NATIONAL RURAL HEALTH MISSION (NRHM)

Budgeting for Change Series, 2011

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This report is the product of a collaboration between the Centre for Budget and Governance Accountability (CBGA), New Delhi and UNICEF India.

It focuses on analysis of public spending on children in selected states and districts of India. Field data reported in this summary report was gathered during 2007-08. The long version of this report is available on www.cbgaindia.org. CBGA and UNICEF gratefully acknowledge the valuable guidance provided by Dr. N.C. Saxena and Dr. A.K. Shivakumar at all stages of the research and analysis.

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Note to readers:
Rs. 10 million is equivalent to Rs. 1 crore
Rs. 100,000 is equivalent to Rs. 1 lakh

1. BACKGROUND

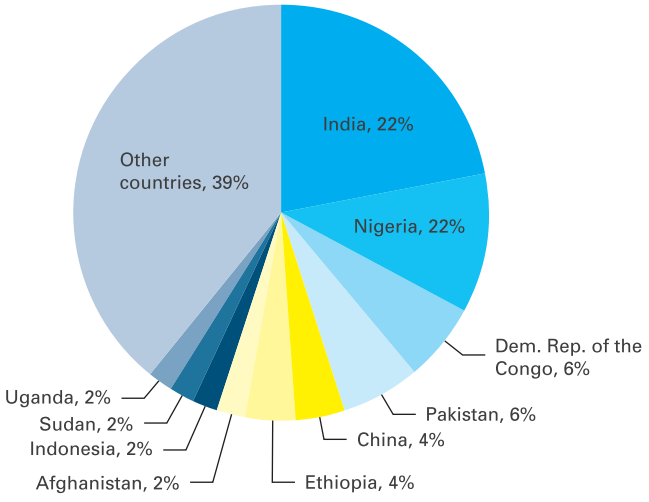
Every year, about 5.4 million children around the world die before the age of one and about 7.5 million die before the age of five[1]. Two thirds of these deaths are preventable[2]. Also, nearly 350,000 women die of complications related to pregnancy and childbirth[3].

In 2010, India accounted for 24 per cent of the total number of infant deaths and 22 per cent of the total number of under-five deaths worldwide.

For India, the comparable estimates are unflattering. Progress on reducing infant and child mortality has been slow – India's under-5 mortality fell from 169 per 1000 live births in 1990 to 69 in 2008, averaging an annual rate of decline of 2.9 per cent. In comparison, Brazil and China averaged a rate of 4.4 per cent reduction in under-5 child mortality since 1990[4]. Not surprisingly, and given the high levels of child mortality to begin with, in 2010 India accounted for 24 per cent of the total number of infant deaths and 22 per cent of the total number of under-five deaths worldwide (Figure 1)[5]. The country's record on reducing maternal mortality was more encouraging – in 1980, 677 Indian women died during pregnancy, delivery or in the six weeks after delivery. By 2008, this number had come down to 254 deaths per 100,000 live births (Sample Registration Survey, 2008). Still, India retained the ignominy of being one of the six countries contributing to more than 50 per cent of the maternal deaths worldwide in 2008 (the others being Nigeria, Pakistan, China, Ethiopia, and the Democratic Republic of the Congo) (Hogan et al 2010).

Recognising child and maternal health as a critical concern, the Government of India launched the National Rural Health Mission (NRHM) in 2005 in the country, with a special focus on 18 states identified as having poor outcome indicators[6]. The idea behind the Mission is to provide universal access to equitable, affordable and quality health care through an

Figure 1: India accounts for 22 per cent of the total number of under-five deaths worldwide



Source: UNICEF, 2011

1 Levels and Trends in Child Mortality: Report 2011, United Nations Inter-Agency Group for Child Mortality Estimation.

2 http://www.unicef.org/childsurvival/index.html

3 Hogan MC et al (2010). "Maternal mortality for 181 countries, 1980—2008: a systematic analysis of progress towards Millennium Development Goal 5". The Lancet 375 (9726): 1609–1623.

4 Bhutta et al (2010). "Countdown to 2015 decade report (2000—10): taking stock of maternal, newborn, and child survival". The Lancet 375 (9730): 2032-2044.

5 Levels and Trends in Child Mortality: Report 2011, United Nations Inter-Agency Group on Child Mortality Estimation.

6 The 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh. These states receive about 60 per cent of total Union Government allocations for NRHM.

The main objective of the National Rural Health Mission is to provide universal access to equitable, affordable and quality health care through targeted interventions, as well as through institutional changes such as more decentralisation of health care.

integrated approach as well as to bring about institutional changes such as decentralisation of the public health system; integration of organisational structures; community participation and ownership of assets; and convergence in services which co-determine health outcomes (e.g. food, nutrition, water and sanitation). The mission's major objectives include:

- Facilitating increased access and utilisation of quality health services by all;
- Reducing child and maternal mortality;
- Universalising access to public services for food and nutrition, sanitation and hygiene and universalising access to public health services with emphasis on services addressing women's and children's health and universal immunisation;
- Preventing and controlling communicable and non-communicable diseases, including locally endemic diseases;
- Improving access to integrated comprehensive primary health care;
- Stabilising population, gender and demographic balance;
- Raising public spending on health along with giving flexibility to states and communities to pool risks through local initiatives;
- Seeing a concomitant reduction in infant mortality rate (IMR), maternal mortality rate (MMR) and total fertility rate (TFR);
- Revitalising local health traditions; and
- Promoting healthy lifestyles.

To fulfil these ends, the mission has the following core and supplementary strategies:

- Training and capacity enhancement of *Panchayati Raj*[7] Institutions to own, control and manage public health services;
- Promoting access to improved health care at the household level through the female health activists (the Accredited Social Health Activist or ASHA);
- Improving facilities for institutional childbirths through provision of referral transport, escort and improved hospital care subsidized under the *Janani Suraksha Yojana* (JSY) for the below poverty line families;
- Creating and upgrading sub-centres, primary health centres (PHCs) and community health centres (CHCs) using untied, flexi-pool grant and maintenance funding;
- Initiating Village Health and Nutrition Days (VHNDs), to educate and mobilise the community;
- Setting up Hospital Development Societies (HDS) or *Rogi Kalyan Samitis* (RKS) and Village Health and Sanitation Committees (VHSCs), for encouraging the involvement of the community at decentralised levels;
- Generating health plans for each village through the Village Health Committee of the Panchayat;
- Implementing inter sectoral District Health Plans (DHPs) prepared by the District Health Mission, which converge health, nutrition, water, sanitation and hygiene activities;
- Integrating, vertically, Health and Family Welfare programmes at the National, State, District and Block levels;

7 The system of decentralized governance in India is also known, popularly, as the *Panchayati Raj*. Panchayat means an elected village assembly and Raj literally stands for governance. The system operates at three levels: village, block and district, each of which is empowered to look after its own affairs.

- Providing technical support to National, State and District Health Missions, for public health management;
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision;
- Formulating transparent policies for deployment and career development of human resource for health;
- Developing capacities for preventive health care at all levels for promoting healthy life styles and reducing consumption of tobacco and alcohol;
- Promoting non-profit organisations particularly in underserved areas;
- Revitalising and mainstreaming other forms of medicine particularly Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (or AYUSH);
- Fostering public-private partnerships while regulating the private sector including the informal Rural Medical Practitioners (RMPs) to ensure availability of quality service to citizens at reasonable cost; and
- Instituting Indian Public Health Standards (IPHS).

There have been some improvements in health outcomes: infant mortality has reduced and the number of institutional births has increased.

Some improvements have been observed in outcomes since the inception of the program. There has been a decline, for instance, in the levels of infant mortality in several states between 2006 and 2009 (Figure 2). As for maternal health, maternal mortality data is not available after 2006. But if the number of institutional births is taken as an indicator of maternal health, improvements have been significant. The total number of institutional births increased from 10.84 million in 2005-06 to 16.80 million in 2010-11 (an increase of about 55 per cent)[8].

