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Democracy and Public Good Provision:
A study of spending patterns in health and rural development in selected Indian states

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Abstract

This paper examines the policy priorities of democratic governments regarding provision of public goods especially healthcare. In the context of increasing budget allocation towards health through the National Rural Health Mission (NRHM) by the central government, this paper studies the trends in public expenditure on health and rural development by state governments in India. When there is widespread poverty and imperfect information among voters, rational governments will choose to spend more of their resources on rural development schemes providing goods that are perceived to be of more political value. In such a setting, healthcare often gets deprioritised. Hence the increasing funds from the central government of India will only give state governments perverse incentives to not raise their contribution towards healthcare to the required level.

Acronyms

NREGS	National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
IAY	Indira Awaas Yojana
PMGSY	Pradhan Mantri Gram Sadak Yojana
SGSY	Swarnajayanti Gram Swarozgar Yojana

Contents

Acronyms 3
1. Introduction 6
2. Background 8
3. Literature Review 10
3.1 Imperfect Competition in Political Markets 10
3.2 Visibility 11
3.3 Targetability and Credit claiming 12
3.4 Health Expenditure in India 12
3.5 Connecting the dots in the literature to inform our analysis 13
4. Methodology 15
5. Analysis 18
5.1 Inter-state disparities in health expenditures 18
5.2 Relative Trends in Government Spending Under Selected Heads 20
5.3 State contribution towards heath vs Rural development expenditure 23
5.4 Himachal Pradesh: Differences in Public Spending 27
5.5 Public Expenditure Choices of State Governments: Why Rural Development over Health? 29
5.6 Ruling out an alternative explanation 34
5.7 Some Limitations and Clarifications 36
5.8 A Summary of the Analysis 36
6. Conclusion 38
Bibliography 40
Appendix 1A: Total State Expenditure under selected heads – Bihar 45
Appendix 1B: Total State Expenditure under selected heads – Madhya Pradesh 45
Appendix 1C: Total State Expenditure under selected heads – Odisha 45
Appendix 1D: Total State Expenditure under selected heads – Rajasthan 46

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Appendix 3A: Total State Expenditure under selected heads – Himachal Pradesh 49
Appendix 3B: Himachal Pradesh - state's contribution in health vs rural development 49

1. Introduction

Public good provision in poor democracies has been a topic of discussion in academic circles in recent times. The dismal track record of democracies in the developing world in providing basic public services to their citizens has puzzled many social scientists leading to a vast scholarship surrounding this area. Of particular relevance is the case of healthcare provision that is crucial for the survival of the poor who could benefit a great deal from an efficient public health sector. Yet healthcare provision in developing countries like India remains largely inefficient and undersupplied. This has led to one of the highest out-of-pocket expenditures on health in the world (Balarajan et al. 2011), keeping millions of people just "one illness away" from poverty (Krishna 2010). Available literature on political markets seems to suggest that governments make rational decisions while deciding their strategic policies and schemes through a careful analysis of the political benefits and costs associated with each spending decision.

This paper aims to understand the policy priorities of democratic governments in Indian states with regard to the provision of public goods with a particular focus on healthcare. It does so in the context of increasing political commitment and funds for rural healthcare from

2. Background

Publ

3. Literature Review

Though Lipset's argument regarding the sustainability of democracy in poor societies has been challenged by many scholars,[3] it seems that a widespread consensus has emerged regarding the characteristics of a developing society (such as information asymmetry, poor literacy, patron-

expenditure in health averaged around 1 per cent of GDP and has even seen a decline in states' health expenditures

are more targetable. However a higher political commitment from the part of the central government is perceived in recent years after the launch of various health schemes under the banner of NRHM. Given that democratic governments in poor regions have political incentives to prioritise rural development schemes over health schemes, it becomes important to study what changes these increasing funds from the centre have brought in the state governments' expenditure patterns in health relative to rural development. Such a comparison enables us to identify the kind of goods that states prioritise relative to the kind of goods that get deprioritised.

4. Methodology

This paper adopts a comparative analysis of public expenditure patterns of six selected state governments in India. Such a comparative study of trends in government spending is expected to give valuable insights into the policy priorities of democratic governments with reference to the political markets they face. Universal healthcare has all the properties of a classic public good. At the same time, activities under rural development that governments in India undertake mostly comprise of employment and public works programmes that are often discussed in the literature as "pork barrel" projects and targeted benefits that politicians tend to favour when there is imperfect information among the voters. Hence health and rural development are taken as the topics of special focus in this paper and the relative expenditure under each of these heads over a decade by state governments is explored in much detail.

The data on expenditure by state governments is gathered from official sources including the Reserve Bank of India (India's central bank), and the Ministries of Health and Family Welfare and the Ministries of Rural Development of the Government of India and those of the respective states.

