Selected Aspects of NRHM Expenditure at the State-level: A Focus on Rajasthan and Karnataka

(Draft Report)

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Abstract

This report analyses selected aspects of spending under the National Rural Health Mission (NRHM) in Karnataka and Rajasthan. Analysis suggests that funds provided by the Central government through NRHM have complimented the expenditure incurred by State governments. Data from these two States does not provide any evidence of substitution of spending by States with funds available under NRHM. Analysis of the pattern of spending shows that about 60-70 per cent of the funds provided under the flexible pools of NRHM are spent at/below the district level. The degree of decentralization was higher in the RCH Flexible Pool than in the Mission Flexible Pool. The level of devolution of funds for facility-level spending was found to be higher in Karnataka than in Rajasthan. Through analysis of data collected from facilities and administrative offices in three districts, the study presents illustrations of the nature of utilization of funds provided to facilities for discretionary spending. The study also attempts to identify factors that limit the level of effective utilization of discretionary funds provided to facilities under NRHM.

I. Introduction

The National Rural Health Mission (NRHM) has been one of the largest health sector initiatives of the Government of India in the recent past. Launched in 2005, the scheme constitutes the core instrument of the Central Government to intervene in the primary and secondary health care system existing in the rural areas of the country. A number of programmes implemented by Government of India in the pre-NRHM period have been subsumed into the scheme and new initiatives have been added to improve the rural health system of the country. The scheme has expanded substantially over the years, and in recent times, has come to constitute an important element of health expenditure in Indian States. In 2010-11, the scheme constituted about two-thirds of the total health spending by the Central Government, and has been a focus of discussions on health sector policies of the country.

NRHM has contributed to State-level health spending in a number of ways. First, the scheme has added to the overall levels and items of health expenditure in various States. New initiatives like the introduction of community health workers ASHAs (Accredited Social Health Activists), hiring of contractual human resources at the local level, and providing emergency ambulance services have been undertaken through health spending at the State-level. Secondly, the scheme has introduced new forms of financing for improving the effectiveness of expenditure. Discretionary funds in the form of Untied Funds, Annual Maintenance Grants and Corpus Grants have been provided to facilities to increase the autonomy and flexibility in spending. Also, in the pre-NRHM period, a number of individual Societies existed at the State and district-level for implementing different programmes of Government of India. With the initiation of NRHM, these societies have been merged to form a single Society in each State and district for implementing the scheme. Releases of funds from the Centre under NRHM are made to a State-level society, which in turn, releases funds to the Societies at the district-level for the implementation of the scheme. Although these expenditures are reported in the audited accounts of the Societies, they are outside the State treasury accounting system.

Some of the new initiatives and changes in mode of fund flow make it imperative to analyze NRHM expenditure at the State-level. The additional spending through NRHM, and the adjustment by State Governments to their own health spending in response to NRHM spending (if any), is likely to be specific to States. Also, the extent of decentralization of expenditure through formation of Societies at the district level and provisioning of discretionary funds at the facility level, are likely to vary across States. Moreover, data limitations on certain aspects also restrict analysis to selected States. Information on elements of decentralization need to be culled out from audited reports of State and district-level Societies, and therefore, can only be done for a few States at a point of time. Similarly, detailed information on expenditure incurred in facilities out of discretionary funds is available only at individual facilities. The separation of NRHM expenditure from State treasury accounting system also calls for an adjustment in fund flow between the State treasury and Society in estimating health expenditure at the State-level.

This report analyses selected issues related to NRHM spending in Karnataka and Rajasthan. In particular, we focus on three issues. First, we examine the additional contribution of NRHM to the level of health spending at the State-level, and the adjustment by the State governments to its own health spending (if any) in response to this spending. Secondly, it analyzes the extent of decentralization achieved under NRHM at the district and sub-district-level in selected districts of the two States. Thirdly, it highlights the nature of expenditure incurred by facilities out of discretionary funds provided to them, and discusses some of the problems faced in utilizing these funds.

Data on expenditure related to health spending by the two States have been taken from the *Finance Accounts* of the respective States, compiled by the Comptroller and Auditor General of India. Population figures and price deflators for converting expenditure to constant prices (1999-00 prices) have been sourced from the Central Statistical Organization (CSO). Information on State-level NRHM expenditure has been taken from the audited accounts of the State Health and Family Welfare Societies in the two States. For analysis at the sub-district level, audited reports of District Health and Family Welfare Societies have been used. Information on items of expenditure out of

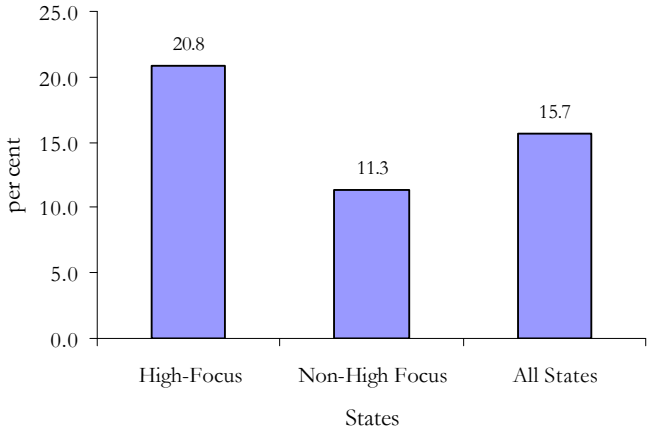
discretionary funds, and on issues related to the problems of their utilization, has been collected through field visits to selected facilities in districts of the two States.

II. Contribution of NRHM to Health Spending in Karnataka and Rajasthan

(A) Changes in the Level and Composition of Spending

The contribution of NRHM to health expenditure at the State-level has been significant in recent years. In 2010-11, contribution of the RCH and Mission Flexible Pools (which constitute bulk of the expenditure under NRHM) accounted for about 16 per cent of the total health expenditure of all States (Figure 1).[2] Importantly, the contribution has been higher in high-focus States (about 21 per cent), than in non-high focus States (about 11 per cent).[3]

Figure 1: **Share of NRHM Spending to Total Health Spending of States, 2010-11**



Aggregate estimates of NRHM contribution to total health spending in the State are however, less precise. If States' expenditure through the treasury and NRHM expenditure

[2] Total health expenditure indicated here, refer to the sum of expenditure indicated in State budgets and the flexible pools under NRHM.
[3] North-eastern States have been excluded from the analysis of high-focus states. Similarly, small States and UTs have been excluded from the analysis of non-high focus States.

through Societies are added up to derive the total health expenditure in the States, the figure is overestimated. This is because, the States' share of contribution towards NRHM is included both in State's budgetary expenditure and NRHM expenditure incurred through Societies, and this leads to a double counting. The fund flow between the State treasury and the State Health and Family Welfare Societies, thus, needs to be adjusted in the estimation of the total health expenditure at the State-level. To correct the problem, we net out the States' contribution towards NRHM from their budgetary expenditure, and add it to NRHM expenditure reported in audited reports of State Health and Family Welfare Societies to estimate the total health spending for the States of Karnataka and Rajasthan.

In 2009-10 and 2010-11, NRHM expenditure on average contributed about 17 per cent of total health expenditure in Karnataka, and 25 per cent of total health expenditure in Rajasthan. In per capita terms, this translates to a NRHM contribution of Rs. 88 and Rs. 127 (in a total health spending of Rs. 537 and Rs. 484) in 2010-11, in Karnataka and Rajasthan, respectively (Figure 2 and Figure 3). As a number of schemes which existed in the pre-NRHM period have been subsumed under NRHM, (e.g. disease control programmes and family planning services), only a part of this expenditure is additional expenditure on account of introduction of NRHM. The additional contribution of NRHM has been primarily in terms of expenditure under the Mission Flexible Pool and increased expenditure towards RCH services. The RCH and Mission Flexible pools together constituted more than 90 per cent of the expenditure under NRHM, 60 to 70 per cent of which was under the Mission Flexible Pool alone.

NRHM has complimented health spending by the State Government in specific areas. A significant expenditure under NRHM is in the form of hiring contractual human resources, and maintenance/construction of primary and secondary health care facilities in States, which complimented health spending by State Governments in these areas. These items accounted for about 25 per cent of the total expenditure under flexible pools in Karnataka, and about 31 per cent of expenditure under flexible pools in Rajasthan (Table 1). Additionally, the scheme has added new items of expenditure through direct transfers schemes and discretionary spending in facilities, which are not incurred by State Governments. In fact, direct transfers form the single largest component of spending

under NRHM, constituting about a quarter of total expenditure under the two flexible pools in these States (Table 1). These include financial incentives under schemes like the Janani Suraksha Yojana, family planning compensation by the Central Government, and Thai Bhagya and Madilu of the Government of Karnataka. Together, direct transfers, facility-level discretionary funds, human resources and construction services constituted about two-thirds the total expenditure under the two flexible pools in these States (Table 1). Substantial amounts were also spent on referral transport in Karnataka, and insurance schemes in Rajasthan, in addition to qualitative aspects like generating awareness and training. Table 2 and Table 3 show the share of various components under RCH and Mission Flexible Pool in Rajasthan and Karnataka in 2009-10 and 2010-11.