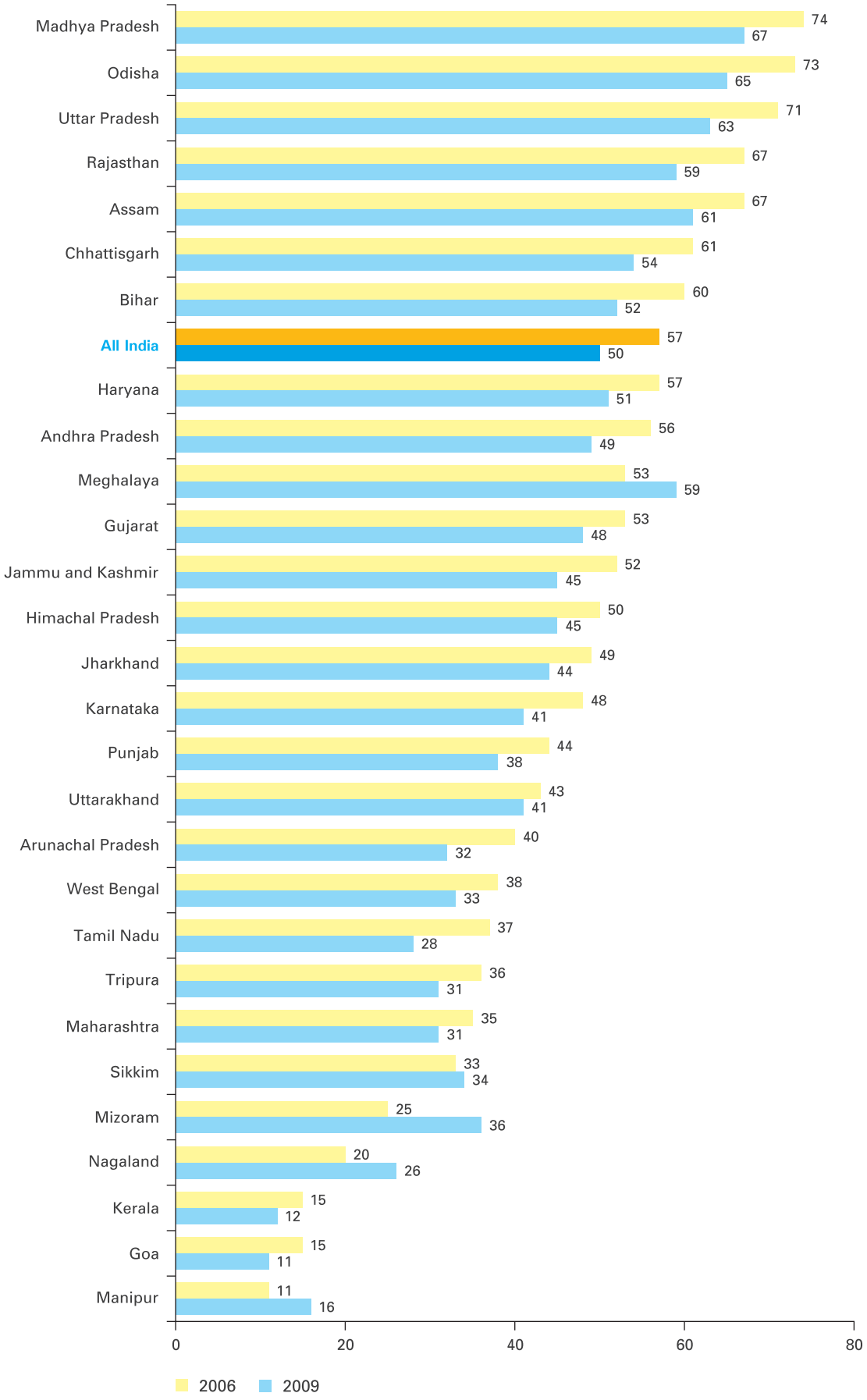
Given that India has the unenviable position of contributing to one in every five deaths of infants and under-five children in the world, clearly more needs to be done. The first step is making funds available. Budgetary allocations for NRHM more than doubled from Rs. 6,788 crores in 2005-06 to Rs. 15,258 crores in 2010-11. It is difficult to attribute an improvement in eventual outcomes to the Mission's progress. However, it is possible to explore the extent to which these allocations translate into outputs and services delivered.

This summary report assesses the quality of public spending on NRHM with regard to the outputs and services it promises to deliver. The focus is on unpacking and understanding constraints that affect implementation of this key flagship programme of the Government of India. These include both financial bottlenecks (e.g. under-employment of funds) and procedural bottlenecks (related to processes around planning and programme delivery). To do so, we use secondary data from the Ministry of Health's Health Management Information System (HMIS) as well as primary data collected by the Centre for Budget Governance and Accountability (CBGA) in 2007-08. Using these sources, this brief attempts to track the flow of public health funds from the Union Government to the State Governments, further down to the district, block and primary health centre level in two states of India – Uttar Pradesh and Chhattisgarh[9].

8 NRHM, State Wise Progress as on 31.03.2011.

9 Specifically, the case studies cover Barh and Jakhora blocks in Lalitpur district of Uttar Pradesh, and Chhuria and Dongargaon blocks in Rajnandgaon district of Chhattisgarh.

Figure 2: Marginal decline in infant mortality in India (from 57 deaths per 1000 live births in 2006 to 50 in 2009)



Source: Sample Registration System Bulletins

2. KEY PROBLEMS

Before one gets into the outputs achieved through existing allocations, it is important to know how the NRHM allocations are distributed and through what 'organisational' route these funds flow. As mentioned above, the Mission focuses on 18 states. The Union Government plan outlay is therefore channelled through a weighting system towards the development of health systems in these 'focus' states with relatively poor health indicators, mostly the Empowered Action Group (EAG) states of the central north Indian belt and the northeast region of the country. A memorandum of understanding between the Union Government and the State Governments posits a ratio of 85:15, with the latter commencing their contribution during the period of the Eleventh Five Year Plan (2007-12)[10].

As for the institutions responsible for planning and disbursing funds, the NRHM umbrella comprises of a Mission Steering Group (MSG) at the top, with equivalent State and District Health Missions below. Each district in the country prepares a District Health Plan (DHP), which is subsequently integrated into a State Project Implementation Plan (PIP) that is finally submitted by the State Government to the Union Government. The Union Government releases funds directly to the State Health Societies, based on the State PIP.

Public health spending in India is substantially lower than the amounts spent on health by other developing countries.

As we shall see later, the complex manner in which funds flow from the Union Government to the State Government, down to the level of the district, block and primary unit of service delivery (in this case the Primary Health Centre) impinges on effective delivery of services under NRHM. This summary report looks at this issue through the lens of the two case studies of Uttar Pradesh and Chhattisgarh, recognising upfront the caveat that findings for the two states cannot be generalised to all states. But before talking about such underlying bottlenecks, one must ask: are funds available for the NRHM sufficient in the first place? And more importantly, are these adequately utilised?

2.1 Are available funds sufficient?

That public health expenditure in India is far from adequate can be simply inferred from the fact that it is only about 1.3 per cent of the country's Gross Domestic Product (GDP). While it has increased from 0.9 per cent (in 2004-05) to about 1.3 per cent of GDP at present, spending by the government on health is still short of the 2 per cent of GDP promised at the end of the Eleventh Five Year Plan period. Also, it is substantially lower than the amounts spent by other developing countries on health (3-4 per cent of GDP)[11]. Even as a proportion of total government expenditure, the share of health was about 2 per cent in 2010-11[12].

The Government of India has increased allocations for health through the National Rural Health Mission since 2005, with the Reproductive and Child Health and Universal Immunisation programmes being subsumed

10 For north-eastern states, the ratio is 90:10.

11 Jha, P. and S. Das. 2011. India's Fiscal Policy Space for Investing in Children. IHD-UNICEF Working Paper Series, Children of India: Rights and Opportunities: Working Paper 4.

