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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

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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 the central government since the launch of the National Rural Health Mission (NRHM) in 2005. However healthcare in India is a subject that state governments have control over and so any improvement in health provision will not be achieved without active political will and resources from the state governments. Hence a comparative analysis of trends in public expenditure by state governments could give valuable insights into the priorities and choices of rational governments responding to political markets. Specifically the paper investigates the changes in health expenditure of state governments relative to changes in their expenditure on rural development after the launch of NRHM and the subsequent influx of funds from the central government.

Past studies on democracy and public good provision in India (Keefer and Khemani 2003; Dreze and Sen 1995, 1996; Banerjee and Somanathan 2004) do not take into account the most recent developments in the health sector i.e. the launch of NRHM and increased central budget allocation for healthcare. On the other hand, the more recent studies on health budgets in India (Duggal 2009; Berman and Ahuja 2008) do not analyse public expenditures of states through the lens of theories on democracy and hence they do not link public expenditure

patterns with democratic politics. This paper studies public expenditure patterns of different states in India from a political perspective. In the context of the new public interest on health and nutrition and a renewed attention and commitment from the central government, this study will analyse the policy priorities of individual state governments linking them to the political market conditions that they face and the characteristics of the goods that they are expected to provide.

Through a comparative study of trends in health and rural development expenditure in the budgets of six state governments in India, the study reveals a growing prioritisation of rural development expenditure relative to health expenditure in the five poor rural states (Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh) with the notable exception of Himachal Pradesh. Unlike healthcare which is a classic public good, the goods provided under rural development schemes are of more political value to these governments due to their high visibility, easy targeting and credit-claiming.

Hence, the central argument of the paper is that under conditions of widespread poverty and imperfect information among voters, rational governments choose to spend more of their resources on providing goods that are of more political value to them. In such a setting, healthcare often gets deprioritised. It is also argued that the increasing funds from the central government will only give state governments perverse incentives to not raise their contribution towards healthcare to the required level.

The paper is organised as follows. First, the reader is provided with a brief background discussion setting the context for the study. Second, the paper discusses the theoretical and empirical literature relevant to this field, mapping out the different aspects of political markets and public goods that require consideration. The third section briefly discusses the methodology adopted in this paper laying out the rationale behind the choice of states and variables for the analysis. Next, the relative trends in public expenditure in health and rural development sectors are analysed in detail and the properties of rural development schemes, in contrast to healthcare, are discussed. Finally, the concluding section presents the findings of the study.

2. Background

Public good provision in India is largely managed by state governments. This is particularly true in the case of healthcare. The central government, though influential in designing and planning health policies, leaves the responsibility of implementation entirely to the states (Duggal 2009, p.15; Sinha 2012, p. 17). Hence it is not surprising that the democratic politics in these states has led to very different outcomes in terms of health indicators. While states like Kerala, Tamil Nadu, Himachal Pradesh and Maharashtra are better performers in health indicators, other states like Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh perform significantly low in matters of health and nutrition. These inter-state disparities are also reflected in the wide differences in per capita health expenditures in these states.[1]

It was in this context that the Government of India launched its flagship health programme ***National Rural Health Mission (NRHM)*** in 2005. The aim was to increase India's public expenditure on health from 0.9 per cent to 2-3 per cent of GDP and address inter-state disparities in health by identifying 18 ***high focus states*** which were to receive increased funds for health initiatives every year from 2005 (Ministry of Health and Family Welfare 2005-2012). NRHM funds are routed through the state budgets (Berman and Ahuja 2008, p.214) with the departments of health and family welfare under each state government receiving the funds from the Ministry of Health and Family Welfare, Government of India. In Section 5.1, we will see that despite the increased funds from the central government, the inter-state differences in health spending continue to remain.

Another important expenditure head in state budgets is ***rural development***. In state budgets, the rural development expenditure figures are categorised under 'economic services' and these largely relate to anti-poverty programmes (Dev and Mooij 2002, p. 853). The largest programme implemented across the country is the *Mahatma Gandhi National Rural Employment Guarantee Scheme* (MGNREGS, more commonly known as NREGS). Though NREGS is the flagship programme of the Government of India, it is excluded from our study because the funds for NREGS are transferred directly from the central government to the nodal implementation agency (DRDA) of each district (Ministry of Rural Development 2008, p. 39). State governments play a major role in designing, planning, preparing proposals for grants and implementing a majority of the centrally sponsored schemes (CSSs) in rural

[1] For a detailed discussion on inter-state disparities in per capita health expenditures, see section 5.1 and Table 2.

development. Moreover, all state governments have their own rural development schemes funded from their resources. This allows us to consider the rural development expenditure as seen in state budgets to be largely determined by the state's enthusiasm in implementing central and state schemes.[2]

Some major rural development schemes of the central government along with a brief description are given below. This is expected to help the reader get a better sense of the government schemes in India as they are discussed in further detail in the analysis section (section 5).

Indira Awaas Yojana (IAY) is the rural housing scheme of the Government of India. It was launched in 1985-86 as a sub-scheme under various rural development schemes and became an independent scheme from January 1996 (Ministry of Rural Development 2012a, p. 2). The major target groups under this scheme are below poverty line households belonging to Scheduled Castes/Scheduled Tribes, freed bonded labourers and minorities among others (widows, non-SC/ST BPL households, ex-servicemen etc.) (ibid., p. 3).

Pradhan Mantri Gram Sadak Yojana (PMGSY) is the flagship programme of the central government to provide rural road connectivity across India. It was launched in December 2000 (Ministry of Rural Development 2012b, p. 1). Planning, grant of funds and execution of works under the scheme are done through proposals submitted by the state executing agencies nominated by the state governments (ibid.).

Swarnajayanti Gram Swarozgar Yojana (SGSY) is an integrated self employment scheme for the rural poor that was launched in April 1999. It focusses on organising the rural poor into self-help groups, training and capacity building and helping them in income-generating activities through bank credit and government subsidy (Government of India, 2011).

[2] This argument is discussed in more detail in section 5.6

3. Literature Review

The literature around democracy, public good provision and poverty reduction has been expanding in recent times. Scholars continue to argue whether democracy is good or bad for poverty reduction and for efficient public goods provision. The spectacular successes by certain authoritarian regimes to drastically reduce poverty and to improve the provision of welfare-enhancing public goods like health and education have attracted the attention of social scientists and policymakers. In comparison to democracies in the developing world which have had moderate to low levels of successes in eliminating poverty and efficiently providing public goods to their citizens, these successful authoritarian regimes demand so much attention that this "authoritarian moment" (Bardhan 2008) is of normative concern to lovers of democracy (Varshney 2000).

The vast literature on democracy and development seems to be spread along two main strands. The first strand consists of the considerable amount of studies that have been done on the merits of democracy vis-à-vis the merits of authoritarianism for implementing pathways to development, poverty reduction and social welfare (see for example, Ross 2006; Olson 2000; Bardhan 1999; Sen 1981, 1999; Przeworski et al. 2000). The second strand of studies looks at why democracies have been slow in reducing poverty and providing public goods. These studies have revolved around electoral politics in developing countries and the special features of these societies that hinder the efficient functioning of the democratic system like clientelism and patronage, imperfect information, party systems etc. (See Keefer and Khemani 2003; Stokes 2009; Varshney 2000; Hagopian 2009). Due to constraints on time and words, we will limit our discussion to the second strand focussing on the difficult policy choices that democratic governments in developing societies have to make that in turn affect their patterns of expenditure and policy priorities.

3.1 Imperfect Competition in Political Markets

The idea that societies need to have the "right conditions" for democracies to sustain and effectively function is not new. Seymour Martin Lipset in his influential work, "Some Social Requisites of Democracy: Economic Development and Political Legitimacy" (1959) argued that "democracy is related to the state of economic development. Concretely, this means that the more well-to-do a nation, the greater the chances that it will sustain democracy" (p. 75).

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-client networks etc.) that could be considered as conditions that are not conducive for the efficient performance of a democratic system.

Lack of information among voters is often cited as a reason for imperfect functioning of elected governments and failure of political markets to provide broad public goods like healthcare. Voters, who do not have enough information about government policies and the performance of various politicians/ political parties, are more likely to be easily influenced by electoral promises and political campaigns. This "political market imperfection" (Keefer and Khemani 2003) becomes especially relevant in poor constituencies where significant sections of the population are poor and therefore do not have enough access to media and communication channels like newspapers, radio, television etc. (Fiorina 1990). Access to politically relevant information through media sources has been found to have a crucial role in determining public spending and redistribution patterns of elected governments both in India (Besley and Burgess 2002), and in the US (Stromberg 2004). Hence imperfect information among voters could be seen as an important feature of a developing society that in turn influences the political process, policy priorities and public spending choices of elected governments.

