Federal Fiscal Transfers on Health: Implications of Fourteenth Finance Commission Recommendations at Subnational Level

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3.1 Introduction

Health is a very basic element of human development, and poor status of human health causes capability deprivation and leads world's poverty and unemployment (Sen 1999). Improvement of the health status of citizens by providing basic health care services is therefore deemed as a very fundamental responsibility of the government in 'welfare nation'. The governments worldwide have had a crucial role in delivering and controlling health care services (Rao and Choudhury 2012). In most low-and-middle-income countries including India, however, the public spending on health has limited the access to public health facilities thereby leads people to go to private providers, and results in large out-of-pocket health expenditure (WHO 2004).

For the low-and-middle-income countries, public health expenditure is an important aspect of reformative health policy (Barenberg et al. 2016), especially when the world is moving towards Universal Health Coverage along with Sustainable Development Goals. The level of governments spending on health in India is one of the major concerns in public policy debate because several high-level official documents like Approach Paper of Twelfth Five-Year Plan, National Commission on Macroeconomics and Health, High Level Expert Group for Universal Health Coverage, and Programme Implementation Framework of National Rural Health Mission have all recommended for the raise of public health expenditure from existing one percent level to around three percent of national income. Nevertheless, the national government has played only a modest role in health care financing and provision because health is under the subject of subnational governments by Indian Federalism. The country is currently used about 4% of its income (gross domestic products) to consume health care, and out of that only around 1.2% is combined public health expenditure by centre and states (NHA 2016). The central government contributes merely about one-third with the states assuming most financial burden of public health expenditure.

But, the resource mobilization powers assigned to subnational level governments fall short of their expenditure responsibilities. There is a structural imbalance of the financial resource mobilization between central and states governments, referred as vertical imbalance and existed since independence because the Constitution of India provides quasi-federation with more power to the centre for

allocation of resources. Right from the beginning, therefore, intergovernmental financial transfers are designed to deal with the existing imbalances between different levels of governments that have assigned different fiscal powers. Indeed, the vertical transfer is crucial in federalism because the states at subnational level have assigned some major expenditure responsibilities such as law and public order, agriculture, health, education and so on due to their close proximity to the local issues. Further to these, the adoption of developmental planning and emphasis on decentralized fiscal activities have widened the role of subnational governments to provide better social and economic services. So as to meet their expenditures liabilities however the subnational governments are highly dependent on central transfer of financial resources. In fact, the subnational level fiscal management is to a large extent shaped by the central devolution of funds and expenditure commitments by states that arise from time to time.[1]

The fiscal stance of subnational state-governments in general has attained an enormous focus in most public debates since latter half of the eighties when states have started experiencing serious fiscal imbalances (Das 2015). It might has led the Indian Finance Commission (FC) to recommend a state level fiscal reforms such as the rule-based framework to enact fiscal responsibility and budgetary management (FRBM). Notably, the fiscal position of subnational states is deemed as imperative in the national macroeconomic policies because states are accounted for almost sixty percent in the combined expenditure by central and states governments. In view of the growing importance of subnational financial patterns in economy as well as reformative intergovernmental transfer systems over time, there are very extensive researches on the issue of fiscal federalism in India. In fact, enormous studies are available over the last few decades that critically reviewed the existing patterns of vertical and horizontal devolutions resources (Bagchi and Chakraborty 2004; Chakraborty 2011; Chalam and Mishra 1997; Rangarajan and Srivastava 2008; Rao and Singh 2007; and so on). There are three broad channels for devolution of federal financial resources from centre to states: (1) statutory transfers as share of central taxes and non-plan grant-in-aid by Finance Commission, (2) formula based normal central assistance to state plan and special sub-plan schemes by erstwhile Planning Commission, and (3) discretionary grant by union ministries for central schemes which also include the erstwhile direct transfer to state-level implementing agencies. Nevertheless, the Finance Commission transfer has remained the major source of federal devolution to subnational states, reached at around 57% in recent past during Thirteenth Finance Commissions (FFC 2015: 51). Among the non-FC transfers, normal central assistance has marked just around 5%, and the rest about 38% was on the route through union ministries (ibid: 159). Nowadays, all the resources are channelling through FC and Union Ministries (UMs), and accumulated only in the State Consolidated Fund. Of course, there are several plan components in the ministerial channel such as special central assistance, special plant assistance, central plan schemes and centrally sponsored schemes. Noteworthy to mention, a major part of the ministerial fund is observed for the centrally sponsored schemes (such as National Health Mission − a flagship scheme to improve human health in the country). In both

[1] Nevertheless, the states are themselves inherently uneven in terms of their own resource mobilizations at subnational level. Such an inequality is termed as horizontal imbalances and caused by the statewide variations in revenue generations and expenditure responsibilities since there are region-specific disparities and diverse socioeconomic structure among states.

statutory and ministerial transfers, however, there are some resources clearly earmarked as developmental grant to improve specific sector like health, education, etc. As an example, the previous Finance Commissions have recommended a performance-based grant-in-aid to improve health status pertaining to the outcome indicator of infant mortality rate (IMR).

