Role of National Health Mission in Health Spending of States: Achievements and Issues

No. 317
24-August-2020

Mita Choudhury and Ranjan Kumar Mohanty

National Institute of Public Finance and Policy
New Delhi

Role of National Health Mission in Health Spending of States: Achievements and Issues

Mita Choudhury[1]
Ranjan Kumar Mohanty[2,3,4]

Abstract

The current phase of the National Health Mission is scheduled to end by 2021, and the next phase of the scheme is around the corner. This paper undertakes an analysis of the contributions of the scheme in health spending of States, and highlights specific factors affecting them. The analysis suggests that the scheme contributed to reduction of inequality in health spending across states and added funds to the lower tiers of the health pyramid. The contribution of the scheme was however, limited in strengthening health systems in relatively poor performing 'high-focus' states. Lack of complementary inputs in states, capacity issues and weak public financial management affected the performance of the scheme. The paper throws light on some of the issues that need attention in the next phase of the scheme.

[1] Associate Professor, National Institute of Public Finance and Policy, New Delhi
[2] Assistant Professor, National Institute of Public Finance and Policy, New Delhi
[3] We are extremely grateful to NITI Aayog for extending support to this work.
[4] We would like to thank Rashi Mittal for excellent research assistance in the study.

The National Health Mission (NHM) has been the primary instrument of the Union government for supporting State health systems in India. Initiated in 2005, the scheme brought in new initiatives by the Union government and consolidated existing ones to strengthen primary and secondary health care services across Indian States. The Central support to State-health systems was conceived to ensure that a basic set of health services is provided to the entire population: rural population in the first phase (2005-2012) and urban population (along with rural) since 2013. The scheme has been operational for nearly 15 years now, and its current phase is scheduled to end by March 2021. With the next phase of the scheme around the corner, an understanding of the contributions of the scheme and the factors affecting them assume relevance. This paper undertakes an analysis of the scheme from a financing perspective, and tries to derive an understanding on how the scheme has contributed to health expenditure in States.

The paper examines four broad dimensions of NHM contribution. First, we assess the contribution of NHM in reducing inequality in public spending on health across States. Central intervention through schemes like the NHM is primarily targeted at reducing inter-state inequalities, and to that extent reduction in inequality in health spending across States is an expected outcome. Second, we analyze the utilization of NHM funds vis-à-vis allocation across States and components, to gain insights on the actual contribution of the scheme vis-à-vis the expenditure targets. Third, we examine the components of health spending in which NHM has added funds to States' health spending. This reflects the nature of financial support provided to States and the complementary role played by NHM in financing primary and secondary care. Fourth, we highlight some of the factors that determine the nature of utilization of NHM funds and have contributed to the scheme's financing performance.

II. Financing features of NHM, the Approach and Data sources

A. Allocation, Releases and Expenditures under NHM

The resource envelope of NHM has four components: Resource support from GoI, state share of funds, and unspent balances with SHSs. The total approval by GoI out of each of these three sources every year, is used as the allocation in this analysis. It reflects all funds potentially available for expenditure on the scheme. Actual expenditures are lower than the amount released to SHSs by both the levels of governments. NHM expenditures used

in this analysis are the actual expenditures incurred for the scheme by State Health Societies (SHSs). This includes all expenses incurred by SHS out of the funds received from the Centre, States and unspent balances.

Information on state-wise NHM allocation (including unspent balances) have been compiled from the yearly Record of Proceedings (RoPs)/supplementary Record of Proceedings (RoPs) provided by the Ministry of Health and Family Welfare. State-level information on releases (both Central and state share) have also been sourced from the Ministry of Health and Family Welfare. Actual expenditures (both aggregate and quarterly) have been compiled from the Financial Management Reports (FMRs) submitted by SHSs in States.

B. Treasury vs. Non-treasury route

NHM is jointly funded by the Central and the State governments. Although in the initial years, NHM was fully funded by the Central government, the share of funds contributed by state governments has increased consistently over the years. Both the Central and the State' contribution of funds is released to State Health Societies (SHSs) for implementation of the scheme. Till 2013-14, the share of the Central government was directly credited to the bank accounts of SHSs, bypassing the treasuries of the State governments. Since 2014-15, funds are first released to state treasuries, which then release them to SHSs.

When Central funds were transferred outside the state treasury, these were not included in State budgets. Since 2014-15, with routing of Central funds through state treasuries, these transfers have been included in state budgets. We make necessary adjustments to take into account these differences, and ensure comparability of budgetary expenditures over the years.

C. Treatment of Infrastructure Maintenance

The Central government extends support to States for salaries of some regular staff at health facilities, state family welfare bureaus and health and family welfare training centers. This support is extended through funds for 'Infrastructure Maintenance' (IM) under NHM, and is treated differently from others. Funds for this component are provided to state governments on a reimbursement basis, and therefore, Central releases for this component in any financial year do not necessarily pertain to that year. Also, as salaries

of regular staff can only be disbursed through state treasuries, it is released only to State governments (not to SHSs). Expenditure on IM therefore, is not incurred by SHSs.

We exclude expenses on IM from our analysis, due to differences in accounting of expenses under IM *vis-à-vis* others. To the extent that Central support to States through IM existed even prior to NHM, its exclusion is unlikely to affect the inferences on the contribution of NHM.

D. Coverage of States and Period of Analysis

We use information from 29 States for much of the analysis. The period of analysis differs depending on the issue being analyzed. For examining the contribution of NHM in reducing inequality of health spending across States, we use information for the period 2012-13 to 2017-18. To analyze utilization of funds and the contribution of different components under NHM we use information between 2015-16, 2016-17 and 2017-18. Health expenditure by state governments have been compiled from *Finance Accounts* published by the Comptroller and Auditor General of India (CAG) for each state over the years.

All funds related to NRHM-RCH Flexible pool, Flexible pool for communicable and non-communicable diseases and National Urban Health Mission have been included in the analysis.

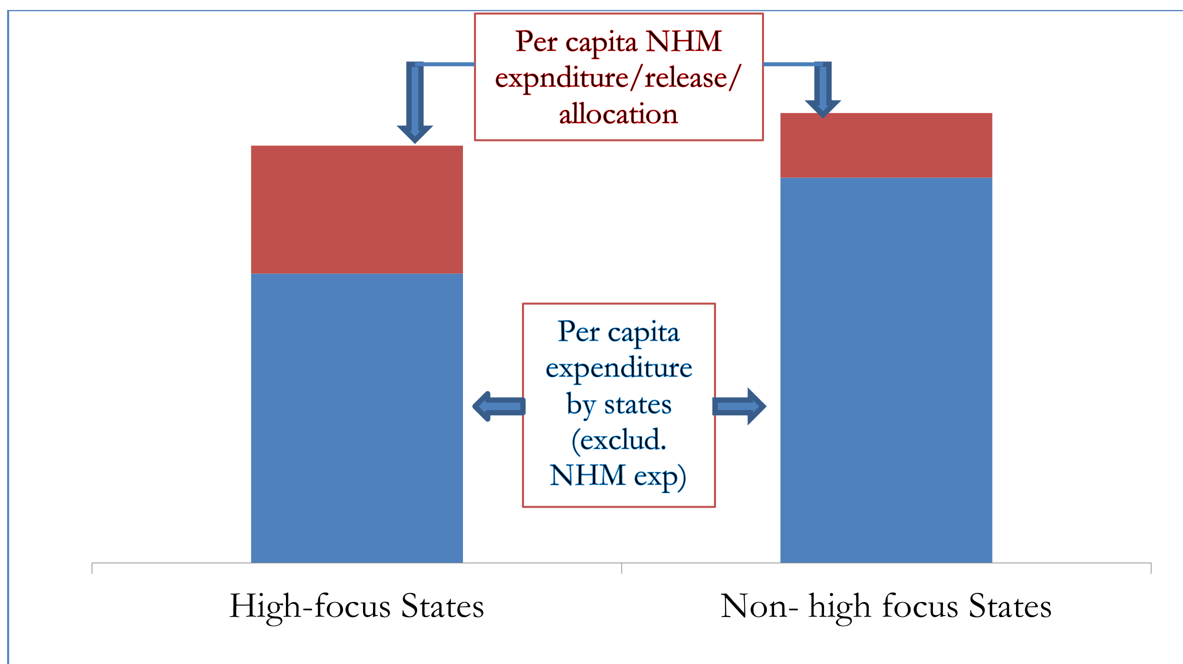
III. Inequality in Health Spending Across States

NHM laid a special focus on 18 States with weak public health indicators and/or health infrastructure, which is indicative of the fact that reduction in inequality of health achievements across States was an intended outcome. Many of the States with weak health indicators ('high-focus' States) were also the poor States of the country, and had low levels of public spending on health. Fund allocation formulae under NHM therefore, assigned a higher weightage to these high-focus States with a view to increase public spending and address the issue of inequality in public spending.

To understand the extent of reduction in inequality of public spending across States, we examine three questions. First, how much was added by NHM in per capita terms in *high focus* vis-à-vis *non-high focus* States. A relatively high contribution in non-high focus states should translate into a reduction in inter-state inequality in public spending on health. Second, we examine to what extent the variation in per capita health

spending across States (measured by the coefficient of variation) reduced with the addition of NHM funds? In addition, we compare the actual achievements in inequality reduction *vis-a-vis* what the scheme was potentially aiming for through the allocation and the releases. A pictorial depiction of the approach for measuring addition through NHM funds is shown in Fig 1.

Figure 1: Pictorial depiction of the approach to measuring addition of NHM funds



We examine the issue in two stages. First, we examine the per capita NHM releases by the Central government alone over and above the total health expenditure incurred by States in *high focus* and *non-high focus* states. This broadly corresponds to the 'equalization principle' discussed by earlier Finance Commissions (e.g. 12th Finance Commission) and other studies, which states that Central transfers should be aimed at reducing inequality in health spending across states. It is notable that total health expenditure by states here is inclusive of state share towards NHM. In the second stage, we examine how the central and state shares together, have added to per capita health spending in the two groups of states. The former provides an understanding of the role of the Central government in reducing expenditure inequality across States through NHM, while the latter highlights the holistic contribution of NHM (Centre and states combined) in reducing inequality in health expenditure across states.

NHM releases by the Central government have contributed to reduction in differences in per capita health spending across states. On average, between 2012-13 and 2017-18, the Central government released Rs. 80 per capita (at current prices) in *non-*

high focus states *vis-à-vis* Rs. 101 per capita in *high-focus non-NE* (hereafter *high focus*) states (Figure 2). In terms of actual expenditure, the additions were Rs. 92 and Rs. 73 per capita respectively (Figure 3)[5]. Notably, in *high-focus NE* states, per capita NHM releases and expenditures were about 3 to 4 times higher than others (Figure 3).

Central releases were more important for poor performing *high-focus* states than others at the margin (Figure 3). This is indicated by the fact that releases from the Central government accounted for a significantly high share of total health spending in these states as compared to others (15 versus 9 per cent) (Figure 3). In terms of expenditure, the share was 14 per cent in *high-focus* states as opposed to 8 per cent in *non-high focus* states (Figure 3).

Together, with Centre and state contributions, the scheme was able to reduce inequality in per capita health spending across States substantially (Figure 4). Between 2015-16 and 2017-18, if one excludes NHM expenses, the coefficient of variation (CV) in per capita health spending across states (at current prices) turned out about 0.82.[6] With NHM expenditures, the coefficient of variation reduced to 0.71, which indicated a significant reduction in inequality in health spending across states (Figure 4). In per capita terms, the difference between per capita health spending in *high-focus* and *non-high-focus* states reduced from Rs. 314 per capita to Rs. 282 per capita (Figure 4).

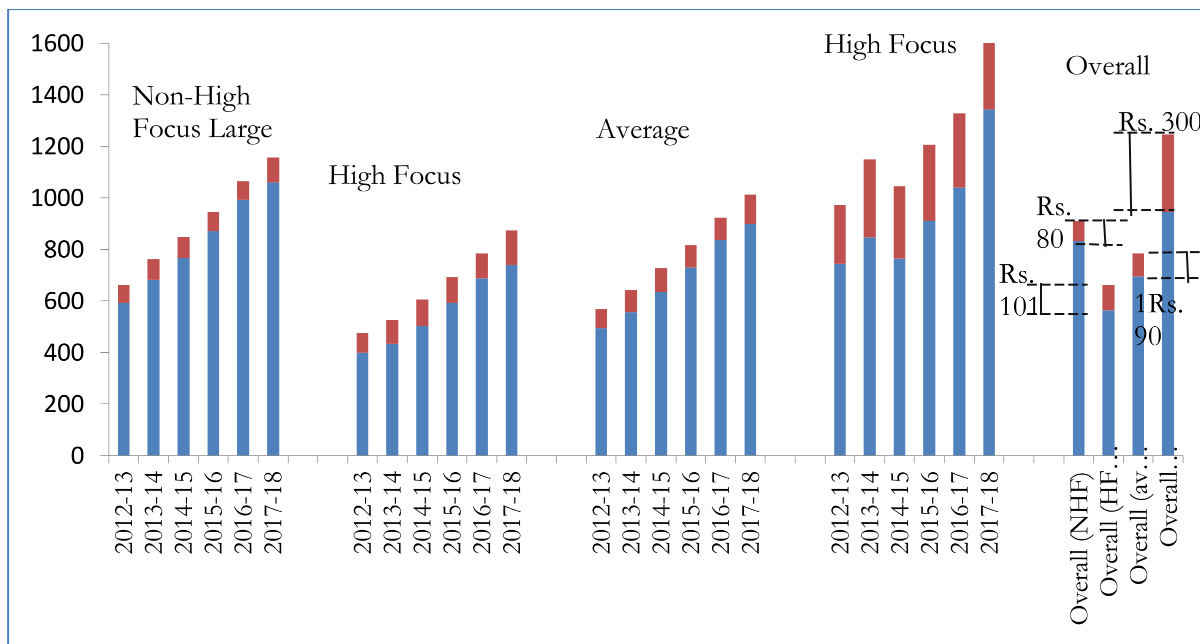
The reduction in inequality could have been substantially higher if SHSs could utilize all NHM releases; and even more, if the entire allocation was utilized. The scheme had the potential to reduce coefficient of variation in per capita public spending on health across States from 0.82 to 0.67. In practice, it could reduce the CV only to 0.71 as the entire NHM allocation could not be utilized (Figure 4).

