
Improving government financial transfers for health and their utilization: State experiences

Policy Paper: HSTP/2021/1

April 2021

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This policy paper attempts to present resource allocation, utilization, and absorption across four Indian states. It highlights key issues and provide recommendations to improve the health financing process that facilitate greater flexibility and efficiency in financing of the programs. The experiences of policy makers who have successfully handled systemic issues, developed best practices, and ensured results for the state have been included as a part of the learnings. Further, in terms of continued centre-state engagement in implementing health schemes, the current financial transfers for Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) have been included as a case example.

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This policy paper titled 'Improving government financial transfers for health and their utilization: State experiences' has been developed by Health Systems Transformation Platform (HSTP) and the partner(s) to share the learnings of various states on fiscal transfer for health.

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Acknowledgement

We deeply thank all the stakeholders who participated in the discussions and provided their insights to this work. We thank our CEO, Rajeev Sadanandan, my HSTP colleagues Rahul Reddy, Sanjeev Kumar and Vijayashree for their inputs to the article.

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Introduction

Adequate public financing is key to achieve universal health coverage (UHC) in India and across states. Despite a sustained economic growth, India's public spending stands at 1.20% of GDP and out of pocket expenditure (OOPE) is quite high at 58.7% of total current health expenditure ("National Health Accounts Estimates for India" 2019). Further evidence suggests millions of people are pushed to poverty due to high OOPE on health ("The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings: | Economic and Political Weekly" n.d.). The National health Policy 2017 recommended increasing public health expenditure to 2.5% of GDP by 2025(Ministry of Health and Family Welfare n.d.). The states spending on health should be increased to at least 8% of their respective budgets by 2020. Currently all states are spending less than 8% except for Meghalaya (9%). The average spend across states is 5.18% (4.1%- 9%). The per capita health expenditure across all states is Rs. 1218 (Rs. 616-Rs. 6937) with a wide inter-state variation (Ministry of Finance, n.d.). Given the low public spending on health and diverse needs of health sector due to changing population health and disease dynamics, timely allocation, utilisation, and resource absorption are critical.

As per the UN Sustainable Development Goal 3, which focuses on "Ensuring healthy lives and promoting well-being for all at all ages", a robust and timely program administration is one of the most integral part of achieving equitable and greater access to health services. Thus, to facilitate effective administration, it is crucial to have an organized and timely flow of funds for undertaking diverse activities for the health sector. A recent study conducted by Indian Institute of Public Health Bhubaneshwar (IIPH-B) that looked into resource allocation, fund transfer process, utilization and pattern of spending on different programmes brought out the complexity of the fund transfers and under-utilization due to low absorption capacity in the districts. The analysis published on National Health Mission financing of states by National Institute of public Financing and Policy (NIPPF) (Choudhury and Kumar Mohanty n.d.) have brought out key issues of how delays in financing affects both the utilization of funds and performance of states which are critically linked.

Given this, the present policy brief makes a modest attempt to understand resource allocation, utilization and absorption across four Indian states. This policy brief highlights key issues and provide recommendations to improve the health financing process that facilitate greater flexibility and efficiency in financing of the programs under their ambit to policy makers especially for Department of Health and Family Welfare, Government of Odisha.

Methodology

We have used the available secondary literature, interacted with key stakeholders to understand the fund flow mechanism, resource absorption at district and below and other key issues and challenges of public health financing in Odisha drawing inferences from other states – Kerala, Tamil Nadu, and Karnataka. These states were chosen to learn their best practices as they have been able to streamline their processes and show good fund utilization. The learnings would be useful for Odisha too. The state health accounts report of Odisha, the recent NIPFP report on National Health Mission funds, the Biju Swasthya Kalyan Yojana- Universal Health coverage scheme have been considered for detailed review to understand the fund flows process. An alternative funding mechanism being followed for sharing the centre and state share of funds for the recent Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) was also reviewed. An effort is made to understand how the centre and state co-sponsored scheme has addressed certain long standing fund transfer issues of National Health Mission (NHM). Discussions with key stakeholders from health and finance department Odisha and more progressive states on specific issues were undertaken to identify the areas for improvement and learnings from other key states who have addressed similar issues.

Key issues related to financing through NHM

In India, both the union and state government are responsible for providing resources for health. As per the latest health accounts report the state's share is 69 % of the total government spending on health and rest is by the Centre. The union government mainly transfers funds through finance commission and departmental grants for various centrally sponsored schemes implemented at the state level. The introduction of NRHM in 2005 marked noticeable changes in the process of resource transfer from the union government to the states. From 2005, funds under NRHM were directly transferred to the independent state societies for easier administration and better utilization of funds. However, in 2014-15, the union government changed the process and has reintroduced transferring funds to state treasury and treasury further transfers to the state NHC society. There has been shift in the state share which was earlier 25% till year 2015 and later has been increased to 40%. This section below gives a brief account of fund transfer and utilization at state level.

- 1. There is a delay in releasing the record of proceedings for the financial year, thus delaying the decision-making process at the state level, and leading to an unproductive quarter.**

The Record of Proceedings document enlisting the budget items for NHC is generally released in the months between June-August and some states much earlier for the same financial year (Choudhury and Kumar Mohanty n.d.). Annexure-1. This delay in release of the sub budget items leads to generally a delay of a quarter in decision making concerning the allotment of budget to multiple program activities. Also, due to this delay, the state NHC is not able to complete all the program activities planned for the financial year as several action items depend on budget allocation such as awarding contracts, procurement, etc. Although the states can carry unspent funds from the previous year for continuing certain activities as per approval, new activities planned for that year cannot be started. Since States also need to submit their proposals on time the team should initiate the preparations and provide sufficient time for review by the Ministry and meet the timelines strictly.

