Health Policy and Federalism in India
James Warner Björkman

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Introduction

This paper explores relationships between the provision of health care in India and its federal structure of government. Governmental institutions are not neutral; they shape the behavior of political actors that directly impact on policy development. Through multiple veto-points, interregional tax competition and regional jurisdictions, a federal system influences and constrains government activity – including public health systems (Jordan 2008). After sixty-plus years of federalism, India has a disorganized health system with mismatched funding among levels of government and a concentration of health care professionals in urban areas. Patterned on the 1946 Bhore Report with tiers of integrated responsibilities and logical structures, the health system in India is simultaneously centralized and a patchwork of programs. Public health services involve a complex agglomeration of providers that are controlled by state and federal authorities.

As contextual background, India’s population of 1.3 billion is governed by a democratic federal system that includes the central Government of India, 29 constituent states, seven union territories, 593 districts and, in most states, three levels of local rural government (panchayati raj) at district, block and village levels. Of the 29 states, 19 have populations of more than 25 million – and one state, Uttar Pradesh, with over 200 million inhabitants, approximates the population of Brazil. With 17% of earth’s total population, one of every six humans lives in India. The annual demographic growth is 1.6%; half of all Indians are below 25 years of age, and almost two-thirds below 35. By 2030 India is predicted to have more than 1.53 billion people.

To appreciate India’s political system, a brief sketch puts its institutions in perspective. During the Raj, India’s princely states had considerable discretion over their internal affairs but remained under British rule (Rao and Singh 2005). In the early 20th century, a system of ‘dyarchy’ evolved in which provinces of British India had responsibilities for domestic functions while the empire retained overall control. Even the Indian nationalist movement developed a federal structure based on regions and linguistic lines. In 1928 the Motilal Nehru Committee of the Indian National Congress stated that an independent India would be parliamentary, bicameral, and federal (Stepan et al. 2011: 55). India has a legacy of central planning and a concentration of power that has left governments at state and local levels in a subordinate position.

Historical legacies shape any polity. Centuries of colonial rule facilitated communication and the spread of the English language that underpinned mass mobilization. But given the trauma of partition and its aftermath, the post-independence Constituent Assembly focused on the unity and integrity of India. The fear of excessive federalism and the risks
of centrifugal forces were cogently articulated. The constitutional framework finally adopted departed significantly from all existing models of federalism. Self-rule and shared rule were combined in unorthodox ways that produced a hybrid termed quasi-federalism. Unlike the 1869 US Supreme Court ruling in Texas v White that confirmed the United States as ‘an indissoluble union of indestructible states’, India’s Constituent Assembly created an indissoluble union of destructible states.

**Institutional Description**

In order to manage geographic size and social complexity, the founding fathers of the Indian Constitution established a network of constituent units analogous to geographic divisions in the United States. At the same time, they adopted the parliamentary system of government used in the United Kingdom, a framework that had previously applied only to unitary states (Austin 1999). India thus has a quasi-federal parliamentary system of government. Its strong Centre has proved resilient and, given social diversities and cleavages, is considered indispensable for maintaining social harmony. Even during the current era of economic liberalization, the Centre retains control over all macroeconomic levers. Proponents of state autonomy in India do not challenge a strong Centre but want stronger states within the same framework.

Federalism in India differs from other federations in the world because it is not a group of independent entities (states, cantons, provinces) that joined together to form a federation by conceding a portion of their rights of government. Rather it is a distributional entity that derives its power from a single source. Sovereignty and governance are distributed and shared among several entities and organs. Dr Bhimrao Ramji Ambedkar, chair of the Drafting Committee of the Constituent Assembly, stressed the importance of describing India as ‘Union of States’ rather than a ‘Federation of States’:

> “Though the country and the people may be divided into different States for convenience of administration, the country is one integral whole, its people a single people living under a single imperium derived from a single source.”

The Indian constitution defines the distribution of federal powers between the Centre and the states. Unlike the federal governments of the United States, Switzerland or Australia, residual powers remain with the Centre – as in the Canadian federal system. Federalism in India is strongly biased toward the Union Government. Features of federalism in India include:

- Both houses of Parliament based on population: Lok Sabha (House of the People) directly, Rajya Sabha (Council of States) indirectly.
- Consent of a state is not required by the Parliament to alter its boundaries.
- No state, except Jammu and Kashmir, can have its own Constitution.
- No state has the right to secede.
- No division of public services between Centre and states.

As defined by the Constitution, powers of the states and the Centre are divided among three lists. The **Union list** consists of 99 items on which Parliament has exclusive power to legislate. Among these are defense, armed forces, atomic energy, foreign affairs, citizenship, extradition, railways, airways, communications, currency, foreign trade,
inter-state trade and commerce, banking, insurance, income tax, export duties, etc. The State list consists of 61 items in which uniformity is desirable but not essential. The state legislature has exclusive power to make laws on these subjects but, under certain circumstances, Parliament can also make laws on subjects in the State list. However, Parliament then has to pass a resolution with 2/3rds majority that it is in the national interest to legislate on this state list. Selected items in this list include law and order, police forces, health care, transport, land policies and electricity. Though states have exclusive powers to legislate on items in the State list, several articles in the Constitution identify situations in which the Centre can legislate on these items.