Another interesting aspect is that the study of relative expenditure on various heads (healthcare and rural development) is done in the context of increased funds and political commitment from the centre. The central government's role gathers special mention as it has an advisory role to the states in formulating policy guidelines on healthcare though the implementation aspect is often left to the states (Duggal 2009, p.15; Dev and Mooij 2002, p. 857). The plethora of programmes under the National Rural Health Mission testifies this.

spending patterns and draw broader conclusions on the policy choices of politically rational governments.

Table 1: Vital characteristics of states included in the study

India & States	Rural Population (% of Total Population)	Rural Literacy Rate (% of literates in rural population)

5. Analysis

This section will analyse the comparative changes in the observed patterns of public spending in health and rural development by six state governments in India. First it is established that even after the launch of NRHM and increased focus (and funds) on health from the central government, the inter-state disparities in per capita health expenditures persist. Informed by the review of literature presented earlier, an analysis of the relative changes in health

states after 2005, their per capita expenditures on health remain significantly low compared to the best-performing states.

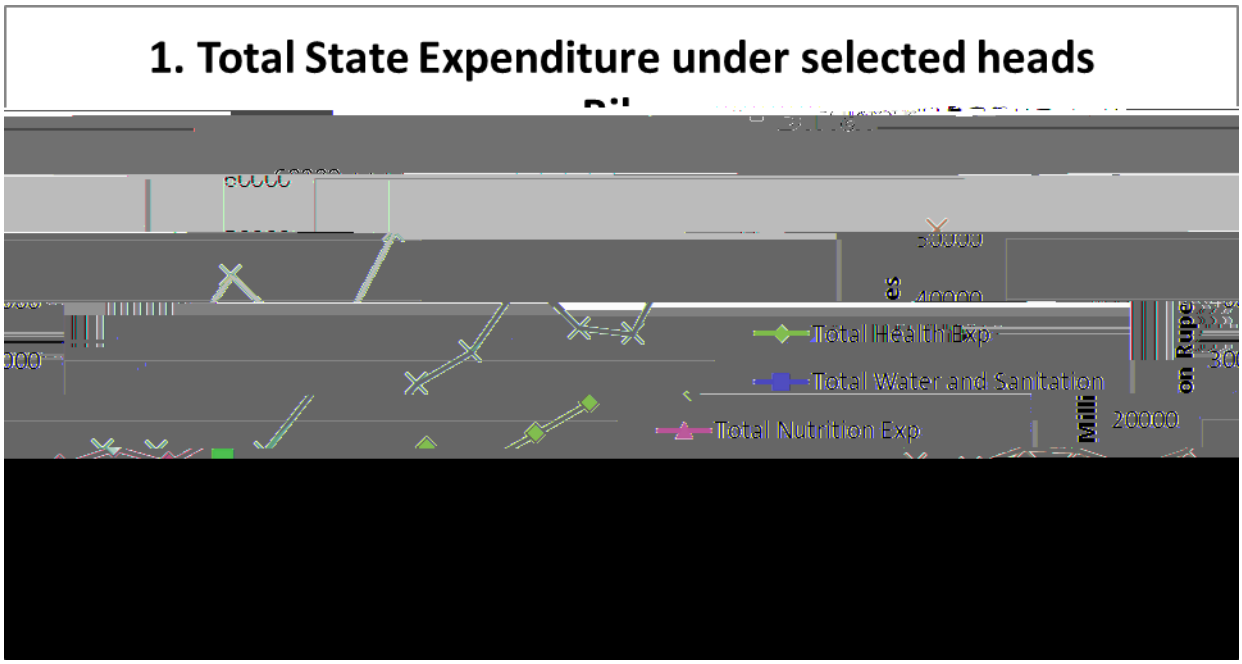
Table 2: Per Capita State Health Expenditure[6]

