

India's Human Capital: The Regulatory Context for Leveraging Federalism

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Abstract

Investing in human capital through interventions in nutrition, health, and education is critical for achieving sustainable inclusive growth. However, despite many public interventions, India's human capital indicators remain low, and have likely worsened from the disruptions caused by the COVID-19 pandemic. There are also significant inter-State disparities. India's human capital interventions have been marked by growing centralisation, not just by the Centre vis-à-vis the States, but also by the States vis-à-vis local governments, that form the third tier in India's federal structure. This growing centralisation may have misaligned incentives with respect to accountability and effective delivery of public services. Drawing from international best practices and an analysis of the constitutional scheme, a more decentralised and targeted approach within the contours of India's federal structure may be the best way to build civil society engagement, address failures in accountability, and ultimately, improve India's human capital outcomes.

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I Introduction

Human capital has been defined as the knowledge, skills, competencies, and attributes embodied in individuals that facilitate the creation of personal, social, and economic well-being (United Nations Economic Commission for Europe, 2017). It 'consists of the knowledge, skills, and health that people invest in and accumulate throughout their lives, enabling them to realise their potential as productive members of society' (World Bank, n.d.). According to the World Bank's 2020 Human Capital Index, a child born in India will only be 49 percent as productive when she grows up as she could have been if she had enjoyed complete education and full health as compared to the benchmarks developed by the index (World Bank, 2020). India ranked at 116 out of 174 countries on this index. Investing in human capital through well-targeted interventions in areas such as nutrition, health, education, and employment, is critical for addressing poverty, especially in a country like India which has one of the youngest populations in an ageing world.

This paper looks at some of the relevant national and state-level indicators and statistics related to India's human capital outcomes. Subsequently, it gives an overview of India's human capital interventions, including specific schemes and spending patterns. It then covers relevant international regulatory experiences, followed by an analysis of India's constitutional scheme and its division of powers and responsibilities in areas related to human capital. Subsequently, it examines the de facto centralisation that has been apparent in India's human capital interventions. This centralising trend is also explored in the context of the third tier in India's federal structure. Finally, it proposes a way forward for India to improve its human capital outcomes, with specific recommendations for each tier of government.

II The status of India's human capital

India as a whole

It is well established that India performs poorly compared to other countries on multiple human capital indicators.

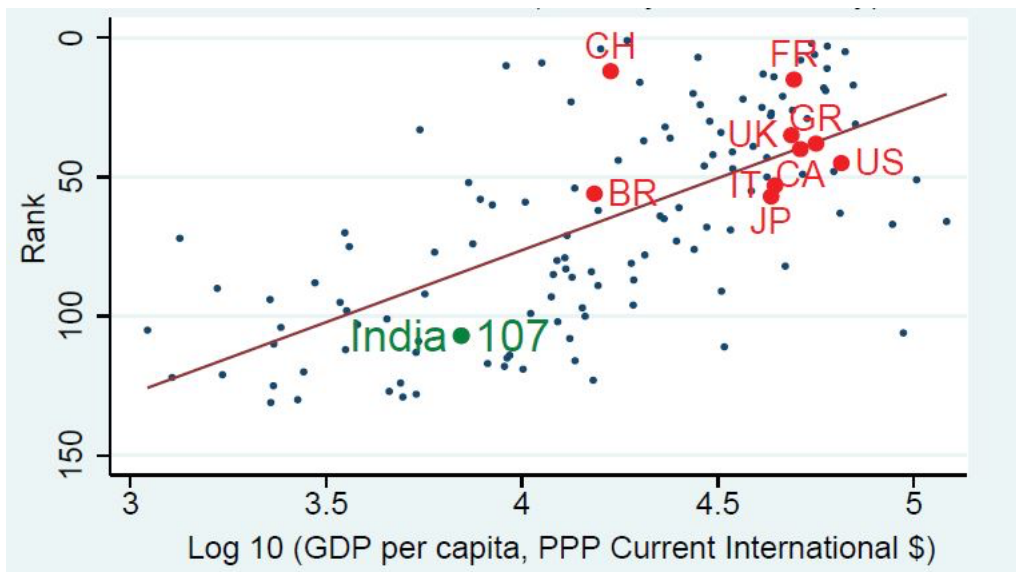
- In a cross-country comparison of India's performance on key health outcomes such as life expectancy, maternal mortality, and child stunting, India's statistics are found to be behind those of other Asian and BRICS countries (Table 1).
- The 2020 Global Hunger Index, another cross-country comparison, ranked India at 94 out of 107 countries (von Grebmer et al, 2020). This placed India behind its neighbours such as Sri Lanka, Nepal, Bangladesh, and Pakistan.
- The 2020 Global Innovation Index assessed India's performance in education as part of the Innovation Input Sub-Index's Human Capital & Research Pillar (Cornell University, INSEAD, & WIPO, 2020). India ranked 107 out of 131 countries in primary and secondary education, which is below expectation for its level of development (Figure 1).

Table 1: Key Health Outcomes: India and Other Countries, 2011-19

Country	Population (millions)	Fertility (children per woman)	Life Expectancy (years)	Under-five Mortality (per 1,000 live births)	Maternal Mortality (per 100,000 births)	Child Stunting (%)
Bangladesh	167	2.1	72	30	173	36
Brazil	210	1.7	75	14	60	7
China	1,400	1.7	76	9	29	8
India	1,352	2.2	69	37	145	38
Indonesia	267	2.3	71	25	177	36
Malaysia	33	2.0	76	8	29	21
Russia	147	1.8	72	7	17	5
S. Africa	59	2.4	64	34	119	27
Sri Lanka	22	2.2	77	7	36	17
Thailand	68	1.5	77	9	37	11
Vietnam	95	2.0	75	21	43	25

Source: FC-XV (2020)

Figure 1: India’s performance in primary and secondary education compared to its level of development and other countries¹



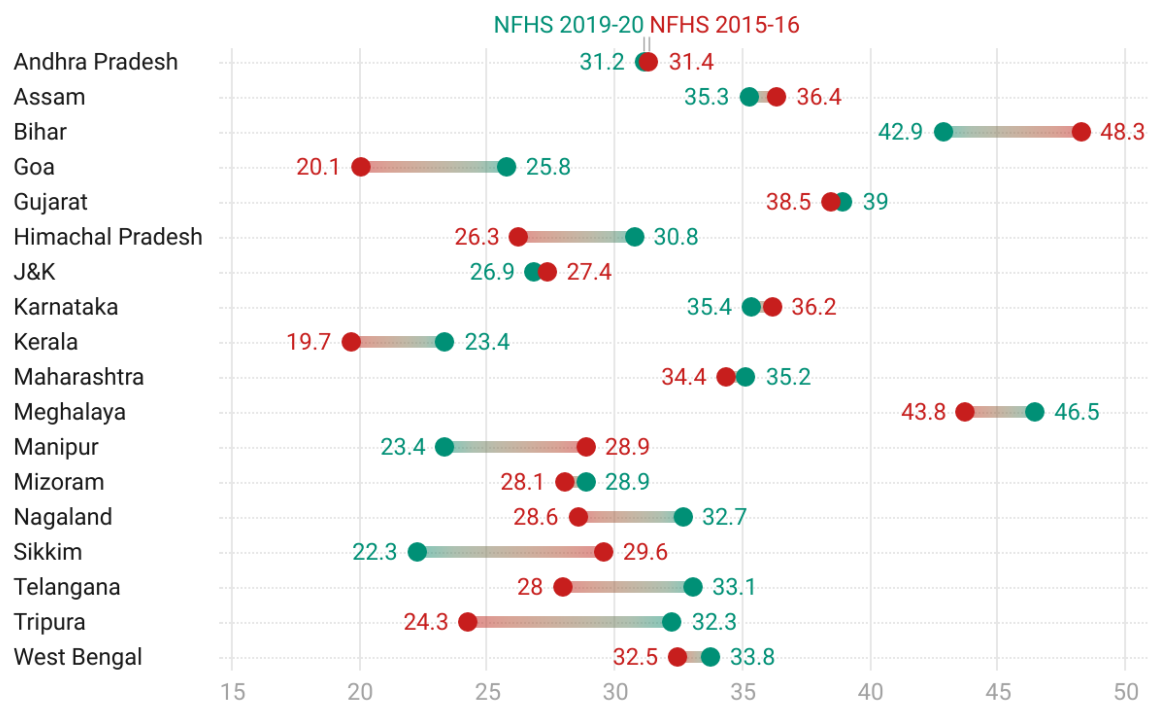
Sources: Cornell University et al (2020); Economic Survey 2020-21, Ministry of Finance (2021b)

India’s national performance on other health indicators such as malnutrition, anaemia, and maternal mortality ratio is just as worrying and, in some cases, worsening.

On malnutrition:

- A Lancet study of malnutrition indicators from 1990 to 2017 found that malnutrition was the predominant risk factor for death in children younger than five years of age in every Indian State (while also noting substantial variations in malnutrition across States; Swaminathan et al, 2019). There is a direct link between malnutrition and diseases, and it is especially lethal in combination with infectious diseases (Press Trust of India, 2021).
- The first-phase data of the National Family Health Survey (NFHS) 5 for the year 2019-20 shows that malnutrition indicators have stagnated or worsened in most States and Union Territories as compared to NFHS-4 (2015-16) data (Figure 2).

Figure 2: State-wise Changes in Proportion of Stunted Children



Source: MoHFW (2020)

Similarly, on anaemia:

- The NFHS-5 indicates that anaemia among pregnant women has increased in several States compared to NFHS-4 data (2015-16) (Press Information Bureau [PIB], 2020).