The Concurrent list consists of 52 items where, again, uniformity is desirable but not essential. Items on this list include marriage and divorce, transfer of property other than agricultural land, education, trustees and trusts, civil procedure, contempt of court, drugs and poisons, adulteration of foodstuffs, contracts, bankruptcy and insolvency, economic and social planning, etc.

The Constitution of India establishes full Union control over the states. Articles 352 to 360 empower the Centre to take over the executive of the states on issues of national security or on the breakdown of constitutional machinery. According to Article 356, states must exercise their executive power in compliance with laws made by the national government. The latter appoints Governors to oversee states. On recommendation of the Centre’s Council of Ministers, the President of India can dissolve the legislative assembly of a state by invoking Article 356 if and when that state fails to comply with directives given by the Center.

Constitutionally, except in a few cases, union law trumps state law. If any provision of a law made by a state legislature contravenes any provision of law made by Parliament on which Parliament is competent to enact, or contravenes any provision of an existing law with respect to one of the matters enumerated in the Concurrent List, then the law made by Parliament, whether passed before or after the law made by the legislature of such a state, will prevail and the law made by the legislature of the state is void. However, even in the heyday of Congress dominance and the command economy, the states sat at the bargaining table with the center with enough political clout to scuttle policy initiatives of the central government and to introduce their own (Sinha 2005:83-88).

Although the 1950 Constitution of India outlines the allocation of central and state-level responsibilities for health care, these have never been matched with political commitment or substantial resources. While responsibilities are theoretically decentralized, the system is centralized in practice. Despite being constitutionally responsible for health care, state governments in India lack policy autonomy and capacity (John 2010; Reddy et al. 2011).

The same limitations apply to local governments in India. Based on recommendations of the 1958 Balwantrai Mehta Committee, most states introduced a three-tier system of rural local government: district council (zila parishad), intermediate level (panchayat samiti), and gram panchayat at village level (Björkman 1979:19-26). Charged with such activities as community development, plans and oversight of health and education, the panchayat system had no independent role due to lack of resources coupled with vaguely defined responsibilities. Lacking financial resources and clearly defined powers, the panchayat
bodies became mere agents for state authorities.

Despite the constitutionally enabling amendments of 1992, local finances remain under the strict control of state-level departments or their subordinate offices at district and sub-district levels (Mahal et al. 2000). With salaries directly paid by the appropriate state department, personnel in schools and primary health facilities rarely report to, and are not accountable to, elected local representatives. The fact that elections to panchayats have been held infrequently, or not at all, has eroded their legitimacy and credibility. Senior political representatives such as members of parliament and the state legislature are often appointed to these local bodies, further curtailing their limited role (Björkman and Chaturvedi 1994).

In 1983 the Union Government of India appointed the Sarkaria Commission to examine the balance of power between state and central governments and to suggest changes in the constitutional framework of center-state relations. After eliciting information and conducting deliberations, the Commission in 1988 submitted a 1600-page report with 247 specific recommendations. While the commission concluded that the center had too much power and recommended greater decentralization by allowing states more autonomy (Ray 1988), in practice it endorsed the status quo. It is widely agreed that the changes recommended by the commission have not been implemented (Bagchi 2003).

After the Sarkaria Commission and the onset of Indian liberalization in the 1990s, greater decentralization had been expected. But transition towards a decentralized form of fiscal and political federalism proved to be difficult. States continue to rely on the Centre for direction and resources, and the limited powers devolved to the states have not been extended to rural and local bodies of government. Unsurprisingly, in 2002 the National Commission to Review the Working of the Constitution reported that centralization remains the root cause of India’s institutional problems.

A step towards decentralization did occur in 1992 when the 73rd and 74th amendments to the Indian Constitution were adopted. Enacted in response to calls for more responsibility in local governments, the amendments sought to increase the autonomy of municipalities and Panchayati Raj institutions at district, block and village levels by granting them constitutional status (Johnson 2003; Rothermund 2008; Singh 2008). The amendments gave local bodies the responsibility for 28 development activities including health and sanitation, family welfare, women and child development, drinking water, poverty alleviation and the public distribution system. These amendments were intended to provide local governments with greater autonomy and generated hopes for improving the quality and effectiveness of public spending by pushing decision-making about local public goods down to the local level (Bagchi 2003).

Despite the 73rd and 74th amendments, however, little autonomy has been given to local governments. Reforms anticipated after the Sarkaria Commission and the constitutional amendments have not occurred; power remains centralized at national level and, relative to local bodies, at state level. This centralization has been exacerbated in the area of fiscal matters where local governments have no influence and rely on their respective state
governments to finance health services. To compound matters, state governments have limited funds to allocate to local governments because they too are disadvantaged in fiscal powers (National Commission on Macroeconomics and Health 2005; Singh 2008).

Since the 1980s, decentralization has been frequently debated in India. Recommendations of the Sarkaria Commission, the 73rd and 74th Amendment Acts, and the 2002 National Commission to Review the Working of the Constitution exemplify this debate. However, with significant implications for health policy, power has not been delegated downwards. The political centralization of powers has distorted incentives at all levels of government in India, including its health system. Although local governments have responsibilities for health services, they have not been allocated authoritative power or funds to carry out these responsibilities.