---

[5] Assuming actual expenditures by the center is in proportion to its share of release.

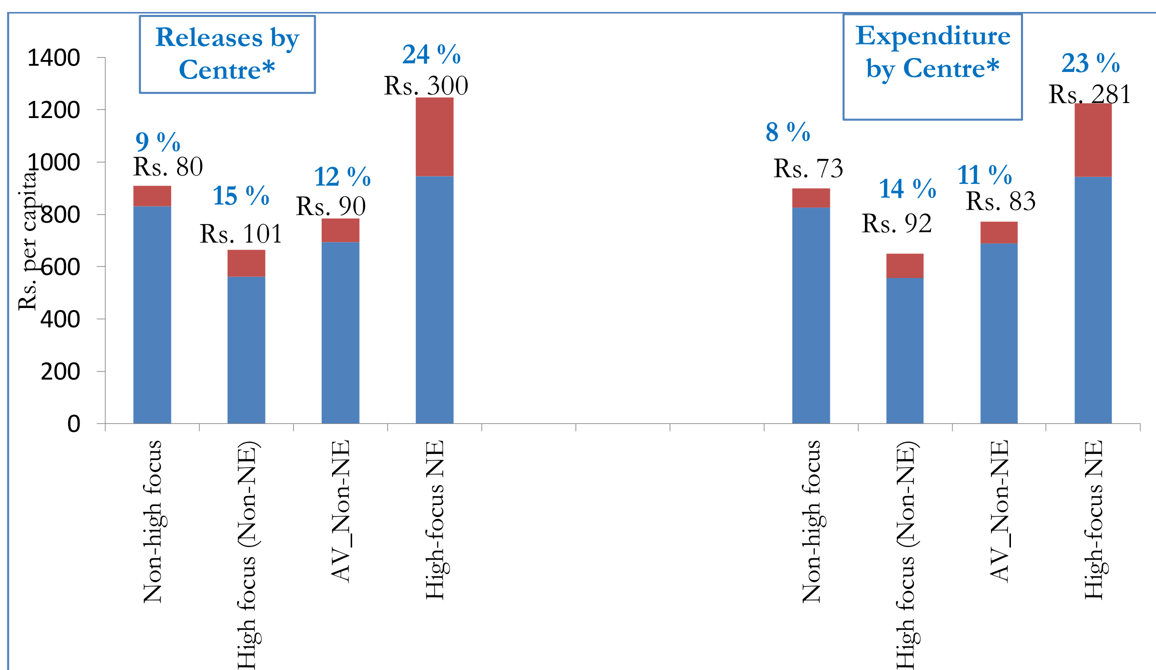
[6] This pertains only to high-focus and non-high focus states excluding NE.

Figure 2: Average per capita NHM Releases by Central government over state spending, 2012-13 to 2017-18 at current prices (Rs. Per capita)



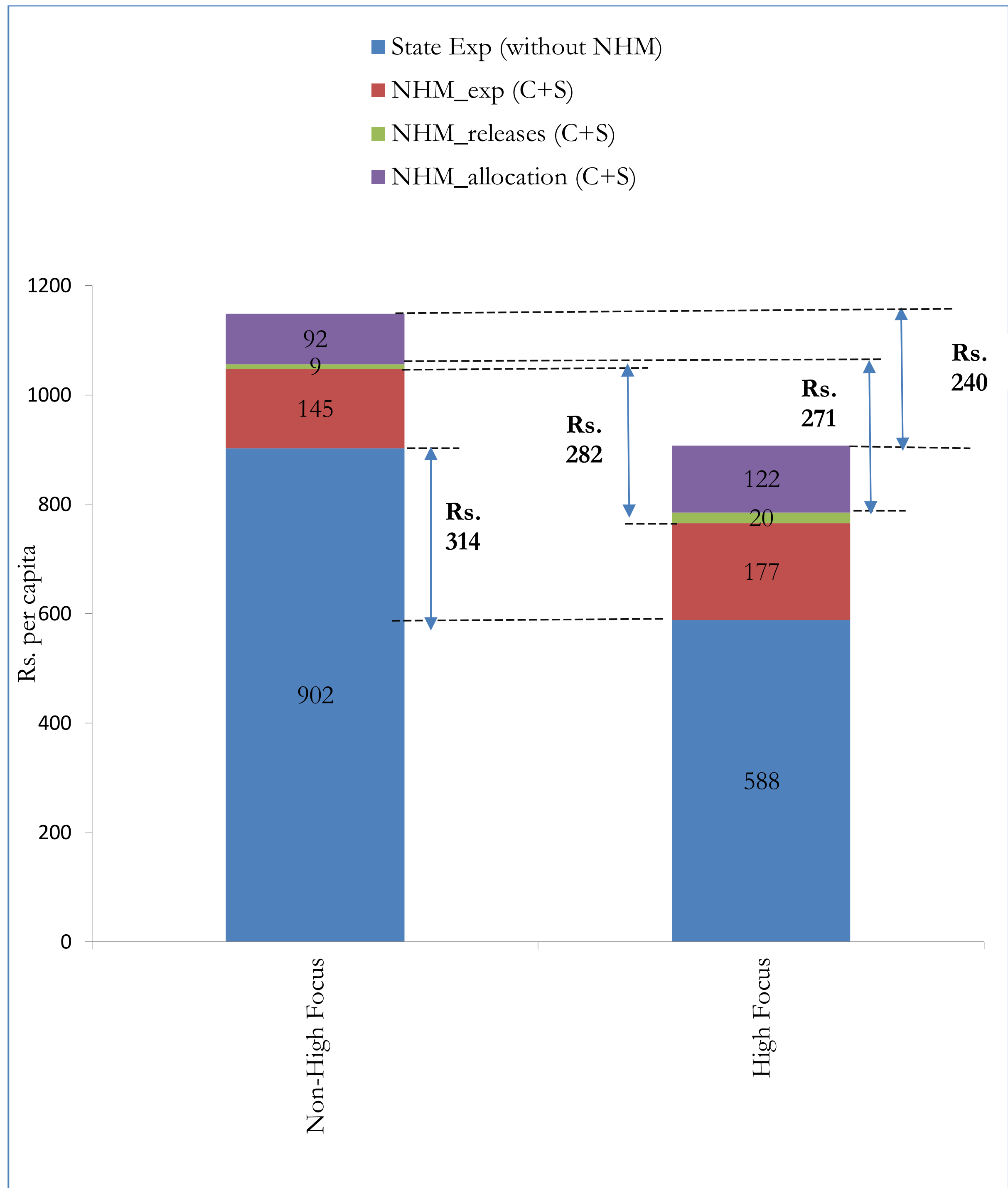
Note: State spending includes state share released towards NHM

Figure 3: Average per capita NHM Releases and Expenditure (Rs.) by Central government over state spending and share in total (per cent), 2012-13 to 2017-18 at current prices (Rs. Per capita)



Note: *Expenditure by Centre has been calculated by spitting total NHM expenditure in proportion of releases by states and Centre in the given period. Percentage figures indicate share in total expenses. State spending includes state share in the form of releases or actual spending on NHM.

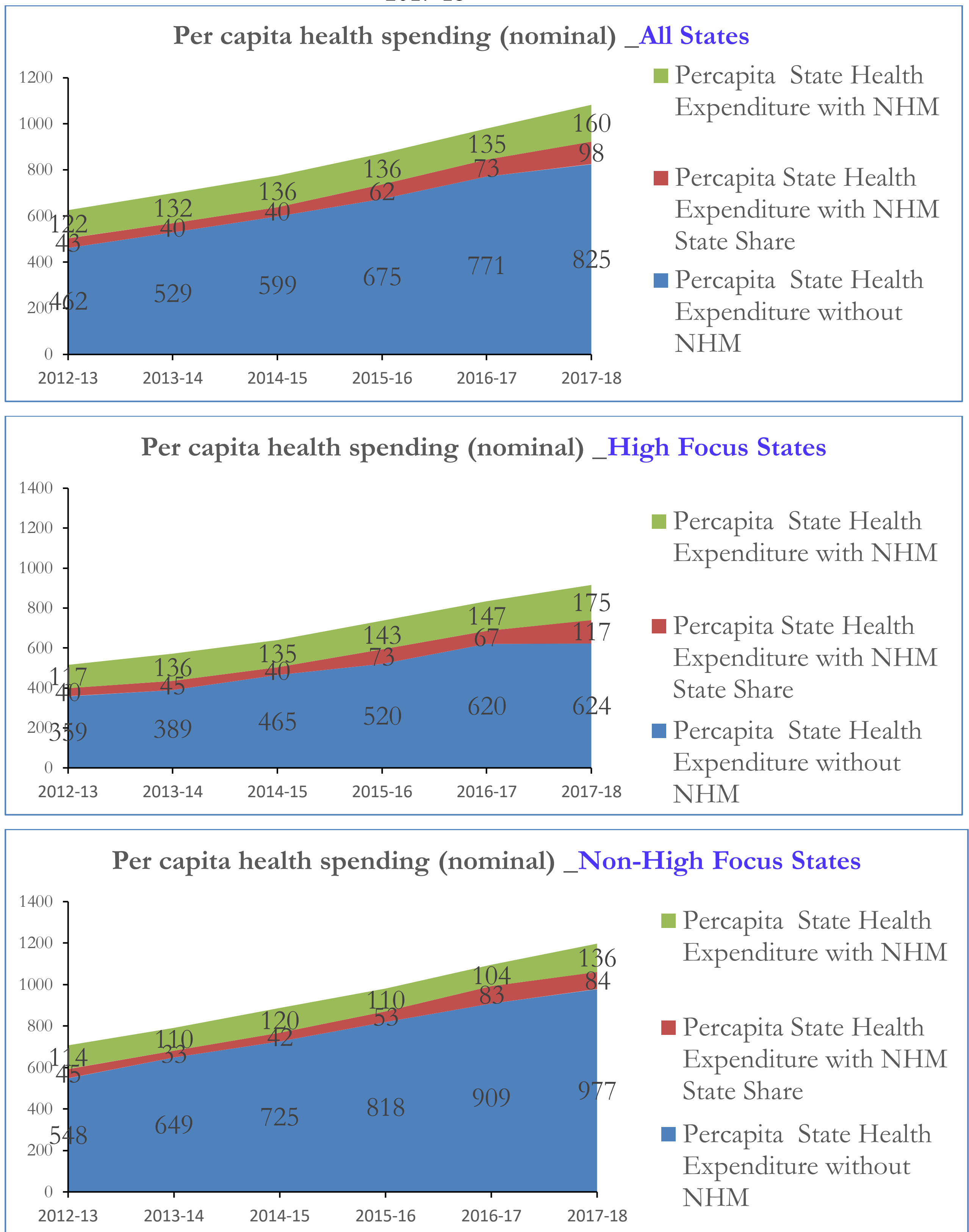
Figure 4: Average per capita NHM Allocation, Release and Expenditure by Central government over state spending, between 2015-16 and 2017-18 at current prices



Coefficient of Variation

State Expenditures (without NHM): **0.82**
State Expenditures + NHM Expenditures: **0.71**
State Expenditures + NHM Releases: **0.70**
State Expenditures + NHM Allocation: **0.67**

Figure 5: Per capita health spending across different categories of states, 2012-13 to 2017-18



IV. Utilization of NHM funds

Utilization of funds under NHM has been low. On average only about 58-59 per cent of funds allocated to states were utilized in 2017-18 and 2018-19 (Table 1).[7] The low utilization levels are also mirrored in high unspent balances in SHSs. A report published by CAG in 2017 indicated that the volume of unspent balances in 27 states in 2015-16, was of the order of Rs. 9509 Crore. As these unspent balances have remained out of funds released from state and central budgets, they are recorded as expenditures in government budgets, but remain unspent by SHSs.