- 2. Record of Proceedings (RoP) is very strictly categorized in program verticals making it difficult to adopt a holistic approach with regards to limited budget flexibility.**

The sub-budget items related to the administration of different programs are recorded as fixed allotments for different verticals without any room for major flexibility in budget spending. Due to a strict vertical categorization, the budget for sub-categories is not flexible enough for pooling of budgetary funds for various activities. Such pooling of funds is often required for establishing cross linkages within multiple programs. This situation leads to some programs and activities being overfunded and other activities remaining underfunded, thereby reducing the planned impact of activity and programs. Though there is scope for reappropriation of funds with the approval of the center, it is an elaborate process to get approval that has to be followed both at the centre and state level. There is also a need to align the financial allocation for activities taking in account the state's performance in achieving the MCH goals and the SDGs. If the MCH goals have been met already, the finances for MCH

can be diversified into different domains, considering the burden of diseases especially to NCDs. For eg: the MCH indicators for state of Kerala is almost close to those of developed countries but they have a huge burden of NCDs, so the proportion of fund allocation can be increased to address the current burden.

Also, the sub-budget items listed in the NHM Record of Proceedings consists of overlap and duplicate assignment of budget between sub-categories of expenditure. Such overlap again leads to overutilization and underutilization of budgets for various activities.

3. Inability to utilize the allocated funds completely leading to unspent balances which get adjusted for the subsequent financial year

Overall, the utilization of funds across states have been around 58% which leads to huge unspent balance. Further most of the expenditure (about 40%) is done in the last quarter which does not ensure consistent fund availability for various activities. Across states the utilization varies from 69 % in Odisha to 80% in Tamil Nadu and Kerala each (Choudhury, Mohanty, and Kumar Mohanty n.d.). The expenditure as a proportion of available budget in 2017-18 was over 75 per cent in Tamil Nadu, Gujarat, Madhya Pradesh, and Kerala while it was less than half of the available budget in Telangana (43 per cent) and Maharashtra (42 per cent). As per the Comptroller Auditor General (CAG) audit in 2015-16, the total unspent balance in 27 states was found to be about Rs. 9509 crores (Quint n.d.) In FY 2016-17, unspent balances amounted to 10,595 crores. This increased in FY 2017-18 to 12,431 crore and further to `12,594 crore in FY 2018-19(Research n.d.).

The key reasons for underspending are mainly weak health system, human resource constraints, governance and complex process of procurement and construction required. The utilization also varies component wise with reproductive and child health activities absorbing funds better at 84% while others like Mission flex pool 60%, communicable disease 53%, Non-communicable diseases 23% and National Urban Health Mission (NUHM) activities 81% in 2018-19.

Another reason is also the time taken for resources to reach the districts for implementation as per approved activities by the program officers from the time the amount is received in state treasury from Government of India. Delays occur in the transfer of funds from the treasury to the NHM head office, in transferring the funds from the headquarters to district health societies with multiple bank accounts for various program verticals which causes more delays to utilize the fund and also reduces transparency and makes it very complicated to track the funds.

4. Tracking budget spending on sub-category items is difficult

As of now, the resource envelope for budget items concerning NHM is composed of extensive multiple sub-budget items. Due to a lack of definite coherence in categorization, the tracking of spending on programs and their related aspects becomes very difficult as the administration needs to continuously categorize every micro aspect of spending rather than adopting a holistic approach for program implementation and budget tracking.

Voices of State Policymakers

Karnataka

Fund release issues: The NHM funds flow mechanism is similar to many states with no major changes. The process is manual file still and goes through 45-50 steps overall up and down the hierarchy for approval taking about 65-70 days in total for funds to be available. E-office implementation can actually track the file and identify where the delays are happening. Further it takes some more time for it to reach the districts mostly around July/August.

Fund Utilization issues: The expectation of NHM both at the state and centre is that 15% of funds to be utilized by June, 45% by September and at least 75% by December. Even after fund release the main issue is full utilization of funds. With a lot of efforts about 75-80% was utilized. For programmes where in direct benefit transfer like Janani Suraksha Yojana (JSY), are needed they may be missed as funds are not available at that time and more effort is needed to track and ensure payments to the beneficiaries. The programme officer responsible is also key to drive the activities and utilize the funds as per approved annual Programme Implementation plan (PIP). The Health and Wellness centres (HWCs) programme was well managed, and funds fully utilized and also was part of the national pilot for HWCs. Many a times the officers are burdened with additional charge and may not be able to focus on all areas.

Health system strengthening pool, civil works especially getting no objection certificates, delays leading to revised estimates, procurement of drugs and equipment due to tendering takes time are the main areas where spending is a challenge. Small budget heads like dental, leprosy and blindness activities funds also remain unspent while big ticket items due to visibility the progress is reviewed, monitored and gets done. Another issue is once funds are transferred to village health, sanitation and nutrition committee they cannot be taken back even if they are non-performing, and the amount gets left unspent.

District program officers are contractual staff and their acceptance at the district level and capacity to co-ordinate was limited as the district health officers are from the services.

One of the best practices tried is supportive supervision by reviewing 10 districts at a time with all program officers of the district not only for physical and financial progress but also to suggest qualitative improvements. The district health officers, and program officers are aware of the gaps and most of the action is at the district level, they need facilitation to resolve the bottle necks.

There is a need to simplify the process, reduce multiple steps, multiple bank accounts.

Kerala

Fund release issues: The fund flow mechanism is same as other states but works on e-office which brings in some timeliness and the process takes around 40-45 days comparatively less than Karnataka though it goes through same number of desks up and down. Even after all approvals the actual release of funds to the programs may be released based on other competing programmes, fund availability based on the financial situation of the state and to some extent negotiations and convincing of finance department needed. The deficit finances in the states is mainly due to Kerala investing more on education and health initially and later the expenses shifted to non-plan funding leading to high borrowing and revenue not keeping up with expenditure especially for human resources and pension liabilities.