Figure 2: **Real Per Capita Budgetary Expenditure (at 1999-00 prices), (net of State's contribution towards NRHM), and Per Capita NRHM Expenditure in Karnataka 2005-06 to 2010-11**

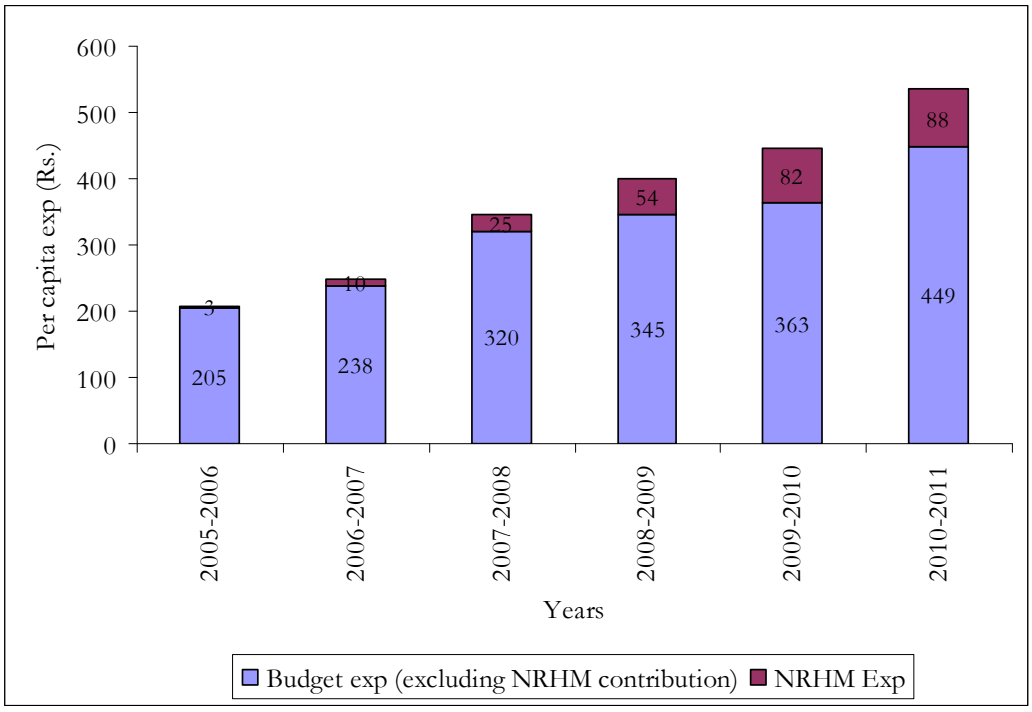


Figure 3: **Real Per Capita Budgetary Expenditure (at 1999-00 prices), (net of State's contribution towards NRHM), and Per Capita NRHM Expenditure in Rajasthan 2005-06 to 2010-11**

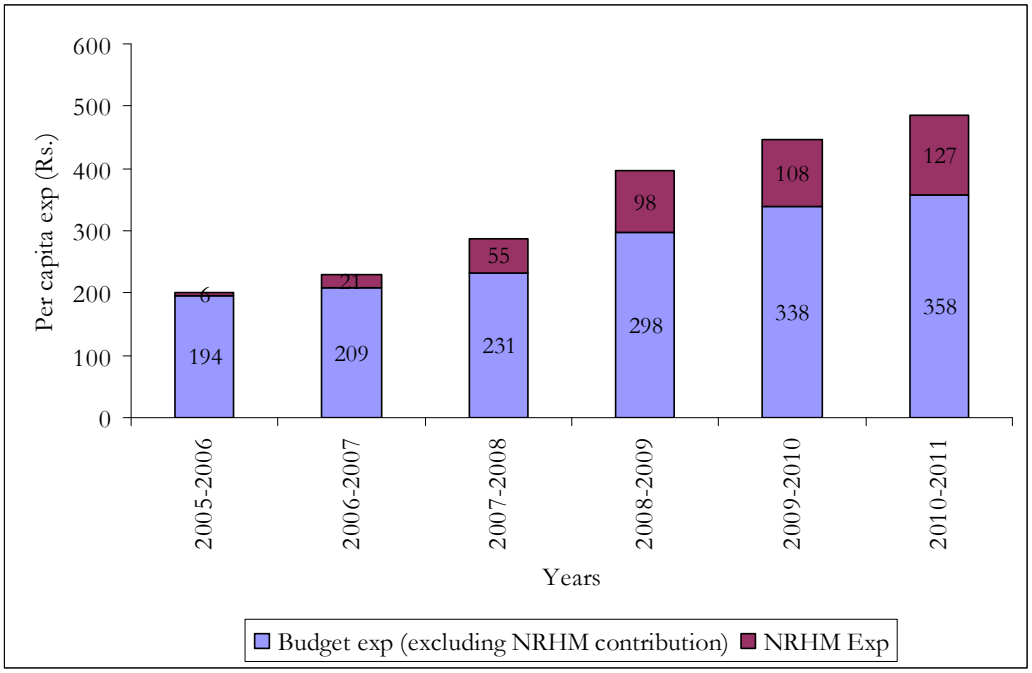


Table 1: **Composition of Expenditure under the Mission and RCH Flexible Pool in the years 2009-10 and 2010-11 (per cent)**

Heads of Expenditure	**Karnataka**	**Rajasthan**
Human Resources	**12.9**	**11.9**
Construction/Renovation	**11.8**	**18.7**
Direct Transfers	**26.3**	**27.1**
Untied Fund	**12.5**	**8.6**
Total of above	**63.5**	**66.3**
Awareness Generation	0.9	2.6
Training	5.0	3.8
Monitoring and evaluation	0.5	0.6
Camps	0.5	0.7
Program Cost	3.0	4.9
Referral Transport	13.7	4.4
Procurement of drugs	2.3	2.2
Planning and Implementation	0.7	0.1
Others (including insurance schemes)	9.8	14.4
Total	100	100

Table 2: **Share of Expenditure on Major components under RCH Flexible Pool, in Rajasthan and Karnataka, 2009-10 and 2010-11**

	Rajasthan		Karnataka	
Component	**2009-10**	**2010-11**	**2009-10**	**2010-11**
Maternal Health	60	62	27	29
Family Planning	13	13	22	17
Infrastructure and Human Resources	5	9	31	31
Procurement	5	5		
Training			8	9
Total of above components	**83**	**89**	**89**	**86**
Other Expenditure	17	11	11	14
Total Expenditure (Rs. Crore)	**280**	**285**	**124**	**160**

Table 3: **Share of Expenditure on Major components under Mission Flexible Pool, in Rajasthan and Karnataka, 2009-10 and 2010-11**

	Rajasthan		Karnataka	
Component	**2009-10**	**2010-11**	**2009-10**	**2010-11**
ASHA	4	6	11	5
Untied Funds, Annual Maintenance Grants and Corpus Grants	19	10	17	22
New Constructions/Renovations	34	26	21	15
Referral Transport / Mobile Medical Units	8	14	25	19
Additional Contractual Staff	16	17	2	2
Incentive Schemes (primarily Madilu Kits and Mosquito Nets)			10	14
Procurements	0.03	0.1	1	5
Health Insurance Scheme (primarily Mukhya Mantri Jeevan Raksha Kosh)	7	9		
Total of above components	**81**	**82**	**86**	**82**
Other Expenditure	19	18	15	18
Total Expenditure (Rs. Crore)	**371**	**520**	**314**	**319**

Notably, NRHM has also contributed to the funding of a number of State schemes. The State contribution towards NRHM includes expenditure on a number of State government schemes. In Karnataka, the State contribution includes expenditure on schemes like Thai Bhagya, Madilu and Suvarna Aarogya Suraksha (Table 4). Similarly, in Rajasthan, the State contribution includes expenditure towards schemes like Mukhya Mantri Jeevan Raksha Kosh and State wise Emergency Ambulance Scheme (Table 5). Although a separate budget contribution has been marked as the State share of NRHM in Rajasthan, and since 2010-11, as the State share of NRHM in Karnataka, the amount considered as State share is inclusive of the expenditure towards these schemes. In fact, in Rajasthan, unless one includes expenditure on these State schemes, the state's release towards NRHM was less than the requirement of 15 per cent mandated under NRHM (Table 5). Interestingly, State schemes like Madilu and Thayi Bhagya in Karnataka were initiated around 2007-08, the year of initiation of the 11th Plan, which made it mandatory for the States to contribute 15 per cent of total NRHM spending. These newly initiated schemes were funded through NRHM as part of the State contribution.