The utilization levels were marginally lower in the group of states with poor health achievements (*high-focus* states) than relatively better ones (*non-high focus* states) (Table 1). However, there was marked variation in utilization even among the high-focus states (Table 1). On one hand, there were states like Bihar and Uttar Pradesh whose utilization levels have been consistently on the lower side, there are states like Madhya Pradesh and Odisha which have performed remarkably well in terms of utilization (Table 1). Even among the *non-high focus* states there is significant variation. While states like Tamil Nadu and Gujarat had utilization levels of around 80 per cent, there were states like Maharashtra, whose utilization was among the worst in the country (Table 1).[8]

States could utilize funds for reproductive and child health services (RCH flexible pool) much more than others (Table 1). Funds for strengthening health systems could be utilized to a lesser extent, particularly by *high-focus* states (Table 1) Many of the HF states had weaker health systems (poor HR and other infrastructure issues), which posed hurdles to absorption of funds in Mission flexible pool. These States also had poor governance and capacity issues, which affected utilization. A substantial part of RCH pool was in the form of direct fund transfers, which were less prone to problems of capacity and issues of health systems. Among flexible pool for disease control programs, utilization for non-communicable diseases was significantly lower than funds for communicable diseases (Table 1). However, on average, as 85-90 per cent of NHM allocation related to RCH and Mission flexipool, the overall utilization was driven by these components.

---

[7] Utilization of some of the earlier years was also around the same level (Choudhury and Mohanty 2019).

[8] It may be noted that the reduction in inequality in per capita health spending across states through NHM would have been higher if utilization of funds in *high-focus states* was better. As *high-focus* states had lower utilization than *non-high focus states*, the actual reduction in inequality was lower than the scheme's potential.

In both the RCH and Mission Flexi-pool, utilization was low in components which required more complex processes in execution such as procurement of drugs and equipment, new constructions, new initiatives, strategic interventions. Less complex components from the perspective of execution, such as direct transfers under maternal health, salary payments to ASHAs and program management expenses, were utilized more. Capacity issues are also reflected in the fact that utilization was particularly low in funds for components like new innovations and strategic interventions.

Utilization was also skewed across different quarters of the financial years. On average, about 40 per cent of total utilization in states happened in the last quarter of the financial year (Table 2). The first quarter was particularly bleak in terms of utilization, with less than 15 per cent of funds utilized (Table 2). The disproportionate loading of expenditure and utilization in the last quarter may have implications for the effectiveness with which funds are utilized. The skewness of utilization within the financial year is partly driven by the nature of approval and release process, which we discuss in the next section.

Working Paper No. 317

Table 1: Overall and component-wise utilization ratios under the National Health Mission, 2017-18 and 2018-19 (per cent)

States	2017-18							2018-19						
	High-focus States (Other than North East)							High-focus States (Other than North East)						
	Over all	Part I (Tot)	RCH	MFP	CD (Part II)	NCD (Part III)	NUHM (Part IV)	Over all	Part I (Tot)	RCH	MFP	CD (Part II)	NCD (Part III)	NUHM (Part IV)
Bihar	45	46	63	34	41	25	30	39	41	61	30	20	28	26
Chhattisgarh	65	66	74	63	56	44	65	52	53	80	45	51	37	58
Himachal Pr	60	64	80	60	48	11	12	71	71	66	73	87	25	53
J & K	54	55	61	53	46	42	43	66	67	69	66	43	49	67
Jharkhand	52	53	68	46	64	32	31	67	71	71	71	44	18	38
Madhya Pr	77	78	90	71	83	83	54	67	69	80	63	40	70	34
Odisha	67	68	84	61	63	23	85	65	66	84	60	53	27	81
Rajasthan	53	54	68	47	68	49	50	63	64	67	62	34	57	59
Uttar Pr	53	53	64	49	52	37	62	47	46	65	41	55	45	64
Uttarakhand	68	66	94	54	85	96	104	70	71	82	68	69	31	72
Average	**57**	**57**	**70**	**51**	**56**	**39**	**58**	**53**	**54**	**69**	**49**	**44**	**40**	**59**
	Non-high Focus Large States							Non-high Focus Large States						
Andhra Pr	69	68	57	72	69	78	69	70	70	86	65	67	86	74
GOA	38	40	27	44	31	19	48	43	47	43	49	14	45	42
Gujarat	78	78	80	76	86	71	76	79	77	86	72	92	71	93
Haryana	67	67	74	65	77	41	74	70	71	70	72	68	27	68
Karnataka	57	57	63	56	67	46	61	58	57	70	54	75	70	66
Kerala	76	77	68	81	74	75	70	69	68	97	62	82	50	74
Maharashtra	40	41	55	37	67	31	27	53	57	78	52	59	33	31
Punjab	57	56	69	54	52	14	85	54	55	77	51	25	42	62
Tamil Nadu	86	88	84	89	89	76	73	91	90	91	90	76	124	99
Telangana	42	42	30	48	35	44	45	48	47	44	48	53	43	61
West Bengal	72	77	77	77	47	20	63	76	82	83	82	42	18	68
Average	**61**	**62**	**65**	**61**	**66**	**46**	**56**	**66**	**67**	**78**	**64**	**63**	**57**	**62**

Working Paper No. 317

	High Focus North Eastern States							High Focus North Eastern States						
Arunachal Pr	42	41	34	44	67	23	82	58	57	70	53	69	67	96
Assam	61	63	67	61	42	28	61	71	73	79	71	50	28	68
Manipur	30	32	36	31	44	4	11	48	46	45	47	35	149	39
Meghalaya	58	63	42	74	34	17	44	52	52	46	54	61	34	71
Mizoram	44	49	44	50	24	21	45	81	78	69	81	134	60	113
Nagaland	30	30	32	29	32	13	42	54	57	59	57	52	27	41
Sikkim	52	51	37	55	69	43	67	54	56	38	62	38	48	54
Tripura	50	50	62	47	60	37	52	64	65	74	62	48	51	77
Average	53	55	53	55	43	22	51	65	66	68	65	55	43	66
All States	**58**	**59**	**67**	**56**	**58**	**40**	**57**	**59**	**60**	**72**	**55**	**52**	**48**	**61**

Source: Actual Expenditures have been compiled from the FMR of States. Data on the total budget have been compiled from the RoPs/supplementary RoPs and FMR of States. The total budget includes both committed and uncommitted unspent balances in each year and the resources expected from both the Union and State Governments for the scheme. Utilization is calculated as actual expenditure as a percentage of the total budget in the respective parts. *Note*: RCH - Flexible Pool for Reproductive and Child Health; MFP - Mission Flexible Pool; CD - Flexible Pool for Communicable Diseases; NCD - Flexible Pool for Non-Communicable Diseases, and NUHM - Flexible Pool for National Urban Health Mission. As FMRs do not include information on expenditures under 'Infrastructure Maintenance' (IM), these were excluded from the above analysis.

Table 2: Cumulative expenditure in each quarter under the National Health Mission, 2016-17 to 2018-19 (per cent)

States	Expend. between Apr-Jun (Q1)			Cum expend at the end of Sept. (Q2)			Cum expend at the end of Dec (Q3)			Cum expend at the end of Mar (Q4)		
	2016-17	2017-18	2018-19	2016-17	2017-18	2018-19	2016-17	2017-18	2018-19	2016-17	2017-18	2018-19
	High-Focus States (Other than North-East)											
Bihar	9	9	10	29	23	28	44	43	53	100	100	100
Chhattisgarh	19	11	14	39	38	39	64	50	65	100	100	100
Himachal Pr	9	9	12	44	26	48	62	58	67	100	100	100
J & K	14	12	16	35	36	37	60	66	67	100	100	100
Jharkhand	16	13	12	41	31	23	61	53	44	100	100	100
Madhya Pr	8	11	0	33	32	24	58	61	56	100	100	100
Odisha	9	12	12	35	35	29	61	61	53	100	100	100
Rajasthan	14	16	0	37	38	35	63	69	63	100	100	100
Uttar Pr	12	10	0	35	28	33	58	52	57	100	100	100

Working Paper No. 317

Uttarakhand	13	7	13	28	18	31	56	21	64	100	100	100
Average	**12**	**11**	**5**	**35**	**31**	**31**	**58**	**55**	**57**	**100**	**100**	**100**
	Non-high focus Large States											
Andhra Pr	11	19	17	32	40	48	58	70	71	100	100	100
GOA	16	19	17	40	44	38	66	64	57	100	100	100
Gujarat	11	11	0	31	30	30	55	60	57	100	100	100
Haryana	15	17	14	39	40	35	61	65	68	100	100	100
Karnataka	11	7	12	36	25	37	61	57	57	100	100	100
Kerala	14	14	11	33	33	38	64	63	65	100	100	100
Maharashtra	7	10	7	26	31	25	59	63	49	100	100	100
Punjab	17	15	0	37	31	39	62	53	62	100	100	100
Tamil Nadu	7	15	14	40	46	37	69	64	64	100	100	100
Telangana	13	7	24	29	41	46	52	66	70	100	100	100
West Bengal	15	14	19	37	32	48	59	46	68	100	100	100
Average	**11**	**13**	**12**	**34**	**35**	**37**	**60**	**60**	**62**	**100**	**100**	**100**
	High Focus North Eastern States											
Arunachal Pr	6	9	11	19	28	40	34	49	49	100	100	100
Assam	10	8	12	30	29	33	58	48	60	100	100	100
Manipur	18	14	16	47	34	27	68	64	57	100	100	100
Meghalaya	13	21	13	30	23	27	72	77	53	100	100	100
Mizoram	17	11	15	37	26	26	56	57	52	100	100	100
Nagaland	13	24	14	30	51	33	61	79	54	100	100	100
Sikkim	17	15	15	40	38	29	51	64	55	100	100	100
Tripura	14	11	11	28	33	26	61	59	54	100	100	100
Average	**11**	**10**	**12**	**30**	**30**	**32**	**57**	**54**	**57**	**100**	**100**	**100**
All States	**12**	**12**	**8**	**34**	**32**	**34**	**59**	**57**	**59**	**100**	**100**	**100**

Source: Financial Management Reports (FMRs) of respective States

Working Paper No. 317

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		
2017-18				Madhya P	Himachal P	AP	Arunachal P.	Nagaland
				Rajasthan	Kerala	Assam	Bihar	Sikkim
					Odisha	Chhattisgarh	Goa	Uttarakhand
					Tamil Nadu	Gujarat	J & K	
					Tripura	Haryana	Karnataka	
					Uttar Pradesh	Jharkhand	Maharashtra	
					West Bengal	Meghalaya	Manipur	
						Punjab	Mizoram	
						Telangana		
2018-19				AP	Assam	Bihar	Goa	Arunachal P.
				Kerala	Chhattisgarh	Gujarat	Karnataka	
				Manipur	J & K	Haryana	Odisha	
				Sikkim	Madhya P	Jharkhand	West Bengal	
				Tamil Nadu	Maharashtra	Meghalaya		
					Rajasthan	Punjab		
						Telangana		
						Tripura		
						Uttarakhand		

Working Paper No. 317

	AP	Bihar	Arunachal P.			Tripura		
2019-20	Rajasthan	Gujarat	Assam					
	Tamil Nadu	Haryana	Chhattisgarh					
		J & K	Goa					
		Karnataka	Himachal P					
		Kerala	Jharkhand					
		MP	Meghalaya					
		Maharashtra	Mizoram					
		Manipur	Nagaland					
		Odisha	Punjab					
			Sikkim					
			Telangana					
			Uttar Pradesh					
			Uttarakhand					
			West Bengal					

V. Factors Affecting Utilization of NHM Funds

Utilization of NHM funds was adversely affected by several factors. First, there were institutional weaknesses in the fund flow architecture of NHM, which led to substantial delays in flow of funds to SHSs. At the Central level, there were delays in approval of NHM budgets for various states. Till 2018-19, NHM budgets for most states were approved only towards, or after the end of the first quarter of the financial year (Table 3). This resulted in a situation where the release of first installment of NHM funds to most States was initiated only after the first quarter of the Financial year (FY). This is mirrored in the fact that only around 12 per cent of NHM expenditure incurred by States was booked in the first quarter of the FY (Table 2). In many cases, even after approval, there was delay in the release of first installment, as releases were conditional on submission of documents like utilization certificates, audit reports, etc. For example, in U.P., in 2017-18, although the NHM budget was approved in the first week of June, the sanction order for the release of first instalment of NHM funds was issued only in October, after nearly half the FY was over (Table 3, Appendix Table A4).

The delay in approval of NHM budget of states by the Central government however, seems to have remarkably reduced in 2019-20 (Table 3). NHM budget of all states in the year was approved by March 2019. This has been a significant step forward in improving timeliness of fund flows.

At the state-level also, there are substantial delays in release of funds from the state treasury to SHSs. The delays were relatively less in states with better utilization levels. In Gujarat, in 2017-18, nearly a quarter of the funds were credited to SHS in less than a month's time, and about 80 per cent in less than 2 months (Table 4). In 2018-19, the delay was even less: about 60 per cent credited in less than a month, and the remaining in about 1.5 months (Table 4). The relatively less delay ensured that most of the funds were credited by the end of the third quarter of the FY (Appendix Table A1, Table A2).

