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How effective has the Central Government been in nudging the states for financing Primary Health Care? An analysis of fiscal federal relations in India

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How effective has the Central Government been in nudging the states for financing Primary Health Care? An analysis of fiscal federal relations in India.

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Lancet Global Health Commission on Financing for people-centred PHC

The Lancet Global Health Commission on Financing for people-centred PHC (2020 – 2022) is committed to drawing on robust, evidence-based knowledge to generate useful findings and actionable recommendations to inform decisions made by governments and partners that shape the effective financing of primary health care. Our work is focused on enhancing, protecting and enabling the appropriate resourcing of primary health care as a critical engine for the achievement of universal health coverage.

Country case studies

The Commission organised 10 case studies. Each country lead consultant and team undertook a scoping review to identify 'hot topics' in the financing of PHC in the respective countries. The teams then chose a 'deep dive' topic on which to undertake primary research. The 10 case studies were undertaken in: Brazil, Chile, China, Estonia, Ethiopia, Finland, Ghana, India, New Zealand and the Philippines.

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Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited social health activist
CSS	Centrally Sponsored Schemes
FC	Financing Commission
FMR	Financial Monitoring Reports
GDP	Gross Domestic Product
HPD	High Priority Districts
HR	Human Resources
LMIC	Low- and Middle-Income Countries
NHM	National Health Mission
NPCC	National Program Coordination Committee
NRHM	National Rural Health Mission
OOPE	Out of Pocket Expenditure
PBF	Performance Based Financing
PBP	Performance Based Payments
PHC	Primary Health Care
PIP	Programme Implementation Plans
QALY	Quality Adjusted Life Year
ROP	Record of Proceedings

Executive Summary

Constitutionally, health is a State subject in India, which implies that the major responsibility for financing healthcare lies with the States. However, the Central Government also contributes to the financing of healthcare through Centrally Sponsored Schemes (CSS). In 2005, the Central Government created an "architectural" reform to strengthen Primary Health Care (PHC) by launching the National Rural Health Mission (NRHM) – later in 2013 renamed as National Health Mission (NHM) after incorporation of an urban component. With the NHM, the Central Government introduced several fiscal instruments to encourage State governments to increase their spending on PHC. We undertook this study to examine the extent to which the Central Government was able to use these fiscal instruments, as part of NHM, to 'nudge' the extent and pattern of PHC spending by the States.

We used a mixed-methods approach. Our quantitative work aimed to determine the temporal trends in financing for PHC and map it against the intervening policy changes in the federal arrangements for funding. It also aimed to assess the extent to which the level and pattern of funding proposed by the States was approved by the Central Government and identify the extent to which the Central Government was responsible for shaping these decisions for funding PHC at the State level. We obtained the Program Implementation Plans (PIP) and Record of Proceedings of 4 Indian States – Haryana, Bihar, Tamil Nadu and Kerala, for the years 2013-14 to 2019-20. We also reviewed the Financial Monitoring Reports of these States. We selected these states to represent different Central Government shares of contribution to PHC, a proxy for central influence on provision. In addition, we tracked the overall level of NHM funding at all-India level, disaggregated by Central and State shares from 2008 to 2019. We also evaluated the extent to which budgets proposed by States were approved. Next, we held in-depth interviews with 16 purposively selected stakeholders from Central and State Government to elicit from them the dynamics of the fiscal federal relationship, the process of budgeting, the extent to which the Centre's fiscal instruments worked, and the broader influence of these policy instruments to nudge the States.

We found that the Centre used a set of primary instruments to nudge the patterns of PHC spending by the States. One of these instruments was in the form of states' matching grants for NHM funds (which increased from 15% to 40% over the years), along with a set of other conditionalities to be fulfilled by the states to receive central government contributions. In 2013-14 the Centre also introduced a performance-based incentive, based on a set of criteria for releasing the final 10% of the approved budget which recently (in 2018-19) increased to 20% of the budget. The new instruments, which involve applying a new set of 7 performance criteria aimed primarily to enhance efficiency in spending and accountability, are yet to come into force – largely due to the disruption brought about by the COVID-19 pandemic since 2020. The steep increase in matching share of states from 25% (introduced in 2011-12) to 40% from 2016-17 was due to larger (macro level) budgetary allocation policy decision arising from the 14th Finance Commission's decision which reduced the budget for all CSS, including NHM. The extent to which these conditionalities led to effective and efficient management of the NHM's overall budget is a part of this study. The instruments to nudge the patterns of primary care spending at State level

included the conditionalities imposed by the Centre, and the consultative planning process for preparation of PIP which provided the Centre to exercise its power.

Overall, the allocations for PHC have increased over the last 10 years, much of which is attributed to increase in States' contributions. Per-capita State spending on primary care increased by the same rate in the 4 states selected for this study, irrespective of the level of Central share in overall State health spending. It suggests that the rise of State health spending is not correlated with the level of influence which the Centre was able to exert through the fiscal instruments. We found that State spending is more dependent on its overall ability to raise resources, and thereby being able to contribute the conditional matching grant required under NHM. More research, in terms of trends in spending for different social sectors at state level, would shed more conclusive light on whether the increased share of tax revenue devolved to the States through the Finance Commission eventually resulted in greater spending by States on PHC.

Besides the impact on States' spending on primary care, our study found that the NHM created a context in which the Central Government became a primary agenda-setter and shaped health sector priorities for primary care. It was able to influence what went in and out of the NHM's benefit package at State level. This was possible because the Centre brought in additional funding for the health sector in States, thereby determining how it would be utilized. Consequently, it was able to set priorities and a shift in thinking in planning to prioritize measurement of outputs rather than inputs, lay emphasis on equity in allocation of resources, and create institutional structures which provided greater visibility and importance to the health sector in general and specifically to PHC. Since the NHM is concerned more about strengthening PHC, one can safely assume that this higher importance was for PHC.

While several States did opine on the restrictive role of conditionalities, the data suggest that over the years States have learnt to manage the conditionalities and get the budgets approved by the Centre. The so-called performance-based funding (PBF) instruments (yet to be implemented) are more of accountability measures to 'nudge' the States to achieve certain performance as a condition of receiving the Central funding, rather than a source of additional funding in the way PBF has been implemented in other low- and middle-income countries (LMIC). The intent of Central Government is to use PBF as an instrument to enhance the visibility of the State health departments within the State leadership, as failure to achieve the performance indicators indirectly indicates an inability of the State to secure the Central funding available to it. PBF, when it is implemented in the future as envisaged, may also bring out its inherent weaknesses, conceptually and operationally.

To conclude, the Central Government in India used fiscal measures to nudge the States by creating an environment of collective planning, as well as transfers of revenue and sharing of budget. The States' contribution to PHC could be further enhanced by making it mandatory for States to spend on achieving universal coverage of services which are found to be cost-effective, as defined by a threshold of cost per quality adjusted life year. Further, the receipt of Central Government grants could also be made contingent on achieving this conditionality. Together, these measures would help to further the advocacy of the right to health and Universal Health Coverage.

1. Introduction

Public financing of health care has historically been low in India, remaining stagnant at about 1% of its gross domestic product (GDP) for decades. As a result, out-of-pocket expenditure has been the mainstay for financing health care. The recent National Health Accounts puts the share of private sources at about 68% of the total health expenditure, and about 85% of this private expenditure is paid out-of-pocket by households at the point of care. (NHSRC and NHM 2019) Constitutionally, healthcare is a State subject, implying that States are responsible for allocating resources and managing the health services. The Central Government adds to this public expenditure on health through creation of programmes or schemes which are completely or partly Centrally sponsored.

In order to give a major boost to public health spending by providing additional funding for PHC, and to bring about "architectural changes" in the health system to deliver primary care, the Government of India introduced the National Rural Health Mission (NRHM) in 2005. During the last 15 years, NRHM, which was later in 2013 renamed as National Health Mission (NHM) with the addition of an urban component, has remained a flagship program of the Government for both financing and provision of PHC. Besides enhancing the coverage of services, the programmes brought about several reforms to improve both efficiency and equity in delivery of health care services.

The NHM also provided a unique broader contextual environment in which the Central Government became an active player in shaping the health agenda at the State level. In the political scenario of a federal state, the NHM led to reforms in both the funding flows as well as sharing of funds with States, providing greater policy levers to the Central Government to influence State government's health sector priorities and funding decisions. The NHM is a tax-funded supply side financing scheme, in which both Central and the State governments contributed, in a share which was initially 90:10 respectively, but later after several iterations currently stands at 60:40. To be eligible to receive the Central funding, the States had to comply with a set of rules which were called 'conditionalities'. These conditionalities became a principal source of what is referred to by Lukes (1974) as the '1st dimension of power'[1]. Using the conditionalities, the Central Government attempted to exercise its power to make States spend more on PHC. In addition, the Central Government also exercised the '2nd dimension of power' by trying to set the agenda and shape the priorities of the health sector.

In addition to the conditionalities, the Central Government also introduced a mechanism of performance assessment and accountability and made the release of a certain share of the approved resources contingent upon achieving a threshold level of performance. In other words, this is a mechanism of 'contract compliance' where Centre attempted to

1. According to the framework provided by Lukes, 3 dimensions of power in policy making are defined. The first dimension describes the power exercised by 'A' to make 'B' do something which 'B' would not have done otherwise. In other words, the 1st dimension of power deals with explaining why certain policies are made. In the context of our study, this refers to the power exercised by the Centre to make States undertake certain programmes/ interventions, which they would either not have done, or would not have done in immediate foreseeable future or in the current plan period. The 2nd dimension of power refers to the power exercised in 'agenda setting', wherein certain issues are not allowed to be brought on the policy agenda. This describes the power of not letting policies being made. In the content of our case study, this refers to instances where programmes proposed (in Program Implementation Plan) by the State are declined for funding by the Centre. (S. Lukes, 1974); Buse K, Mays N, Walt G (2005)

ensure compliance to certain performance. These performance-based incentives which were initially set at 10% of the total NHM funding, were increased to 20% in 2018-19.

As part of the Lancet Global Health Commission on Financing PHC, a scoping review was undertaken to identify the potential hot topics from the Indian context to be investigated in greater detail. Among the different topics that were identified, a deeper exploration of the environment of health care financing for PHC considered most relevant. In particular, the primary objective of this report is to assess the extent to which the Central Government has been able to 'nudge' the States to influence the extent and patterns of health care spending through the uses of these policy levers. In addition, we also aim to identify how the different policy levers could be made more effective to develop a stronger system of fiscal federalism for PHC financing in India.

