

NHM in Maharashtra: Budget Trends 2015-16 to 2018-19



NHM Machinery, Fund Transfer,
Decentralization and Challenges Faced



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NHM Budget Trends in Maharashtra 2015-16 to 2018-19

Introduction

Universal access to healthcare has been recognized as a crucial Right both globally and in India. The Supreme Court has interpreted Article 21 of the Indian Constitution (“Right to Life with dignity”) as the government having a constitutional obligation to provide health care facilities and the Alma Ata Declaration, 1978 recognized it globally with 131 countries signing it. Yet India’s public healthcare today is failing it people. Around 55 million Indians were pushed into poverty due to high out of pocket (OOP) expenditures in 2011-12. 8286 doctor positions at Public Health Centers (PHCs) are vacant in India and 7.8% of the PHCs don’t have a single doctor. 81% of the Community Health Centers (CHCs) do not have specialists in India. These facts point to a highly inefficient public health system which is unable to provide affordable, adequate universal healthcare. An important and often cited reason for this is the abysmal public health expenditure in the country. There are two prominent reasons for this, one is the low budget allocation by the government, and the second is the under spending.

Despite India being the fastest growing emerging economy in the world it remains one of the lowest spenders on public health. In 2015-16, India’s public health expenditure was 1.02% despite being a ‘lower middle-income country’ when the average expenditure of countries in that category was 2.5%. Bhutan, for example, is a country in the same income category as India, but it spent 2.5% of its GDP in 2015-16. Even the ‘low income countries’, the poorest category of countries in the world according to the World Bank, had an average expenditure of 1.4% in 2015-16 which is greater than India’s expenditure that year. Nepal for example comes ‘low income countries’ and it spent 1.1% of its GDP. While the National Health Policy 2017 says the government should spend 2.5% of the GDP on health by 2025, the government expenditure in 2017-18 (BE) was a mere 1.4% of the GDP.

In order to have a closer look at the public health budgets one can look at the National Health Mission (NHM). NHM, launched in 2013 is the single largest scheme in India’s health sector and accounts for a third of all government expenditure on health. Hence in order to understand the poor state of the Indian public health system, it is crucial to understand NHM and its budgets. And this publication will focus on NHM budgets (particularly NRHM) and its machinery in the state of Maharashtra for the period 2015-16 to 2018-19.

National Health Mission

National Health Mission (NHM) remains the largest healthcare program for the people in India. Before NHM was launched in 2013, the National Rural Health Mission (NRHM) was launched in 2005 to serve the poor rural population, particularly the women, children and the marginalized. It aimed to bring affordable, accessible and quality healthcare to the rural population. In 2013 the National Urban Health Mission (NUHM) was launched to cater to the urban population. And with that both NRHM and NUHM were made into sub-missions under the larger NHM. It accounted for a third of all expenditure on health in 2017-18 in India. The vision of NHM is “Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people’s needs, with effective inter-sectoral convergent action to address the wider social determinants of health”.

NHM aims to “create a fully functional, decentralized and community-owned system with greater inter-sectoral coordination” so that several factors affecting the health of people such as water, sanitation, education among others are addressed. In the process it aims to reduce OOP. While the initial date for the termination of the mission was 2017, it has been now set to 2020 with certain additional salient features.

These new features state that NHM will now be the principal vehicle for Universal Health Coverage (UHC) and SDG-3, the goals of NHM will be aligned to National Health Policy 2017 and SDG-3, there will be a shift from selective care to comprehensive primary healthcare which would include treatment for Non-Communicable Diseases, general healthcare, palliative care, etc. through strengthening of SHCs/PHCs as Health & Wellness Centers. It has also been stated NHM will be integrated with the National Health Protection Mission within Ayushmann Bharat.

NHM Budgets

Since ‘health’ is a state subject the legislative responsibility regarding health is with the state. The Union Government also intervenes in ‘health’ with two kinds of schemes, Centre Sector and the Centrally Sponsored Schemes (CSS). **The distribution of the total NHM budget between Centre and State is currently 60:40 since the 14th Finance Commission came into force in 2015-16 from the earlier 75:25.** NHM which comes under the Ministry of Health and Family Welfare (MoHFW) accounts for 55% of the budget of MoHFW in 2018-19.