India's maternal mortality ratio has improved, but there is still a long way to go:

- In recent years, India has made progress in improving its maternal mortality ratio, which has reduced from 556 per 100,000 live births in 1990 to 130 per 100,000 in 2016 (Central Bureau of Health Intelligence, 2019).
- While this is encouraging, it is almost double the Sustainable Development Goal target of 70 per 100,000, to be achieved by 2030.

As for education, both the National Achievement Survey (NAS) 2017 and the Annual Status of Education Report (ASER) 2018 show poor learning outcomes, especially in rural areas.

- The NAS 2017 revealed that 33 percent of students in the third grade could not read small texts with comprehension, and this number increased to 46 percent by the eighth grade. 44 percent of students in the third grade could not use basic math to solve daily life problems, and this increased to 62 percent in the eighth grade (National Council of Educational Research & Training [NCERT] & Ministry of Human Resource Development [MoHRD], 2019).
- The ASER 2018 showed that 73 percent of students in the third grade in rural India could not follow second grade textbooks and 72 percent of such students could not do subtraction (ASER Centre, 2019). The inability to read is a critical stumbling block and is one of the primary reasons for children being “left behind”, i.e., not being at the expected level of their grade despite being enrolled in school (Banerji, 2021, pp. 181-2).
- India’s Gross Enrolment Ratio (GER), i.e., the student enrolment as a proportion of the corresponding eligible age group in a given year, was 96.1 percent in elementary schools (first to eight grade) in 2018-19, but this figure reduced to 76.9 percent and 50.1 percent in secondary (ninth and tenth grade) and senior secondary school (eleventh and twelfth grade), respectively, for the same year (Ministry of Finance [MoF], 2021b).

To a large extent, these failures appear linked to absenteeism among public providers of health and education, the inability to link payment to performance, and the resultant capture and leakage of public funds (including in other government subsidies) by special interest groups. These are symptoms of a lack of accountability and are symbolic of the effects of command-and-control systems that have been observed in countries with a centralised governance structure (Muralidharan, 2019; Devarajan, Khemani, & Walton, 2014).

Inter-State disparities

Beyond cross-country comparisons and national-level indicators, we now look at comparisons of human capital indicators across individual Indian States. Generally, there are significant inter-State disparities in this regard, which mirror the effects of command-and-control systems of governance on political incentives at the State level, similar to the national level. States that have empowered their third-tier local governments to a greater degree appear to have performed better in terms of human capital outcomes. This is not surprising, given that decentralised systems tend to have better accountability, civic engagement, and service delivery.

Inter-State disparities in certain health indicators are illustrated below.

Life expectancy:

- Life expectancy at birth ranges from 65.2 years in the State of Chhattisgarh to 75.3 years in the State of Kerala (Office of the Registrar General & Census Commissioner, 2020c).

Fertility rates:

- Sikkim, Goa, and Kerala have total fertility rates of 1.1, 1.3 and 1.8, respectively, which are similar to those in advanced countries, but in Meghalaya and Bihar the rates are much higher at 2.9 and 3.0, respectively (Ministry of Health & Family Welfare [MoHFW], 2020).

Infant and children under-five mortality rates:

- In 2018, the infant mortality rate ranged from four infant deaths per 1,000 live births in Nagaland, to 48 deaths per 1,000 live births in Madhya Pradesh (Registrar General & Census Commissioner, 2020a). On mortality rates for children under five, States such as Kerala, Tamil Nadu, Maharashtra, and Punjab have achieved the Sustainable Development Goal target (Fifteenth Finance Commission [FC-XV], 2020). However, other States need significant improvements to meet this target.

A similar picture emerges in the case of education indicators as well.

Literacy rates:

- As per National Sample Survey data for 2017-18, while the national literacy rate is 77.7 percent, this figure varies considerably across States, from 66.4 percent in Andhra Pradesh to 96.2 percent in Kerala (National Statistical Office, 2020).

Enrolment ratios:

- According to first phase NFHS-5 data for 2019-20, Sikkim had the highest enrolment rate in pre-primary school for children aged five years at 41.2 percent. Among the States assessed, Assam had the lowest percentage, at a significantly lower 4.4 percent (MoHFW, 2020).
- While the GER in 2018-19 at the elementary level was above 90 percent in 29 States and Union Territories, it was only 77.9 percent in Jammu & Kashmir. At the secondary level, while nearly two-thirds of States and Union Territories had a GER above 90 percent, it was a considerably lower 57 percent in Bihar (MoF, 2021b).

Quality of education:

- The NAS 2017 shows that the performance on language tests among third-grade students ranges from 79 percent in Andhra Pradesh to 58 percent in Uttar Pradesh, and on mathematics test it ranges from 75 percent in Karnataka to 56 percent in Punjab (among large States).
- Similarly at the fifth-grade level, Karnataka has the highest language and mathematics scores at 71 and 67 percent respectively, with Punjab and Uttar Pradesh having the lowest language scores at 50 percent each, and Punjab having the lowest mathematics score at 43 percent (NCERT & MoHRD, 2019).

III Overview of India's human capital interventions

The status of India's human capital is a cause for concern, and the statistics mentioned above do not take into account the effects of the COVID-19 pandemic. Yet, human capital has not been ignored by Indian policymakers. Over the last several decades, there has been a plethora of government policies and schemes that have sought to address human capital issues.

For example, on health and nutrition:

- In 2017, the Union Ministry of Health & Family Welfare brought out a new National Health Policy which aimed to inform, clarify, strengthen, and prioritise the role of the Government in shaping health systems in all its dimensions, including investments in health, organisation of

healthcare services, prevention of diseases, access to technologies, developing human resources and better financial protection strategies, and strengthening regulation (MoHFW, 2017).

- In the same year, the NITI Aayog published its influential National Nutrition Strategy (NITI Aayog, 2017). Based on this strategy, the Poshan Abhiyan (a Centrally Sponsored Scheme or CSS) was launched. This scheme, along with six other schemes, comprised the Umbrella Integrated Child Development Scheme (ICDS). In her speech introducing the budget for the year 2021-22, the Union Finance Minister announced that four of these schemes would be merged to form the new Mission Poshan 2.0 (Pant & Ambast, 2021).
- The National Health Mission which comprises the National Rural Health Mission and the National Urban Health Mission is a major health CSS.
- In 2018, the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) was launched for providing health insurance.

Notwithstanding these interventions, the reality is that healthcare in India remains predominantly private.

On education:

- The National Education Policy of 2020 highlights the importance of universal provisioning of quality early childhood development, care, and education, and the need to achieve this as soon as possible and no later than 2030 (MoHRD, 2020).
- The Samagra Shiksha Abhiyan, which comprises the old Sarva Shiksha Abhiyan and two other schemes, has been the Centre's flagship education CSS since 2018.

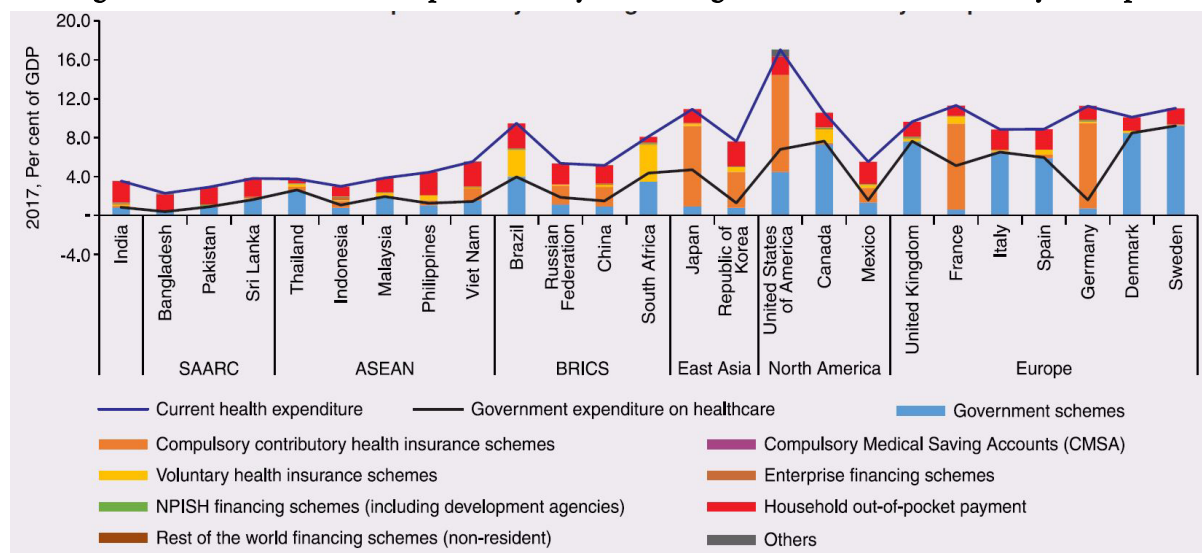
Quality aside, it is worth noting that India spends just 4 percent of Gross Domestic Product (GDP) as public expenditure on human capital, specifically 1 percent on health and 3 percent on education.² This compares poorly with India's peers and is especially concerning given the gaps in India's public financial management system, which has a significant effect on expenditure efficiency and outcomes.

Figure 3 illustrates this in the context of health expenditure, revealing that government expenditure on healthcare is significantly higher in countries such as Sri Lanka, Thailand, Brazil, and South Africa. Moreover, the biggest share of health expenditure in India is borne by household out-of-pocket payments to the private sector, which is also subject to significant inter-State variations. Compared to this, in developed countries such as Japan, the United States of America, Canada, and Western European and Scandinavian countries, the share of household out-of-pocket payments is remarkably low. The bulk of health expenditure in these countries is either from government schemes or compulsory contributory health insurance schemes.