Overall, we found that the Central Government used several fiscal tools to influence the magnitude of State Governments' spending on PHC. These included matching grants, changes in Central and State share, conditionalities favouring the allocations for primary care, as well as governance frameworks which provided greater importance for health sector and PHC in particular. Over the last six years, PHC spending has increased, largely because of increased State contributions. Secondly, we found that the Central Government influenced the pattern of PHC spending. This was achieved by influencing the process of planning wherein the Central Government exercised its power to influence which services go in and out of the States' package financed under NHM. Thirdly, although States comply with the conditionalities imposed by the Central Government to receive funding, they do not find that the conditionalities enhanced effective utilization of the funds, and thereby the effective implementation of the NHM. The study also highlights the role of the 14th Finance Commission in reducing the overall fiscal space available to the Centre for Centrally Sponsored Schemes (CSSS), including NHM, since 2015-16.

In summary, besides influencing the extent and pattern of PHC spending, the Central Government also exercised its power to make the States undertake programmes and services which it prioritized. Secondly, it became an important agenda-setter in the space of health. Thirdly, it influenced several other fundamental philosophical changes in primary care – for example the emphasis on equity and efficiency, and a shift in planning from creating infrastructure to measuring processes and outputs.

In Section 2, we describe the system of financing for PHC in India, in terms of sources of funds, financing flows, and the provider payment mechanisms. We describe the same for care which is provided in both the public and private sector. This section also describes in detail the "architectural reforms" in financing and funding flows created under NHM. In Section 3, we describe the methodology adopted for data collection and analysis for this study. The methods for collection of both the qualitative data, through stakeholder interviews, and quantitative secondary data analyses are described here. We present our principal findings as well as its discussion in Section 4. In Section 5, we conclude by providing a summary of our findings and their implications for health financing policies for PHC in India in the future.

2. Financing for Primary Health Care

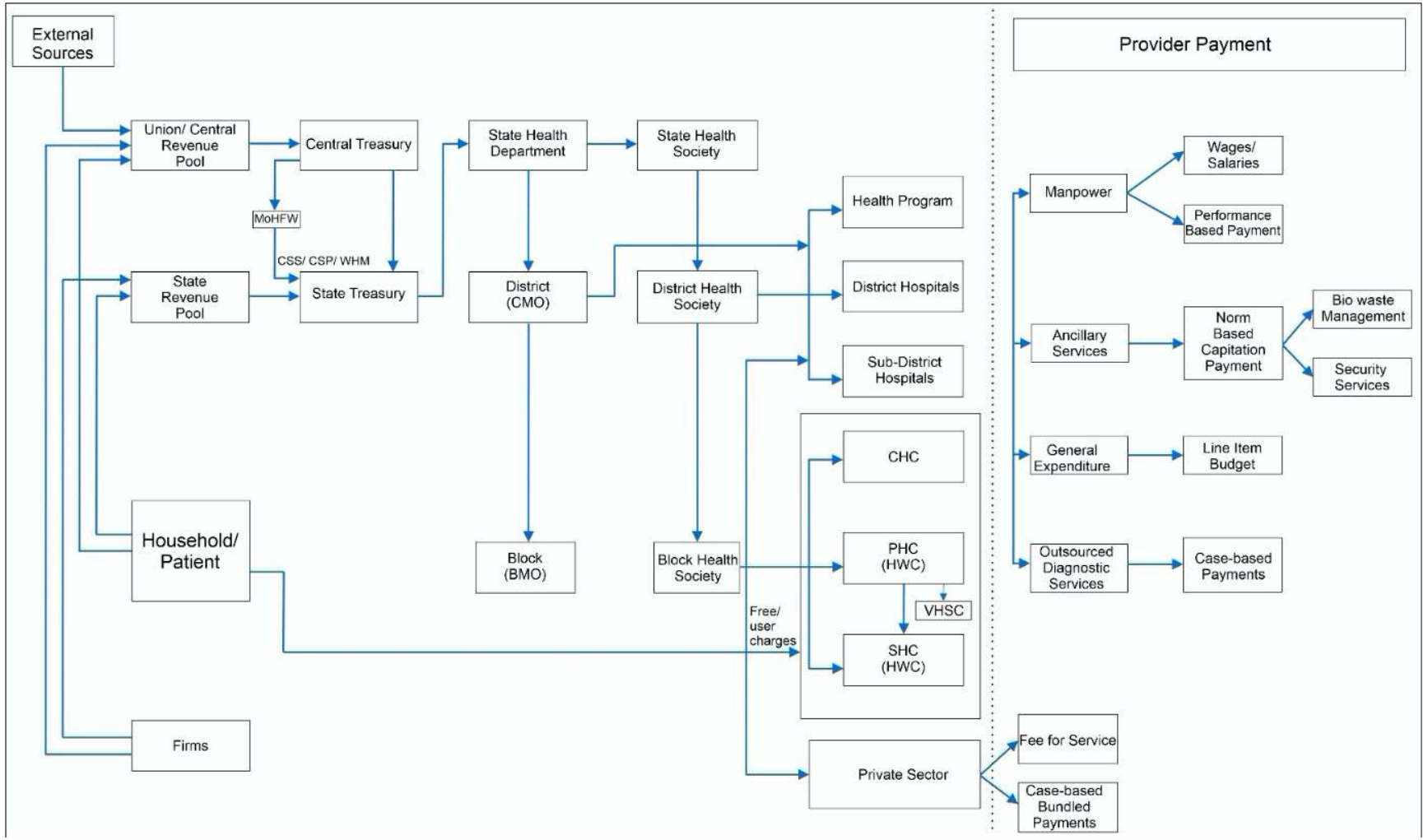
A large majority (of about 70%) of the Indian population utilizes the private sector for outpatient care. It is notable to highlight here that the share of public sector in utilisation of outpatient care has grown in recent years from 19.5% in 1995-96 to 25% in 2014, to about 30% in 2017-18. These are the years during which nationally representative household surveys were conducted. Out of pocket expenditure (OOPE) as % of Total Health Expenditure is 58.7, while it is 63.3% of Current Health Expenditure and about 2.2% of GDP (NHSRC, 2019).

The public health sector is financed using a supply-side approach, wherein tax money is used to create health care infrastructure, pay salaries to the health workers, and procure drugs and consumables for delivering services. More recently, some of the diagnostic and ancillary services (such as security, waste management, housekeeping etc) are outsourced to the private sector and are paid using either a case-based bundled payment system (for diagnostic services) or a normative formula similar to a capitation payment system, linked to the unit of health infrastructure serviced. For example, the payment for health facility waste management is based on the number of beds in the facility, or number of health facilities serviced. Some of the personnel, for example the accredited social health activists (ASHAs) are largely paid based on performance-based payments (PBP).

A significant share of primary outpatient care is delivered by the private sector, paid through out-of-pocket payments (sourced from either income, savings, or by borrowing or selling of assets) made directly by households at the point of use. The provider payments for PHC in the private sector is usually fee-for-service, or in some cases it is determined based on a fixed bundled payment for a package of services. A typical example of the latter is the provision of screening diagnostic services in private facilities.

Until 2005, the flow of primary care funds in public sector was through the consolidated funds of the State in the treasury account. Any funding received from the Central Government or the Department of Finance in the State was received in this account. It was subsequently used for various purposes. With the creation of NRHM in 2005, to simplify the processes for utilization by drawing and disbursing officers, an alternative route was created. A mix of devolution and delegation exemplifies the level of financial decentralization which accompanied the NHM. Semi-autonomous organizations (under Societies Act) were initially created at national, state, district levels to manage the funds. However, from the early 2010s, the flow of funds reverted to the earlier arrangement, namely through treasury route to enable better tracking and monitoring of resources.

Figure 1: Overview of financing sources, flows and provider payments for Primary Health Care in India



Source: Reconstructed from, Berman P, Manjari B and Rajesh Jha, Tracking financial resources for PHC in BIHAR, India (Harvard T H Chan School of Public Health, Boston 2017)

Note: CHC: community health centre; PHC: primary health centre; HWC: health and wellness centre; CMO: chief medical officer; BMO: block medical officer

3. Methodology

The objective of the present study is to determine the extent to which the Indian Central Government was able to use different fiscal measures and tools to influence the overall levels and patterns of PHC financing through the State Governments.

Selection of States

As the first step, we selected 4 states – Kerala, Bihar, Haryana and Tamil Nadu for our analysis. The choice of these 4 states is based on the extent of Central contribution within the NHM funds at the State level. We hypothesise that a higher share of Central Government contribution in overall State health financing would be associated with an enhanced ability of Central Government to influence the States' decision on how much and where to spend for primary care. Since the data on share of Central Government in overall State financing for primary care is not known, we used the extent of NHM funding in the total State health care spending as a proxy. While Kerala (with 8%) has the lowest share of NHM in their overall health budget in 2018, Bihar (37%) has the highest. Haryana and Tamil Nadu both had about 20% of the total spending on health contributed by NHM funds (see Table 1).

Table 1: Share of National Health Mission (Centre and State) and State Health Spending in total State spending on health, 2015

State	NHM (Centre plus State) %	State Health Spending %
Bihar	37.2	62.8
Haryana	20.2	79.8
Kerala	8.1	91.9
Tamil Nadu	20.7	79.3

Source: Authors' calculations based on NHM's reports of respective states

Data Sources and Collection

To assess changes in allocations for PHC over time and determine its relationship with different policy levers, we reviewed the Program Implementation Plans (PIPs), Record of Proceedings (ROP) as well as the Financial Monitoring Reports (FMR) for each of the 4 states, which were obtained from the websites of respective State NHM. We also obtained the data on the States' contribution to health from the report of the Reserve Bank of India. The data were obtained for the period 2013-14 to 2019-20. These data were cleaned and prepared for analysis.

Secondly, in order to explore the factors influencing the financing decisions at State level and to assess the effectiveness of the Central Government's conditionalities and performance measurement criteria for monetary incentives, we organized virtual in-depth interviews of 9 stakeholders from the Central Government, and 7 officials from the State

Governments. Verbal informed consent was obtained for the purpose of interview. The participants were given detailed information on the purpose of the study, risks and benefits involved, and the potential use and dissemination of the study findings. Both the researchers interviewed the key informants and made hand-written notes. The stakeholders were interviewed to obtain their views on the role which the Central Government has played, through the instruments created within NHM, to influence the decisions of the State Government. In particular, we asked the State officials to assess how they perceived the conditionalities and PBF, the extent of 'decision space' that was offered to them, as well as what could be done to further improve the existing cooperative fiscal federalism.

