Fiscal Space and Prioritisation of Health in Government Budget

A Study of Indian States

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Assessing the available fiscal space and evaluating its sources for the states, the objective of the paper is to understand whether states' health spending is constrained by a lack of fiscal space or a lack of prioritisation of the health sector. The assessment in 2019 showed that several states had a significant amount of fiscal space that was not being utilised for the health sector, indicating a lack of prioritisation. States can reduce their unrealised fiscal space by identifying and selecting the sources that can potentially be used for the health sector. However, this can be done only if there is a policy move to prioritise the health sector to garner the additional resources for health.

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Goal 3 of the 2030 agenda of the Sustainable Development Goals (SDGs) adopted in 2015 by the United Nations (UN) member states aims to ensure

> good health and well-being for all at all ages by improving reproductive, maternal and child health, ending the epidemics of major communicable diseases, reducing non-communicable and environmental diseases, achieving universal health coverage (UHC) and ensuring access to safe, affordable and effective medicines and vaccines for all. (UN 2016)

Countries have embarked on various paths and adopted several strategies to achieve UHC. These efforts are powered by improved health finances, which remain one core parameter in the UHC challenge. Health financing, along with effective health expenditure management, will continue to play a critical role in realising the UHC goals in low- and middle-income countries (LMICs), including India.

The third National Health Policy (NHP) in India in 2017 separately outlined the country's quantitative goals for health status indicators, health system performance, and health system strengthening with the target of meeting the SDGs for the health sector. Till recently, India's combined (centre and state) government health expenditure as a percentage of gross domestic product (GDP) was around 1%; this has now reached 1.2% in 2020–21 and 1.3% in 2021–22, respectively, during the post-COVID-19 period as compared to 0.9% in the pre-COVID-19 year in 2019–20. However, there is a wide variation in health expenditure (HE) as a percentage of gross state domestic product (GSDP) across Indian states. In the pre-COVID-19 year (2019–20), HE/GSDP varied from a low of 0.6% in Gujarat, Maharashtra, and Karnataka to a high of 1.4% in Chhattisgarh, and 3.3% in the hilly state of Arunachal Pradesh. Some of the states with high per capita net state domestic product (PCNSDP) like Punjab, Haryana, Telangana, and Andhra Pradesh (AP) spend less than 1% of their GSDP on health. The situation did not change during the post-COVID-19 year, with HE/GSDP varying from as low as 0.6% in Telangana to a high of 2.7% in Bihar and 4% in some of the hilly states. Major states like Gujarat, Maharashtra, and Karnataka continued to spend less than 1% of their GSDP on health. Health expenditure as a share of the total budget for the states is far below the NHP-recommended 8% in 2021–22, except for Delhi, Puducherry, Goa, and some hilly states.

Health is constitutionally a state subject in India, and the onus of achieving the health goals remains majorly on the

states. To achieve the SDGs and improve health outcomes in India, it is important to devote adequate resources to health, which in turn raises an important question: Are the subnational entities able to effectively raise resources for health? This, of course, depends on their availability of overall fiscal space. While there is a substantial body of research around fiscal space globally, in India, the discussions have remained mostly focused around national efforts; relatively much less has been discussed and debated around fiscal space at the sub-national level, which is quite different from that at the union level. The states have different sources of revenue and also depend on the union for the transfer of resources. They also have additional fiscal constraints on how they can spend these resources, especially for the centrally sponsored schemes (CSSs). Moreover, they are also bound by fiscal limits set by the fiscal responsibility legislation.[1]

In the context of the historically low government spending on health in India and consequent high out-of-pocket spending on private healthcare across states, it is important to understand whether the states are unable to raise health spending due to genuine fiscal space constraints or are unwilling to prioritise the health sector despite the availability of fiscal space. This paper attempts to answer this question by assessing the available fiscal space at the sub-national level in India. It analyses the possibility that limited fiscal space might play a role in restraining the level of health spending.

Next, we review the concepts, definitions, and measurements used in the literature on fiscal space, which is followed by presenting the data and the methodology adopted in this paper. Subsequently, the results are presented in three subsections. The first part shows the method of selection of states for assessing fiscal space based on health outcomes. The second part assesses the available fiscal space of the selected states, and in the third part, an analysis of the different sources of fiscal space for these states is carried out. Finally, we present conclusions and policy recommendations.

Concepts, Definitions and Measurement of Fiscal Space

The concept of fiscal space emerged in the late 1990s as a consequence of the International Monetary Fund (IMF)-supported programmes[2] provided to the financial crisis-affected countries. The IMF-supported fiscal adjustment programmes led the countries to focus on fiscal discipline too narrowly, compromising their long-run growth (Perotti 2007; World Bank 2007). Countries in Latin America, Europe, and several other affected countries advocated for relaxing fiscal constraints to allow them additional borrowing to create fiscal space for investments in physical and human capital considered crucial for economic growth (Heller 2005; Perotti 2007; World Bank 2007). Therefore, the concept of "fiscal space" gained importance for creating space for public spending on investments and social expenditures that were perceived as beneficial for the countries. Discussions on fiscal space have been further widened by the World Bank, United Nations Development Programme, and several non-governmental organisations with the argument that the current spending on health and education should have a valid claim on any available fiscal space from borrowing, as they have higher returns over the long run (Heller 2005).

In the early 2000s, this concept gained more importance in the context of meeting the Millennium Development Goals[3] (MDGs) commissioned by the UN. The progress on MDGs was uneven in developing countries and other low-income countries; the MDG on maternal and reproductive health, newborn and child health remained off-track (https://sdgs.un.org/2030agenda). *MDG Gap Task Force Report* (2015) noted the gaps in access to essential medicines at affordable prices in these countries. The MDGs transitioned to SDGs[4] in 2015 to deliver on the unfinished MDG commitments and to further strengthen global partnerships.