While not constitutionally specified, political parties operate the structures of government in democratic politics. For more than a century, India’s political history has been shaped by the Indian National Congress that emerged from a 19th century association of political amateurs into a 20th century mass nationalist movement and then into a political party that dominated the first two decades of post-independence politics. The impacts of federalism on Indian health policy and performance are due in no small measure to the changing fortunes of the Congress Party that remains one of India’s two national political parties, the other being the Bharatiya Janata Party (BJP). ‘National’ refers to the number of parliamentary constituencies throughout India in which a political party nominates its candidates; in contrast, ‘regional’ parties field candidates in a relatively limited area of the Indian Union – usually confined to a single state or a small region of the country.

The last election in which the Congress Party obtained a majority of seats in Parliament was in 1984. Domination by one party gave way to a coalition system in which no single party has been able to achieve a majority in the Parliament. Electoral politics in India is characterized by coalition building among political parties in order to form a majority and thus to form the government (Mathur and Björkman 2009). Other than a few exceptions in the 1990s, the pattern has been for multi-party coalitions led by the Congress or by the BJP – respectively the ‘United Progressive Alliance’ (UPA) or the ‘National Democratic Alliance’ (UDA). But technically these ‘airbus’ coalitions remain minority governments because each requires support in the Parliament by political parties outside (not members of) the respective coalition.

The year 1989 was a watershed because, for the first time since independence, a national election resulted in a hung parliament; no party won a majority. An era began of coalition governments in a multiparty system. The multiparty system was further ‘federalyzed’ by the rise of regional parties. State parties like the Dravida Munnetra Kazagam (DMK) in Tamil Nadu and the Telegu Desam Party (TDP) in Andhra Pradesh began to play a key role in forming coalition governments at the center and in making policy (Rudolph and Rudolph 2010a:152).

One feature of ‘national’ political parties has been their top-down centralizing tendencies in government policies. Regional parties, on the other hand, favor maximum discretion or
decentralized autonomy. The Members of Parliament in the 15th Lok Sabha (2009-2014) represent 38 political parties, all but two of which are ethnic or regional enterprises. In the foreseeable future, it is unlikely that a single party will be able to form the Union’s central government in New Delhi but single political parties do form the governments in many states and union territories. The emergence of regional parties as centers of power in India is one of the most important developments in the country’s post-independence history. In the 2014 general elections required for the 16th Lok Sabha, regional parties will play a pivotal role in the formation of the next union government. It is even possible that India’s next general elections will produce a ‘third front’ government headed by the leader of a regional party.

After an unstable period during the late 1980s and early 1990s, electoral competition at the national level has achieved a surprisingly stable balance of power (Vaishnav 2013). During the past five general elections, shares of aggregate votes won by the two national parties versus ‘the rest’ illustrate that the respective popularity of these two groupings has a steady pattern. The share of votes won by regional parties exceeded 50% for the first time in 1996. After dipping a bit, their share of votes returned to 51% in 2004 and rose again to 53% in the 2009 election. This fragmented vote has affected the share of seats won by regional parties in Lok Sabha elections. As in 1998, regional parties in the 15th Lok Sabha provide 41% of all MPs – a decline from the two previous elections. In 2009 the share of votes of regional parties reached its highest level but, given India’s electoral system of first-past-the-post, their share of seats declined because of fragmentation.

**Economic Description**

Dramatic shifts in India’s economic policy help account for the changing nature of Indian federalism. By 1991, when India changed course from a command economy to a market economy, the system was literally broke. The central government’s Planning Commission no longer had public funds to invest; India could not pay its current account balance. The radical reduction of public investment by the Center created a need for private investment to replace it that was quickly met by the more enterprising state governments. State chief ministers began to play leading roles in India’s emergent ‘federal market economy’ as they sought to convince both domestic and foreign investors about the opportunities and incentives available in their respective states (Rudolph and Rudolph 2010a).

India has a chronic imbalance between its government revenues and expenditures as well as a growing trade imbalance. Its fiscal deficit in FY2011-2012 was 5.8%, sharply higher than the 3.5% four years earlier, and it will rise in the near future due to new obligations. Initially promulgated as a presidential ordinance in July, the National Food Security Act became law in September 2013. Based on eligibility, this ‘Right to Food’ guarantees five kilos of subsidized grains monthly to approximately two-thirds of India’s population. The fiscal deficit will undoubtedly exceed its target of 4.8% of GDP due also to imports of oil because India imports 80% of its oil, the price of which continues to rise.

Likewise India’s current account deficit widened to a record 4.2% of GDP in 2011-2012, far above the 2.5% of GDP that the Reserve Bank of India considers a sustainable level.
The key reason for the large current account deficit lies in the trade deficit that ballooned due to India’s relatively poor competitiveness as well as its high imports of oil and gold. Greater diversification of exports across destinations and products is essential to bridge the trade deficit, but this gap cannot be bridged without boosting labor productivity and enhancing transportation infrastructure, especially ports. As for gold, the introduction of inflation-linked bonds would help reduce its physical import. The reduction of oil imports requires greater energy efficiency plus aligning domestic oil prices to international prices.