Table 4*: Number of days taken to credit Central Share in SHS account of Gujarat

	Between issue of SO by GoI and receipt of funds in the State treasury			Between receipt of funds in State treasury and credit to SHS Account		
Number of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
2017-18						
0-7	446.33	69.53	4	-	-	-
8-15	76.19	11.87	13	6.34	0.99	14
16-30	119.41	18.60	20	152.26	23.72	26
31-90	-	-	-	403.62	62.88	56
90+	-	-	-	79.71	12.42	99
Total	**641.93**	**100**	**-**	**641.93**	**100**	**-**
2018-19						
0-7	568.86	98.26	3	-	-	-
8-15	10.08	1.74	11	15.15	2.62	14
16-30	-	-	-	339.91	58.71	23
31-90	-	-	-	223.88	38.67	44
90+	-	-	-	-	-	-
Total	**578.94**	**100**	**-**	**578.94**	**100**	**-**

Source: State Health Society (SHS) Gujarat, and Finance Department, Government of Gujarat.
Note: Relates only to funds which were credited to SHS within the financial year.

In Odisha, most of the funds were credited in less than a month's time in 2017-18 (Table 5).[9] In 2018-19, although the time taken in Odisha to release funds from state treasury was relatively high, it was an unusual year, and needs to be treated with caution.10 Due to relatively quick releases of funds three-fourths of the funds received by SHS in Odisha was credited to the account of SHS by the end of the third quarter of the financial year (Appendix Table A3).

[9] In 2015-16 and 2016-17 too, funds were credited to SHS in less than a month's time (Choudhury and Mohanty 2019)

[10] There were temporary hitches due to the process of transition from manual to online modes of payment.

***Table 5*: Number of days taken to credit Central Share in SHS account of Odisha**

	Between issue of SO by GoI and receipt of funds in the State treasury			Between receipt of funds in State treasury and credit to SHS Account**		
Number of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
			2017-18			
0-7	546.73	85.89	3	1.69	0.27	4
8-15	89.85	14.11	12	126.59	19.89	11
16-30	-	-	-	477.97	75.08	23
31-90	-	-	-	30.33	4.76	39
90+	-	-	-	-	-	-
Total	**636.58**	**100**	**-**	**636.58**	**100**	**-**
			2018-19			
0-7	306.19	47.57	2	1.55	0.24	6
8-15	337.44	52.43	9	12.42	1.93	11
16-30	-	-	-	374.58	58.20	24
31-90	-	-	-	187.52	29.13	58
90+	-	-	-	67.56	10.50	113
Total	**643.63**	**100**	**-**	**643.63**	**100**	**-**

Source: State Health Society (SHS) Odisha and Finance Department, Government of Odisha
* Note: Relates only to funds which were credited to SHS within the financial year.

In the three states with low utilization: U.P, Maharashtra and Bihar, the time taken to release funds from state treasury to SHSs was remarkably high. In U.P., nearly two-thirds of the funds credited to SHS were done with a lag of more than 3 months in 2017-18 (Table 6). In 2018-19, although the delays were relatively less, the average time taken to credit funds to SHS was more than 2 months (Table 6). In Bihar, on average, it took more than 3 months to credit funds to SHS by the state treasury (Table 7). In 2018-19, the delay was so high that funds were credited only in February and March, the last two months of the financial year (Table 7, Appendix Table A5). Even in Maharashtra, a relatively better performing non-high focus state, it took about 2 to 2.5 months to credit funds to SHS from state treasury (Table 8). Bulk of this delay is due to complex administrative processes associated with release of funds from the state treasuries of the three states. In Bihar, U.P. and Maharashtra, the paper file for release has to pass through a minimum of 32, 38 and 25 desks respectively. In Gujarat and Odisha, it was about 10-16 desks (Appendix Figure A1, Figure A2 and Figure A3, Figure A4 and Figure A5).

***Table 6*: Number of days taken to credit Central Share in SHS account of Uttar Pradesh**

	Between issue of SO by GoI and receipt of funds in the State treasury			Between receipt of funds in State treasury and credit to SHS Account		
Number of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
			2017-18			
0-7	810.62	45.90	4	156.52	-	1
8-15	-	-	13	-	-	-
16-30	955.58	54.10	20	157.05	8.89	22
31-90	-	-	-	297.38	16.84	83
90-180	-	-	-	1155.25	65.41	113
Total	**1766.20**	**100**	**-**	**1766.20**	**100**	**-**
			2018-19			
0-7	1624.98	100	1	-	-	-
8-15	0.01	0	12	-	-	-
16-30	-	-	-	-	-	-
31-90	-	-	-	1319.98	81.23	65
90-180	-	-	-	305.01	18.77	113
Total	**1624.99**	**100**	**-**	**1624.99**	**100**	**-**

Source: State Health Society (SHS) Uttar Pradesh and Finance Department, Government of Uttar Pradesh

***Table 7*: Number of days taken to credit Central Share in SHS account of Bihar**

	Between issue of SO by GoI and receipt of funds in State treasury			Between receipt of funds in State treasury and credit to SHS Account		
Number of days	Amount credited (Rs Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs Crore)	Distribution (per cent)	Average no. of days
			2017-18			
0-7	591.87	100.00	3	-	-	-
8-90	-	-	-	-	-	-
90-180	-	-	-	591.87	100.00	123
Total	**591.87**	**100**	**-**	**591.87**	**100**	**-**
			2018-19			
0-7	801.6	100.00	2	-	-	-
8-90	-	-	-		-	-
90-180	-	-	-	431.58	53.84	171
180+				370.02	46.16	189
Total	**801.6**	**100**	**-**	**801.6**	**100**	**-**

Source: State Health Society (SHS) Bihar and Finance Department, Government of Bihar

***Table 8*: Number of days taken to credit Central Share in SHS account of Maharashtra**

	Between issue of SO by GoI and receipt of funds in the State treasury			Between receipt of funds in State treasury and credit to SHS Account		
Number of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
2017-18						
0-7	306.15	52.87	4	-	-	-
8-15	-	-	-	-	-	-
16-30	272.87	47.13	19	-	-	-
31-90	-	-	-	524.01	90.50	53
90+	-	-	-	55.01	9.50	106
Total	**579.02**	**100**	**-**	**579.02**	**100**	**-**
2018-19						
0-7	744.67	100.00	2	-	-	-
8-15	-	-	-	-	-	-
16-30	-	-	-	-	-	-
31-90	-	-	-	513.02	68.89	76
90-180	-	-	-	114	15.31	121
180+				117.65	15.80	210
Total	**744.67**	**100**	**-**	**744.67**	**100**	**-**

Source: State Health Society (SHS) Maharashtra and Finance Department, Government of Maharashtra

The existence of SHS outside the administrative boundary of the State Governments has added complexities. Being outside the State administration, NHM funds can be released to SHS only in the form of Grants-in-aid (GIA), which in turn can be released only on issuance of a Sanction Order (SO) by the State Government. Much of the time consumption in the release process of States is in the issuance of SO. This is unlike withdrawals within the State administration where the approval of the budget is adequate to withdraw funds from the State treasury and no separate SO is required for release of funds. In addition, NHM grants cannot be withdrawn directly by SHS from the State treasury as they are not a part of the State administration.

Utilization are also sometimes adversely affected by factors unrelated to the financial architecture. Deficiencies of physical inputs (like lack of human resources) in State health systems pose major constraints in utilizing NHM funds. Many of the interventions under NHM assume the existence of a certain set of complementary inputs in States, which are inadequate in many of the High-focus States. Partially due to this, the

utilization of funds under the Mission flexible pool in better performing States is higher than the poor performing States.

A significant amount of fund released by the Central government to state treasuries were also not released to SHS within the financial year. In Maharashtra, Bihar and U.P, in at least one of the years, a substantial amount of fund released by Central government to state treasury were not released to SHS within the financial year. In Gujarat and Odisha, the two states with better utilization of funds, the proportion of Central funds not credited to SHSs was 5 per cent or less.

In Maharashtra, U.P. and Bihar, a significant proportion of state share (about a third of the total) was not released to SHSs in both the financial years. Again, in both Odisha and Gujarat, more than 90 per cent of state shares were credited to SHSs. In some States like U.P. the request for state shares is initiated only after the Central share is credited into the SHS bank account. This is unlike states like Gujarat and Odisha where request for release of state shares is sent along with the request for release of Central funds.

Rigidities in the financial architecture of NHM also reduces effectiveness in the use of funds. Structuring the NHM budget into more than a 1,000 budget lines, complicates the implementing structure resulting in reduced transparency, which in turn affects the flow of funds. For example, budgets are segregated into different pools, and within each pool into multiple budget lines. The segregation of budgets result in requirement of separate financial reporting for each program. This is mirrored in the existence of multiple bank accounts in implementing agencies. The main (group) bank account of SHS is often subdivided into eight to nine sub-accounts to ensure segregation of funds under different programmes. Releases to district health societies are made separately from each of these bank accounts. Similarly, multiple bank accounts exist at the level of districts and blocks, and funds are released from each of these accounts to implementing agencies at the lower level or to health facilities. In U.P., this results in more than 3000 bank accounts under the NHM implementing structure. In Gujarat, the corresponding number is close to 1000. The network of bank accounts and releases from each account at different levels for expenditure on different parts of the programme reduces transparency in accounting and complicates the fund release process.

VI. Areas of Complementarity: NHM Spending in States

Bulk of the expenditure under NHM was towards RCH services and health systems strengthening in rural areas. On average, around 86 per cent of allocation and 89 per cent of expenditure under the scheme was towards NRHM-RCH flexible pool; the remaining towards communicable diseases, non-communicable diseases and urban health (Table 9). In high-focus states, NRHM-RCH flexible pool constituted an even higher share; indicating an almost exclusive focus on this component (Table 9). Within the pool, expenditure was particularly targeted to a few heads. Although the pool had about 55 broad heads of expenditure, only 5 heads accounted for around 60 per cent, and 10 heads accounted for around 80 per cent of the allocation and expenditure (Appendix Table A1). The top 5 heads included expenditures on maternal health, human resources, procurement, expenditure on ASHAs and hospital strengthening; and the remaining 5 included untied funds/Annual maintenance grants, Program/NRHM management cost, new constructions/renovations, family planning, National Ambulance Services. With 45 heads accounting for less than 20 per cent of the expenditure under the pool, there is potential for consolidation of both aggregated and disaggregated budget heads under these heads.

Table: 9 Distribution of allocation and expenditure across different pools of NHM funds, 2015-16 to 2018-19

NHM Pools	Per cent of total expenditure					Per cent of total Approval				
	2015-16	2016-17	2017-18	2018-19	Average (2015-18)	2015-16	2016-17	2017-18	2018-19	Average (2015-18)
	High-focus States (Other than North East)									
NRHM-RCH Flexible Pool	90.7	89.5	90.8	91.1	90.6	87.4	88.4	90.1	90.0	89.1
Flexible Pool for Communicable Diseases	4.2	4.6	4.0	3.5	4.0	5.1	5.1	4.1	4.2	4.6
Flexible Pool for Non-Communicable Diseases	1.7	2.0	1.6	2.0	1.8	3.0	3.3	2.4	2.6	2.8
National Urban Health Mission	3.3	3.9	3.5	3.4	3.5	4.4	3.3	3.4	3.1	3.5
	Non-high Focus Large States									
NRHM-RCH Flexible Pool	84.9	82.8	85.2	85.3	84.6	74.8	79.4	84.0	84.2	81.1
Flexible Pool for Communicable Diseases	5.2	5.4	4.0	4.2	4.6	5.5	5.3	3.7	4.4	4.7
Flexible Pool for Non-Communicable Diseases	2.7	2.9	2.1	2.8	2.6	4.2	3.9	2.8	3.2	3.4
National Urban Health Mission	7.2	8.9	8.7	7.8	8.2	13.8	11.3	9.5	8.3	10.5
	High Focus North Eastern States									
NRHM-RCH Flexible Pool	91.8	89.4	91.2	92.2	91.2	84.8	82.6	87.4	90.6	86.4
Flexible Pool for Communicable Diseases	4.6	5.9	4.8	3.5	4.7	7.9	9.2	6.0	4.1	6.7
Flexible Pool for Non-Communicable Diseases	2.3	3.1	1.8	2.2	2.3	5.2	5.9	4.4	3.3	4.7
National Urban Health Mission	1.4	1.6	2.1	2.0	1.8	2.1	2.2	2.2	2.0	2.1
	All States									
NRHM-RCH Flexible Pool	88.6	86.8	88.5	88.7	88.2	82.4	84.4	87.5	87.8	85.8
Flexible Pool for Communicable Diseases	4.6	5.0	4.1	3.8	4.3	5.5	5.5	4.1	4.3	4.8
Flexible Pool for Non-Communicable Diseases	2.1	2.5	1.8	2.3	2.2	3.7	3.7	2.7	2.9	3.2
National Urban Health Mission	4.6	5.8	5.6	5.2	5.3	7.8	6.3	5.8	5.0	6.1

Source: Author's compilation from the Financial Management Reports and the RoPs/supplementary RoPs of respective states.