The budget allocated for NRHM is generally much larger than the budget for NUHM since the latter is a much younger policy. Between 2014-15 and 2017-18, Maharashtra’s allocation for NRHM has fluctuated during this period, with NUHM funds constantly reducing.

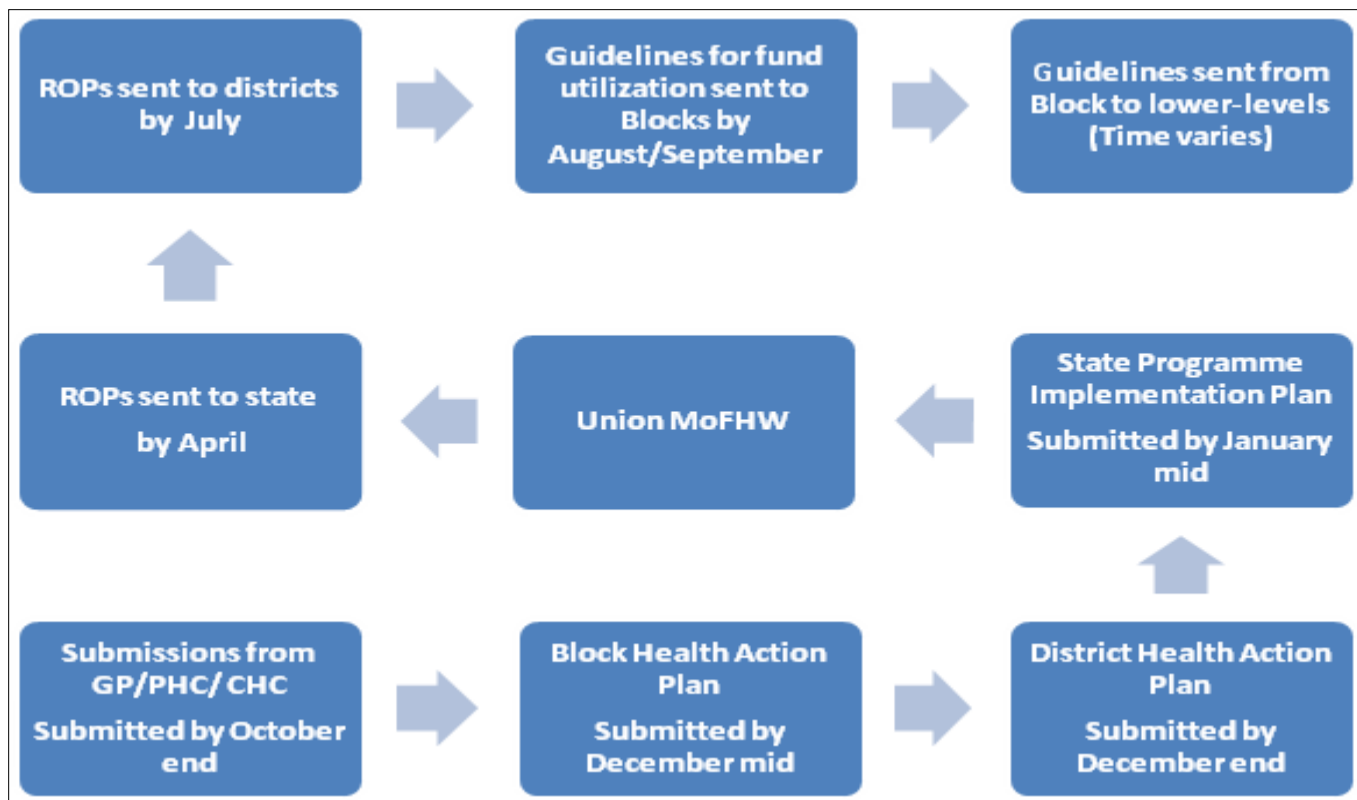
Year	2014-15		2015-16		2016-17		2017-18	
	Alloc.	Expend.	Alloc.	Expend.	Alloc.	Expend.	Alloc.	Expend.
NRHM	1299	1826	1068	1672	1122	1691	1476	662
NUHM	318	7.8	214	61	142	81	113	57

*Fig. in crores. Data Source– PIB Press Release- <http://pib.nic.in/newsite/PrintRelease.aspx?relid=176245>

