Health policy and federalism in India

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ABSTRACT

This paper addresses the question of how the position of Indian states in terms of their approach to welfare state policies interacts with the centre-state relationships that characterise health policymaking. In India's version of federalism health policymaking has been influenced by four mutually interacting sources: international public health discourses; Indian government programmes and policies; civil society organisations concerned with health; and the political economy of the different states and their associated political regimes. Public health issues sometimes achieve high policy profile at the government of India but very rarely do so at state level. This divergence provides fertile spaces for negotiation and conflict. An analysis of the path-dependency of the allocation of health functions to different national and sub-national levels of government contextualises a case study of the National Rural Health Mission, 2004-2014. This shows the limits to the central government's ability to implement a universalising, rights-based programme across the country. An explanation for the different outcomes can be found in the variety of state systems within the country. Finally, the paper assesses whether the changes introduced since 2014 show a new federal order in the making and provides preliminary insights from state responses to the 2020 Covid-19 outbreak.

Key words: Health policies; federalism; India; Centre-state relationships; human development index; international public health; National Rural Health Mission

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1. Introduction

A common pattern in federal systems is of devolving health services delivery to lower administrative levels (Castles et al. 2005). Reasons often advanced for this include local accountability, participatory governance, improved responsiveness and managerial efficiency (Zaidi et al. 2019). Funding such as for health insurance is often retained at the central level, with the benefit of spreading risk. In relatively old and 'coming-together' federations such as the US, Canada, Australia, constitutions usually only list the powers of the centre and leave residual powers with the state. South Asian countries inherited central governments with over-riding powers. In India, the President (under advice from the Prime Minister) can remove state governments if the centre deems this to be necessary, or if the ruling party at the centre can manoeuvre enough state legislators to abandon a government that is controlled by an opposition political party. Centralised structures were not only inherited from the British but they were also, in some respects, then strengthened.

In the Indian constitution's concurrent list (topics shared between the centre and the states) are the control of drugs and poisons, population policy and family planning, medical and other forms of higher education, and regulation of the medical and para-medical professions. Institutions of national importance and for professional and technical training and research, and relations with the outside world (such as quarantine) are reserved to the centre (Rao & Choudhury 2012: 5). India's picture is further complicated by financial settlements between the centre and the states. Historically, Indian finance commissions, which have reported every four or five years from 1951, have kept the most financially productive areas of taxation for the central government, and have used varying mechanisms to allocate resources to the different states, and to find a balance between allocations for general and for specific purposes.[1]

Understanding how health systems work in federal nations like India requires analysis not only of structures but also of decision spaces, 'the implementation and ongoing

management – the practices on the ground – of any health system' (Marchildon and Bossert 2018: 1). The conflict, negotiation and innovation in everyday practices of India's federal system have involved disputes between states and the central government over efforts by the centre to pressure states to implement centrally-sponsored and -funded schemes (Chaturvedi 2011). In India's version of neoliberalisation, the central government understood the weakness of public health services in most of the country as a failure of state provision. It has chosen to introduce elements of the private provision of medical services into what was originally envisioned as a version of the British National Health Service; used the state increasingly to monitor private provision rather than being the main supplier of health care services itself; and reduced the redistributive elements in health and health-related policies (Schrecker 2016: 952; Qadeer and Baru 2016). The central government has also attempted to by-pass state governments in some fields by making direct grants to local bodies.

This paper discusses the role of path-dependency in how centre-state relationships in health have developed in India since the British period, and then uses a variety of sources to assess the changing mechanisms which structure the decision spaces between the two levels. Drawing from public policy analyses of multi-level governance, and a recent classification of inter-state differences in social policy that analyses the roles played at sub-national levels (state, district, municipality and civil society organisations active at these levels) in moulding these differences. A case study of the National Rural Health Mission (NRHM, 2005-14) offers some insights into how inter-state differences – for example, in organizational capacities and accountability mechanisms – shape negotiated outcomes in terms of policies implemented (Roman, Cleary, and McIntyre 2017: 365). The paper concludes with some observations on changes in centre-state relationships in health since 2014.

2. Theoretical framework

Tillin et al. (2015) (see Table 1) provide a framework for the analysis of inter-state differences. In the context of evolving state political economies, their analysis considers the nature of political leadership, the capacity and autonomy of the bureaucracy, the strength of civil society organisations (CSO) and other organised interest groups, and their relationship with the state. It also takes account of the design of different social welfare programmes in its efforts to understand outcomes (Tillin, Deshpande, and Kailash 2015: 17). This is part of a more general effort by Tillin and others to bring domestic politics back into discussions of social welfare policymaking, in contrast to overly economistic accounts (Tillin and Duckett 2017). Tillin (this special issue) has recently proposed a revised framework which attempts to bring further variables into classifying states using cluster analysis.

Health has played only a small part in Tillin's classificatory schema, and the health sector has not been the focus of sustained attention in applying it. Nonetheless, the classifications that emerge share family characteristics with other classifications in which demographic and health indicators play a larger role, such as the NW/SE demographic divisions (Dyson and Moore 1983), and the BIMARU states (Bihar, Madhya Pradesh [MP], Rajasthan and Uttar Pradesh [UP]) identified by Ashish Bose (Bose 2007). These insights are mirrored in the Government of India's allocation of additional funding to eight so-called Empowered Action Group (EAG) states, eight states in India's north-east, and the mountainous north-western states of Himachal Pradesh and Jammu and Kashmir (Sharma 2015).[2]

<<Table 1 about here >>

In understanding how and why states differ in their approach to health policy planning and implementation, Tillin et al. downplay the role of ideological commitments (such as those of the Communist Parties that have led the states of Kerala and West Bengal for different periods). They assert,

> ‘the link between politics and policy processes across India cannot be reduced either simply to clientelism or to expansionary fiscal distortions linked to the election cycle. … Rather, … different regional political settlements and leadership play a central role in determining the shape that policies take in different places (Tillin et al. 2015: 9).