It is so evident that the central transfers to states are both tied (to a sector say health) and untied.[2] Regarding tied versus untied federal transfers, there are two recent policy decisions in line with the FFC Recommendations to promote cooperative federalism. *First*, there are more untied and less tied funds in the composition of federal transfers to offer greater flexibility to states (14th FC made the highest ever increase in tax devolution, and expected to enhance transfer around 8% through statutory channel).[3] Such an important policy shift in the recommendations of FFC may have clear implication in the pattern of resource distribution of state governments' budgets. The non-statutory transfer of central ministries is also expected to affect due to limited fiscal space of union government (FFC 2015). Choudhury et al. (2016) have raised the concern about reducing ministerial transfer, which is anticipated to affect much on developmental expenditure under centrally sponsored schemes (CSS). Yet, there is the direction of compensation using untied central resources because larger tax devolution may enhance fiscal space with autonomy for the states. In spite of that the central government has *finally* decided to continue on the important CSS like NHM. Several recent studies have estimated that there is a net financial gain to the states following recommendations of the FFC (Chakraborty 2015; Shetty 2016; World Bank 2016). A very recent analysis by Choudhury et al. (2016) has pointed out that the federal transfer to states during first two years of 14th FC award period is likely to reduce as compared with the average of 13th FC period, and this is due to contractionary central grants mostly devoted to social sector under CSS (NITI Aayog 2015). The states have also given lower priority to social sector expenditure in preliminary phase of the 14th FC period (pp. 18). Further, a fairly regular grant-in-aid to states in statutory route based on the health status has desisted by FFC. All these facts might have led to a serious implication on public health expenditure at subnational level. Therefore, the immediate concern is to what extent the states are being able to prioritise their public health expenditure in changing compositions of federal fiscal transfers comprising more untied and less tied resources. The aim of this study is to assess comparatively the impact of FFC recommendations on tied and untied health expenditures in light of the 'high focus' and 'non-high focus' states on the health indicators.[4]

In this chapter, we would analyze the extent of health expenditure at subnational level by sources of revenue as tied and untied resources available for public health purposes. The disintegration of central

[2] Tied transfers to the states are earmarked fund to specific sectors without any autonomy of intersectoral reallocation by states. NHM fund, for example, is an earmarked fund to health sector, and states can't use it on non-health purposes. In contrast, revenue deficit grant is untied transfer, and state has autonomy to spend its own way. There are some transfers such as *central assistance to state annual plans*, and may be termed as 'semi-tied' in the sense that states have full autonomy to set its own plan for any sector but the allocated central resources of such a specified plan can't be shifted to other plans of the states. Nevertheless, the semi-tied central transfer may well be clubbed into untied fund because states have full freedom of choice while plan for it.

[3] It may be observed that the corresponding transfers between 13th and 14th Finance Commissions are 67.4% and 75.2% in aggregate federal transfers to states (FFC 2015: 50 & 437).

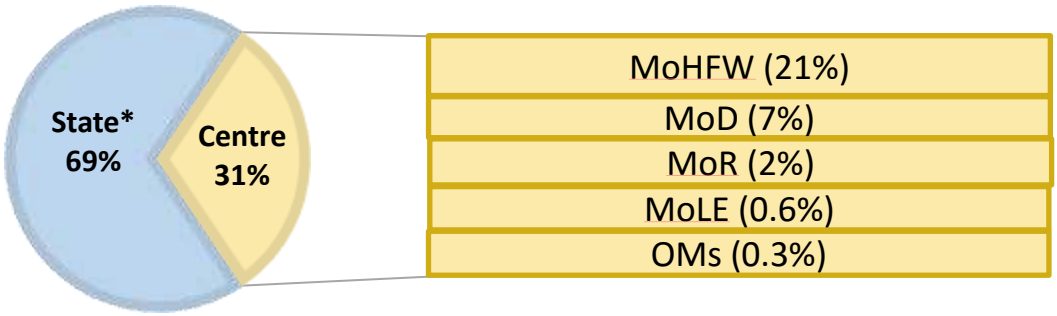
[4] Nevertheless, these states are almost similar to EAG (*empowered action group*) and Non-EAG states in term of statewide socioeconomic backwardness. Henceforth, EAG would be treated same as high focus and so on.

fiscal transfers by source would help identify the comparative effects on state-level public health expenditure for the recent federal policy shift with FFC Recommendations. Prior to proceed with this core objective of assessing central transfer on states' public health expenditure, a review of relevant literatures is offered for public health expenditure under the federal structure of India. Subsequently, the study of fiscal resources in federal system available for health is presented in light of the recent Finance Commissions. Final section summarizes the findings.

3.2 Review of Public Health Expenditure in India

India's public health expenditure is historically at very low level and stagnant over the decades, which may be led to a worse performance on health indicators of the country.[5] As per the UNDP report on human development (HDR 2015), India is ranked at 127th in terms of maternal mortality rate as well as female life expectancy at birth, 141st on under-five mortality rate, 143rd on infant mortality rate, and 156th for the share of health expenditure in gross domestic products among the listed 188 countries. Such a poor health status of the country clearly indicates about inaccessibility of its vast population to attend adequate health care through private expenditure (Rao and Choudhury 2012, Sengupta 2013). These facts might result-in to recommend for scaling up combined governments' spending on health to 3% of GSDP by HLEG-UHC (2011). Nevertheless, the combined public spending on health is till at 1.2% against its desired level of 3%. That Gupta and Chowdhury (2014) observed, in this limited public resource pool available for health, the major share around 70% has encountered from *consolidated fund of states*, and central ministries have spent the rest, encompassing overwhelming part by Ministry of Health and Family Welfare (see Figure 3.1).