3.2 Visibility

Imperfect information that characterises any developing society profoundly influences the political dynamics in operation there. This has the implication that politicians try to overcome the information barrier between them and the voters by opting for goods that are easily and immediately visible and those that clearly "signal" good performance by the responsible politician (Rogoff and Sibert 1988). Visibility of a good essentially means the ease with which voters are able to assess the good and identify the politician or the political party responsible for the provision of the good. This "*visibility effect*" is particularly relevant in the case of public goods, like healthcare, which are classic examples of goods with very low *intrinsic visibility* (Mani and Mukand 2007). In democracies where credibility among politicians/political parties is low, politicians tend to have higher discount rates for the future and shorter time horizons leading to provision of more private goods (Keefer and Vlaicu

[3] For a summary on criticism against Lipset's analysis, see Diamond (1992, p. 451)

2005). Studies on political cycles and elections have also revealed that incumbent governments, operating under conditions of information asymmetry, tend to spend more on current expenditure which are more *immediately visible* and hence bring more political value than capital expenditure projects that are difficult to coordinate with periodic elections (Rogoff 1990; Vergne 2009). Bearing in mind these concepts of intrinsic and immediate visibility, it is logical to understand why a politically rational government in a poor region (like some of the poorest states in India) would underprovide a public good like healthcare which is intrinsically and immediately less visible as opposed to more visible employment or public works programmes.

3.3 Targetability and Credit claiming

Another interesting consequence of imperfect information in political markets of developing countries is that politicians have an incentive to choose policies that can provide targeted benefits which they can easily claim credit for. *Credit claiming* assumes special significance in such a setting (Mayhew 1974). Providing targeted benefits to groups of voters is often perceived as the easiest way to communicate to voters and claim credit for these goods (Mayhew 1974; Lizzeri and Persico 2001). These benefits could be in the form of employment schemes, transfers, subsidies etc. that could be targeted towards a particular group of voters aimed to appease them. Local "pork barrel" projects in the form of public works have the additional advantage of targeting a geographical constituency that not only benefits from the project but also from the jobs created in the process (Drazen 2000; Milesi-Ferretti et al. 2002, p. 609; Vergne 2009). This demonstrates why in developing democracies there might be an overprovision of targeted transfers, job programmes and public works projects. Further, this could be used to partially explain why in poor and developing countries public goods like healthcare that have universal benefits are usually of suboptimal quality or are undersupplied by democratic governments.

3.4 Health Expenditure in India

An analysis of expenditure patterns is one of the best ways to understand the political commitment of a government on several issues and thus by extension its policy priorities and choices with regard to the political market it faces. Many researchers have studied the trends in social sector expenditures – especially health expenditures – in India and there seems to be a general consensus that the social sector expenditure in India is relatively low compared to international standards (Dev and Mooij 2002). In particular, until 2005, India's public

expenditure in health averaged around 1 per cent of GDP and has even seen a decline in states' health expenditures from 0.89 per cent to 0.69 per cent of GDP during the period from 1999-2000 to 2004-05 (Berman and Ahuja 2008, p. 210). This trend has been reversed with the launch of the flagship programme of the central government, the National Rural Health Mission (NRHM) in 2005 which aimed to raise the total government spending on health to 2-3 per cent of GDP by 2012 (Ministry of Health and Family Welfare 2005-12) as a result of the rising demands from the public for greater political commitment on health (Berman and Ahuja 2008, p. 209). Researchers have observed that despite increased political commitment from the central government, the state governments have been lagging behind in their implementation of health schemes (Duggal 2009; Berman and Ahuja 2008). This observation has resulted in a rising interest in studying the reasons for this inertia on the part of the states. One of the main reasons cited by scholars is the lack of absorption capacity of states meaning their inability to plan and spend resources (Berman and Ahuja 2008). However Duggal (2009) challenges this explanation and argues that the problem is of twofold – one relates to the issue of fungibility, with the states using the increasing central funds to reduce their own contribution towards health, and the second relates to the subversion of the decentralisation process with growing centralisation of health budgets. All this makes one comprehend that the problem lies at the level of states and there is a need to better understand the dynamics of expenditure choices faced by the states.

3.5 Connecting the dots in the literature to inform our analysis

The problem of imperfect information becomes the starting point for this paper as it analyses the spending patterns of democratic governments in selected Indian states. With high levels of poverty and illiteracy, the voters in some of the poorest states of India have low access to information. In such a setting, the underprovision of healthcare and the low quality of health services seem to be not very surprising. Healthcare has most of the properties of a classic public good. Given that it has very low intrinsic and immediate visibility, it is difficult for voters to accurately assess its quality and make connections to a single politician for taking the initiative for its provision. Moreover, improvements in health outcomes take a longer time to manifest and often do not get the voter's attention making politicians with higher discount rates and shorter horizons to focus on other goods. Moreover, it is difficult to target benefits in a healthcare programme and hence credit claiming becomes harder. This has to be seen in contrast to the rural development schemes that governments in India undertake – such as wage and self-employment schemes, and public works – which enjoy greater visibility and

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.

An inter-regional comparison within India becomes feasible because the states share similar structures with regard to governance, administrative, and fiscal matters. In matters of public good provision, especially healthcare, states are the main decision-makers. Moreover, it is observed that states contribute to around 75 per cent of all government expenditure on health in India and hence, any change in the states' health spending drastically changes the total public health expenditure (Berman and Ahuja 2008, p.210). Apart from their influential role in healthcare provision, state governments are instrumental in the planning, design and implementation of most centrally sponsored programmes (Duggal, 2009) and funds for some of these are routed through state treasuries (or sometimes executive agencies appointed by the states) on the basis of their demands for grants from the central government. [4]This allows us to make sure that the states are the right units of analysis for this study in order to understand the provision of healthcare in rural India relative to a multitude of other development programmes/schemes.

[4]. For a detailed discussion see Section 5.6

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. Hence this provides a good experimental setting for the paper as it can study the changes in expenditure patterns by the states given the increasing flow of funds from the centre for health reforms.

The six states chosen for the study include ***Bihar, Madhya Pradesh, Odisha (earlier called Orissa), Rajasthan, Uttar Pradesh and Himachal Pradesh***. All of these states belong to the category of high focus states receiving increased funds from the Government of India under the National Rural Health Mission (NRHM). All the six states are predominantly rural. With the notable exception of Himachal Pradesh, these are some of the worst performing states in most health indicators including maternal mortality rate, infant mortality rate, disease burden and malnutrition levels. Besides the per capita health expenditures in these five states have been traditionally low even compared to Indian standards.[5] Except Himachal Pradesh, all the other states included in the study are some of the poorest states in India with per capita incomes well below the national average and significant sections of their populations below the national poverty line. Moreover these five states have very low levels of literacy compared to the national average. Himachal Pradesh, despite being one of the best performing states in every social indicator (including those of health), is included as a high focus state under NRHM due to its mountainous topography and consequent access difficulties (Sundararaman 2012). Hence in the context of increasing funds and (thus) political commitment from the centre to improve health conditions in these six states, we have (1) Himachal Pradesh that is highly rural but highly literate and good performing in terms of health, and (2) five other states (Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh) that are highly rural but less literate and worse performing in terms of health. This interesting variation on two accounts – (a) the level of information among voters and (b) the level of responsiveness of government (reflected in health performance) – gives us sufficient room to explore the possible reasons for the observed differences in public

[5] See Table 2 for a comparison of per capita health expenditures between states in India

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)	NRHM Status	Infant Mortality Rate (in 1000 live births)
India	68.84%	68.91%		47
Bihar	88.70%	61.83%	High Focus	55
Madhya Pradesh	72.37%	65.29%	High Focus	67
Odisha	83.32%	70.78%	High Focus	62
Rajasthan	75.11%	62.34%	High Focus	60
Uttar Pradesh	77.72%	67.55%	High Focus	71
Himachal Pradesh	89.96%	82.91%	High Focus	40

Source:

a) Statistics on rural population and rural literacy rate are obtained from Census of India 2011, Provisional Population Totals, Office of the Registrar General & Census Commissioner, India.
b) NRHM Status from NRHM Mission Document 2005-2012, Ministry of Health And Family Welfare, Government of India
c) Infant Mortality Rates for Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh from Annual Health Survey (AHS) Bulletins 2010-11, Office of the Registrar General & Census Commissioner, India.
d) Infant Mortality Rates for Himachal Pradesh and India are from Sample Registration System (SRS) Bulletin, December 2011, Office of the Registrar General & Census Commissioner, India.