Table 4: **Contribution to NRHM from State Budget of Karnataka under different budget heads**

Head of Account in State Budget	**Programme Name**	**Amount of Contribution (Rs. Lakhs) in**		
		2008-09	**2009-10**	**2010-11**
2210-80-800-0-18	EMRI	1000	1000	2000
2210-80-800-0-06	EMRI	875	8461	
2210-80-800-0-17	Thai Bhagya	2400		1209.41
2211-00-103-0-73	Madilu	400	2249.1	421
2210-80-800-0-15	Health Insurance (Suvarna Aarogya Suraksha)	1600	500	
2210-01-104-0-01-222	Drug	1000		
2210-03-800-0-18	**State Share (NRHM)**			**10000**
	Total (Released from State Budget)	**7275**	**12210**	**13630**
	15 per cent of total releases (including infrastructure maintenance)	**7097**	**6481**	**8813**

Table 5: **Contribution to NRHM from State Budget of Rajasthan under different budget heads**

Head of Account in State Budget	Programme Name	Amount of Contribution (Rs. Lakhs) in		
		2008-09	**2009-10**	**2010-11**
2210-01-110-05-02-12	State wise Emergency Ambulance Scheme	1800	1000	2500
2245-02-106-05-28	Purchase of Search, Rescue and communication machinery and equipment	252		
2210-01-110-03-01-12	General Hospital	291		
2211-800-02-01-90	Mukhya Mantri Jeevan Raksha Kosh (30:70)		2632	1650
2210-06-101-17-28	Integrated Health Vigilance Scheme		44.19	26.63
2211-800-01-90	National Rural Health Mission (NRHM) (15:85)	8557	7369	
2211-800-02-03-90	National Rural Health Mission (NRHM) (15:85)			10500
	Total (Released from State Budget)	**10900**	**11045**	**14677**
	15 per cent of total releases (including infrastructure maintenance)	**11859**	**11047**	**12584**

(B) Changes in Health Expenditure by State Governments following NRHM

In a federal structure, resource transfer for health from a higher to a lower level of government (in the Indian case, Central to State Governments) is meant to compliment health expenditure at the lower level. Empirical studies across the world have, however, shown that, in practice, the lower level of governments often adjust their own spending, or substitute their own funds, with additional funds received from the higher level of Government (the 'substitution effect').[4] In India too, under the National Rural Health Mission (NRHM), there has been an increase in resource transfers from the Central Government to the State Governments. This section examines the impact of increased central funding through NRHM on the level and nature of health spending by the states

[4] Some studies that have documented such practice are: Raich (2002) and Moreno (2003) in Mexico; Lalvani (2002) in India; Sanchez, Smart and Zapata (2003) in Colombia; Sagbas (2004) and Saruc and Sagbas (2008) in Turkey; Alvarado (2003) and Aragon (2005) in Peru; Bryson and Cornia (2003) in the Czech Republic; and Hall (2002) in Costa Rica.

of Rajasthan and Karnataka. Specifically, it examines whether the States of Karnataka and Rajasthan have substituted their own expenditure with increased health spending by the Centre through NRHM.

Substitution of state's own funds with central funding can take place in three forms. First, in response to additional funds being available from the Central Government through NRHM, States may reduce the aggregate level of their own spending on health services. In such a case, *ceteris paribus*, one will observe a decline in States' own health spending with increase in NRHM transfers. Secondly, in response to increased availability of Central funds for rural health services through NRHM, States may shift health expenditure away from rural to non-rural health services. In such a case, one is likely to observe a declining share of State's rural health spending in total health spending of states. Thus, even if the aggregate level of health spending remains unchanged, this will be reflected in a shift in composition of State's health spending away from rural health services. Thirdly, with additional availability of funds through NRHM, States may slow down the rate of growth of own spending on health relative to spending on other areas. This will result in a decline in share of health expenditure in total expenditure of a State. In the context of Karnataka and Rajasthan, we attempt to understand the issue of substitution by examining these issues. Specifically, we examine if there has been a decline in any of the following (i) State's own health spending after the initiation of NRHM, (ii) rural health spending to total health spending by a State and (iii) health spending to total spending of a state. Decline in any of the above, would suggest a particular type of substitution of States' own funds with additional Central transfers under NRHM.

Some recent evidence exists on the issue of substitution of health spending in Indian states. A recent study on the effect of Central transfers for health in India, has found evidence for substitution of state's own health spending with additional central transfers. Rao and Choudhury (2012), in a study of budgetary data on 14 major States of India for the period 1991-92 to 2007-08, find that there is a significant negative association between changes in the level of Central transfers and changes in States' own level of health spending. The study finds that a unit increase in Central budgetary transfers to States for health, leads to a significant decrease in States' own spending on health and

vice versa. The study however excludes off budget central transfers, which include releases under schemes like the NRHM.

Here, we examine the trend in per capita health spending of States following NRHM. Figure 4 and Figure 5 indicate the trends in budgetary expenditure on health in Karnataka and Rajasthan respectively. In both the States, the trends do not indicate a fall in real per capita health spending of the States since the initiation of NRHM in 2005-06. There was, however, a slowdown of State's own health spending between 2007-08 and 2009-10 in Karnataka, and 2008-09 onwards in Rajasthan. In Karnataka, the increase in State's health spending in the period of slow growth was primarily in the form of the State's contribution towards NRHM. If one excludes the State contribution towards NRHM in these years, the real per capita health spending in Karnataka was nearly stagnant. It is possible that the additional requirement of contribution towards NRHM constrained the State from increasing spending on heads other than NRHM. In general, while there was a slowdown in growth of State's health spending in a few years since the initiation of NRHM in both the states, there is no evidence of a fall in the absolute level of health spending following NRHM.

While there has been no fall in absolute levels of health spending, it is possible that the States slowed down the rate of increase of health spending, keeping in view the additional transfers under NRHM. In such a case, the growth rate of health spending is expected to be lower than the growth of total spending in these States, and is expected to translate into a decline of the share of health spending to total spending of States. An examination of the share of health spending to total spending in these States does not suggest any such fall in the post NRHM period (Table 6). This implies that, in both Rajasthan and Karnataka, the growth rate of health spending was not slower than the growth of overall spending by the States in the post NRHM period.

Figure 4: **Trend in real per capita budgetary health expenditure (1999-00 prices) of Karnataka (Rs.)**

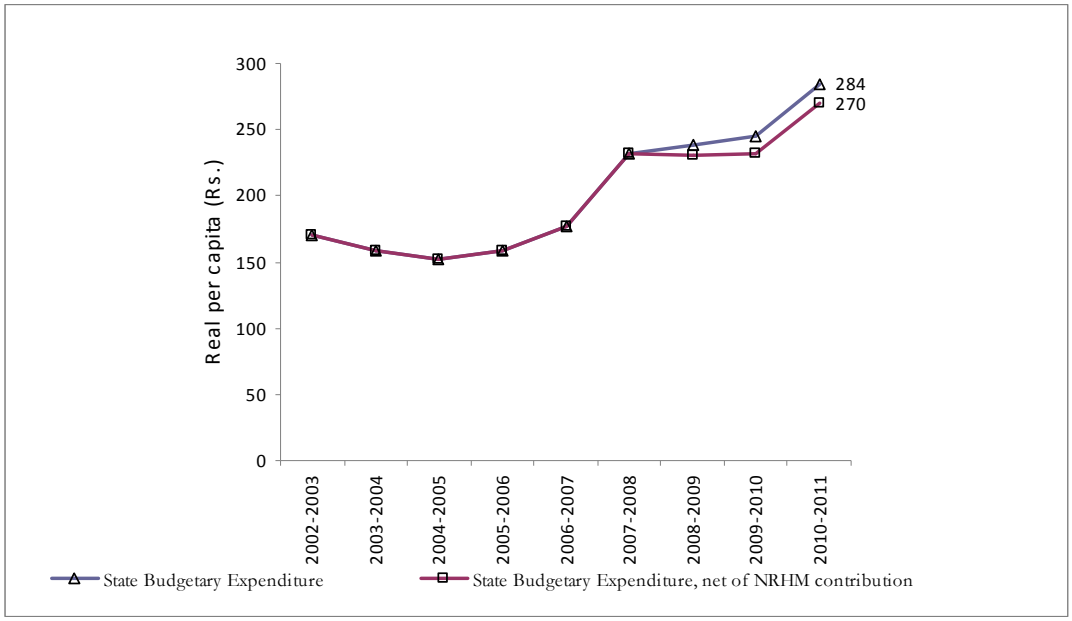


Figure 5: **Trend in real per capita budgetary health expenditure (1999-00 prices) of Rajasthan (Rs.)**