This is linked to ‘the capacity and autonomy of the bureaucracy’ (Tillin et al. 2015: 17, 24-26). For Tillin et al., some states have followed a consistent path towards a welfare state on the basis of social democracy, in some cases since the 1940s (Kerala, and for a while, West Bengal). Others (like Andhra Pradesh [AP] and Tamil Nadu) have moved in this direction as part of competitive populism, in states where elections often lead to exchanges of power between two competing parties or alliances. In all four states, CSOs make significant contributions to policymaking. Odisha and Chhattisgarh (since 2000) are ‘incorporationist,’ in that a more top-down set of policies has achieved some measure of welfare state there. In the second set of states, welfarist policies have emerged only occasionally. In Gujarat, welfare has been tied to business interests and initiatives; in UP and Bihar, identity politics has left little space for collective agreement to address common social welfare challenges (Singh, 2015). Tillin et al. (2015) describe Jharkhand (and other states, at some periods) as ‘predatory’, in which resources are skimmed off for the use of a small political and business elite. Although Gujarat has a strong history of CSOs, and some notable pilot projects in health and education, the other states in this second group have weak CSOs. Applying this framework generated a six-fold table (see Table 1).

The next section sets out the path-dependencies behind India’s constitutional settlement of 1950 and discusses the tensions and conflicts that characterise the ‘practices on the ground’ of centre-state relationships in health policy. After sketching briefly how centre-state issues were created and debated up to 2004, I then discuss how the centre used the Planning Commission and the stream of external assistance it controlled to influence state health

activities both directly and indirectly in this period. These mechanisms had already weakened by 2004, when a Congress-led coalition came to power. Examples of this weakening power include the centre's inability to introduce a National Drugs Authority, and the rising complaints against Centrally Sponsored Schemes (CSS). The National Rural Health Mission (NRHM) (2004-2014) is then analysed as a case study of, in part, an attempt to by-pass state governments and to devolve powers and funds to Panchayati Raj (local government in rural areas), to NGOs or to public-private partnerships. The Tillin et al. (2015) typology of Indian states is then assessed in terms of its utility in understanding variations in state responses. The paper concludes by arguing that the changes introduced by the BJP-led governments of 2014 and 2019, the shrinking role of public health provisions in large parts of India, and the increasing role of global pressures that change the options for all levels of government in India herald a new turn in centre-state health policy relationships.

3. India's health sector: from 'double-devolved' to State subject, 1858-1990

In India's health system, patterns of relationships between institutional levels – centre, state, and local governments, and non-governmental organisations – show both path-dependency and the impact of critical junctures.[3] Public policy with respect to health under the British dates from 1858. Reforms in the later 19th century, such as the increasing involvement of Indians at the higher levels of the government, left the basic structure unchanged. The establishment of local self-government after 1882 had a significant impact only in the 20th century. Innovations in health policy were always limited by the main demands on the state – the maintenance of law and order, protection of the external boundaries, and financial rectitude – and by the racial assumptions that underpinned some aspects of the direction and management of public expenditure.

In 1919, several spheres of government were transferred to provincial ministers, responsible to elected assemblies. Defence, police, international relations were retained either by the Central Government or by official members of the Centre or Provincial executive councils, or both. This division of powers between the centre and the provinces was left virtually unchanged by the reforms of 1935 and is the basis of India's independent constitution of 1950.[1] With respect to health, this pattern reflected those in early federations such as Canada, US, Australia, or Switzerland, before the expansion of health care and social welfare more generally that took place after 1945. The recent efforts of anthropologists and historians to delve deeper into the everyday processes of the operation of the post-colonial state in South Asia offer some clues about the impact of the transfer of power from the British. The general conclusion is that the transfer was of a 'step-in-your-shoes' kind (Maddison 1971: 71-73; see also Gould 2017; Gould, Sherman, and Ansari 2013), that nonetheless often undermined due process in apparently unchanged bureaucratic structures. Research in Pakistan shows how the discontinuities in bureaucratic processes from the British period have allowed the ideal of a rational and disinterested bureaucratic decision-making process to be turned on its head, creating an economy of the circulation of official paper that blurs the distinction between private and public interests (Hull 2012). Partha Chatterjee (2004) conceptualised India's political processes between those in civil society, largely the urban middle classes, and political society, communities who are objects of biopolitical governance and inscribed and categorized as such. Those in political society are the people who remain marginalised and excluded from the presumed benefits of programmes initiated by state and civil society institutions (see further below).

[1] This pattern was also followed in Pakistan until 2010, when all health responsibilities were devolved to the provinces and federal health ministries were dissolved (Zaidi et al. 2019).

Post 1945, both the outgoing British and the incoming Congress-led governments envisaged conscious planning for health services. Yet the Indian Medical Service (IMS), whose officers took senior positions in central and provincial health services under the British, was abolished in 1948. This has two significant consequences: the central government no longer has its own personnel working in the state ministries, and able to influence health policy implementation at that level; and the states no longer have people working in the central government who have first-hand experience of the issues that concern them. It also means that when national policies are being discussed, the states are rarely sitting at the table; this is the case for the National Rural Health Mission (NRHM), the case study I discuss in sections 5 and 6 of this paper. By contrast, the equivalent Indian Civil Service was retained, merely changing its name to the Indian Administrative Service (IAS). Thereafter, in health policy implementation, the central government relied on persuasion at meetings of the Central Council of Health (CCH), established in 1950, on the financial incentives offered through the Five-Year Plans, and on informal influence to implement public health reforms in the states.

Ministers, generalist civil servants from the health ministry, and technical advisers from their health directorates attended meetings of the CCH, supplemented by a changing body of observers, including, during the 1950s and early 1960s, some from the US government and the Ford and Rockefeller Foundations. A Central Council of Family Planning (and later, Family Welfare) was brought into a Central Council of Health and Family Welfare from 1988. The motions passed by the CCH were only advisory. This exposed the centre's weak position, which led some critics to call for a new all-India cadre of medical administrators.