The challenges faced by reduced social sector expenditure in the late 1990s as a result of IMF-supported programmes in low-income countries along with the adoption of MDGs in the early 2000s and SDGs initiatives in 2015 put an increased focus on creating fiscal space for essential public spending in a fiscally sustainable manner (Heller 2005, 2006; Roy et al 2007; Barroy et al 2016; Barroy and Gupta 2020). This concept of fiscal space was subsequently developed and adapted for the health sector post the adoption of MDGs to close financing gaps to achieve health goals (PAHO 2015; Barroy et al 2016, 2018; Heller 2006). It was Heller who first coined the concept of fiscal space for health in 2006 and discussed the prospects of creating fiscal space for health in low-income countries. Subsequently, fiscal space for health gained increased traction in global and national platforms for attaining UHC—one of the important health goals of SDGs. Essentially, the lack of adequate and sustained levels of resources for health has been identified as a major constraint in achieving better health outcomes, especially in LMICs, with a concomitant emphasis on creating fiscal space for health (Tandon and Cashin 2010).

Definition and Measurement of Fiscal Space

The term fiscal space has been frequently used in policy discussions without much clarity on the definition (Heller 2005). The definition of fiscal space is still evolving and remains somewhat imprecise (Ostry et al 2010; Roy et al 2007; Heller 2005). Also, neither its measurement nor the possible policy implications are very clear (Ostry et al 2010).

In its broadest sense, fiscal space has been defined by Heller (2005) as the availability of budgetary room to provide additional resources for a desired purpose without jeopardising the fiscal sustainability of a government's financial position. Perotti (2007) claimed that the notion of fiscal space, coined by Heller (2005), is a restatement of intertemporal government budget constraint[5] since it emphasises the fiscal sustainability of a government's financial position. In this respect, deriving the fiscal sustainability condition[6] becomes a key driver for the fiscal space concept. In other words, estimating a sustainable level of debt and, therefore, the corresponding deficits beyond which the debt will be unsustainable is an important aspect of fiscal space assessment. Different methods are adopted to assess the fiscal sustainability condition in the

literature (Buiter 1985; Blanchard et al 1991; Buiter et al 1993; Bohn 1998, 2005, 2007; Ostry et al 2010; Auerbach and Gale 2011). Ostry et al (2010) have defined fiscal space as the scope for further increase in public debt without jeopardising sustainability and have advocated its measurement as the difference between current debt and the limit beyond which debt will be unsustainable. A similar approach is proposed by Buiter (1985), Blanchard et al (1991), and Auerbach and Gale (2011), where fiscal space is measured as the difference between the current fiscal balance and constant fiscal balance that stabilises debt at a sustainable level over the medium term. An analysis of fiscal space is considered to be important as a tool to assess, monitor or predict the sources and level of fiscal resources available for the health sector, as stated by Tandon and Cashin (2010).

The recent work on fiscal space for health is mostly related to creating fiscal space (Barroy and Gupta 2020; Barroy et al 2018; Tandon and Cashin 2010; Barroy et al 2016; Heller 2006); relatively less work has been done on the assessment of the available fiscal space in a country. The prospects of creating fiscal space for health were explored by Heller (2006) where five ways of creating fiscal space were recommended: (i) raising revenue share in GDP, (ii) reprioritisation of expenditure, (iii) external grants, (iv) borrowing, and (v) seignorage. The other sources of fiscal space, as suggested by Tandon and Cashin (2010), were conducive macroeconomic conditions, earmarked taxations, health sector-specific grants, foreign aid, and increasing the efficiency of health expenditure apart from the re-prioritisation already pointed out by Heller (2006). Improved financial management in the health sector, along with higher revenue generation, has been seen as an important way to create fiscal space for health (Cashin et al 2016; Barroy and Gupta 2020, 2021).

The brief overview indicates that revenue raising and favourable macroeconomic conditions that enable better revenue collection remain the most robust ways of expanding fiscal space. However, these conditions do not necessarily ensure an increase in fiscal space for health, mainly because in most contexts, the health authorities have a limited role in both allocations for health and its utilisation out of the increased overall fiscal space (Barroy and Gupta 2020).

In India, creating overall fiscal space via raising revenues has remained a challenge. Given the large informal sector, tax collection and compliance have been a major problem faced by the policymakers (Hemming 2020). India's tax–GDP ratio was 17% in 2021–22, much lower than that of Organisation for Economic Co-operation and Development countries (Reserve Bank of India 2023) and World development indicators. Thus, augmentation of resources has been a key constraint in expanding fiscal space. Given the scarcity of resources, efficient expenditure management remains an important source of fiscal space.

Hemming (2020) has called attention towards a more sophisticated approach to expenditure planning and budgeting in India to ensure adequate allocation towards health and other pro-poor programmes from newly created fiscal space. One of his key recommendations is for health ministries of the union and states to develop and modify health sector spending strategies continuously well in advance of budget preparation, as part of the medium-term expenditure framework (MTEF)[7] of the two levels of the government. Although MTEF statement is mandatory under Section 3 of the Fiscal Responsibility and Budget Management Act (FRBMA) in India, there is scope to further analyse how the health expenditures are designed and allocated annually both at the central and state levels.

Barroy and Gupta (2020, 2021) introduced the concept of budgetary fiscal space for health (defined as the potential resources budgeted and used for health through public finance management [PFM]) in three stages: first, budgetary space for health is determined by the annual public expenditure envelope, which is a function of the overall fiscal space. The second is the share of public expenditure dedicated to health, and the last is effective and flexible PFM. PFM is essential to evaluate how budgeted funds are allocated and implemented through the health system. Budgetary space for health is considered important as it embraces both revenue and expenditure policies in a framework where, on the one hand, health authorities have limited control over the overall fiscal space but, on the other, have greater control over the budgetary decisions and practices in the health sector. This arrangement is likely to enhance the effectiveness of budget dialogue and negotiations between finance and health authorities (Barroy and Gupta 2020, 2021).

An assessment of fiscal space will involve three steps (Tandon and Cahsin 2010): (i) justify the objective for which the additional health expenditure is needed; (ii) systematic analysis of the potential for increasing fiscal space; and (iii) identifying the most viable source of increasing fiscal space for health based on the analysis carried out in the second step. We use a broadly similar methodology in our analysis as given here.