Figure 3.1: Extent of health expenditure by centre and states

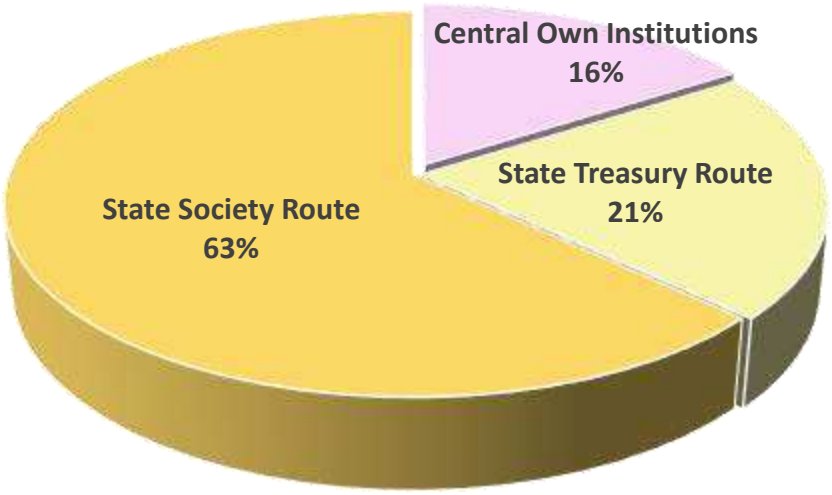


Notes: *state is inclusive of the local bodies; MoHFW=Ministry of Health and Family Welfare, MoD=Ministry of Defence, MoR=Ministry of Railways, MoLE=Ministry of labour and Employment and OMs=Other Ministries.
Source: Gupta and Chowdhury (2014)

[5] Yet, there are some debates globally and nationally in the literates about resultant health outcomes by enhancing public spending on health. Filmer and Pritchett (1999), Kaur and Misra (2003), Makela et al. (2013) and World Bank (2004) are in the view that the public health expenditure has very little effect on health outcomes; while Anand and Ravallion (1993), Bhalotra (2007), Farahani et al. (2010) and others have found a positive impact on the health status.

Notably, except for the MoHFW, public health expenditure about 10% accounted for rest of central ministries like Defense, Railways and other ministries (CGHS) are typically the central sector schemes implemented directly by central level agencies with states have no role to play as per the federal structure. There are indeed some central sector schemes such as AIIMS like hospitals, and offer health services to common peoples at the state level. So, the central resources on health may well be accomplished directly by central authorities (central sector schemes) as well as state authority (state plan schemes including CSS). It has been estimated by Choudhury et al. (2011) that around 16% of central fund has channelized through central government's own institutions, and the same are beyond our scope in the present study which essentially analyses federal transfer to state level authorities. It is however observed from following Figure 3.2 that the overwhelming part (84%) of central resources on health has routed through the state level authorities via State Consolidated Fund (state treasury) and direct transfer to state level health societies. Since the year 2014-15, the direct central transfer to state society has been discontinued and all fund are now routed via state treasury.

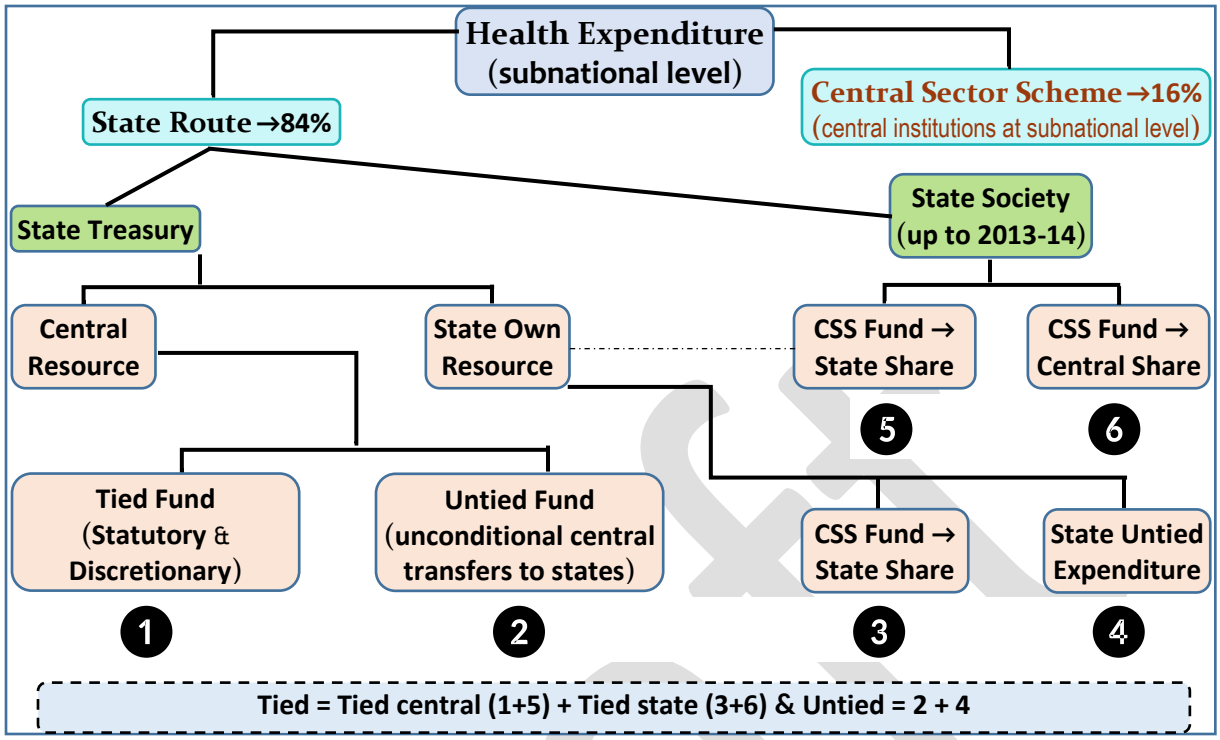
Figure 3.2: Pattern of central resource flows on public health