The Economic Survey 2020-21 observed that there is a negative correlation between the level of government expenditure and out-of-pocket expenditure across countries and between Indian States. Particularly, at lower levels of government expenditure (less than 3 percent of GDP), even a marginal increase in government expenditure, provided it is well-managed, can lead to a substantial decrease in out-of-pocket expenditure. In India's case, it stated that if government health expenditure were to increase from the current 1 percent to about 2.5 to 3 percent of GDP, as envisaged in the aforesaid National Health Policy 2017, then the share of out-of-pocket spending could reduce from 65 percent

to 35 percent (MoF, 2021b). India’s health spending is far below the targets mentioned in the National Health Policy 2017 (Table 2).

Figure 3: Current Health Expenditure by Financing Schemes: Cross-Country Comparison



Source: RBI (2020)

Table 2: India’s Current Health Spending v. National Health Policy 2017 targets

National Health Policy (2017) -Targets	Current Position (2018-19)
Increase public health expenditure to 2.5% of GDP, in a progressive manner by 2025 [#]	0.96% of GDP*
Increase State sector health spending to more than 8% of their budget by 2020 [#]	5.18% of total States’ expenditure *
Primary health expenditure to be two-thirds of the total health expenditure [#]	53% (approx.) ^

Sources: # MoHFW (2017); * State Finance Accounts, 2018-19; ^ Ministry of Health & Family Welfare, Government of India

In her 2021-22 budget speech, the Union Finance Minister mentioned an increase of 137 percent in the outlay for health and wellbeing compared to the previous year’s budget (Government of India, 2021). However, this figure includes the outlays for indirect health determinants such as water, sanitation, and nutrition in the health budget.³ For primary healthcare and the public health system, the increase is closer to 10 percent; and the outlay for nutrition is, in fact, significantly lower compared to the previous budget (Datta & Chaudhuri, 2021; Pant & Ambast, 2021).⁴

Figure 4 and Table 3 include details regarding State health expenditure as well. The overall health expenditure by the Centre and the States as a percentage of GDP has barely increased in recent years (remaining below 1 percent of GDP). The States are responsible for about 70 percent of the total health expenditure, with the Centre contributing only 30 percent. However, State expenditure on

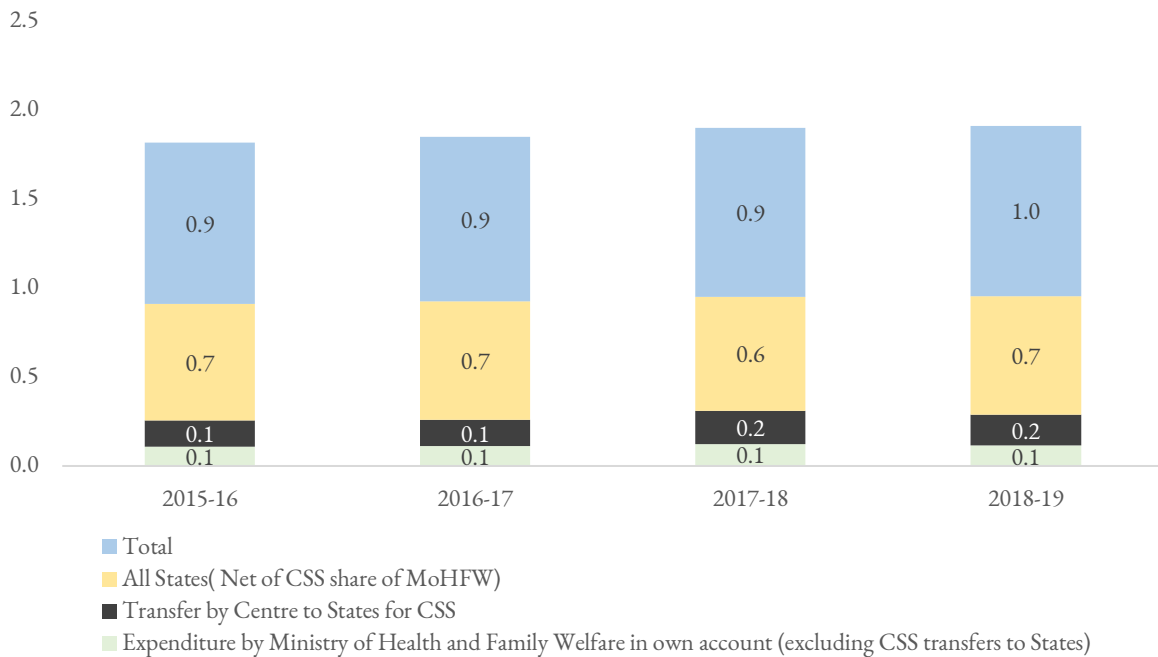
health as a percentage of Gross State Domestic Product (GSDP) remains very low, at an average of just 0.86 percent.

There are also large inter-State variations in the per capita spending on health:

- The per capita health spending of Bihar, Uttar Pradesh, and Jharkhand is about half of that of Kerala and Tamil Nadu (FC-XV, 2020).
- A study found that Indian States could be divided into two distinct groups, where States in the first group (including Uttar Pradesh, Bihar, Gujarat, Orissa, and others) were found to have higher quality of healthcare coming at higher costs. States in the second group (including Kerala, Tamil Nadu, Chhattisgarh, Uttarakhand, and others) had achieved high levels of quality at lower per-patient costs compared to similar-performing States in the first group. Thus, inter-State disparities in healthcare exist in terms of quality as well as costs, with certain States not only having higher public expenditure on health, but also more efficient expenditure (Das, Daniels, Ashok, Shim, & Muralidharan, 2020).

In case of education as well, Figure 5 illustrates that India’s public expenditure is much lower than advanced countries.

Figure 4: Healthcare Expenditure of Centre and States (as percentage of GDP)



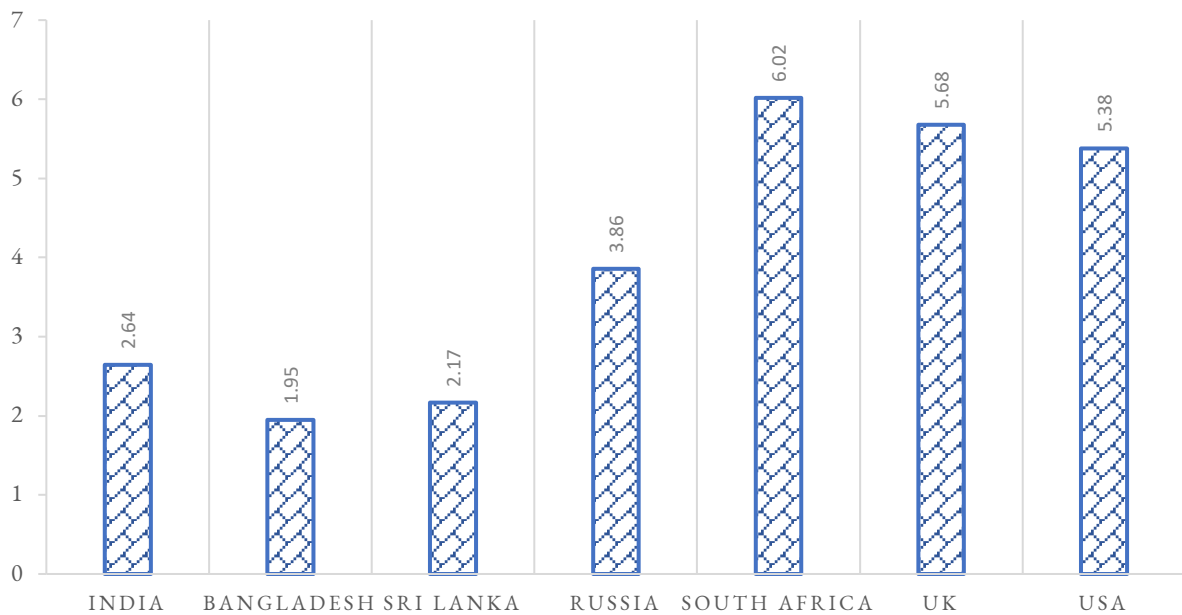
Sources: Union Budgets; State Finance Accounts; Ministry of Statistics & Programme Implementation, Government of India

Table 3: Health Expenditure by Indian States (2018-19)

State	Total Health Expenditure as % of Total Expenditure	Health Expenditure as % of GSDP	Per Capita Health Expenditure (Rs)
<i>Andhra Pradesh</i>	4.92	0.86	1441
<i>Arunachal Pradesh</i>	6.15	4.54	6937
<i>Assam</i>	6.8	1.43	1360
<i>Bihar</i>	4.96	1.31	616
<i>Chhattisgarh</i>	5.11	1.21	1303
<i>Goa</i>	7.2	1.24	6207
<i>Gujarat</i>	6.14	0.66	1478
<i>Haryana</i>	4.3	0.55	1422
<i>Himachal Pradesh</i>	6.49	1.46	3074
<i>Jammu & Kashmir</i>	6.85	2.87	3145
<i>Jharkhand</i>	5.41	1.1	913
<i>Karnataka</i>	4.66	0.62	1429
<i>Kerala</i>	5.91	0.91	2048
<i>Madhya Pradesh</i>	4.5	0.96	947
<i>Maharashtra</i>	4.28	0.49	1069
<i>Manipur</i>	5.32	2.32	1813
<i>Meghalaya</i>	9.06	3.1	3055
<i>Mizoram</i>	6.18	2.62	4907
<i>Nagaland</i>	4.98	2.28	2968
<i>Odisha</i>	5.18	1.15	1308
<i>Punjab</i>	4.1	0.62	1059
<i>Rajasthan</i>	6.33	1.26	1552
<i>Sikkim</i>	6.2	1.52	6165
<i>Tamil Nadu</i>	5.48	0.75	1653
<i>Telangana</i>	4.19	0.62	1405
<i>Tripura</i>	6.95	1.84	2340
<i>Uttar Pradesh</i>	4.89	1.09	807
<i>Uttarakhand</i>	5.44	0.85	1878
<i>West Bengal</i>	5.35	0.82	983
All States	5.18	0.86	1218
General States	5.04	0.8	1148
North-East and Himalayan States	6.48	1.72	2256

Source: State Finance Accounts, 2018-19; Ministry of Statistics & Programme Implementation, Government of India

Figure 5: Public expenditure on Education as a percentage of GDP: A Cross-Country Comparison (2018-19)



Source: FC-XV (2020)

As opposed to the slight increase in health expenditure as a percentage of GDP, education expenditure by the Centre and the States had reduced from 2.78 percent in 2015-16 to 2.64 percent in 2018-19 (Figure 6).⁵ The National Education Policy 2020 aims to increase this to 6 percent of GDP over the next decade, but that target remains far away. An increase in education expenditure must be accompanied with improved expenditure efficiency and public financial management processes, as highlighted by the Fifteenth Finance Commission (2020).