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 expenditure as opposed to changes in rural development expenditure as reflected in the state budgets is considered. More detailed analysis of the state's own contribution towards health (when the central funds routed through the state budgets are subtracted) reveals that the state governments are not increasing their share towards healthcare provision as much as their enthusiasm towards rural development spending. A deeper analysis into the type of rural development schemes that are being implemented in these states suggest that states prefer to spend their fungible resources on schemes like employment programmes, housing schemes and public works projects that are politically more valuable to them.

5.1 Inter-state disparities in health expenditures

The huge inter-state disparities in terms of health indicators that were discussed in the previous sections could be invariably linked to the differences in health expenditure between states in India. The significant variation in terms of the policy priorities of different state governments is reflected in their per capita health spending prior to the launch of the National Rural health Mission (NRHM) by the central government and the subsequent influx of funds from the Centre to the states. The objectives of the central government when it launched NRHM were to increase its health expenditure from 0.9 per cent to 2-3 per cent of GDP and to address the inter-state disparities in health by giving special attention to 18 high focus states (Ministry of Health and Family Welfare 2005-12). Hence the high focus states received greater amounts of resources to help improve their health infrastructure and services and this is seen reflected in an improvement in their per capita health expenditures. It is seen that in 2011-12 the per capita health spending in the worst-performing (high focus) states show an improvement and are now closer to that of the best-performing (non-focus) states. Table 2 shows a comparison between the average per capita state health spending in 2002-05 (prior to NRHM) and the per capita state health spending in 2011-12 (six years post the launch of NRHM). However it is worth noting that despite the increased flow of funds to the high focus

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**	
Worse Performing States	*Rupees*	***Worse Performing States***	*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
Average (Worse performers)	***136.92***	***Average (Worse performers)***	***341.05***
Better performing States		***Better performing States***	
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
Average (Better performers)	***261.28***	***Average (Better performers)***	***614.44***
Average (Better performers except Himachal Pradesh)	***211.98***	***Average (Better performers except Himachal Pradesh)***	***535.91***

Source:
Average per capita state health spending 2002-05 – Berman and Ahuja 2008, p. 215
Per capita state health expenditure 2011-12 – Author's own calculation using expenditure data from State Finances: A Study of Budgets, RBI, 2012 and population data from Office of the Registrar General & Census Commissioner, India, 2011.

The increase in per capita health expenditures in the worst-performing states has clearly not reached the expected level of parity with that of the best-performing states. In fact, these states were given the "high focus" status specifically to "address the inter-state and inter-district disparities… including unmet needs for public health infrastructure" (Ministry of Health and Family Welfare 2005-12, p. 4). Such a catch-up process logically requires higher investments in public health in the worst-performing states. The state governments being the instrumental players in decision-making in health policy and programmes, makes us probe

[6] Goa, Jammu and Kashmir and North-eastern States are not included as the analysis does not concentrate on them. These states have relatively low population and consequently high per capita spending and are therefore treated as outliers.

further into what the priority expenditure heads for these states would be, given that there is evidence that health is de-prioritised.

5.2 Relative Trends in Government Spending Under Selected Heads

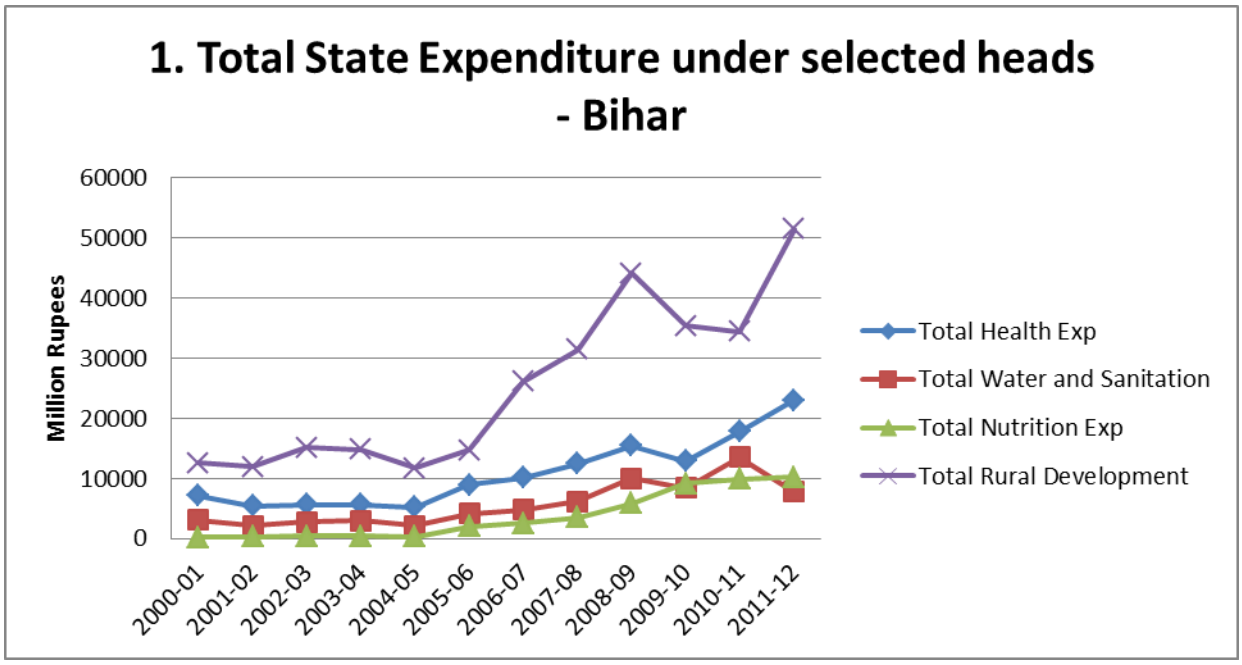
The worse- performing states in India in terms of health are also the states which are predominantly rural and lag behind in terms of all other aspects of development with high levels of unemployment, low per capita incomes, low connectivity with fewer transportation and communication channels, and less access to safe drinking water and sanitation facilities. These inter-regional disparities between states in India have been highlighted by many scholars (Deaton and Dreze 2002; Datt and Ravallion 2002; Dreze and Sen 1995, 1996). For instance, in Madhya Pradesh, one of the least developed states in India, only 22.6 per cent of households had access to toilet facilities and a mere 18.1 per cent had access to piped drinking water (IIPS 2010a). The state, along with Bihar, Uttar Pradesh, Rajasthan, Odisha and five other states, is also identified to have the lowest levels of rural connectivity (ILO 2005, p. 23) and hence requires greater investments rural road and other infrastructure. This demonstrates that the governments in these less developed states in India have to make huge investments in a multitude of goods and services including health and nutrition, water and sanitation and rural development schemes and an analysis of the patterns in the government expenditures under these heads will help us understand their policy choices better.

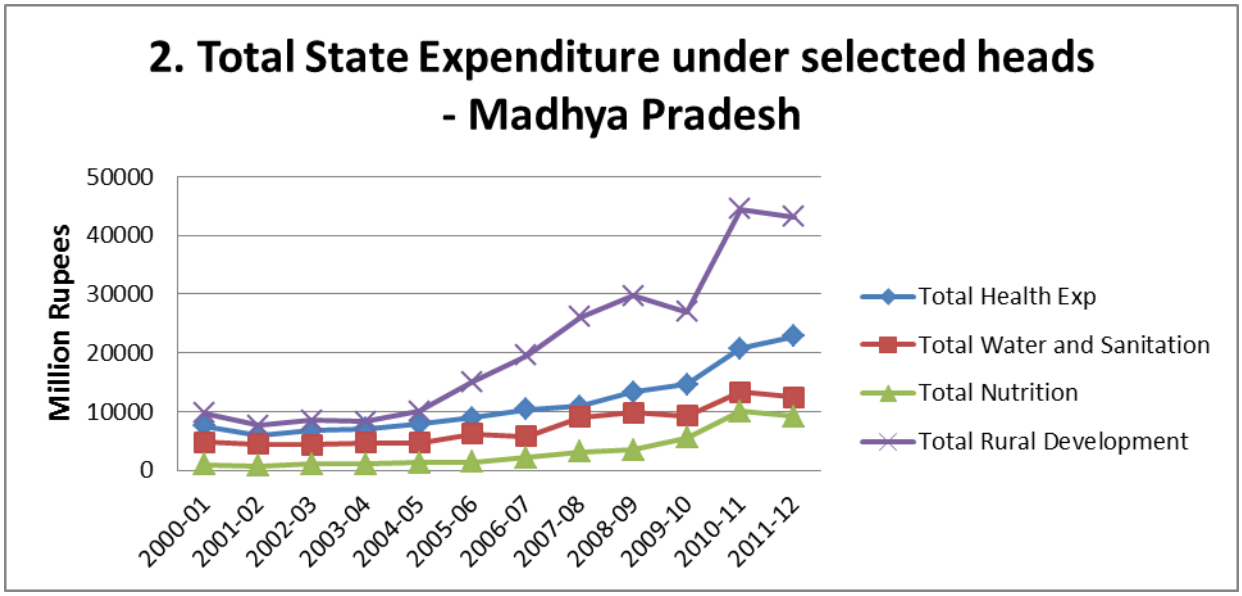
Keeping in mind the above mentioned development investment/expenditure needs in the poorest states in India, the public expenditure patterns of five less developed states – Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh – are studied in detail. As mentioned in the methodology section, the rationale for choosing these states is that they are less literate, highly rural, and are low performers in health indicators. These states also belong to the category of high focus states identified for health reforms by the central government. Figures 1-5 graphically present the trends in the state governments' spending under four separate heads.