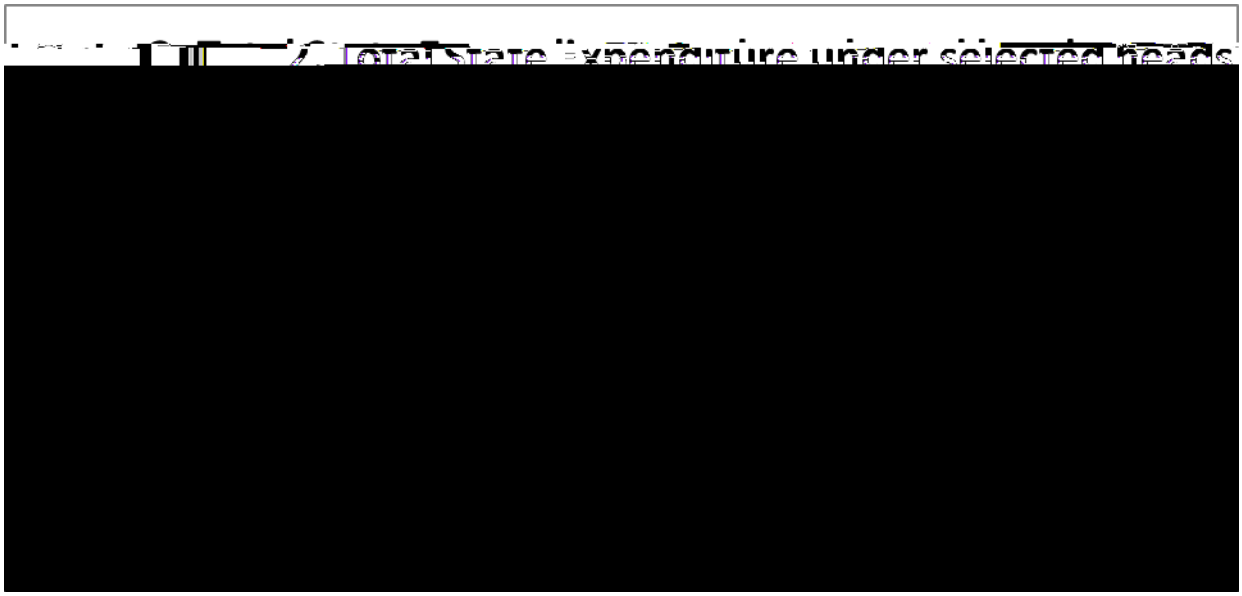
Average Per Capita State Health Spending 2002-05		**Per Capita State Health Spending 2011-12**	
	Rupees		*Rupees*
Bihar	84.76	Bihar (NRHM High Focus)	222.08
Madhya Pradesh	136.73	Madhya Pradesh (NRHM High Focus)	315.03
Odisha	147.86	Odisha (NRHM High Focus)	312.17
Rajasthan	178.53	Rajasthan (NRHM High Focus)	379.88
Uttar Pradesh	115.04	Uttar Pradesh (NRHM High Focus)	291.37
Chhattisgarh	141.02	Chhattisgarh (NRHM High Focus)	492.67
Jharkhand	154.51	Jharkhand (NRHM High Focus)	374.16
Kerala	270.21	Kerala	738.17
Tamil Nadu	207.00	Tamil Nadu	500.02
Himachal Pradesh	557.11	Himachal Pradesh (NRHM High Focus)	1085.63
Maharashtra	195.05	Maharashtra	426.45
West Bengal	174.10	West Bengal	408.35
Haryana	174.34	Haryana	522.96
Punjab	251.13	Punjab	619.48

Source:

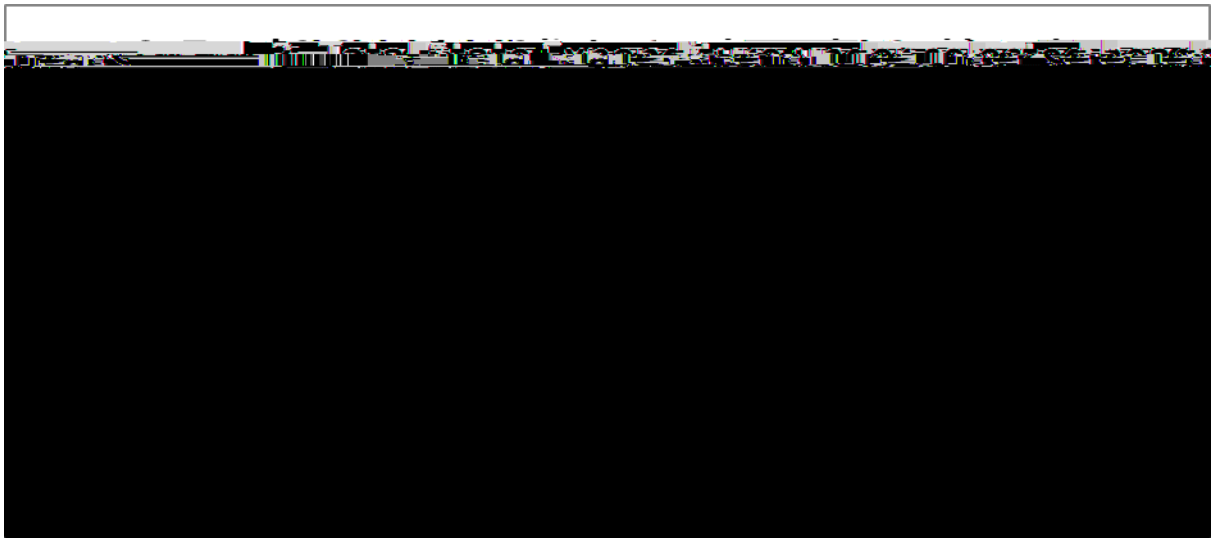
A broad view of the trends in state governments' spending under the selected heads is possible from a careful look at figures 1-5.