India’s balance of payments crisis in 1991 generated radical economic reforms in which tariffs were reduced, foreign investors were allowed in Indian markets, and procedures were simplified. The impending economic crisis, however, is more dangerous. The IMF has warned India that the fall in its growth rate since 2008 may engulf it in the same trap that once plagued Latin America and then countries in Southeast Asia. In 1997-1998 the latter had an external balance of payments crisis that, given their convertible currencies, experienced huge outflows of cash and led to devaluation. Problems in real estate caused trouble for the banking sector and a sharp rise in unemployment. As India did not have full convertibility of the rupee at that time, it avoided the trap. Instead a surge occurred in its growth rate; from 1998 to 2011, India’s average economic growth was 7%.

India had also been able to minimize the effects of the 2008 world economic crisis. The Reserve Bank of India tightly controlled interbank foreign exchange, and the economy was not oriented towards exports. India’s ratio of debt to GDP was low and growth in local demand caused rapid domestic development. Since then, the problems for India’s economy have become legion. While India is among the world’s most rapidly growing economies, its growth rate has slowed considerably and it remains one of the world’s poorest countries. Although it has relatively large amounts of foreign currency reserves, the current account deficit has recently deteriorated. Excluding remittances from workers overseas, India’s current account deficit is just over 4% of GDP. Rising wages, property and food prices fuel inflation. In October 2013 the Union Ministry of Commerce and Industry reported a 7% inflation rate. Between 1969 and 2013 the inflation rate averaged 7.7% with an all-time high of 34.7% in September 1974 and a record low of minus 11.3% in May 1976.

India’s love for gold is well known. The total amount of gold in India is incalculable but, after crude oil and capital goods, gold is the third largest of its imports. Prime Minister Man Mohan Singh said that among the reasons for imbalanced trade is the huge import of gold that is an unproductive asset. However, he dismisses the likelihood that India will undergo an economic crisis because Indians invest in assets (particularly gold) that suck liquidity out of the market. In 1991, India collateralized its gold and opened its economy to global competition.

India’s current account and fiscal deficits have adversely affected economic stability by pushing up inflation and undermining growth. As strategies, the government must focus on quality spending by channeling resources towards infrastructure and human capital while reducing unproductive spending, particularly on food, fertilizer and fuel subsidies. Furthermore, the government must implement revenue-enhancing reforms by making the
tax system more efficient and improving compliance (Deorukhkar and Herrero 2013).

India’s persistently high inflation is fallout from myriad factors that are both cyclical and structural in nature. These include supply-side bottlenecks, high reliance on imported energy and lax fiscal policy. While a loose fiscal policy has boosted aggregate demand, particularly across rural areas, an enabling environment to enhance supply response is missing, thus aggravating inflationary pressures. Containing inflation near the Reserve Bank of India’s comfort zone of 4 to 5 percent is crucial to facilitate sustainable growth.

Being an economy primarily driven by domestic services, the share of manufacturing has been stagnant at 16% of GDP. India’s Asian peers – China, South Korea, Taiwan – have benefited from a strong manufacturing sector that enables greater employment creation, attracts stable foreign direct investment and bolsters development of infrastructure. But bottlenecks in land acquisition, archaic labor laws, poor physical infrastructure, tight regulation and unfavorable tax rules deter growth in India’s manufacturing sector. The Government of India has approved a policy to increase the proportion of manufacturing in the GDP to 22% in a decade and in turn create millions of jobs and add capacity to sustain the pace of economic growth. Given past performance, however, effective implementation of the policy will be difficult.

Subsidies have helped to create a rudimentary social safety net in India but poor targeting and an ineffective physical and social infrastructure contribute to fiscal stress with limited progress in poverty alleviation. Having tripled since 2006, food subsidies are driven by increasing costs of procurement and transportation that are the main drivers of the higher cost of food grains. Subsidized food and fuel such as kerosene and LPG are intended for those below the poverty line (BPL) who have a ration card to prove their economic status. Data reveal, however, that about half of poor rural households do not have a BPL card; in Bihar the number is 80%. A large share of subsidized items are sold illegally, hoarded, or diverted to non-household use. The current structure of subsidies in India is regressive in the long-term and not sustainable from both fiscal and growth perspectives. The solution lies in gradually moving to a more effective direct cash-transfer system that is better targeted, eliminates profits by middlemen, and creates space for investment in infrastructure (Deorukhkar and Herrero 2013).

Other issues that challenge India’s economy involve education, sanitation, inequality and labor laws. Although India has a large number of English speakers (important for the call-center industry and for world trade), high levels of illiteracy exist – especially in rural areas and among women, one-third of whom remain illiterate. Likewise many Indians lack basic amenities such as access to running water. According to the 2011 Census, 59% of Indian households have a mobile phone while only 47% have a toilet on the premises (including pit latrines that do not use running water). Limited access to toilets is a major problem that puts drinking water for millions of people at risk. India has the worst of the problem. With approximately 600 million practicing ‘open defecation’, the country has more than twice the number of the next 18 developing countries combined.