The central government mostly relied on IAS officers and the Planning Commission in its efforts to influence the implementation of health policy in the states. The Planning Commission offered financial inducements, either from central government or from international aid resources. These became the main basis for new developmental expenditures

in health and population programmes as well as for maintaining support for preventive campaigns (against smallpox, malaria etc.), family planning and some water supply and sanitation programmes. Elsewhere in the health budget, Plan allocations paid only for new developments. Recurrent costs became part of the non-Plan, state-funded budget after the relevant Plan period. The pattern of proposed expenditures by these categories changed from Plan to Plan. In 'health' the role of the centre generally, if erratically, increased from the Third Plan (1960-65) to the Fifth Plan (1979-84), but (for example) the introduction of multi-purpose and community health workers in 1977 short-circuited the five-year planning process.

The five-year and annual plans often stressed rural preventive and public health programmes (Jeffery 1986a). This strategy, drawing its key ideas from both Britain's National Health Service and Russian models involving state-employed personnel at primary health centres serving designated populations, fit with Nehru's desire to use India's planning processes to push the country towards socialist objectives.[4] But expanding the numbers of paramedical or nonmedical health personnel received less emphasis in practice than did the creation of new medical colleges for doctors, which met more clearly the political interests of state-level politicians (Jeffery 2019). The roles of the Planning Commission, the CCH and international assistance reflected a deep-seated belief amongst health planners that the state governments could not be trusted with issues of public health and a fear that expenditure decentralization might 'lead subnational governments to deprioritise social policy spending in favour of other priorities' (Mejia Acosta and Tillin 2019: 120). In health policy, spending was often diverted to areas deemed less important by the central government. Barring rare exceptions, and in only a few states, populist health ministers preferred rent-seeking and expenditures on iconic large-scale hospitals and medical colleges and large construction contracts to the mundane tasks of clean water, sanitation, community-level health workers and immunization campaigns that would build solid public health systems (Ganguly and Thompson 2017).

4. Health and Federalism under the Pluralisation of the Party System, 1991-2004

In the 1980s, the Central Government provided about 20% of State health expenditures, heavily weighted towards contraceptive services and reproductive and child health, programmes for the control of specific diseases, and public health. By the mid-1990s, the poorer States were failing to match or replace Central funds, and their expenditures on public health were only about 75% of those reached in 1989-90 (Purohit 2001: 97). Central Government spending on public health barely changed in real terms between 1989-90 and 2005-06, despite the rapid increase in spending on the National Aids Control Organization: spending in other areas drifted down (Economic Research Foundation 2006: 15). Relative to other similarly resource-constrained countries, India's share of public expenditures in the health sector is low. In 2001, households accounted for about 70 percent of health spending, states contributed about 14 percent, the central government about 8 percent, with local governments adding only about 2 percent (Economic Research Foundation 2006: 7-8).

Nonetheless, between 1990 and 2008 health indicators improved, suggesting that declining morbidity and mortality had little to do with health service provisions. For example, the maternal mortality ratio in India approximately halved in this period: most of the decline occurred between 1990 and 2000 (Hogan et al. 2010: 6). Yet indicators of skilled birth attendance – often regarded as a key contributor to improved maternal health – rose only from 36 percent in 1992-93 to 50 percent in 2005-06. Inter-state variations remained high: in UP, skilled birth attendance rose from 18 to 29 percent, whereas in Tamil Nadu they rose from 73 to 93 percent. Throughout the country, poor women, especially in the 'backward' states, had worse maternity experiences: even by 2005-06, only 14 percent of poor women in UP had a skilled birth attendant, compared to 83 percent of poor women giving birth in Tamil Nadu (Pathak, Singh, and Subramanian 2010: Table 3). 'Until 2005, reducing maternal mortality was

not a political priority in the country' (Shiffman and Ved 2007: 785) but that was true of almost all India's poor health indicators.

There was a policy vacuum, at the centre and especially in the states, in this period:

> 'many states do not have a clear health policy. The strategies of the states are mostly guided by the National Health Policy and national health programs. There is no systematic effort at the state level to plan, and monitor the delivery of health services (which) continue to be supply pushed (rather) than demand driven' (Ramani and Mavalankar 2006: 4).

Furthermore, the states used their veto powers when possible. A major example was the attempt by the government of India to introduce a National Drugs Authority (NDA). The Drug Controller General of India (DCGI) has limited influence over state drugs controllers. While the central government is responsible for the safety, efficacy, and quality standards for pharmaceuticals and medical devices, state governments are responsible for licensing, approvals, inspection and recalls of drugs manufactured within their domain. Efforts to establish an NDA to centralize procedures and ensure national uniformity in the regulatory processes started in the 1970s and became more urgent after India joined the World Trade Organisation in 1995 (Mashelkar 2003). These failed, as a result of resistance from states; drug manufacturers can still apply for production and marketing approval in any state that is willing to do so: once approval is granted in one state, the permission applies across the country. The balance between state and centre in pharmaceuticals regulation has been steadily redrawn in the interests of external oversight in order to protect Indian exports.

World Bank-financed reform programmes were implemented prior to 2004, including improvements in drug procurement in Tamil Nadu, community participation in hospital management in MP, and a telemedicine project in AP (Ramani and Mavalankar 2006: 9-10). Because India was not a major participant in the earliest World Bank-financed health

programmes it did not suffer from the mistakes (such as a rush to user charges) made in these early efforts. But India's resistance to external pressures did not reflect strong indigenous efforts to deal with recurrent problems, either by the Planning Commission or by states themselves. Exceptions were innovations in some southern states, such as Tamil Nadu, with its mid-day school meals programme and its Medical Services Corporation.