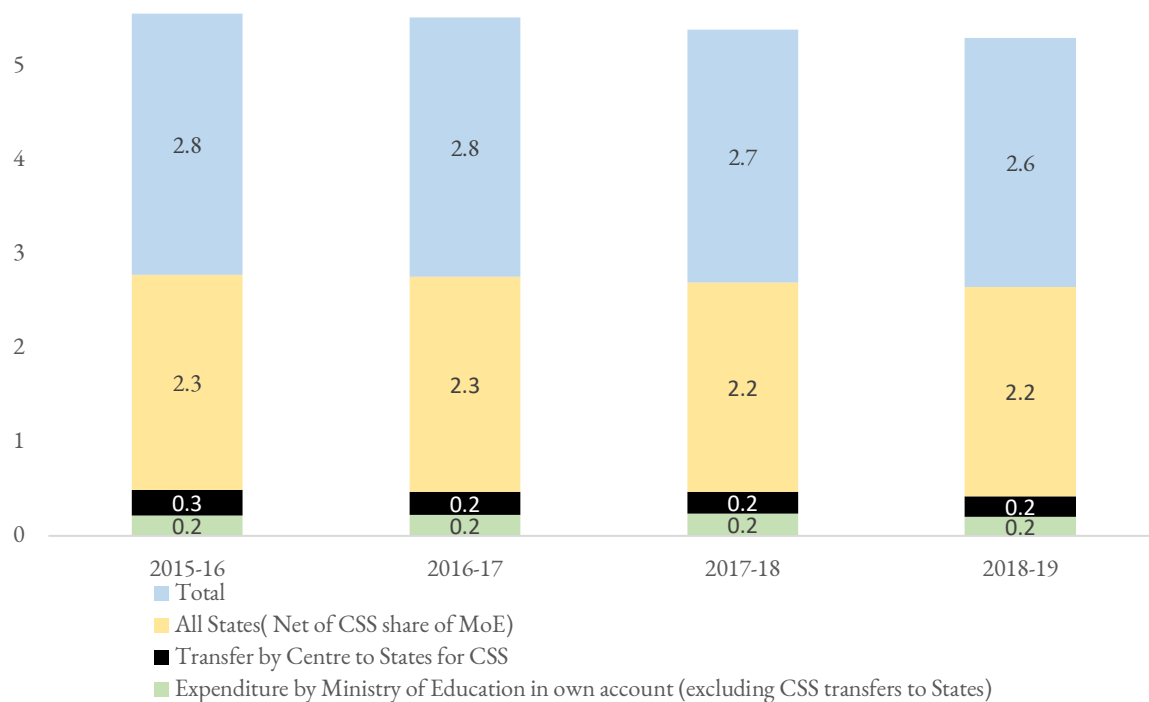
In the Union Budget for 2021-22, the allocation for the Ministry of Education (MoE; formerly, the Ministry of Human Resource Development) was reduced by 6 percent compared to the allocation in the previous year's budget, with the School Education & Literacy Department's allocation being reduced by almost Rs 5,000 crore (Chopra, 2021). The amount allocated to the MoE forms about 2.67 percent of the Central Government's estimated expenditure for 2021-22.

While about 84 percent of total expenditure in the education sector is done by the states, there are significant differences among states on the extent of their expenditure on education (FC-XV, 2020). Moreover, state education spending has not increased significantly over the years (Reserve Bank of India [RBI], 2020):

- In the budget estimates for 2020-21, education expenditure as a ratio to aggregate expenditure ranged from 23.2 percent in the Union Territory of Delhi to a mere 6.5 percent in Telangana.
- In their 2020-21 budgets, all States and Union Territories had estimated that they would spend, on average, 14.7 percent of their aggregate expenditure on education, down from 16.3 percent in 2011-12.

- The education spending as a percentage of GSDP among States was, on average, 2.8 percent in the State budget estimates for 2020-21, which was a slight increase compared to 2.5 percent in 2011-12.

Figure 6: Expenditure on Education by Centre and States in India (as percentage of GDP)



Sources: Union Budget; State Finance Accounts; Ministry of Statistics & Programme Implementation, Government of India

IV International Regulatory Experience

The need for a bottom-up regulatory approach is now being recognised internationally. This approach entails accounting for territorial diversity, different levels of government working together, and enabling local institutions that are more accountable to be at the forefront of food security and nutrition (OECD, FAO, & UNCDF, 2016). Across countries, there has been a gradual process of fiscal decentralisation, with a trend shift in the distribution of expenditures and revenue towards sub-national governments accompanied by rising decentralisation of health and education spending. For example, in most OECD (Organisation for Economic Co-operation and Development) countries, health and education have been effectively decentralised to subnational governments (James, 2019), and that is also the case to some extent in unitary states (such as the Scandinavian countries, Japan, and the United Kingdom). Decentralised responsibilities do not necessarily mean decentralised financing. There can be bloc financing with general conditions that allow significant subnational discretion. However, it has also been observed that large-scale crises such as financial shocks and global pandemics constitute critical junctures during which transformative changes in inter-governmental

relations can follow. This often results in greater centralisation in fiscal relations, and there is a risk of this repeating because of the COVID-19 pandemic.

By taking government 'closer to the people', a decentralised system facilitates better information about citizens' needs and wants, greater participation of citizens in selecting, planning, and executing public projects that respond to those needs and wants, and greater accountability of public officials to citizens for their decisions and use of resources (Faguet, 2014; Faguet & Pöschl, 2015). Not only do local governments in a decentralised system have better access to information regarding citizen needs, they also have greater incentives to respond to those needs and ensure that public service providers fulfil them. Decentralisation thus paves the way for human capital interventions that are more customised to local needs and preferences, which tend to vary across different regions. These advantages of a decentralised system point towards a democratic deepening that produces better-quality public goods and more effective government (Faguet, 2014; Faguet & Pöschl, 2015).

Compared to a decentralised system that is complex and based on the coordination and cooperation of multiple levels of government, a centralised command structure may be simpler to manage, but more susceptible to government failures at different points in the chain of relationships involved in the formulation and implementation of public policy (World Bank, 2003). While the greater complexity of a decentralised system can be more difficult to manage, it is more robust since it implies greater suppleness in the system's response to failure in any of its parts (Faguet, Fox, & Pöschl, 2015).⁶ Moreover, there is evidence to suggest that government failure in such a system is less likely, given the incentives that local governments have in building civic engagement and ensuring effective service delivery. Ultimately, decentralised systems of governance are likely to be more accountable, and this leads to better-designed and implemented human capital interventions.

These international trends towards decentralisation and the theoretical benefits of such a system are backed by studies that demonstrate a positive correlation between decentralisation and human capital (Blöchligeri & Égerti, 2013). For instance, the experiences of Brazil and Argentina illustrate the benefits of decentralising healthcare to urban local bodies. Argentina's Plan Nacer, which involved city governments receiving funds from the national health ministry based on population coverage, has had a positive effect on health outcomes. The probability of low birth weight, for example, fell by as much as 23 percent in Argentina (Badgaiyan & Kumar, 2021).

In a study of Bolivia and Columbia, it was found that decentralisation led to greater public investment into primary social services such as education, water, and sanitation (Faguet & Sánchez, 2008). In Bolivia, public investment in education became more responsive to local needs, rising disproportionately in areas with the worst education indicators. In Columbia, school enrolment increased in districts that had greater control over educational finance and policymaking (and were not bound by centrally controlled criteria). Similarly, in a study of Swiss cantons, the degree of decentralisation was found to be positively related to educational attainment (Barankay & Lockwood, 2007). Another study of 21 OECD countries over the period 1970-2000 found that higher fiscal decentralisation (up to a point) was beneficial for the efficiency of the public sector in providing health and education services (Adam, Delis, & Kammas, 2014).

V The nature of India's constitutional scheme

In recent years, India has taken some steps towards fiscal decentralisation which have implications for its human capital. This is highlighted by the Fourteenth Finance Commission's (2014) recommendation to increase the States' share in tax devolution from 32 to 42 percent, which was effectively retained by the Fifteenth Finance Commission (2020).⁷ The significance of this can be appreciated when seen in the context of the Indian Constitution's federal structure.