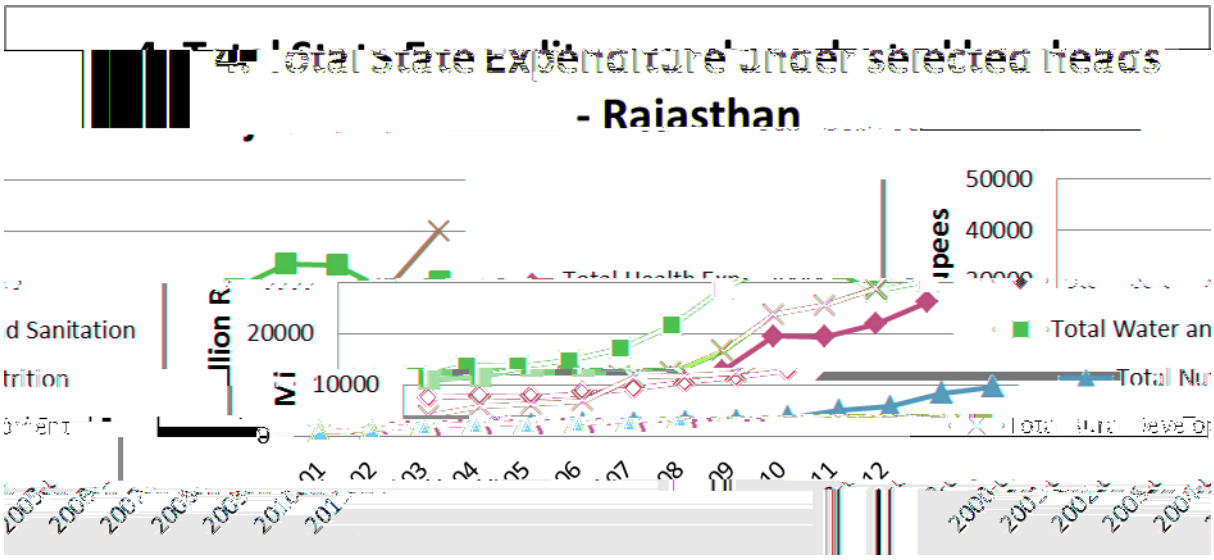
Figure 1- 5: Expenditure patterns of selected state governments[7]

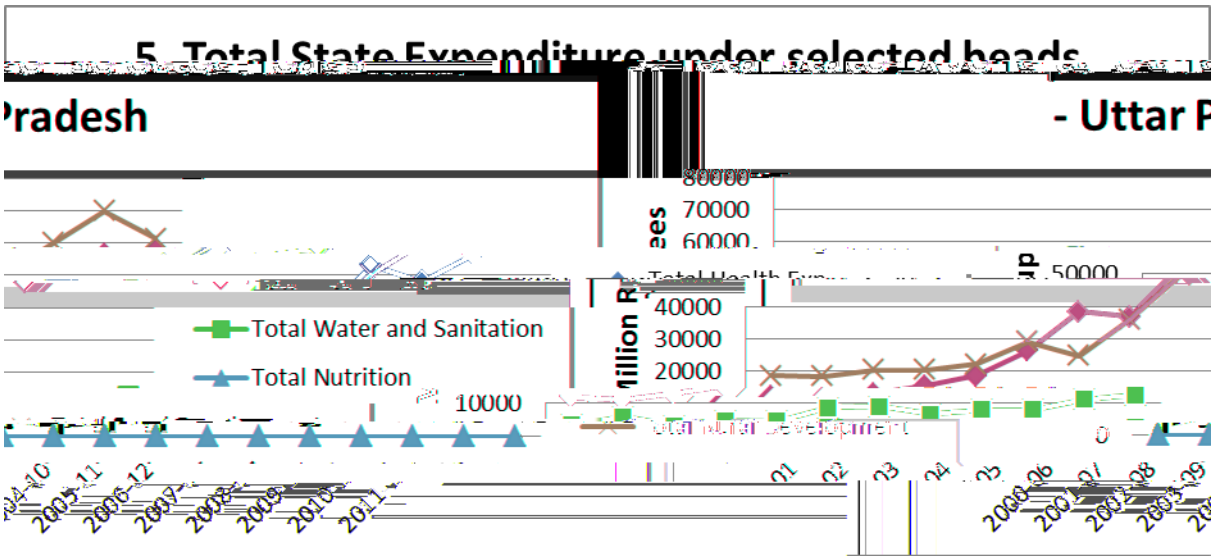




[7] Total Expenditure includes both the revenue and capital expenditures of state governments. Since part of NRHM funds are routed through state treasuries, the total state health expenditure includes some of centre's funds.