Thirdly, we did a review of published and grey literature to contextualise our findings. This grey literature included several unpublished reports, working papers, and meeting notes which we were able to obtain following discussions with the stakeholders.

Data Analysis

The data of the ROPs and budget documents were analysed to assess the following:

a) Total and per capita budget approved as part of the NHM budget to generate trends over time.
b) Trends in the budget, disaggregated by Central and States share, were also determined to analyse whether States share increased during the last 6 years.
c) Trends in the approved budget was also analyzed for each of the major budget heads to assess if there were any major gainers or losers in the overall state budget because of the influence of Central Government.
d) The percentage of proposed PIP budget, disaggregated by major heads, which was approved by the Central Government was computed. A trend of the percent of budget approved was plotted.
e) The proportion of the line items where the proposed budget was reduced was assessed. A trend over years was also examined at the state level.
f) The mean, 25th and 75th percentile of the extent to which the budget was reduced by the Central Government, for individual major heads was also computed in each state.
g) Finally, we undertook a thematic analysis of the ROP document to identify:
    i. Which line items of the budget had the largest reduction
    ii. The reasons cited for reduction in the approved budget

We undertook a thematic analysis of the interview notes prepared by interviewing the Central Government and State Government representatives.

4. Findings & discussion

4.1 Policy Instruments of Central Government to influence the extent and pattern of Primary Health Care financing of Indian States

As a senior official of the Central Government put it: "constitutionally, the centre has little space (not much space) as health is [largely viewed] as states' subject", but there are other channels, namely the Finance Commissions and Centrally Sponsored Schemes (which includes NHM), through which the Centre has had positive though limited success in nudging states to enlarge their budget for health sector".

Many important policy changes have been introduced over the past 15 years or so (especially since about 2011) at the Central level that have the potential to influence the extent of states' funding for PHC.

These policy instruments operate primarily at three levels: (a) The share of states as matching budget to the Centre's contribution to NHM; (b) Role of Finance Commissions (FCs) especially since 14th FC (2016-2020) in sharing the divisible pool of revenues raised through taxation between the centre and the states – this has impacted significantly in the overall budget available for all CSS and by implications NHM as well, and (c) the creation of performance-based incentives from Centre to State, wherein a proportion of the total approved budget (initially 10%, later increased to 20%) is released contingent on meeting of pre-laid performance standards.

The design of the NHM prescribed the ratio of contributions from the states and the centre. States' matching share in the NHM overall resource envelope changed over time. Until 2011-12, Centre's vs States' share was in the ratio of 85:15; from 2012-13, the state contribution was raised to 25% and since 2016-17 it has been further increased to 40%. The "Framework for implementation (2005 – 2012)" of NRHM anticipated this scenario (as the following quote from NHM implementation strategy framework illustrates) for increasing role of the states (MoHFW, 2005, p.10):

> "*In order to step up the expenditure on public health over the next 5 years, the states also have to very significantly increase the allocation for the health sector in their budgets, since they contribute almost 4/5th of the current total expenditure. The Executive Finance Committee has agreed that under the NRHM, 100% grants be provided to the states during the 10th Plan [2002-07], which could be phased downwards to 85% in the 11th Plan [2007-12], and 75% in the 12th Plan [2012-17]*"

Remarkably, the Centre-States share of the NHM budget proceeded almost as envisaged in the 2005 framework: states' share was increased to 15%by 2008, then to 25% in 2012-13. The increase in states' share to 40% in 2016-17 can be traced to significant changes in fiscal federalism brought about the 14th Finance Commission. The Finance Commission is a Constitutional body which is constituted once every five years by the Government of India to determine (among other things) the sharing of tax revenues collected by the Government, between the Centre and States. States' fiscal space for health could be

influenced through (a) contributions from a centrally sponsored scheme, namely NHM and (b) an increase in the states' share of divisible pool of overall resources from the centre, which is transferred to states based on a set of criteria (translated into a formula).

Three significant changes have taken place since 2015: (a) a significant increase (from 31% to 42%) in the share of tax revenue that is devolved to the states as recommended by the 14th FC; (b) the revised conditionality on states' share of NHM funding to 40% since 2016-17; and (c) significant changes in performance-based incentives made in 2018-19 from the earlier ones first introduced in 2013 - although these modified incentives are yet to be implemented due to reasons discussed below. We argue that both b and c were the result of Central Ministry of Health's response to (a) which was a policy change brought about by the Central Government's Ministry of Finance. We present these developments briefly below.

The rationale for this significant increase in the transfer of resources to states was to provide them more fiscal autonomy in the allocation of resources for developmental needs of states as perceived by them. As the 14th FC put it: "... a compositional shift in transfer from grants to tax devolution is desirable for two reasons: first, it does not impose an additional fiscal burden on the union Government. Second, an increase in tax devolution would enhance the share of unconditional transfers to the States. The tax devolution only meant an increase in share of the revenue which would be disbursed to the State, and not any additional revenue generation sources". (XIVFC, 2014, p.90). The 14th FC's reason for the enhanced share of states in divisible tax pool with the Union/Centre was a step-in response to states' representation: a majority of states in fact demanded that at least 50% of the net tax revenue with the Union should be devolved to states, besides other demands. As the following words of 14th FC graphically summarizes states' representations:

> *"An overwhelming majority of States have suggested reducing the number of CSS as well as outlays on them. Some States have suggested that the Union Government bear the entire cost of new CSS launched in the future. According to them, this would act as an effective check on the introduction of new CSS. The States have pointed out that apart from requiring them to provide matching contributions, conditions are also imposed for them to access Central funds for CSS. This makes it difficult for the States to provide the required level of budgetary support from their own expenditure programmes. The States, the Commission was told, also often get penalised for their inability to make matching contribution and thus cannot access CSS funds. Further, the CSS impinges upon the fiscal autonomy of the States, as they do not have any say in design of these schemes and face many restrictions in their implementation. In this context, many State Governments are of the view that FC-XIV should raise the aggregate share of tax devolution in the divisible pool. A few States have also suggested that there should be only formula-based transfers from the Union to States, and CSS funds should be routed through the State treasury for better monitoring, outcome assessment and accountability...."*

Further, the following observations are noteworthy:

> *"The States have pointed out that introduction of CSS midway during the year and changes in the sharing pattern of existing CSS imposes an unpredictable fiscal burden on the States and distorts their expenditure priorities. It also creates a mismatch between the budget provisions of the CSS, the quantum approved and the actual amount released by the Union Ministries. States suggested that the introduction of CSS and release of funds should be done in one go at the beginning of a Five-Year Plan and should continue over the five-year period to ensure continuity of CSS."* [XIVFC, 2014, p.88-89].

This contrasted with the views of the Ministry of Finance (at the Centre). The Centre's views on their shrinking fiscal space is summarized by the 14th FC thus:

> *"The Ministry of Finance, in its memorandum, has argued in favour of retaining the existing level of tax devolution in accordance with the recommendations made by the FC-XIII. The Ministry has contended that the Union Government is faced with the dual challenges of meeting its new fiscal consolidation roadmap as well as increasing allocation of resources for developmental investment in critical sectors for the purpose of reviving growth. In this context, the Ministry has argued that any change in vertical devolution in our reference period would prove to be detrimental for the Union Government's fiscal health."[*XIVFC, 2014, p.87*].*

Considering the views of the union / centre and states, 14th FC eventually recommended thus:

> *"Considering all factors, in our view, increasing the share of tax devolution to 42 per cent of the divisible pool would serve the twin objectives of increasing the flow of unconditional transfers to the States and yet leave appropriate fiscal space for the Union to carry out specific-purpose transfers to the States." [*XIVFC, 2014, p.90*]*

With the overall increase in the states' share in the divisible tax revenue, states were expected to increase their investment on health and other developmental activities, which fell predominantly in the domain of the State as per Constitutional obligation.

It is important to add here a significant consequence of 14th FC's above recommendation on shrinking the overall budget allocation / outlays for CSS, which in turn has the potential for inhibiting /curtailing additional funds for NHM which is one of the major CSS. This is discussed further below.

Now we turn to the changes in the conditionalities introduced under NHM funding since 2015-16 (in the years following the recommendations of the 14th FC). As mentioned earlier, states' share in the NHM funding increased from 15% to 25% in 2012-13, and to 40% in 2016-17, a year after the 14th FC's recommendations came into effect.

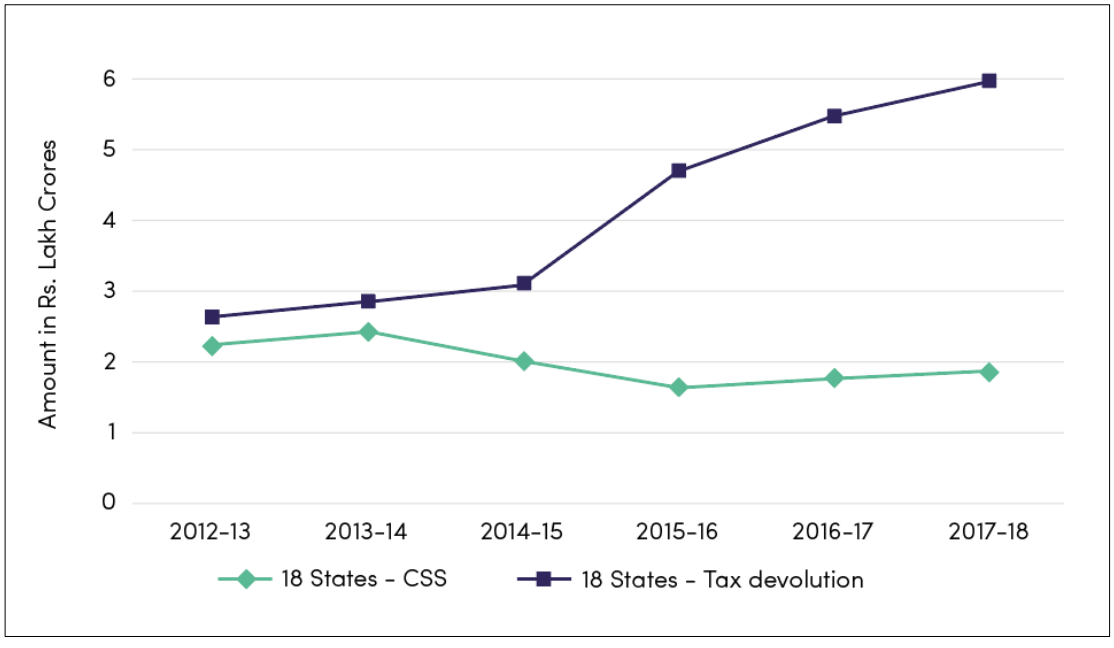
Almost from the beginning of N(R)HM, states were urged to increase their annual health budget by 10%, over and above the 15% share under NRHM ("to avoid any substitution effect in the overall state health budget", as an official put it). A quantum jump in the

states' share from 25% (made in 2012-13) to 40% (in 2016-17), was achieved by Government of India through a sub-group of Chief Ministers on "Rationalisation of Centrally Sponsored Schemes" formed in March, 2015 by the Prime Minister [NITI Aayog, 2015]. The sub-group's deliberations were made in the context of the recommendations of the 14th FC by Government of India with regard to the increase in States share (from 32% to 42% of the net Union Tax Receipts), which as a result, "shrunk the fiscal space available with the Union Government to fund CSS" (page iv, ibid). The sub-group through a series of consultations with various states / regions arrived at the following recommendation (page v of the Report):