Source: Choudhury et al. (2011)

As discussed, the central transfer to states has two components: sector-specific tied fund and untied fund. While the erstwhile society route transfer was wholly tied fund to health, treasury route fund had more untied than tied resources almost until 13th FC period. A flowchart of the transfer of federal resources is presented in Figure 3.3. It may be observed from flowchart that the components 1 and 5 accounted for central tied transfer with component 3 and 6 as matching state tied resource in the presence of both treasury and society routes. No matter if component 5 boils down into 3 and 6 merges with 1 due to abolition of society route. It is however hardly possible to identify disintegrated untied components as 2 (central share) and 4 (state share), and such an analysis is not very imperative especially in the present study. In the both tied and untied funds, there are statutory as well as discretionary transfers involved. For example, the incentive grant by 13th FC on statewide health status is tied statutory transfer. Then again, the central finance on NHM scheme is a tied ministerial transfer.

Figure 3.3: Flowchart of federal tied and untied resources on health



3.3 Impact of Federal Fiscal Transfers on State Health Expenditure

3.3.1 Pattern of public expenditure during recent periods under FCs

Union of India in 1947 began with a major diversity between provinces in terms of culture, resources, politics and institutions in a bargain to form a federation would certainly entail *de facto* asymmetry at subnational level in socioeconomic status. Our comparative analysis of EAG (high focus) and Non-EAG (non-high focus) states during last three successive FC-periods suggests that the subnational level total expenditure relative to gross state domestic product (TE/GSDP) is differed across states in both EAG and Non-EAG groups. Of course, the TE/GASP ratio of EAG states in general is moderately higher than Non-EAG states. The higher level of spending by EAG states is also observed for other relevant expenditure variables in normalized term, such as development expenditure (DE/GSDP), social sector expenditure (SE/GSDP) and health expenditure (HE/GSDP). Pertaining to the recent three FCs, there is an increase of almost all expenditure variables in both EAG and Non-EAG states from 12th to 13th and 13th to 14th periods of Finance Commission; the increase in 14th FC period over 13th FC period is however more perceptible in EAG states (see Table 3.1).[6]

[6] The study follows definition used by RBI in its reports on State Government Finances on the development and social sector expenditures; all the expenditure variables are inclusive of revenue account and capital account, and health expenditure comprises medical, public health and social welfare. Further, an annual average (geometric mean for variables considered in ratio term and arithmetic mean for variables in real term) is estimated to represent respective periods under Finance Commissions. While the entire duration of five years has considered for the 12th FC (2005-10) and 13th FC (2010-15), only two years average (2015-17) is applicable

Table 3.1: Different aspects of expenditure relative to GSDP in recent FCs period

EAG		TE/GSDP	DE/GSDP	SE/GSDP	HE/GSDP	Non-EAG	TE/GSDP	DE/GSDP	SE/GSDP	HE/GSDP
12th FC	Bihar	26.5	16.1	8.7	1.1	Gujrat	13.4	8.6	4.3	0.4
13th FC		24.8	15.9	8.4	0.9		13.2	8.7	4.8	0.6
14th FC		29.6	20.7	10.7	1.3		14.2	9.5	5.4	0.8
12th FC	Chhattisgarh	17.2	11.7	6.1	0.6	Maharashtra	12.1	7.6	4	0.4
13th FC		18.9	13.5	7.1	0.8		11.6	7.4	4.4	0.4
14th FC		26.3	20.8	10.1	1.4		13.2	8.3	5.1	0.6
12th FC	Madhya Pradesh	20.9	12.6	5.7	0.7	Kerala	13.5	6.1	3.9	0.6
13th FC		22.4	13.4	6.9	0.8		14.8	7.1	4.6	0.8
14th FC		25.1	18	9.4	1.1		17.5	8.2	5.1	1.1
12th FC	Odisha	18	10	5.7	0.6	Tamil Nadu	14.1	7.9	4.5	0.5
13th FC		19.3	12.8	6.8	0.7		14.1	8.3	5.1	0.6
14th FC		25	18.1	8.7	1.2		16.1	9.5	5.3	0.7
12th FC	Rajasthan	17.9	11.1	6.6	0.8	West Bengal	16	7.5	4.7	0.6
13th FC		16.5	10.9	6	0.8		15.4	7.9	5.6	0.7
14th FC		23.1	14.4	7.4	1.2		20.3	10.2	6.3	0.8