12 Expenditure Budget Volume I, Union Budget 2010-11, Government of India.

Allocations for the NRHM have increased since the launch of the programme in 2005, but they are still short of the outlays promised for the Mission under the Eleventh Five Year Plan.

under the umbrella programme. However, if one compares the outlays for the programme as against those promised under the Eleventh Five Year Plan, a significant gap emerges. While the Planning Commission had recommended a total outlay of Rs 89,478 crore for the Mission for the Eleventh Plan period, the total budget allocation made by the Union Government in the first four years of the Plan period (2007-08 to 2010-11) was Rs 52,059 crore, which is only 58 per cent of the total quantum of funds recommended originally. For the financial year FY2011-12, the outlay recommended for NRHM is Rs. 18,172 crores. If one were to include the budgetary estimates of FY2011-12, the total allocations for NRHM for the five-year period work out to 78 per cent i.e. about three-fourths of the funding originally envisaged under the Eleventh Plan.

The next issue that emerges is of inter-state allocation. Taking Rajasthan as an example, the state accounts for about 10 per cent of maternal deaths in the country. However, it received only 5.8 per cent of NRHM funds from 2005-06 to 2009-10. In contrast, the state of Maharashtra, which has lower numbers of maternal deaths, received more than 7 per cent of NRHM funds over the same period (Table 1). Given the statistics, it would be expected that states that account for larger numbers of maternal and child deaths, such as Rajasthan would get a greater share of funds to improve their health outcomes Instead, the allocation of funds seems to be driven more by a state's share in the rural population (as evident from comparing the columns on rural population and allocations in Table 1), and by the state's ability to spend the funds (as we would see later, in section 2b)

Inter-state allocation, instead of being needs-based, is seemingly driven by an individual state's share in the total rural population.

Besides Union Government allocation, State Governments too contribute to health funding, including funding for safe motherhood initiatives. One indicator for the priority accorded to the latter is the maternal health budget allocation as a proportion of the total expenditure

Table 1: Allocation of Funds vis-à-vis requirements (as a percentage of total)

% Share	Maternal Deaths	Live Births	Rural Population	Allocations
UP/Uttarakhand	21.6	12.5	18.6	17.2
MP/Chhattisgarh	10.0	7.6	8.2	8.6
Rajasthan	9.5	6.2	5.8	5.8
Odisha	5.8	4.8	4.2	3.8
Bihar/Jharkhand	10.5	8.6	12.8	10.9
Kerala	1.3	3.4	3.2	2.5
Maharashtra	2.6	5.1	7.5	7.5
Tamil Nadu	2.3	5.2	4.7	5.0

Source: SRS Bulletin on Maternal Mortality in India 2004-06, Registrar General of India. Fund allocation and rural population data are from Managment Information System (MIS), NRHM

Table 2: Maternal Health Budget and Total Public Spending on Health (in Rs crore) (2005-06 to 2007-08)

	Chhattisgarh			Uttar Pradesh		
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
Maternal Health	42.5	124.4	118.5	494.3	643.7	918.2
State Budget	331.3	506.3	646.6	3,067.4	4,301.8	4,624.3
NRHM	84.6	136.3	151.8	573.3	720.4	1,086.4
Total Spending on Health	415.9	642.6	798.5	3,640.7	5,022.3	5,710.8
Maternal Health as % of Total Spending on Health	**10.2**	**19.3**	**14.8**	**13.5**	**12.8**	**16.0**

Note: Total spending on health in the State includes funds spent through State budget and NRHM. The Union Government's contribution to NRHM does not figure in the State budget as funds go directly to the State Health Society, bypassing State budgets. The maternal health budget consists of programmes reflected in the State budget and those bypassing it like RCH.

Source: State budgets and MIS/NRHM.

More than three-fourths of health spending in India is comprised of out of pocket expenditure.

on health in the state. Table 2 shows that in both Uttar Pradesh and Chhattisgarh, spending on maternal health increased, but until 2007-08 it was around 15-16 per cent of the total public spending on health. In contrast, more money was spent towards financing the Mission's Flexi-Pool activities (e.g. ASHA, untied funds and new constructions)[13].

Another indicator of the adequacy of public spending on health is its comparison with what people spend on health out of their own pockets. Most studies suggest that more than three-fourths of the health expenditure in India is paid privately, indicating that public health systems in India are either inadequate or inefficient in providing health services, for which clearly a demand exists. Also, of the out of pocket expenditure on health, about 70 per cent is towards outpatient care, which is not covered under any insurance. It is not surprising that health shocks comprise the single largest factor resulting in entire households falling into poverty.

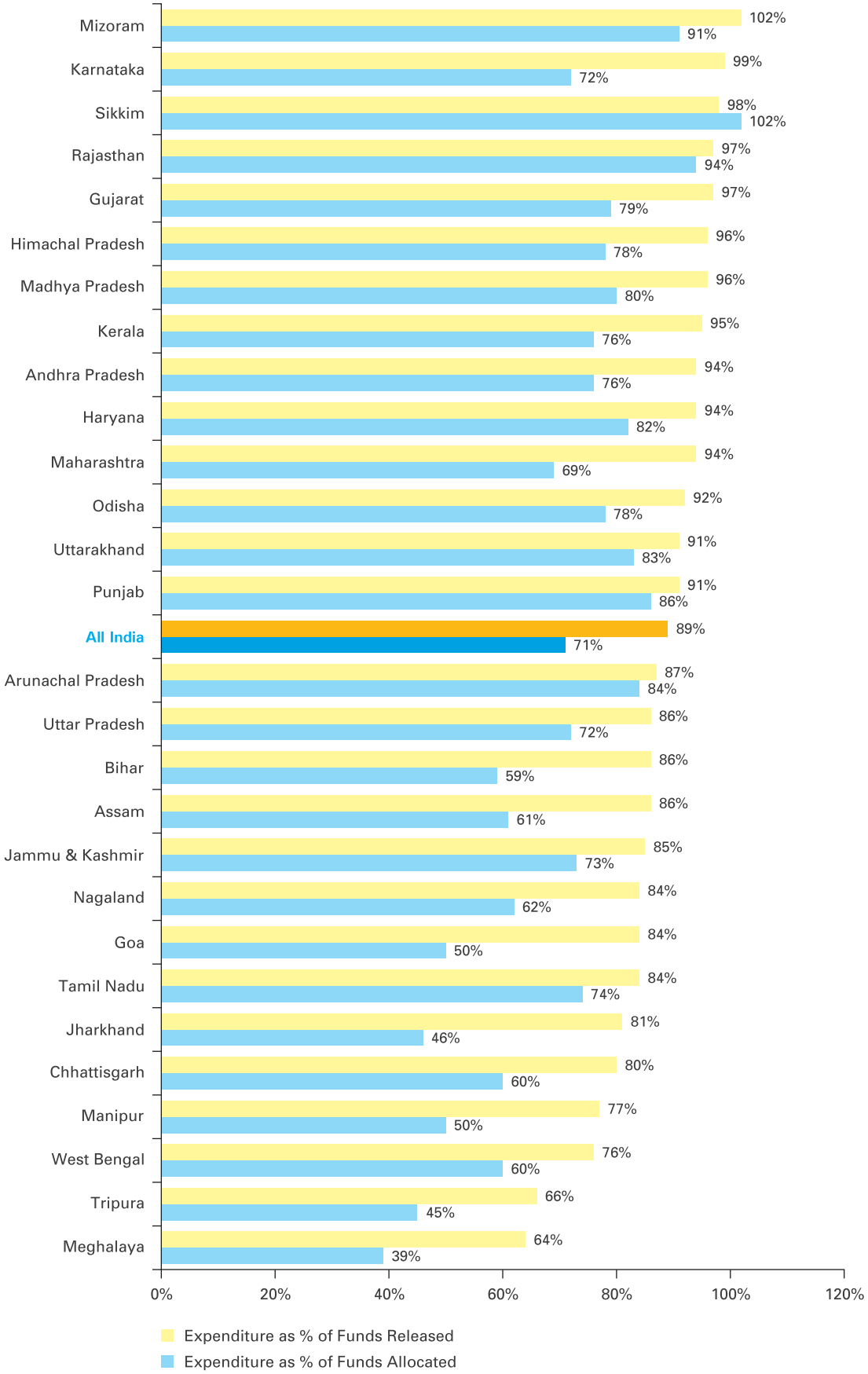
2.2 Are funds adequately utilised?