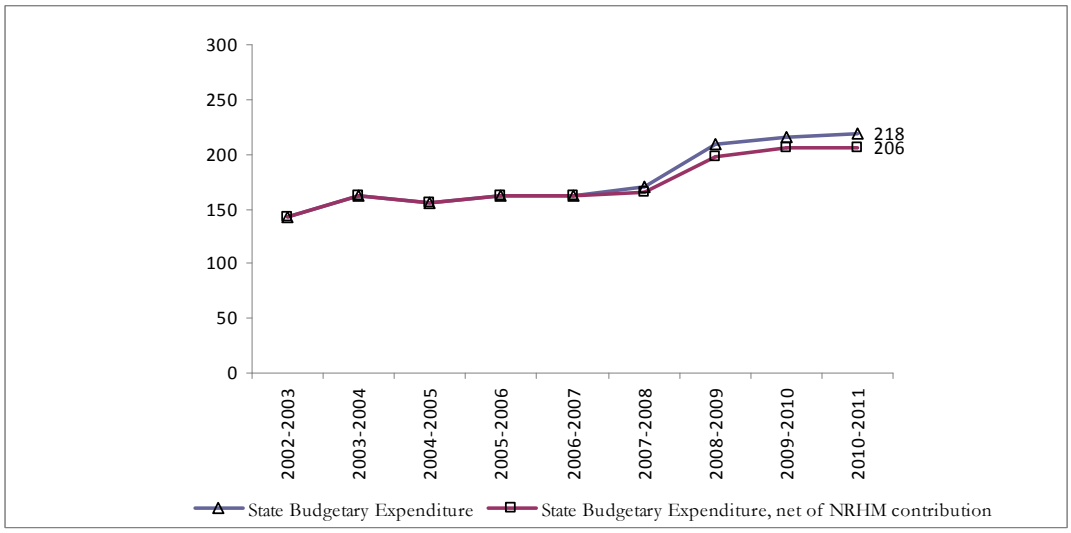


Table 6: **Share of health expenditure to total expenditure in Karnataka and Rajasthan, 2006-07 to 2010-11** **(per cent)**

	2006-07	2007-08	2008-09	2009-10	2010-11
Karnataka	3.61	3.95	4.26	4.05	4.37
Rajasthan	4.99	4.91	5.91	5.79	5.63

There is also no evidence of a shift in expenditure away from rural health services in these States in the post NRHM period. In States like Karnataka, bulk of the expenditure on rural health services is incurred through local bodies, and therefore, we examined the ratio of expenditure on rural health services (including those incurred by local bodies) to total health spending of the two States. Figures in Table 7 and 8 indicate that, in both Karnataka and Rajasthan, the proportion of spending on rural health services has remained nearly constant over the years providing no evidence for substitution of funds by these States. On the whole, evidence does not suggest any substitution of States' own health expenditure with the initiation of NRHM in Karnataka and Rajasthan.

Table 7: **Share of Expenditure in various health services in Karnataka (per cent of total)**

Heads of Expenditure	**1998-99 and 1999-00**	**2003-04 and 2004-05**	**2008-09 and 2009-10**
Urban Health	35.5	31.7	27.0
Rural Health Services	33.0	32.8	34.4
Family Welfare	14.5	17.4	15.3
Public Health	5.8	5.4	3.6
Medical Education Training and Research	11.2	12.6	19.7

Note: Expenditure on rural health services include grant in aid to local bodies.

Table 8: **Share of Expenditure in various health services in Rajasthan (per cent of total)**

Heads of Expenditure	**1998-99 and 1999-00**	**2003-04 and 2004-05**	**2008-09 and 2009-10**
Urban Health Services	33.9	35.6	36.7
Rural Health Services	30	32.1	29.2
Family Welfare	18.7	17.5	17.5
Public Health	9.5	7	8.3
Medical Education Training and Research	7.9	7.8	8.3

Note: Expenditure on rural health services include grant in aid to local bodies.

III. Decentralization of NRHM spending

Introducing greater autonomy and flexibility through decentralization of expenditure has been an important aspect of NRHM. This has been attempted through greater provisioning of funds and allowing a certain degree of discretion in spending to each tier of health infrastructure in a state. From the State-level, funds are transferred to District Health and Family Welfare Societies (DHFWS) set up in each district for planning, monitoring and implementation of NRHM. These Societies either directly incur expenditure, or transfer resources to health facilities and block/taluk-level administrative tier for incurring expenditure. Funds transferred to facilities include funds for discretionary spending like untied funds (UF), annual maintenance grants (AMG) and corpus grants (CG). This section examines the distribution of expenditure across four administrative tiers in Karnataka and Rajasthan: State, district, block/taluk and health facilities. The share of expenditure incurred at these levels is used as a measure of the level of decentralization achieved under NRHM.

We focus on three aspects for the analysis. First, we examine the distribution of expenditure under NRHM between the state and the district-level. Districts form the primary unit of implementation in NRHM, and the extent of expenditure booked at this level provides some indication of the level of decentralization. Secondly, we focus on a few selected districts (where field visits were undertaken) and examine the proportion of expenditure incurred at the sub-district-level: by facilities and other block and district administrative tiers. Although the findings from the selected districts may not be representative for the state as a whole, these are indicative of the extent of decentralization in those districts of the State. Thirdly, we analyze the extent of expenditure out of discretionary funds that is incurred at the facility-level. Discretionary funds are provided to facilities under NRHM to increase the autonomy and flexibility in spending. Within a broad set of guideline, facilities can incur expenditure out of these funds as per their requirements. In practice, however, expenditure under these funds is also incurred outside the facilities, either by block or district-level administration, resulting in lower autonomy and flexibility to facilities than intended. Given this, we analyze the share of discretionary expenditure incurred by facilities and use it as a measure of decentralization at the sub-district level.

Annual audit reports of State and District Health and Family Welfare Societies (DHFWS) have been used for this analysis. In Rajasthan, as facility-level expenditure is reported only in block-level audit reports, these have also been used in the analysis. Audit reports were collected during field visits to State headquarters and districts of the States. For State and district-level expenditure, data provided in the annual audit reports of the State Health and Family Welfare Societies (SHFWS) of the two States have been used. Notably, district-level expenditure reported in the State audit reports is not strictly comparable between Rajasthan and Karnataka. In Rajasthan, these include only expenditure that is incurred by various DHFWS in the State. In Karnataka, these also include expenditure at the Divisional level and on health services provided by various trusts and organizations. For comparison across the two States, therefore, we extract information on expenditure by DHFWSs and use it to identify district-level expenditure. DHFWS are responsible for implementation of NRHM in districts and a higher level of expenditure by these entities is indicative of a greater degree of autonomy or flexibility at the district-level. All expenditure incurred at the Division level and by Trusts and organizations are clubbed with State-level expenditure in this analysis. Given data limitations for facility-level expenditure, we are compelled to focus on a few districts in both the States. The facility-level analysis has been done for Dungarpur district in Rajasthan, and Chamarajanagar and Bidar districts in Karnataka. For both the States, data on average expenditure for the years 2009-10 and 2010-11 under the RCH and the Mission Flexible Pool have been used for the analysis.

Analysis suggests that about 60 to 70 per cent of the total expenditure under NRHM was incurred at the district and sub-district level, and the remaining at the state-level (Figure 6 and 7). Notably, the share of expenditure incurred at the district and sub-district levels was much higher in the RCH flexible pool (88 per cent in Karnataka and 92 per cent in Rajasthan) than in the Mission flexible pool (48 per cent in Karnataka and 56 per cent in Rajasthan). In the RCH flexible pool, direct transfer schemes like the Janani Suraksha Yojana and compensation for sterilization are implemented at the local level, and this increases the share of spending at district and sub-district levels in this pool. The relatively higher share of State in the Mission Flexible Pool arises from different components in the two States. In Rajasthan, expenditure on 'New Constructions', 'IEC-

BCC NRHM' and 'New Initiatives' were largely incurred at the State-level, while in Karnataka, expenditure on 'health insurance', 'KHDC' and 'Incentive Schemes' was incurred at the State-level under the Mission Flexible Pool. In both the States, expenditure on 'referral transport' was incurred at the State-level, while payment of contractual human resources was done at the district-level.