NHM Machinery in Maharashtra

PIP and ROP

The current system in place for budgets has two crucial documents called the Program Implementation Plan (PIP) and Record of Proceedings (ROP). The PIP has the strategic plan with the activities and priorities to address public health issues, an annual health plan for the state. One of the most unique and lauded feature of NHM is the decentralized nature of health planning. The process for making the PIP starts in October when the State intimates the district about the resource envelope available for the forthcoming financial year. The entire process is given below-



Districts participate in the planning of the funds through the District Health Action Plan (DHAP). The District Programme Management Unit (DPMU) prepares the DHAP based on the Block Health Action Plan (BHAP) which is prepared by the Block Programme Management Unit (BPMU). The BHAP is prepared using the facility level plans and village level plans. These plans are prepared based on the assessments of the targets, both physical and financial, from the previous PIP. In this way, the planning system is decentralized, where plans being made at the village and facility level are accounted for, rising up the hierarchy to the State PIP (SPIP) submitted to the central government.

The SPIP is sent to the National Programme Coordination Committee (NPCC) where the states and UTs meet with the Centre to discuss their plans. After the discussions, the approvals are sent through the ROP. There are times when the ROP is unsatisfactory, in which case the state sends their demands again and the ROP comes later. This can push the cycle of budget away from the cycle of the financial year.

For example, in 2018-19, the PIP was submitted by the Government of Maharashtra on the 22nd of February, 2018. The NPCC meeting took place on the 22nd of March, 2018 and NHM; Government of India suggested some revisions. The revised PIP was submitted on the 12th of April requesting for Rs. 4183 crores. The ROP arrived on the 26th of July, 2018 which stated that the resource envelope was Rs. 4631.13 crores and the total approved budget was Rs. 4406.98 crores. **While the financial year starts from the 1st of April 2018, the ROP was received only on the 26th of July 2018.**

The question arises then ‘what does the government do between the period of 1st of April and 26th of July if they have not received the new budget?’. **The answer is that the government spends the unspent budget from the previous financial year.**

Challenges in Decentralized Health Planning

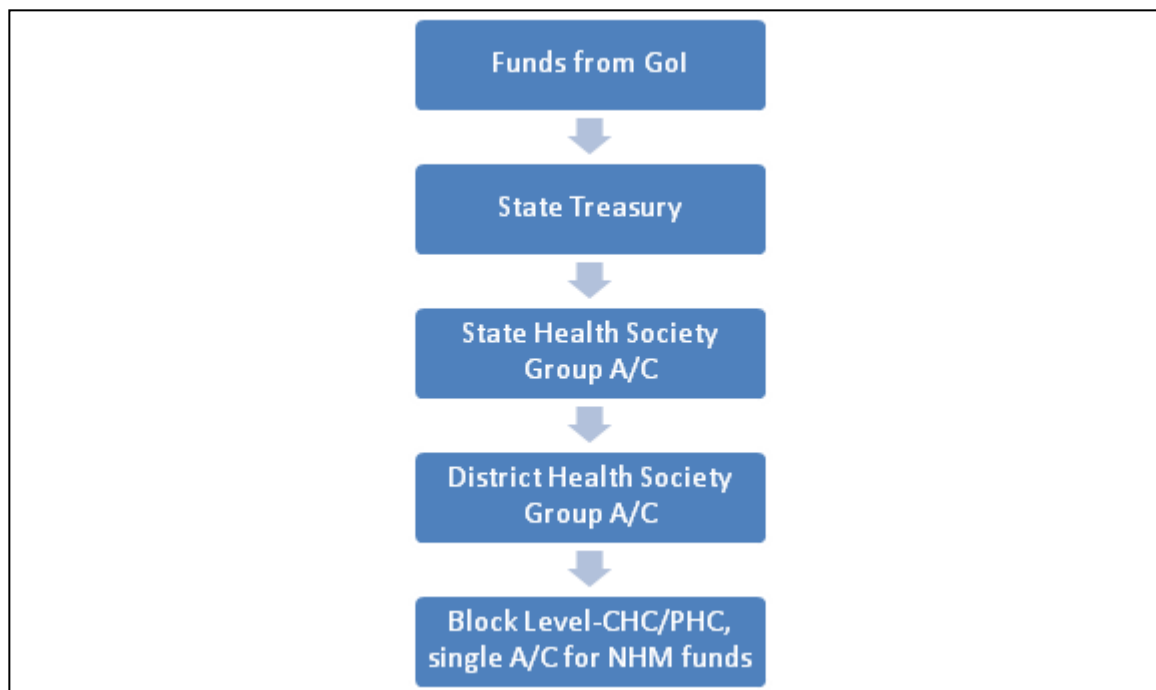
As noted above, process for PIP is decentralized, starting from taking inputs of health plans for villages, blocks, and districts. The village-level health cadres can speak to the Auxiliary Nurse Midwives (ANM). The ANM can submit the needs to the Medical Officer (MO) at the PHC. The flexipool provides for the fiscal space as well to add new initiatives to improve the health of the villagers. Formats are given to stakeholders at all these levels (ANM, PHC MO, Block Health Officer, District Health Officer, State Health Society) to fill according to the health action plan that they want for the forthcoming financial year. But in reality, the planning is not truly decentralized due to poor awareness amongst those filling the formats and the poor participation of people in the planning process. The literature (Seshadri, et al., 2016, SATHI, 2016, Adsul N, 2016) that exists on the decentralization of health planning in India under NHM points to various limitations in it. Several barriers to including priorities of the communities in the health plans noted in Shukla et al. (2014) are-