In the financial year 2018-19 and 2019-20 due to the flood relief activities the budget was cut up to about 30% and the funds were also released very late in end of March due to which the funds could not be utilized. If funds are not released on time for eg: construction, it hurts the programme and also where direct benefit transfers are to be done like Janani Suraksha Yojana the beneficiaries miss out as many are lost from tracking.

Fund utilization issues: The utilisation in Kerala overall has been 85%. This is mainly due to existing structure in place to absorb the funds and ownership at all levels.

One of the best practices in Kerala is common planning for 3 level of budgeting at Panchayat/local self-government level, state funds and NHM funds by deciding what is to be done, under which funds could be used and where it needs supplementation. Bottom-up approach once well-done eases implementation and any unanticipated issues could be handled be supplementary budget or reappropriation if needed for immediate resolution. The administrative process is completed in advance so the funds can be utilized. Any incentive funds utilization from programmes for eg: earlier Rashtriya Swasthya Bima Yojana (RSBY) and now Ayushman Bharath PM-JAY are decided at institutional level with proper guidelines provided by the Government orders. Resources are also raised from Kerala infrastructure fund board for certain activities. Local self-government earmarks 10% of their fund for health. Intersectoral coordination with women and child development, Ayushman Bharat-Karunya Arogya Suraksha Paddhati (AB KASP) provide complementary support.

The family health centre concept has improved primary care services in Kerala and better referral linkages are established. Palliative care services, Neonatal screening for congenital metabolic disorders, haemoglobinopathies were all initiated as part of innovative NHM financing and then scaled up.

Another initiative that has helped is the new generation younger doctors who have joined as hospital managers under administrative public health cadre are making a difference in the way hospitals are managed. The district programme officers are from state health services and work closely with the other officers who are experienced and specialized in their specific programs like NCD or tuberculosis (TB) who have greater ownership and ensure proper implementation. The NCD program funds are utilized well both due to the burden of the disease and also structures are in place.

The secretary Health also have a stable term of around 5 years and Mission director NHM normally have 3-5 years tenure which provides a lot of stability to the programme implementation.

The key suggestion to other states is they should have reasonable targets to be achieved, people should be accountable, and defined policy guidelines for posting in difficult areas for a fixed period and bring them back after completion of tenure. The procurement contracts should be corruption free with a good system in place like Tamil Nadu. The infrastructure and sub-divisional and district hospital to be improved with major specialities and super speciality care available in District hospitals and medical colleges like cath labs and oncology services.

Tamil Nadu

Fund release issues: The state has not faced any delays in fund flows and funds are transferred within a day. The main issue is the line item budgets, multiple accounts limited flexibility and funds provided to facilities without proper profiling of people being served. Need based financing and output-based financing models could be considered which improves efficiency.

Fund utilization: The state has been able to consistently utilize 80-90% funds and there are no issues. The procurement system is the backbone of Tamil Nadu health system which ensures timely supplies, centralized quality control and proper payments. The public health cadre being practiced in the state is the magic bullet to ensure implementation of all programs. Most of the government doctors do not practice outside the public facilities. All staff including for NHM are recruited through the medical recruitment board with Finance department concurrence and there are no contractual staff. There are no Asha's under NHM, recently village health volunteer was included for NCD screening through Mahilayar Thittum, Self-help groups (SHGs) and honorarium paid to the SHGs.

Supplementary budget concept is good as it is difficult to plan for all eventualities. It helped in force majoure events like Chennai floods, Dengue outbreak, Covid 19 Pandemic as priorities shifts and some flexibility mid-year is useful.

Few innovative programs done under NHM include establishment of trauma care system, ST elevation Myocardial infarction (STEMI) program, Script care for stroke, health services for wandering mentally ill patients through emergency care and provide treatment, geriatric care set up in every district, family folder concept and others. All these initiatives were data driven

Strategic purchasing of health care along with health technology assessment is critical along with strong public system. A 50:50 proportion provides a good balance.

Odisha

Fund release issues: Odisha received the approval letter during the month of June in 2016-17 and 2017-18 and as late as August in 2018-19. There has been a significant improvement in the year 2019-20 wherein most states received the approvals early by February 2020. Mostly the turnaround time for release of funds once approvals are in place and it is done within 2-3 days (Annexure-2). Since they have 7 financial advisors within the department of health posted from the finance department of which one officer is exclusively responsible for NHM, the process is seamless and only about 10 desks it passes for approval within the department. Further, one engineer from government public works department also monitors the civil works which constitutes a significant proportion of total NHM resources. In Odisha during 2017-18, 85% of the funds from GOI was credited to state treasury within 7 days while it was only 48% in 2018-19. The reasons for the delay need to be explored. Also, the transfer of 95% of funds to the state health societies took about 30 days in 2017-18 while only 40% of the funds were transferred in 30 days in 2018-19.

Compared to states like Kerala and Tamil Nadu where the district programme staff are from the state services providing stability and continuity, in Odisha the district programme staff are contractual. Another concern is most of the times the Chief district medical officers have only few months to maximum of 2 years of services left which reduces motivation to take on challenging initiatives.

Fund utilization: Odisha has fared better in fund utilization than the national average at 67% in 2017-18 and dropped slightly to 65% in 2018-19. The fund utilization for Odisha in various quarters during the year 2018-19 was found to be 12%, 29%, 53% and 100% in the last quarter. RCH pool utilization is good and is data driven while services utilization are demand driven. It was emphasized that The NRHM and NUHM pools are different currently which could be merged for better utilization especially for similar programme activities. The requirement for Utilization certificates and need to break up expenditure for specific activities like behaviour change communication (BCC) and specific disease programmes is an issue. Some activities like IEC, training funds are tied to programmes and not very flexible. NCD budget utilization is lower due to capacity issues. The population-based screening has helped in identifying 15 districts where dialysis machines need to be placed and especially at sub district blocks for eg: in Cuttack district where the burden of chronic renal disease was higher.