> 'From now onwards, the sharing pattern for NHM, which is one of the Core Schemes should be:
> For 8 North Eastern, and 3 Himalayan States: Centre: State: 90:10
> For other States: Centre: State: 60:40
> For Union Territories: Centre: 100%'

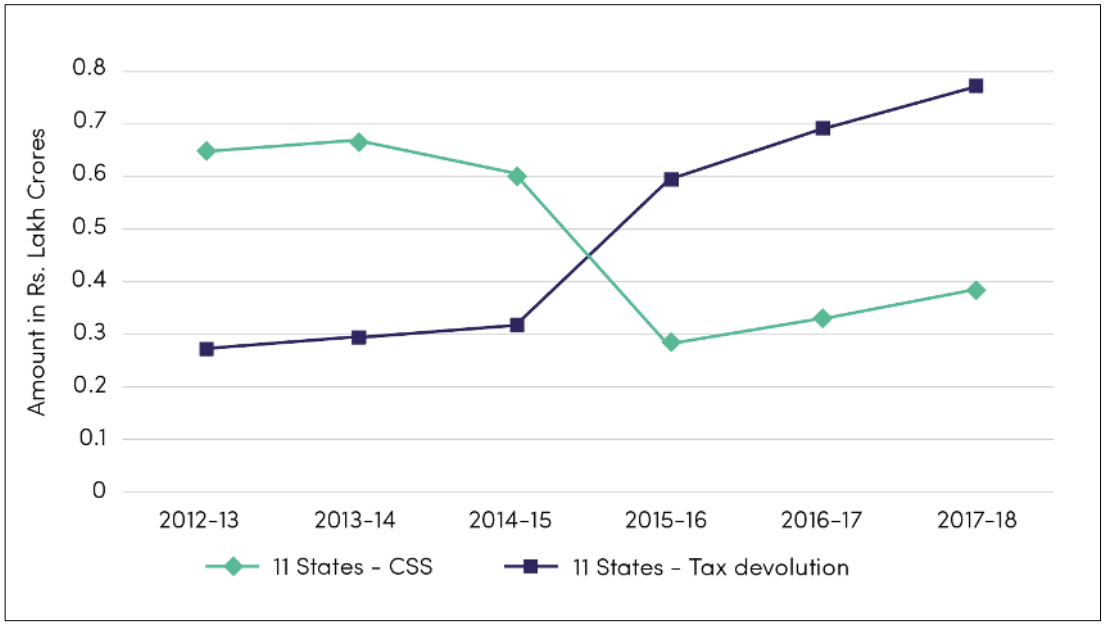
The following Figures 2 and 3 from a recent budgetary analysis of the impact of the 14th FC on CSS (Shindhushree 2018) illustrate the extent to which the budget outlays for CSS fell between 2013-14 and 2017-18, and that this was falling even before the 14th FC's recommendation regarding sharing of tax revenue between the centre and the states. The 60:40 sharing brought in for NHM (along with many other schemes) has certainly reduced the financial burden on the centre which otherwise would have been far higher since 2015-16.

Figure 2: Outlays for CSS – 18 States (on 60:40 sharing Pattern)



Source: Shindhushree 2018, p.40

Figure 3: Outlays for CSS - 11 States (on 90:10 sharing pattern)



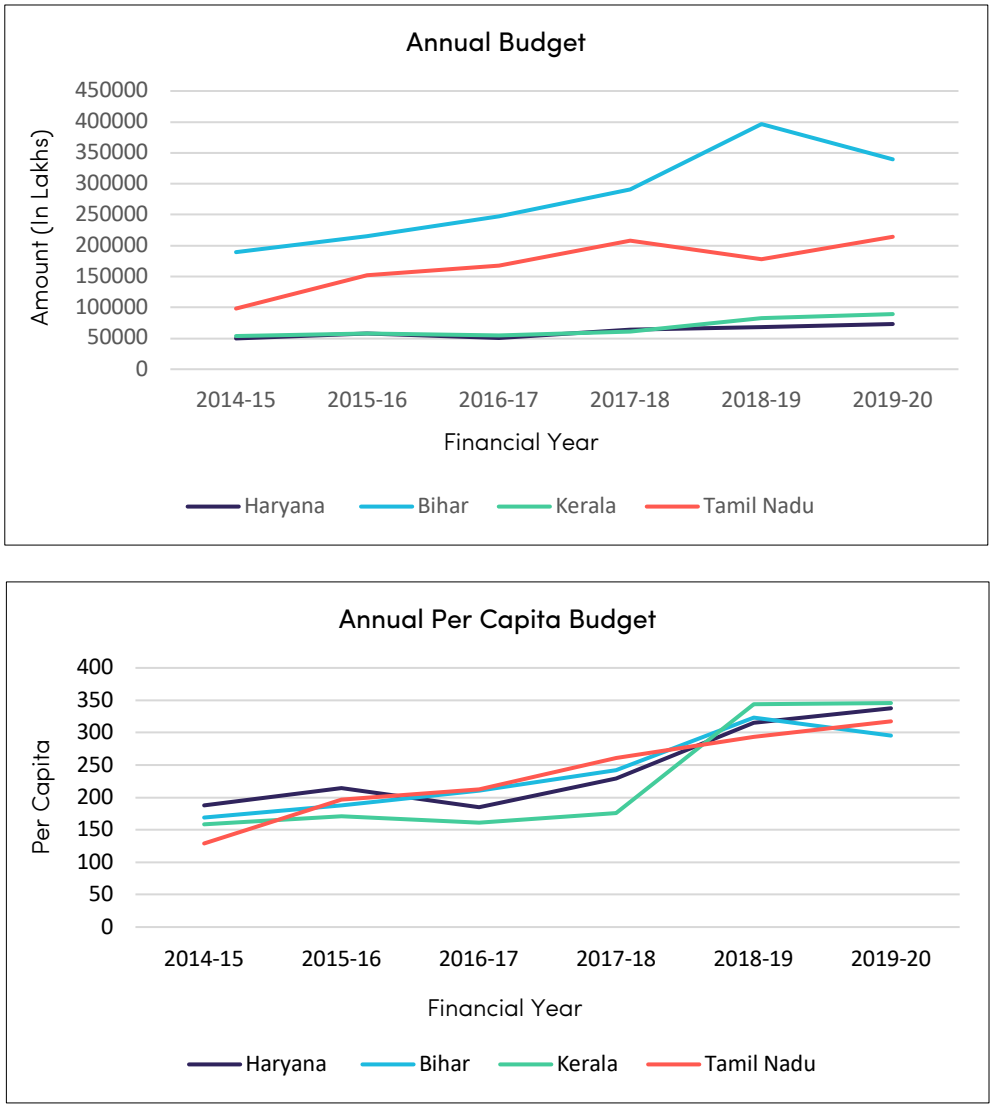
Source: Shindhushree 2018, p.40

The crucial question is how far this fall in the share of CSS outlays impacted the allocation for NHM, particularly since 14th FC's recommendation and introduction of 60:40 share in 2016-17. We return to this question below.

The Central Government also exercised policy levers aimed to determine the patterns of financing. Two principal instruments were used for the same. Firstly, the process of planning involved a decentralized planning by the State, which had to be approved by the Centre. A formal platform for consultation – National Program Coordination Committee (NPCC), was created, which led to the Centre and State mutually agreeing for the State to carry out health care interventions and programmes, for which budget was approved. Through this mechanism, the Centre was able to exercise its power to make the States undertake certain programmes and interventions as per a common mandate. Secondly, the Centre used a set of conditionalities for the State to adhere to, contingent upon which the budget was approved. In this way, the Centre, sets the agenda for PHC provision and influencing the patterns of PHC spending.