State Governments' ability to spend is a criterion for deciding future allocations: states that spend more, get more funds.

Financial allocations under the National Rural Health Mission are based on Programme Implementation Plans (PIPs), which are prepared by State Governments and are subject to approval by the Union Government. Though the first two installments are released unconditionally, subsequent ones are released subject to expenditure of at least 50-60 per cent. States that fail to spend their previous installments do not receive subsequent tranches. In fact, the unspent balance of the previous year is incorporated into the next year's allocation. This is a problem because states that are able to spend their funds more efficiently get more funds in subsequent rounds. Thus, instead of financial allocations under the National Rural Health Mission being needs based, the state's ability to spend becomes the criterion to decide the flow of funds.

13 Uttar Pradesh State Report (http://mohfw.nic.in/NRHM/Documents/High_Focus_Reports/UP_Report.pdf)

Figure 3: Significant variation in spending capacity across states



Notes: * Total expenditure includes additional funds provided by the State government (if any) # Total expenditure figures presented here are not strictly comparable with the funds released by the Union Government because expenditure includes additional funds provided by the State government (if any)

Source: Compiled by CBGA from data available on http://mohfw.nic.in/NRHM.htm

Utilisation levels vary across states, with states like Jharkhand being able to utilise less than half of their allocated funds.

Figure 3 compares state-wise expenditures with the total funds released. It shows that overall, NRHM expenditures are reasonably high with about 89 per cent of the funds released for the programme between 2005-06 and 2009-10 being utilised at an all India level. But there is room for improvement for states like West Bengal, Tripura and Meghalaya given that states like Rajasthan, Gujarat and Karnataka are able to achieve near full utilisation. Also, if spending is compared against the original budgetary allocation approved, then one sees significant under-utilisation across states, with states like Jharkhand being able to utilise less than half of the allocated funds. This reflects the difference between funds approved on paper and those finally released. Between 2005-06 and 2009-10, only about 80 per cent of Government of India allocations were released.

2.3 Poor Quality of Fund Utilisation

To assess the quality of spending, it is vital to define some parameters that would help arrive at the nature of funds being spent. The following parameters of quality can be identified as the main problems:

i. Spending across components

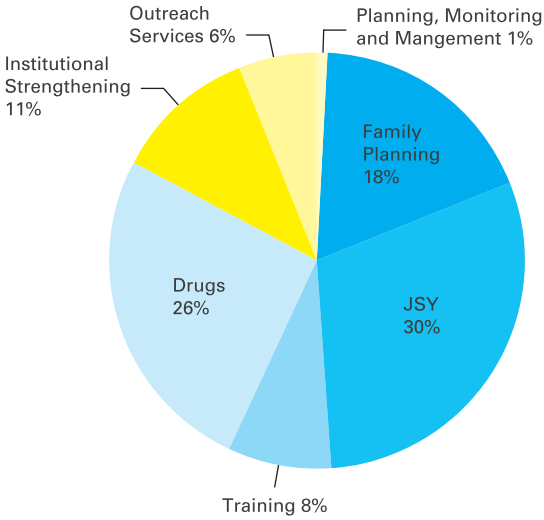
Three main categories within the overarching goals of the Mission – National Rural Health Mission-A (Reproductive and Child Health Flexible Pool), National Rural Health Mission-B (Mission Flexible Pool or Additionalities) and National Rural Health Mission-C (Strengthening Immunisation) – are relevant for maternal and child health. The other component is the Pulse Polio Immunisation that has been in and out of part C during the initial years of the programme.

More money is spent on financing entitlements like the *Janani Suraksha Yojana*, than on components related to system strengthening e.g. planning, monitoring and innovation.

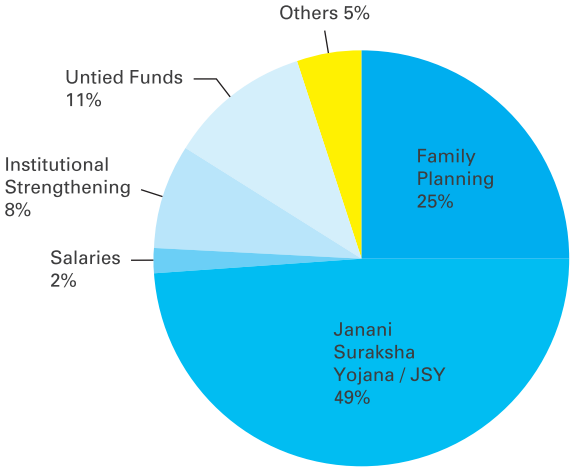
Health Management Information System (MIS) data suggest that utilisation of funds at the state and district levels is not uniform across components with states and districts being able to spend money on some activities while funds for other areas remain idle. In Rajnandgaon district in Chhattisgarh for instance, during 2007-08, some items could be identified which had high levels of utilisation and others on which spending was perpetually low. Funds for Family Planning, *Janani Suraksha Yojana* (JSY), Intensive Pulse Polio Immunisation and activities supported by partner agencies such as United Nations Children's Fund (catch-up rounds) were utilised. However, the training component experienced low or sporadic utilisation (Figure 4). It is also evident that issues of system strengthening like planning and monitoring received lesser focus than spending on entitlements e.g. JSY (Figure 4).

The situation was no different in Lalitpur, Uttar Pradesh (Figure 4). Components related to system strengthening like planning, monitoring, innovation and hiring of staff remained largely under-utilised, even as more money was spent on entitlements. Also, utilisation at times only meant transferring funds to the next level. There was hardly any expenditure reporting from the block level.

Figure 4: Skewed Spending across Components at District Level in 2007-08



Rajnandgaon
Source: Data from District Health Society, Rajnandgaon



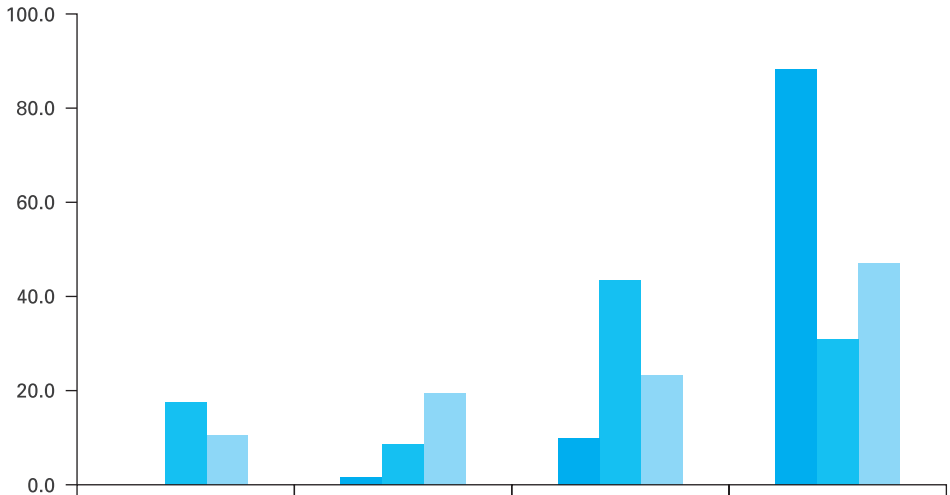
Lalitpur
Source: Financial Management Report, Lalitpur, 2007-08

Spending is not uniform across quarters, with the last quarter of a fiscal year accounting for, in some states, nearly half of the total expenditure incurred for that year.

ii. Spending across financial quarters in a year

Another method of assessing the quality of spending is to analyse whether funds are spent all through the year or at the end of the fiscal year. Taking Chhattisgarh as a case study, the state's health spending during the initial years of the National Rural Health Mission was concentrated in the last two financial quarters. In 2005-06, about 88.1 per cent of the expenditure was incurred in the last financial quarter.