But before exploring this structure, it is worth noting that the Constitution recognises health and education as fundamental rights and includes them under several directive principles of State policy (India Const. arts. 41, 45, & 47). The Supreme Court has, in several judgments, held the right to health as being part of the right to life (India Const. art. 21; *Bandhua Mukti Morcha v. Union of India*, 1984; *Consumer Education & Research v. Union of India*, 1995; *State of Punjab v. Mohinder Singh Chawla*, 1997). After the 86th constitutional amendment in 2002, the right to education for children between the ages of six and 14 is now constitutionally recognised (India Const. art. 21A). Under the directive principles contained in Part IV of the Constitution, the State is required to direct its policy towards securing the health and strength of workers, men, and women, and ensuring that children are given the opportunities and facilities to develop in a healthy manner. The State also must make effective provision for securing the right to work, the right to education, and the right to public assistance in cases of unemployment, old age, sickness, and disablement. The State is also expected to endeavour to provide early childhood care and education for all children below the age of six years. Finally, the State is also conferred with a primary duty to improve public health and raise the level of nutrition and the standard of living. While these directive principles are not enforceable in court, they are expected to be fundamental in the governance of the country (India Const. art. 37).

The Constitution envisages three tiers of government, viz. the Centre, the States, and local governments which comprise panchayats for rural areas and municipalities for urban areas. Legislative and executive powers are divided among the first two tiers by the Constitution itself, according to the list system of the Seventh Schedule (India Const. arts. 73, 162, 246, & sched. VII). The Union List comprises matters over which Parliament and the Central Government have exclusive powers, and the State Legislatures and State Governments have exclusive powers over State List matters. The Centre as well as the States have powers over the Concurrent List, but the Centre's powers prevail in case of a conflict over any matter from this list. This means that the provisions of a central law will prevail over the conflicting provisions of a state law on a Concurrent List matter and can also limit a State Government's executive power over such a matter (India Const. art. 254, cl. 1 & art. 162). As far as matters relevant to human capital are concerned, public health and hospitals are included in the State List, and the broader subject of economic and social planning is found in the Concurrent List (India Const. sched. VII, list II, entry 6 & list III, entry 20). Interestingly, education was shifted from the State List to the Concurrent List by the 42nd constitutional amendment in 1976 (India Const. sched. VII, list III, entry 25).

Fiscally, while the Constitution assigns the bulk of expenditure responsibilities to the States, it is the Centre that has the major revenue sources. To address this vertical imbalance, the Constitution provides for fiscal transfers through tax devolution and grants-in-aid from the Centre to the States in accordance with recommendations of the Finance Commission (India Const. arts. 270, 275, & 280). In addition to these, the Centre can make 'grants for any public purpose', even if the purpose in

question is a matter in the State List (India Const. art. 282). These grants are outside the purview of the Finance Commission, which effectively means that the Centre can freely exercise its discretion in making these grants. Also, while fiscal transfers that are part of tax devolution are unconditional, i.e., States can choose to use that money as per their own discretion, transfers under grants-in-aid or Centrally Sponsored Schemes (CSSs) under Article 282 can be conditional. Therefore, an increase in the States' share of tax devolution, as recommended by the Fourteenth Finance Commission, represents a more meaningful form of decentralisation. The States are free to use the funds they receive through the tax devolution route in any manner.

The third tier, comprising panchayats and municipalities, received constitutional recognition only in 1992 after the 73rd and 74th constitutional amendments (India Const. parts. IX & IXA). The Constitution envisages these bodies as exercising powers over matters contained in the Eleventh (for panchayats) and Twelfth (for municipalities) Schedule lists. From the point of view of human capital, relevant matters include education, health and sanitation, women and child development and social welfare for panchayats, and public health and planning for economic and social development for municipalities (India Const. sched. XI, entries 17, 23, 25, 26, & sched. XII, entries 3, 6). However, unlike in the case of Seventh Schedule matters vis-à-vis the first and second tiers, powers over Eleventh and Twelfth Schedule matters are not automatically conferred upon the third tier. Instead, the Constitution leaves it up to individual States to determine the extent to which they wish to empower third tier governments within their State (India Const. arts. 243G & 243W). States can also decide the types and extent of taxes that panchayats and municipalities can levy, collect, and appropriate, and are also responsible for transferring funds to the third tier in the form of tax revenue sharing and grants-in-aid (India Const. arts. 243H & 243X). Thus, there is potential for vast disparities in the roles played by third tier governments across States, both in terms of the responsibilities entrusted to them and in their fiscal capacity to perform them.

Overall, from the scheme of distribution of powers outlined above, the Constitution indicates a clear preference for lower-level governments to take the lead in health and education, which are critical for human capital. Even when the Constitution allocates a role for the Centre in this area, it does so through the Concurrent List and not the Union List. The fact that States have powers over the Concurrent List as well, unlike in the case of the Union List, has important implications for the manner in which the Centre ought to design its interventions in Concurrent List matters. On an analysis of the origins of the list system contained in the Indian Constitution, it emerges that the rationale for placing matters in the Concurrent List was that while such matters may be more naturally suited for the State List, certain overarching considerations warrant the Centre's involvement (Chatterjee, Agarwal, James, & Sengupta, 2019). Originally, these considerations were threefold: the interests of uniformity, encouraging States to innovate, or accounting for inter-State effects (Joint Committee on Indian Constitutional Reform, 1934).⁸ This explains why, for instance, public health as aforesaid is in the State List, but preventing the inter-State spread of infectious diseases is in the Concurrent List (India Const. sched. VII, list III, entry 29). This also helps contextualise the transfer of education from the State List to the Concurrent List and how it ought to be interpreted: not as the States being completely sidelined from education, but rather, as the Centre's intervention being seen as necessary to encourage State innovation in this critical sector (through, for example, mandating minimum standards or establishing broad frameworks).

A constitution bench of the Supreme Court has observed in a landmark case that “...federalism in the Indian Constitution is not a matter of administrative convenience, but one of principle...” (*S.R. Bommai v. Union of India*, 1994, p. 217). The Seventh Schedule contains the principled bedrock of Centre-State relations, and its scheme, far from being a dead letter, should inform and animate the actions of the Centre and States. For the Centre’s human capital interventions to be grounded in the letter and spirit of the aforesaid constitutional scheme, they should be broadly oriented towards planning, coordinating, facilitating, and encouraging State actions.

VI Centralisation in practice

Despite significant shifts towards greater State autonomy in the political, economic, and social policy spheres, the overall centralised nature of India’s fiscal architecture persists. Indeed, in practice, India has witnessed an entrenched and growing centralisation. Apart from the aforesaid transfer of education to the Concurrent List, this can also be seen from the passing of central laws such as the Right of Children to Free and Compulsory Education Act, 2009, the National Food Security Act, 2013, as well as the highly centralised handling of the COVID-19 crisis (James, 2020; Sahoo & Ghosh, 2021). Another significant area in which this is illustrated is the manner and extent of the Centre’s use of CSSs in human capital interventions.

CSSs have formed a sizeable chunk of inter-governmental fiscal transfers over the years and are set to comprise around 23 percent of the total transfers that will be made to States in 2021-22 (MoF, 2021a). In fact, from 1950 to 2014, CSSs used to be part of plan transfers which were made systematically and periodically as per the recommendations of the Planning Commission, an extra-constitutional body set up by the Centre through an executive resolution (Singh, 2016). Resorting to CSSs has also been seen as a means through which the Centre has responded to political challenges, such as the strengthening of regional political power that accompanied the initial decade of economic liberalisation (Singh, 2017). The prominence that the Centre has historically given to CSSs as the preferred route for making grants to the States is questionable for several reasons.

On a combined reading of the provisions contained in Chapter I of Part XII of the Constitution (Articles 264-291), it appears that grants under Article 282 (CSSs) were not originally meant to play such an outsized role. This provision is categorised under the sub-chapter ‘Miscellaneous Financial Provisions’, unlike Articles 270 (tax devolution) and 275 (grants-in-aid) which are categorised under the sub-chapter ‘Distribution of Revenues between the Union and the States’. The latter sub-chapter also includes Article 280 which provides for the Finance Commission that is empowered to make recommendations to the Centre regarding transfers under Articles 270 and 275. Together, Articles 270, 275, and 280 represent a comprehensive and finely balanced fiscal federal framework, envisaging regular inter-governmental fiscal transfers guided by a dedicated and neutral constitutional body. In this context, it is worth noting that the constitutional expert Nani Palkhivala, in an opinion submitted to the Ninth Finance Commission, had characterised the power under Article 282 as more of a residuary power. In his view, grants-in-aid under Article 275 as per Finance Commission recommendations were the more appropriate, regular route for making grants (Ninth Finance Commission, 1989).

It has also been argued before the Supreme Court that the use of Article 282 as an alternative channel of regular transfers from the Centre to the States disrupts the delicate fiscal equilibrium which the Finance Commission is expected to bring about through the regular channel under Article 275. While the Supreme Court in that case ultimately gave a wide interpretation to Article 282 and did not restrict the use of CSSs, it also noted that “Article 282 is normally meant for special, temporary or ad hoc schemes.” (*Bhim Singh v. Union of India*, 2010, p. 578). Thus, although the pervasive use of CSSs under Article 282 is not unconstitutional per se, there is a strong case to be made that it deviates from the spirit of the constitutional scheme and strays from the intentions of the framers of the Constitution (Singh, 2021). Through mainstreaming the CSS route and by creating a parallel institutional framework with the Planning Commission for many years, the Centre has arguably been upsetting the Constitution’s federal balance (Sharma, Gupta, & James, 2021).