1. Health
2. Water and Sanitation
3. Nutrition
4. Rural Development

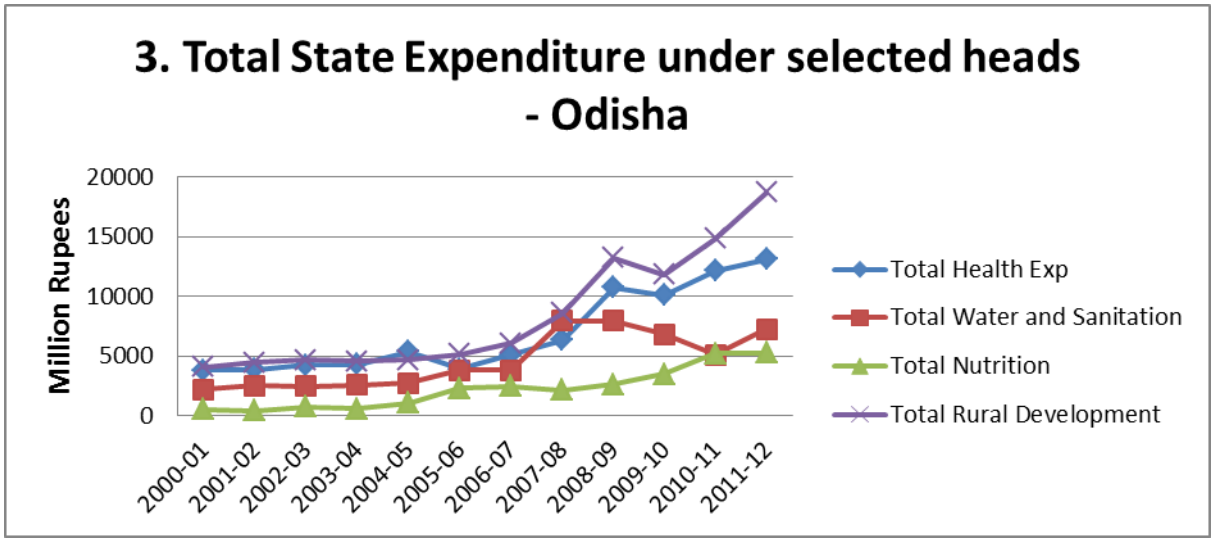
A broad view of the trends in state governments' spending under the selected heads is possible from a careful look at figures 1-5.

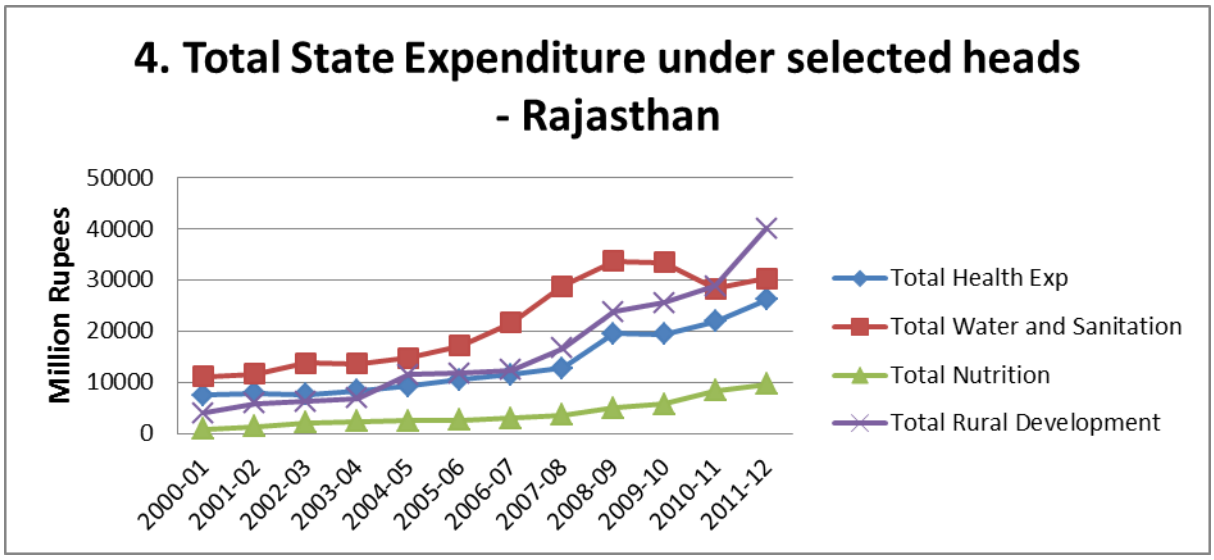
Figure 1- 5: Expenditure patterns of selected state governments[7]

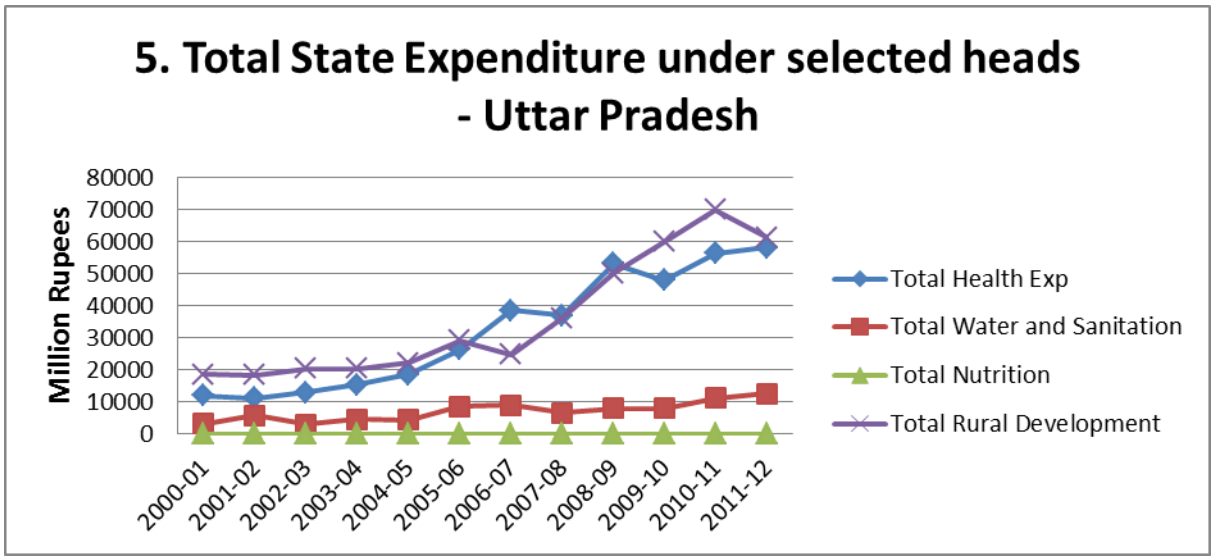




[7] Total Expenditure includes both the revenue and capital expenditures of state governments. Since part of NRHM funds are routed through state treasuries, the total state health expenditure includes some of centre's funds.







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 divergence is observed to have built up between the expenditure on rural development and that on the other heads (health, water and sanitation, and nutrition) over a period of twelve years from 2000-01 to 2011-12. This is particularly pronounced and obvious in Bihar (figure 1) and Madhya Pradesh (figure 2). In the other states, Odisha, Rajasthan and Uttar Pradesh, such a trend is not obvious here but becomes pronounced when the state's contribution towards healthcare is studied (figures 8-10, section 5.3). While the state governments' spending on health, nutrition, and water and sanitation shows a gradual increase over the years, the spending on rural development has seen a greater and sharper increase. This allows us to see that the state governments in these five states seem to be giving increasing priority to rural development sector relative to the other sectors.