Corporate Social responsibility (CSR) funds are raised for specific activities especially from District mineral fund and Odisha mineral bearing areas development corporation. Member of Parliament local area development funds (MPLADS) and Member of Legislative assembly local area development funds (MLADS) are also roped in for e.g.: in providing Advanced life support system ambulances. Innovation funds under NHM are considered for projects based on a defined process that is supported by Norway India Partnership which vets small scale studies and identifies suitable programs for scale up for eg: QR coding of Mother and child protection card.

Odisha is also part of the pilot of the MOHFW National financial auditing and management system (NFAMS). This new system works through a single bank account and subsidiary accounts as needed within the same bank for different centrally sponsored schemes as per the sharing pattern approved. There will be a state level account and cost centres virtual accounts created up to the Community health centre level. Primary health centres and Village health sanitation committee accounts will be physical accounts which handle about 2-3% of funds, mostly untied. The amount that can be drawn are also predetermined as per the programme implementation plan (PIP) budget and will only be

replenished once utilization happens. This avoids unnecessary parking of money and eases monitoring and reconciliation. Currently thousands of accounts are involved in the fund flow process of NHM.

The 15th finance commission recommendation (“15th Finance Commission Report Tabled, Recommends State Health Spending to Be Increased by over 8%” n.d.) for increasing state level allocation to more than 8% and funding for urban health and wellness centres and sub-district levels units to develop infrastructure is a welcome initiative. Further the Pradhan Mantri Atmanirbhar Swasth Bharat Yojana is also expected to infuse funds for health which could improve the health care at all levels which states can look forward too.

National Urban Health Mission (NUHM) Odisha

On 23rd February 2014, Hon’ble Chief Minister had launched the NUHM program at Rourkela (Orissa 2016). Since then, State had made significant efforts to improve quality of health services for urban population. The efforts included conceptualizing the new programs, developing guidelines, building new infrastructures. The NUHM fund flow is presented in Annexure-3(National Health Mission, n.d.). These efforts have potentially played a significant contribution in overall utilization of NUHM funds i.e., 85 % and 81 % in FY 2017-18 and 2018-19 respectively. Sample Registration System Bulletin May 2020 reveals that Odisha still needs to achieve the national averages for Urban health Outcome for Infant Mortality Rate, Crude death rate (“SRS Bulletin Sample Registration System Office of The Registrar General, INDIA” 2020).

Barroy Kabanika et al (Barroy et al., n.d.) framework led comprehensive study on budget planning, programs prioritization and implementation could be instrumental in bridging NUHM gaps for the state. This conceptual framework shows how strong budget formulation is linked with good health outcomes. These steps are: Strong Budget formulation, connect with program priorities, better execution, and improved health outcomes. Strong budget formulation is an outcome of good quality planning, which reflects the actual need of the population. A strong budget formulation narrows down the disconnect with priorities and ultimately leads to aligned programmatic budget appropriations. This leads to better execution, which results in improved health outcomes.

State Health Accounts Odisha

According to the state health accounts report of Odisha, total health expenditure constituted 4.58% of Gross State Domestic Product (GSDP) of which the share of public expenditure was 1.12% and rest 3.46% was private in 2013-14. Further, the distribution of health expenditure showed that the risk pooling mechanism was weak as the share of out-of-pocket expenditure (OOPE) in total health expenditure was 76%, the state and central government jointly contributed to 20.3%, whereas the share of social health insurance (both publicly funded Rashtriya Swasthya Bima Yojana (RSBY) and Employee state Insurance Scheme (ESI) constituted just 1% of total health expenditure. A further breakdown of household expenditure indicated that a majority around 58% was spent on medicine, followed by diagnostic and patient transport. The introduction of Biju Swasthya Kalyan Yojana (BSKY) which aims at providing free health care services to all citizens across government facilities and makes special provision to access services from private empanelled facilities for vulnerable population is a major stride towards reducing Out of pocket expenditure (OOPE) in the state. However, it is

premature to gauge the impact of BSKY on OOPE and over the years it may have help provide financial risk protection against hospitalisation in the state.

Incentive approach in NHM financing of states

NHM introduced the incentive mechanisms based on conditionalities framework (National Health Systems Resource Centre n.d.) of which the incremental improvement as per the NITI Aayog ranking of states on ‘Performance on Health Outcomes’ has highest weightage followed by operationalization of Health and Wellness Centres (HWCs), provisioning of mental health services in districts covered under the National Mental Health Program, Screening of 30 plus population Non-Communicable Diseases, Implementation of Human Resource Information System (HRIS) and grading of Primary Health Centres (both Urban and rural) Annexure-4.

Based on this assessment the net incentive eligibility of the states is decided. Earlier (2017) this was up to 10% of the NHM budget of the state but now the steering group of NHM has increased this amount to 20% (2018) of the resource envelope to build health competition among states and better outcomes. The net incentive for financial year 2019-20 has been computed and details of few selected states/UT are eligible for the amount are presented in the Table-1.