Aside from constitutional issues, there are well-reported issues in the design of CSSs as well. The conditions attached to CSSs are often rigid, overly prescriptive, and uniform across States. They are also typically input-based, i.e., focused on the intended use of funds, as opposed to output-based. Minute implementation details such as the process of hiring and training modules are generally determined by the Centre, and the fixed norms do not leave much room for States to customise the schemes to their specific needs (Kapur, 2020). Against this, international experience reveals a growing consensus that output-based conditions are more effective and efficient in bringing about the desired results. For example, a condition could be set to achieve an output such as increasing the rate of high school graduation, without imposing conditions on inputs such as the number of teachers. This might be a better way of achieving the desired outcome of increasing the number of skilled professionals, and it allows for State-level flexibility in approaches as well. A specific example of a simple and effective output-based conditional transfer that may be cited here is Canada’s health transfer programme (FC-XV, 2020).

Moreover, CSSs typically have a cost-sharing model, with the States expected to provide a portion of the funding, even though they do not have any effective say in the planning of the scheme itself. This is quite incongruous, especially given that many CSSs cover subjects in the State and Concurrent Lists, such as the health and education CSSs mentioned earlier. In fact, as per the calculations of the Fourteenth Finance Commission (2014), the Centre’s spending on state subjects increased from 14 percent to 20 percent between 2002-2005 and 2005-2011, and from 13 percent to 17 percent in the same period on concurrent subjects. Such cost-sharing arrangements pre-empt the States’ fiscal space and leave lesser room for States to design their own schemes.

More concerning are studies which suggest that States with lower per capita income and weaker fiscal and institutional capacity find it difficult to avail the benefits of CSSs (Rao, 2017). In other words, States that are most in need of central assistance are likely getting the least of it, meaning that CSSs appear to be worsening the existing horizontal imbalance between States. While it is technically open for States to say no to CSSs, given the vertical imbalance and the Centre’s continued reliance on CSSs as a major instrument of fiscal transfers, most States cannot afford to exercise this option.

Thus, through the extent and nature of its use of CSSs, the Centre has been effectively directing the minutiae of human capital interventions. This goes against the international and empirical evidence cited above that indicate that interventions from lower levels of government are better suited for building civic engagement, changing political incentives, and improving governance and human

capital outcomes. It is also at odds with the constitutional scheme that envisages a different, more facilitative and coordinating role for the Centre, and also a more sparing use of CSSs. The influence exercised by the Centre on State expenditure priorities through the planning process and CSSs has contributed to poor service delivery and inefficient expenditure (Singh, 2017).

As mentioned above, the Fourteenth Finance Commission's recommendation to increase the States' share in tax devolution from 32 percent to 42 percent appeared to be a welcome step towards meaningful decentralisation. In principle, States were set to have more funds at their disposal to use unconditionally, according to their own localised priorities. However, the increase in tax devolution was offset by reductions in central contributions to CSSs (requiring States to pay more) (Aiyar & Kapur, 2019), and by an increase in cesses (Daniyal, 2019). Since cesses do not form part of the divisible pool that is subject to tax devolution, an increase in cesses meant that the divisible pool shrunk, and ultimately lesser money was received by States. As for CSSs, States were forced to use their increased tax devolution money to fund their now-enhanced contributions to CSSs (which remained conditional).

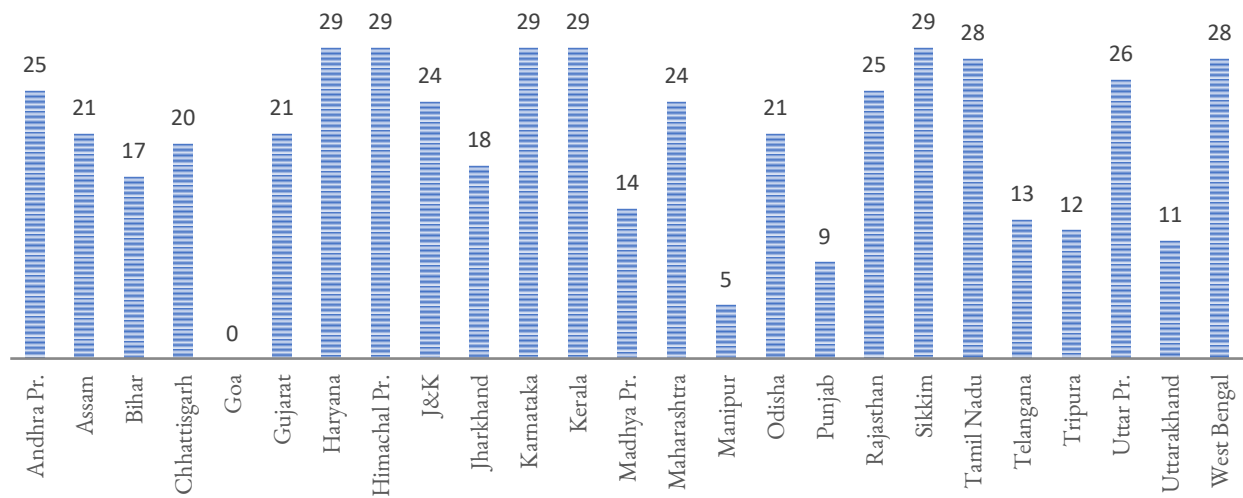
What this meant, overall, was that the Fourteenth Finance Commission's recommendations did not in fact lead to greater decentralisation. Strategic changes in other components of the fiscal architecture effectively counteracted the greater flexibility that should have flowed from enhanced tax devolution. This is reflected in the fact that in the years after the commission's recommendations, State expenditure did not shift across sectors, but rather continued as per the existing status quo at the time (Aiyar and Kapur, 2019).

VII Centralisation and the third tier

Ironically, States, too, have been responsible for centralisation insofar as third tier governments are concerned. As aforesaid, the Constitution leaves it up to the States to determine the extent of devolution to third tier governments, with the subjects in the Eleventh and Twelfth Schedules not being automatically vested in the latter. In the words of Sivaramakrishnan (2016, p. 571), who was one of the bureaucrats involved in the drafting of the 74th constitutional amendment, this is "The most significant lacuna in the constitutional framework on local government..." Most State laws on panchayats and municipalities do not clearly demarcate functions for the third tier, and as Figure 7 illustrates in the case of panchayats, there is significant variation in the extent of devolution across States.

Instead of adequately devolving powers and responsibilities to the third tier, States have often created parallel executive bodies to carry out those very functions. For example, even though planning for social and economic development is included in the Twelfth Schedule for municipalities as aforesaid, many States have established Development Agencies that perform this function and are directly controlled by the State (Sivaramakrishnan, 2016). This practice was challenged before the Supreme Court, but the court upheld it (*Bondu Ramaswamy v. Bangalore Development Authority*, 2010).

Figure 7: Devolution of Subjects (no.) by States to Panchayats (from the 29 Eleventh Schedule Subjects)



Source: Ministry of Panchayati Raj [MoPR] & Tata Institute of Social Sciences [TISS] (2016)

Third tier governments are not fiscally empowered either. These bodies, especially rural local bodies, have meagre own revenue sources and are significantly dependent upon the Centre and the States in this regard. In addition to this, the introduction of the Goods and Services Tax further took away some of their traditional revenue sources such as entertainment tax, entry tax, stamp duty, and mineral royalties. The collection of property tax, another major source of revenue for third tier governments, is also very low in India (only 0.1 percent of GDP, as compared to 3 percent of GDP in countries like the United States of America, the United Kingdom, and Canada) (FC-XV, 2020). The Thirteenth Finance Commission (2009) had recommended that all States set up dedicated Property Tax Boards to assist municipalities in developing independent and transparent procedures for assessing property tax. However, most States have failed to do so. To substantiate the resources of local governments, all Finance Commissions since the Tenth Commission have been devolving resources to the third tier.⁹ The Fifteenth Finance Commission (2020) recommended Rs 4,36,361 crore to the local bodies for the period 2021-26.

The Constitution also envisages State Finance Commissions that would make recommendations for tax devolution, grants-in-aid, assignment of taxes, etc. from the State to the third-tier governments (India Const. arts. 243-I & 243-Y). State Finance Commission recommendations are also expected to form the basis on which Union Finance Commissions recommend measures to supplement the resources of local bodies (India Const. art. 280, cl. 3(bb) & cl. 3(c)). However, most States have not constituted these commissions on time, and their reports have not been submitted on time either. The Fifteenth Finance Commission (2020) has recognised this issue and recommended that no grants should be given to any State after March 2024 that does not comply with the constitutional provisions pertaining to State Finance Commissions.

Ultimately, as Sivaramakrishnan (2016, p. 560) observed, "...although local representation has been achieved, we are still struggling to attain local self-government." States have thus constrained civic

engagement and improvements in accountability that tend to accompany truly decentralised systems of governance and service delivery.

VIII Towards a solution

Addressing Pritchett's (2009, p. 4) characterisation of India as a "flailing state", Singh (2017) has argued that government failure in India is the result of over-centralisation, recommending that greater expenditure and revenue authority needs to be pushed down to lower levels of government. The preceding sections of this paper have shown that India is performing poorly on most human capital indicators (with considerable inter-State disparities), that international and empirical evidence as well as the constitutional scheme point towards decentralisation as the appropriate means to address this; and yet, India has been employing a centralised approach. In order to improve India's human capital, it is critical to rejuvenate India's federal structure. For this, changes are required at several levels.

At the Central level

To begin with, the Centre needs to increase its spending on health and education in real terms, unlike the recent instance of modifying the definition of the health budget and reprioritising existing programmes. Beyond increasing the quantum of expenditure on human capital, the Centre should also reconsider the manner in which it spends this money, focusing on building openness and civic engagement in the reporting and assessment of public spending. Given that public health is a state subject, and that education and socio-economic planning are concurrent subjects, the Centre should design and orient its approach accordingly. This means that the Centre should play an enabling and facilitative role, coordinating State-led efforts.