4.2 Effectiveness of Central Government Policy Instruments to Influence the 'Extent' and 'Pattern' of Primary Health Care Financing

Figure 4: Trends in approved overall and per-capita budgets (in real-term) in 4 Indian states, 2014 to 2019, for NHM

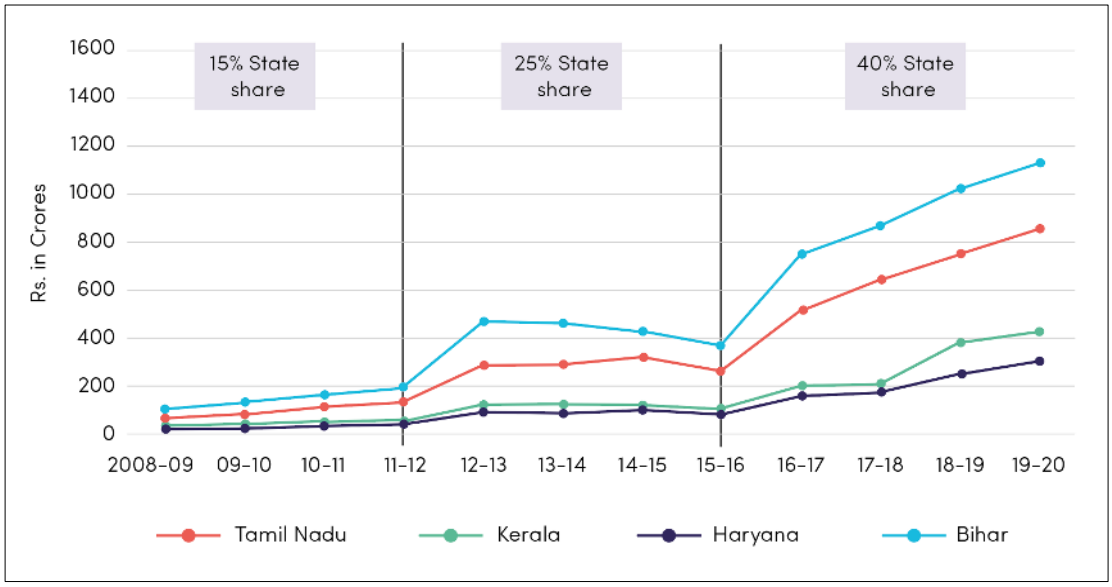


Source: Authors' own calculations based on RoPs of respective states

As seen from Figure 4, an increasing trend was observed in the overall and per capita budget approved under NHM (Central and State share combined, for respective states) during the last 6 years. It is important to emphasize here that these are "total approved amount" and does not reflect whose share – Central or State, contributed to this increase. Figures 5-6 show the level of states' and centre contribution in NHM funding over the years. From year 2016-17, states' contribution in absolute amount in all four states has shown a steep rise (Figure 5), while the Centre's contribution in absolute terms does not show any consistent pattern (Figure 6). In fact, although the Centre's contribution continued to increase during 2019/20 in Bihar, its contributions in absolute terms have fallen during 2019-20 in other three states. Together, these findings imply that the Centre

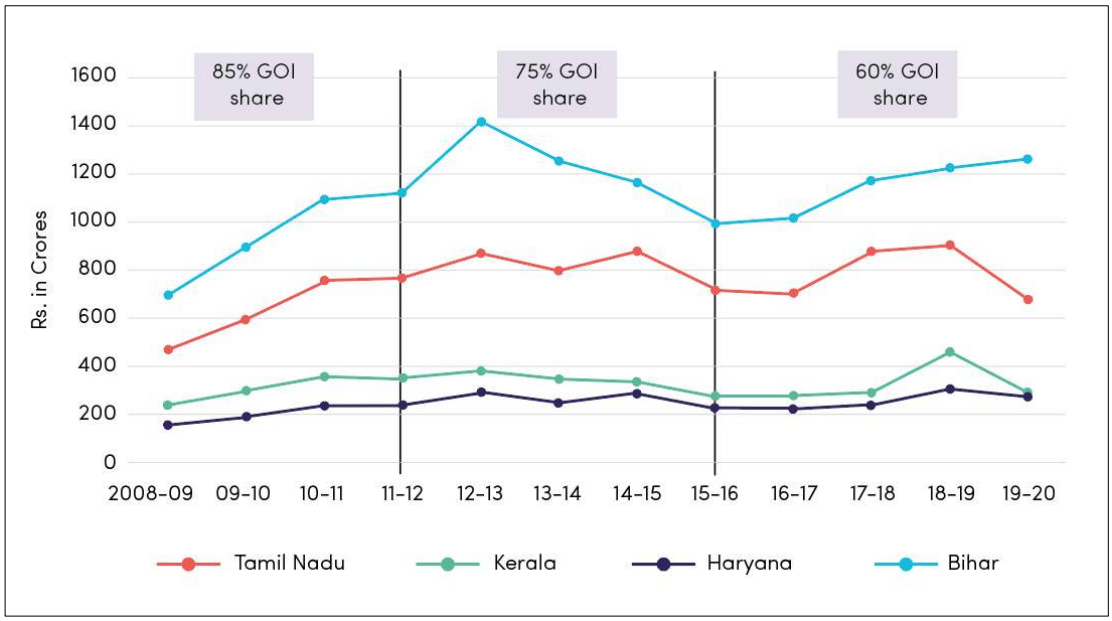
was able to influence an increase the allocation for primary care, driven by the enhanced contributions by the State.

Figure 5: Trends in State Governments contribution to National Health Mission funding, 2008-2019



Source: Report of Proceedings (RoPs) of respective states, for various years

Figure 6: Trends in Central Government contribution to National Health Mission funding, 2008-2019

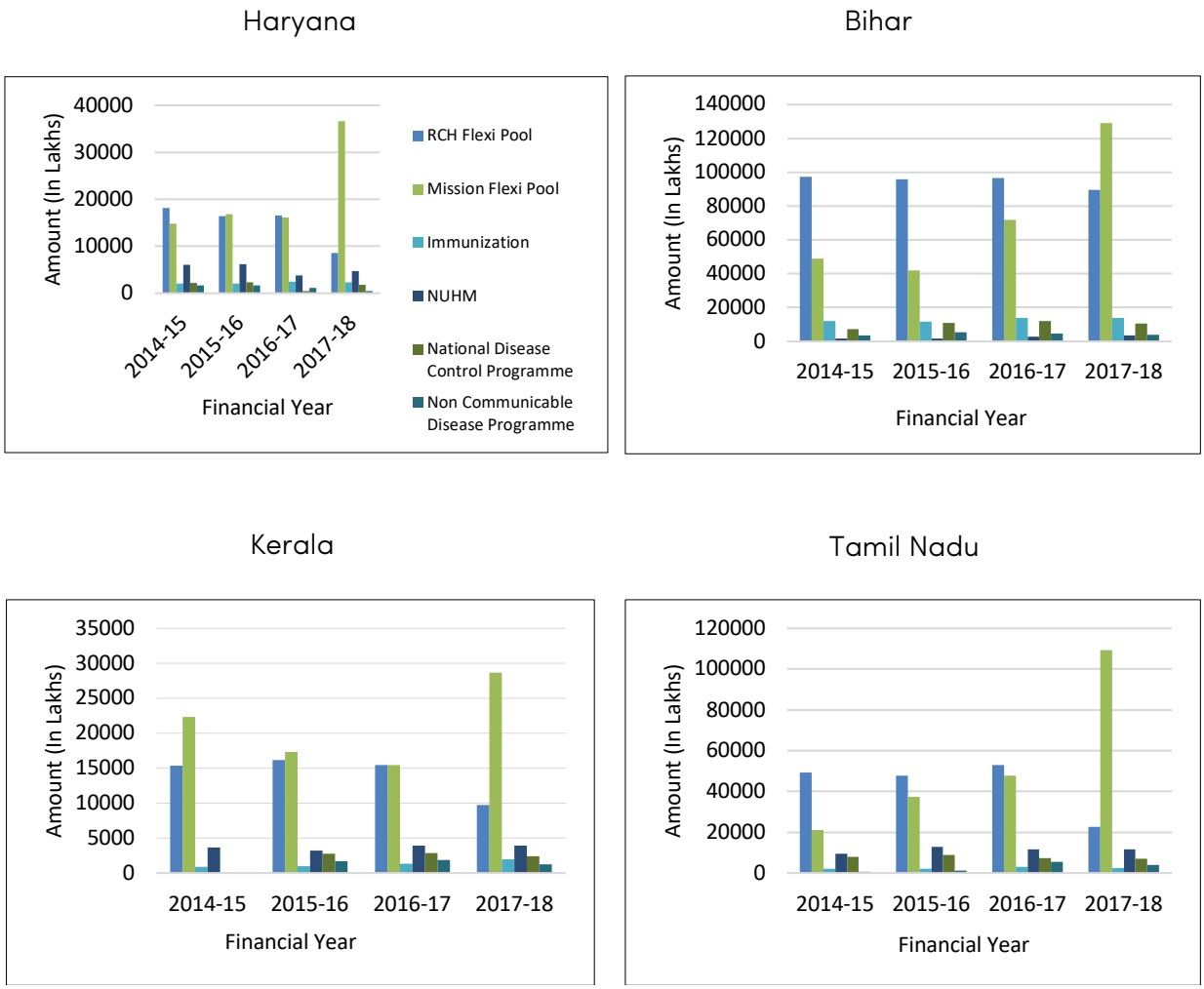


Source: Report of Proceedings (RoPs) of respective states, for various years

Figure 7 shows how funding increases have been distributed across budget heads. Much of the increase in the NHM allocation over the years can be attributed to increase in the

amount allocated to "Mission Flexipool", which has been particularly steep in 2017-18 (Figure 7). This flexipool contains items such as the untied funds, maintenance grants, and payment for ASHAs, together with others aimed at improving infrastructure. Other budget heads, including the funds for reproductive, maternal and child health; immunization; urban health; and other communicable and non-communicable diseases have not registered any significant change. This could possibly be a sign of the States' trying to park more funds in Mission Flexipool which offers greater discretion for utilization.

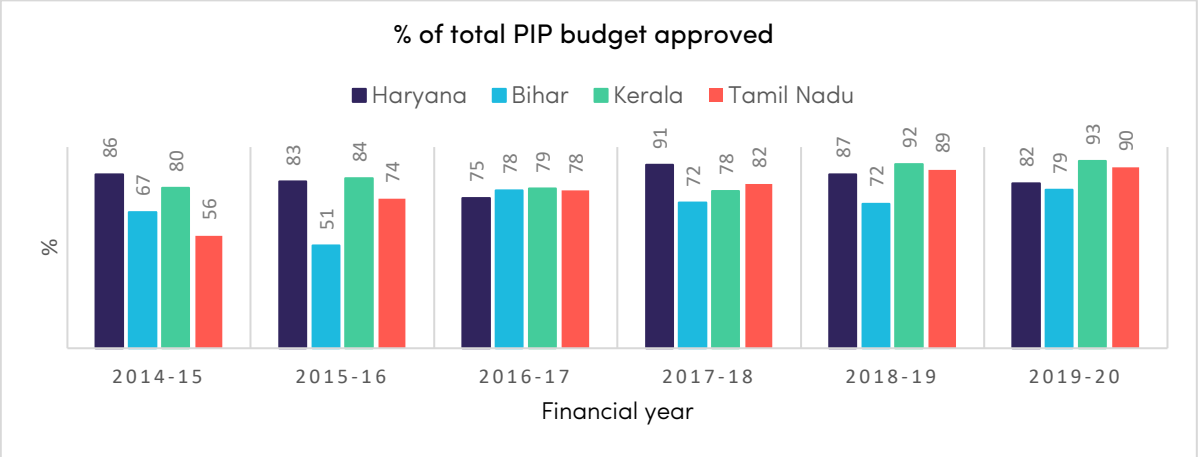
Figure 7: Trends of Approved NHM Budget, Disaggregated Head wise, 2014-2018[2]



Source: Authors' own calculations from RoPs of respective states for various years

[2] Since the budget heads changed from 2018-19 onwards, Figure 7 is restricted up to data for 2017-18 for the sake of comparability.