Table-1: State-wise incentive for the year 2018-19

State/UT	Net incentive (%)	Disbursal amount calculated (Rs. crores)
Haryana	13%	71
Assam	12%	295
Punjab	8%	62
Kerala	8%	63
Karnataka	6%	139
Tamil Nadu	4%	129
Odisha	3%	163

Odisha lost mainly in Niti Aayog ranking (-11), PHC star rating (-5) and Human resource information system (-9) parameters which could be improved to raise more resources to the state. Odisha can ensure that it makes up its score by completing the PHC star rating activity and updating the details of all the staff and their details in the portal for human resource information. States that have received higher incentives have done well in these parameters. Arunachal Pradesh, Sikkim, Meghalaya, and Nagaland were not eligible and lost nearly 20% of the funds due to the strict criteria of meeting immunization targets (at least 75%) in the year 2018-19(Team, n.d.). There needs to be some adjustments for states than to completely eliminate them from this financing.

Perspectives from the National Health Mission, MoHFW, GoI

Fund release and utilization issues: One of the critical steps for some states is also to release the matching state share which gets delayed. Further in states like Jharkhand, Uttar Pradesh, Madhya Pradesh there are issues of low absorption capacity and inadequate utilization. The main reason also is lack of organized procurement system in place. Tamil Nadu for example has even empanelled agencies for construction work also. The issues of empowered action group (EAG) states are also

different. Though centre provides 30% more to these states they are not able to spend the resources effectively.

The incentive and disincentive mechanisms were mainly brought in to increase the utilization. Every year the set of indicators are revised to get states to focus on different priority areas.

Centre has also taken efforts to reduce the line items from 2000 activities to 18 thematic areas. The idea is to make the program implementation plan process simpler and move towards data-based planning. States are also provided flexibility to reappropriate funds with communication to centre especially in special circumstances (Cloud burst in Uttarakhand, cyclones in Odisha) but many states are still reluctant to use that flexibility and reach out to centre. The 5 flexi-pools also were created to ensure untied funds could be used for specific activities. Still many vertical programs are ignored such as mental health, oral health, elderly care by states.

An unfinished agenda still is that in every state there are greater than 20 software and they are not integrated with the financial management. The pilot e-vittapravaha in Madhya Pradesh was done to integrate and provide both physical and financial progress by specific programs in real time.

National health mission has undertaken many health financings reforms to ease the implementation of programs. The introduction of Public financial management system (PFMS) was a significant step and currently a pilot for National Financial Auditing and Management System (NFAMS) is ongoing in 5 states namely Assam, Tamil Nadu, Haryana, Bihar and Odisha for 6 modules. The challenge is to roll out in all states.

Alternate Financing Structure: Case of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is a Centre and State co-sponsored scheme providing in-patient hospitalization and selected day care services to eligible beneficiaries as defined by the Socio-economic and caste census (SECC 2011) including erstwhile beneficiaries under Rashtriya Swasthya Bima Yojana (RSBY) if left out in SECC 2011. The scheme is implemented by the National Health Authority (NHA), the nodal agency. The fund sharing pattern is 60:40 in all states except North-eastern states (90:10). The centre supports 100% of the funds to the Union Territories.

The financing mechanism of AB PM-JAY is different from the NHM fund flow route and the details are represented in the Annexure-2. The states have to create an Escrow account in banks which have the necessary technology solution to handle real-time updating in the AB PM-JAY portal and submit details within 7 days of account creation to the NHA. The states will release their share first followed by the central share to the escrow account as per the defined beneficiaries, ceiling amount and the sharing pattern agreed in the Memorandum of understanding (MOU) of states with NHA.

For states implementing in insurance mode the premium as finalized following due process to be released to Insurance company within 7 days of receiving the funds as per the sharing pattern applicable to the states. If any refund of premium to insurance companies has to be done due to unspent amount as per the agreement it will be shared between state and centre in the same ratio. The funds are released to the insurance company in 3 instalments.

For states implementing in trust mode centre will release 50% of the ceiling share per beneficiary household upfront to the states after MOU is executed. The second tranche of 25% will be paid as an advance at the end of second quarter. Once 75% is utilized and utilization certificate is provided then the last tranche will be paid. The subsequent years based on the expenditure of previous year first 50% amount will be provided. Any interest earned on the funds will also be considered between state and centre in the same sharing pattern.

In addition, the administrative expenses are also paid to the states in two tranches May and October in the following manner:

Up to 1 lakh eligible beneficiaries	Rs. 200/family or one crore whichever is higher
1-10 lakh eligible beneficiaries	Rs. 150/family or two crore whichever is higher
>10 lakh eligible beneficiaries	Rs. 50/family or 15 crore whichever is higher

The administrative funds are also apportioned for specific purpose with human resources expenditure (15%), office costs (20%), Information Technology (IT) system (25%), Information education communication (25%) and contingency (15%).

The key feature of this system is it bypasses the treasury route thereby reduced time for approval processes avoiding delays in fund transfer. The second aspect is that the central share is released only after the amount from the state is released to the escrow account created for this purpose. Thus, the state share commitment is also ensured. The central share money also does not get mixed with other amounts received from the centre for different purposes. The tracking of funds spent on different head of accounts and also amount paid to the main stakeholder (public and private empanelled hospitals) is also possible on real time basis. This leads to a transparent process which is very critical in sustaining the public private partnership.

Learnings for Odisha

The review of literature and interaction with policy makers have provided few interesting perspectives which can be a learning for Odisha and others states and can be summarised as follows:

1. Timely release of funds is crucial and non-negotiable.
2. Critical human resource especially Mission directors, programme officers and district program managers from state health services having a stable tenure can enhance their skills and provide continuity in implementation, better ownership than contractual staff as district program officers.
3. Public health cadre staff to manage programs at the facility can act as a magic bullet to relieve clinical staff to perform their duties.
4. Supportive supervision and regular monitoring of the program both quantitatively, financially and qualitatively would help.
5. The state should develop planning capacity to optimise achieving its objectives by pooling all resources and financing components of the plan from the source of funding whose guidelines allow that item of expenditure.
6. Local resource mobilization with CSR initiatives can supplement delays or shortfalls of funds.
7. Enhancing health grants through local self -governments in both urban and rural settings as done by Kerala would be effective in delivery of health services.
8. Procurement system improvements would ensure smooth logistics of drugs and equipment's availability at the facilities.