“Poor understanding of planning and poor attention to community-priorities which do not require financial outlays, complicated formats for planning which are inaccessible to non-experts, very little time to develop plans, people fill the formats within days or weeks, Rugna Kalyan Samiti (RKS) meetings are irregular and Panchayati Raj Institution (PRI) members are not oriented to play their roles and responsibilities. Inappropriate expenditures controlled by specific officials “

A survey conducted by SATHI in two blocks of Gadchiroli among 33 key stakeholders revealed that none of the Gram Panchayat members interviewed knew about the process of PIP. The understanding of PIP itself was very limited with most of them associating it with the mere format to be filled. The need to build the capacities of the stakeholders is evident. As Shukla et.al (2014) have stated, having mere formal spaces for people’s participation and official orders for such bodies does not necessitate decentralization and participatory planning processes. Their research has shown that systemic capacity building and continuous support for key stakeholders with efforts in advocacy lead to greater participation of local communities and greater utilization of funds as per community’s priorities.

Fund Transfer

The process of transfer of budget in NHM from the Union was direct with the Consolidated Fund transferring funds to the State Health Societies (SHS). This process was present till March 2014, since April 2014 the Consolidated Fund would issue the Sanction Order (SO) to the Treasury in the state which would later transfer the funds to the SHS. This reform added another level to the architecture of the fiscal transfer for schemes sponsored by the Centre. The fund flow is shown below. **It is important to keep in mind that the state funds corresponding to the central funds for the Tribal Sub-Plan are directly sent from the Tribal Development Department to the Zilla Parishad (the district government) unlike the rest of the funds which are directed via the State Health Society.**



Each facility receives three types of funds from NHM. They are the RKS Grants, Annual Maintenance Grants (AMG) and Untied Funds. The distribution of the budget in terms of facility levels is 70% at the block-level and below, 20% at the District-level, and 10% at the State-level.

Type of Facility	RKS Grants/each facility/per annum (in Rs.)	AMG/each facility/per annum (in Rs.)	Untied Funds/each facility/per annum (in Rs.)
District Hospital	5 lakh	N.A	N.A
SDH	1 lakh	N.A	N.A
CHC/ UGPHC /Area Hospital	1 lakh	1 lakh	50,000
PHC	1 lakh	50,000	25,000
Sub-Centre	N.A	10,000 (selected sub-centres)	10,000/20,000 (varies from sub-centre to sub-centre)

Challenges in Fund Transfer

Maharashtra has an unduly lengthy process for releasing funds from the State treasury to the SHS (Chaudhury and Mohanty, 2018). There are minimum 25 desks through which the paper file for release funds needs to pass through before the funds are actually released to the SHS. This, they argue causes a delay in the release of funds, in 2016-17 around a quarter of the funds released from the Consolidated Fund at the Centre to the State

treasury was not released to the SHS. Around 56% of the State share was received by the SHS only in the last month of the financial year 2016-17. In 2015-16, 13.4% of the funds took 4 months to get transferred from the State treasury to the SHS whereas in 2016-17, 13.9% of the funds took 4 months to do the same. 86.6% of the funds were delayed by 1-3 months in 2015-16, whereas in 2015-16, it reduced marginally to 85.7% of the funds.