Within the 10 broad heads in NRHM-RCH flexible pool which covered close to 80 per cent of NHM expenditure, around two-thirds of the expenditure was incurred on state health facilities in states (Table 10). These included expenditures towards human resources, drugs and equipment, untied funds, construction activities and other infrastructure. The remaining one-third was incurred outside the health facilities, either by way of direct transfers to beneficiaries (through JSY and compensation for family planning), or expenditure on linkages between health facilities and the community (ASHAs and National Ambulance Service), or expenditure on program management (Table 10). Direct transfers accounted for about 14 per cent, expenditures on linkages between health facility and community accounted for another 15 per cent, and program management 7 per cent of the total on these heads (Table 10). In high-focus states, a higher proportion of expenditure was incurred outside health facilities in comparison to non-high focus states, particular in the form of direct transfers to beneficiaries. Within expenditure on health facilities, expenditure on human resources was particularly low in high-focus states than non-high focus states.

Table 10: Classification of Expenditure under 10 major heads of expenditure under NRHM-RCH Pool 2015-16 to 2018-19

Direct Transfer to Beneficiaries **(Not directly on health Facilities)**	JSY + Compensation for Family planning	**14 %**	**1/3 rd**
Linkages between health facilities and Community	ASHAs + National Ambulance Service	**15 %**	
Program Management		**7 %**	
Expenditure on health facilities	Human Resources + Procurement of drugs and equipment	**37 %**	**2/3 rd***
	Hospital Strengthening + New Constructions/renovations + Untied funds	**20 %**	
	Maternal Health + Family Planning (Excl. JSY & compensation)	**8 %**	

Source: Financial Management Reports of SHSs *Note*: * More than 60 % are towards primary health care services or for services in facilities at the level of CHC and below

About 60 per cent of total expenditure on health facilities was incurred towards primary health care services or for services in facilities at the level of CHC and below. Specifically, on human resources, nearly three-fourths of expenditure were towards CHCs and below. Even in procurement, although not all expenditure heads were identifiable with the level of facility on which they were incurred, at least a third were clearly marked and identified with primary health care services, which included maternal and child health services, family planning and adolescent services.

VII. Summary

Contributions of NHM has been consistent with the underlying rationale for Central transfers for health. The scheme has reduced inequality in health spending across states, and added funds to the lower tiers of the health pyramid. The contribution has been particularly substantial towards reproductive and child health services.

The potential of the scheme was however, much more than what it achieved. On average, the scheme could utilize less than 60 per cent of funds available for the scheme. This translated into substantial unused public funds remaining in the bank accounts of SHSs. A particularly worrying feature has been the fact that in States with weak health systems (high-focus states), absorption of funds for strengthening health systems has been relatively low. This was partially due to deficiencies in physical inputs (like lack of human resources) and capacity issues in these states. Many of the interventions under NHM assume a certain set of complementary inputs in states, which are inadequate in many of the high-focus states. Poor capacity for absorption of funds, is reflected in the fact that components which involved relatively more complex planning and execution like procurement and construction had low utilization rates. Further, public financial management issues including complex and rigid financial architecture and delays in fund flows affected the scheme.

Notably, a significant amount of state share towards the scheme could not be released by States to implementing agencies. This needs to be explored in the larger context. With the initiation of Ayushman Bharat (AB), states would not only have to bear 40 per cent of the cost of NHM, but also a similar share for AB. The twin burden of state shares towards NHM and AB may be difficult to accommodate in States with poor resource base.

Reference

Choudhury, M., R. K. Mohanty, (2018), "Utilisation, Fund Flows and Public Financial Management under the National Health Mission", *NIPFP Working Paper No. 227,* https://www.nipfp.org.in/media/medialibrary/2018/05/WP_2018_227.pdf

Choudhury, M., R. K. Mohanty, (2019), "Utilisation, Fund Flows and Public Financial Management under the National Health Mission," ***Economic and Political Weekly*, **Vol. 54, No.8, pp: 49-57.

Comptroller and Auditor General (2017): "Report of the Comptroller and Auditor General of India on Performance Audit of Reproductive and Child Health under National Rural Health Mission for the Year Ended March 2016," Union Government (Civil), Ministry of Health and Family Welfare, Report No 25 of 2017 (Performance Audit).

Appendix Tables

***Table* A1:** Date of Receipt of Different Instalments released by GoI during the year 2017-18 in Gujarat

Release Towards	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
NRHM-RCH Flexi pool	May 12, 2017	June 28, 2017	28.7
		July 24, 2017	4.1
		July 11, 2017	0.5
		August 8, 2017	12.1
		July 1, 2017	1.2
NCD	May 18, 2017	July 1, 2017	0.6
		August 2, 2017	3.0
		September 25, 2017	0.2
NUHM	May 19, 2017	June 19, 2017	2.4
CD	June 16, 2017	August 4, 2017	0.3
		August 1, 2017	0.6
		August 7, 2017	3.2
NUHM	September 15, 2017	October 17, 2017	1.2
	October 23, 2017	December 28, 2017	0.4
NCD	October 24, 2017	December 1, 2017	0.3
NRHM-RCH Flexipool	October 24, 2017	December 1, 2017	2.7
NCD	October 24, 2017	January 19, 2018	0.0
		January 15, 2018	0.1
NRHM-RCH Flexipool	October 24, 2017	January 19, 2018	0.3
		January 12, 2018	0.8
		December 20, 2017	1.3
CD	October 31, 2017	January 19, 2018	0.4
		February 3, 2018	0.0
		January 23, 2018	0.1
	November 9, 2017	December 28, 2017	0.1
		December 20, 2017	0.4
NUHM	December 21, 2017	February 8, 2018	2.0
		March 28, 2018	12.2
NRHM-RCH Flexipool	December 29, 2017	January 23, 2018	8.5
		January 25, 2018	1.9
	December 30, 2017	February 3, 2018	3.6
		March 31, 2018	0.5
CD	February 13, 2018	March 23, 2018	0.8
NRHM-RCH Flexipool	February 27, 2018	March 31, 2018	0.6
CD	March 5, 2018	March 31, 2018	3.7
	March 15, 2018	March 31, 2018	0.3
NCD	March 15, 2018	March 31, 2018	0.7
Total			**100**

Source: State Health Society, Gujarat

***Table* A2:** Date of Receipt of Different Instalments released by GoI during the year 2018-19 in Gujarat

Release Towards	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
NRHM-RCH Flexipool	June 26, 2018	July 26, 2018	49.5
NCD	June 29, 2018	August 28, 2018	2.2
		August 4, 2018	0.6
CD	June 29, 2018	August 28, 2018	2.9
		August 4, 2018	0.8
NUHM	July 9, 2018	August 1, 2018	0.9
NRHM-RCH Flexipool	July 27, 2018	September 4, 2018	3.5
NUHM	July 30, 2018	October 25, 2018	0.0
		September 26, 2018	0.2
NRHM-RCH Flexipool	July 30, 2018	September 4, 2018	8.9
NCD	July 30, 2018	September 4, 2018	0.7
CD	August 6, 2018	September 4, 2018	0.9
		October 9, 2018	0.2
	September 19, 2018	November 19, 2018	0.4
NRHM-RCH Flexipool	December 26, 2018	January 19, 2019	5.1
		March 6, 2019	14.0
		March 22, 2019	0.0
NCD	January 1, 2019	March 12, 2019	1.2
	January 4, 2019	February 7, 2019	0.1
		March 12, 2019	0.1
		March 14, 2019	0.3
		February 7, 2019	0.0
NUHM	February 7, 2019	March 16, 2019	0.2
		March 28, 2019	2.5
		March 29, 2019	0.0
	February 25, 2019	March 13, 2019	2.5
		March 20, 2019	0.3
CD	February 27, 2019	March 13, 2019	0.1
NUHM	February 28, 2019	March 27, 2019	0.0
		March 20, 2019	0.3
NRHM-RCH Flexipool	February 28, 2019	March 14, 2019	0.1
		March 16, 2019	0.8
		March 27, 2019	0.7
Total			**100.0**

Source: State Health Society, Gujarat

***Table* A3:** Date of Receipt of Different Instalments released by GoI during the years 2017-18 and 2018-19 in Odisha

Release Towards	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
2018-19			
NRHM-RCH Flexipool	May 22, 2018	June 18, 2018	52.4
CD	May 29, 2018	June 28, 2018	2.1
NUHM	May 29, 2018	June 28, 2018	0.3
NCD	May 31, 2018	June 28, 2018	2.3
NRHM-RCH Flexipool	July 27, 2018	October 16, 2018	3.1
	July 30, 2018	November 22, 2018	10.0
NCD	July 30, 2018	October 16, 2018	0.6
NUHM	July 30, 2018	October 16, 2018	0.1
CD	August 6, 2018	November 22, 2018	0.5
NUHM	December 4, 2018	January 5, 2019	1.0
NRHM-RCH Flexipool	December 18, 2018	February 27, 2019	1.7
	December 24, 2018	February 27, 2019	20.1
	February 22, 2019	March 31, 2019	1.6
NUHM	February 26, 2019	March 31, 2019	1.0
NRHM-RCH Flexipool	February 27, 2019	March 31, 2019	0.2
CD	February 27, 2019	March 31, 2019	0.5
NUHM	February 28, 2019	March 31, 2019	0.1
NRHM-RCH Flexipool	March 13, 2019	March 25, 2019	1.9
	March 22, 2019	March 31, 2019	0.2
Total			**100.0**
2017-18			
NRHM-RCH Flexipool	May 4, 2017	May 25, 2017	53.6
NCD	May 18, 2017	June 29, 2017	2.4
NUHM	June 14, 2017	July 10, 2017	1.0
CD	September 27, 2017	October 27, 2017	2.3
NUHM	September 29, 2017	October 27, 2017	0.5
	October 23, 2017	November 17, 2017	0.2

NRHM-RCH Flexipool	October 24, 2017	November 17, 2017	1.6
		November 17, 2017	4.4
NCD	October 24, 2017	November 17, 2017	0.3
NRHM-RCH Flexipool	December 18, 2017	January 5, 2018	3.2
	December 18, 2017	January 5, 2018	8.7
NUHM	December 21, 2017	January 10, 2018	4.6
NRHM-RCH Flexipool	December 30, 2017	February 13, 2018	1.3
		February 13, 2018	3.5
CD	February 13, 2018	March 9, 2018	6.1
NRHM-RCH Flexipool	February 27, 2018	March 27, 2018	1.8
CD	March 5, 2018	March 27, 2018	2.5
NRHM-RCH Flexipool	March 13, 2018	March 27, 2018	0.9
CD	March 15, 2018	March 27, 2018	0.9
		March 29, 2018	0.3
NCD	March 15, 2018	March 27, 2018	0.1
Total			**100.0**

Source: State Health Society, Odisha

***Table* A4:** Date of Receipt of Different Instalments released by GoI during the years 2017-18 and 2018-19 in Uttar Pradesh

Release Towards	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
2018-19			
NRHM-RCH Flexipool	October 25, 2018	January 2, 2019	71.4
		February 26, 2019	17.5
		December 31, 2018	0.5
		March 6, 2019	1.3
	February 22, 2019	March 29, 2019	9.4
CD	November 29, 2018	March 29, 2019	0.0
NUHM	November 29, 2018	March 2, 2019	0.0
NUHM	December 28, 2018	March 29, 2019	0.0
Total			**100.0**
2017-18			
NRHM-RCH Flexipool	October 6, 2017	February 13, 2018	41.0
		January 24, 2018	6.9
		February 3, 2018	0.0
	October 9, 2017	January 24, 2018	3.9
NCD	October 9, 2017	January 24, 2018	0.9
		February 12, 2018	0.1
		February 3, 2018	0.0
		February 13, 2018	3.8
NUHM	October 9, 2017	February 13, 2018	1.6
		February 12, 2018	0.2
		February 3, 2018	0.0
CD	October 23, 2017	February 13, 2018	0.3
		January 24, 2018	0.1
NRHM-RCH Flexipool	November 2, 2017	February 12, 2018	5.0
		February 13, 2018	17.3
NUHM	November 2, 2017	January 24, 2018	1.1
NRHM-RCH Flexipool	March 6, 2018	March 31, 2018	8.9
CD	March 15, 2018	March 22, 2018	8.7
NCD	March 15, 2018	March 17, 2018	0.1
Total			**100**

Source: State Health Society, Uttar Pradesh

***Table* A5:** Date of Receipt of Different Instalments released by GoI during the years 2017-18 and 2018-19 in Bihar

Release Towards	Year	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
NRHM-RCH Flexipool	2017-18	July 14, 2017	November 17, 2017	100
NRHM-RCH Flexipool	2018-19	August 24, 2018	February 14, 2019	53.84
NRHM-RCH Flexipool	2018-19	September 20, 2018	March 29, 2019	46.16

Source: State Health Society, Bihar

Table A6: Date of Receipt of Different Instalments released by GoI during the years 2017-18 and 2018-19 in Maharashtra