Data Sources and Methodology

Data: The following fiscal variables have been used in the analysis—states' own tax revenue (SOTR), states' own non-tax revenue (SONTR), grants from the centre (grants), share in central taxes (SCT), state government's health expenditure,[8] and total expenditure of the state governments. The data for these variables are taken from the Economic & Political Weekly Research Foundation (EPWRF) as sourced from the Reserve Bank of India's (RBI) study of state finances. The data on GSDP at current prices are sourced from the National Statistical Office, Ministry of Statistics and Programme Implementation. Data on health outcomes, infant mortality rate (IMR) and maternal mortality rate (MMR) are compiled from various Sample Registration System (SRS) bulletins, Office of the Registrar General and Census Commissioner, India (ORGI), and SRS-Special Bulletin on Maternal Mortality in India, ORGI, respectively.

Methodology: To assess the fiscal space, we first select the states based on their primary reason for raising resources to achieve better health outcomes, that is—the states that are in

need of fiscal space for health. Thus, we look at two indicators of health outcome—IMR and MMR—and compare the values with those evidenced by the top-performing state.

The mean deviation of the health outcome gap of all states from the top-performing state is computed and labelled as the mean gap. The states with gaps higher than the mean gap are referred to as states with poor health outcomes and vice versa. These gaps are more relevant than the SDG targets which are uniform for all countries irrespective of disparate challenges faced by different countries. This is a key methodological and analytical angle in the paper, and as stated by Osborne et al (2010)

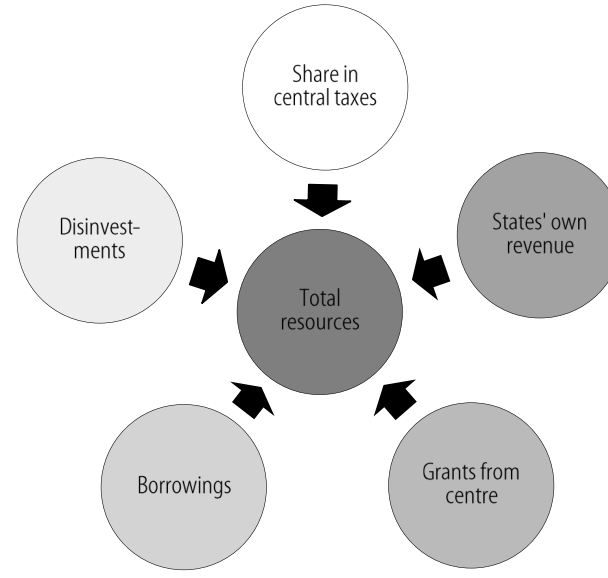
> The different goals and targets will however represent different degrees of challenge and ambition for different countries depending on their present state of development and other national circumstances. So, when it comes to implementation different countries will need to give different degrees of attention and effort to the different goals and targets, depending on where they stand in relation to them at present, their differentiated responsibilities and their different capabilities and resources. The balance between the social, economic and political effort needed to deliver the different objectives is also likely to be different in different countries.

Second, the average of all the states' government health expenditure to GSDP (HE/GSDP) is computed to classify the states as above and below the average. Third, we compare the state-wise health outcomes' gap of *t* year with the HE/GSDP of *t-1* year. The health expenditure is taken for 2019 and the health outcome gaps are analysed using IMR in 2020 and MMR in 2018–20, with a gap of one year from health spending to allow for possible lag effect on health outcomes. We do not take variables such as per capita health spending, since the aim is to compare HE/GSDP with the fiscal variables that are taken as a share of GDSP.

Finally, we assess the available fiscal space of the selected states as the gap between the actual fiscal space and the potential fiscal space and name this gap as the "unrealised fiscal space" (URFS). The presence of URFS will imply the availability of overall fiscal space for the states. The potential[9] fiscal space is taken from the projections of the finance commission reports (Fourteenth Finance Commission Report 2015–19 and Fifteenth Finance Commission Report 2021–26), Government of India). The terms of reference (TOR) mandate the finance commission to examine the taxation efforts of state governments and the potential for additional resource mobilisation to improve their tax–GSDP ratio, based on which the finance commission projects the tax revenue of the states. The finance commission also projects the GSDP at current prices from the state-wise comparable series provided by the Central Statistics Office (CSO), Government of India. It must be noted that the assessment of fiscal space is solely based on the potential resources as projected by the finance commissions. It is possible to carry out a separate exercise to estimate the potential resources of the states separately, by a detailed analysis of states' resources, which is not being attempted here.

The URFS is estimated for 2019 to understand if states had available fiscal space that could have been used for the health sector. The premise is that if fiscal space were available and health outcomes were poor enough to warrant a higher level of health spending, the states would not prioritise the health sector. On the other hand, states with low fiscal space availability and poor health outcomes can be deemed constrained by the availability of resources rather than a will to prioritise the health sector. Of course, it is entirely possible that the same states, once they manage to get sufficient resources, might still not put these resources towards the health sector. However, this way of analysis gives a clearer picture of health spending prioritisation and constraints of states. The URFS is also estimated for the most recent year for which data is available—2021–22 for the same states—to compare with 2019–20 and to evaluate the current status of available fiscal space.