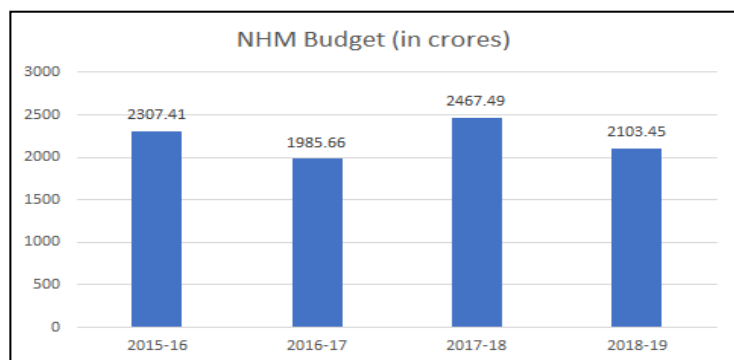
Majority of the delay takes place in the transfer of funds from State treasury to the SHS in Maharashtra and not in the transfer from the Consolidated Fund to the State treasury. The money that does not reach the SHS in the current financial year is adjusted in the next financial year. The expenditure that was committed for the previous financial year is continued in the next financial year and the ROP takes into account this unspent balance.

Budget Trends

According to the Minister of State for Health and Family Welfare, the MoU signed between the Centre and the States/UTs states that state budget on health should increase by 10% every financial year. In the case of Maharashtra, the opposite has been witnessed where the overall health budget has dropped and particularly in the case of NHM. The financial year (FY) starts on the 1st of April and ends on 31st March. There are 4 quarters in each FY, and we have used quarters to understand the trends.

1. NHM Overall Budget

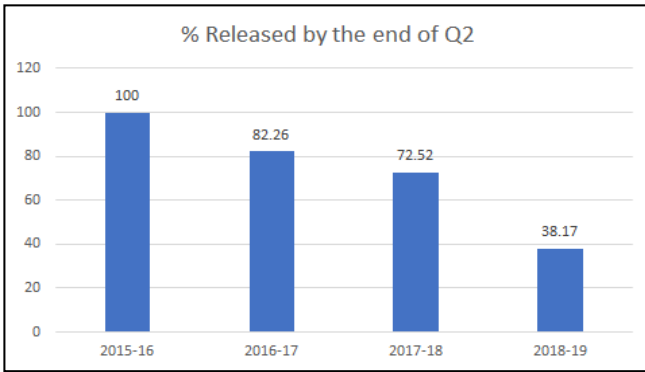
The overall budget for NHM has been fluctuating over the past 4 FYs. It was the lowest in 2016-17 at 1985 crores and the highest in 2017-18 at 2467 crores. It has dropped in 2018-19 to 2103 crores.



* Source: BEAMS

2. Release of Funds

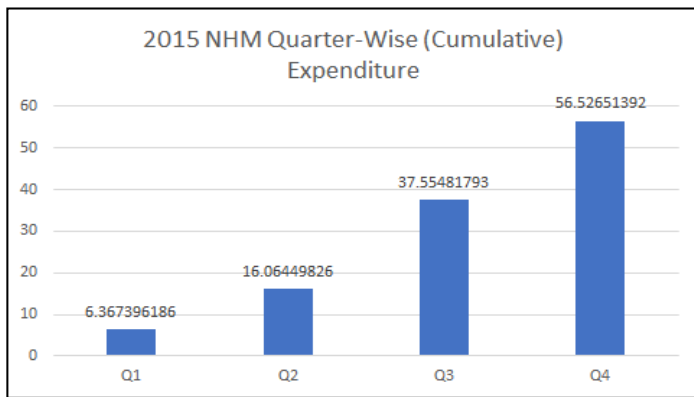
Taking the end of the 2nd quarter (Q2) as a point to measure the release of funds since that signals the end of half the financial year (April to September), the percentage of funds released in NHM have been shown below. There is a clear downward trend with 2015-16 seeing 100% release of funds by October whereas 2018-19 seeing slightly above one-third of the funds being released by the end of the second quarter.