Figure 8: Trends in the Percentage of Proposed Budget Approved by Central Government

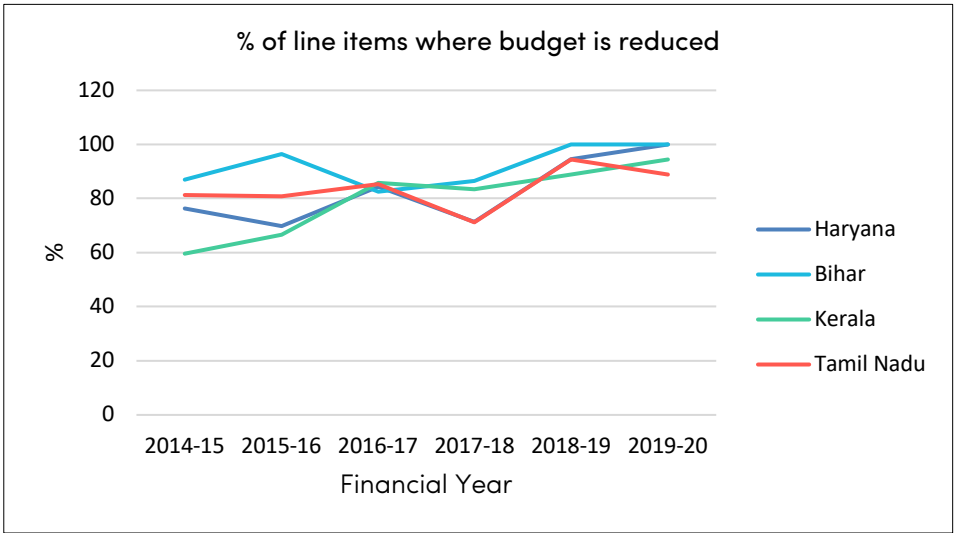


Source: Authors' own calculations from RoPs of respective states for various years

A few State officials opined that the Central Government's conditionalities "have been restrictive" and led to States "not being able to undertake proposed activities". They also opined that "the budget was subject to cuts as a result of State not being able to adhere to certain conditionalities". On the contrary, Central Government officials noted that "the Centre has been very flexible in trying to accommodate the States' claim of meeting the conditionalities". For example, while the States are asked to increase the allocation on primary care by more than 10%, such a conditionality is assumed to be met, even if the increase in allocation was for secondary or tertiary care. To investigate these contradictory observations, an analysis of the extent to which States' proposed budgets were approved by the Central Government was undertaken, which shows that the percentage of the total PIP budget approved has risen significantly over the last 6 years (Figure 8). For example, the proportion of budget which was approved by the Central Government increased from 67% to 79% in Bihar between 2014/15 and 2019/20, and the corresponding increase in Tamil Nadu was from 56% to 90%. Further, it also appears that States with an overall better health system, such as Tamil Nadu and Kerala, have been able to secure (and utilise) more than 90% of their proposed budget from NHM.

A deeper investigation of the budget documents shows that the proposed budget (by the States) for an overwhelming majority (more than 80% in recent years) of total line items were subject to a cut – even if by a small amount - by the Central Government (Figure 9). This implies that the Centre does reduce the extent of proposed budget by States for individual activities or programmes. However, if we see this together with Figure 8, which shows that the overall proportion of approved budget has increased, then it can be inferred that even if the budget is reduced based on the negotiation between the Central and State Government, the extent of this reduction is not significant. To summarize, while proposed budgets for more than 80% of the individual line items were reduced by the Central Government (Figure 7), the cumulative effect at the overall level in the State budget varied from 7% to 21% in 2019-20 (Figure 8).

Figure 9: Percentage of line items where Budget is reduced

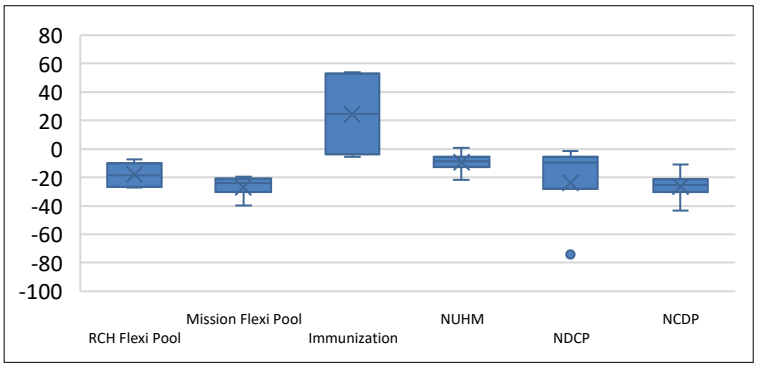


Source: Authors' own calculations from RoPs of various states for various years

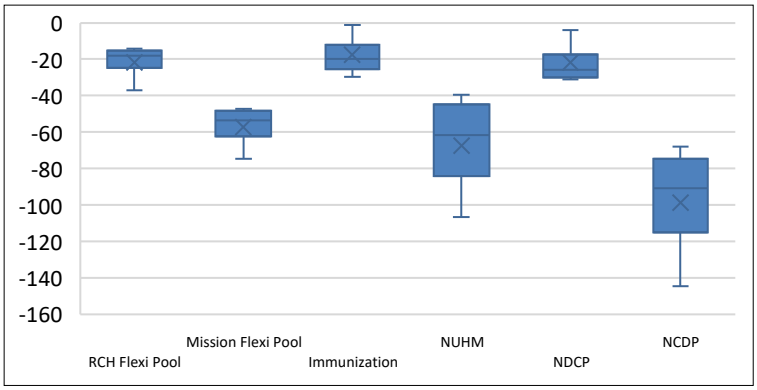
The above observation is further substantiated in the findings from Figure 10 which shows quantitatively the extent to which the proposed budget is reduced by the Central Government. The mean reduction in approved as against the proposed budget was less than 20% for majority of the individual major heads in all states, except Bihar where the reduction from the proposed budget was significant. According to both the Central and the State Government officials, the extent of reduction in proposed budget could partly by attributed to the capacity within the States' officials to prepare plans which should be 'as per the Central Government guidelines and adherence to conditionalities'. As one State official put it, obtaining the Central funds was dependent on 'innovativeness of the state to overcome conditionalities, and that too within the broader political context and priorities of state'. An example of such a case was the compliance of the conditionality for increase in State share through creation of a conditional cash transfer scheme (for pregnant women), creation of new medical colleges, and scaling-up of health insurance scheme. The budget for immunization in Haryana saw an increase over that what was originally proposed. This can be partly explained by the introduction of newer vaccines. Haryana was one of the states where new vaccines such as PCV and Rotavirus were piloted. Since such decisions took place after the original budget was proposed, and therefore were reflected in an increase in immunization budget relative to what was proposed by the State.

Figure 10: Budget heading-wise reduction in the proposed PIP budget, 20013-19

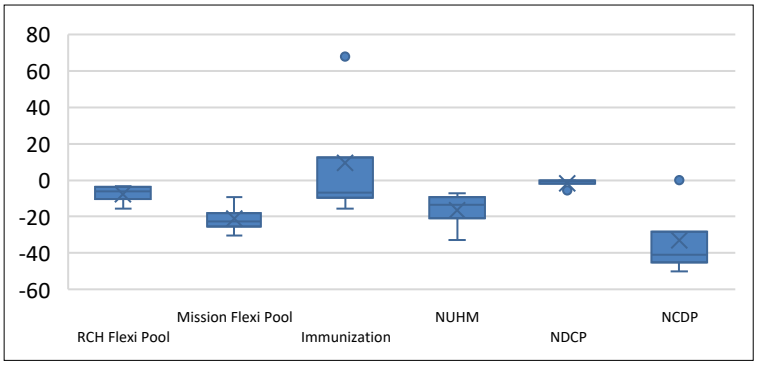
Haryana



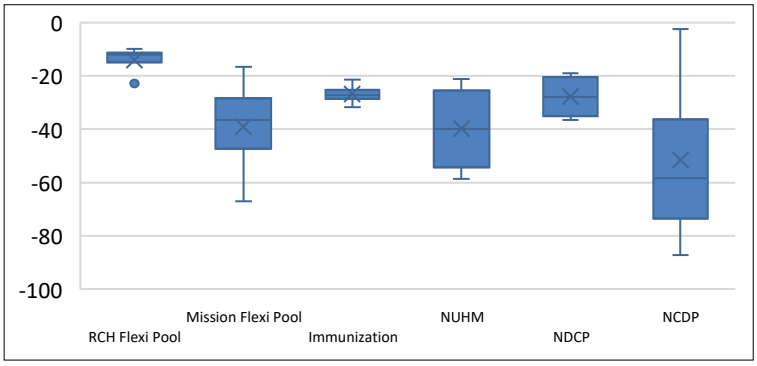
Bihar



Kerala



Tamil Nadu



Source: Authors' own calculations from RoPs of respective states, for various years

Surprisingly, the major line item where the budget was cut more frequently in each of these states was Mission Flexipool. Within this major head, the minor line items where the proposed budget was cut by the Central Government, included ASHA incentive, human resources, hospital strengthening, and procurement.

The above budgetary analysis does not seem to indicate significant (negative) influence of the Centre on the States' decision to spend on PHC. This is further substantiated by Figure 4, which shows that the per capita increase in NHM budget in Bihar, which has a higher share of Central Government (Table 1), was more or less similar to the other three states. This implies a rejection of our earlier hypothesis of a dose-response relationship – i.e., higher the share of Central contribution in state spending, more is it able to influence to bring about an increase in State commitment for spending on PHC. Lack of a dose-response relationship could possibly be attributed to a general capacity at the State level to prepare budgets, and get the budgets approved by adhering to conditionalities. In addition, the approved budget in a given year is also contingent upon the extent of utilization of funds during the previous year, which is again dependent on the capacity of States to absorb the funding.