Release Towards	Date of Sanction Order	Date of receipt in SHS Account	Share of total receipt from GOI (per cent)
2018-19			
NRHM-RCH Flexipool	June 15, 2018	September 1, 2018	52.8
		September 19, 2018	6.3
		December 24, 2018	7.9
RNTCP	June 20, 2018	January 1, 2019	0.7
		February 13, 2019	0.8
NLEP	June 20, 2018	January 25, 2019	0.0
		February 12, 2019	0.0
		March 29, 2019	0.3
NUHM	July 9, 2018	December 24, 2018	2.3
NRHM-RCH Flexipool	July 27, 2018	February 13, 2019	0.6
		March 29, 2019	3.8
NRHM-RCH Flexipool	July 30, 2018	October 12, 2018	9.4
		February 13, 2019	1.4
		January 7, 2019	1.1
NUHM	July 30, 2018	December 24, 2018	0.6
RNTCP	August 6, 2018	January 1, 2019	0.2
		February 13, 2019	0.2
NLEP	August 6, 2018	January 25, 2019	0.0
		February 12, 2019	0.0
		March 29, 2019	0.1
NUHM	November 28, 2018	February 20, 2019	6.7
NRHM-RCH Flexipool	December 18, 2018	March 29, 2019	1.6
	December 24, 2018	March 29, 2019	2.5
NUHM	December 24, 2018	March 29, 2019	0.8
Total			**100.0**
2017-18			
NRHM-RCH Flexipool	November 2, 2017	December 30, 2017	78.7
		January 1, 2018	11.8
NUHM	November 27, 2017	March 16, 2018	9.5
Total			**100.0**

Source: State Health Society, Maharashtra

***Figure A1*: Process for release of NHM funds from State treasury to State Health Society in Bihar**

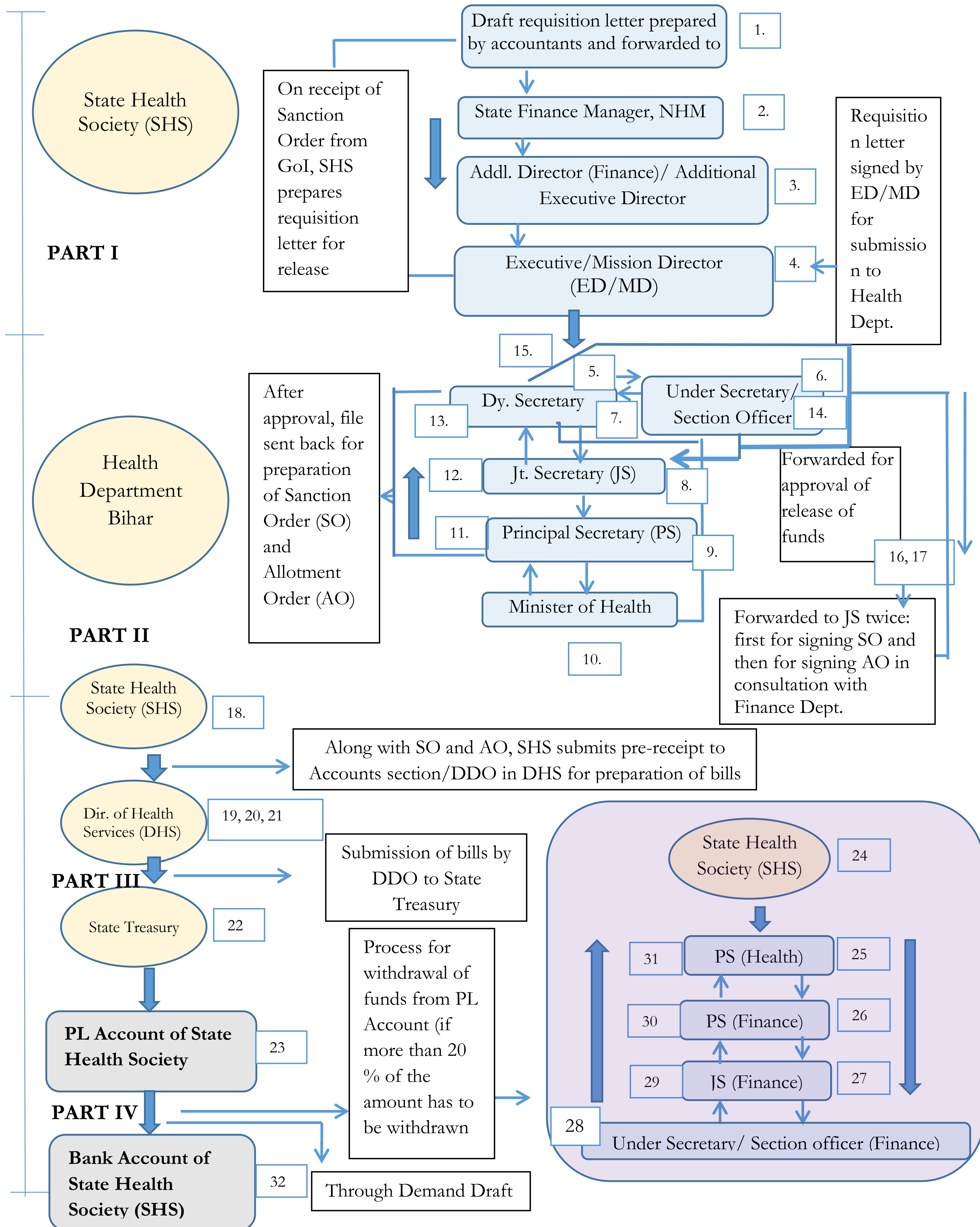


***Figure A2*: Process for release of NHM funds from State treasury to State Health Society Maharashtra**

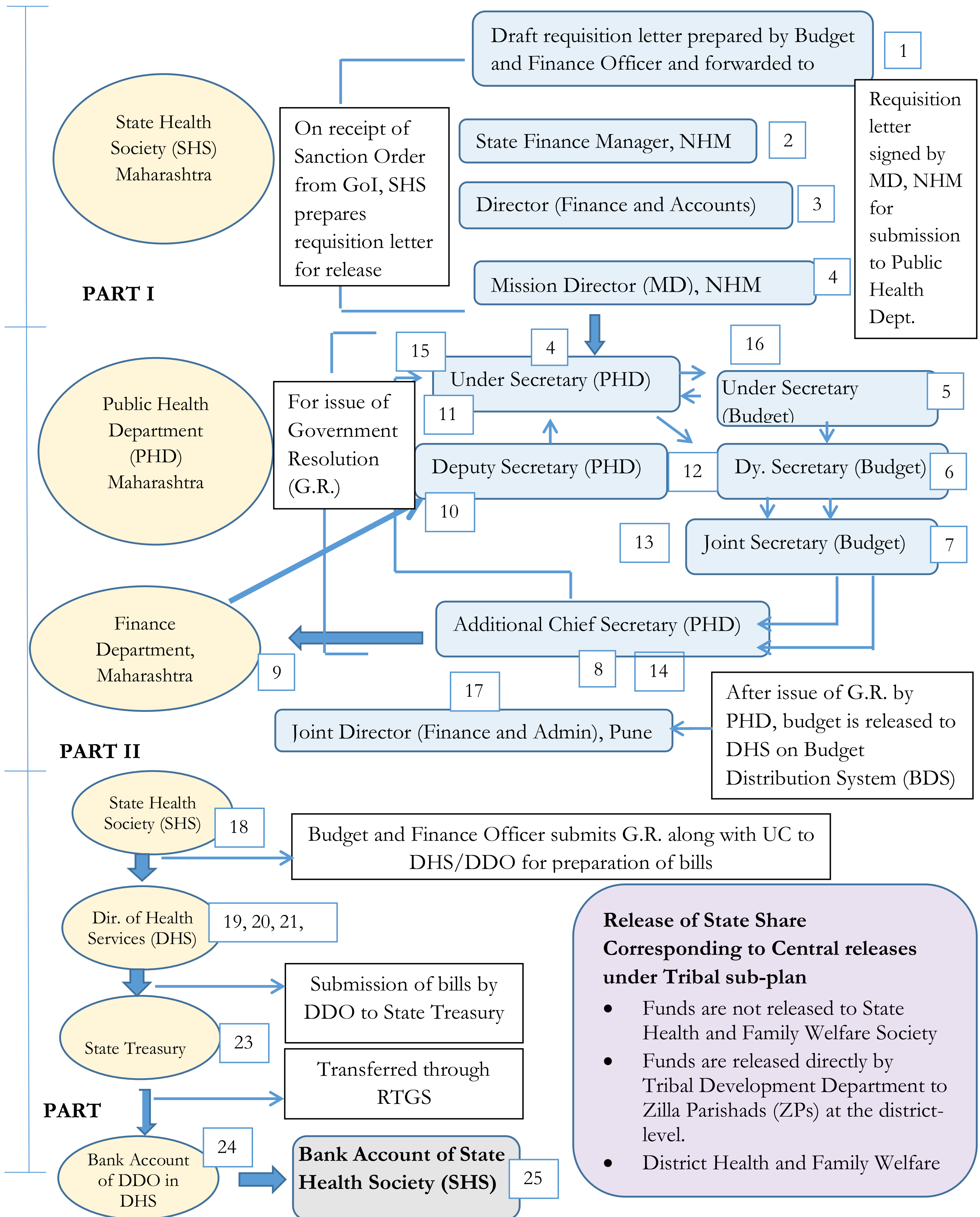


***Figure A3*: Process for release of NHM funds from State treasury to State Health and Family Welfare Society in Odisha**