5. Health Policymaking 2004-14: How to spend the new resources

The election of the Congress-led United Progressive Alliance (UPA) coalition government in 2004 made a significant change to the profile of health policy. Although never as high profile as other innovations, health became a social policy priority. Coalition partners, especially the Left Front, the Samajwadi Party and the Bahujan Samaj Party, agreed a common minimum programme that promised, *inter alia*, a rise in the public sector spending on health to 'at least 2-3 percent of the GDP' by 2009, focusing on primary health care, health insurance and making life-saving drugs available at reasonable prices. This was to be implemented through a National Rural Health Mission (NRHM). This would, however, need contributions from state finances, which were in a bad shape (Mohanty 2007: 25). The central government faced the challenge of 'designing the most effective and efficient way to expand universal social rights while reducing territorial inequalities' (Mejia Acosta and Tillin 2019: 115).

Increasingly well-organised civil society organisations and academic actors, including Nobel Laureate Professor Amartya Sen, Jean Drèze, and Aruna Roy, gave strong support to the NRHM. The latter two served briefly on a National Advisory Committee which successfully lobbied for several innovative social welfare programmes. The UPA used the 2002 National Health Policy framework, that addressed issues of health equity and considered the role of social determinants of health. From 2004-2009 the UPA tried to integrate existing health programmes into the NRHM and to implement principles of equity, decentralisation, and

empowerment of local institutions, and to strengthen the primary health system (Das and Cottler 2017: 155). The UPA also received external advice, particularly in the shape of the prominent economist Professor Jeffrey Sachs, of Columbia University (Bajpai and Sachs 2004).

The NRHM resulted from powerful ideas and advocacy coalitions. Actors from across a range of institutions (the Planning Commission, NGOs, health providers, academic public health experts and international donor agencies) successfully pushed for a more interventionist central role in health (Mukherji 2013). The policy shift can be characterised as a return to efforts to make the public sector dominant in public health provision, but to do so in new ways. It occurred when three independent streams – problems, policies and politics – came together (Kingdon 2013). 'Conditions,' like poor health indicators, became 'problems'; sets of possible solutions were available; and elections, along with international attention, prompted UPA politicians to focus more on health issues. Contributory factors to health 'conditions' becoming 'problems' were that the left-parties supported Congress in exchange for more social welfare policies. Maternal mortality came to prominence in these ways in 2005 (Shiffman and Ved 2007); another example is the introduction of public-private partnerships in health insurance (Shroff, Roberts, and Reich 2015). Sonia Gandhi, the President of the coalition's leading party, the Indian National Congress, acted as a policy entrepreneur; Prime Minister Man Mohan Singh selected health insurance from several policy proposals by a national commission; and others co-ordinated a task force that included Indian and international technocrats. 'In other words, health reform leadership needs political skill and judgment, in addition to political will and commitment' (Shroff et al. 2015: 114). Significantly, it is hard to detect any significant contribution by state governments to this process.

Key to implementation of the NRHM was a massive increase in the availability of public sector resources. Throughout the Tenth Five Year Plan period (2002-3 to 2006-7), but especially after 2005-06, central government revenues rose by 15% or more per year, faster

than the economy, because growth was disproportionately located in sectors easier to tax. This growth continued through the global economic downturn after 2008-9. The turnaround from the situation in 2002 was remarkable. From 2006-07 to 2011-12 the combined medical and health expenditures of the states and the central governments more than doubled. The long-term objective of the Twelfth Plan (2013-14 to 2017-18) was to establish 'a system of universal health coverage' (Planning Commission 2013: 287), which would have seemed utopian 10 years previously.

6. Case study: Differential impacts of NRHM on the states, 2005-2014

These changes in the national health policy context appeared to be transformative. But the state governments, who remained much more significant as funders of health programmes than was the central government, and who, in constitutional terms, had prior claims to policy-making, rarely provided key inputs when these policy changes were being debated. Health policy makers are overwhelmingly located in New Delhi, whether in academic, civil society organisations (CSOs) or government circles. States could have provided input to national health policy statements, such as examples of innovative schemes that could be scaled up to the national level, and, in this way, play a role. This avenue has, however, been restricted to a few fields, such as drug procurement, health insurance or maternal and child health services. At the state level, the confluence of problems, policies and politics rarely happens. The print media rarely take up health issues (Drèze and Sen 2013) and when they do, they focus on scandals rather than the state of the public health more generally. Public health issues have had very low salience by comparison with the attention paid to public sector provisions of education. The Covid pandemic has changed the situation somewhat. But in general, there is very little evidence of public health being a high priority for the mass media. In addition to discussions of personal health advice and reporting of high death rates from specific diseases, medical care

issues are covered: these usually focus on corruption or the alleged failings of individual doctors and the use made by political leaders to capitalise on the feelings of bereaved relatives. Thus, despite the evidence that health outcomes in UP, Bihar, Rajasthan and MP are much worse than in Tamil Nadu, Kerala, Karnataka and Maharashtra, state policymakers in the first set of states have never picked this as a 'problem' that needed to be addressed urgently, nor have health policy entrepreneurs emerged in these states. In order to establish this argument, this section uses the Tillin et al. (2015) framework to select a sample of states and then analyses how they differed in their responses when these large conditional cash flows became available.

The NRHM was the last effort of the Planning Commission-based system through which the central government attempted to manage public health initiatives in India (Swenden and Saxena 2017). By 2012-13 the NRHM was spending Rs 184 billion a year – drawing massively from a central government health budget that was some four times as large (in simple monetary terms) as it had been 10 years previously. But when adjusted to take account of inflation and population growth, central public health expenditures in 2014-15 were only about 30% higher than those of 2004-05.[5]

The NRHM followed the emphases of the National Health Policy of 2002 on decentralisation, links to NGOs and the private sector, and a search for alternate sources of finances and insurance schemes (Dhingra and Dutta 2011: 1521). Prasanna Hota, secretary of the federal Ministry of Health and Family Welfare at the time, summarised the purpose of the NRHM as follows:

> to increase the outlays for health from 0.9% to 2-3% of GDP over the next five years and to undertake systemic correction of the health system to effectively utilize such increased outlays for sustainable outcomes. The Plan of Action of the Mission aims at reducing regional imbalances in health outcomes by relating health to determinants of good health viz. sanitation, nutrition and safe drinking water; pooling resources; integration of

organizational structures; optimization of health manpower, including Ayurveda, Unani, Siddha and Homeopathy (AYUSH); decentralization and district management of health program akin to Sarva Shiksha Abhiyan;[6] community participation and ownership of assets; induction of management and finance personnel into the district health system, and operationalizing effective referral hospital care at CHC level (Hota 2006: 193).