Figure 6: **Share of NRHM Expenditure at State and District Level in Karnataka, 2009-10 and 2010-11**

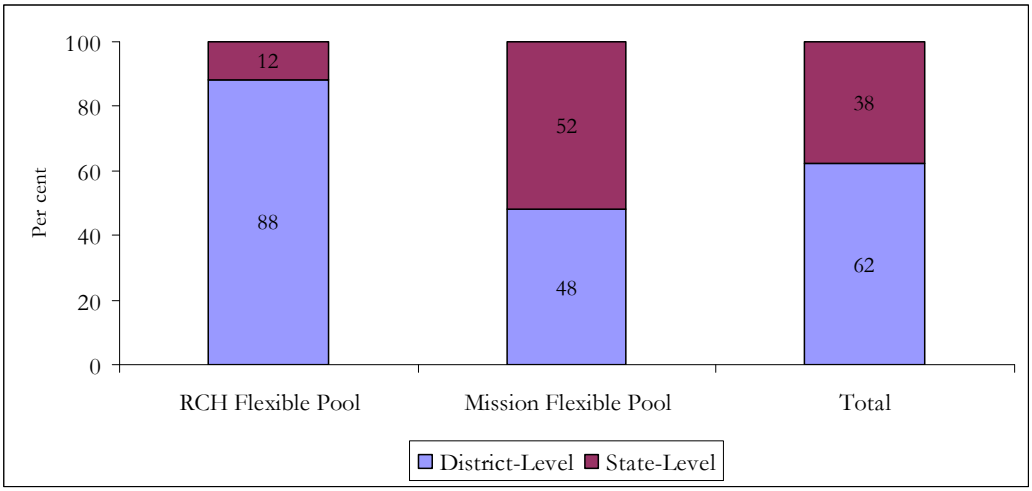
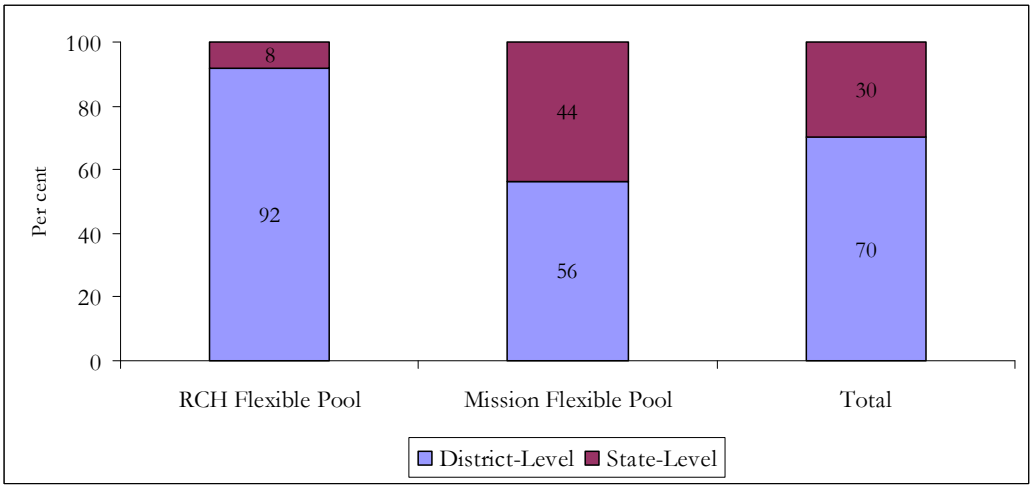


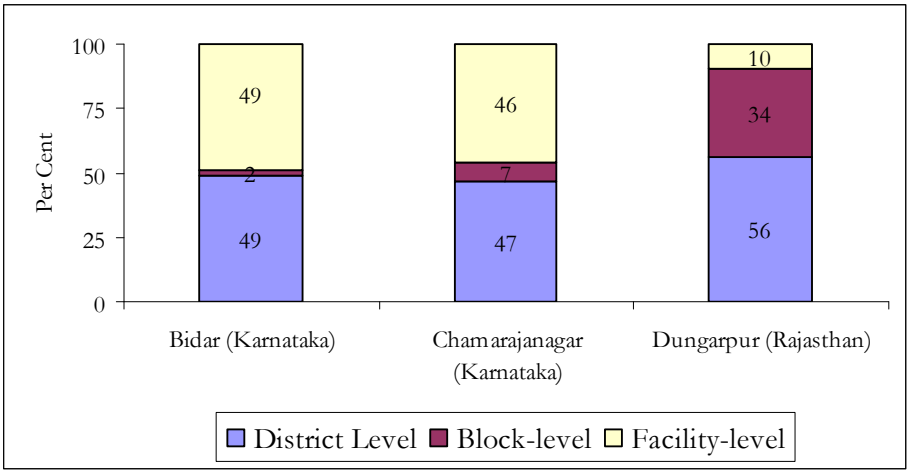
Figure 7: **Share of NRHM Expenditure at State and District-Level in Rajasthan, 2009-10 and 2010-11**



The extent of fiscal decentralization below the districts is analyzed specifically for three selected districts: Bidar and Chamarajanagar in Karnataka, and Dungarpur in Rajasthan

(Figure 8). Analysis suggests that, in both the States, around 50 per cent of the total expenditure within districts was incurred by the district-level administration (Figure 8). Between the expenditure incurred at the block-level and at the facility-level, the distribution is skewed towards blocks in the case of Dungarpur, and towards facilities in Bidar and Chamarajanagar (Figure 8). In Dungarpur, block health officer incurs about 34 per cent, while facilities incur only about 10 per cent of the total expenditure in districts (Figure 8). In contrast, in Bidar about 49 per cent of expenditure in the district was incurred at the facility-level. Similarly, in Chamarajanagar, about 46 per cent of expenditure in the district was incurred at the facility-level.

Figure 8: **Distribution of Expenditure at Sub-district level in Selected Districts of Karnataka and Rajasthan, 2009-10 and 2010-11**



Analysis of expenditure out of discretionary funds provided to facilities in the form of Untied Funds, Annual Maintenance Grants and Corpus Grants also suggests that the proportion of expenditure incurred at the facility-level was significantly higher in Karnataka than in Rajasthan. Facilities in Bidar and Chamarajanagar spent about 43 and 49 per cent of the total spending under these funds in the respective districts, while those in Dungarpur spent only 7 per cent of the same. Notably, in both the States, although these funds were meant to be incurred by facilities, some of it was spent at the block and the district-level set up under NRHM. The analysis of discretionary spending by facilities in these districts suggests that the extent of decentralization in Karnataka was considerably higher than in Rajasthan.

On the whole, the analysis suggests that the extent of decentralization was relatively lower in the Mission Flexible Pool than in the RCH Flexible Pool. In both the States, around half the expenditure under the Mission Flexible Pool is still incurred at the State-level. At the sub-district-level, while the proportion of spending by the district administration was broadly similar in the two States, the share of spending by facilities was higher in the selected districts of Karnataka than in Rajasthan. Also, a higher proportion of discretionary funds were spent at the facility-level in Karnataka than in Rajasthan. Both these facts point towards greater decentralization in Karnataka than in Rajasthan.

IV. Field based study on Untied funds, Annual Maintenance Grants and Corpus Grants

The nature of expenditure under untied funds, annual maintenance grants and corpus grants are not documented in the audit reports of State and district health and family welfare Societies. These reports provide information on the level of spending under these heads, but not on the actual items on which these expenditures are incurred. Description of the actual items of expenditure incurred out of discretionary funds was required to derive an understanding of the nature of flexibility gained by facilities through provisioning of these funds. This information is recorded only in cash books and ledgers of individual facilities and had to be collected from a field based study. Field visits were therefore undertaken in selected districts of Karnataka (Bidar and Chamarajanagar) and Rajasthan (Dungarpur). During the visits, qualitative information about problems related to the utilization of these funds in facilities, was also collected through discussions with doctors and other health personnel.[5]

The districts chosen for field visits were relatively backward in the respective States. These were chosen with the presumption that the capacity for implementation is likely to be relatively poor in these districts, and studying these districts may provide insights into problems of utilization of these funds. The chosen districts also had a reasonable level of expenditure from discretionary funds, which was important for an understanding of the

5 Field visit to Bidar in Karnataka, and Dungarpur in Rajasthan were undertaken in the month of November 2011. The district of Chamarajanagar in Karnataka was visited earlier in September the same year.

nature of expenditure being incurred. Dungarpur in Rajasthan was a tribal dominated district and ranked among the worst in terms of HDI (Human Development Index). In Karnataka too, the district of Chamarajanagar district in the south, and Bidar in the north ranked among the worst in terms of HDI among districts. The level of expenditure under discretionary funds was higher than the State average in Chamarajanagar and lower than the State average in Bidar. The level of expenditure in Dungarpur in Rajasthan was close to the State average. Facilities from three blocks in each district were covered in the field visits.[6] A total of 37 facilities were visited as part of the field study; 19 in Karnataka and 12 in Rajasthan. In Karnataka, the number of facilities visited in Bidar and Chamarajanagar was 12 and 7 respectively.[7]

During the field visits, information on expenditure under these funds in 2009-10 and 2010-11 was collected from the cash books, ledgers, and files containing original vouchers maintained at the facilities. In Rajasthan, most facilities recorded only voucher number and the amount spent in the cash books and ledgers, and did not record description of the item of spending. As a result, in Rajasthan, data for this report were compiled by the facilities specifically on our request from the original vouchers maintained in files in the facility.[8] On the other hand, in Karnataka, most facilities recorded description of items purchased in cash books and ledgers. Two facilities reported only voucher numbers and amount spent; data for these two facilities have been excluded from the analysis.[9] The existing records in most facilities in Karnataka did not provide separate accounts for Untied Funds, Annual Maintenance Grants and Corpus Grants. As a result, the analysis for this report presents combined data for all the three accounts.[10]

[6] Total number of blocks were 4 in Chamarajanagar and 5 each in Bidar and Dungarpur

[7] The proportion of CHCs, PHCs and SCs visited in Chamarajanagar, Bidar and Dungarpur was 1:4:2, 3:6:3 and 3:5:4 respectively. In Bidar, the CHCs visited were Nittur, Kamalanagar and General Hospital (GH) Aurad; PHCs visited were Thana Khushnoor, Halbarga, Muchalamb, Belura, Kitta, and Kanji; and SCs visited were Kotyagal, Madnoor, and Nittur. Since GHs are considered equivalent to CHCs for NRHM grants, GH has been considered equivalent to CHC. In Chamarajanagar, the facilities visited were as follows: Nanjedevanapura CHC; Harave, Sathegala, Hundipura, and Heggadahally PHCs; and Nanjedevanapura, and Agrahara SCs. In Dungarpur, the CHCs were Galiyakot, Bichhiwara, and Damri; PHCs were Chikhli, Punali, Vassi, Taltiya, and Sabli; SCs were Chundavada, Jogivada, Narnia, and Silohi.