9. Efforts to be made to increase the incentive amount from NHM that can be received for the state.
10. Data driven advanced planning in co-ordination with other department stakeholders could also provide support for better implementation of programs.
11. Strengthening and investing in public hospitals to cater to high morbidity burden and high mortality health conditions like cardiac care and oncology services will improve health outcomes.
12. The family health care concept of Kerala is a good example to invest resources to ensure strong primary care close to the community.

Policy & Advocacy Recommendations

Categorization of funds: We propose an approach to categorize the sub-budget items based on broader themes of applicability. The categorization will aid in making the entire budget more flexible and will assist in adopting a holistic approach towards providing equitable and greater access to healthcare for citizens.

The proposed categorization is done at three levels as mentioned below:

Level 1: Type of Healthcare under Universal Health Coverage

Level 2: Sub-budget items relating to program implementation.

Level 3: Line-item categories for categorization of sub-budget items

Level 1: Type of Healthcare under Universal Health Coverage is divided as follows:

- A. Primary Healthcare
- B. Secondary Healthcare
- C. Tertiary Healthcare

Level 2: For every type of healthcare, the sub-budget items which are directly related to the program implementation will be categorized instead of specific program wise.

Level 3: Pertaining to every type of healthcare these inputs as cross cutting categories across all activities instead for specific programs e.g., lab technician for Tuberculosis, leprosy prog etc., separately. Thus outputs/outcome-based financing can increase utilization and also accountability.

Convergence of Schemes: The sub-categorization of the above line items shall pave way for convergence of health-care schemes in order to streamline the public service delivery to the beneficiaries. There are many areas of duplication between the NHM programs (Procedures like haemodialysis, cataract, deliveries, Rashtriya Bala Swasthya Karyakram (RBSK) and AB PM-JAY schemes where deduplication is difficult and there may be double dipping of funds. Tracking of such instances is also difficult due to lack of real-time data sharing.

The high-level expert group for UHC constituted by Planning Commission in October 2011 ("High Level Expert Group Report on Universal Health Coverage for India Executive Summary Planning Commission of India Submitted to the Planning Commission of India New Delhi" 2011) gave similar recommendations, indicating that UHC can only be achieved through the allocative efficiency of existing health schemes that must converge in due course and strengthening primary health care should be of special focus. The focus on convergence of National and State health care schemes will help in reduction of the disease burden facing communities along with early disease detection and prevention, which are essential for realizing better health care access and cost outcomes. The emphasis will be on investing in primary care networks and holding providers responsible for wellness outcomes at the population level. This importance on extensive and high-quality primary care network is likely to reduce the need for secondary and tertiary facilities and the costs needed to set them up.

Learning from Best practices: Scaling up of the National financial auditing and management system (NFAMS) could also help in quick transfer and reconciliation and reduce the unspent balance under the NHM program.

States to ensure full utilization of the funds under the incentive scheme of NHM allocation and also scale up the best practices of other states to ensure maximum absorption of funds.

Conclusion

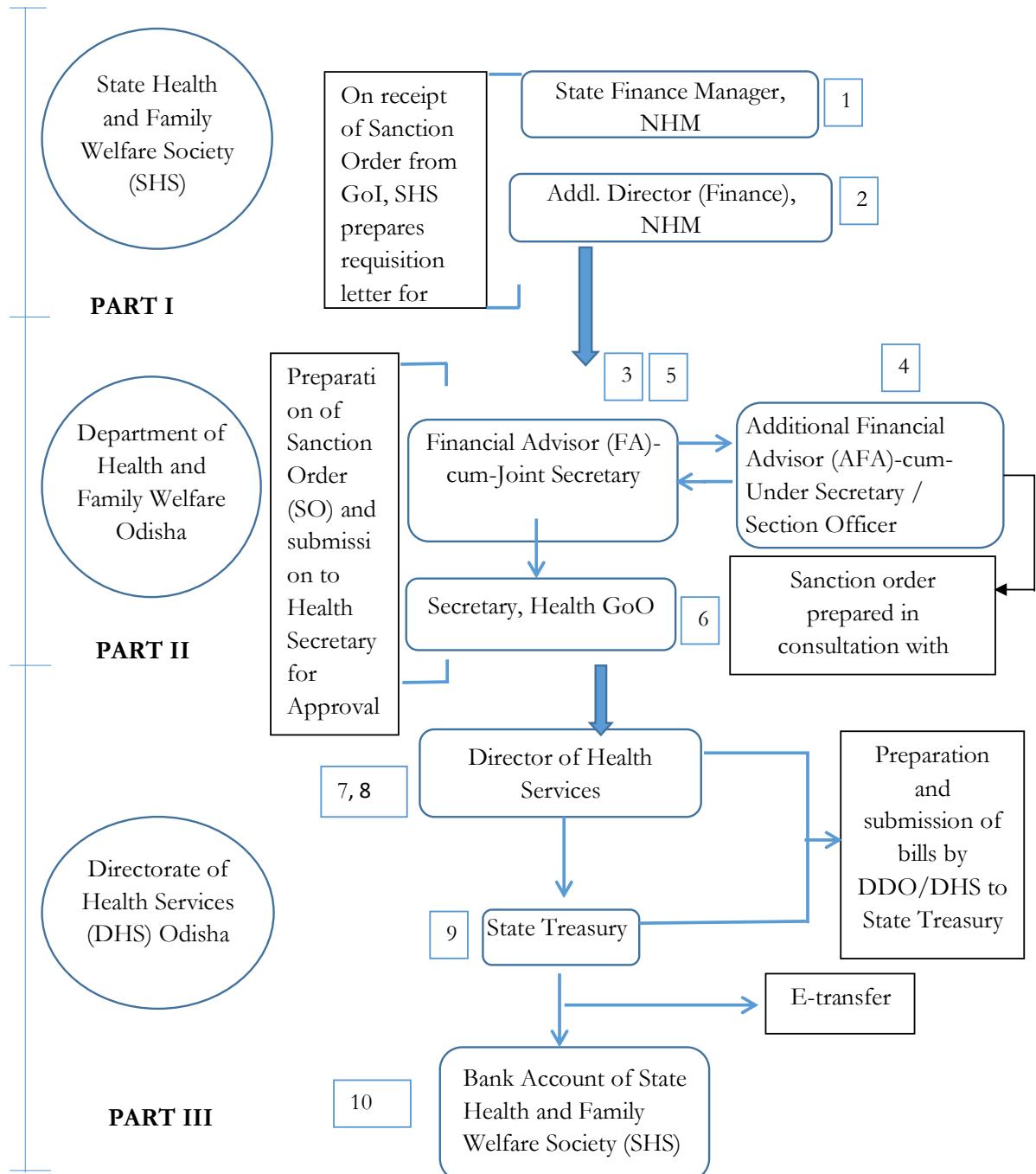
Financing is a critical lever to improve the health system. It should be made simple, easy to track, flexible to the local needs and timely to ensure its purpose is served.