Source: Author's compilation from –

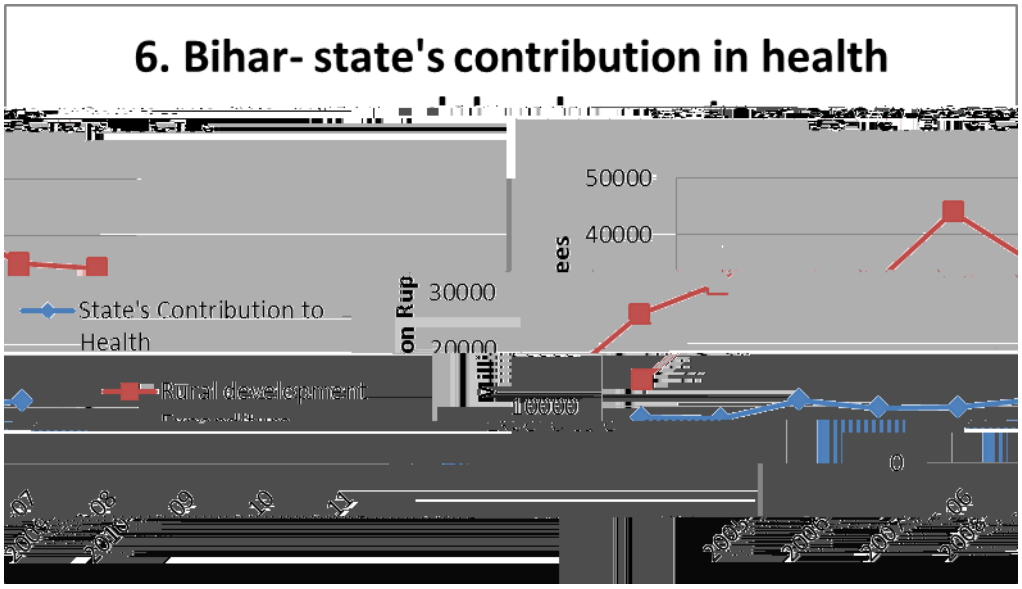
(a) State Finances: A Study of Budgets of 2011-12, RBI, 2012

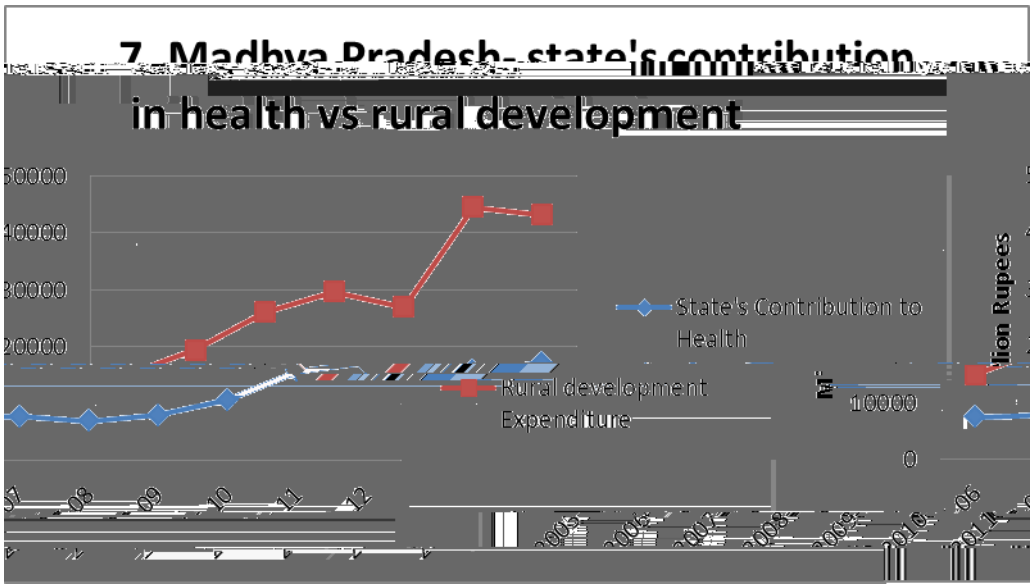
(b) Handbook of Statistics on State Government Finances – 2010, RBI, 2010

A growing

Though data constraints do not allow us to obtain a similar calculation for the state's own contribution to the rural development expenditure, it is argued that this expenditure head in state budgets is largely controlled by the state (which is to be discussed in more detail in Section 5.6).