Figure 1: Total Revenue Sources of the State Government



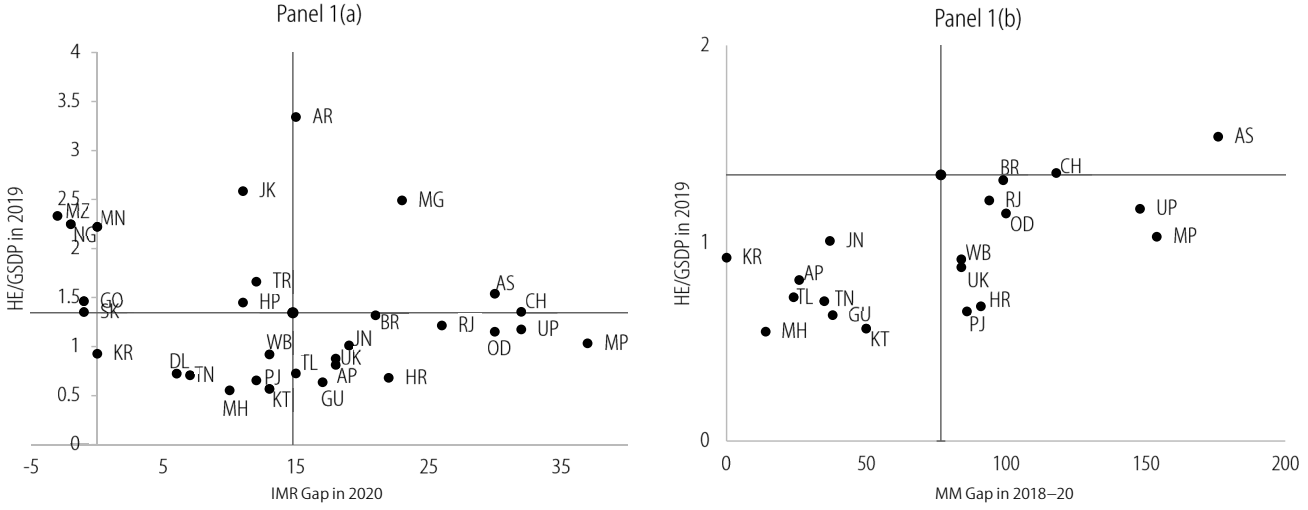
The fiscal space of a state government is the sum of all financial resources of the state. These resources comprise SOTR, SONTR, SCT, grants, disinvestment proceeds, and borrowings (Borr) (Figure 1). Disinvestment proceeds are not considered for computing the URFS as these are not regular flows. Grants include finance commission grants, grants for CSS, grants for central sector schemes, and other grants. There are several existing CSS (30 schemes as per 2019–20 budget and 56 schemes in 2024–25 budget) and central sector schemes (721 schemes in 2019–20 budget and 659 schemes in 2024–25 budget). This study considers only finance commission grants and not other grants, since the latter is a cumbersome state-wise exercise, which can be taken up in a subsequent study.

We assess the unrealised fiscal space for selected states using the following equation:

$$\text{URFS} = \left(\frac{\text{SOTR}^{\text{P}}}{\text{GSDP}^{\text{P}}} + \frac{\text{SONTR}^{\text{P}}}{\text{GSDP}^{\text{P}}} + \frac{\text{Borr}^{\text{P}}}{\text{GSDP}^{\text{P}}} + \frac{\text{SCT}^{\text{P}}}{\text{GSDP}^{\text{P}}} + \frac{\text{FC Grants}^{\text{P}}}{\text{GSDP}^{\text{P}}}\right) - \left(\frac{\text{SOTR}^{\text{A}}}{\text{GSDP}^{\text{A}}} + \frac{\text{SONTR}^{\text{A}}}{\text{GSDP}^{\text{A}}} + \frac{\text{Borr}^{\text{A}}}{\text{GSDP}^{\text{A}}} + \frac{\text{SCT}^{\text{A}}}{\text{GSDP}^{\text{A}}} + \frac{\text{FC Grants}^{\text{A}}}{\text{GSDP}^{\text{A}}}\right)$$

The superscript *P* and *A* are used to represent the projected and actual resources of the states, respectively. $GSDP^{P}$ is the projected GSDP based on the projections of the finance commission.

Figure 2: State-wise IMR Gap in 2020, MMR Gap in 2018–20 and HE/GSDP in 2019



AP: Andhra Pradesh, AR: Arunachal Pradesh, AS: Assam, BR: Bihar, CH: Chhattisgarh, DL: Delhi, GO: Goa, GU: Gujarat, HP: Himachal Pradesh, HR: Haryana, JK: Jammu and Kashmir, JN: Jharkhand, KR: Kerala, KT: Karnataka, MG: Meghalaya, MH: Maharashtra, MN: Manipur, MP: Madhya Pradesh, MZ: Mizoram, NG: Nagaland, OD: Odisha, PJ: Punjab, PU: Puducherry, RJ: Rajasthan, SK: Sikkim, TL: Telangana, TN: Tamil Nadu, TR: Tripura, UK: Uttarakhand, UP: Uttar Pradesh, WB: West Bengal.
Source: Authors' calculation.

The ratio, $\frac{Borr^P}{GSDP^P}$ represents the borrowing ceiling[10] as percent of GSDP, which is 3% as recommended by the Fourteenth Finance Commission.

Adding the *SOTR* and *SONTR* will give us the states' own revenue, which is a state subject. Also, once the borrowing ceiling is fixed, it is up to the states whether they want to fully utilise this space. The remaining components—*SCT* and grants—are part of the central transfers. The projected and actual variables are taken as a percentage of GSDP for measuring the *URFS*. Even though the actuals might not be equal to the projected numbers, the ratios are presumed to be the same with minimum variance under normal conditions.

Results

Health outcomes and health expenditure gaps—selection of states: Kerala has been taken as a benchmark for health outcome goals. Historically, Kerala and Goa have had lower IMRs than the goal of 28 per 1,000 live births envisaged in the NHP 2017. Kerala has been successful in persistently lowering its IMR over the years and it has reduced from 16 to 6 per 1,000 live births between 1991 and 2000.

Similarly, Kerala has been the first state to attain the SDG and NHP goals for MMR. MMR in Kerala was 19 per lakh live births in 2018–20 against the SDG target of 70 per lakh live births to be attained by 2030. While other states like Tamil Nadu, AP, and Maharashtra have also lowered their MMR significantly, Kerala has shown results much earlier, and therefore, we use Kerala's MMR as a benchmark to compare MMR of other states.

We compute the mean deviation of health outcome gap of all states from Kerala—the mean gap—and map these against HE/GSDP in Figure 2 to select states for this study.