The Centre could play this coordinating role by encouraging knowledge-sharing between States by developing knowledge platforms that promote cross-State learning. India's health and education systems are a rich canvas of experimentation and variations in implementation, particularly in the area of service delivery. But the insights and lessons derived from this heterogeneity have not been systematically documented across States. Some of the modalities through which the Centre could contribute here include creating institutional hubs, organising learning events, partnering with academia, and facilitating exchanges between practitioners. The Centre should create and support independent and credible institutional mechanisms to support information exchange and monitoring (Boex & Martinez-Vázquez, 2004). The Centre could also actively encourage innovation by funding pilot schemes on a range of health system issues such as last-mile service delivery in remote areas, urban health innovations, telemedicine, and private sector engagement models. These pilots should necessarily involve effective monitoring and evaluation in order to generate evidence, whether positive or negative, that can then be used by relevant implementing agencies across the country.

Further, on the aforesaid point of institutional mechanisms, the Centre should revive institutional forums of inter-State dialogue and cooperation. The Planning Commission used to function as such a forum along with the National Development Council where State Chief Ministers could negotiate plan transfers that were linked to CSSs. But after the Planning Commission's abolition in 2014, followed by the creation of the NITI Aayog, there has been an institutional vacuum (Aiyar & Tillin,

2020) and decisions over central transfers to the States have been appropriated by central line ministries and the Union Ministry of Finance (Swenden & Saxena, 2017).

To address this, the Centre should consider revitalising the Inter-State Council, a constitutional body under Article 263 that was set up in 1990 (and last met in 2017). It is specifically charged with the duty of investigating and discussing subjects in which the Centre and the States have a common interest, and with making recommendations for better coordination of policy and action (India Const. art. 263). It includes the Prime Minister and other cabinet ministers from the Centre, and State Chief Ministers, and it has occasionally functioned as a forum for formalised collective discussion and approval of various matters that have federal implications (Singh, 2016). In addition to this, Article 263 has also been used to set up the Central Council of Health and Family Welfare (which last met in 2019), an advisory body that includes Health Ministers from the Central and State Governments (PIB, 2019). It is mandated to consider and recommend broad lines of policy with respect to all aspects of health and to promote and maintain cooperation between the health administration at the Centre and State levels. Centre-State cooperation should be meaningful and institutionalised, and not merely *ad hoc*. In the context of this institutional vacuum, the Chairman of the Fifteenth Finance Commission observed in a recent lecture that “... there needs to [be] serious consideration on building entities by way of a permanent consultative mechanism” (Singh, 2021, p. 22). As seen above, there are many existing options that can be revived in order to address this gap.

The Centre should refrain from offsetting the tax devolution amounts that are payable to States, as it has done in the past by altering the cost-sharing ratios of CSSs and through cesses. The Fifteenth Finance Commission has retained the higher level of tax devolution that was recommended by the Fourteenth Finance Commission, and the unconditional nature of these vertical transfers should be effectuated in spirit. Concomitantly, the heavy reliance on CSSs should be reduced, and tax devolution and grants-in-aid should be the primary sources of vertical fiscal transfers.¹⁰

The remaining, restructured CSSs should be made more flexible so that States are allowed and encouraged to innovate and adapt these schemes to meet their unique requirements. As noted by the Fifteenth Finance Commission (2020), the PM-JAY allows States to co-brand it with their own schemes, choose whether to adopt a trust or insurance mode, use the Central Government’s Information Technology system or their own system, to adapt the benefit package and eligibility/coverage groups, and so on. As opposed to this, the erstwhile Rashtriya Swasthya Bima Yojana (RSBY) required States to contract insurance companies to fulfil the role of health care purchasers with no option to establish a government trust. The RSBY insisted on the use of its own Information Technology system and did not allow any co-branding with existing state insurance schemes. The National Health Mission has moved towards greater flexibility as well (FC-XV, 2020).

There should be greater collaboration between Central and State governments in the design of CSSs from the outset (Sengupta, Sharma, Gupta, Ravindran, & Sengupta, 2018). This should reflect in CSSs having customised terms for individual States rather than the one-size-fits-all MoUs that States currently sign with the Centre for CSSs. Even with standardised CSSs, greater flexibility and effectiveness will result from switching to output-based conditions from the current input-based ones, as seen from international experience. As recommended by the Fifteenth Finance Commission (2020, vol. 1, p. 279) on this point:

There is a need to shift the focus of inter-governmental fiscal health financing from inputs to outputs/outcomes while advancing the measurement agenda as an accountability tool. Complementary to this flexibility, the Union Government can shift the focus of CSS and transfers away from line-items and activities and towards outputs and outcomes, with States being empowered to choose their own pathways to achieve results. Financing can be provided based on bilaterally agreed 'compacts' related to specific objectives (for example, service delivery outputs or specific outcomes) instead of exhaustively discussed implementation plans. To support this approach, the Union Government can support initiatives to enhance data systems, monitoring and evaluation and transparency. One recent example is the NITI Aayog Health Index, which produces an annual report documenting progress among states across twenty-three key health indicators.

While it is desirable for CSS conditions to be customised and flexible, one area in which standardised processes would be beneficial is in monitoring and evaluating the use of CSSs across States. For CSSs to effectively achieve their outcomes, they should be supplemented with measurable indicators of performance and processes of reporting on those indicators that are transparent, credible, and consistent (Sengupta et al, 2018). Performance indicators should be jointly defined and determined by the Centre and States, which would help reinforce the values of joint ownership and accountability towards achieving shared goals (Shah, 2010). Standardised reporting processes across CSSs will help in assessing their effectiveness in a uniform manner (Sengupta et al, 2018). This should be complemented with improvements in the coverage, timeliness, quality, and integrity of fiscal reporting generally as part of public financial management reforms at the Centre and State levels (Singh, Patel, & James, 2021). In line with these principles, the Fifteenth Finance Commission (2020) has recommended performance-based education grants to incentivise improvement in learning outcomes in States, measured by a subset of the MoE's Performance Grading Index (PGI).¹¹

Such standardised processes can help establish an environment of predictability and transparency, safeguard the credibility of evaluation, help in effectively managing non-compliance, and institute a system of checks and balances to ensure accountability (Spahn, 2012). It would also be in keeping with the facilitative role that the Centre needs to perform in this area.

At the State level

For States to play a bigger and more meaningful role in human capital interventions, they need to have adequate fiscal resources that they can use as per their discretion. As discussed above, a lot depends on the Centre, for this. At the same time, the States should also improve their planning capabilities and rationalise their own programmes and spending priorities in order to focus on human capital development. They should also work towards improving their public financial management systems and facilitating more civic engagement and accountability.

The Fifteenth Finance Commission (2020) has recommended that health spending by States should be increased to more than 8 percent of the States' budgets by 2022. It also proposed that primary health care should be the number one fundamental commitment of each and every State and that primary health expenditure should be increased to two-thirds of the total health expenditure by 2022. For enhancing service provisioning and ensuring the availability of trained human resources, the commission also recommended starting specialist DNB (Diplomate of National Board) courses in district hospitals and investing in the training of the allied healthcare workforce. It also recognised

the need to invest in critical care hospitals and public health laboratories to address regional health inequities and pandemic-preparedness. The commission's sectoral grants for health specifically included allocations for all these sub-components.

The Fifteenth Finance Commission (2020, vol. 1, pp. 56-8) has also made several specific reform suggestions pertaining to education. For building resilience in India's public education system, it suggested:

In the light of the Covid-19 pandemic, it is necessary for states to design an amalgamation of digital and physical classes curriculum. To ensure that children do not suffer because of closure of schools, every school must have an information and communication technology (ICT) lab and smart classroom. Underprivileged children should be given pre-loaded devices.

For improving learning outcomes in schools:

- Attaining foundational literacy and numeracy for all children should become the core target for States.
- State Governments need to work towards having *functional schools* which have minimum size, adequate teachers, and basic infrastructure.

And specifically, on the use of technology:

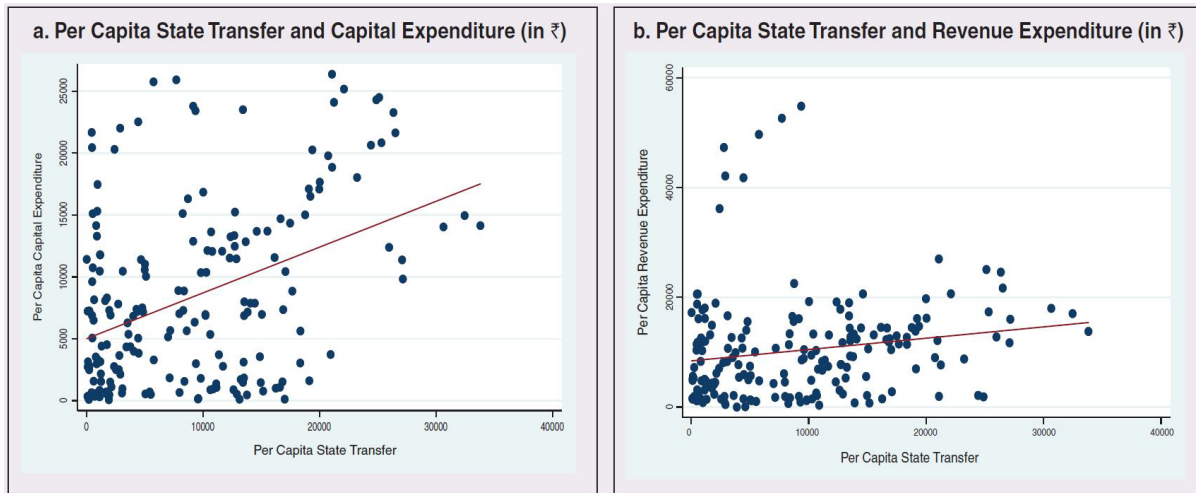
- MIS [Management Information System] needs to be put in place by all States which can have information like teacher attendance, enrolment data and learning levels. It may also contain feedback. This can become a basis for making policy decisions.
- Based upon the information from MIS, a targeted approach can be followed where the schools at the bottom on certain parameters can be identified and resources may accordingly be devolved.
- All out-of-school children need to be mapped digitally in order to bring them back to school. Similar system needs to be developed for vulnerable children. The data should be fed into a centralised database.