Figure 5: Spending across the Financial Year in Chhattisgarh (2005-06 to 2007-08)

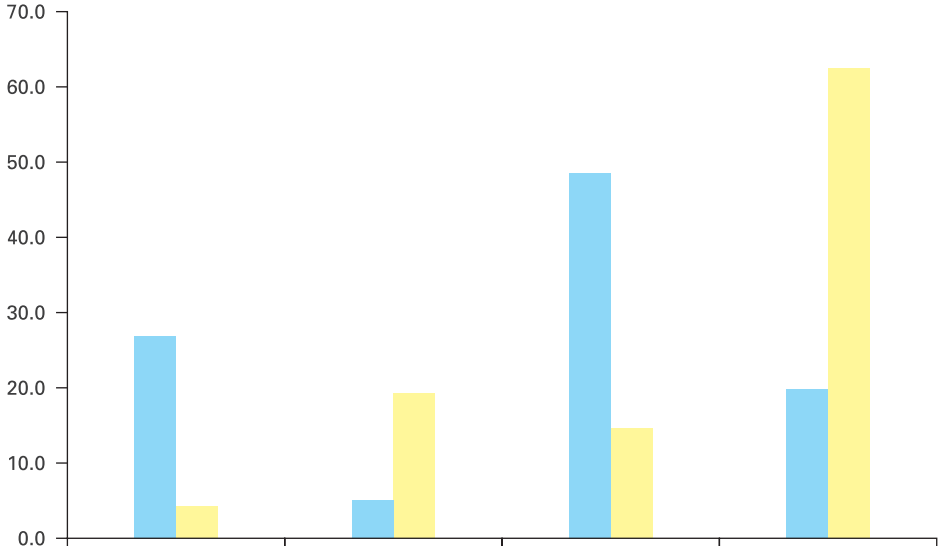


	Q II June	Q II Sept	Q III Dec	Q IV March
2005-06	0.0	1.8	10.1	88.1
2006-07	17.4	8.6	43.2	30.8
2007-08	10.5	19.2	23.4	47.0

Source: Quarterly Progress Report, State Health Society, Chhattisgarh

In subsequent years, the trend improved a little. In 2006-07, 30.8 per cent of the spending was in the last quarter (though almost three quarters of the total spending was in the latter half of the year). In 2007-08, almost half of the funds were spent in the last quarter of the financial year (Figure 5). A similar situation was observed at the district and block levels (Figures 6 and 7).

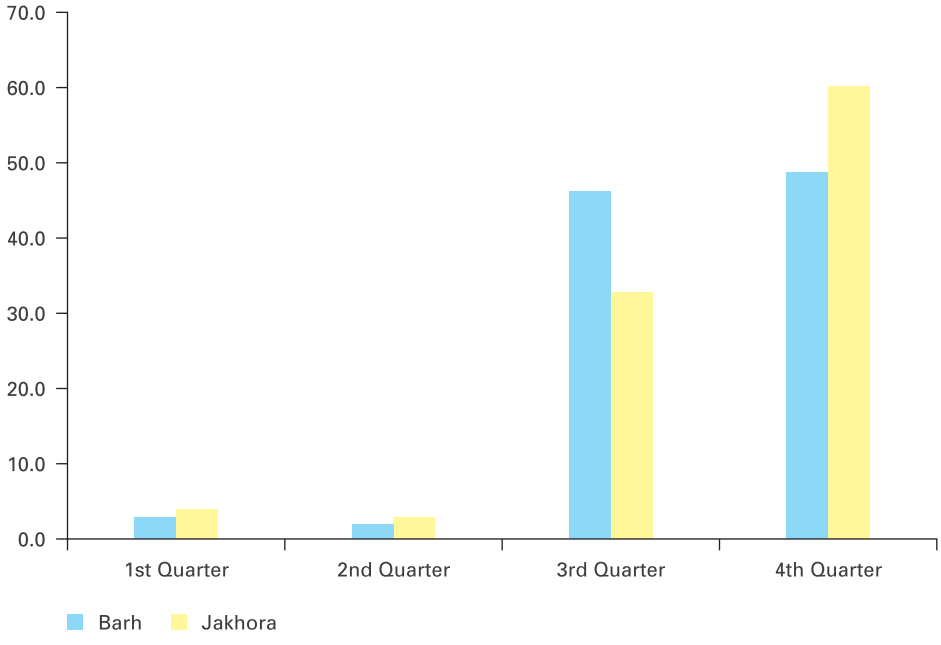
Figure 6: Spending across the Financial Year in Rajnandgaon district, Chhattisgarh in 2007-08



	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Transfers to districts	26.7	5.1	48.4	19.8
Expenditure Incurred	4.2	19.2	14.3	62.3

Source: Data from District Health Society, Rajnandgaon

Figure 7: Spending across the Financial Year at the Block level in Uttar Pradesh in 2007-08



Source: Ledger Books, Office of the Chief Medical Health Officer, Lalitpur

2.4 Institutional and Budgetary Bottlenecks that Constrain Fund Utilisation

In sum, most states are unable to fully utilise the funds available under NRHM. There is greater focus on funding entitlements than on institutional strengthening through activities like training, planning or monitoring. Also, the fact that most funds are spent in the last quarter of a fiscal is indicative of the manner in which the programme is delivered – mostly in the routine, and without any annual planning or budgeting. In this section, we draw upon CBGA's fieldwork to discuss some of the institutional and budgetary bottlenecks, which prevent states from utilising funds effectively.

Most states lack the capacity to prepare and cost out health plans, particularly at lower levels of administration.

i. Weaknesses in Planning

To begin with, most states lack the capacity, particularly at the district and lower levels, to prepare and do costing of district health plans. This means that the exercise of costing i.e. translating physical interventions into financial requirements continues to be done without any checks on ground realities. The capacity of staff at higher levels is also inadequate for appraising plans submitted by the lower levels. The amount of time and effort required for carrying out bottom-up planning is not sufficiently provided for, owing to excessive workload and non-availability of crucial staff (e.g., State Programme Manager, District Programme Manager, Finance Officer and Data Officer). In any financial year, almost the entire first quarter is spent on preparing plans and the fourth quarter is spent on reporting, leaving little time for actual implementation. One possible solution to reduce the burden and allow for better spacing between planning and implementation is to shift to a system of biennial planning.

Taking Chhattisgarh again as an example, until 2008-09, district Project Implementation Plans were not prepared in the state. This meant that allocation of funds was done in a completely arbitrary fashion. It was only in January 2008 that a technical group coordinated by the State Human Rights Commission, together with the National Rural Health Mission and Reproductive Child Health Programme Management Unit initiated the planning process.

Project Implementation Plans are top-down and are seen as a stand-alone process; they are neither consolidations of district plans, nor are they consulted for fund disbursal.

In Uttar Pradesh too, at the time of CBGA's field visit, both at the State Health Society and at Lalitpur, the preparation of Project Implementation Plans was seen as a stand-alone process. Neither was the State Project Implementation Plan a consolidation of the district plans nor was the plan consulted for fund disbursal. In most of the districts, including Lalitpur, preparation of Project Implementation Plans was outsourced to agencies, thus undermining the entire concept of bottom-up planning. The Comptroller and Auditor General (CAG) of India's mid-term review of the National Rural Health Mission also recognises this issue (Box 1).

ii. Bottlenecks in Budgetary Processes

Among the factors that impede fund utilisation under NRHM are the several bottlenecks that arise in reporting and monitoring budgets and

Box 1: Review of NRHM by CAG – Highlights

CAG reviewed the functioning of NRHM in State Health Societies (SHS) across 33 States/Union Territories, District Health Societies (DHS) of 129 districts and 2,369 health centres at the block and village levels for the period 2005-06 to 2007-08. It noted a huge backlog of unspent balances in many states. It also pulled up 17 States/Union Territories (several special focus ones included) for sub-standard implementation and for not adhering to the long-term objectives of the programme. Flaws cited in implementation ranged from lack of decentralised planning, poor fund management, to non-achievement of targets.