Inequality has risen in India rather than decreased. While economic growth was expected
to pull India’s poor above the poverty line, economic growth has been uneven with its benefits accruing disproportionately to the skilled and the wealthy. Many of India’s rural poor are yet to receive any tangible benefit from the India’s economic growth. With the spread of television in villages, they are increasingly aware of the disparity between rich and poor. But as India has one of the largest budget deficits in the developing world there is little scope for increasing investment in public services like health care and education.

Finally, inflexible labor laws cause domestic problems as well as discourage foreign investment. Because firms that employ more than 100 people cannot fire workers without government permission, firms are discouraged from expanding. Both national and state governments avoid tackling the issue of politically sensitive labor laws because trades unions have an important power base. While labor laws helpfully protect individuals, they undermine economic growth in the collectivity.

**Policy Analysis of India’s Health System**

India spends five percent of its GDP on health care, a proportion in line with developing countries at similar income levels, but the portion of health spending undertaken in the public sector is about 20 percent – well below most other countries. The private sector provides the vast bulk of health care services. In India, almost nine-tenths of all health expenditures are out-of-pocket and paid to the private sector. India has one of the world’s highest levels of out-of-pocket financing with debilitating effects on the poor. Socially marginalized communities depend on the public health system, but deficiencies in public systems in terms of lack of capacity and insufficient resources force the poor to seek health care in an unregulated private sector, borrowing money or selling assets (land, cattle, even children) to pay for such services. It has been estimated that each year one-third of Indians who are hospitalized will fall below the poverty line because of hospital expenses (Mahal et al. 2000). Inequities in the health system are aggravated by the fact that, until recently, public expenditures on health in India never exceeded one percent of GDP.

The private sector, however, has greatly expanded over the years, due partly to failure of the public sector health system and partly to policies of economic liberalization. India’s private sector accounts for 93% of hospitals, 85% of doctors, 80% of outpatients, 64% of hospital beds and 57% of inpatients (Venkat Raman and Björkman 2009). Although unregulated and inequitable, the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart.

Each state has its own set of actors that influence the policy processes in the state. How different states have dealt with the private sector is one example of divergent approaches and results. Recognizing the dominance of the private sector (including both for-profit and non-profit providers), several states have drafted legislation to regulate private hospitals. Given the limited capacity of state governments to enforce such laws, however, it is doubtful that these can significantly improve quality of care and may instead be misused to harass private providers (Peters et al. 2003:254).
To review problems in India’s health system, the national Ministry of Health and Family Welfare periodically releases a National Health Policy Report. While its 2002 report recommended improvements in the system, the central government ignored state actors – another example of the dominance by the Centre (Gupta 2002). By acknowledging the need for greater civil society integration and for increased public investment, the 2011 report made policy recommendations but without a plan for implementation. The latter report vaguely hints at allocating health funds to states based on performance indicators and notes that states must start contributing independently to primary health care.

But these reports on national health policy do not adequately address basic health needs. They appear to be window-dressing or prophylactic pronouncements full of suggestive movements but without any embarrassing consequences. On the contrary, since the early 1990s “fiscal profligacy and mismanagement by state governments, and imbalances in the sharing of resources and constitutional responsibilities, have made them more dependent on the central government for financial resources” (Peters et al. 2003:250). While the states account for 75-90% of public spending on health, about 80% of the funds are committed to human resources such as salaries and wages, which make the states depend on the Centre for critical inputs such as drugs, equipment and other non-wage items.

Centrally sponsored schemes have become a powerful instrument for intervention in the states. They are changing the federal balance of power by making it possible for the Centre to shape state policies and priorities even in fields that are constitutionally under state jurisdiction, such as education and health. State ministries and departments, local bodies, and externally funded NGOs become de facto agents of the Center in ways that subvert state autonomy policy (Rudolph and Rudolph 2010a:157). While the states prefer block grants that they can control, the Center favors specific purpose assistance that implements its priorities.

India’s framework for public health policy is weak, a problem that is compounded by a restrictive interregional fiscal transfer system (NCMH 2005). Local governments have no appreciable fiscal autonomy because they rely on funding through grants from state-level agencies. These grants are characterized by restrictions and are often wasted through the inefficiencies of bureaucracy (Wyke 2009). Expenditures by local governments depend on their respective state governments that retain constitutional responsibility for health. States that fund local governments through a State Finance Commission have devolved limited fiscal power to local governments largely because these states fall short in terms of their own revenue.

Horizontal fiscal inequalities refer to disparities among constituent units within the same federation; vertical fiscal inequalities refer to disparities in fiscal capacity between the central government and the constituent states. In federal systems, equalization policy concerns horizontal redistribution aimed at tackling fiscal inequalities among constituent units (Bird and Tarasov, 2004; Boadway and Shah, 2007; Stark, 2009). The goal is to find a balance between preserving the autonomy of constituent units and ensuring relatively equal access to public benefits and services across an entire country despite the
institutional decentralization inherent to federalism. Australia’s Goods and Services Tax is a good example because some of the revenues generated by this 10% tax are allocated to its states on a per capita basis and the balance on the fiscal capacities and expenditure needs of each state in order to reduce horizontal fiscal inequalities among them (Morris 2002). Discussions about GST have been underway in India since 2000; the 2007-2008 central budget of the Union Finance Minister announced that GST would be introduced in April 2010 and preparatory committees were duly appointed that produced a series of reports but to date (February 2014) nothing has yet been decided.