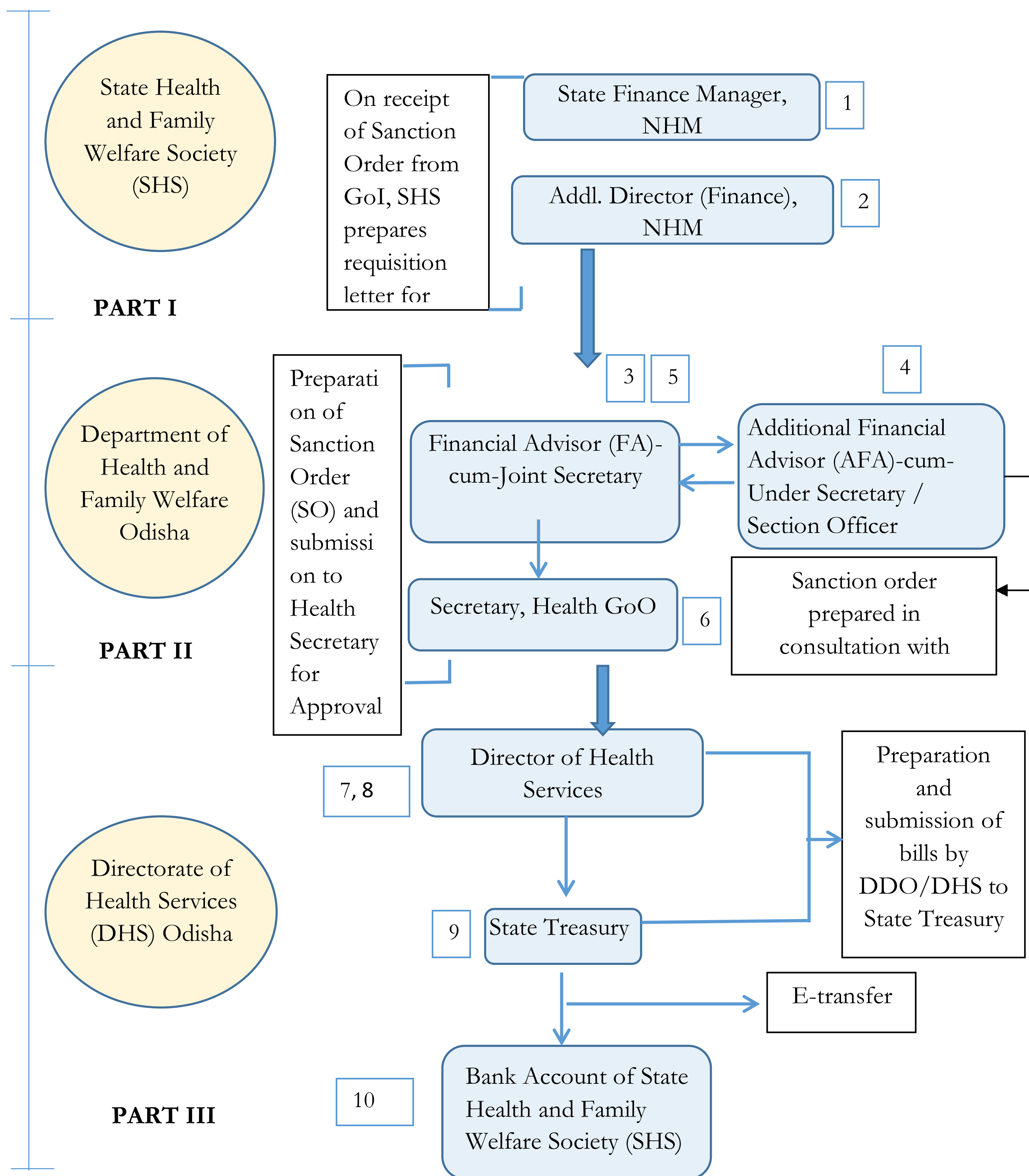


***Figure A4*: Process for release of NHM funds from State treasury to State Health Society in Gujarat**

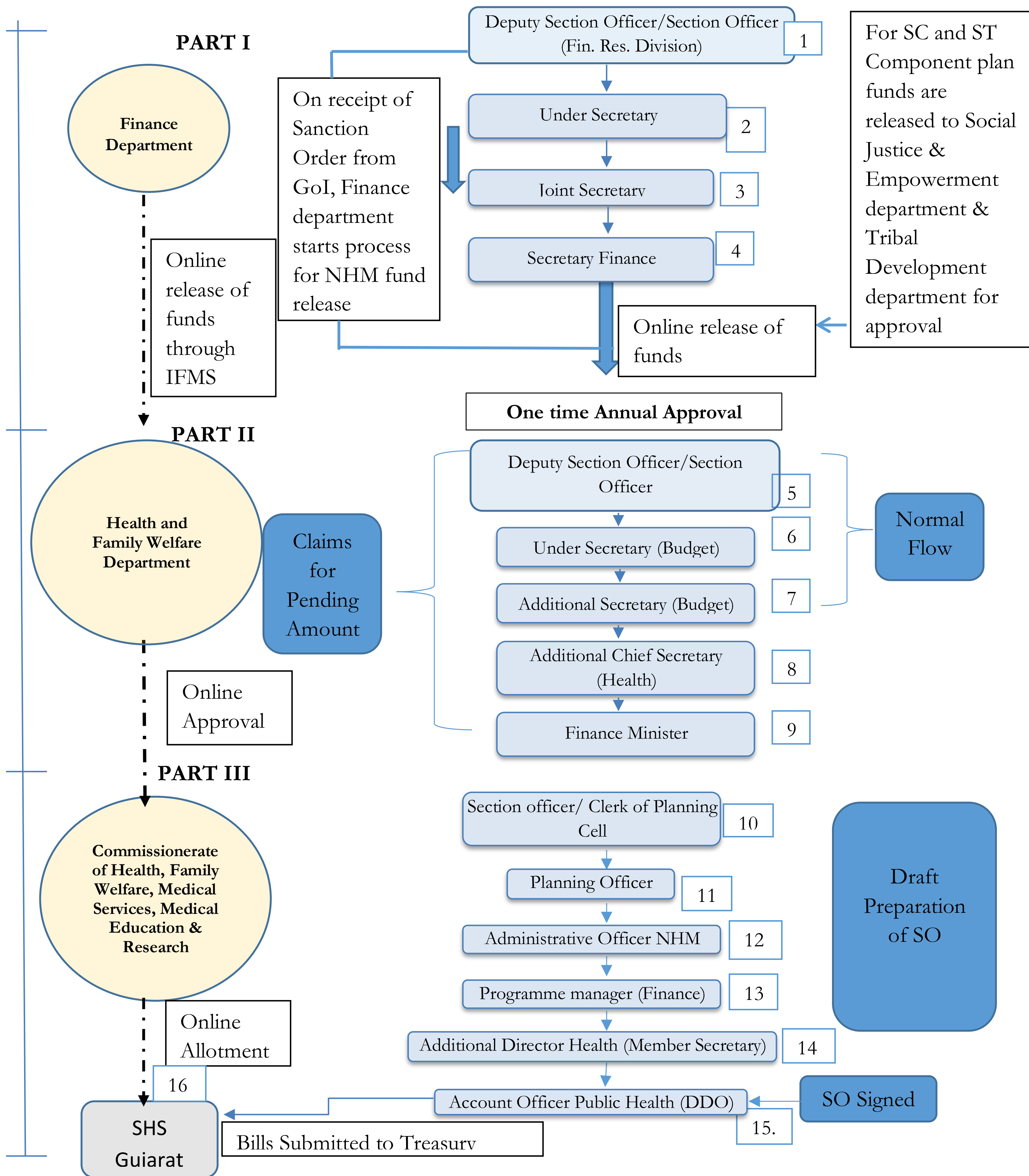


***Figure A5*: Process for release of NHM funds from State treasury to State Health Society in Uttar Pradesh**

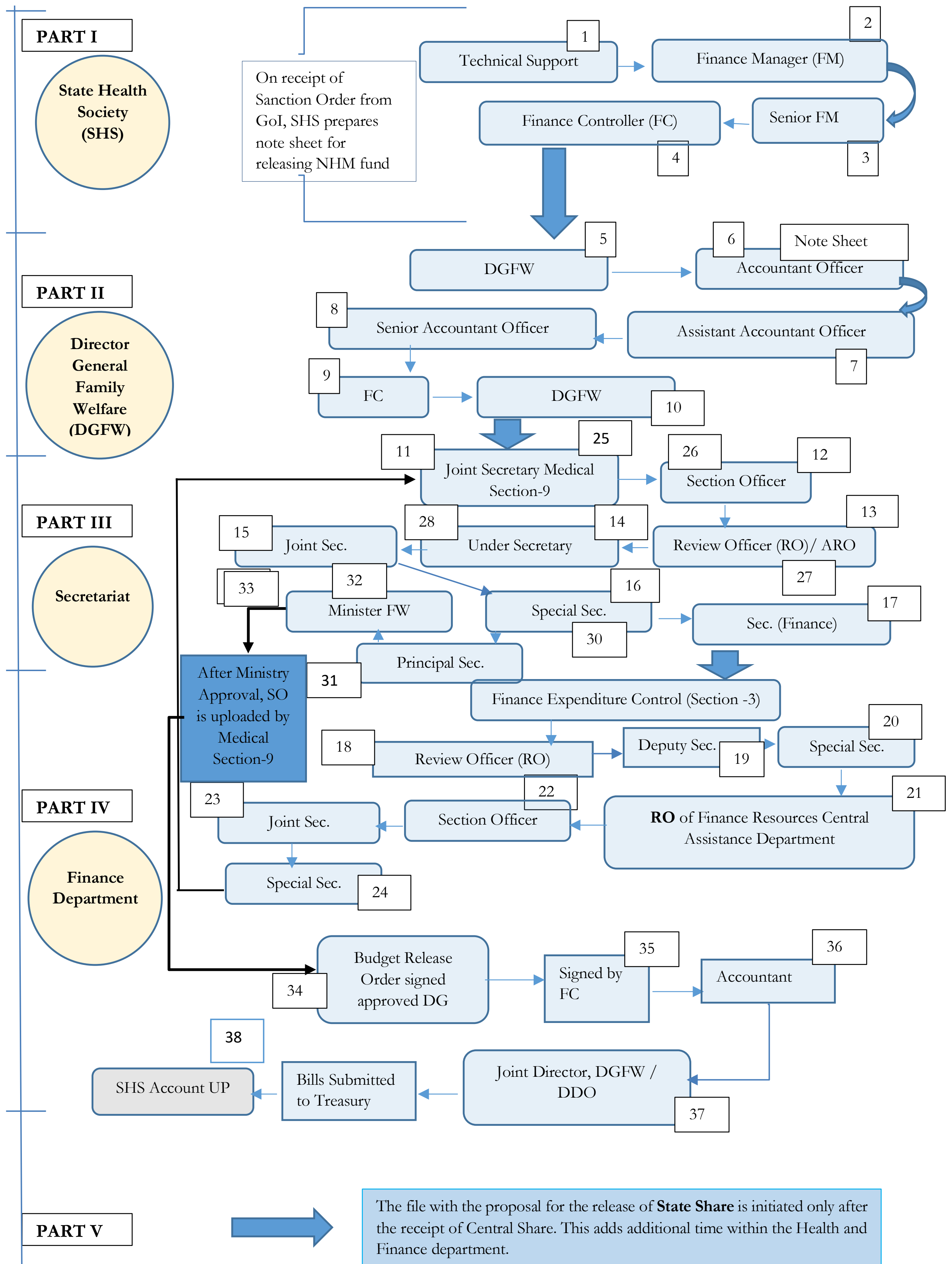


Table A7: Distribution of Allocation and Expenditure of NRHM-RCH Flexible Pool, 2015-16 to 2018-19

		All States		HFS excluding NE		NHFS		NE	
	Strategy/Activities	**Allocation (%)**	**Expenditure (%)**	**Allocation (%)**	**Expenditure (%)**	**Allocation (%)**	**Expenditure (%)**	**Allocation (%)**	**Expenditure (%)**
	RCH Flexible Pool	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
1	Maternal Health	46.94	51.52	51.38	57.76	40.33	41.73	41.60	45.96
2	Child Health	4.47	3.99	3.58	3.25	5.57	5.18	6.58	4.47
3	Family Planning	11.74	10.48	13.29	12.00	10.43	9.19	5.15	3.71
4	RKSK	1.00	0.50	0.70	0.37	1.46	0.72	1.31	0.54
5	RBSK	8.95	8.75	6.90	6.18	12.86	13.88	7.42	5.61
6	Tribal RCH	0.25	0.39	0.04	0.03	0.62	1.04	0.19	0.23
7	PNDT Activities	0.20	0.14	0.15	0.10	0.26	0.20	0.31	0.16
8	Training	7.09	3.55	6.41	2.86	7.80	4.46	9.34	5.02
9	Programme / NRHM Management Cost	19.21	20.55	17.42	17.35	20.46	23.39	28.10	34.31
10	Vulnerable Groups	0.15	0.13	0.13	0.10	0.21	0.20	0.01	0.01
	Mission Flexible Pool	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
11	ASHA	10.10	13.62	10.89	15.17	8.98	12.37	10.23	11.06
12	Untied Funds/Annual Maintenance Grants /Corpus Grants To HMS/RKS	5.52	7.31	5.29	6.82	6.07	8.35	4.38	5.09
13	Rollout of B.Sc. (Community Health)	0.05	0.02	0.06	0.02	0.03	0.01	0.04	0.02
14	Hospital Strengthening	12.51	10.63	15.11	13.63	9.81	7.87	8.26	7.25
15	New Constructions/ Renovation And Setting up	8.56	5.83	10.61	6.28	5.87	4.63	7.90	9.01
16	Implementation of Clinical Establishment Act	0.01	0.00	0.01	0.00	0.00	0.00	0.06	0.03
17	District Action Plans	0.04	0.03	0.03	0.02	0.05	0.03	0.10	0.09
18	Panchayat Raj Initiative	0.19	0.14	0.23	0.13	0.14	0.16	0.13	0.08
19	Mainstreaming Of AYUSH	1.00	1.36	0.94	1.47	1.11	1.27	0.84	1.14
20	IEC-BCC NRHM	2.68	2.18	3.29	2.63	1.76	1.54	3.07	2.75
21	National Mobile Medical Vans (Including Recurring Expenditures)	1.44	1.35	1.56	1.08	1.19	1.52	1.86	1.97

22	National Ambulance Service	4.30	4.91	6.14	7.33	2.25	2.65	2.01	2.40
23	PPP/ NGOS	1.36	0.94	1.48	0.68	1.03	0.98	2.15	2.24
24	Innovations (If any)	2.63	1.91	2.58	1.51	2.96	2.54	1.42	1.17
25	Planning, Implementation and Monitoring	3.33	2.80	2.90	2.96	3.97	2.75	3.10	2.11
26	Procurement	20.06	17.25	15.65	14.00	26.00	20.98	20.71	17.43
27	Drug Ware Housing	0.64	0.27	0.85	0.27	0.42	0.26	0.33	0.30
28	New Initiatives/ Strategic Interventions	0.83	0.38	0.62	0.30	1.21	0.51	0.41	0.18
29	Health Insurance Scheme	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	Research, Studies, Analysis	0.03	0.01	0.03	0.01	0.03	0.02	0.01	0.00
31	State Level Health Resources Centre(SHSRC)	0.05	0.05	0.02	0.03	0.10	0.08	0.00	0.00
32	Support Services	0.22	0.17	0.22	0.15	0.19	0.20	0.35	0.11
33	Other Expenditures (Power Backup, Convergence etc.)	0.62	0.64	0.86	1.19	0.41	0.14	0.07	0.03
34	Collaboration with Medical Colleges and Knowledge Partners	0.05	0.02	0.06	0.03	0.03	0.02	0.00	0.00
35	National Programme for prevention And Control of Deafness	0.20	0.08	0.19	0.08	0.18	0.07	0.32	0.17
36	National Oral Health Programme	0.11	0.07	0.05	0.03	0.18	0.10	0.20	0.14
37	National Program for Palliative Care (New Initiatives Under NCD)	0.06	0.03	0.02	0.00	0.10	0.05	0.10	0.03
38	Assistance to State for Capacity Building (Burns & Injury)	0.02	0.01	0.01	0.00	0.02	0.01	0.07	0.04
39	National Programme for Fluorosis	0.31	0.28	0.46	0.46	0.13	0.11	0.12	0.09
40	Human Resources	23.10	27.72	19.83	23.72	25.79	30.80	31.75	35.07
	IMMUNISATION	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
41	RI strengthening project (Review meeting, Mobility support, Outreach services etc)	45.02	41.42	42.34	39.57	48.20	43.44	51.70	47.22
42	Salary of Contractual Staffs	0.77	0.83	0.81	0.82	0.53	0.65	1.80	2.16
43	Training under Immunisation	2.96	1.74	2.69	1.82	2.56	1.37	8.10	3.42