In the interest of reducing 'regional imbalances,' while the increased central government plan outlay was available to the whole country, it was specifically designed to benefit 'focus' states, the eight EAG states of the central north Indian belt along with ten more from the northeast and from the mountainous northwest of the country.

The means employed to achieve these goals, especially the forms of decentralisation and an increase in community participation, were new. The NRHM aimed to integrate vertical disease-specific programmes at the national, state, district and block levels. Rather like other social sector initiatives introduced by the UPA, the NRHM tried to promote a devolved public health delivery system, along with bottom-up structural change with enhanced governance and accountability (Gill 2009: 11-12). A new cadre of female health activists (ASHAs) was linked to Panchayati Raj institutions, through village health and sanitation committees (VHSCs). Other foci were pulse polio immunization, infrastructure maintenance, and a national disease control programme.

Several financial innovations (Berman and Ahuja 2008) were aimed at supporting these objectives. 'Flexible pools' for expenditures on reproductive health as well as the full range of NRHM expenditures, and decentralized decision-making was introduced for state governments and state and district societies to allocate resources themselves, amongst an approved list of options, for example. Funds were channelled through state- and district-level 'societies' – formally independent of the state governments (so they could be funded directly from the centre) but non-profit. District Health Societies, for example, were designed to support the

District Health Mission (bringing together different layers of administration within a district): 'it is a facilitating mechanism for the district health administration as also the mechanism for joint planning by NHM related sectors.'[7] To ensure that funds for the District Health Mission would be transferred to the implementing agencies without delay, transfers were to be made directly to State Health and Welfare Societies, bypassing state budgets (Rao and Choudhury 2012: 16).[8]

The flexible pool funds were allocated according to population, with focus states receiving 30 percent higher allocations. The central government's allocation for NRHM was to be increased by 30 percent annually for the first two years and thereafter by 40 percent, and the states were required to contribute an additional minimum of 15 percent of the central government's allocations or an increase of 10 percent in their health budgets every year in 2007-2012 (Rao and Choudhury 2012: 21). Between 2005-06 and 2008-09 evidence on health spending suggests, however, that inter-state inequalities increased rather than reduced, so that the difference between the per capita public spending in the top three states (Kerala, Tamil Nadu, and Punjab) and the bottom three states (Bihar, Madhya Pradesh, and Orissa) increased, leading to a further divergence between the two categories of states (Rao and Choudhury 2012: 13).

Per capita health spending was closely correlated with state income levels, which also increased from 2000-15, with the wealthier states growing their health expenditures faster. In part, this was due to the poorer states substituting central government funds for their own, especially up to 2007-08, at the beginning of the NRHM. Efforts to increase the fiscal responsibility of the states created perverse incentives for states to reduce spending in health, as in other social sectors (Rao and Choudhury 2012). Given these disparities, it is not surprising that state inequality-adjusted health development indicators for the 2010s continue to suggest 'staggering inequalities' (Suryanarayana, Agrawal, and Prabhu 2016). The NRHM was even

unable to ensure that its funds differentially benefited the poorer states (Swenden and Saxena 2017: 50), let alone to direct resources to the poorer districts within states. By the end of the UPA government in 2013-14, states were very varied in their willingness to spend their own resources on developmental activities, rather than on salaries and other fixed costs. In this case, the states with preferential treatment under the NRHM were, surprisingly enough, more likely to do so than the wealthier states (Aiyar and Kapur 2019: 193). The weakness of the relationship suggests, however, that the targeting of funds was not very effective.

The sources of advice that were sought by NRHM policymakers makes clear the international dimensions of the 2004-05 policy shift. Although for many years the Government of India has accepted very little health funding from international sources, the World Bank and other donors who worked on similar lines were the major exceptions (Jeffery 1986b; Jeffery 2020). This funding was seen as a source of additional resources to encourage structural changes. Compared to the overall public expenditures on health, foreign funding has fallen further to a very low level; nonetheless, foreign advisers played important roles in developing the core ideas of the NRHM (Jeffery 2020). The proposals were in line with World Bank prescriptions, and a group of US-based public health experts was called in during 2004-05 to help shape the NRHM. Professor Jeffrey Sachs, of the Earth Institute at Columbia University, chaired an international advisory panel that met at least annually from 2005-2013. Other members of the panel included Sonia Ehrlich Sachs, of the Centre for Sustainable Development, part of the Earth Institute, and representatives of the Bill and Melinda Gates Foundation. The minutes of the second meeting of this group show that the Panel pressed regularly for a role for the private sector, though Sachs himself argued that 'other health policy issues like Health Insurance and Public Private Partnership' were important, 'but maintained that for (the) poor, there was no substitute to a well-functioning public system'.[9]

What is notably absent from this account is a clear role for state governments, except as co-funders. The minutes of the first meeting of the International Advisory Panel suggest that disdain for State politics was felt by the Minister: 'there is a management challenge and reflecting it into States (where [the] view is narrow and segmented)'. The Panel expressed a desire to find out how to 'institutionalize a 10-year perspective, insulated from politics at State and Union level sufficient to ensure vision reaches the end point'. The Minister saw a need to have the 'District as a unit not a State'. Given the poor record of some states in implementing health programmes that might contribute to improving health equity, such views are understandable. What this meant, however, is that far from decentralizing public health sector expenditures, as many analysts predicted or saw overall, 'India became far more centralized in its financing for social policy even as politics and the economy became more decentralized' (Aiyar and Kapur 2019: 191).