As a result, it can also be concluded that much of the effect of the increase in the State spending for primary care can be potentially attributed to the role of increasing the state share of NHM budgets under NHM (from 15% to 40%) – with this in turn largely influenced by overall reduction in the share of CSS outlays accentuated by the recommendation of the 14th FC. (Figure 2 and 3). The more recently introduced performance-based funding (since 2018-19) is yet to be implemented and therefore we cannot evaluate its role. Equally important in shaping this funding story, however, is the role of the Central Government in general in setting the agenda as well as shaping priorities which is described in the next section.

Interview respondents were also invited to comment on other ways in which the central government could exert influence on PHC spending. One policy maker opined that, similar to mechanisms of decision-making using health technology assessment in certain countries, we should evolve a threshold of how cost-effective it is to intervene to gain a quality adjusted life year (QALY) in India. Once this is done, it should be mandatory for the States' to spend on interventions which are below a certain threshold. The receipt of Central Government grants should also be made conditional upon such interventions being included in the benefit package of PHC, the official argued.

4.3 Role of Central Government in Shaping Priorities and Setting the Agenda for Primary Health Care

The State officials unanimously echoed the strong influence of the Central Government in the following areas:

1. Setting the State Priorities for Health

The Central Government exercised significant influence on setting the agenda for health and development at the State level through the mechanism of the National Programme Coordination Committee (NPCC). This committee is chaired by the Mission Director and includes representatives of the state, technical and programme divisions of the MoHFW, national technical assistance agencies providing support to the respective states, other departments of the MoHFW and other Ministries as appropriate. The Central Government used this mechanism to exercise its power to make the States plan certain health services which they may not have done otherwise during that planning period. Examples to this effect cited by the State officials included creation and strengthening of newborn services in health facilities, creation of flexible funds available with facilities for local civil works and upgradation. More recently, this is exemplified in the creation of Health and Wellness Centres for the provision of comprehensive PHC.

The Central Government also exercised its power by not letting States perform certain functions that were not aligned to the Centre's priorities. For example, Haryana state could not get funding for its own version of the school health program – *Indira Bal Swasthya Yojana*, since the Central Government had conceived and planned introduction of *Rashtriya Bal Swasthya Karyakram* (RBSK). The latter is an example of the second dimension of power where the Central Government became an agenda-setter and did not let the State introduce certain policies.

2. Placing emphasis on 'equity' in planning and allocation of resources for PHC

The Central Government created several mechanisms for promoting equity in the allocation of resources, starting from broader formula and higher weightage to Empowered Action Group (EAG) states. The EAG states include a set of 8 North Eastern and weaker states on the basis of health indicators and health infrastructure. Under this method, while all states received an overall envelope to plan their health services using a standard per-capita allocation, the EAG states were provided 33% higher allocation after the per-capita standard allocation. In addition, special plans were created for high priority districts (HPDs), which is another example of allocations as per 'need' principle. Besides this, higher norms were set for payment to personnel who serve in difficult areas to promote availability of human resources in rural and remote areas.

3. Imparting greater 'visibility' to health department

Health and Family Welfare Society – a semi-autonomous body was created, as part of the NHM reforms, at each decentralized level, i.e., State and district. These 'societies' comprised of members from different departments and ministries that were entrusted the role of planning for health care services. As a result of the multi-sectoral involvement and monitoring by the leadership at each level, the health department got better visibility. As a result of the wider scrutiny at the highest level for functioning of health department within

the State due to involvement of senior political and administrative leadership in the Societies, there was accountability in States to be able to obtain Central funds, which required adherence to conditionalities. Inability of the State to adhere to conditionalities, and hence being unable to obtain the Central funding as part of NHM, was viewed as inefficient.

4. Shifting the strategy from 'creating infrastructure' to 'funding service delivery'; and from inputs to output measurement

The State Departments of Planning, which were the principal drivers of preparing plans prior to 2005, had mainly focussed on creating additional infrastructure such as building more health facilities, creating more human resources etc. Introduction of NHM in 2005, manifested in development of 'activity-based' budgets, instead of the earlier approach of incremental budgeting. Secondly, with the start of activity-based budgeting, the focus shifted to planning for delivery of services.

5. Centrally sponsored scheme allowed the State bureaucrats to garner greater funds for health from the State Department of Finance.

Having the instrument of a Centrally sponsored scheme (CSS) meant that there were 'push' and 'pull' forces operating to enhance the overall spending on health. Firstly, there was a pressure on the State government program managers and bureaucrats to ensure that the Central funds were garnered, as these were visible to the State leadership. On a similar note, the State health bureaucrats also cited being recognised as 'better capable' (as a result of the CSS) to negotiate with the State department of Finance to get greater funding for health, as the receipt of Central funding had to be matched with a State component as well. Comparison between the department of fisheries (which does not have any CSS) and health was cited as an example to illustrate the point, wherein the former did not have any significant programme (no CSS scheme) to 'pull' the State finances for its department.

4.4 Performance-Based Funding for Primary Health Care

The performance-based incentives introduced in 2013-14 at 10% of the total government support to NHM, were increased in 2018-19 to 20%, based on a new set of seven conditionalities [National Health Mission, 2019].

The key conditionalities used for 10% performance-based incentives, from 2013-14 (extracted from RoP of TN 2013-14) included:

a) Responsiveness, transparency and accountability (up to 8% of the outlay).
b) Quality assurance (upto 3% of the outlay).
c) Inter-sectoral convergence (upto 3% of the outlay).
d) Recording of vital events including strengthening of civil registration of births and deaths (upto 2% of the outlay).
e) Creation of a public health cadre (by states which do not have it already) (upto 5% of the outlay)
f) Policy and systems to provide free generic medicines to all in public health facilities (upto 5% of the outlay)
g) Timely roll out of *Rashtriya Swasthya Bal Karyakram* – a program for screening for childhood diseases, deficiencies and defects (up to 5% of the outlay)
h) Enacting/adopting a bill like the Clinical Establishment Act, 2010 as per their requirement, to regulate the quality and cost of health care in different public and private health facilities in the State (up to 5% of outlay).
i) States providing more than 10% increase in its annual health budget as compared to the previous year will attract additional incentive.
j) States to implement the nurse practitioner model to strengthen the nursing services.

As we can note, some of these above conditionalities are very specific (and measurable such as provision of free generic medicines in all public health facilities), while many others are systemic in nature and more difficult to measure (such as "responsiveness, accountability and transparency" and "intersectoral convergence").

Despite challenges in measuring the extent to which states were able to adhere to the conditionalities and benefit from the performance-based incentives, many officials (in the centre and states) viewed that these initiatives have positively "nudged many states to slowly make progress in budgetary planning process, thus strengthening public health delivery system".

From 2018-19, performance-based incentives were increased to 20% and 7 new criteria were introduced. These are given below (with weightage shown in brackets):

1. Improving Incremental performance based on NITI Aayog Report (40)
2. Operationalizing Health and Wellness Centres (HWC) (20)
3. Implementing Human Resource Information System (HRIS) (15)
4. Grading of District Hospitals (10)
5. Mental Health Services in Districts as per framework (5)
6. Screening of 30+ population for Non-Communicable Diseases (5)
7. Rating of PHCs (both Urban and rural) on their functionality (5)

How do these differ from the earlier set of conditionalities for the 10% incentives that were introduced in 2013-14? How were they implemented and what was the process? How are these new set of 7 conditionalities implemented? The next few paragraphs elaborate these points.

In simple words, penalty / incentives meant the following: states earn certain (positive or negative) points based on their performance (against certain parameters set under each conditionalities). The aggregate points earned get converted into monetary resources, which could lead to a loss of up to 20% of the NHM resource envelope; or get released as incentives (up to 20% of the NHM resource envelope). All states will get up to 80% of the resource envelope; but the final 20% of the approved resource envelope is released based on states performance as per conditionalities. Whether one could call this kind of payment / release of funds as "performance-based incentives" or just call it "conditional release of budget" is not clear. As one senior official put it: "these are play of words. But these are essentially steps to bring about more accountability in spending public resources and the state that perform better year on year basis would have more funds from NHM". But in the Indian discourse on incentives and conditionalities, to quote the 13th FC (XIIIFC, 2009, p.36), conditionalities have always been viewed as incentives:

> *"To improve transparency and accountability, thus enabling a 'feedback' route in improving policy formulation and implementation: If grants were to incentivise greater transparency and accountability in public spending, then they would improve the effectiveness of public expenditure and targeting of public goods. Thus, the conditionalities should be viewed as incentives to act and to improve the effectiveness of public expenditure. There is a general consensus in policy literature on Indian public expenditure that there exists huge scope for doing this."*

The revised set of 7 conditionalities (proposed in 2018-19) are more quantitative and measurable. While "All the seven indicators were allotted different weightage for calculation of incentives/ dis-incentives *based on their importance*", as the Report puts it (NHM, 2019, p.2), it does not elaborate how these weights were arrived at. States' involvement in arriving at these conditionalities and respective weightages is not evident from our discussions with state officials. Of all these conditionalities, the one that has attracted the most attention (of everyone, including the media) has been the NITI Aayog's annual report on "incremental performance (Health) Index" of states.[3]

How have the states responded to these new PBIs which translate into 20% of NHM resource envelope?

Some states have given in writing their concerns with Niti Aayog's methodology for measuring incremental performance on health based on 28 indicators. Let us briefly look at the components of these indicators:

Of the Seven Performance Indicators, Niti Aayog's report on states performance on health (year on year basis) gets 40% weightage; the remaining 6 performance indicators get 60% weightage (as mentioned earlier). Niti Aayog's Health Index has 28 sub-indicators. These are categorized into domains of Health Outcomes (with 14 indicators), Governance and

[3] For details of the methodology for calculation of incentives points, refer (NHM, 2019)

Information (with 3 indicators), and Key inputs/processes (with 11 indicators) (Guidelines, Niti Aayog, December 2016). Health Outcomes include the following: Still Birth Rate, Neonatal Mortality Rate, Under Five Mortality Rate, Maternal Mortality Ratio, Total Fertility Rate, Proportion of LBW among new-borns and Sex Ratio at Birth, besides 7 intermediate indicators (such as full immunization coverage, proportion of institutional deliveries).