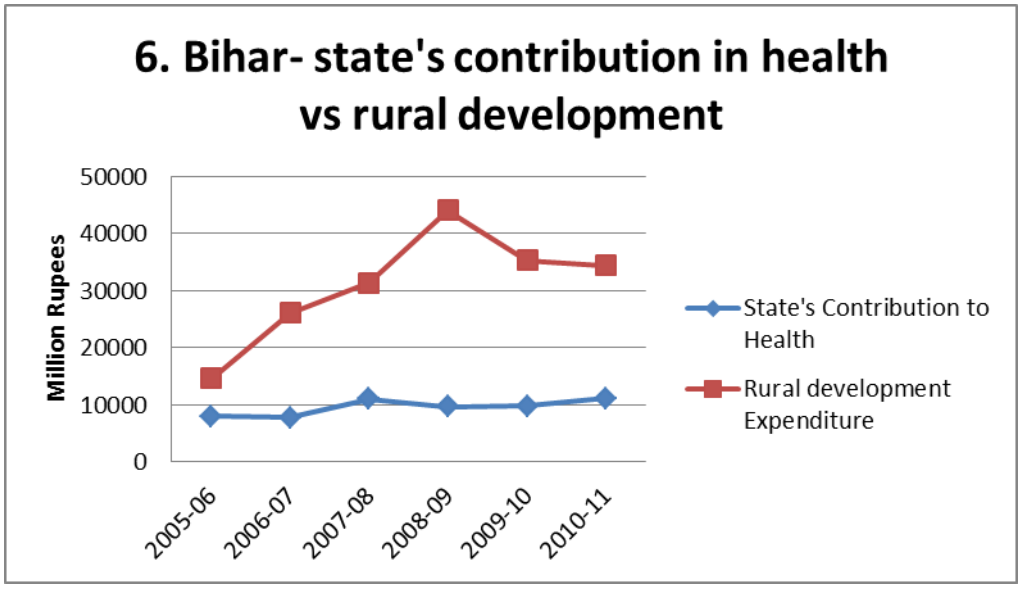
5.3 State contribution towards heath vs Rural development expenditure

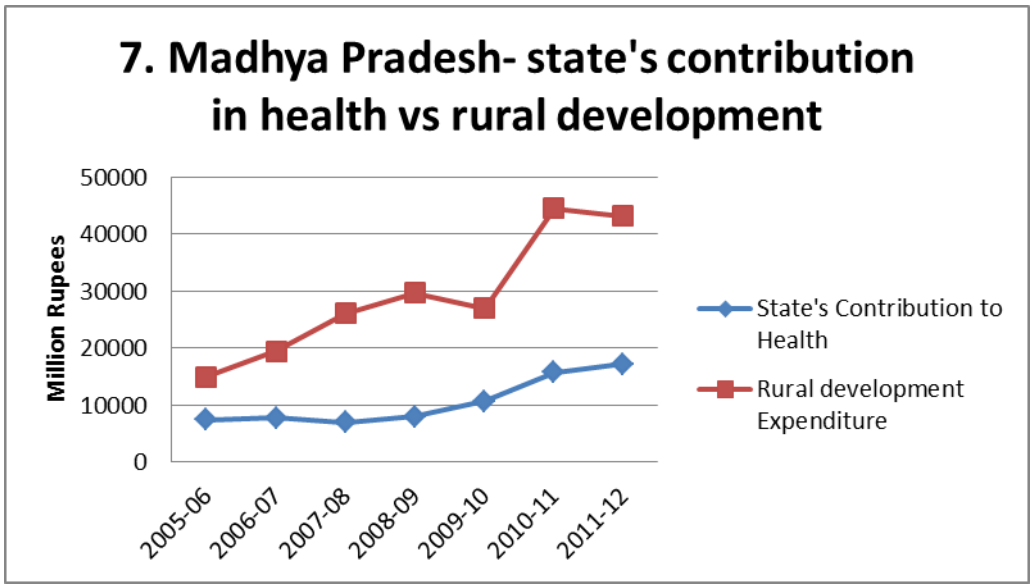
Healthcare being a public good that is often said to be neglected by democratic governments aiming for short term electoral gains, it is imperative that our analysis goes further deep into state health expenditures. The lacklustre performance by states in terms of health indicators despite rising political commitment from the central government through NRHM and increased public attention from the media is pointed out by many researchers (Duggal 2009; Balarajan et al. 2011; Berman and Ahuja 2008). As discussed earlier, state governments are the main decision-makers in terms of healthcare and more than three quarters of the public expenditure on health is incurred by the state governments (section 4). In the context of increased central government funds towards health, scholars have identified a problem of fungibility on the part of the states while dealing with health provision (Duggal, 2009). There exists a compelling case to look at state governments' own contribution towards health and identify trends in the same.

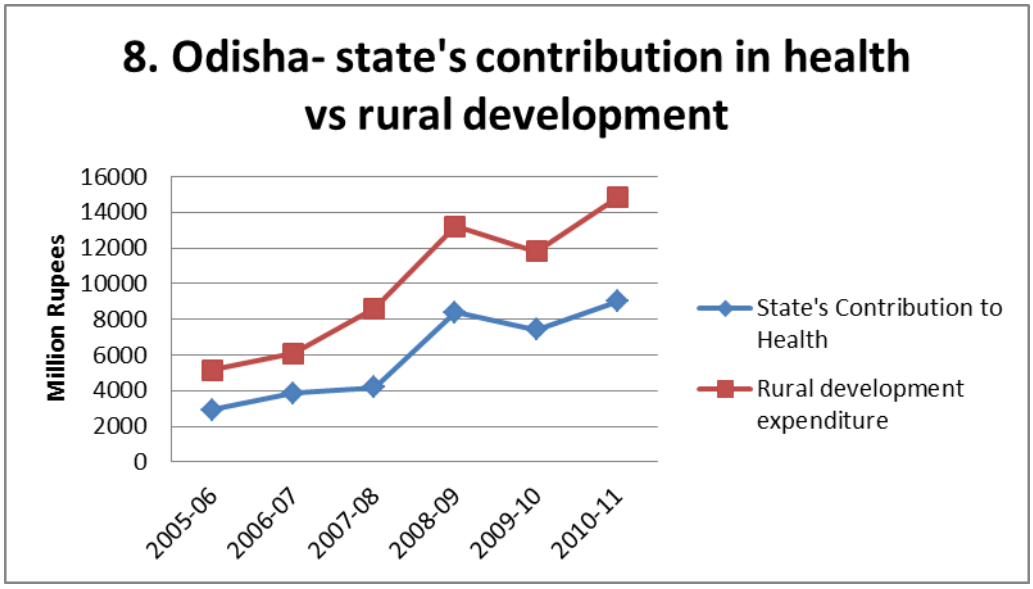
We deal with the health expenditure patterns in the five poor states in India, discussed earlier in this section, by looking at the state governments' own contributions towards public health. Such a calculation of the share of state governments in health becomes necessary because a part of the central government's allocation under NRHM, mainly infrastructure maintenance is routed through state treasuries and hence will be shown in state budgets (Berman and Ahuja 2008, p. 214). Hence the state budgets reflect both the centre's contribution and the states' contribution towards healthcare in a particular fiscal year (ibid.). The states' contribution is calculated by subtracting the central government's release of funds (under NRHM) from the total expenditure on health as reflected in the state budgets.

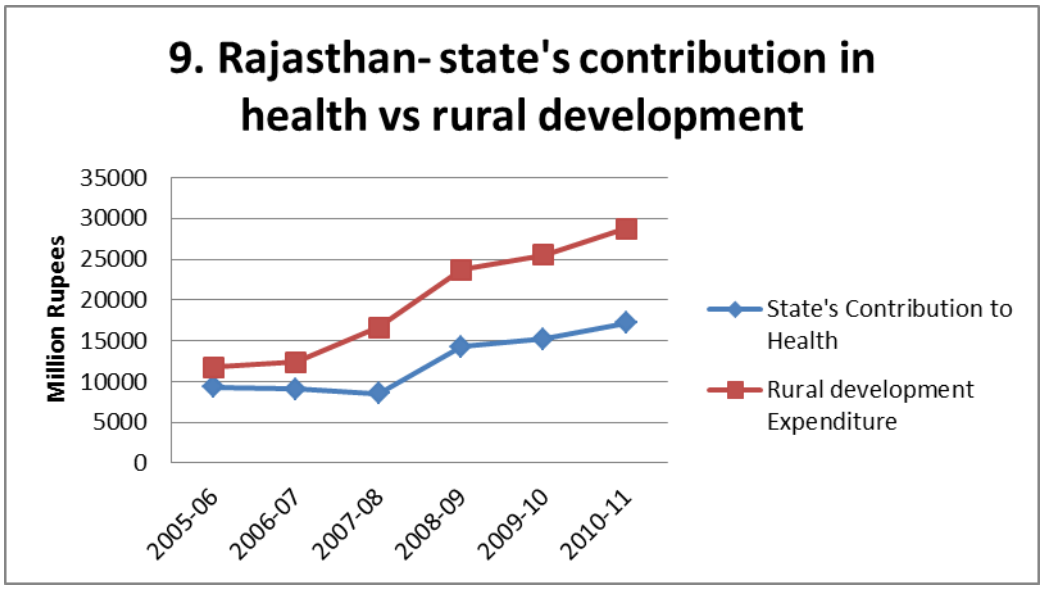
Though data constraints do not allow us to obtain a similar calculation for the state's own contribution to the rural development expenditure, it is argued that this expenditure head in state budgets is largely controlled by the state (which is to be discussed in more detail in Section 5.6).