From Figure 2, we get four cases described in the four quadrants: QI, QII, QIII, and QIV and present these in Table 1. Quadrants I and II comprise states with HE/GSDP greater than equal to the average share with varying health outcomes gap in these two quadrants; the health outcome gap is greater than the mean gap in QI, whereas it is less than equal to the mean gap in QII. The states in QIII and QIV represent the states with HE/GSDP less than the average share, with the former having a health outcome gap less than equal to the mean gap and the latter with a greater than the mean gap.

Table 1: Description of the Quadrants

Quadrant I (QI): HE/GSDP ≥ average share and health outcomes gap > mean gap	Quadrant II (QII): HE/GSDP ≥ average share and health outcomes gap ≤ mean gap
Quadrant III (QIII): HE/GSDP < average share and health outcomes gap ≤ mean gap	Quadrant IV (QIV): HE/GSDP < average share and health outcomes gap > mean gap

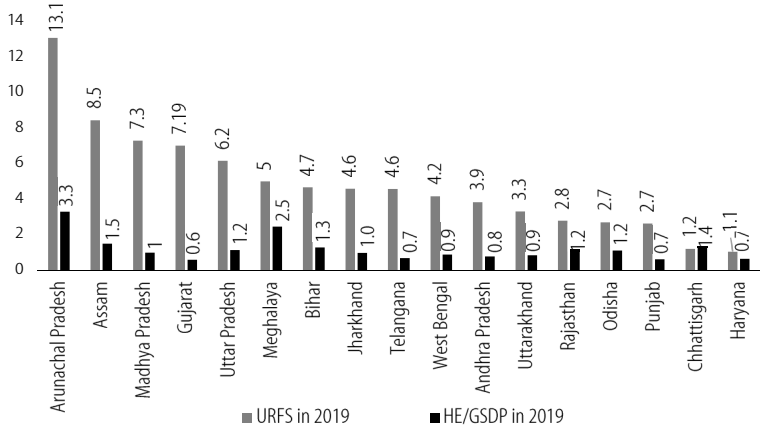
Average share represents the average of all states for HE/GSDP. Mean gap represents the mean deviation of health outcome gap of all states from Kerala.
Source: Authors' calculations.

Based on the analysis of all the four quadrants, two distinct problems can be identified: efficiency (QI and QII) and prioritisation (QIV). States in QIII are not of immediate concern because these states have achieved better health outcomes with a relatively lower level of spending on health.

The states in QI with a higher-than-average government health expenditure are states that need to improve their health outcomes. Although the states in QII are doing better, they are spending more than the average health spending of all states. Efficiency in spending is crucial along with increased finances, more so when resources are scarce. For QIV states, prioritisation of health seems to be a challenge—these states have both lower levels of health spending and relatively poor health outcomes.

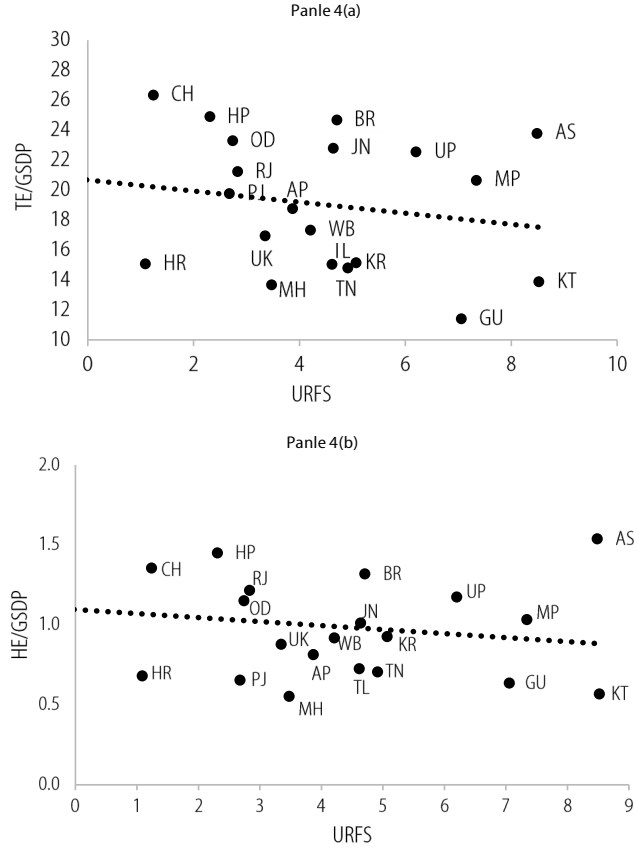
In this paper, we do not focus on the efficiency issue but analyse states that need to close their health outcome gaps. Thus, the focus will be on states with high HE/GSDP and high health outcome gaps (QI), and states with low HE/GSDP and high health outcome gaps (QIV). The aim is to understand whether government health expenditure can be further

Figure 3: URFS and HE/GSDP of Selected States in 2019 (as % of GSDP)



Source: Authors' calculation.

Figure 4: Relation between URFS and TE, HE as Percent of GSDP in 2019



Source: Authors' calculation.

increased for QI states given that they already have a high HE/GSDP ratio, and whether QIV states have the fiscal space to prioritise the health sector and raise health spending. Based on this, the states selected for the assessment of fiscal space are mentioned in Table 2.

Table 2: Selected States for Fiscal Space Analysis for 2019

HE/GSDP	High-focus States	Middle-focus States
	Both IMR and MMR gap > mean gap	IMR gap or MMR gap > mean gap
<Average	BR, HR, MP, OD, RJ, UP, UK (QIV)	AP, GU, JN, PB, WB (QIV)
≥Average	AS, CH (QI)	AR, MG (QI)

Source: Authors' calculation.

The 16 selected states can be further classified into two categories based on their health gaps: high-focus states and middle-focus states. States with both the IMR gap and MMR gap above the mean gap are classified as high-focus states, and the states with at least one of the health outcome gaps above the mean gap are classified as middle-focus states. In the next section, we assess the available fiscal space of the selected states for 2019 based on URFS for QI and QIV states.