On the positive side, the CAG report observed increased institutional child births and primary immunisation of children in the targeted age group in some surveyed states while describing the programme as "a major step forward". It said the Mission had the potential to transform health delivery systems in the country through "greater State participation and effective monitoring of fund-usage, more localised mass media efforts and community oriented health measures to tackle malnutrition and locally endemic diseases and raise awareness".

spending. CBGA's fieldwork in 2007-08 suggested that maintenance of reports and database was extremely poor. The State Health Society in Uttar Pradesh, for instance, was unable to provide the CBGA survey team requisite financial data for 2006-07 since the data officer, appointed on an 11-month contract, had left the job.

Inappropriate maintenance of accounts impedes implementation and creates room for fraud.

Delays in fulfilling reporting requirements were another related problem. The CBGA team found that the 2005-06 Audit Report of Uttar Pradesh was submitted on December 29th 2006 with a delay of 151 days (the due date for its submission was July 31st 2006). The 2006-07 Audit Report was submitted on October 29th, 2007 with a delay of 90 days. Delays in submission of Quarterly Progress Reports reduced in 2007-08 in comparison with 2006-07, though delays still averaged 12 to 17 days in both the years.

Inappropriate maintenance of accounts was also found to impede effective implementation of the National Rural Health Mission. In complete contravention of the norm of the programme being audited by state audit agencies, independent chartered accountants were found to be auditing the programme in Uttar Pradesh. An examination of supporting vouchers revealed that payments had been made to contractors without obtaining technical completion reports, while funds had been spent on training of Accredited Social Health Activists without any record of attendance. There were also few receipts against payment of honorarium to these community healthcare workers.

Box 2: Utilisation of Untied Funds in Rajnandgaon district, Chhattisgarh

Untied funds are quite unique in nature, providing for autonomy to ground level staff to spend according to their local needs. This is at variance with the usual forms of funding where there are pre-assigned tasks identified against available funds.

However, lack of clear guidelines to utilise these funds can often lead to their not being used at all, or being used for unnecessary activities. In their fieldwork in Rajnandgaon, Chhattisgarh, the CBGA team found that Auxiliary Nurse Midwives (ANMs) at the sub health centres (SHCs) and doctors at the primary health centres (PHCs) were, largely, unable to utilise the fund. Some of the ANMs interviewed by the CBGA indicated that non-cooperation of panchayat[14] members including the sarpanch[15] (who operated the account) was one of reasons why funds remained unspent.

It was also noted that implementing officials had limited capacity to plan their priorities and take administrative decisions. This often led to unnecessary items being procured with the untied funds. It was not as if state level officials did not intervene to stop these activities. At times, plans prepared at lower levels were rejected at the higher levels. For instance, the NRHM review team rejected the proposal for utilisation of untied funds for the District Hospital in Rajnandgaon, which was approved by the district magistrate. But this was rare.

Expenditure under Untied Funds in two Blocks (Amounts in Rs)

SHC Mohad, Dongargaon			SHC Salhota, Chhuriya		
Date of receipt	**Amount Received**	**Expenditure**	**Date of receipt**	**Amount Received**	**Expenditure**
08.12.05	10000.0	1500.0	29.03.06	10000.0	9000.0
12.04.06	8800.0	15000.0	03.05.06	8800.0	
14.03.08	10000.0	4000.0	24.03.08	10000.0	
Total	**28800.0**	**20500.0**	**Total**	**28800.0**	**9000.0**

The table above reveals the extent of utilisation of untied funds in two sub-health centres (SHCs) in Rajnandgaon. Though the utilisation was quite high at Mohad SHC located in Dongargaon, in Salhota the utilisation remained very low. Mohad, where the SHC is functional for about 40 years, and which has a permanent building and a senior ANM, utilised a substantial part of the fund for maintenance and construction activities. On the other hand, the reason cited for under-utilisation of untied funds in Salhota was the absence of an independent SHC building, which limited the possibilities of maintenance and repair work.

Source: CBGA fieldwork

14 The panchayat is the lowest unit of elected government in India.

15 Elected head of the village level, local government.

Procedures and guidelines for utilising untied funds are unclear.

Lack of clarity in procedures and guidelines emerged as yet another issue impeding fund utilisation. Most of the guidelines provided by the Union Government were in English, written in a cumbersome style, making it difficult for implementing officials to comprehend. In Chhattisgarh, guidelines for the *Janani Suraksha Yojana* had been changed several times since the programme's introduction in the state. Procedures and guidelines for utilisation of untied funds were also unclear (Box 2).

Inadequate delegation of financial powers further affected implementation. The CBGA team found that several Chief Medical Officers were not aware of their administrative and financial powers as Mission Directors. Most acted as Chief Medical Officers "in charge", and hence, did not have the authority to approve any financial transactions[16].

Delays in the flow of funds are usually on account of inefficiencies at various levels of transfer (state, district and block level).

However, the biggest hurdle observed in the budgetary process was delays in the flow of funds. To illustrate, the flow of funds under the Mitanin[17] training programme in Chhattisgarh was tracked by CBGA through the State Health Society to the district and finally to the block level. Two situations were compared: one prior to the introduction of the Electronic Fund Transfers system in the state and the other, after its introduction. In 2006-07, the funds released under the Mitanin Training from the Union Government finally reached the blocks after a gap of 229 days from the date of release. In comparison, it took 85 days for the funds to reach the blocks after the e-transfer system had been put in place. However, a closer look revealed that e-transfers saved only about 24 days of time in transferring funds. Instead, the main "savings" came from reducing delays in transfer from the State Health Society to the District Health Societies (57 days) and from there, downwards to the Block Medical Officers (54 days). In other words, the reduced time of transfer was primarily on account of efficiencies achieved in various offices at the state and district levels, than on account of changes in the process of transfer itself.

In comparison in Uttar Pradesh, at the time CBGA did its fieldwork, funds were being sent based on demands from the districts wherein every individual demand for a specific activity was sent separately. This meant that there were a large number of releases leading to unnecessary complexity in fund management, especially at the district level. After the demand letters reached the Programme Officer in the state, it took on an average 70 days for the funds to be sanctioned. To compound the delay in fund transfers, the amounts were transferred in small and numerous installments. In Uttar Pradesh, in 2007-08, funds were sent to the blocks in 34 installments, involving multiple line departments and hence, causing delays.

iii. Systemic Weaknesses

A major reason for poor health services is staff shortages in the states. At the state level, shortages are highest in the case of specialists. In Chhattisgarh, non-formulation of recruitment guidelines has led to

16 Joint Review Mission, of the Reproductive and Child Health Scheme (II).

17 The Mitanin is a community health volunteer selected by the community itself to work on health awareness interventions.

Staff shortages, especially those of specialists at Community Health Centres, affect programme implementation considerably.

non-appointment. In Uttar Pradesh, many Primary Health Centres have been converted into Community Health Centres without providing basic human resources and other facilities. Although many Community Health Centres have been declared First Referral Units, these are still without adequate staff, particularly specialists (see Tables 3 and 4).

The situation is almost the same at the district level (Tables 5 and 6). In interviews with the CBGA survey team, block level officials said that staff shortages affected programme implementation considerably. In Dongargaon block of Rajnandgaon district in Chhattisgarh for instance, none of the three specialist posts had been filled until the time of the CBGA survey, due to which, caesarean section deliveries were not carried out at the Community Health Centre (CHC). Officials at the CHC also claimed that no permanent

Table 3: Vacancies in skilled service providers in Chhattisgarh

Particulars	Required	In position	Shortfall	Shortfall (as % of required)
Health Worker (Female)/ANM at Sub-Centres	20521.0	17245.0	3276.0	16.0
Health Worker (Male) at Sub-Centres	20521.0	2097.0	18424.0	89.8
Health Assistant (Female)/LHV at PHCs	3692.0	2040.0	1652.0	44.7
Health Assistant (Male) at PHCs	3692.0	4518.0	Surplus	NA
Doctor at PHCs	3692.0	2861.0	831.0	22.5
Obstetricians & Gynaecologists at CHCs	515.0	378.0	137.0	26.6
Physicians at CHCs	515.0	282.0	233.0	45.2
Paediatricians at CHCs	515.0	281.0	234.0	45.4
Total specialists at CHCs	2060.0	1256.0	804.0	39.0

Source: RHS Bulletin, March 2010.