Source: Author's analysis from RBI State Finance Data and State Budget Documents

In Table 3.2, the key variables of our interest (development expenditure, social sector expenditure and health expenditure) are presented relative to total expenditure of respective states. Health expenditure is also presented with reference to social sector expenditure. It is observed from the table that there is virtually no difference in the pattern of expenditure components between EAG and Non-EAG states. However, development expenditure as a whole in Kerala, West Bengal and Tamil Nadu to some extent is lower than rest of the selected states. Except for a few cases, there is just a marginal improvement in the ratios of different components of expenditure across states during the FC periods; the affirmative expenditure in 14th FC over 13th FC may well be observed only in the development expenditure of EAG states. For health expenditure, the increase of HE/TE and that of HE/SE ratios in 14th FC over 13th FC is most imperative in Chhattisgarh among EAG states and Kerala and Gujrat to some extent among Non-EAG states.

for the 14th FC. Further, the relevant financial years of the 14th FC period, that is to say 2015-16 and 2016-17 are respectively revised estimate and budget estimate; other FC periods are on actual basis in our entire analysis.

Table 3.2: Different aspects of relative expenditure (%) in recent FCs period

	EAG	DE/TE	SE/TE	HE/TE	HE/SE	Non-EAG	DE/TE	SE/TE	HE/TE	HE/SE
12th FC	Bihar	60.8	33	4	12.1	Gujrat	63.9	32.1	3.2	10
13th FC		64.1	34	3.5	10.2		66.4	36.6	4.7	12.7
14th FC		69.9	35.9	4.5	12.4		66.8	38.1	5.5	14.4
12th FC	Chhattisgarh	68	35.4	3.4	9.7	Maharashtra	62.6	33.3	3.3	9.9
13th FC		71.6	37.8	4	10.6		63.7	38	3.8	10
14th FC		79	38.4	5.5	14.3		63.4	38.6	4.3	11.2
12th FC	Madhya Pradesh	60.1	27.1	3.5	12.9	Kerala	45.4	28.9	4.7	16.4
13th FC		59.8	30.9	3.8	12.3		48.2	30.9	5.4	17.4
14th FC		71.5	37.5	4.3	11.5		46.6	29	6.1	21
12th FC	Odisha	55.8	31.5	3.3	10.6	Tamil Nadu	55.8	31.6	3.8	12
13th FC		66.2	35.3	3.7	10.5		59	36.2	4.5	12.4
14th FC		72.5	34.8	4.7	13.6		58.8	32.9	4.5	13.8
12th FC	Rajasthan	62.2	36.9	4.4	12	West Bengal	46.8	29.6	4.1	13.7
13th FC		66.1	36.7	5.1	13.8		51.5	36.5	4.5	12.4
14th FC		62.2	31.9	5	15.8		50.3	31.2	3.9	12.5

Source: Author's analysis from RBI State Finance Data and State Budget Documents

With respect to the real growth in different expenditure components at 2011-12 price level, however, there are some important observations: the rate of growth of total expenditure as well as its components like development, social and health expenditures from 13th to 14th FCs over 12th to 13th FCs is higher in all selected states under Non-EAG category; the growth rate is lower in almost all cases for the EAG states (see Table 3.3).

Table 3.3: Different aspects of real expenditure growth in recent FCs period

	EAG	TE	DE	SE	HE	Non-EAG	TE	DE	SE	HE
12 to 13 FCs	Bihar	48.4	54.9	52.9	29.5	Gujrat	51.7	57.1	71.2	120
13 to 14 FCs		64.3	78.6	72.9	115		30.1	30.6	35.1	51.1

12 to 13 FCs	Chhattisgarh	56.1	64.4	62.7	83.9	Maharashtra	39	39.9	57.2	60.9
13 to 14 FCs		64.6	80.7	67.8	122		30.8	30.5	33	48.1
12 to 13 FCs	Madhya Pradesh	58.9	58.6	80.2	74.1	Kerala	53	62.2	62.9	74.9
13 to 14 FCs		44.6	72.5	75.7	63.9		50.5	46.1	41.5	68.6
12 to 13 FCs	Odisha	46	70.8	62	64.4	Tamil Nadu	51.2	59.1	72	77
13 to 14 FCs		55.1	68.9	53	93.1		37.6	37	25.1	38.4
12 to 13 FCs	Rajasthan	39.7	49.7	38.7	59.9	West Bengal	31.7	41.9	58.4	46.3
13 to 14 FCs		78.8	66.7	54.7	76.9		52.6	49.4	31.7	31.7