Assessment of fiscal space of the selected states in 2019: The assessment of fiscal space for QIV states, in 2019 (Figure 3) shows a significant amount of unrealised fiscal space both for high- and middle-focus states; URFS ranged from 7% for Madhya Pradesh (MP) and Gujarat to 1% for Haryana for QIV states. As for QI states, the URFS ranged from 13% for Arunachal Pradesh to 1% for Chhattisgarh.

We deduce that the high-focus states (Assam and Chhattisgarh) and middle-focus states (Arunachal Pradesh and Meghalaya) in QI were not fiscally constrained, and since these states were already spending above the average ratio on health, the issue of efficiency of spending cannot be ruled out. The QIV states were also not fiscally constrained and, potentially, could have increased their available fiscal space for health.

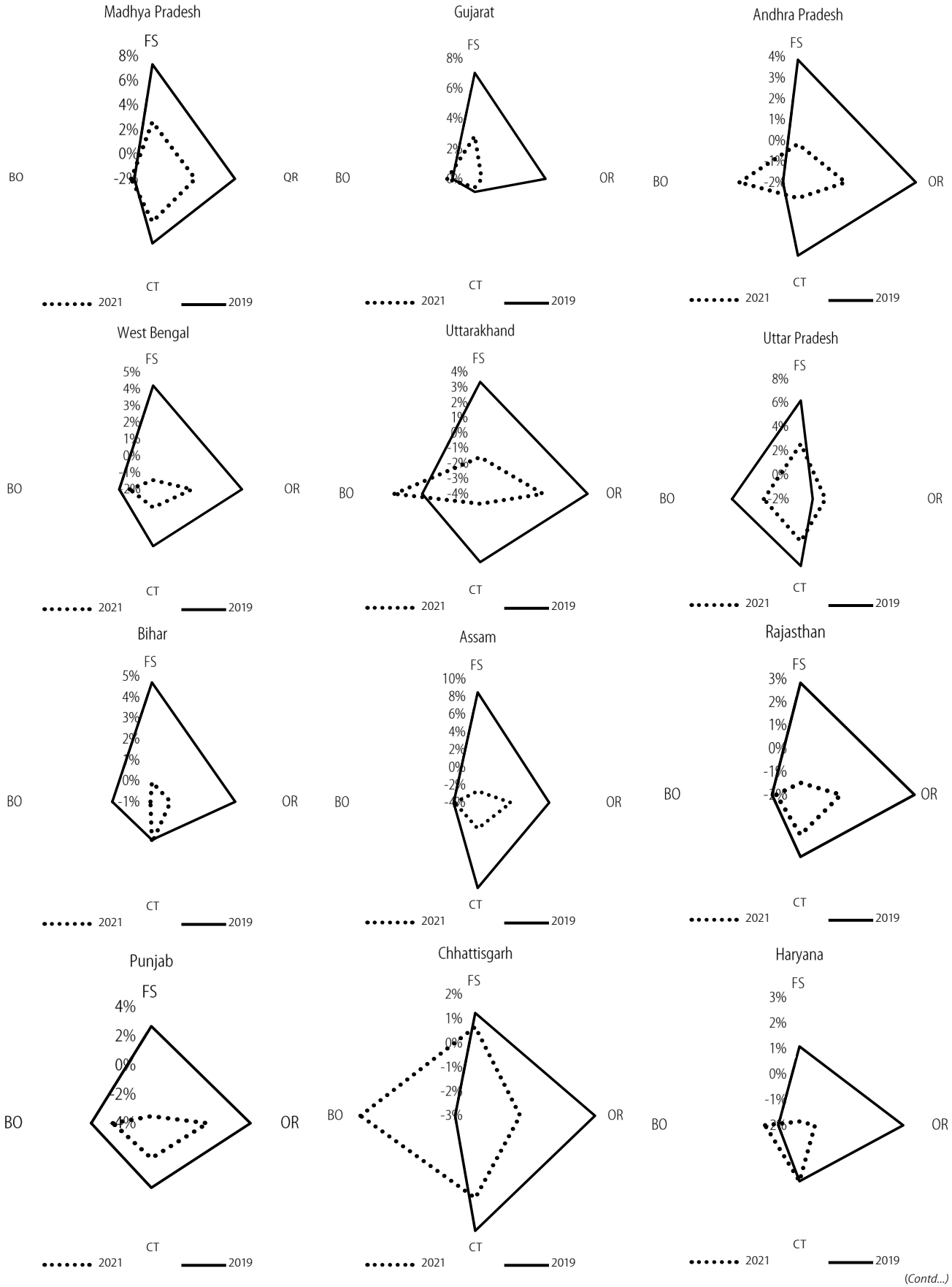
Figure 3 shows that both the high- and middle-focus states—except for Chhattisgarh (in QI)—could have increased their health spending ratio by reducing their URFS and closing the gap between potential and actual resources of the states.

Figure 4 shows that total expenditure as a percentage of GSDP (TE/GSDP) and HE/GSDP have a somewhat negative correlation of -0.4 with URFS, indicating a decline in TE/GSDP and HE/GSDP as URFS increases in the states. As HE/GSDP is also positively correlated (0.8) with TE/GSDP, HE/GSDP gets affected by both a decrease in TE/GSDP and an increase in URFS. However, it is clear from Figure 4 that there can be many variations across states: the same level of URFS can be consistent with different levels of TE/GSDP and HE/GSDP indicating that other factors are also at play that determine how states spend their resources.

Nevertheless, an important way to increase the HE/GSDP in the states will be to reduce the URFS, for which one has to know its sources. An analysis of the sources of URFS for 2019 and 2021 in the next section enables a better understanding of the options that states have to increase their fiscal space.