[8] Random checks were carried out to validate the data provided by facilities.

[9] As the proportion of such facilities was small in Karnataka, we excluded such facilities from the analysis in Karnataka.

[10] Total number of blocks were 4 in Chamarajanagar and 5 each in Bidar and Dungarpur

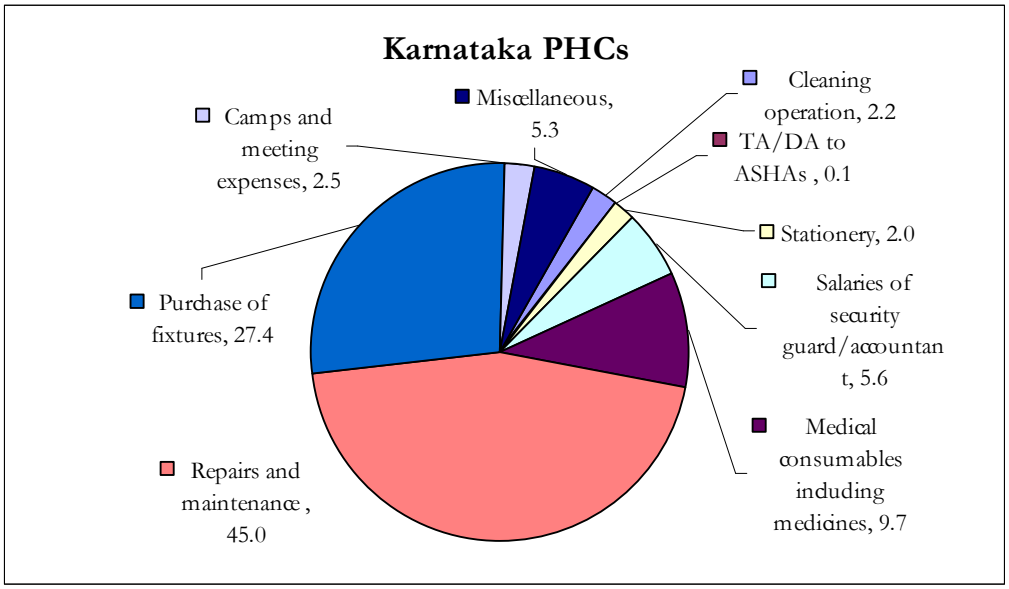
(A) Composition of expenditure

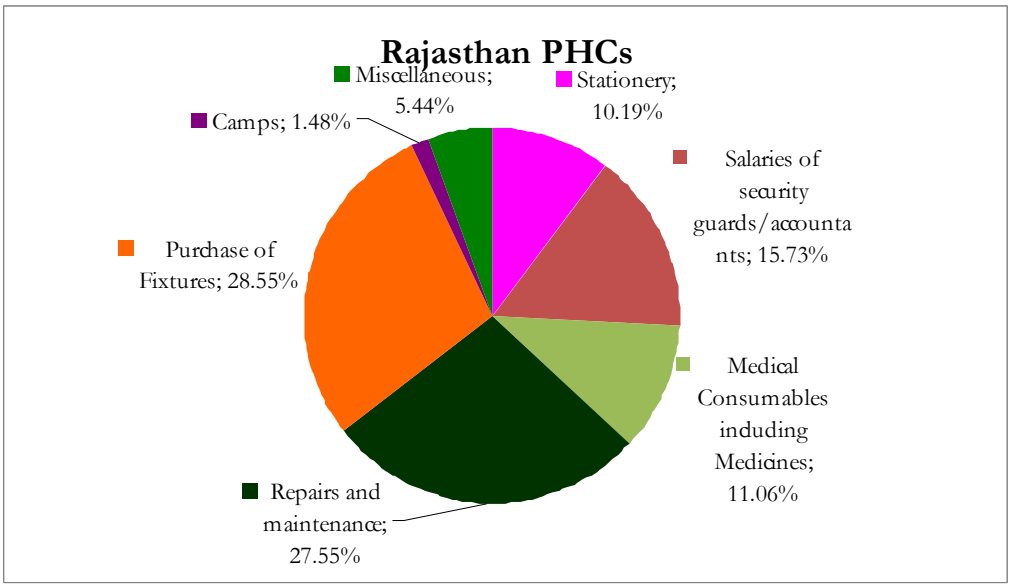
'Repairs and maintenance, 'Purchase of fixtures' and 'Purchase of medical consumables including medicines' constituted the three largest components of expenditure out of discretionary funds at PHCs in both the States (Figure 9).[11] In Chamarajanagar, these items accounted for 92 per cent of the total discretionary expenditure at PHCs. The corresponding figure in Bidar was 74 per cent. In Dungarpur, this accounted for about 67 per cent of total expenditure under discretionary funds. These three components also constituted the major items of expenditure in CHCs of Karnataka and SCs of Rajasthan (Figure 10 and Figure 11). Around 84 per cent of total discretionary spending of CHCs of Chamarajanagar and 78 per cent of total discretionary spending of CHCs in Bidar were on these items. Similarly, in Dungarpur, these items constituted nearly 80 per cent of total discretionary spending in SCs. Other expenditure in these facilities included cleaning the facility and its premises, camps and meetings, stationery, salaries of contractual employees like security guards and accountants, telephone bills and transportation costs.

Repairs and maintenance constituted an important component of expenditure of sub-centers in Karnataka (Figure 11). Together with purchase of stationery, it constituted about 70 percent of the total discretionary spending by SCs in Chamarajanagar and 40 per cent of total discretionary spending by SCs in Bidar. Expenditure was also incurred on medicines and kits, cleaning of facility premises, health and sanitation days in SCs of both the districts of Karnataka. The extent of expenditure on each of these items varied significantly across facilities and over the years. For example, in Chamarajanagar, annual expenditure on medical consumables including medicines varied from Rs. 487 in a year in a sub-centre to Rs. 8097 in another sub-centre.

[11] Repairs and maintenance include expenditure on repair of fixed assets like deep freezer, inverter, etc., as well as civil and electrical repairs in the health facility. Purchase of fixtures includes purchase of assets like, electrical fittings, beds, cots, chairs, PC stabilizers etc. Medical consumables include test tubes, blades, hand gloves, etc.

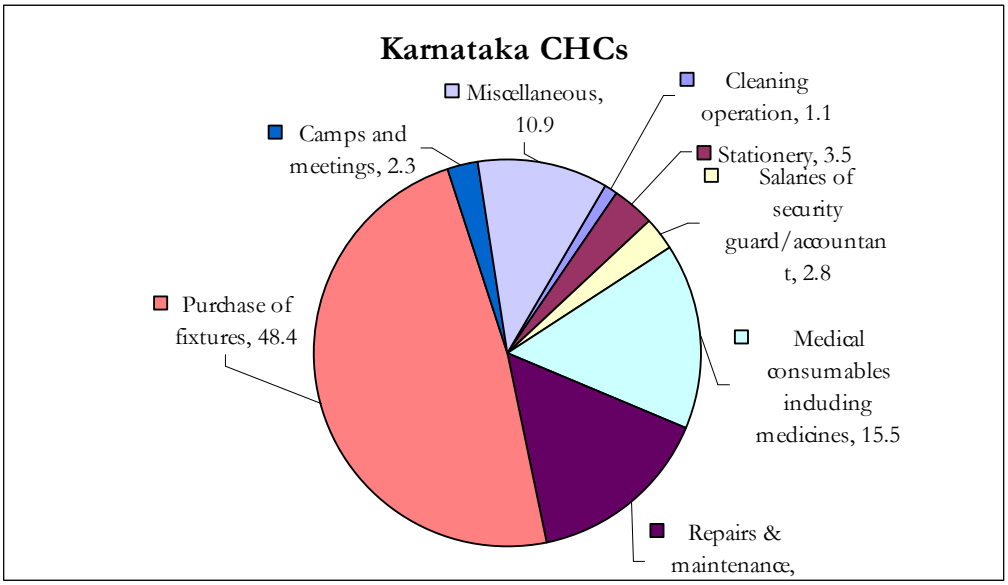
Figure 9: **Composition of Expenditure out of Discretionary Funds at PHCs in Karnataka and Rajasthan, 2009-10 and 2010-11**