Source: Author's analysis from RBI State Finance Data and State Budget Documents

3.3.2 Pattern of public health expenditure between 13th and 14th FCs

The observed increase in different components of expenditure at subnational level during FFC period may be the fact of availability of more federal resources following 14th FC Recommendations (World Bank 2016). Further, as expected, the composition of federal transfer between tied and untied funds has changed in favor of more untied resources. Choudhury et al. (2016) observed that the tied transfer has decreased by 6.5% while untied part has increased by 8.5% in the central gross divisible pool between last year of 13th FC and first year of 14th FC (2014-15 to 2015-16). In order to apprehend this issue in health sector expenditure at subnational level, Figure 3.4 portrays the growth in real term for health expenditure in general as well as its tied and untied components between 13th FC to 14th FC periods. It is now evident that the growth of tied fund to health is much lower (even negative for Kerala) than untied fund irrespective of EAG and Non-EAG states. The highest growth of tied fund is observed for Madhya Pradesh and Rajasthan about 30% in EAG states, while Tamil Nadu witnessed a highest growth of tied fund (22%) among Non-EAG states. Untied fund has experienced a fairly low rate of growth from 13th to 14th FCs; whatsoever the growth, it is moderately higher in EAG states than Non-EAG states (except for Kerala).

A more comparative feature in the composition of tied versus untied health expenditures in 13th and 14th FC-periods are presented by Figure 3.5. Expectedly, the proportion of untied health expenditure has increased in both EAG and Non-EAG states during 14th FC period over 13th FC period. As an example, there was the 50:50 combination for tied versus untied health expenditure in Bihar during 13th FC period, and the same has changed into 28:72 during 14th FC period. It is however observed from the figure that the change in composition of the tied versus untied expenditure between 13th and 14th FCs is more obvious for EAG states.

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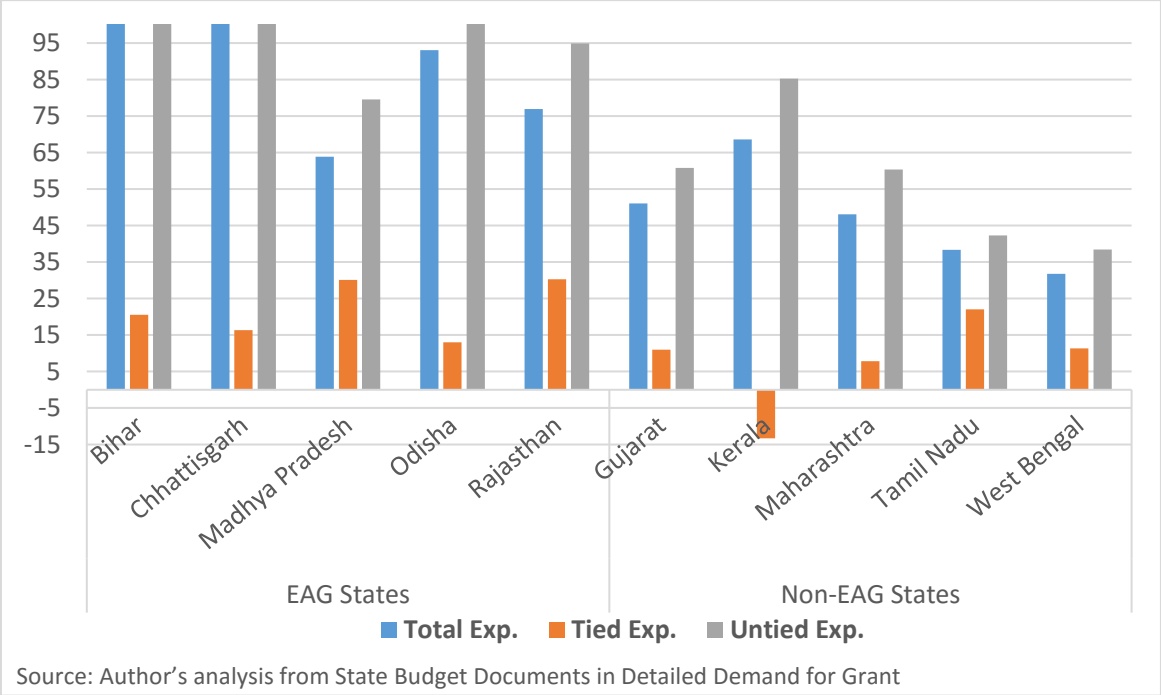
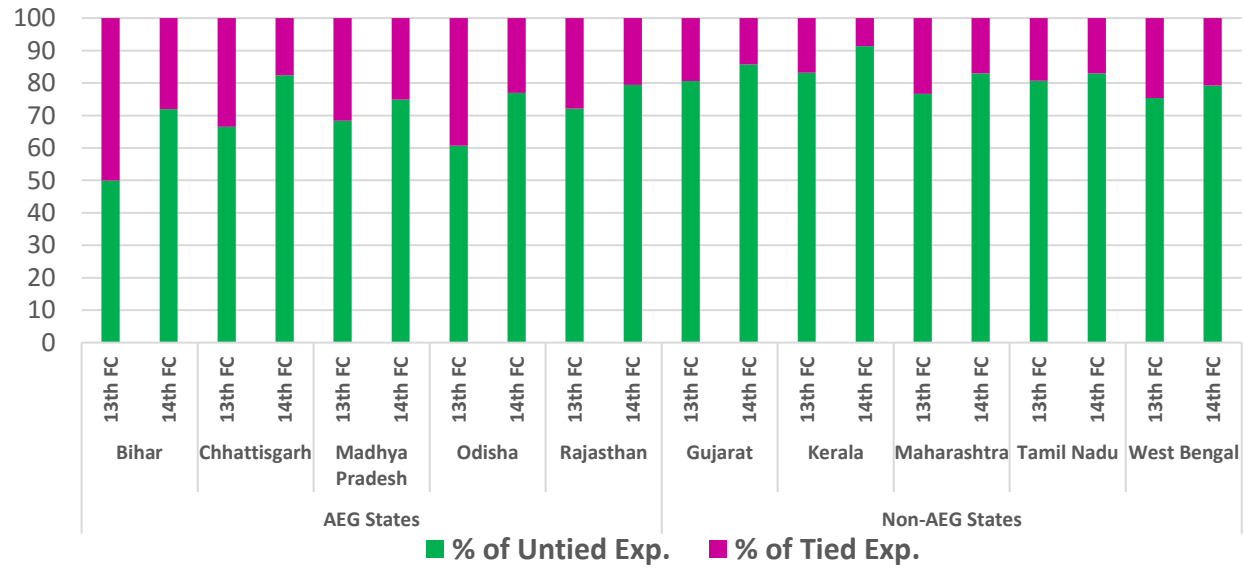
Figure 3.4: Growth of real total, tied and untied fund for health between 13th and 14th FCs