Like other federal systems of government, India has problems of imbalances within and between its federal components. Vertical imbalances occur when states incur expenditure disproportionate to their sources of revenue while attempting to fulfill their constitutional responsibilities. Horizontal imbalances occur among states due to historical backgrounds and differences in resource endowments. To address imbalances, the Indian Constitution provides measures to bridge the financial gap between the Centre and the states. In order to facilitate intergovernmental transfers, a Finance Commission is appointed every five years to recommend ways to share resources between the Indian Union and its states. In 2012 the 14th Finance Commission was established; chaired by Yaga Venugopal Reddy, former Governor of the Reserve Bank of India, it will operate during 2015-2020. After assessing India’s financial scene in terms of revenues and expenditure, it will recommend allocation of tax-resources to the states of the Indian Union to balance equity and growth.

The major responsibilities assigned to the states include agriculture, irrigation, public order and public health. However, the most profitable taxes are assigned to the central government such as taxes on income from nonagricultural sources, corporation tax and customs duty. While a long list of taxes is assigned to the states, only the tax on the sale of goods is significant for generating revenues. In turn, the states provide limited revenue autonomy to local governments that have little legislative autonomy. In practice, revenue authority and legislative autonomy in India have not been increased to match the political decentralization mandated by federalism.

The combination of constitutional assignments of tax and spending authority in India produces vertical fiscal imbalances. In 2006, the states raised 38 percent of all combined government revenues but incurred 60 percent of expenditures. Transfers from the center made up most of the difference. The Planning Commission makes grants and loans for implementing development plans as well as coordinates central ministry transfers that account for almost one-third of center-state transfers. There are over 100 such schemes, but attempts to consolidate them have failed. Local governments are even more dependent on transfers from higher levels. Aggregate local government spending was only about five percent of total government spending at all levels, while local revenue from own sources was only one percent of total government revenue (Singh 2008).

Because states have the constitutional authority to determine their own health systems, decentralization of powers over health care in India varies by state. Since constitutional amendments in 1992, the three tiers of institutions for Panchayati Raj have the bulk of health care responsibilities for their constituents. But Primary Health Centers operate in an underfunded and weak public health system while the private health system dominates
in terms of facilities, skilled professionals and resources – and it is concentrated in urban areas (Bansal 1999; NCMH 2005; Reddy et al. 2011).

In 2005 the National Rural Health Mission (NHRM) began to revamp the public health care system “by increasing funding, integration of vertical health and family welfare programs, employment of female accredited social health activities in every village, decentralized health planning, community involvement in health care, strengthening of rural hospitals, providing united funds to health facilities, and mainstreaming traditional systems of medicine into the public health system.” (Reddy et al. 2011:763) The program covers all of India but focuses on 18 states with poor infrastructure. Although NHRM is centrally funded and vertical in organization, its implementation and execution are at state and local levels. In the state of Karnataka, decentralization of power was one of the first initiatives to reform its health system by integrating communities and people into the planning process (Sudarshan and Prashant 2011).

Adopted in 1992, the 73rd and 74th Constitutional Amendments required the states to delegate some administrative functions and taxation powers to local governments in rural and urban areas. In the forefront of decentralization of powers was Kerala (Narayana and Kurup 2000), which has achieved “some of the highest indicators of social development in the developing world” (Chaudhuri 2003:5). Kerala has an impressive history of public engagement as well as local management of public services despite political polarization between two ideologically opposed parties (Communist and Congress).

Yet despite these achievements, Kerala in the 1990s faced a ‘health crisis’ triggered by outbreaks of contagious disease, increased numbers of HIV/AIDS cases, the rise of parasitic and infectious diseases, and a decline in longevity. Given deterioration in health conditions, the Left Front state government in 1996 launched a People’s Campaign for Decentralized Planning that gave local governments about 38 percent of development expenditures. By empowering local actors, Kerala sought to motivate community participation. In the second year of the campaign, there was a dramatic increase in the participation rates of marginalized people while women and child development services improved significantly (Chaudhuri 2003; Elamon et al. 2004).

Compared to other Indian states, Kerala’s public health system functions relatively well. But although the Kerala government transferred control of primary health centers to local panchayats in 1996, Varatharajan et al. (2004) found that these panchayats allocated a smaller proportion of resources to health than the state government had allocated prior to decentralization. They concluded that decentralization brought no significant change to the health sector in Kerala and may actually jeopardize its future.

In May 2013 the Union Cabinet approved another scheme – the National Urban Health Mission – to be implemented in cities and towns of more than 50,000 inhabitants. With its focus on the urban poor, NUHM is expected to cover almost 80 million Indians in slums and disadvantaged urban areas by facilitating equitable access to quality health services through a revamped primary public health system. The government proposes to set up one Urban Primary Health Center for every 60,000 people; one Urban Community
Health Center for five-six Urban PHCs; an Auxiliary Nurse Midwife for 10,000 people; and a community worker or Accredited Social Health Activist for every 200-500 households.