NHM Quarterly Trends

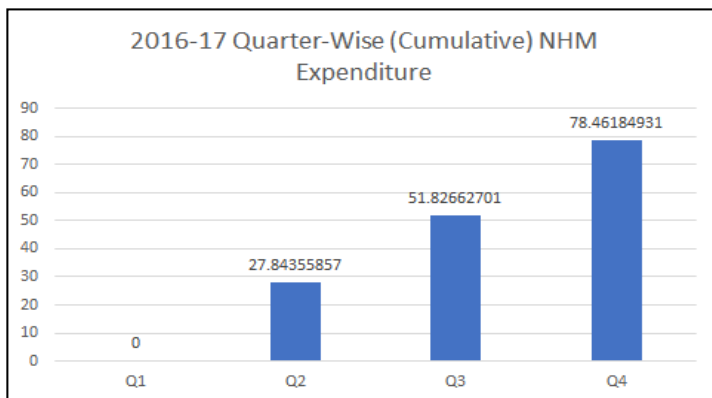
To understand the expenditure of NHM funds over the course of the year, the expenditure has been tracked on the basis of quarters.

2015-16



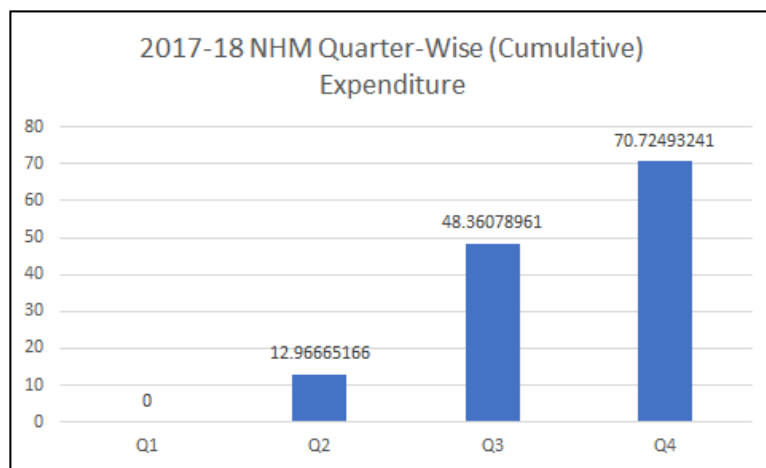
In the financial year 2015-16, the NHM funds saw only 6.36% being spent in the first three months. And the cumulative expenditure increased with the second quarter seeing 10% being spent, the third quarter seeing 16% being spent and last quarter seeing almost 20% being spent. By the end of the financial year only 56% of the NHM funds had been spent.

2016-17



In the financial year 2016-17, 0% was spent in the first quarter, 27% spent in the second quarter, 24% spent in the third quarter and 27% spent in the last quarter. By the end of the year only 78% of the NHM funds had been spent.

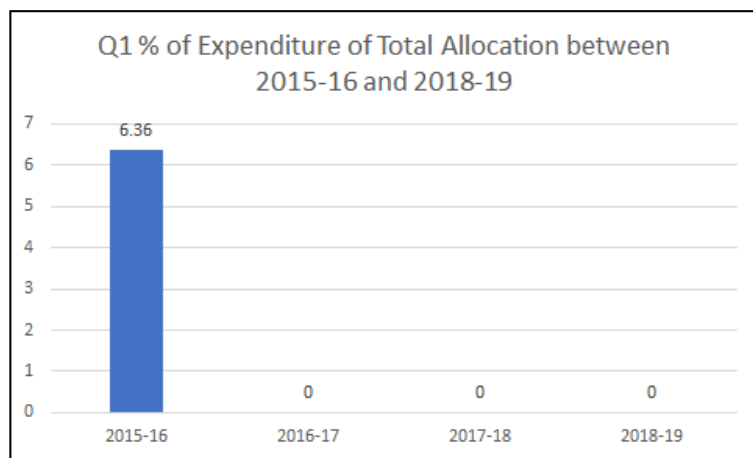
2017-18



In 2017-18, again 0% was spent in the first quarter, 12% in the second quarter, 36% in the third quarter and 22% spent in the last quarter.