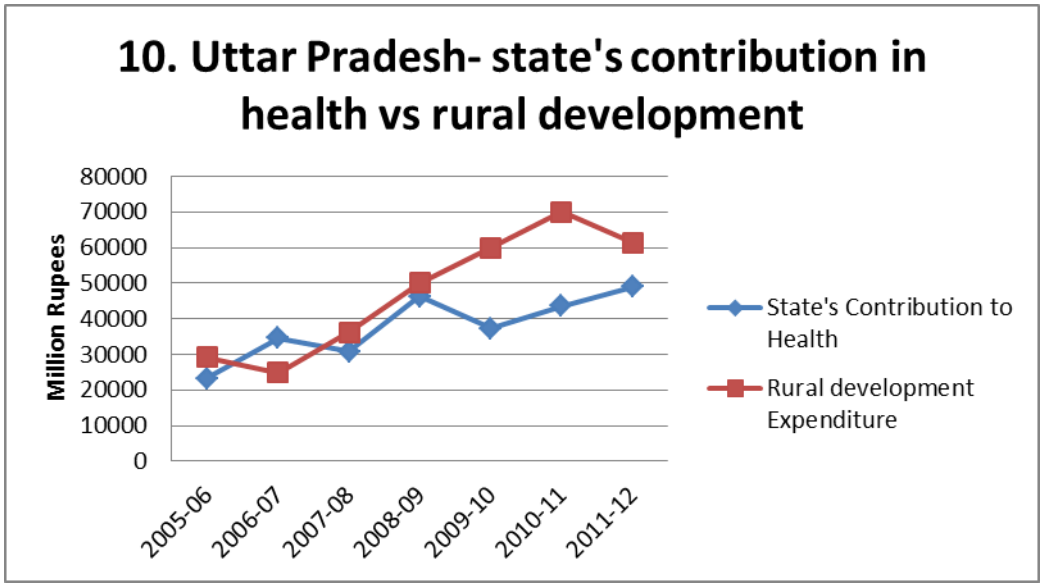
Figure 6-10: Comparing state's own contribution to health with its rural development expenditure











Source: Author's own compilation from

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 that are of more political value.

In such a context, increased funds from the central government may not provide the intended results. With the states having the power to decide their expenditure choices using their own resources, increased central governmental grants might provide them with perverse incentives to not raise their health spending to the required level. The increasing influx of funds from the centre could be used by states to camouflage the lack of political will to increase their

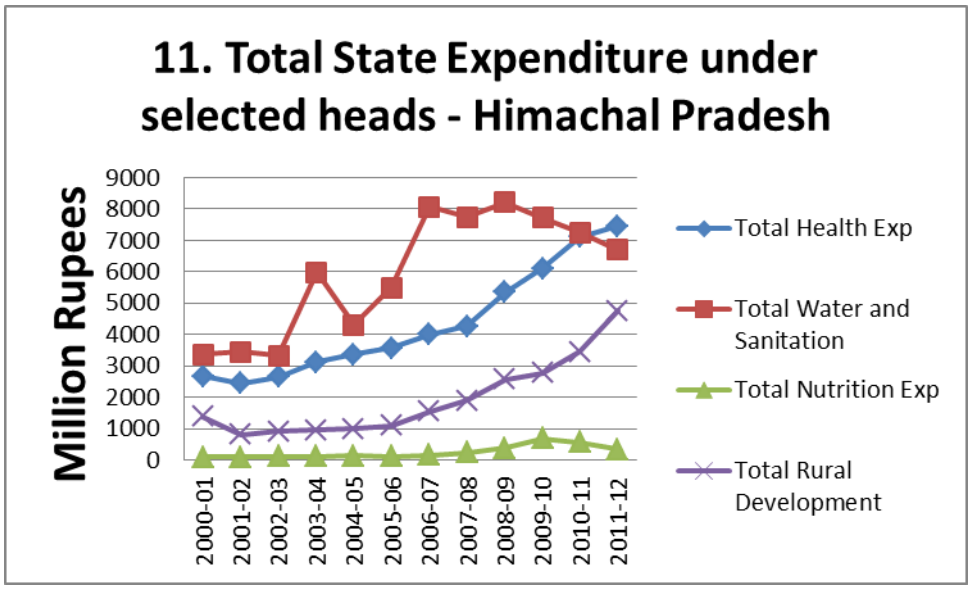
own contributions towards health. This has to be viewed in the light of the particular features of public goods like healthcare that make them politically less appealing as opposed to other goods (see Section 5.5 for a detailed discussion).

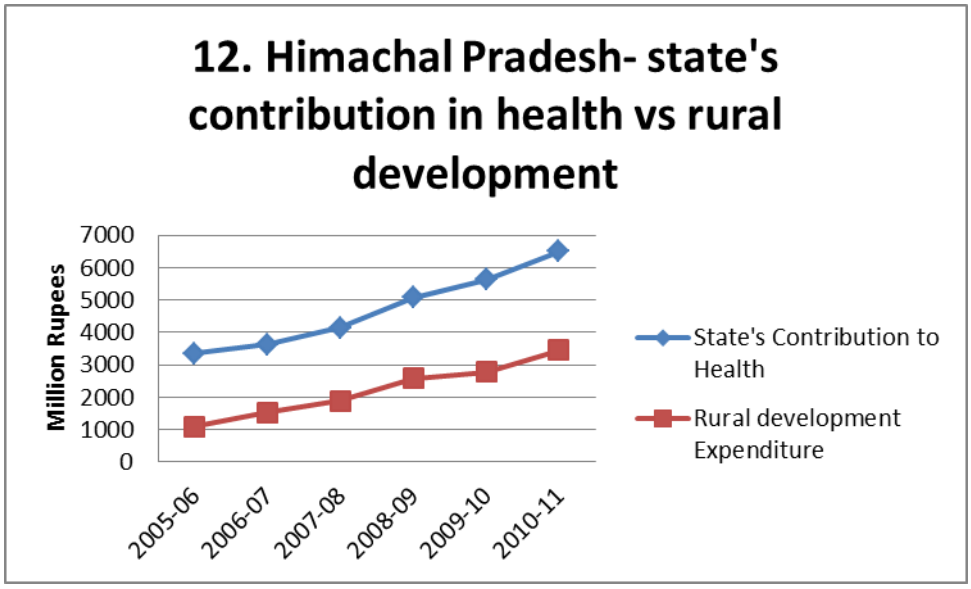
5.4 Himachal Pradesh: Differences in Public Spending

As mentioned in the Methodology section, our analysis includes the state of Himachal Pradesh apart from the five states that have been discussed. Himachal Pradesh is seen as one of the best performing states in India in terms of social indicators with high levels of literacy, good health indicators and high per capita health expenditures. Yet, it shares some common features with the five worse-performing states in our analysis as it is predominantly rural and is categorised as a high focus state under NRHM (due to access problems) and consequently receive greater funds from the central government. Therefore, the inclusion of Himachal Pradesh in the analysis allows us to explore this variation - in terms of literacy and government responsiveness (due to better public health provision) – to better understand the differences in trends in social expenditures.

A cursory glance at figures 11 and 12 reveals that the trends in the Himachal Pradesh government's relative spending are widely different from the five states of Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh.

Figure 11-12: Expenditure Trends – Himachal Pradesh





Source: Author's own compilation from

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

The increase in health spending in Himachal Pradesh seems consistent relative to the increase in rural development expenditure in the state (figure 11-12). It is puzzling why despite having a significant rural population and its difficult mountainous topography, the rural development expenditure in magnitude is less than the state's health contribution. This trend has persisted for a long time in Himachal Pradesh as noted by Fan et al. (2000, p. 3583) as they analyse public expenditure in Indian states during the period 1973 – 1993. However, this pattern could partially be explained by the low incidence of rural poverty in Himachal Pradesh and its high per capita income. Himachal Pradesh is one of the best performing states in human development – with good health indicators and low levels of child malnutrition (HUNGaMA 2011) and with majority of households having access to drinking water and sanitation facilities (IIPS 2010b). However the political commitment by the state government to provide broad public services like health and nutrition as evident from the consistent increase in expenditures on these fronts is in line with the state's better performance in social indicators including health.