Annexure-1 Delayed release of record of proceedings year-wise by NHM (Choudhury, Mohanty, and Kumar Mohanty n.d.)

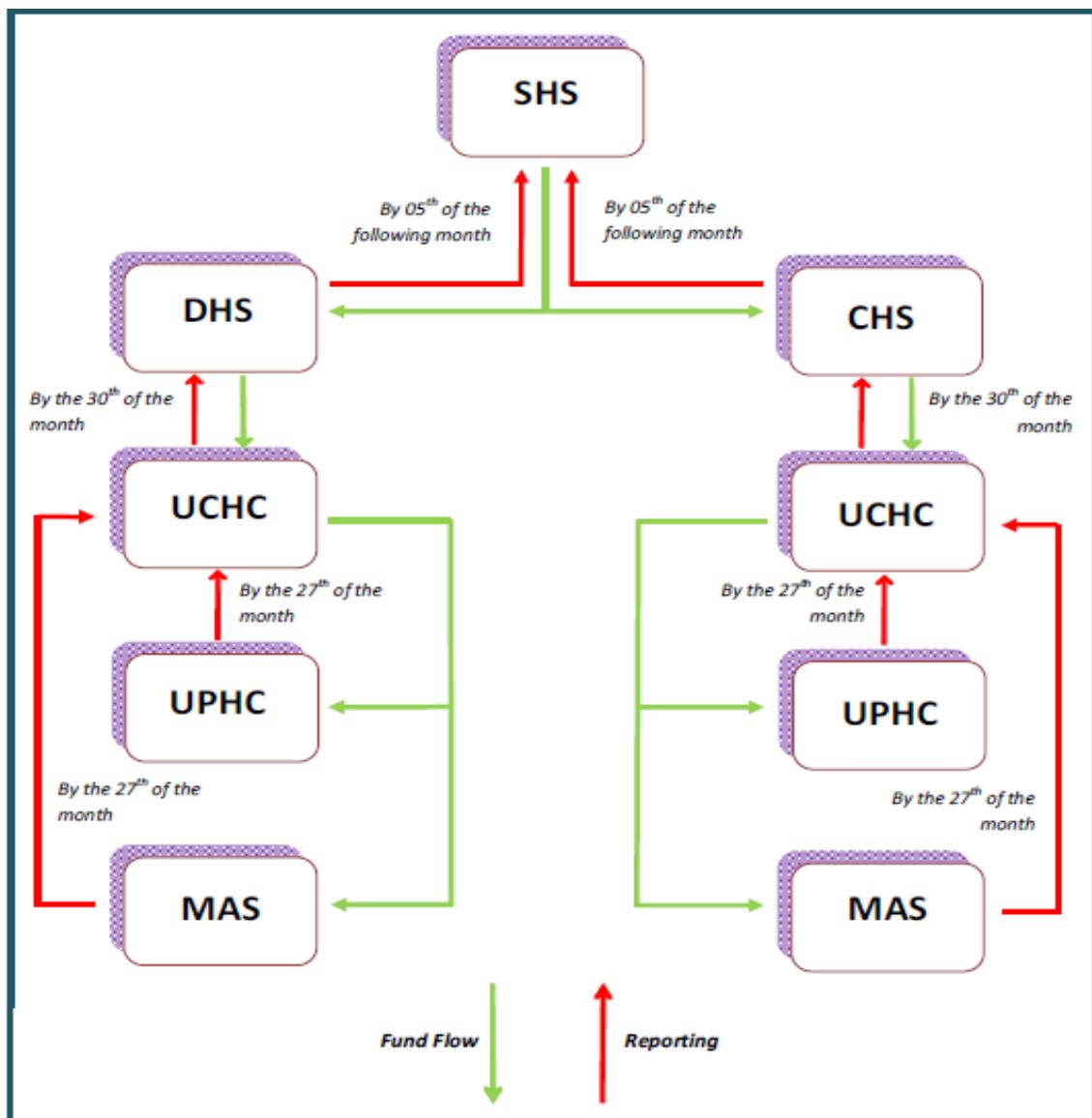
Table 3: Date of Record of Proceedings/Approval letter for NHM Budget Issued to States, 2016-17, 2017-18, 2018-19 (per cent)