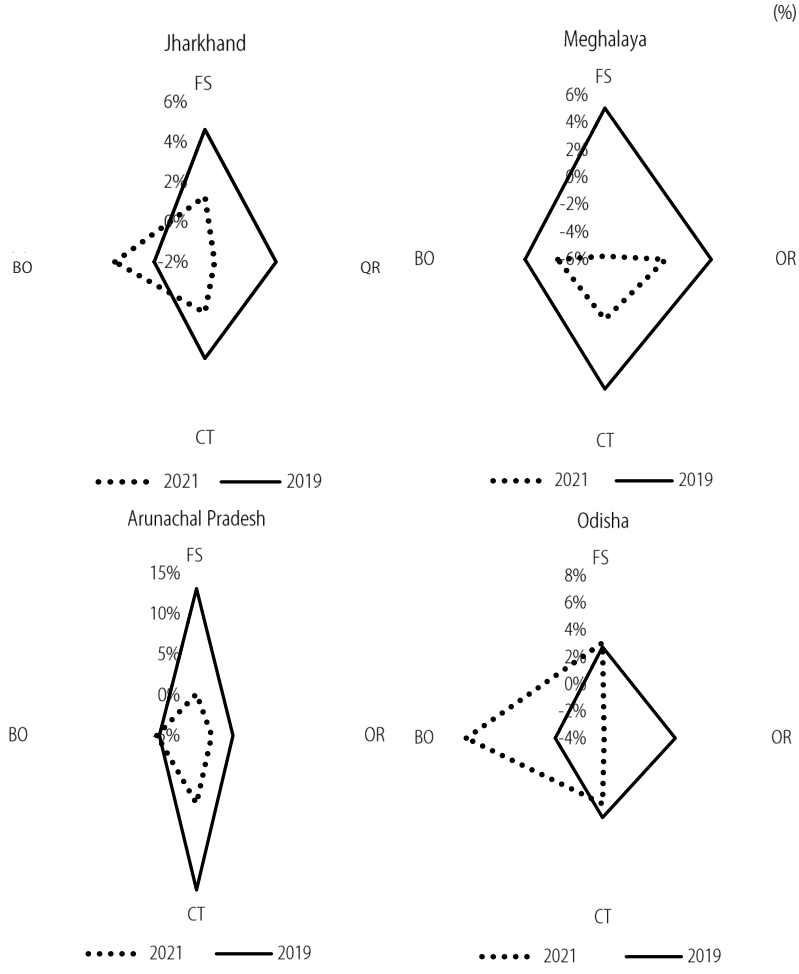
Sources of URFS of the selected states in 2019: The URFS was not sourced equally from own resources (OR), borrowing (BO), and central transfers (CT) for all the states. The evaluation of sources of URFS in 2019 (Figure 5, p 49) shows that out of 16 states, 14 had URFS from own resources (OTR and ONTR), the higher percentage being unrealised from OTR for all the states. URFS from own resources varied from -1% in Uttar Pradesh (UP) to 4.7% in Gujarat. URFS from own resources was in the range of 1% to 2% for Meghalaya, Chhattisgarh,

Figure 5: Fiscal Diamond—Sources of URFS of the Selected States in 2019 and 2021



(*Contd...*)

Figure 5: Fiscal Diamond—Sources of URFS of the Selected States in 2019 and 2021 *(Continued)*



FS represents fiscal space, BO is the borrowing, OR is the own revenue which includes OTR and ONTR and CT represents central transfers to state governments which include SCT and FC grants. These are all as percentage of GSDP.
Source: Authors' calculation.

Except for the central transfers, the rest of the components of URFS—states' own revenue and borrowings—are the revenue-generating functions of the state governments. To increase the total resources, the states need to reduce these URFS with sustainable support from central transfers to the states. This has the potential to enhance the states' health expenditure if health is prioritised by the states.

URFS in 2021 and its sources: The URFS was reduced in nine states in 2021 compared to all 16 states in 2019 under this study. Five high-focus states—Bihar, Haryana, Rajasthan, Uttarakhand and Assam and four middle-focus states, AP, Punjab, West Bengal, and Meghalaya—could successfully reduce their URFS. The URFS estimated in these nine states was negative. Assam, Meghalaya, Rajasthan, and Punjab, could successfully reduce their URFS from all three sources, that is, own resources, borrowing, and central transfers which contributed to the reduction in their overall URFS (Figure 5). A decrease in URFS from central transfer in Uttarakhand and AP played a significant role in reducing its URFS in 2021. In Bihar and Haryana, a decrease in URFS from own revenue and borrowing contributed to the fall in their URFS, while in West Bengal, the sources were borrowing and central transfer (Figure 5). On the contrary, seven states—Odisha (3%), Gujarat (2.9%), MP (2.6%), UP (2.6%), Jharkhand (1.3%), Chhattisgarh (0.7%), and Arunachal Pradesh (0.1%)—showed positive URFS; the last two states belong to QI category, with Chhattisgarh being a high-focus state and Arunachal Pradesh a middle-focus state, respectively.

Odisha, Jharkhand, and Chhattisgarh had URFS from borrowing and central transfer and not from own resources, with the highest URFS sourced from borrowing (Figure 5). Gujarat and UP showed URFS from all three sources with the highest contribution from borrowing in Gujarat and from central transfer in UP. In MP, the sources were central transfer and own resources, while in Arunachal Pradesh, the URFS was sourced only from central transfer.

Although the available fiscal space has increased in 2021 from 2019 followed by a reduction in URFS, not all these states could translate this into an increase in HE/GSDP above the all-states average (Table 3). Punjab, Haryana, Uttarakhand, West Bengal, AP, and Rajasthan could not increase their HE/GSDP

Jharkhand, and Odisha. However, we found no URFS from own resources for UP and Arunachal Pradesh.

The URFS from borrowing was only observed in four states, UP (3.7%), Gujarat (1.5%), Bihar (0.9%), and Jharkhand (0.4%); the rest of the states exhausted this space and showed a negative URFS from borrowing.