44	Cold chain maintenance	0.54	0.82	0.21	0.36	1.03	1.50	0.63	1.22
45	ASHA Incentive	21.16	23.36	24.39	24.81	16.64	22.00	17.35	17.25
46	Pulse Polio operating costs	28.79	31.01	28.68	31.97	30.51	30.15	18.99	26.84
47	Other activities (if any, pls. specify)	0.77	0.81	0.87	0.66	0.52	0.90	1.30	1.85
48	NIDDCP	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
49	Establishment of IDD Control Cell	21.27	13.64	15.23	11.56	23.18	14.57	31.63	16.26
50	Establishment of IDD Monitoring Lab	3.11	5.05	2.46	3.33	2.56	6.44	6.38	6.24
51	Health Education and Publicity	4.97	7.68	4.97	4.96	3.96	6.00	7.76	15.83
52	IDD Surveys/Re-surveys	5.32	6.34	6.83	5.01	3.99	4.60	5.08	11.85
53	Supply of Salt Testing Kit (form of kind grant)	16.23	25.81	22.55	31.28	11.43	19.97	13.19	24.42
54	ASHA Incentive	43.90	28.04	42.39	39.22	50.98	27.74	28.04	6.22
55	Other activities (if any, pls. specify)	4.24	13.44	5.57	4.63	3.77	20.69	2.08	19.17

Notes: HFS: High Focus States, NHFS: Non-high Focus States, NE: North-Eastern States

Table A8: Utilization Rates by Components under NRHM -RCH flexible pool 2015-16 and 2017-18

Strategy/Activities	All States	HFS excluding NE	NHFS	NE
	Utilisation Ratio	Utilisation Ratio	Utilisation Ratio	Utilisation Ratio
RCH Flexible Pool	**68.2**	**69.3**	**67.0**	**65.6**
Maternal Health	74.6	77.5	68.5	74.9
Child Health	59.8	63.1	60.9	41.4
Family Planning	61.5	62.7	60.0	50.4
RKSK	31.0	34.5	29.6	22.9
RBSK	65.3	60.7	73.0	43.5
Tribal RCH	-	49.6	-	76.3
PNDT Activities	47.8	48.1	50.7	35.1
Training	34.0	30.1	40.0	31.6
Programme / Management Cost	74.3	69.6	78.8	84.2
Vulnerable Groups	62.4	61.8	63.6	25.4
Mission Flexible Pool	**55.6**	**52.3**	**59.1**	**60.8**
ASHA	69.2	65.0	77.0	65.8
Untied Funds/Annual Maintenance Grants /Grants To HMS/RKS	71.1	62.4	81.8	69.5
Rollout of B.Sc. (Community Health)	10.4	10.5	0.0	10.4
Hospital Strengthening	49.7	48.0	52.4	55.7
New Constructions/ Renovation and Setting up	45.8	41.6	45.7	69.6
Implementation Of Clinical Establishment Act	21.7	13.1	53.2	26.5
District Action Plans (Including Block, Village)	38.4	32.0	37.2	52.9
Panchayat Raj Initiative	36.9	24.3	70.0	38.8
Mainstreaming Of AYUSH	75.6	79.8	69.5	83.6
IEC-BCC NRHM	44.4	39.4	52.0	57.5
National Mobile Medical Vans (Including Recurring Expenditures)	49.8	33.3	79.3	54.4
National Ambulance Service	61.7	60.7	62.3	75.2
PPP/ NGOS	46.3	31.4	55.8	66.8
Innovations (If any)	38.5	29.7	48.7	46.6
Planning, Implementation and Monitoring	47.5	54.8	41.8	41.9
Procurement	45.6	44.2	45.9	50.4
Drug Ware Housing	18.8	13.0	31.3	52.2
New Initiatives/ Strategic Interventions	20.9	16.0	23.9	25.8
Health Insurance Scheme	-	-	-	-
Research, Studies, Analysis	21.0	5.9	41.8	2.7
State Level Health Resources Centre(SHSRC)	52.6	77.5	46.0	13.0
Support Services	43.0	35.4	64.7	19.5
Other Expenditures (Power Backup, Convergence etc.)	64.5	72.2	31.0	69.1
Collaboration with Medical Colleges and Knowledge Partners	26.7	23.0	36.8	-

National Programme for Prevention and Control of Deafness	21.7	16.7	22.3	35.5
National Oral Health Programme	31.2	19.2	34.9	35.8
National Program for Palliative Care (New Initiatives Under NCD)	10.5	2.1	13.7	6.7
Assistance to State for Capacity Building (Burns & Injury)	-	-	-	-
National Programme for Fluorosis	38.8	40.1	34.8	48.1
Human Resources	67.4	63.3	71.7	67.2
IMMUNISATION	**63.4**	**67.2**	**59.2**	**56.4**
RI strengthening project (Review meeting, Mobility support, Outreach services etc)	56.7	65.5	48.8	46.7
Salary of Contractual Staffs	70.3	66.2	80.2	72.4
Training under Immunisation	34.5	40.9	32.6	23.1
Cold chain maintenance	79.8	-	71.8	-
ASHA Incentive	70.2	66.0	80.5	62.0
Pulse Polio operating costs	69.2	72.2	63.5	82.0
Other activities (if any, pls. specify)	65.0	43.4	-	99.7
NIDDCP	**31.1**	**28.7**	**31.0**	**37.1**
Establishment of IDD Control Cell	18.3	23.0	14.5	20.2
Establishment of IDD Monitoring Lab	47.8	42.5	58.0	40.8
Health Education and Publicity	44.1	30.2	34.9	80.5
IDD Surveys/Re-surveys	32.2	21.7	19.1	99.5
Supply of Salt Testing Kit (form of kind grant)	50.7	48.2	51.9	69.5
ASHA Incentive	12.4	14.7	8.8	10.9
Other activities (if any, pls. specify)	71.0	24.9	-	-

Source: Financial Management Report of various State Health Societies (SHSs)

Table A9: Classification of Expenditure under 10 Major Heads of NRHM-RCH Flexipool

STATES		STRATEGY/ACTIVITIES	2015-17
All States	Direct Transfer to Beneficiaries	JSY + Compensation for Family planning	15
	Linkages between health facilities and Community	ASHAs + National Ambulance Service	15
	Program Management	Programme Management	6
	Expenditure on health facilities	Human Resources + Procurement of drugs and equipment	35
		Hospital Strengthening + New Constructions/renovations + Untied funds	21
		Maternal Health + Family Planning (Excl. JSY & compensation)	8
High-Focus States (other than NE)	Direct Transfer to Beneficiaries	JSY + Compensation for Family planning	20
	Linkages between health facilities and Community	ASHAs + National Ambulance Service	17
	Program Management	Programme Management	6
	Expenditure on health facilities	Human Resources + Procurement of drugs and equipment	27
		Hospital Strengthening + New Constructions/renovations + Untied funds	22
		Maternal Health + Family Planning (Excl. JSY & compensation)	8
Non-High Focus States	Direct Transfer to Beneficiaries	JSY + Compensation for Family planning	8
	Linkages between health facilities and Community	ASHAs + National Ambulance Service	13
	Program Management	Programme Management	6
	Expenditure on health facilities	Human Resources + Procurement of drugs and equipment	43
		Hospital Strengthening + New Constructions/renovations + Untied funds	20
		Maternal Health + Family Planning (Excl. JSY & compensation)	9
NE	Direct Transfer to Beneficiaries	JSY + Compensation for Family planning	8
	Linkages between health facilities and Community	ASHAs + National Ambulance Service	12
	Program Management	Programme Management	8
	Expenditure on health facilities	Human Resources + Procurement of drugs and equipment	44
		Hospital Strengthening + New Constructions/renovations + Untied funds	21
		Maternal Health + Family Planning (Excl. JSY & compensation)	7

Source: Financial Management Report of various State Health Societies (SHSs)

Table A 10: Classification of Expenditure under NRHM-RCH Flexipool in High Focus States other than NE

STATES	STRATEGY/ACTIVITIES	2015-17
Bihar	Direct Transfer to Beneficiaries	38
	Linkages between health facilities and Community	11
	Program Management	8
	Expenditure on health facilities	43
Chhattisgarh	Direct Transfer to Beneficiaries	12
	Linkages between health facilities and Community	29
	Program Management	9
	Expenditure on health facilities	49
Himachal Pradesh	Direct Transfer to Beneficiaries	4
	Linkages between health facilities and Community	12
	Program Management	7
	Expenditure on health facilities	77
Jammu & Kashmir	Direct Transfer to Beneficiaries	9
	Linkages between health facilities and Community	6
	Program Management	6
	Expenditure on health facilities	79
Jharkhand	Direct Transfer to Beneficiaries	21
	Linkages between health facilities and Community	20
	Program Management	5
	Expenditure on health facilities	54
Madhya Pradesh	Direct Transfer to Beneficiaries	20
	Linkages between health facilities and Community	16
	Program Management	5
	Expenditure on health facilities	58
Odisha	Direct Transfer to Beneficiaries	17
	Linkages between health facilities and Community	11
	Program Management	10
	Expenditure on health facilities	63
Rajasthan	Direct Transfer to Beneficiaries	23
	Linkages between health facilities and Community	10
	Program Management	5
	Expenditure on health facilities	62
Uttar Pradesh	Direct Transfer to Beneficiaries	19
	Linkages between health facilities and Community	21
	Program Management	5
	Expenditure on health facilities	56
Uttarakhand	Direct Transfer to Beneficiaries	13
	Linkages between health facilities and Community	17
	Program Management	9
	Expenditure on health facilities	61

Source: Financial Management Report of various State Health Societies (SHSs)

Table A 11: Classification of Expenditure under NRHM-RCH Flexipool in Non-High Focus States

STATES	STRATEGY/ACTIVITIES	2015-17
Andhra Pradesh	Direct Transfer to Beneficiaries	8
	Linkages between health facilities and Community	15
	Program Management	4
	Expenditure on health facilities	72
Goa	Direct Transfer to Beneficiaries	1
	Linkages between health facilities and Community	15
	Program Management	11
	Expenditure on health facilities	74
Gujarat	Direct Transfer to Beneficiaries	11
	Linkages between health facilities and Community	20
	Program Management	8
	Expenditure on health facilities	61
Haryana	Direct Transfer to Beneficiaries	6
	Linkages between health facilities and Community	25
	Program Management	9
	Expenditure on health facilities	60
Karnataka	Direct Transfer to Beneficiaries	11
	Linkages between health facilities and Community	13
	Program Management	6
	Expenditure on health facilities	70
Kerala	Direct Transfer to Beneficiaries	7
	Linkages between health facilities and Community	4
	Program Management	9
	Expenditure on health facilities	80
Maharashtra	Direct Transfer to Beneficiaries	7
	Linkages between health facilities and Community	16
	Program Management	8
	Expenditure on health facilities	69
Punjab	Direct Transfer to Beneficiaries	5
	Linkages between health facilities and Community	10
	Program Management	5
	Expenditure on health facilities	80
Tamil Nadu	Direct Transfer to Beneficiaries	5
	Linkages between health facilities and Community	3
	Program Management	5
	Expenditure on health facilities	87
West Bengal	Direct Transfer to Beneficiaries	9
	Linkages between health facilities and Community	12
	Program Management	6
	Expenditure on health facilities	73
Telangana	Direct Transfer to Beneficiaries	8
	Linkages between health facilities and Community	20
	Program Management	5
	Expenditure on health facilities	67

Source: Financial Management Report of various State Health Societies (SHSs)

Table A12: Classification of Expenditure under NRHM-RCH Flexipool in NE States

STATES	STRATEGY/ACTIVITIES	2015-17
Arunachal Pradesh	Direct Transfer to Beneficiaries	1
	Linkages between health facilities and Community	7
	Program Management	10
	Expenditure on health facilities	81
Assam	Direct Transfer to Beneficiaries	10
	Linkages between health facilities and Community	12
	Program Management	6
	Expenditure on health facilities	72
Manipur	Direct Transfer to Beneficiaries	5
	Linkages between health facilities and Community	14
	Program Management	17
	Expenditure on health facilities	65
Meghalaya	Direct Transfer to Beneficiaries	3
	Linkages between health facilities and Community	9
	Program Management	12
	Expenditure on health facilities	75
Mizoram	Direct Transfer to Beneficiaries	3
	Linkages between health facilities and Community	7
	Program Management	15
	Expenditure on health facilities	75
Nagaland	Direct Transfer to Beneficiaries	2
	Linkages between health facilities and Community	6
	Program Management	17
	Expenditure on health facilities	75
Sikkim	Direct Transfer to Beneficiaries	2
	Linkages between health facilities and Community	6
	Program Management	10
	Expenditure on health facilities	82
Tripura	Direct Transfer to Beneficiaries	4
	Linkages between health facilities and Community	18
	Program Management	10
	Expenditure on health facilities	67

Source: Financial Management Report of various State Health Societies (SHSs)

MORE IN THE SERIES

- Patnaik, I., and Pandey, R., (2020). Moving to Inflation Targeting, W.P. No. 316 (August).
- Choudhury, M., and Dubey, J. D., (2020). Equity in Intra-State Distribution of Public Spending on Health: The Case of Bihar and Tamil Nadu, W.P. No. 315 (July).
- Damle, D., and Anand, T., (2020). Problems with the e-Courts data, W.P. No. 314 (July).

Mita Choudhury, Associate Professor, NIPFP
Email: mita.choudhury@nipfp.org.in

Ranjan K. Mohanty, is Assistant Professor, NIPFP
Email: ranjan.mohanty@nipfp.org.in

National Institute of Public Finance and Policy,
18/2, Satsang Vihar Marg, Special Institutional Area (Near JNU),
New Delhi 110067
Tel. No. 26569303, 26569780, 26569784
Fax: 91-11-26852548
www.nipfp.org.in