Year	January	February	March	May	June	July	August	September
2016-17				Kerala	Gujarat	AP	Arunachal P.	Nagaland
				Madhya Pradesh	Himachal P	Bihar	Assam	
					Jharkhand	Chhattisgarh	Meghalaya	
				Karnataka	Goa		Mizoram	
				Maharashtra	Haryana		Telangana	
				Manipur	J & K		Tripura	
				Odisha	Rajasthan		Uttar Pradesh	
				Punjab	Sikkim		Uttarakhand	
				Tamil Nadu	West Bengal			
				Madhya P	Himachal P	AP	Arunachal P.	Nagaland
2017-18				Rajasthan	Kerala	Assam	Bihar	Sikkim
					Odisha	Chhattisgarh	Goa	Uttarakhand
				Tamil Nadu	Gujarat	J & K		
					Tripara	Haryana	Karnataka	
				Uttar Pradesh	Jharkhand	Maharashtra		
				West Bengal	Meghalaya	Manipur		
					Punjab	Mizoram		
					Telangana			
				AP	Assam	Bihar	Goa	Arunachal P.
				Kerala	Chhattisgarh	Gujarat	Karnataka	
2018-19				Manipur	J & K	Haryana	Odisha	
				Sikkim	Madhya P	Jharkhand	West Bengal	
				Tamil Nadu	Maharashtra	Meghalaya		
					Rajasthan	Punjab		
						Telangana		
						Tripura		
						Uttarakhand		

Annexure 2: NHM fund flow process in Odisha (Choudhury, Mohanty, and Kumar Mohanty n.d.)



Annexure-3. NUHM Fund Flow and Reporting-Odisha (National Health Mission, n.d.)



Note: In the absence of a UCHC, funds would be released by the CHS to the UPHC directly. The UPHC shall release the funds to MAS. The reporting structure would be just reverse of the fund flow.

Abbreviations:

- SHS- State Health Society
- DHS- District Health Society
- CHS- City Health Society
- UPHC- Urban Primary Health Centre
- UCHC- Urban Community Health Centre
- MAS- Mahila Arogya Samiti

Annexure 4- Conditionality framework for incentives 2018-19(National Health Systems Resource Centre n.d.)

Full Immunization Coverage (%) to be treated as the screening criteria and Conditionalities for 2018-19 to be assessed only for those EAG, NE and Hill states which achieved at least 75% full Immunization Coverage. For rest of the States/UTs the minimum full Immunization Coverage to be 80%.

SN	Conditionality ¹	Incentive/penalty	Source of verification	% Incentive/ Penalty ²
1.	Incentive or penalty based on NITI Aayog ranking of states on 'Performance on Health Outcomes'	<p>Based on the ranking which will measure incremental changes:</p> <ol style="list-style-type: none"> 1. The states showing overall improvement to be incentivized 2. States showing no overall increment get no penalty and no incentive 3. States showing decline in overall performance to be penalized <p>% of incentive/penalty to be in proportion to overall improvement shown by the best performing state and the worst performing state: +40 to -40 points</p>	NITI Aayog report	+40 to -40
2.	Grading of District Hospitals in terms of input and service delivery	<p>At least 75% (in Non EAG) and 60% (in EAG and NE states) of all District Hospitals to have at least 8 fully functional specialties as per IPHS: 10 points incentive</p> <p>Less than 40% in Non EAG and 30% in EAG to be penalized up to 10 points</p>	HMIS and NITI Aayog DH ranking report	+10 to -10
3.	Operationalization of Health and Wellness Centers (HWC)	<p>At least 5% of the total budget to be proposed for HWC and CPHC. State to operationalize 10% of SCs and PHCs as HWCs</p>	State report NHSRC report	+20 to -20
4.	% districts covered under Mental Health program and providing services as per framework	<p>If 75% of the districts covered:5 points</p> <p>If 50% districts in Non-EAG and 40% districts in EAG states: incentive 3 points</p> <p>Less than 40% EAG and less than 50% Non EAG to be penalized 3 points</p> <p>Less than 30% in EAG and 40% in Non EAG to be penalized 5 points</p>	Report from Mental Health Division MoHFW	+5 to -5

¹The conditionalities apply to both urban as well as rural areas/facilities

²Numbers given in the table are indicative of weights assigned. Actual budget given as incentive /penalty would depend on the final calculations and available budget. The total incentives to be distributed among the eligible states would be 20% of the total NHM budget.

SN	Conditionality¹	Incentive/penalty	Source of verification	% Incentive/ Penalty²
5.	% of 30 plus population screened for NCDs	15% of 30 plus population screened for NCDs: 5 points incentive 7% of 30 plus population screened for NCDs: 3 points incentive Less than 3% of 30 plus population screened for NCDs: 3 points penalty Less than 2% of 30 plus population screened for NCDs: 5 points penalty (Out of total State population)	Report from NCD division MoHFW and State reports Any Survey data available	+5 to -5
6.	HRIS implementation	Ensure implementation of HRIS for all HRH (both regular and contractual) in the state. Salary invoice and transfer orders to be generated by HRIS. Line listing of all staff for all facilities to be available. HRIS data should match with HMIS reporting. Cases where it doesn't, state should provide reason and numbers. +10 to -10 for HRIS operationalization and +5 to -5 for synchronization with HMIS	HRIS (State) and HMIS report	+15 to -15
7.	Grading of PHCs (both Urban and rural) based on inputs and provision of the service package agreed	75% (in Non EAG) and (60% in EAG and NE) of the PHCs having 3 or more star rating: 5 points incentive 50% (in Non EAG) and 40% (in EAG and NE) PHCs having 3 or more star rating: 2 points incentive Less than 40% (in Non EAG) and 30% (in EAG and NE) of PHCs having 3 or more star rating to be penalized: 5 points	HMIS	+5 to -5

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