> "*A composite index would be calculated which focuses on measuring the 'level' of health status of each State (calculated as a weighted average of the various indicators). The change in the index from the base year to a reference year, and in each subsequent year, will be the measure of incremental improvement of each State, relative to its own baseline performance."* (NITI Aayog, 2016, p.9*)*

A critical view of these outcome indicators as performance indicators on a year-to-year basis is best articulated by NHM-TN (as articulated by an official):

> *"It is theoretically incorrect to make a year-on-year assessment of outcome indicators. These impact variables are a result of a large number of socio-economic factors and the actions of health department could at best have a lagged effect on them. Consider for example, LBW, TFR and Sex Ratio – all these are only indirectly related to the health sector performance but are closely related overall state's action in other sectors and socio-cultural factors".*

Another criticism from officials of states is that some of the indicators are based on National Surveys (such as the National Family Health Survey) and projections from national surveys, which do not reflect the actual figures that are available with states programme implementors.

The crux of such reactions from states is that while they do see the importance of measuring performance of states, having a composite index of the kind proposed is not a right step – "it is flawed conceptually".

The above commentary reflects the views of other states as well. Yet NITI Aayog's ranking of states' incremental health performance index, which carries 40% in the overall scoring for release of 20% of NHM funding as incentives, remains. So far, NITI Aayog has come out with two such reports, providing inputs for arriving at the overall score for the 20% incentives for the year 2018-19 and 2019-20 (as reflected in respective RoPs of the four sample states). However, due to ongoing COVID-19, the disbursement of incentives for the last two financial years has not been applied as per plan. As a result, it is not yet possible to discern the effect of this recently changed PBF tool on the extent or pattern of financing for PHC. The implications of this new set of conditionalities (as PBF) for release of the final 20% of the budget outlay, if and when they are applied (post COVID-19 phase), need further discussion in the policy circles, primarily whether such as conditionalities would be "fair" to those states whose absorptive capacity is low (as reflected by the fact that on average nearly 45% of NHM funds (already transferred to state treasuries) remain unutilized in the recent past (Mita C, and Mohanty R.K. 2020). To the extent that underutilization is due to such weak existing supply side factors, such states will continue to suffer from the existing system of performance measurement.

The story so far

There is an overwhelming observation that NHM over the past 15 years, has certainly given a face-lift to the health sector across the states. Centre's nudges to states to enhance their investment in PHC has had positive impact: states' health budgets have increased slowly, though not to the extent of 8% of the total state budget inclusive of all departments and sectors to be achieved by 2020, as stated in the National Health Policy 2017. A recent estimate (for 2018-19) shows that the average state health expenditure is 5.2% of total expenditure (XVFC, 2020, page 271), far below the National Health Policy's goal of 8% (GoI, 2017, p.5)

NHM's contributions have played a complementary role to states' health budget – to the extent the conditionality that states health budget should have an annual increment of 10% ("roughly" as an official put it). The NHM has significantly enhanced the pace of reduction of infant mortality, as evidenced in a recent analysis that tracked the decline of IMR during last 20 years [Prinja et al 2021]. Initial hesitancy of the states regarding conditionalities were overcome as "we slowly understood the Union's priorities", as an official from Haryana explained. "NHM certainly changed states' approach to PHC. There are examples: attention towards RMNCHA+ (Reproductive Maternal, Neonatal Child Health Care and Adolescent), RBSK (*Rashtriya Bal Swasthya Karyakram* – program for screening and treatment of childhood defects, deficiencies and disorders) from NHM's budget, states, inclusion of AYUSH (*Ayurveda, Unani, Siddha and Homeopathy* – Indian Systems of Medicine) component in PHC, etc. Other examples include "JSSK (*Janani Shishu Suraksha Karyakram* – a program for free institutional delivery and treatment for neonates), vaccines and mental health in recent years".

States had perhaps more differences with respect to deployment of Human Resources (HR). For example, although one of the conditionalities states that additional auxiliary nurse midwives (ANM) should be posted at specific facilities and they should not be relocated to another facility, in practice substitution effects do continue to take place and it is near-impossible to monitor such practices. States are supposed to fill their regular posts as per norms/workload, while most states continue to suffer from a significant level of vacancies resulting in poor performance. However, instead of filling these sanctioned positions of human resources through the usual State budget, the States were incentivised to fill these posts through the NHM budget on "contractual mode". This meant that the NHM budget served as a substitution to the State budget, rather than being able to complement it, with regard to HR.

Transfer of funds from the Centre to the States' treasuries have become more efficient in terms of reducing the delays in transfers at different levels, as is evident from a recent empirical study (Mita C, and Mohanty R.K. 2020), though delays in transferring funds from State to district (Societies) level remain, resulting in large unspent funds either due to poor absorptive capacity (largely due to lack of HR and infrastructure etc,) or other reasons. Such factors evidently result in poor performance of many districts and the states, further adversely impacting their eligibility to receive their share of the 20% of the NHM funding as incentives. This is a vicious cycle from which states continue to suffer – but as one official put it, "this is a reflection of poor accountability and governance issue".

States' demand for release of NHM funding in one go and "leave the implementation to us" and "monitor only our performance" may not become a reality in the near future. New conditionalities (for 20% incentives) may continue to irk states, particularly the indicators and methodology used for ranking states' health performance. But such conditionalities will certainly enable the centre's ability to contain its expenditures – as a fiscally prudent measure given the overall reduction in the fiscal space since 2015-16 for CSS. States' demand for more flexibility for use of the NHM funds will continue to be met with the following rhetorical question, as one senior NHM official from Delhi put it: "please ask them [states] – where their priorities are denied due to these conditionalities?". To which "an apt response" was put forward by another state level NHM official: "it is easy to illustrate. Please ask them [the Centre], why do they insist on one-size-fits-all staffing pattern in Health and Wellness Centre across the states disregarding states' financial capacity and timeline over which they can achieve such norms?". Our examination of the budget data seems to support that while the budgets were finally shaped through the consultation with the Central Government, a mechanism which the Centre uses to set priorities, the extent to which the proposed budgets are approved by the Central Government has increased to the tune of 90% in recent years. This shows that gradually the States have evolved their capacity to plan based on the norms of Centre. Moreover, it is also linked with the capacity of the States to absorb the funds received. One definite positive impact of NHM's funding pattern is the reduction in disparity in per capita public spending across states (Mita C and Mohanty R.K. 2020), despite high level of under-spending of funds transferred to states. Clearly there is a need to find ways to reduce such underspending and thereby achieve the full potential of the limited financial resources.

Way Forward?

States' demand for NHM's contribution with no conditionalities is not likely to come true in the future. NHM is the 4th largest CSS of the Centre – consuming about 10% of the total budget for all CSS. Therefore, the fate of NHM, as it stands, is inevitably bound with the future of CSS. With the proliferation of CSS over years, conditionalities are likely to play a larger role in the future. Assessment of states' accountability in the utilisation of public resources measured with performance indicators (including health outcomes) will also remain contentious and unresolved at least in the near future. While many states may continue to depend significantly on Centre's contributions, they need to have a more concrete plan in building their PHC delivery system towards achieving Universal Health Coverage. As a senior state official from the Finance department put it bluntly: *"If I increase the state's health budget from the current 1% to 2% of state GDP, as has been repeatedly urged in many platforms and reports, does the state health department have a plan to spend it?"* However, it may be contended that the capacity to spend is built once the funding is gradually increased. Moreover, several published reports point to gross inadequacy of current funding compared to the need [Singh D et al. 2021; and Prinja et al. (2012). Enlarged fiscal space may be required. But prudence in spending is more essential. Having a clear road map for PHC is vital and an important part of the case for increased PHC spending.

But to prepare a road map, states need capacity (a) to make realistic estimates of the cost of delivering (primary, secondary and tertiary) healthcare (b) to arrive at a threshold level of cost-per year of quality adjusted life year (QALY) gained through primary healthcare interventions and (c) to carry out an analysis of the budgetary implications. At present,

both the Centre and States have a long way to go in building such a capacity. Some work on developing an evidence base for cost of PHC has resulted in development of a National Database of Health System Cost' [Prinja et al 2020; Bahuguna et al 2020].

However, this would need to be updated with estimates of cost of comprehensive PHC. India's Health Technology Assessment agency needs to work out an explicit estimate of threshold cost per QALY gained for interventions to be considered cost-effective. The States as well as the Centre need to ensure universal access to services which are found to be cost-effective, given this threshold. The conditionalities to receive Central Government's funding should include the States' investment in interventions which are found cost-effective. In a way, this would bring some degree of confluence between policies for universal health coverage and those advocating for a Right to Health.

While pandemics may serve as a catalyst for investing more in building the health care system, a more rational, principled, and evidence-based approach is the best way to mobilise – either from the Centre or from within States – higher budgetary allocations for PHC in the future. The current policies constructed around conditionalities, as they are now, although may have increased the public spending for PHC, a lot more needs to be done. Given the needs for PHC, the allocations need to be increased further significantly. We argue that the three steps way-forward (a-c) mentioned above, while it might be an arduous way, may possibly be a fair and effective way in building a robust PHC system in India, where there would be more money for PHC and more health for the money being spent."

5. Implications for LMICs

Our study findings may have significant value for many LMIC settings where the nature of governance follows a federal structure, or decentralization and devolution reforms are being carried out for financing and provision of PHC. The key learnings can be summarized in four parts. Firstly, our study demonstrates how the policy levers and power dynamics between the central and state (or provincial level in other settings) can be used to 'nudge' the states towards a common goal of increasing the spending on PHC through a model of cooperative fiscal federalism. Using such a model can be especially useful in settings where income inequalities across states and provinces may require a role for Central Government to create a framework for risk adjustment and equalization.

Secondly, and more importantly, we show that the institutional arrangements of sharing of public revenues, as well as conditionalities linked to adherence to a common minimum set of processes, are instrumental in nudging the decentralized institutions towards a common agreed program of work.

Thirdly, the eventual outcomes of such fiscal instruments are dependent on some of the contextual governance frameworks which are created. For example, in the Indian context, the creation of the Society structures and its linked accountability frameworks led to the health sector and PHC in particular gaining higher priority by States.

Finally, our study also shows that performance-based funding may even lead to negative consequences, and enhance inequalities, 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 was demonstrated in our study, where the States with poor capacity to absorb allocated funds and adhere to conditionalities, could not obtain necessary additional funding linked to performance measurement, and as a result may even risk an increase in vertical equity in allocation of resources.

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