to play an increasingly important role as India commits more public money to health care and aims to achieve Universal Health Coverage. The central government has expressed its desire to use transfers to achieve four main objectives: (1) increase overall government health spending as a percentage of GDP, (2) gradually equalize spending across states; (3) encourage states to prioritize certain types of health care (e.g., primary care) and specific health interventions with high cost-effectiveness (e.g. child immunizations); and (4) drive better performance in key health indicators and in health system efficiency. At the same time, the central government will need to consider ways in which central transfers to the states, either through state health budgets or state-based insurance funds operating as separate purchasers, can strengthen the health financing reforms that India adopts to expand financial protection.

To do this, the central government has an array of transfer mechanisms at its disposal. Experience from other countries suggests that a combination of (a) non-matching block grants combined with certain broad health system standards and output/outcome goals, plus (b) matching grants that are targeted to certain priority health services (and that give a higher match to low income states, provided they demonstrate fiscal commitment within their own budget means), may need to be designed and tested over the next few years.

The experience of countries as diverse as Brazil, Canada, Germany, Mexico, and the U.S. show how such fiscal transfer programs continuously evolve over time. Vigorously political dialogue among central and state leaders, plus improvements in financial and health performance monitoring systems, must go hand in hand with building a robust, fair, and efficient fiscal transfer program. For India, these challenges will be compounded by the urgency of expanding public spending for health as a share of GDP from a very low historical base, at a time when the Indian economy is growing rapidly and a relative increase in government health expenditures will require extra efforts to allocate and use resources efficiently.

Unless they are expanded dramatically, fiscal transfer programs will not enable India to increase government health spending by the very large rate of 25-43% per annum, required for the country to reach its target of having public expenditures for health amount to 3% of GDP (Tandon, 2010).

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