A 2012 review describes some of the problems faced by NRHM in its implementation. The additional weight of 30 percent for the 'focus' states was insufficient; there was no mechanism to ensure that the states made matching and additional contributions; and the large allocations in central funding did not turn into actual expenditures:

> In 2009-2010, for example, the funding allocated for the program was Rs 115.9 billion, but the actual expenditure was just Rs 46.6 billion or 40 percent of that amount (Rao & Choudhury, 2012: 17).

As a result, the actual pattern of expenditure differed from the planned allocations. Unspent sums were reallocated to those states that could reassure the Planning Commission that they would spend the money appropriately:

> Secondly, the involvement of the states in the reform program was much less than desired. As the funds were directly transferred to the implementing societies [i.e. the State and District Health Societies mentioned above], the states gave up their own

supervisory and management role as well (Rao & Choudhury, 2012: 17; see also Aiyar and Kapur, 2019: 193).

Narwal describes the transfer of flexi-pool funds directly to the State and District Health Societies (SHSs/DHSs) as a 'rather novel development':

> (It) not only reduced unnecessary red tape and transaction costs but also put more control in the hands of health officials/ functionaries and enabled them to undertake necessary institutional strengthening down to a village-level health facility' [despite the fact that, from the 11th Plan, the NRHM was] 'a shared cost programme with central and state governments respectively contributing 85 and 15 percent (Narwal 2015: 126).

This generalisation needs to be unpacked, however. To begin with, as Rao and Choudhury note, it remains unclear just how much money went into these district health societies, compared to the funds that continued to flow through the state ministries. Further, what such money might have been spent on is hard to ascertain. In the case of UP, for example, there is strong evidence that perhaps half the money supposedly spent under the NRHM between 2007 and 2012 was misappropriated (Tiwari 2015). Secondly, inter-state variations in how the programmes were implemented were considerable. Here I focus on one of the NRHM's flagship policies – the Janani Suraksha Yojana (JSY, or Safe Motherhood Scheme). I apply the model of approaches to welfare state policies in India developed by Tillin et al. (2015). As a test of their approach I ask how these characteristics affect the kinds of centre-state relationships that emerged through the NRHM period, selecting one state from each cell for comparison. Data in Table 2 give some idea of the wide diversity in public health sector provisions and indicators since 2000.

<<Table 2 about here >>

Bihar, UP, Uttarakhand, MP, Orissa, Rajasthan, Jharkhand, Chhattisgarh, and Assam account for 62% of India's maternal deaths, and 12% of the world's maternal deaths, with

maternal mortality ratios (MMRs) above 300 maternal deaths per 100,000 births per year. Kerala, Tamil Nadu, and Maharashtra, with MMRs around 100 per year, achieved the target set by Millennium Development Goal 5 (MDG 5) by 2011. Gujarat and AP were in the middle, with MMRs of 160 and 154 in 2004-06 (Randive, Diwan, and De Costa 2013). In terms of maternal and child health, then, these indicators produce a picture that approximates to the different welfare regimes set out in Table 1. The main outlier is AP, and this is in line with more recent analyses that suggest that the AP government was friendlier to the private sector in introducing its health insurance scheme than were Kerala or Tamil Nadu (Deshpande, Kailash, and Tillin 2017: 96-97). In terms of changes over time, as predicted, Kerala and Odisha saw steady growth in Human Development Index outcomes between 2005 and about 2011, whereas Gujarat and UP were nearly stagnant. The outliers here are AP again – also stagnant – and Jharkhand, which experienced a considerable change, albeit from a very low starting point. Some help towards understanding these outcomes can be derived from data on financial transfers from the centre to the states.

<<Table 3 about here>>

In terms of the effects of the NRHM's financial transfers, an expert working group concluded that:

> Analysis reveals that the additional central transfers had not sufficiently responded to state needs, and the program's one-size-fits-all approach in focus states failed to account for socioeconomic differences among them. NRHM spending instead was closely linked to a state's ability to request and spend NRHM funds rather than to a state's intrinsic need for health services. The program aimed to allow states to propose their own action plans based on their specific needs, but in practice states had to adhere to budget line items prescribed by the central government. The cash transfer program—Janani Suraksha Yojana—appears to have increased the number of institutional deliveries in India, but it

is unclear whether payments actually reach women and whether its focus on deliveries has diverted attention from other reproductive health services. Further, there is limited evidence of its impact on outcomes. In general, there is disagreement about, and limited evidence to show, that NRHM has improved health outcomes (Mukherjee and Fan 2014: x).

The working group suggest that 'most high-priority states have managed to spend infrastructure funds but have been unable to use the other components effectively' and that whereas UP and Gujarat managed to spend about 80 percent of their overall allocations in 2012-14, Jharkhand could manage only about 60 percent, and Odisha, 75 percent (Mukherjee and Fan 2014: 9, 11). When the states' own contributions are added in, the differences in funding available per head of population or per birth are enormous, with Kerala spending almost twice per capita on NRHM than any of the other sampled states (see Table 4).

<<Table 4 about here>>

In other words, the central government's efforts to increase health funding and reduce regional inequalities through the NHRM faltered because of the very bureaucratic details and other underlying structural issues that the programme aimed to rectify.

In effect, the NRHM – like other attempts at reform – came up against the very different understandings and practices of state apparatuses in different parts of India. These are largely captured by the positions held by states within the welfare type analysis of Tillin et al (2017). Unfortunately, there is insufficient ethnographic or other evidence from across India to allow a comparative analysis of how the different state governments operate on a daily basis. Following from the work of Hansen et al (Hansen et al. 2001), Akhil Gupta's study of the development efforts of the government of UP (Gupta 2012: 278) concludes that 'the poor [will] continue to be "targets" of programs intended to shore up the legitimacy of ruling regimes but … make little difference to whether they live or die.' While this helps to explain why, in UP, state

politicians and medical bureaucrats were able to divert substantial resources despite the attempts to 'neutralise' the state bureaucracy:

> Much of the 10 000 crore rupees (£1.3bn; €1,5bn; $2bn) allotted to Uttar Pradesh under the initiative was siphoned away by the current and previous state government and did not reach or benefit the people for whom it was intended (Chatterjee 2012).