Quarter-Wise Expenditure

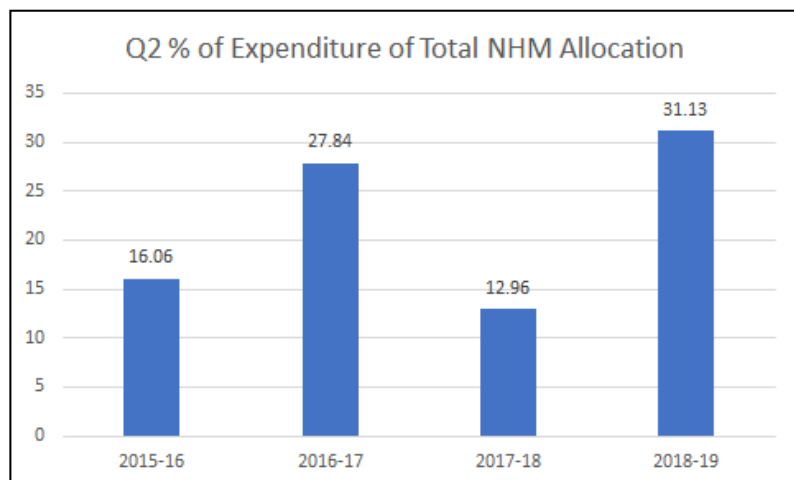
Q1- Except for 2015-16 all FYs saw no expenditure in the first quarter (April-June). And even in 2015-16, only 6.36% of the NHM budget was spent. This is a disappointing feature of Maharashtra budgets where usually no money is spent in the first quarter. This is dangerous trend considering that NHM is the principal vehicle for UHC at this point. **No expenditure would mean denial of the right to health to the rural and urban poor in the first three months of the financial year.**



**Percentage of funds spent by the end of the 1st quarter. Source: BEAMS*

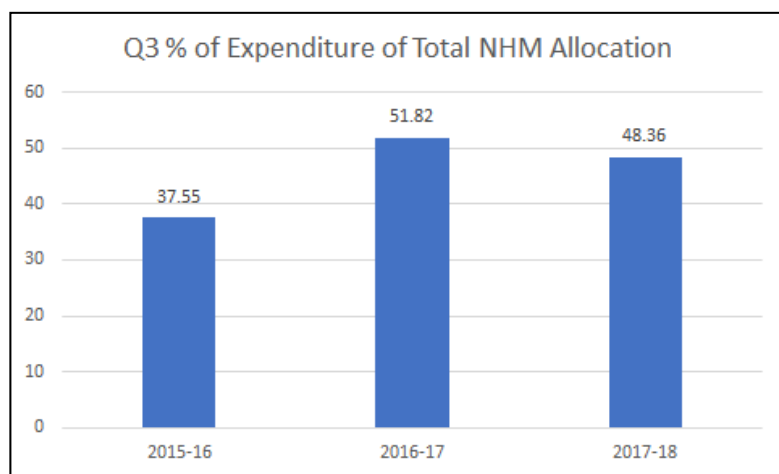
Q2- The second quarter (July-September) saw better expenditure with 2015-16 spending 16.06%, 2016-17 seeing 27.84% and 2017-18 seeing 12.96% expenditure. In the current financial year 31.13% was spent in the second quarter which is good since this quarter is when the monsoon occurs and there is an increase in the spread

of diseases, especially vector-borne diseases. The government needs to ensure even and consistent fund-flow so that some funds are always available at the ground-level.