The cost of NUHM for five years is estimated at 225 billion rupees or US$3.5 billion so about US$700 million per year. While the Centre will fund 75 percent of the mission and each state 25 percent, the funding ratio for the seven states in northeastern India and the special category states of Jammu and Kashmir, Himachal Pradesh and Uttarakhand will be 90:10. The NRHM mechanisms now operating in rural India will be strengthened to meet the needs of NUHM.

India is a multi-ethnic federal system featuring cultural, linguistic and religious diversity. As there is evidence that homogeneity benefits by having a strong central government (Obinger et al. 2005), heterogeneity may require greater decentralization to maximize its benefits. A striking example of the role of health care in strengthening national identity in a multinational country is Canada where universal health care has become a powerful national symbol despite the fact that public health insurance is operated by the provinces (Banting 2005; Boychuk 2008).

As noted above, there has been a proliferation of schemes sponsored by the Government of India. Because India is a ‘Union of States’, its states and union territories administer internal affairs. It seems odd for the Centre to run central schemes in and for states when it need only transfer money for specific purposes. However, central schemes are used as ‘vote-buying’ machines by whatever political parties are in power. Centralization of financial and economic power leads to increasing dependence of the states on the Centre. Three examples follow in the policy domains of education, health and employment.

**Sarva Shiksha Abhiyan** (Education for All Movement) is a program of the Government of India aimed at the universalization of elementary education that had been mandated in 2002 by the 86th amendment to the Constitution of India. The amendment established free compulsory education as a fundamental right for all children between six and 14 years of age. As an intervention program of the central government, Sarva Shiksha Abhiyan has been operational since 2000-2001 but its roots can be traced to 1994 when the District Primary Education Program (DPEP) was launched with the objective of universal primary education (Björkman and Mathur 2002). Over several phases, DPEP covered 272 districts in 18 states of India. On 1 April 2010 the Right to Education Act came into force. Some educationists and policymakers believe that, with the passage of this act, Sarva Shiksha Abhiyan has acquired the requisite legal force for its implementation.

**Janani Suraksha Yojana** (Safe Motherhood) is a central government scheme launched on 12 April 2005 to promote the institutional delivery of babies and thereby decrease neonatal and maternal mortality. Financed 100% by the central government, the scheme integrates cash assistance with delivery and post-delivery care. The success of the scheme is measured by the increase in institutional deliveries among poor families. Accredited Social Health Activists have an important role to encourage women in families below the poverty level to go to institutions (clinics or hospitals) for the birth of their babies. The scheme has differential incentives for rural and urban areas based on whether a state has a
low rate of institutional deliveries (Uttar Pradesh, Uttarakhand, Jharkhand, Bihar, Madhya Pradesh, Chhattisgarh, Rajasthan, Assam, Orissa, Jammu and Kashmir) or a high rate (all other states). Currently conditional cash benefits are as follows:

- **Rural Areas**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mother's package</th>
<th>ASHA's package</th>
<th>Total Package (rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1400</td>
<td>600</td>
<td>2000</td>
</tr>
<tr>
<td>High</td>
<td>700</td>
<td>-</td>
<td>700</td>
</tr>
</tbody>
</table>

- **Urban Areas**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mother's package</th>
<th>ASHA's package</th>
<th>Total Package (rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1000</td>
<td>200</td>
<td>1200</td>
</tr>
<tr>
<td>High</td>
<td>600</td>
<td>-</td>
<td>600</td>
</tr>
</tbody>
</table>

Around 70 percent of India lives in villages, but agriculture contributes only 14 percent of its GDP. According to the Eleventh Five-Year Plan (2007-2012), 300 million Indians live below the poverty line (less than one dollar per day) – an absolute number that has barely declined since 1973 although their proportion in India’s population decreased from 36 percent in 1993 to 28 percent in 2005. The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) guarantees the ‘right to work’ in rural India by providing 100 days of guaranteed wage employment per year to every household whose adult members volunteer to do unskilled manual work. Under the 2005 act, people are entitled to employment, or else the government is liable to pay an unemployment allowance.

The law is the culmination of efforts to ensure security of livelihood for the poor. While employment generation through rural works has a long history in India, no prior program had promised employment as a legal right. Previous top-down schemes of India’s central government included Food for Work (FWP) in 1977, the National Rural Employment Program (NREP) in 1980, the Employment Assurance Scheme (EAS) in 1983, Jawahar Rozgar Yojana (JRY) in 1989, Jawahar Gram Samridhi Yojana (JGSY) in 1999 and Sampoorna Grameen Rozgar Yojana (SGRY or Universal Rural Employment Program) in 2001. In contrast to the earlier schemes, MGNREGA is a rights-based demand-driven employment program that is supposed to be implemented mainly by village-level local government (Gram Panchayats). However, local governments are markedly ill equipped for effective performance in any field, whether employment or education or health care.