Figure 6-10: Comparing state's own contribution to health with its rural development expenditure





a) State Finances: A Study of Budgets of 2011-12, RBI, 2012 – data on health and rural development expenditure
b) Ministry of Health and Family Welfare, Government of India – data on Central Release of NRHM funds

It is worth noting from figures 6-10 that the growth in the states' contribution towards health is modest since the launch of NRHM in 2005-06. Except Uttar Pradesh, the other four states have seen very stagnant contribution towards health in the initial years, with Bihar and Rajasthan showing a decline in the first few years. This has to be seen as reluctance on the part of the states to raise their spending despite increased funds and political pressure from the Centre. The growing divergence between the rural development expenditure and the state governments' share in health expenditure is also of special significance while considering policy choices of governments.

Another interesting observation to make from figures 6-10 is that in most states, the years that have seen a decline or a very slight increase in the state's share in health are also the years that have witnessed a very high rise in the state's rural development expenditure. This is particularly pronounced in Bihar (figure 6). However this trend becomes visible only when we consider the state's own contribution towards health. A simple comparison between the state's overall health expenditure (that includes central government's NRHM funds) and its rural development expenditure does not reveal this trend. Though it is impossible to find which policies and programmes are receiving the states' funds that were meant to be spent for health, this interesting comparison between health and rural development spending is in consonance with the *fungibility* problem of funds meant for health that Duggal (2009) identifies. This phenomenon of state governments using fungible funds to prioritise certain sectors over others is witnessed in several other studies as well. For instance, Pande (2003) finds that greater political representation of backward classes (like scheduled castes and tribes) in Indian states led to increased spending on providing public sector employment for these groups diverting resources away from education expenditure. This further adds strength to the argument that when states consider their resources to be fungible, they may have political incentives to spend more on policies or programmes th

own contributions towards health. This has to be viewed in the light of the particular features of public goods like healthcare that make them politically less appealing as opposed to other goods (see Section 5.5 for a detailed discussion).

5.4 Himachal Pradesh: Differences in Public Spending

As mentioned in the Methodology section, our analysis includes the state of Himachal Pradesh apart from the five states that have been discussed. Himach

market imperfection might not be as significant as it is in the other rural poor states in India. In such a context, politicians tend to focus on provision of broad public services.

5.5 Public Expenditure Choices of State Governments: Why Rural Development over Health?

The observed relative differences in the trends in state governments' spending between public health and rural development warrant further research into its possible reasons. In order to understand what leads governments to choose some goods/schemes (like that of rural development) over other goods/ schemes (like public healthcare programmes), it becomes necessary to analyse the types and characteristics of the goods provided to citizens under rural development schemes. Such an analysis will give us further insights into the political incentives and costs faced by governments operating under conditions of imperfect information and poverty among voters.

Table 3 provides a summary of the different rural development schemes implemented by state governments under study.

Table 3: Rural Development Schemes in Indian States[8]

Type of Rural Development Schemes	**Names of Rural Development Schemes**
Wage Employment Schemes	State Rural Employment Guarantee Schemes (separate from NREGS)
	Employment Assurance Schemes
	Sampoorna Grameen Rozgar Yojana (Rural Employment Scheme)
Self Employment Schemes	Swarnajayanti Gram Swarozgar Yojana (separate schemes both by centre and states in the same pattern)
	District Poverty Initiative Project
Rural Housing Schemes	Indira Awaas Yojana
	Pradhan Mantri Gramodaya Yojana
	State Housing Schemes (under different names in different states)
Rural Roads and other Public Works	Pradhan Mantri Gram Sadak Yojana

[8] The details of different schemes are obtained from the websites of Departments of Rural Development of the Governments of Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Madhya Pradesh

Schemes	State Rural Connectivity Schemes
	Jawahar Gram Samriddhi Yojana
General infrastructure schemes (to be decided by politicians based on the needs of his/her constituency)	MLA Local Area Development Programme
	MP Local Area Development Programme
	Backward Regional Grant Fund
Watershed / Irrigation Schemes	Integrated Wasteland Development Scheme
	Drought-Prone Areas Programme
	Desert Development Programme
Monetary/ non-monetary transfers	National Social Assistance Programme (includes old age pensions, family and maternal benefits)
	Godan Yojana (provision of cattle to rural women)

Source: (Department of Rural Development, Government of Bihar, 2012); (Department of Rural Development & Panchayati Raj, Government of Rajasthan, 2012); (Department of Panchayat & Rural Development, Government of Madhya Pradesh, 2012); (Department of Rural Development, Government of Orissa, 2012), (Department of Rural Development, Government of Uttar Pradesh, 2012); (Department of Rural Development, Government of Himachal Pradesh, 2012).