Source: Author's analysis from State Budget Documents in Detailed Demand for Grant

Figure 3.5: Contribution of real tied and untied fund for health between 13th and 14th FCs



Source: Author's analysis from State Budget Documents in Detailed Demand for Grant

While the health expenditure relative to GSDP as well as TE and in real term (offered in Tables 3.1, 3.2 and 3.3) has increased, and there is a very affirmative growth found for untied health expenditure (portrayed in Figure 3.4) during FFC period, the volume of tied health transfer has experienced an obvious contraction from 13th to 14th FCs. To study the impact of real contractionary effect on tied health expenditure, we have analysed its different components such as the real rate of growth on specific schemes such as prevention and control programmes for communicable diseases (CDs) and non-communicable diseases (NCDs) pertaining to the National Disease Control Programmes of NHM (National Health Mission). Worthwhile to note that almost all the erstwhile centrally sponsored schemes directly devoted to CDs and NCDs are now arranged under the core scheme of NHM. Following Table 3.4 offers a comprehensive list of the central tied transfer to health sector.

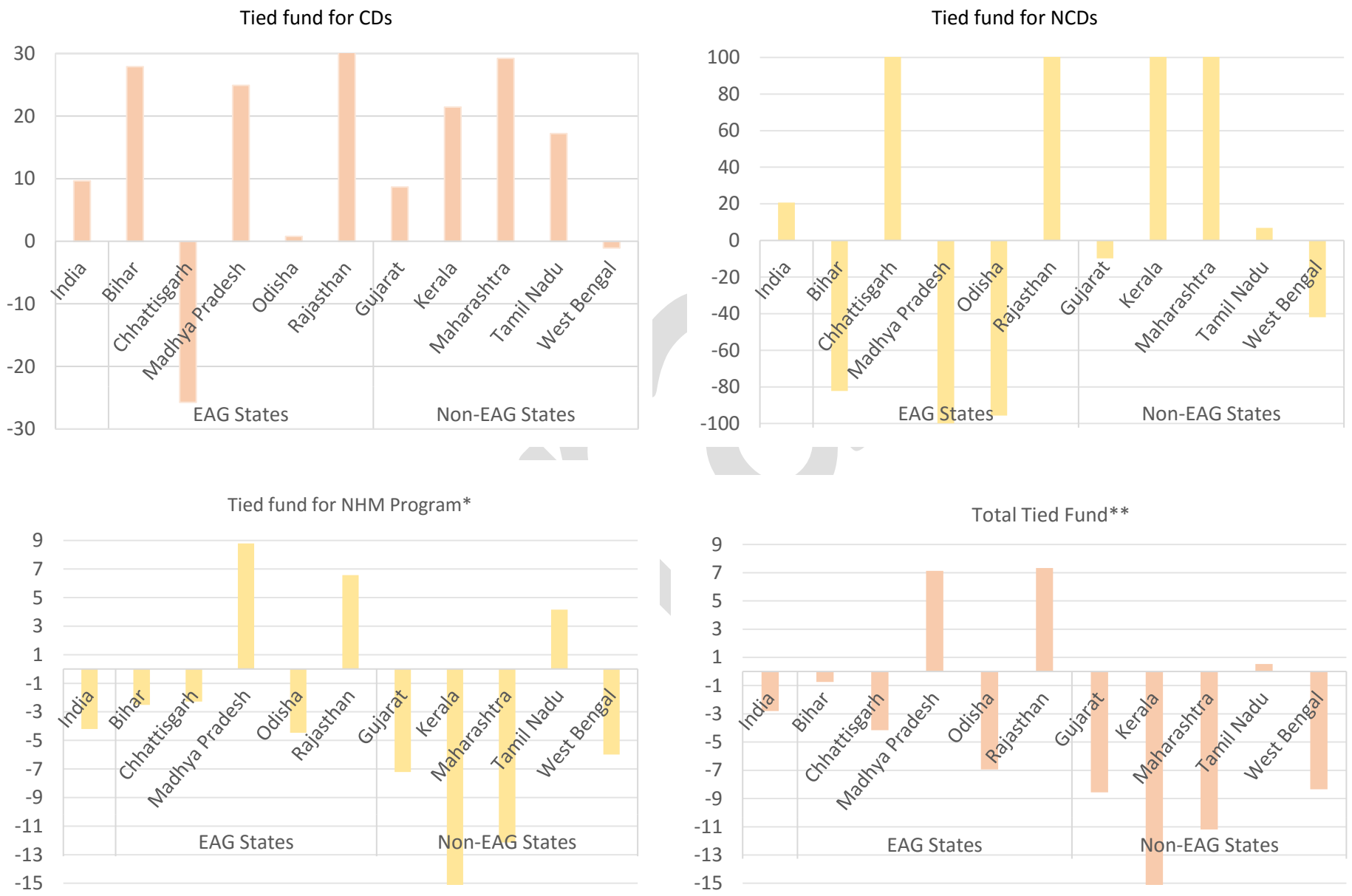
Table 3.4: List of central tied fund to health sector implemented via state agencies