Commonly cited as the source of operational problems, government-run rural health services in India are centralized with little local autonomy over programs or resources. Services are unresponsive to local needs as the population has few alternatives. Despite low coverage of services, there is excess capacity in infrastructure with corresponding shortages of supplies and sometimes of staff. Staff are assigned, rotated and paid without consideration of output or client satisfaction; staff members are inadequately trained, ill equipped and commonly indulge in private practice. Referral systems do not work so patients bypass the rural health infrastructure and, when they can, go directly to hospitals, thereby raising costs and leading to more investment in hospital facilities. In contrast,
private and NGO services are usually decentralized and more accessible, reasons that are often mentioned by clients who use them despite the average quality of such services as well as their fees that are higher than in the public sector (Gupta and Gumber 1999).

In summary, the two constitutional amendments of 1992 provided legal recognition, increased political status, and greater expenditure responsibilities to local governments. The amendments changed the assignments of taxes and expenditures to local governments by more fully specifying their authority and responsibilities. They also instituted a system of state-local fiscal transfers as well as periodic State Finance Commissions patterned on the national variant. But during the two subsequent decades, classic problems have appeared in the implementation of these amendments including lack of clarity, mismatches between revenue and spending authority, and lack of local administrative capacity. Federalism on paper is not federalism in practice.

Conclusions

Poor quality and inefficient delivery of public services in India are pervasive problems that are not restricted to health care. Part of the problem lies in weak mechanisms of accountability for individuals (politicians and government employees) and organizations (ministries and public enterprises). Evidence suggests that decentralization has improved local responsiveness and service delivery in some cases but, unless accompanied by the decentralization of funds and functions, political decentralization is likely to have limited benefits. Heterogeneous services like health care require building local capacity as a critical prerequisite for successful decentralization that might then improve the delivery of services. And some components of health care that are subject to economies of scale or spillovers are not candidates for decentralization. In the complex field of service delivery, one size does not fit all.

The impact of decentralization on service delivery is not straightforward. Its usefulness as a tool varies between poor countries and emerging economies. Where a state lacks the capacity to fulfill its basic functions, there is a risk that decentralization will exacerbate problems rather than reduce them. But in countries where a state is committed to the devolution of power to local tiers of government, decentralization can enhance service delivery. Given the ambiguous link between decentralization and service delivery, decentralization could complicate matters in countries characterized by weak institutions and political conflict. The impact of decentralization depends less on a country’s physical setting – its size or the quality of its infrastructure – than on the capacity of policymakers. In an environment where a government is not fulfilling basic functions, decentralization could be counterproductive. But in countries that fulfill these functions, decentralization may be a powerful tool for targeting the delivery of services (Jütting et al. 2004).

As India demonstrates, government is not one homogeneous entity. Government consists of layers at central, state and local levels that interact with one another as well as operate separately. The efficacy of public expenditures depends not only on their magnitude and composition but also on the layer of government that makes decisions about financing and spending. ‘Too much’ centralization may inhibit efficiency; ‘too little’ may endanger
coherent delivery of services and exacerbate disparities. For more than a century, India has been a laboratory for experimentation on this topic including debates in the 1948-1949 Constituent Assembly and constitutional amendments during subsequent decades … and the jury is still out.

In conclusion, despite its constitutional nomenclature, India is not a federal system. It is a quasi-federal system or, more accurately, a unitary system of government masquerading as a federal one. The circumstances of its origin during the aftermath of Partition provide a partial explanation of the centralizing features of an ostensibly federal government, and likewise the post-independence decades of dominance by a centralized Congress party. It must be added that, despite its multi-tiered structure and its important All India Congress Committee, the party had been predicated on a bottom-up structure of internal elections that had been invented by Mahatma Gandhi in the 1920s; these ceased in 1969 when Mrs Indira Gandhi (Jawaharlal Nehru’s daughter, no relation to the Mahatma) ‘split’ the party (Björkman 1987).

Afterthought
Some argue that the ‘Union’ of India is inherently multilayered and plural rather than unitary. Unlike Europe, where national sovereignty characterizes the state, in India a segmented conception of state power has prevailed that recognized and legitimated the heterogeneity of Indian society. Historically the Indian state preserved subordinate jurisdictions by including rather than eliminating layered and segmented social and political power and thereby created a socially constrained and negotiated political order.

“The British used Mughal ceremonies and language to revitalize the universalism and mystique of the imperial state. Like Persian under the Mughals, [English] became the language of state administration, a mark of elite status and the medium through which political leaders of the subcontinent’s disparate regions and communities deliberated and bargained” (Rudolph and Rudolph 1985). During the Raj, a sub-continental empire existed; its successors of India and Pakistan as well as the 29 states and seven union territories in India’s federal system are contemporary expressions of the regional state.

“The doctrine of sovereignty, with its implications of exclusive jurisdiction, was inimical to the sharing and layering of power among culturally diverse areas that made possible a multi-national empire. India is thought by many to be an anomaly in a world of nation-states because it is a multi-national or pluralist state. A multi-national state is a state that shares sovereignty among a variety of actors. India’s federal system, particularly its linguistic states, is a manifestation of a multi-national state that shares and bargains about sovereignty” (Rudolph and Rudolph 2010b:13,20).

References