At the third tier level

Beyond the Centre and the States, a functionally and fiscally empowered third tier that can effectively intervene in health and education and build civic engagement would not only be more in keeping with the constitutional spirit, but also lead to better human capital outcomes. Local governments are better placed to understand the needs of local citizens and have greater incentives to ensure that these needs are fulfilled. As mentioned previously, improvements in accountability lead to better service delivery. The example of Kerala during COVID-19, where local governments were effectively able to deliver healthcare services, reinforces this point (FC-XV, 2020; RBI, 2020).¹² This was a direct consequence of Kerala's efforts towards meaningful third tier empowerment, especially since its 1996 reforms where 35-40 percent of the State's development budget was unconditionally transferred to third tier governments (FC-XV, 2020). This was critical, given that the spending capacities of local bodies depends heavily on fiscal transfers from their State Governments (Figure 8).

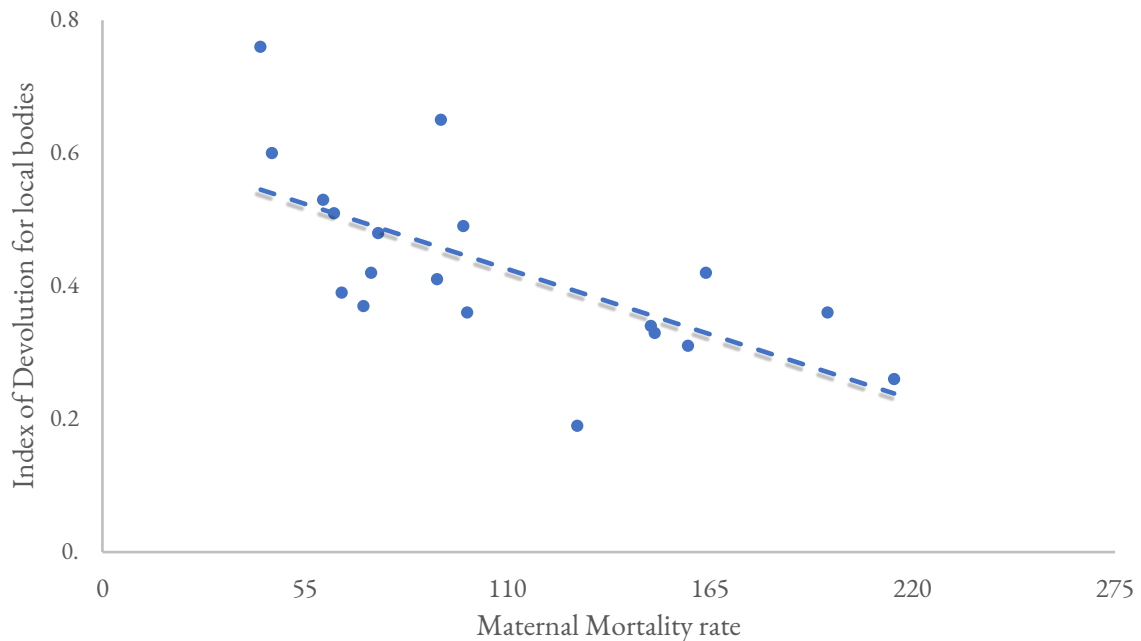
Another example of the link between empowering local governments and improving human capital outcomes can be seen from the negative correlation observed between the maternal mortality rate and the index of devolution to local bodies. This implies that States which have devolved more functions, functionaries, and funds to local bodies have lesser maternal mortality rates (Figure 9).

Figure 8: Urban local body expenditure and State Government transfers (2011-12 to 2017-18)



Source: RBI (2020)

Figure 9: States with a higher Index of Devolution for local bodies have lower maternal mortality rates



Sources: Registrar General & Census Commissioner (2020b); MoPR & TISS (2016)

The true governance potential of our federal structure will only be realised once third tier governments are enabled to contribute meaningfully. For this, firstly, panchayats and municipalities across the country need to be vested with the functions that are listed in the Eleventh and Twelfth Schedules. The 73rd and 74th constitutional amendments had placed the onus for this on the States, but in the three decades since the enactment of these amendments, third tier governments still have

very few powers and responsibilities. Given this, it might be time for constitutional amendments to Articles 243G and 243W that make it mandatory for States to empower the third tier in this regard.

Secondly, just like States themselves, the third tier needs to be fiscally empowered too. To increase the revenue sources of the third tier, States should improve the collection of property tax by taking measures such as setting up Property Tax Boards, as recommended by the Thirteenth Finance Commission (2009). In accordance with the Fifteenth Finance Commission's (2020) recommendation, a constitutional amendment is needed to Article 276 for enabling higher collection of professional tax. Presently, Article 276 provides an upper limit of Rs 2,500 per annum, per person, for professional tax. Instead of this, the power to prescribe an upper limit should be vested in Parliament, acting in accordance with the recommendation of the President, which in turn is made in pursuance of a Finance Commission recommendation. Moreover, the proceeds of this tax should directly go to the third tier, which is presently the case only in certain States (Visakha & Sharma, 2020). Apart from bolstering the third tier's direct revenue sources, they need to receive adequate fiscal transfers through tax devolution and grants-in-aid from States. Since the Constitution envisages State Finance Commission recommendations in this regard, it is essential that these bodies are appointed in a timely and consistent manner by all States.

The Fifteenth Finance Commission (2020) in its report has recognised that third tier governments can play a key role in the delivery of primary healthcare services. In fact, of the total Rs 1,06,606 crore that it has recommended as health grants, Rs 70,051 crore have been earmarked for local governments. This includes specific grants for supporting diagnostic infrastructure to primary healthcare facilities, block level public health units, building-less sub-centres, primary and community health centres, urban health and wellness centres, and conversion of rural sub-centres and primary health centres to health and wellness centres. It observed that involving local governments would make the health system more accountable to the people. At the same time, recent collaborations between the civil society organisation Pratham and the Maharashtra and Uttar Pradesh State governments are indicative of the potential to improve education outcomes by mobilising local governments and communities (Banerji, 2021).

All these measures taken together should help India to reorient its efforts towards improving human capital. Leveraging the true potential of its multi-level federal system represents the best way forward.

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Notes

¹ Brazil (BR), China (CH), Japan (JP), Italy (IT), the United Kingdom (UK), France (FR), Canada (CA), Germany (GR), and the United States of America (US).

² Data compiled from State Finance Accounts and Union Budget, 2018-19.

³ It is debatable whether expenditure on water, sanitation, and nutrition can be considered as part of healthcare expenditure. They are excluded from healthcare expenditure under the System of Health Accounts, a globally accepted standard in this regard (Datta & Chaudhuri, 2021).

⁴ Moreover, the funds allocated in the 2021-22 budget to the Pradhan Mantri Atmanirbhar Swasth Bharat Yojana which is aimed at improving public health infrastructure did not represent an additional health outlay. Instead, funds for this new scheme are to be carved out from the National Health Mission, meaning that it was only a reprioritisation of existing programmes (Rao, K.S., 2021).

⁵ The budget estimates for 2020-21 indicate that this had increased to 3.5 percent (MoF, 2021b).

⁶ Faguet, Fox, and Pöschl (2015) cite an example where corruption or ineptitude among officials responsible for local education in a centralised system can have serious consequences for education in that area. This is contrasted with a decentralised system, where such failings can be attenuated by actions of higher levels of government that share responsibility for local education.

⁷ The Fifteenth Finance Commission recommended a tax devolution of 41 percent to States, after adjusting for the erstwhile State of Jammu and Kashmir.

⁸ The report of the Joint Committee on Indian Constitutional Reform (1934) formed the basis of the Government of India Act, 1935. The latter contained a Seventh Schedule which was retained with modifications in the Constitution of India.

⁹ Since the Tenth Finance Commission (1994) was constituted prior to the 73rd and 74th constitutional amendments, its Terms of Reference did not include recommending measures needed to supplement the resources of local bodies. Despite this, it recommended grants amounting to 1.38 percent of the divisible pool to local bodies, in recognition of its new responsibilities in light of the aforesaid amendments.

¹⁰ There have been some attempts to reduce and rationalise the number of CSSs in the past (Planning Commission, 2011; NITI Aayog, 2015).

¹¹ The annual PGI of States is published by the MoE based on 70 parameters covering five domains, viz. (a) learning outcomes and quality (b) access, (c) infrastructure and facilities, (d) equity, and (e) governance processes. The Fifteenth Finance Commission (2020) chose certain equity outcome indicators within PGI to form the basis of its performance-based education grants to States.

¹² Innovative and successful local government interventions in dealing with the COVID-19 pandemic were also observed in States such as Odisha, Maharashtra, and Rajasthan (Singh, 2021).