1	NHM	Flexipool for CDs like AIDS, TB, Leprosy, Goitre, Vector Borne, etc.
		Flexipool for NCDs like CVD, Cancer, Trauma, Mental, etc.
		Flexipool for NRHM, NUHM, NAM, RCH, Immunisation, etc.
2	RSBY	National Health Insurance Program
3	FC Grant	Finance Commission incentive and special grants on health

The growth of tied fund in real term including CDs, NCDs and NHM from 13th to 14th FC-periods are individually portrayed in following Figure 3.6.[7] It is found that the growth of expenditure solely devoted to CDs is positive in most of the cases for both EAG and Non-EAG states. A serous negative growth of expenditure for CDs is however observed in Chhattisgarh. In this regard, Odisha under EAG group and West Bengal under Non-EAG group have experienced a marginal increase and decrease respectively. For NCD-expenditure, there is a serious negative growth in Bihar, Madhya Pradesh and Odisha, and affirmatively positive growth in Chhattisgarh and Rajasthan among EAG states. In the Non-EAG states, only Kerala and Maharashtra have been able to spend significantly on non-communicable deceases. Overall growth of the tied fund to NCDs has increased about 20% at all-India level. Finally, the NHM fund as well as central tied resources have followed the same pattern of growth in each of the states. Except for Tamil Nadu in Non-EAG group along with Madhya Pradesh and Rajasthan in EAG group, the growth of real expenditures for NHM and central tied transfer are all negative.

[7] For the convenient of our analysis, tied fund on CDs, NCDs and rest NHM (which is exclusive of CD and NCD components) are considered as total expenditure involving both central and state's matching shares; and total tied fund includes only the transfer of central share. Further, RSBY amount is not included due to non-availability of information.

Figure 3.6: Growth of central tied fund (real) on health between 13th and 14th FCs



Source: Author's analysis from State Budget Documents in Detailed Demand for Grant and NHM-HIMS Data

3.4 Summary

In this chapter, we have comparatively analyzed different components of the expenditure as well as growth in real term for tied and untied health expenditure at subnational level between EAG and Non-EAG states during the era of recent few Finance Commissions. The key findings are as follows:

- Following the recommendations by FFC, federal redistribution has increased all important components of expenditure at state level including health sector spending. Several recent studies have also found that there is a net gain of resources in the form of central transfer to states during FFC period. While those studies typically compared last year of 13th FC with first year of 14th FC, our finding is based on an in-depth analysis covering entire period of the 12th and 13th FC with available two years information during 14th FC period.
- Our detailed analysis of tied versus untied funds available for health sector depicts the fact that the rate of growth in real term for untied fund during 14th FC period is much higher than tied fund, particularly in the EAG states which are also high focus group under NHM.
- We found that the growth of tied fund to health in real term is much lower than the untied one during FFC period irrespective of the category of states as EAG and Non-EAG. In search of the root of such shrinkage in tied component, we observed that there is a negative growth of central tied transfer to health between 13th to 14th FCs in both EAG and Non-EAG states.
- A very comprehensive level of analysis using Demand for Grant of several state-budgets since 2010-11 to till date shows that while the growth of tied fund directly devoted to CDs is affirmative (excepting Chhattisgarh), a serous negative growth of expenditure on NCDs is observed for most of the EAG states and a few Non-EAG states during FFC period.

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