Table 4: Vacancies in skilled service providers in Uttar Pradesh

Particulars	Required	In position	Shortfall	Shortfall (as % of required)
Health Worker (Female)/ANM at Sub-Centres	4776.0	2245.0	2531.0	53.0
Health Worker (Male) at Sub-Centres	4776.0	2351.0	2425.0	50.8
Health Assistant (Female)/LHV at PHCs	716.0	683.0	33.0	4.6
Health Assistant (Male) at PHCs	716.0	350.0	366.0	51.1
Doctor at PHCs	716.0	577.0	139.0	19.4
Obstetricians & Gynaecologists at CHCs	143.0	9.0	134.0	93.7
Physicians at CHCs	143.0	11.0	132.0	92.3
Paediatricians at CHCs	143.0	16.0	127.0	88.8
Total specialists at CHCs	572.0	46.0	526.0	92.0

Source: RHS Bulletin, March 2010.

Table 5: Vacancies of Human Resource in Rajnandgaon District, Chhattisgarh (2007-08)

	Sanctioned Posts	Filled	Vacant	Vacancy (as % of sanctioned posts)
Class I Medical Officers	57.0	17.0	42.0	73.7
Class I Medical Officers Posted at the District Hospital	17.0	12.0	6.0	35.3
Class II Medical Officers	134.0	58.0	78.0	58.2
Class II Medical Officers at District level	27.0	13.0	14.0	51.9
Class II Non-Medical Officers	3.0	3.0	1.0	33.3
Nursing and Allied Staff	458.0	396.0	73.0	15.9
Staff Nurse	24.0	33.0	-	
LHV	64.0	47.0	17.0	26.6
Lady Health Workers	356.0	309.0	47.0	13.2

Source: Chief Medical Officer, Rajnandgaon

Table 6: Vacancies of Para-medical Staff in Lalitpur District, Uttar Pradesh (2007-08)

Designation	Sanctioned Posts	Filled Posts	Vacant Posts	Vacancy (as % sanctioned posts)
Male Health Observer	24.0	23.0	1.0	4.2
Male Health Worker	72.0	43.0	29.0	40.3
Female Health Observer	36.0	32.0	4.0	11.1
Female Health Worker	218.0	155.0	63.0	28.9
Pharmacist	29.0	7.0	22.0	75.9
Total	**379.0**	**260.0**	**119.0**	**31.4**
Vacancies of Medical Officers in Lalitpur (2007-08)				
Level	Sanctioned	Filled	Vacant	Vacancy (as % of sanctioned posts)
Level 1	53.0	43.0	10.0	18.9
Level 2	14.0	10.0	3.0	21.4
Level 3	11.0	5.0	6.0	54.5
Level 4	15.0	5.0	9.0	60.0
Total	**93.0**	**63.0**	**28.0**	**30.1**

Source: Office of Chief Medical Health Officer, Lalitpur

recruitment had taken place at the centre for the past 20 years. Other services that require sustained availability of skilled manpower (such as treatment of sick children) were also affected adversely by frequent transfers of doctors and an acute shortage of paramedical staff like pharmacists and Male Health Workers. Besides medical staff, non-availability of managerial staff made management messy. In Rajnandgaon, for instance, the Chief Medical Officer of Health had been transferred several times (between July 2006 and 2008) causing discontinuity in reporting and monitoring.

Health service providers are often reluctant to take rural postings since the emergence of the private health sector in urban areas has provided them with alternative employment avenues.

The issue of human resources is more complex than it seems. First, the states need to have funds to recruit quality human resources. Apart from the question of adequacy of funds is the equally important issue of availability of skilled staff, since states like Chhattisgarh do not produce the requisite number of doctors, nurses or paramedics to deal with the problem. This raises the question of creating more medical and paramedical teaching institutions, which would again require huge funds and teachers. These changes cannot be carried out in the short-term. There is also the issue of sustainability of recruiting human resources. State governments are often faced with the conundrum of whether or not to recruit someone for whom the NRHM funds may not be available after some years, and for whom they themselves do not have the requisite budget or have the budget, but are not willing to spend. The consequence is that many of the appointments are restricted to being contractual in nature. The absence of good contractual arrangements means that health departments are not able to attract or retain good quality people.

Ensuring supply of human resources may be necessary to solve the problem but this may be difficult as health service providers are often reluctant to take rural postings since the emergence of the private health sector in urban areas has provided them with alternative employment avenues. The issue of human resources is therefore linked to revamping of the rural health infrastructure. One measure will be to link post-graduate admissions to rural postings or experience of working in rural areas.

The second systemic weakness that affects implementation of the programme is poor infrastructure. Lack of basic health facilities is an important factor responsible for poor health indicators. According to population norms, Chhattisgarh requires 4164 sub-centres, 659 Primary Health Centres and 164 Community Health Centres. Around 4,776 sub-centres, 716 Primary Health Centres and 143 Community Health Centres were functioning as of March 2010 with a shortfall in Community Health Centres. The situation in Uttar Pradesh was more severe with only about 80 per cent of the required sub-centres and Primary Health Centres and 48 per cent of the Community Health Centres functioning there. As of March 2010, the state needed 5,823 more sub-centres, 698 Primary Health Centres and 582 Community Health Centres, which in turn required substantial capital investment, largely expected to come from the state budget.

Apart from shortages in the number of health centres, the quality of existing infrastructure is poor with no basic amenities like electricity or water supply.

That apart, even for existing facilities, the infrastructure was poor or non-existent. About half of the sub-centres in Chhattisgarh and two-fifths of the sub-centres in Uttar Pradesh did not have buildings as of March 2010. This means that in Uttar Pradesh alone, more than 14,000 sub-centre buildings were still required. While the NRHM provides funds for improving infrastructure, including sub-centre buildings, there are several bottlenecks to utilising existing funds. First, the amount of money

for infrastructure is restricted to some 15 per cent of the total annual allocation. Second, state health departments have to rely on the Public Works Department (PWD) for construction activities. The PWD, however, does not lie under the control of the health department and has its own set of archaic rules. Some states such as Bihar and Rajasthan have therefore moved to a model of having an entirely separate corporation for handling construction activities for the health sector.

Besides the brick and mortar, the primary health centres and sub-centres also lack basic amenities like staff quarters, electricity, water supply or motorable roads. More than three-fourths of the sub-centres in Chhattisgarh do not have quarters for ANMs due to which they need to travel long distances to reach their workplace, leading to irregularities in attendance and working for short duty hours. Many Primary Health Centres and sub-centres are not connected with motorable roads and this hampers access to the health centres, especially during the rainy season and for those with no mode of transport.

The policy guidelines of the second phase of the Reproductive Child Health programme call for the provision of ambulances at Primary Health Centres, Community Health Centres, and First Referral Units for the effective handling of Emergency Obstetric Care. During CBGA's field study, it was found that ambulances were available in all the Primary Health Centres, Community Health Centres and district hospitals visited, but patients usually had to hire a private vehicle such as a taxi or a jeep to reach the facility. This was mainly because either the government ambulance was being used for other emergencies or the driver was not available. A lot has changed since then with several states now having outsourced referral transport services (dial 108). The reach of these services however varies from state to state.

3. CONCLUSIONS

In light of the fact that India still has one of the highest levels of child and maternal deaths all over the world, public health expenditure in India seems grossly inadequate. Besides the low level of government allocation and spending on health, under-utilisation of available funds suggests that the problem is deeply systemic. This summary report throws light on some of such systemic weaknesses that constrain fund utilisation under NRHM – otherwise a programme with huge potential to transform health care delivery in India. These include distorted fund allocation (both across states and components); inadequate capacity among health societies to prepare and cost out health plans; unnecessary delays in fund transfers from one level of the bureaucracy to another; and acute shortages in infrastructure and medical staff, both of which impede sustained, quality delivery of health services.
Our analysis, both of secondary data and primary evidence gathered by CBGA on NRHM implementation in two states suggests that first,

the fund release mechanism for the programme needs to be reviewed. It should reflect a rights-based approach rather than the practice of allocating more funds to states that spend more or have a higher share of the rural populace. Second, the mechanisms for fund transfers need to be assessed in light of the delays in fund flow. Third, more focus needs to be accorded to institutional strengthening particularly of programme staff at the district and lower levels to prepare and cost out health plans, driven through a bottom up, biennial planning process. Finally, urgent attention needs to be given to the most significant issue in providing quality health care – creation of good quality infrastructure with necessary medical equipment and supplies and a skilled human resource base. Adequate incentives should be provided to medical and paramedical staff to encourage rural and difficult area postings. Emphasis should also be placed on permanent recruitment or long-term contracts at every level. HR policies should be instituted for each state, with simple rules around recruiting and retaining human resources within the public health system. Only then will the Mission be able to succeed in its endeavour to guarantee universal access to health.