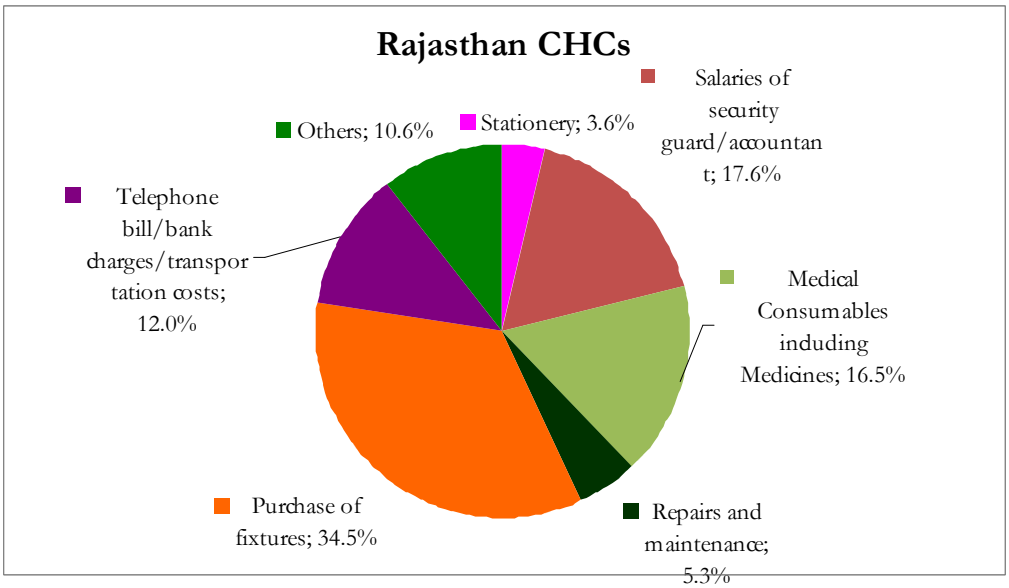




Purchase of fixtures and medical consumables including medicines accounted for bulk of the expenditures in CHCs in Dungarpur. In these CHCs, a substantial expenditure was also incurred on salaries of contractual staff like security guards, accountants, telephone bills, bank charges and transportation cost towards pregnant women. Other expenditure included expenditure on stationery, repairs and maintenance.

Figure 10 **Composition of Expenditure out of Discretionary Funds at CHCs in Karnataka and Rajasthan, 2009-10 and 2010-11**

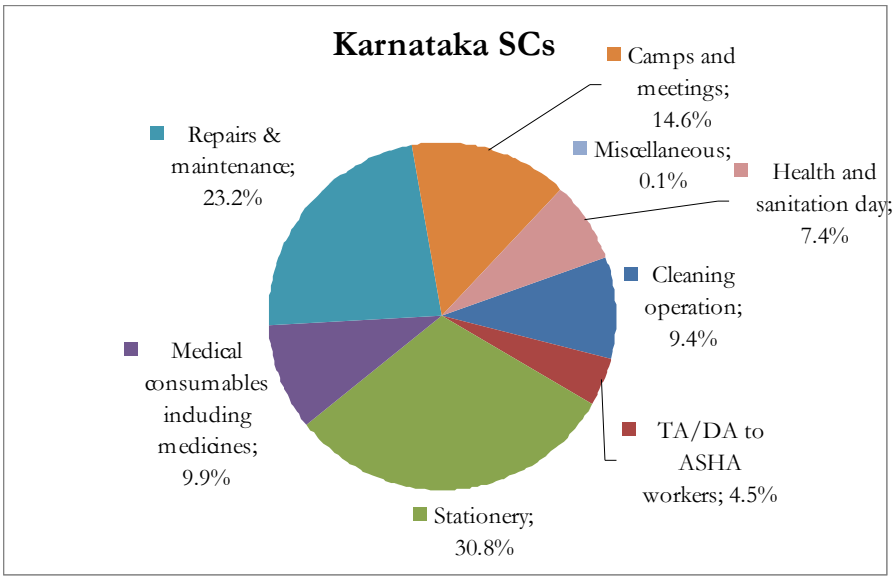


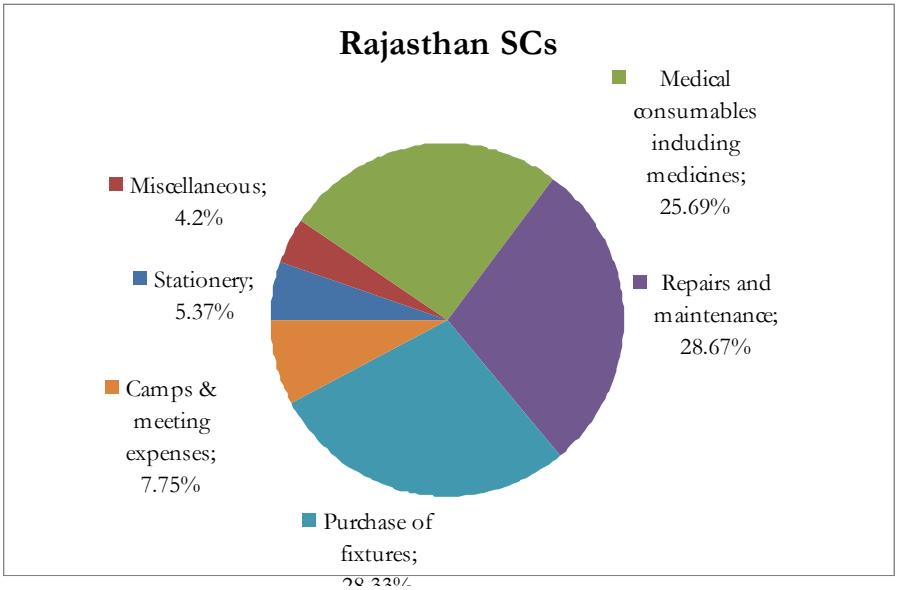


Information on expenditure by three Village Heath and Sanitation Commitees (VHSCs) was also collected in Karnataka: two in Chamarajanagar and one in Bidar. The common items spent in both the districts were on cleaning of facility premises, purchase of fixtures and stationery. Additionally, expenditure was incurred on items like purchasing consumables for pregnant women, purchasing mobile phones, uniform, and transport of

pregnant women to PHCs. In one particular VHSC, an amount of Rs. 15600 alone was incurred towards buying footwear for pregnant women in a year.

Figure 11: **Composition of Expenditure out of Discretionary Funds at SCs in Karnataka and Rajasthan, 2009-10 and 2010-11**





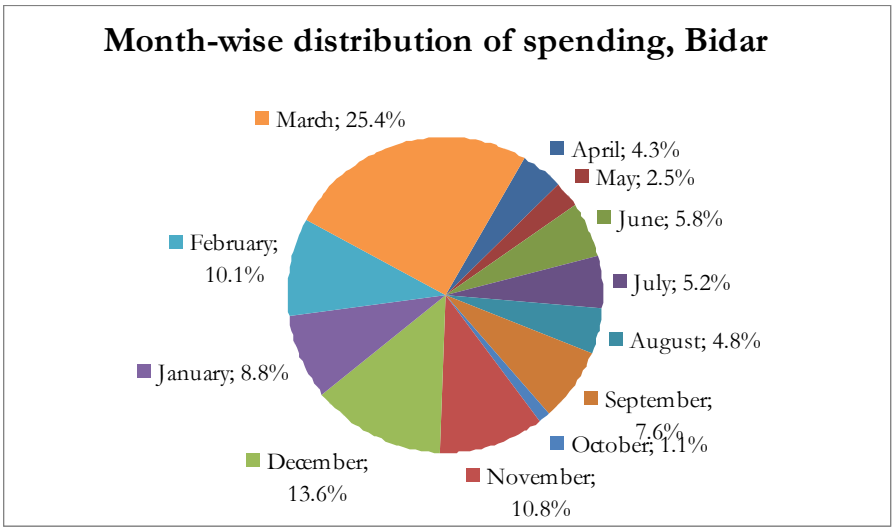
(B) Issues Related to Utilization of Discretionary Funds