While much the same may have happened elsewhere in north India without attracting the same attention, it is clear that this was not true for states in south and west India.

One reason for these differences might be found in terms of the capacity of the state administrations to implement the programmes. There are, however, very few accounts that compare bureaucratic capacity across states in useful ways. Anthropologists of the state in India have provided insights into how lower-level or front-line bureaucrats operate (e.g., Gupta 2012) as have political scientists. Kerala has had a relatively high number of bureaucrats per head of the population and they have been relatively able to resist the most extreme of patronage politics, by comparison with UP, where patronage and identity politics has taken precedence over efficiency or competence in appointments (Kenny 2011: 18, 45; see also Singh 2015). A comparison between Gujarat and Tamil Nadu shows similar contrasts:

> Whereas the Tamil Nadu government has put considerable effort into improving the efficiency and effectiveness of its public administration, there has been a higher degree of politically-motivated transferring of officials in Gujarat. Officials also claimed that Tamil Nadu has a relatively disciplined cadre of upper-level civil servants because it acquires the cream of the crop from the IAS (Joshi and McGrath 2015: 476).

These differences may be related to the degree and nature of subnationalism each state displays. Where subnationalism takes the form of stressing a collective 'us' of the state, versus a 'them' of the national polity, collectivist decision-making is enhanced; where there is no (as in UP) or weak (as in Bihar) subnationalism, collectivist policies are undermined by an identity politics

that is wary of policies that might benefit minorities within the state (Singh 2015: 158-72; 183-5; on UP see also Jeffery, Jeffrey, and Lerche 2013).

Overall, given these deep-rooted differences in state capacity, it is not surprising that the NRHM failed to mitigate the inter-state disparities they were designed to reduce, or to raise health equity issues within states where they had been neglected, despite its high costs (Husain 2011). So far, path dependency has ruled: state-level ideologies, resources, infrastructures and political systems have proved resistant both to incentives and to the shaming effect of drawing attention to poor health outcomes. This suggests that, within India's continuing struggles over the division of power between centre and states, efforts to induce the states to follow a welfare-oriented route only succeed where the state is already welfare-oriented. The 14th Finance Commission shifted more resources directly to the states, reducing the ability of central government to influence state expenditure (Mukherjee and Fan 2014: 6) but more recent analyses suggest that the terms of reference for the 15th Finance Commission may represent efforts to reverse this shift (Swenden and Sharma Forthcoming).

> In this political economy the core goal of centralization – to ensure equity – is undermined while the expectation of decentralization – greater accountability through alignment of expenditure with local needs and preferences, fails to take root (Aiyar and Kapur 2019: 209).

Conclusion

In India, centre-state relationships in health are of diminishing importance for three main reasons: the shrinking role of discretional central funding public for health policy; the growing commercialisation of health services in large parts of India; and the increasing role of external opportunities and pressures that change the options for all levels of government in the country. Some of these predate the demise of the Planning Commission and its replacement by the NITI

Aayog, with a much-reduced role. 'The centre-to-state one-way flow of policy, that was the hallmark of the Planning Commission era, is now sought to be replaced by a co-operative federalism' (Swenden and Saxena 2017), or a 'genuine and continuing partnership of states' according to the Prime Minister's office.[10] Such claims are not borne out by recent evidence, that suggests that Prime Minister Modi's vision of federalism can be understood as a form of centralization, in which states can compete for funding based on centrally determined priorities and parameters; not exactly the same as partnership![11]

The NITI Aayog tried a 'nudge' approach to persuading states to acknowledge inequalities as a necessary step in getting lagging states to act, by launching a Health Index:

> a priority for NITI Aayog and Ministry of Health & Family Welfare (MoHFW) is to prompt States towards improvements in outcomes in the coming years. In this context, NITI Aayog and MoHFW are spearheading the Health Index initiative. … A composite index would be calculated and disseminated annually, with a focus on measuring and highlighting annual incremental improvement of States (Niti Aayog 2017: 6-7).

In the Foreword to the second annual report, published with support from the World Bank, Amitabh Kant, CEO of NITI Aayog, claimed that this had been a useful exercise:

> The release of the first round of Health Index had triggered many useful discussions, including how best to measure health performance, how to strengthen the data collection system, how to identify barriers and motivate actions using data, and how to promote positive competition and learning among the States and UTs. I expect similar kind of discussions, wherein States/UTs can easily identify States that have shown marked improvement in performance from Round one (NITI Aayog 2019).

What is missing from this attempt are plausible strategies to strengthen state-level health planning capacity.[12] Comparisons with Latin America suggest that scholars interested in mapping how state capacity or governance quality varies across subnational units must look

closely at 'features of subnational variation' to provide accounts that are 'closer to the stage of policy implementation which in lower and middle-income countries may be as, if not more, important than levels of social expenditure' (Mejia Acosta and Tillin 2019: 128). This may be only one reason why states rarely take a stronger role in national health policymaking. Health problems, policies and politics rarely align at state level. States defend their constitutional prerogatives, and more active states are reluctant to pool responsibility, and all central government are weak in providing shared mechanisms that enable their input. The centre is also dominated by the states of the populous Hindi-belt, laggards in health policy. This creates a kind of perfect storm, in which incentives to act collectively remain hidden and weak, even though states can now access new financial resources directly, for programmes that suit their own political approach.[13]

At the national level, public sector health programmes in India seem unlikely to escape from a low-level, ineffective pattern, whatever might be possible in the more innovative states. The disappointing experience of the NRHM – of an attempt at a massive push in selected states – may have been so depressing that it has been accepted that the previous model is broken and cannot be saved. There may be some embarrassment at the evidence of a growing divide between the EAG states and the rest, and the few mechanisms available to change the situation. But the preconditions for policy changes are not present in these states, and (in most cases) the situation shows little sign of change. In terms of maternal mortality ratios, infant death rates, access to medical institutions, availability of qualified doctors and a host of other health indicators, as well as in their ability to access and use central government funds, southern India is a world apart from the EAG states. This has been demonstrated most clearly in responses to the Covid-19 pandemic, where Kerala has been heralded as the only state that has been able to marshal health resources effectively to control the outbreak.