GLOSSARY

Acronyms

ANM	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
CAG	Comptroller and Auditor General
CBGA	Centre for Budget and Governance Accountability
CHC	Community Health Centre
DHP	District Health Plans
DHS	District Health Societies
EAG	Empowered Action Group
HDS	Hospital Development Societies
HMIS	Health Management Information Systems
IMR	Infant Mortality Rate
IPHS	Instituting Indian Public Health Standards
JSY	*Janani Suraksha Yojana*
MMR	Maternal Mortality Rate
MSG	Mission Steering Group
NRHM	National Rural Health Mission
PHCs	Primary Health Centres
PIP	Project Implementation Project
PWD	Public Works Department
RKS	*Rogi Kalyan Samiti*
RMP	Rural Medical Practitioners
SHCs	Sub Health Centres
SHS	State Health Societies
TFR	Total Fertility Rate
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

Translations

Janani Suraksha Yojana : Safe Motherhood Scheme

Panchayati Raj Institution : Institution of self-government at the village, block or district level

Rogi Kalyan Samiti : Patient Welfare Committee

Key Terms

Actuals: The figures (of receipts and expenditure) for the previous fiscal year would be referred to as Actuals or Accounts.

Approved Budget: It is the total amount of funds approved by the Central Government as expenditure for the financial year.

Budget Estimates (BE): The estimates presented in this Budget for the approaching fiscal year would be called Budget Estimates (BE).

Central Sector Schemes (also known as Central Plan Schemes): The entire amount of funds for a Central Sector Scheme/Central Plan Scheme is provided by the Central Government from the Union Budget. The State Government implements the Scheme, but it does not provide any funds for such a Scheme from its State Budget.

Centrally Sponsored Schemes (CSS): Government schemes wherein the Central Government provides a part of the funds and the State Government provides a matching grant. The ratio of contributions by the Centre and a State is pre-decided through negotiations between the two. CSS were formulated with monitorable targets at the central level with adequate provision of funds in the Union Budget under various Ministries. The objectives, strategy and methodology of implementation are prescribed and funds are released to the States based on their requirements. These schemes which were initially restricted to a few well defined activities, have multiplied to include considerable areas of activity performed by the State Governments. CSS came into being also due to the availability of external funding for social sector programmes which was earlier available only for economic activities of the Government.

CSS also introduced a new mechanism for fund transfer from the Centre to the States, by routing the funds outside the State Budget through autonomous societies. This was done to address the growing fund flow problems faced by States during the first half of the financial year, leading to untimely releases and delayed implementation.

Electronic Fund Transfer (EFT): The Electronic Fund Transfer system (or National Electronic Fund Transfer) was introduced by Reserve Bank of India in March 2004 through which electronic instructions can be given by banks to transfer funds. EFT allows for paperless direct debit and credit transactions by banks. Prior to this system, a pay order was sent followed by the cheque, which delayed the transfer of funds from one level of government to the other.

Funds Available: It includes the total approved budget for the financial year plus unspent balances with the State Government plus the interest earned on money parked in the bank account.

Funds Released: It is the total amount of funds that are released by the Central Government as expenditure for the financial year. Owing to the problem of poor fund utilisation, the total funds released are usually lower than the total budget approved for the financial year.

Gross Domestic Product (GDP): The Gross Domestic Product (GDP) of a country indicates the size of the country's economy. Usually, GDP of a country for any particular year is expressed as a comparison with its value for the previous year. For instance, if we read somewhere that the GDP in 2007-08 will grow by 5 per cent, what it means is the economy will be 5 per cent larger than what it was last year.

Non-Plan expenditure: Any expenditure of the government that does not fall under the category of Plan Expenditure is referred to as Non-Plan Expenditure. Sectors like Defence, Interest Payments, Pensions, Subsidies, Police, Audits etc. have only Non-plan Expenditure since these services are completely outside the purview of the Planning Commission; while sectors like Agriculture, Education, Health, Water & Sanitation etc. have both Plan and Non-plan Expenditure.

Net State Domestic Product (NSDP): Net State Domestic Product (NSDP) equals the Gross State Domestic Product (GSDP) minus depreciation on capital goods. GSDP refers to the size of the State's economy. NSDP is the most complete measure of productive activity within the borders of a State, though its accuracy suffers from the difficulty of measuring depreciation (or capital consumption allowance).

Plan Expenditure: Plan Expenditure is meant for financing the development schemes formulated under the given Five Year Plan or the unfinished tasks of the previous Plans. Once a programme or scheme pursued under a specific Plan completes its duration, the maintenance cost and future running expenditures on the assets created or staff recruited is not regarded as Plan Expenditure.

Public Expenditure: In the present set of outputs, the terms public expenditure and government expenditure are used interchangeably. Public expenditure is the amount of funds spent by the Government on provision of critical services and functions.

Revised Estimates (RE): The estimates presented in this Budget for the current/ongoing fiscal year based on the disbursements in the first two to three Quarters of the fiscal year would be called as Revised Estimates (RE).

Social Services: There are three kinds of government services/functions – economic, social and general. Government services/functions which usually lead to income generating activities for people and promote the expansion of economic activities in the country are called Economic

Services. Social Services usually refer to the interventions by the Government which are expected to promote social development. Although better outcomes in the social sector, like better education and better health, also contribute towards economic development, this effect would be indirect and take more time to be realized. The term General is meant to distinguish these services from the other two kinds of services, i.e. Economic and Social. E.g. interest payments, repayment of debt, defence, law and order and pensions.

Social Sector: In the discourse on public policy in India, the terms Social Services and Social Sector are used interchangeably. In the present set of outputs, however, the term Social Sector refers to Reserve Bank of India's (RBI) definition of Social Sector. According to the RBI (in its document – State Finances: A Study of Budgets), Social Sector includes all Social Services, Rural Development, and Food Storage and Warehousing.

State Own Tax Revenue: Every State Government mobilises its Own Revenues from various sources. State Governments have been vested with the powers to levy certain types of taxes and duties, which include: Sales Tax (tax on intra-State sale of goods), State Excise (a duty on manufacture of alcohol), Stamp Duty (a duty on transfer of property), Land Revenue (a levy on land used for agricultural/non-agricultural purposes), Duty on Entertainment and Tax on Professions.

State Own Non-Tax Revenue: State Governments can also mobilise from Non-Tax Revenue. Interest receipts, Fees/User Charges, and Dividend & Profits from Government Enterprises together constitute the Non-Tax Revenue of the Government. For instance, if a State owns a hospital and levies user fees, the revenue accruing from the same would comprise part of the State's Own Non-Tax Revenue.

State Plan Schemes: There are three different kinds of Plan Schemes, which are implemented in any State, viz. State Plan Schemes, Central Sector Schemes and Centrally Sponsored Schemes. The funds for State Plan Schemes are provided only by the State Government, with no 'direct contribution' from the Centre. However, the Centre may provide, at the recommendation of Planning Commission, some assistance to the State Government for its State Plan schemes, which is known as 'Central Assistance for State & UT Plans'. Unlike the Centre's grants to a State under central schemes, the 'Central Assistance for State & UT Plans' cannot be tied to any conditionalities of the central government ministries.

Total Central Transfers: Total Central Transfers to State Governments include three components – Share of State in Central taxes, Loans from Centre and Grants from the Centre. Grants comprise of both Finance Commission-recommended grants as well as Planning Commission-recommended grants.

NOTES:

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