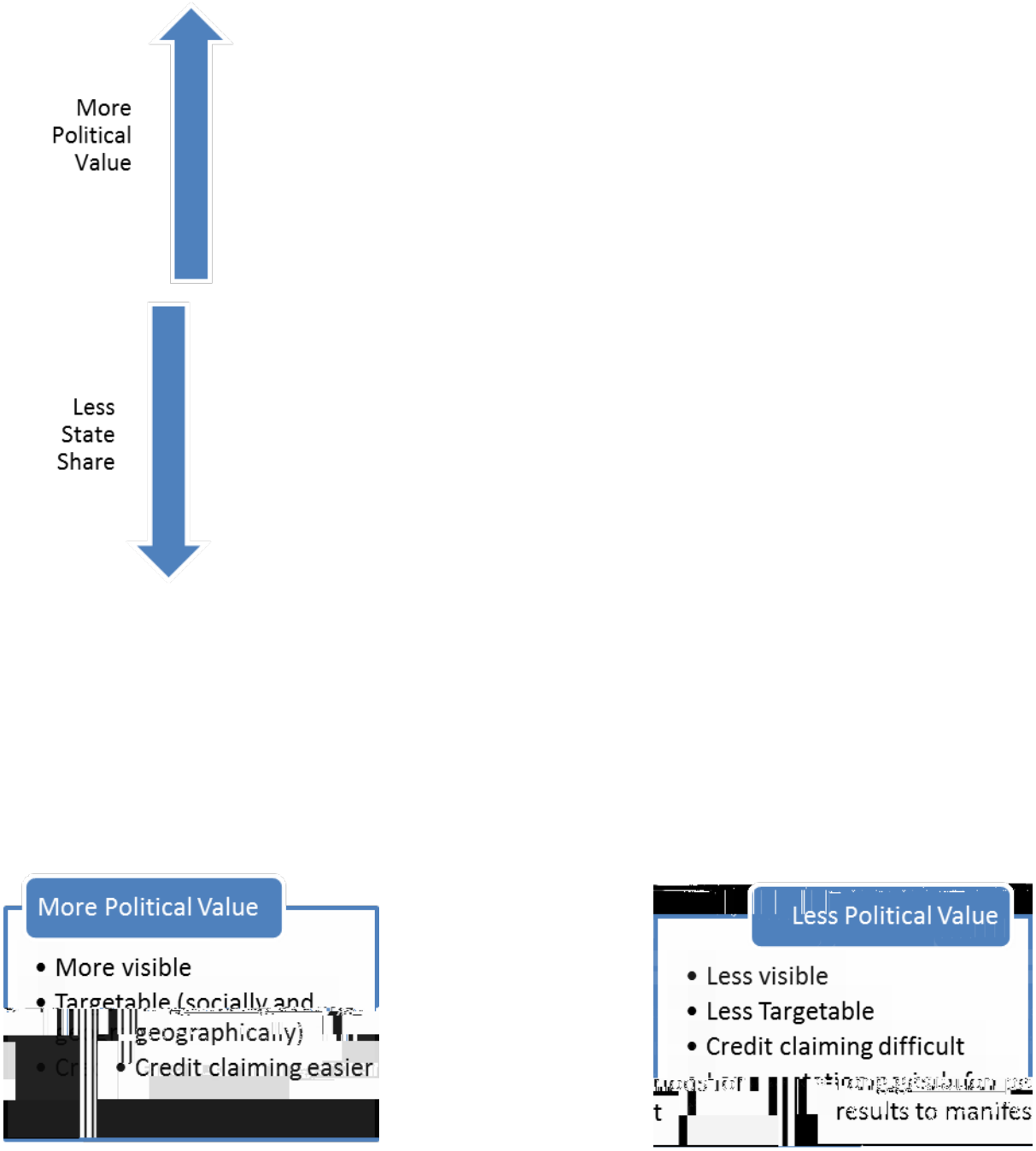
Considering the types of rural development schemes, the growing preference on the part of state governments for rural development over rural health provision seems politically rational. The literature around public good provision by democracies suggest that governments operating in poor and less informed constituencies are likely to spend more on .(g)-4,r“-d( )]T

come under either employment or housing programmes. These schemes involve transfer of private benefits to citizens in the form of wages, subsidies, credit and houses. Monetary

the targeted voters thereby communicating to them the good performance of the politician/party. This allows us to safely say that the importance assigned by governments to public works/rural infrastructure projects as seen in Table 2 could partially be explained by the high political value and electoral gains that are assigned to these goods in a developing democracy.

Hence it is argued that rational governments in regions with imperfect information and widespread poverty among voters respond to political incentives and spend more of their resources on goods (like those provided under rural development schemes in India) that have more political value associated with them. This is depicted in Figure 13. In such a setting,

Figure 13: Policy Choices of State Governments



projects. Hence even if state's contribution to CSSs were significant, it would have been so because of their rising interest in the active implementation of rural development schemes.

Hence it is argued that the sharp rising trend in expenditure on rural development schemes that is reflected in state budgets could be attributed mainly to the states' enthusiasm and preference for these schemes and not to the central government's policies on rural development.