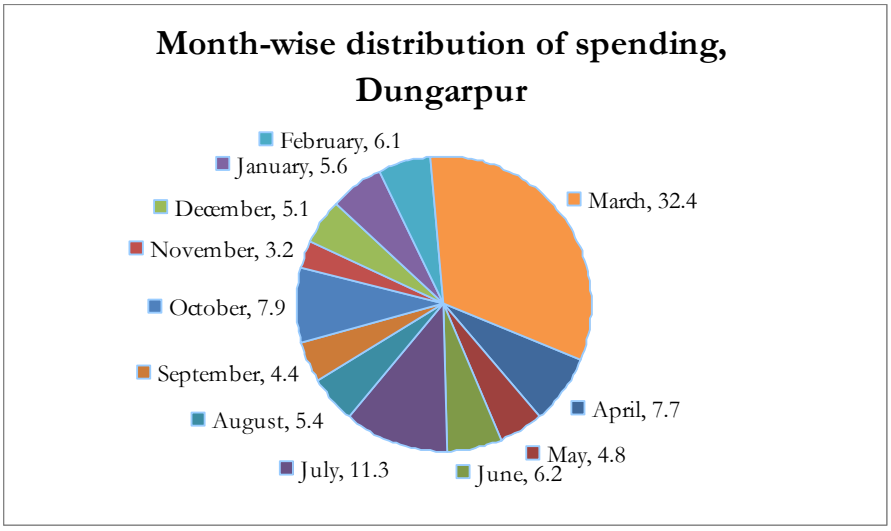
In some facilities, utilization rates were relatively low in specific years, which subsequently resulted in large opening balances. Discussion with health personnel and staff at the facility-level indicated different reasons for this in Karnataka and Rajasthan. In Karnataka, differences between elected representatives at the panchayat-level and the health personnel at the facility-level were pointed out as a reason for lower utilization of funds in some facilities. A few facilities in Karnataka also reported delay in receipt of funds as the reason for large opening balances in some of the early years. Lack of clarity in guidelines in the initial years was also reported as a reason for low utilization in one of the facilities in Karnataka. In Rajasthan, on the other hand, lack of capacity and incentive to spend the discretionary funds appeared to be a major reason for relatively low utilization of funds in a number of facilities. In some facilities of Dungarpur, 'administrative burden' was stated as a reason for reluctance to utilize the discretionary funds. Doctors of a few PHCs in Rajasthan pointed out that in addition to their clinical responsibilities, they were also burdened with various administrative responsibilities like issuing checks under Janani Suraksha Yojana, keeping accounts of expenditure out of untied funds, annual maintenance and providing direct transfers to people under various state government schemes. It was stated that this made it difficult for them to take an initiative for incurring expenditure out of the discretionary funds. While this appeared to be a genuine reason for some facilities with high patient load, the reason seemed unjustified in facilities with negligible patient load. Some medical officers in Dungarpur also questioned the requirement for discretionary funds, as patient load was very low. We categorized such reasons as a 'capacity problem', as they did not seem capable of utilizing these discretionary funds to improve the quality of health services provided at the facility.

Notably, utilization of discretionary funds appeared to be concentrated in the month of March in some of the facilities studied by us. In Bidar, about a quarter of the expenditure was incurred in the month of March alone (Figure 12). In Dungarpur too, a quarter of the expenditure out of untied funds and 40 per cent of expenditure out of Annual Maintenance Grants were incurred in the month of March (Figure 12). This raised a question on whether the expenditure was incurred on the basis of actual need or to ensure utilization of funds. Besides, in Rajasthan, expenditure against a number of items

was booked on the same date in many facilities. Also, in Rajasthan, rate of utilization of annual maintenance grants were lower than the utilization rates of untied funds.

Figure 12: **Month-wise distribution of spending out of Discretionary Funds in Bidar and Dungarpur Districts.**





V. Summary

The National Rural Health Mission (NRHM) has been one of the largest initiatives in the health sector by the Government of India in the recent past. The scheme was launched as a mission for improving the rural health system of the country, and has expanded substantially over the years. The scheme continues to be the major policy initiative of the Government of India in the area of public health, and in recent years has been the focus of discussions on health policies of the country.

This report analyses selected issues related to the contribution of NRHM in terms of health spending in Karnataka and Rajasthan. Specifically, it examines three issues. First, it examines the additional contribution of NRHM to the extent and composition of health spending at the State-level, and the adjustment by the State government to its own health spending (if any) in response to this spending. Secondly, it analyzes the extent of decentralization achieved under NRHM at the district and sub-district-level in selected districts of the two States. Thirdly, it highlights the nature of expenditure incurred by facilities out of discretionary funds provided to them, and discusses some of the issues related to utilization of these funds.

The level of health expenditure has been estimated after adjusting for the flow from the State treasury to the State-level society in the form of State contribution towards NRHM. Analysis suggests that NRHM contributed about 17 per cent of total health expenditure in Karnataka and 25 per cent of total health expenditure in Rajasthan (in 2009-10 and 2010-11). In per capita terms, it contributed Rs. 88 and Rs. 127 (in a total health spending of Rs. 537 and Rs. 484) in Karnataka and Rajasthan. The single largest component of this expenditure (about a quarter of the total) was direct transfers through schemes like the Janani Suraksha Yojana and compensation for family planning. These transfers together with expenditure in the form of discretionary funds, human resources and construction services, accounted for about two thirds of total expenditure under the flexible pools of NRHM in the two States. Additionally, expenditure towards referral transport in Karnataka, and insurance scheme called the Mukhya Mantri Jeevan Raksha Kosh in Rajasthan, are significant items of expenditure under these pools. Notably, the States' contribution towards NRHM in both the States includes expenditure under a number of

State Governments' own schemes. To that extent, a number of State-level schemes were also being funded through NRHM.

An analysis of States' expenditure in the post NRHM period does not suggest any substitution of their own health spending by additional spending through NRHM. There is no evidence of a fall in health spending by States at the aggregate level in real terms. There is also no evidence of a shift of expenditure away from rural health services towards other services, or a greater slowdown in the growth of health expenditure relative to other expenditure by these States. If one excludes State contribution towards NRHM, however, there appear to be some stagnation in States' own health expenditure in Karnataka between 2007-08 and 2009-10, and since 2008-09 in Rajasthan. It is possible that the additional requirement of contribution towards NRHM constrained the States from increasing spending on heads other than NRHM in these years.

Analysis of the extent of decentralization under NRHM was based on data from audited accounts of State and District Health and Family Welfare Societies of the two States, and block-level audit reports (in Rajasthan). Decentralization at the sub-district level was analyzed in three selected districts of the two States: Bidar and Chamarajanagar in Karnataka, and Dungarpur in Rajasthan. Analysis suggests that about 60 to 70 per cent of total expenditure under the flexible pools was incurred at the district and sub-district level in the two States, and the remaining at the State-level. The extent of decentralization was lower in the Mission Flexible Pool than in the RCH Flexible Pool. In both the States, about half the expenditure in the districts was incurred by administrative officers at the district-level. At the sub-district level, the extent of decentralization was higher in the selected districts of Karnataka than in Rajasthan. In Bidar and Chamarajanagar in Karnataka, bulk of the expenditure at the sub-district-level was incurred by health facilities, and a negligible share was spent at the block-level. In contrast, in Dungarpur in Rajasthan, bulk of the expenditure at the sub-district level was incurred at the block-level, and a negligible proportion was spent at the facility-level.

Information on the items of expenditure incurred by facilities out of discretionary funds provides some insight about how discretionary funds are utilized. However, audit reports provide information only on the extent of expenditure out of discretionary funds, but not

on the items of expenditure. Field visits were, therefore, undertaken to selected facilities of the three districts: Bidar, Chamarajanagar and Dungarpur to examine the nature of expenditure incurred out of these funds. During these visits, information on individual items of expenditure under discretionary funds was collected from cash books and ledgers maintained in the facilities. Data from facilities suggest that 'Repairs and Maintenance', 'Purchase of fixtures' and 'Medical consumables including medicines' account for the three largest components of expenditure out of these funds in PHCs. These heads also constituted the major items of expenditure in CHCs of Bidar and Chamarajanagar and SCs of Dungarpur. Additionally, in sub-centers of Karnataka, significant expenditure was incurred on stationary. Other items of expenditure out of discretionary funds include cleaning of facilities and its premises, camps and meetings and salaries of contractual staff like security guards and accountants. An examination of distribution of expenditure across months showed that bulk of the expenditure out of discretionary funds was concentrated in March and sometimes on a specific date. This suggests that some of the discretionary funds were spent just for the sake of utilization of these funds, rather than to meet an immediate requirement.

Qualitative information on the problems related to utilization of discretionary funds gathered through discussions held with doctors and other health personnel in facilities suggests different reasons in Karnataka and Rajasthan. Differences between elected representatives at the panchayat-level and health personnel at the facility-level pose an important hurdle in utilization of funds in facilities of Bidar and Chamarajanagar. Delay in receipt of funds and lack of clarity on guidelines in early years were also cited as hurdles to utilization of funds. In Dungarpur, on the other hand, lack of capacity and incentive to spend discretionary funds appeared to be a major reason for low utilization in facilities.

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Appendix-I

Schematic representation of facilities studied in selected districts of Karnataka and Rajasthan