**Percentage of funds spent by the end of the 2nd quarter. Source: BEAMS*

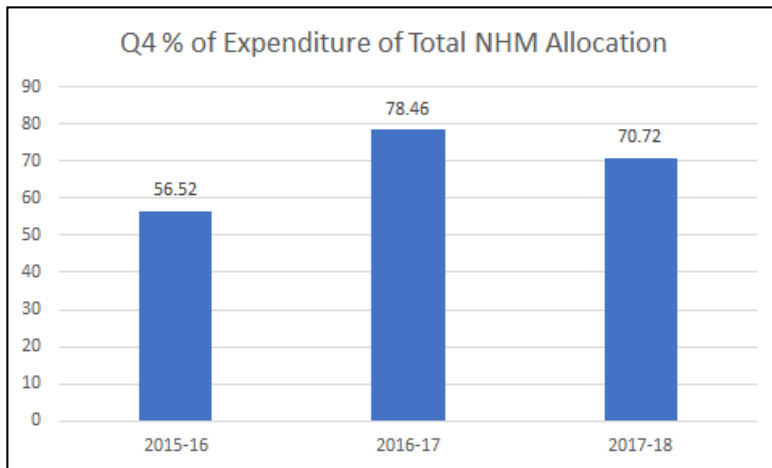
Q3- The third quarter (October-December) saw dismal cumulative expenditure with only 37% being spent by the end of the third quarter in 2015-16. 2016-17 saw only half the funds being utilized by the end of three-fourth of the financial year. 2017-18 saw a reduction with only 48% being spent by the end of this period.



**Percentage of funds spent by the end of the 3rd quarter. Source: BEAMS*

Q4

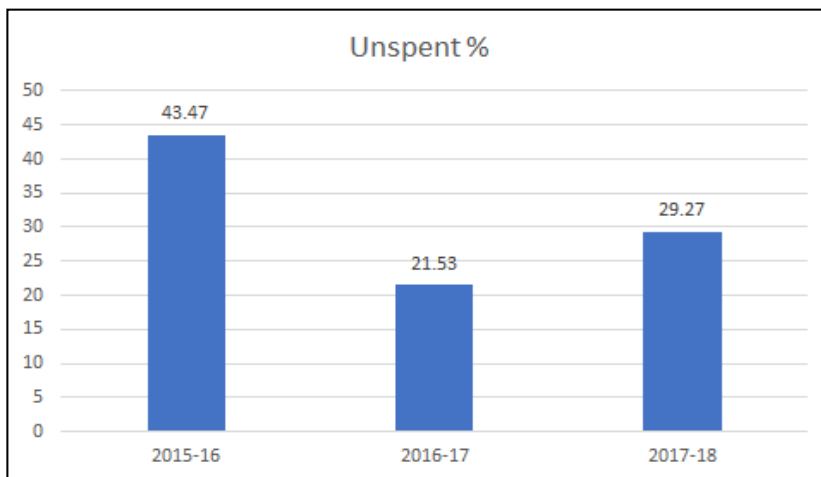
By the end of the year little above half of the NHM funds had been utilized in 2015-16, around three-fourth of the funds in both 2016-17 and 2017-18. **This is a disturbing trend since on an average only 68% of the NHM funds have been utilized each financial year since 2015-16.**



**Percentage of funds spent by the end of the 4th quarter. Source: BEAMS*

6. NHM Unspent Funds

According to BEAMS, the unspent NHM funds in Maharashtra have still been over 21% in the last three financial years. The percentage unspent was considerably high in 2015-16 at 43.47%, dropping to 21.53% in the following year and increasing again to 29.27% in 2017-18 at the end of the financial years. Unspent funds are due to multiple reasons. One known reason is the late release of funds to the State Health Societies (SHS) and the disbursement from there onto the lower-levels.



**Percentage of funds unspent at the end of each FY. Source: BEAMS*

Conclusion

The NHM machinery is such that it allows for participation in the planning process of the NHM funds. The decentralized process does provide the space technically, but there is a long way to go before it exists on the ground. Capacity-building of the villagers and other stakeholders at every step of the planning process might enable utilization of the provision in NHM to have a truly decentralized planning health system, improving planning and utilization of funds for community needs.

Maharashtra's NHM needs higher allocations to fulfill the vision of NHM. Despite the NHP 2017 saying that overall health budget is to be 2.5% of GDP by 2025, currently in the case of Maharashtra neither the overall budget, nor the NHM budget appear to show the required growth per annum to reach the target. The state also

needs a simplified system for the release of funds. Research (NIPFP, 2018) shows states having shorter number of desks spend lesser time on the release of funds. In the case of Maharashtra due to a longer process (25 desks) the release is late by an average of three months, and several times the funds for one financial year are received in the next financial year. Timely transfer of funds would also ensure timely utilization of funds leaving minimal unspent balance to be carried forward to the next financial year. Late release of funds contributes to a percentage of funds being unspent at the end of the financial year. The Financial Management Reports themselves show the high unspent balances in the state every year, which needs to quickly become a feature of the past.

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