As has recently been argued, 'subnational political coalitions, policy legacies, and political leadership affect the design and implementation of a newer generation of social welfare policies' (Deshpande, Kailash, and Tillin 2017: 87). At the same time, if the centre had more influence in health policy at state level, it may not have intervened to reduce inequalities; it might also have undermined the more innovative health schemes which have been developed in Tamil Nadu or Kerala, and those 'piloted at the state level and later scaled up to become national policy (such as Chhattisgarh's Mitanin program for auxiliary health workers, or AP's Aarogyasri health insurance scheme)' (Deshpande, Kailash, and Tillin 2017: 89). The BJP-led central governments, with Modi as Prime Minister, in which representatives from the EAG states have had considerable influence, espouse a business-led growth model, which could undermine the overall equality of health even further. While 'old-style' planners and public health experts see health inequalities as a reason for redoubling efforts to reduce inter-state disparities (Reddy et al. 2011) the NITI Aayog's original economic advisers are, it would seem, entirely happy with gross inequalities of all kinds – as long as the public is not aware of them (Bhagwati and Panagariya 2013: 45-6). It seems likely that this 'Brave New World' will continue beyond 2024, the end of the current government's term.

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Table 1: State welfare regimes in India

Cluster	Sub-Cluster A	Sub-Cluster B	Sub-Cluster C
Welfare regimes	'Social Democratic' e.g., Kerala, West Bengal (in the past)	'Competitive populist' e.g., Andhra Pradesh, Tamil Nadu	'Incorporationist' e.g., Chhattisgarh, Odisha
Inconsistent welfare regimes	'Pro-business' e.g., Gujarat	'Competitive clientelist' e.g., Uttar Pradesh, Bihar	'Predatory states' e.g., Jharkhand

Source: Tillin et al. 2015 pp. 16-20

Table 2: Key health indicators of selected States

Indicator	Kerala	Andhra Pradesh	Odisha	Gujarat	Uttar Pradesh	Jharkhand
Maternal mortality ratio 2004-06	32	154	303	160	440	312
Infant mortality rate 2008	12	52	69	50	67	46
Primary Health Centres with 24-hour delivery facilities	NA	51%	NA	5%	17%	17%
Institutional Births 2005-06	100%	64%	36%	53%	21%	18%
Institutional Births 2012-13	100%	95%	63%	86%	44%	32%

Sources: NITI Aayog webpage; State NRHM Programme Implementation Plans; Rural Health Services Bulletin, March 2009

Table 3: Human Development Indexes for selected states, 2005 and 2010-11

Cluster	Sub-Cluster A	Sub-Cluster B	Sub-Cluster C
Welfare regimes	Kerala	Andhra Pradesh	Odisha
	2005: 0.970	2005: 0.458	2005: 0.229
	2010-11: 0.980	2010-11: 0.466	2010-11: 0.268
Inconsistent welfare regimes	Gujarat	Uttar Pradesh	Jharkhand
	2005: 0.520	2005: 0.212	2005: 0.170
	2010-11: 0.526	2010-11: 0.214	2010-11: 0.218

Source: Drèze and Khera (2012)

Table 4: Key financial indicators for NRHM and JSY for selected States

Indicator	Kerala	Andhra Pradesh	Odisha	Gujarat	Uttar Pradesh	Jharkhand
Total NRHM budget 2013-14	Rs 2,011 crores	Rs2,202 crores	Rs 1,577 crores	Rs 1,673 crores	Rs 6,031 crores	Rs 916 crores
(Per capita)	Rs 602	Rs 260	Rs 365	Rs 277	Rs 305	Rs 278
JSY (also in Gujarat) budget 2013-14	Rs 15 crores	Rs 42 crores	Rs 121 crores	Rs 38 crores	Rs 517 crores	Rs 90 crores
JSY budget per birth	Rs 266	Rs 288	Rs 1,363	Rs 303	Rs 923	Rs 1,125

Source: State NRHM Program Implementation Plans

Notes

[1] More detail on the Finance Commissions is beyond the scope of this paper: for a recent overview see Reddy and Reddy (2019).

[2] The eight EAG states are Bihar, Jharkhand, MP, Chhattisgarh, UP, Uttaranchal, Orissa and Rajasthan); the eight north-east states are Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura; and the two mountainous north-western states are Himachal Pradesh, and Jammu and Kashmir.

[3] Material in this section is taken from Jeffery (1988).

[4] For more on how, over time, states responded to these pressures, see Swenden and Saxena (2017).

[5] Sources: *Economic Surveys* relevant years. Because of changes in the Consumer Price Index base years in this period, constant prices calculations are subject to considerable uncertainty.

[6] *Sarva Shiksha Abhiyan* or Education for All Movement had already been introduced by the Ministry for Human Resource Development

[7] http://nhm.gov.in/nhm/nrhm/institutional-setup-under-nrhm/composition-of-dhm-dhs.html accessed 9 January 2018.

[8] In 2012 the NRHM was extended to urban areas in a retitled National Health Mission, and the flexible pool approach was extended to include an urban flexipool, a flexible pool for communicable disease, and a flexible pool for non-communicable disease including iInjury and trauma (NHM 2012).

[9] The link to these minutes is no longer valid: copies of this material are available on request from the author.

[10] Indian Express, http://indianexpress.com/article/business/business-others/niti-aayog-to-replace-plan-panel/, 2 January 2015.

[11] I am grateful to Wilfried Swenden for this formulation.

[12] For comparable arguments with respect to Brazil, see Machado et al. (2014: 649-50)

[13] I am grateful to Wilfried Swenden for bringing these points to my attention.