This difference in policy priorities of the government of Himachal Pradesh when considering its impressive social and human development might not seem very surprising. Table 1 in Section 4 had shown the high literacy rates among the rural population in the state. Besides, in terms of multidimensional poverty index, the state also has one of the lowest incidences of poverty (Alkire and Santos 2010). This indicates that imperfect information as a political

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 (1) goods that are easily visible by voters (2) benefits that could be easily targeted to groups of voters and (3) goods for which it is easy for politicians to claim credit for.[9] In short, rational politicians choose to prioritise those goods that have more "political value". The types of goods provided under various rural development schemes by the six state governments (listed in Table 3) validate this argument.

Many rural development schemes - like **employment and housing schemes** - take the form of targeted transfers as they have the characteristics of private goods and hence are considered to have more political value. This is particularly relevant for democratic governments in developing countries where party-voter relationships are found to be fragile and fluid (Hagopian 2009) and there are significant imperfections in the political market (Keefer and Khemani 2003). Hence it is not surprising that majority of schemes (in Table 2)

[9] For a detailed discussion about the literature, see Section 3 (Literature Review)

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 transfers (like wages, subsidies and credit) clearly have the characteristics of a private good. Similarly schemes involving non-monetary transfers (like houses and cattle) could also be considered as transferring a private good to the recipients. Therefore it is logical to say that these goods will be more "visible" to less informed voters. This is in line with the argument of Keefer and Vlaicu (2005) that in order to build credibility politicians in developing democracies tend to spend more on provision of private goods.

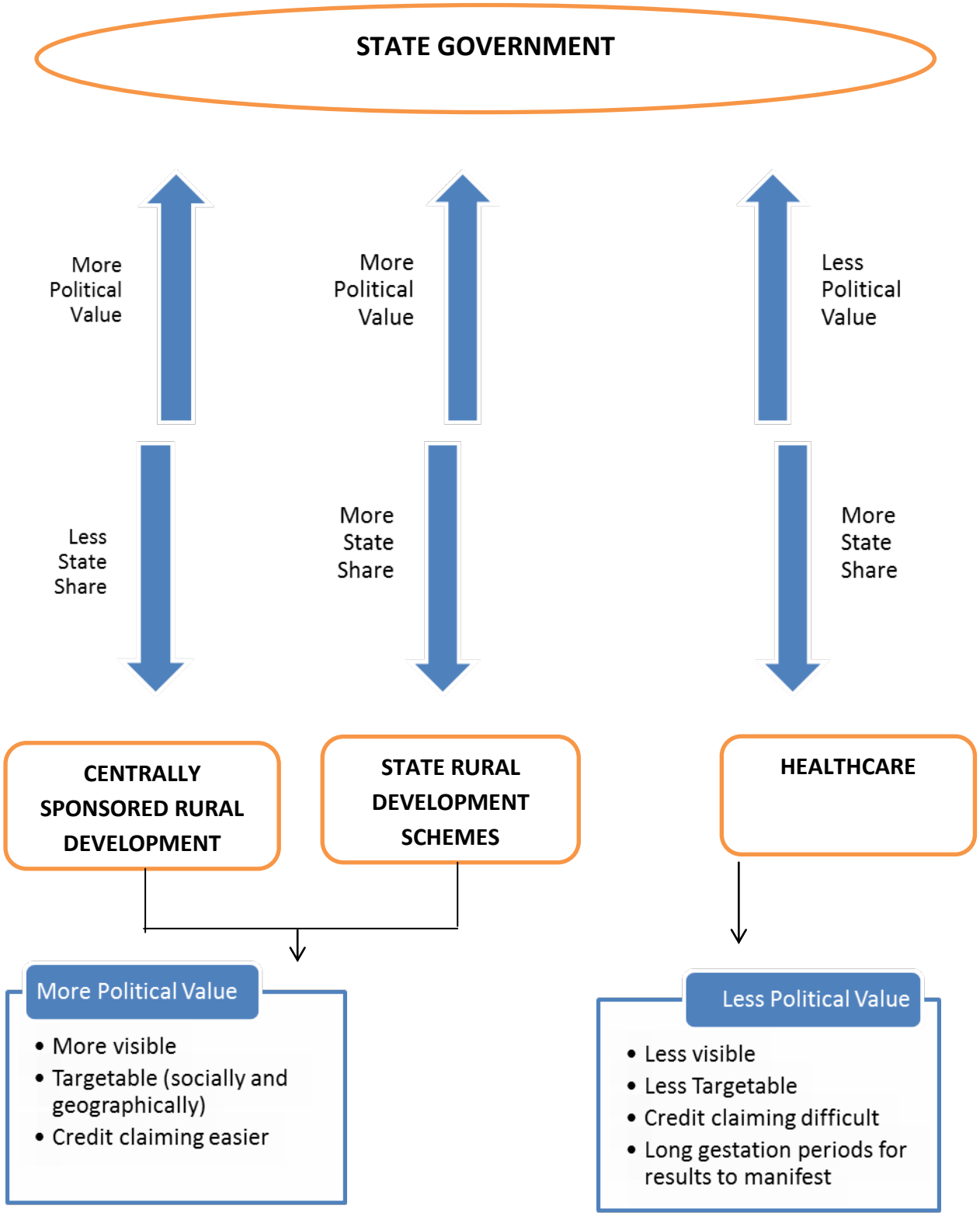
These employment and housing schemes also target social groups (like scheduled castes and tribes) and could prove to be of much political value to the incumbent governments in these states given the importance of identity politics and social polarization in poor less informed constituencies (Keefer and Khemani 2003; Varshney 2000; Milessi-Ferretti et al. 2002). Moreover Bardhan et al. (2008) provide strong evidence that voters in rural regions in India respond better to recurring short-term benefits (like employment, credit, subsidy and relief programmes) rather than significant one-time benefits (with characteristics of a local public good) thereby suggesting "an implicit *quid pro quo* between beneficiaries and the party perceived to be dispensing the benefits" (p. 44). Considering the fact that these short-term benefits take the form of current/ revenue expenditure in the state budgets, all the evidence thus seem to be in consonance with the findings of Vergne (2009) and Rogoff (1990) that governments which focus on electoral gains increase their current expenditure for appeasing voters. Hence the increasing priority given to a multitude of employment and housing schemes by state governments seems to be politically rational.

Public works programmes that come under rural development also tend to be more appealing to politicians due to the innate characteristics and political value assigned to these goods. Rural infrastructure projects like roads, irrigation and watershed projects could be easily used to target constituencies geographically (Milessi-Ferretti et al. 2002). Besides these goods have high intrinsic visibility (Mani and Mukand 2007) and hence credit claiming becomes much easier for politicians (Mayhew 1974). In constituencies with imperfect information, such programmes help politicians to reach out to the voters with goods that "signal" their good performance (Rogoff and Sibert 1988). Besides, while studying political cycles in India, Khemani (2004) finds that state governments in India, eyeing electoral gains, spend more on "public works" like road construction projects. It should also be noted that these public works projects create more local employment increasing their popularity among

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, increased flow of funds from the centre will only have perverse results as state governments (that are decision-makers in healthcare provision) will choose not to raise their health expenditures to the required level.

Figure 13: Policy Choices of State Governments



5.6 Ruling out an alternative explanation

An alternative explanation to this growing divergence - between the rural development expenditure relative to the other selected heads - would be the central government's increased emphasis on rural development, and the proliferation of centrally sponsored schemes under the Ministry of Rural Development. Of particular relevance here is the National Rural Employment Guarantee Scheme (NREGS). The NREGS is India's largest poverty alleviation programme and the central government's flagship rural employment programme (Farrington et al. 2007, p. 42) with the largest budget allocation in rural development in recent years.[10] Other centrally sponsored schemes with large amounts of central funds are the Swarnajayanti Gram Swarozgar Yojana (SGSY), a national self-employment scheme; the Indira Awaas Yojana (IAY), the national rural housing scheme; and the Pradhan Mantri Gram Sadak Yojana (PMGSY), the national scheme for rural road connectivity. Along with these major schemes, there exist several other centrally sponsored schemes on rural development like Integrated Wasteland Development Programme, Drought-Prone Areas programme etc. (as mentioned in Table 3). Hence a close examination of the possibility that the funds for these central government schemes could be responsible for the sharp increase in the states' expenditure on rural development becomes necessary. If such an argument is valid, then the growing expenditure on rural development in the state budgets might not necessarily mean that the states prioritise rural development over other public goods like healthcare.

I argue that this alternative hypothesis - that the central government's schemes on rural development are driving up the state's expenditure on rural development – is not valid to explain the sharp increase in the rural development spending in the state budgets. This argument is based on three grounds.