Central transfers remained unrealised for all states, varying from 0.2% in Haryana to 14% in Arunachal Pradesh. URFS from central transfers was the highest in Arunachal Pradesh, followed by Assam (5.7%), UP, Meghalaya, MP, and Jharkhand (3% to 3.5% in these four states). It was in the range of 1% to 2% in Odisha, Chhattisgarh, AP and West Bengal, while between 0 to 1% in Gujarat, Bihar, Rajasthan, Uttarakhand, Punjab, and Haryana (Figure 5).

Comparing all three sources of URFS, we see that nine states (Gujarat, MP, AP, Uttarakhand, Bihar, West Bengal, Rajasthan, Punjab, and Haryana) had the maximum URFS from other revenues. Six states—Assam, Meghalaya, Chhattisgarh, Jharkhand, Odisha, and Arunachal Pradesh—showed the highest URFS from central transfers and UP showed the maximum URFS from borrowing. Gujarat, Bihar, and Jharkhand were the only states in 2019 with URFS from all three sources (Figure 5).

Table 3: URFS and HE/GSDP of Selected States in 2021 (As % GSDP)

	URFS	
HE/GSDP	Positive	Negative
<Average	GJ, MP, UP, JN, OD,	PJ, HR, UK, WB, AP, RJ
≥Average	CH, AR	AS, BR, MG

Source: Authors' calculation.

ratio above the average share in 2021 despite an increase in fiscal space (Table 3). The HE/GSDP was also below the average share in five other states—Gujarat, MP, UP, Jharkhand, and Odisha—with positive URFS. However, a decrease in URFS, or an increase in FS might not ensure an increase in HE/GSDP unless the sector is prioritised by the state governments.

Conclusions

The fiscal space of 16 states in need of increased health spending due to relatively poor health outcomes was assessed. Twelve states—Bihar, Haryana, MP, Odisha, Rajasthan, UP, and Uttarakhand in the high-focus group, and AP, Gujarat, Jharkhand, Punjab, and West Bengal in the middle-focus group had HE/GSDP ratio below the all-states average share. The remaining four states with HE/GSDP above the all-states average share were Assam and Chhattisgarh (high-focus) and Arunachal Pradesh and Meghalaya (middle-focus).

The assessment of fiscal space in 2019 showed a significant amount of unrealised fiscal space for all 16 states. Since Assam, Chhattisgarh, Arunachal Pradesh, and Meghalaya were already spending above the average ratio on health, the issue of efficiency in spending cannot be ruled out. These states would require policy attention to reduce inefficiency in spending.

On the other hand, the rest of the 12 states with low HE/GSDP were not fiscally constrained and could have increased their health spending by prioritising the health sector. To increase the total resources, these states need to reduce URFS by first identifying the sources, but generally, this could be done from their own revenue and borrowing, with sustainable support from central transfers to the states to enhance health spending.

The analysis also showed that fiscal space increased (decrease in URFS) in 2021 for nine out of the 16 states: Bihar, Haryana, Rajasthan, Uttarakhand, AP, Punjab, West Bengal, Assam, and Meghalaya. However, not all these could translate into an increase in HE/GSDP above the all-states-average. Punjab, Haryana, Uttarakhand, West Bengal, AP, and Rajasthan were not able to increase their health spending despite their poor health outcomes. The process of prioritisation requires an assessment of the needs of the health sector, followed by allocating a greater share of the government's total resources to the departments of health. This process needs analysis, advocacy, and coordination among different departments and ministries, especially finance and health. Clearly, this has not been happening for many of the states that urgently require an increase in their health spending to improve their health outcomes.

In sum, the analysis indicates that lack of fiscal space is not always the reason why states are unable to finance a higher level of health spending. While the states can always find additional ways of raising resources and request the centre to transfer additional funds, there is an implicit rationing of resources going on in many of the states that do have revenues that can be potentially allocated to the health sector. Not being able to do so indicates that those in charge of the health sector are not being able to convincingly convey the urgency to authorities who decide on budget shares across sectors.

NOTES

1 Following the Twelfth Finance Commission, the states enacted the fiscal responsibility legislation (FRL) by 2005–06, which aimed at eliminating the revenue deficit and reducing fiscal deficit (FD) as a share of GSDP to 3% by 2008–09. It has become a mandate of the subsequent FCs to review the finances, deficit and debt levels of the states based on which they suggest measures for maintaining a sustainable fiscal path.

2 IMF provides financial support to countries hit by crisis to restore economic stability and growth. IMF also provides support to low-income countries through policy advice and capacity-building activities at below-market interest rates.

3 In September 2000, world leaders came together at the United Nations to establish a new global partnership and set up MDGs to reduce poverty, hunger, and disease affecting billions of people in their nations by 2015.

4 The 2030 Sustainable Development Agenda adopted in 2015 by all United Nation member states set 17 SDGs, which were considered to be urgent call for action by all developed and developing countries in a global partnership, emphasising on ending poverty, improving health, education, reducing inequality, and spurring economic growth along with tackling climate change and preserving oceans and forests.

5 Higher deficit today should be compensated by higher surplus or lower deficit in the future.

6 Maintaining public finances at a sustainable level over the long term.

7 MTEF statement, presented to Parliament under Section 3 of the Fiscal Responsibility and Budget Management Act (FRBMA), 2003 sets forth a three-year rolling target for the expenditure indicators with specification of underlying assumptions and risks involved. The objective of the MTEF is to provide a closer integration between budget and the FRBM statements.

8 Government health spending refers to the government expenditure on medical, public health, and family welfare.

9 Potential resources could be slightly different from what is considered in this study which is based on the finance commission projections on SOTR, SONTR, SCT and FC grants. Potential fiscal resources could be estimated by a detailed analysis of state resources, separately for each state.

10 Following the Twelfth Finance Commission recommendation, almost all the states enacted the fiscal responsibility legislation (FRL) by 2005–06 which aimed at eliminating the revenue deficit and reducing fiscal deficit as a share of GSDP to 3% by 2008–09. It has become a mandate of the subsequent finance commissions to review the finances, deficit, and debt levels of the states based on which they suggest measures for maintaining sustainable fiscal path.

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