5.7 Some Limitations and Clarifications

It is to be noted that the analysis presented above is not without limitations.

The budgeting and accounting practices adopted at different government levels in India are rather complex and sometimes inconsistent. The author was particularly aware of the fact that apart from the major centrally sponsored schemes like NREGS, SGSY, IAY, PMGSY etc. there is a lack of consistency with the way funds were routed from the central government to the states. Such detailed data was not available in the budget statements of state governments. However, these limitations were found to be not significant and were overcome as discussed in section 5.6.

As a note of clarification, the emphasis in the paper on the de-prioritisation of healthcare provision by state governments is in no way intended to undermine the importance of rural development schemes and their positive benefits to rural households. Employment schemes provide much-needed social security to the poorest of the poor; Infrastructure schemes provide basic amenities to remote villages. However one has to keep in mind the crucial benefits that universal healthcare can provide the poor by significantly reducing their out-of-pocket expenditures thereby preventing poverty traps.

5.8 A Summary of the Analysis

To summarise, this section started with an analysis of the inter-state disparities in health expenditures that persist even after the increased political commitment and flow of funds from the central government to the states after the launch of NRHM. It then examined the trends in government expenditures in five poor rural states in India and found that there is a growing prioritisation of rural development expenditure relative to the state's total health expenditure. This preference for rural development spending is

receiving increasing funds from the centre for health provision, reveals that the trend of prioritising rural development expenditure is quite absent in the state. This difference in the policy choices of the government of Himachal Pradesh is then linked to the presence of more informed voters and the low incidence of rural poverty in the state. Finally, a deeper analysis of the types of rural development schemes being implemented in the states included in the study revealed that goods provided under them were politically more visible, had targetable benefits (sometimes having the properties of private goods) and were easier to claim credit for. In contrast to the provision of healthcare, which is a public good, these goods are perceived to be politically more valuable to incumbent governments. Hence this allows us to argue that increasing funds from the central government for healthcare will only give state

6. Conclusion

This paper set out to understand the policy priorities of democratic governments with regard to provision of public goods especially healthcare. With increased media attention and public outcry at India's dismal performance in terms of important health indicators, the central government has recently increased its political commitment towards healthcare by significantly raising its budget allocation through the National Rural Health Mission (NRHM). In such a context, this paper aimed to understand the trends in public expenditure patterns of state governments in India.

Informed by a review of the literature surrounding democracy and public good provision, a comparative study of the relative trends in government spending on rural development and healthcare was chosen as universal healthcare has the properties of a classic public good whereas employment and public works programmes implemented under rural development schemes are commonly seen as "pork barrel" projects. The study analysed relative expenditure trends in healthcare and rural development by six state governments in India. It was found that in the five poor rural states studied, there was a growing prioritisation of rural development expenditure relative to health expenditure. A deeper analysis revealed that unlike rural healthcare, the kind of goods provided under rural development schemes had more political value to incumbent governments due to high visibility, easy targetability and credit-claiming.

The central conclusion of this paper is in consonance with the theoretical literature in that

institutions in India) has not been implemented to its entirety in these states. Hence this suboptimal provision of public goods might be because the residual authority or power is still left at the level of state governments. Such a proposition could not be proved in this study due to data and time constraints. In political markets with poverty and imperfect information, how much decentralisation and devolution of power is good for public good provision – this seems to be a pertinent question for future research.

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Appendix 1D: Total State Expenditure under selected heads – Rajasthan (Rs. Millions)

(Corresponds to Figure 4)

Expenditure Heads	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Total Health Exp	7493.7	7803.2	7628.8	8288.2	9225.2	10452	11472.3	12743.7	19490.9			

Appendix 2D: Rajasthan - state's contribution in health vs rural development (Rs. Millions)

(Corresponds to Figure 9)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	9346.3	11779.7
2006-07	9039.5	12370.5
2007-08	8509.4	16658
2008-09	14244.2	23740.9
2009-10	15245.6	25520.6
2010-11	17165.6	28764.6

Appendix 3A: Total State Expenditure under selected heads – Himachal Pradesh (Rs. Millions)

(Corresponds to Figure 11)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	3349.5	1102.5
2006-07	3625.3	1535.8
2007-08	4137.2	1884.4
2008-09	5080.2	2572.8
2009-10	5634.7	2780.6
2010-11	6508.3	3449.1

Appendix 3B: Himachal Pradesh - state's contribution in health vs rural development (Rs. Millions)

(Corresponds to Figure 12)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	3349.5	1102.5
2006-07	3625.3	1535.8
2007-08	4137.2	1884.4
2008-09	5080.2	2572.8
2009-10	5634.7	2780.6
2010-11	6508.3	3449.1