Firstly, the flow of funds from the central government for major Centrally Sponsored Schemes (CSSs) is not routed through the state treasuries and hence is not reflected in the state budgets. The central government releases its funds for many large CSSs, including NREGS, SGSY, PMGSY and IAY, directly to the implementing agencies, mainly the District Rural Development Agencies (DRDAs), hence bypassing state budgets (CBGA 2008, Rajaraman and Sinha 2007, p. 2279). For instance, the Centre for Budget and Governance Accountability (2008) notes that as of 2006-07, "the total budgeted outlay under CSS formed

[10] The allocation for NREGS in the Union Budget for 2012-13 was Rs. 330 billion (33,000 crores) and revised estimates for 2011-12 show Rs. 310 billion (31,000 crores) (Business Standard, 2012). This expenditure is significant compared to other rural development and poverty schemes.

46.7 per cent of gross budgetary support for Central Plan and 33.3 per cent of the approved plan outlay of State Governments. Of the 41 schemes that are slated to reach PRIs, 10 programs pertain to rural development and carry more than half of the fund for all schemes by-passing state budget" (p. 14). Hence the increasing expenditure on rural development observed in the state budgets reflects mostly the state governments' rural development projects and the state's contribution to central government's rural development schemes – thereby indicating growing prioritisation of rural development programmes by the state governments over health and nutrition schemes.

Secondly, the major CSSs on rural development are all fairly old schemes that have been in operation for more than a decade. The rural housing scheme, IAY, was launched in 1985 and has been implemented as an independent scheme since 1996 (Ministry of Rural Development 2012a, p. 2). The rural road connectivity scheme, PMGSY, has been in implementation since 2000 (Ministry of Rural Development 2012b). SGSY, the self-employment scheme, was launched in 1999 (Government of India 2011). Similarly, a variety of minor schemes like drought relief programmes and wasteland development programmes have also been in operation for the past few decades. The only notable exception is NREGS, the largest flagship programme, which was launched in 2005. NREGS, however, is almost fully funded by the central government with states contributing only 10 per cent of total expenditure on the scheme (Ministry of Rural Development 2008). Other schemes like IAY, PMGSY and SGSY have the Centre as main contributor (75% of funds) while states contribute only 25% of the total funds for these schemes (Ministry of Rural Development 2012a and 2012b; Government of India 2011). This allows us to say with more confidence that the increased preference of state governments for rural development spending in recent years is not the result of the launch of new central schemes.

Thirdly, most CSSs are demand-driven schemes with state governments playing an instrumental role in designing, planning and implementation of projects. Allocation of funds under these schemes is based on the demands by the states through the proposals submitted to the Ministry of Rural Development, Government of India. For instance, the programme guidelines (Ministry of Rural Development 2012b) for PMGSY, the rural roads scheme, clearly states that the executing agency nominated by the state government will play an important role in designing and planning proposals and executing works once the projects are sanctioned. The same is true for the housing scheme, IAY. Thus it could be argued that even the states' contribution to central schemes depend on the demand by the states for sanction of

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 shown to be more evident when compared to the state's own contribution towards healthcare. A similar analysis of public spending patterns by the government of Himachal Pradesh, another rural state in India

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 governments perverse incentives to not increase their health spending to the required level. As long as they operate in political markets with imperfect information and widespread poverty, rational governments will choose to spend their resources on politically profitable goods and services.

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 when there is widespread poverty and imperfect information among voters, and this is generally true in the developing world, rational governments will choose to spend more of their resources on providing goods that are perceived to be of more political value. Healthcare being a public good might not fit in this category and hence is often undersupplied. It is also argued that in the special case of India, the increasing funds from the central government will only give state governments perverse incentives to not raise their contribution towards healthcare to the required level.

This poses rather uncomfortable questions to the conventional rationale that devolution of power to lower levels of governments improves efficiency of public delivery of services. However one has to acknowledge the reality that decentralisation and devolution of power to the lowest level of government institutions (which are the Panchayats, local governance

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 1A: Total State Expenditure under selected heads – Bihar (Rs. Millions)

(Corresponds to Figure 1)

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	7142.6	5411.4	5685.6	5683.8	5264	8981.4	10159.5	12423	15419.6	12939.1	17796.6	23053.4
Total Water and Sanitati	3128.1	2125.1	2804.6	3016.1	2106.7	4134.6	4787.1	6221.1	9975.7	8374.8	13554.4	7811.9
Total Nutrition Exp	206.7	368.7	413.3	408.1	347.4	2067.1	2608.7	3521.8	5849.3	9146.5	9918.4	10276.1
Total Rural Development	12585.7	11899.5	15091.3	14818.6	11701.6	14668.1	26081.5	31446.3	44118.8	35330.9	34399.1	51469.9

Appendix 1B: Total State Expenditure under selected heads – Madhya Pradesh (Rs. Millions)

(Corresponds to Figure 2)

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	7492	5993	6754.5	7134.6	7832.2	8915.2	10323.5	10888.9	13314.2	14593.9	20730.6	22870.7
Total Water and Sanitation	4789.8	4445.8	4396.7	4640.4	4653.8	6222.1	5792.8	9012.7	9865.9	9225.1	13293.8	12457.3
Total Nutrition	925	793.7	1053.1	1099.5	1351.2	1376.3	2179.4	3136.4	3484.6	5541.5	10065.5	9158.2
Total Rural Development	9698.3	7675.4	8550.8	8325.1	10082.7	15041.1	19499.7	26072.6	29747.4	26999.3	44516.9	43149

Appendix 1C: Total State Expenditure under selected heads – Odisha (Rs. Millions)

(Corresponds to Figure 3)

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	3830.1	3867.8	4247.6	4295.3	5400.6	3925.4	5122.2	6357.5	10750.3	10105.1	12136.2	13094.8
Total Water and Sanitation	2214.5	2513.9	2486.7	2581.8	2755	3834.2	3848.9	7948.6	7963.2	6807	5132.4	7268.8
Total Nutrition	530.6	465.8	769	615.9	1108.1	2305.8	2463.6	2155.8	2668.5	3499.7	5221.9	5259.1
Total Rural Development	4117.7	4479.8	4690.3	4586.7	4677.1	5139.4	6101.1	8611.3	13219.6	11799.1	14824.2	18666.5

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	19335.7	21911.5	26067.8
Total Water and Sanitatio	11100.9	11628.1	13670.1	13618.2	14762.6	17148.2	21634.3	28784.4	33686.7	33342.3	28238.1	30315.7
Total Nutrition	767	1356.6	2035.8	2305.6	2427.5	2559.1	3002.4	3631.8	4967.3	5723.4	8362.7	9614.8
Total Rural Development	3945.6	5874	6225.4	6823	11407.7	11779.7	12370.5	16658	23740.9	25520.6	28764.6	40033.1

Appendix 1E: Total State Expenditure under selected heads – Uttar Pradesh (Rs. Millions)

(Corresponds to Figure 5)

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	11924.1	11124.2	13054.6	15349.8	18487.3	26260	38497.8	36898.9	53053.5	47965.2	56279.6	58151.7
Total Water and Sanitatio	3133	5746.4	2946.8	4639.6	4390.8	8564.4	8982.4	6515.1	8069.4	8085.9	11105	12651
Total Nutrition	0	0	0	0	0	0	0	0	0	0	0	0
Total Rural Development	18543.8	18275.9	20402.4	20361.8	22090.1	29226	24794.9	36171.3	50073.7	59853.1	69915.8	61325.7

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

(Corresponds to Figure 6)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	8003.9	14668.1
2006-07	7770.2	26081.5
2007-08	11046.7	31446.3
2008-09	9745.9	44118.8
2009-10	9794	35330.9
2010-11	11168.6	34399.1

Appendix 2B: Madhya Pradesh - state's contribution in health vs rural development (Rs. Millions)

(Corresponds to Figure 7)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	7430.9	15041.1
2006-07	7813.8	19499.7
2007-08	7060	26072.6
2008-09	7970.7	29747.4
2009-10	10675	26999.3
2010-11	15818.6	44516.9
2011-12	17222.9	43149

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

(Corresponds to Figure 8)

Years	State's Contribution to Health	Rural development expenditure
2005-06	2927.2	5139.4
2006-07	3853	6101.1
2007-08	4194.7	8611.3
2008-09	8403.5	13219.6
2009-10	7413.4	11799.1
2010-11	9011.4	14824.2

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 2E: Uttar Pradesh - state's contribution in health vs rural development (Rs. Millions)

(Corresponds to Figure 10)

Years	State's Contribution to Health	Rural development Expenditure
2005-06	23267.5	29226
2006-07	34520.1	24794.9
2007-08	30799.6	36171.3
2008-09	46266.7	50073.7
2009-10	37205.4	59853.1
2010-11	43500.9	69915.8
2011-12	49021.3	61325.7

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