Utilisation, Fund Flows and Public Financial Management under the National Health Mission: A Study of Selected States

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with
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Executive Summary

In 2010, the Government of India constituted a High-level Expert Group to recommend reforms for efficient management of public expenditure. One of recommendations of the Committee was on the mode of transfer of funds from National to sub-national Governments for various Central (National) schemes including the National Health Mission (NHM). Till then, NHM funds from the Central Government were directly transferred to implementing agencies (IA) in States bypassing the treasuries of the State Governments. The Committee raised concerns about accountability of fund transfers outside the State treasuries, and suggested that all Central scheme funds should be released to IA through State treasuries.

Since April 2014, funds for various Centrally Sponsored Schemes including NHM are being released to implementing agencies through State treasuries. This change in the architecture of fund flows has affected the process of budget execution of the single largest scheme in the health sector: the National Health Mission. NHM contributes about a third of all Government health expenditures in the country, and its budget execution has important implications for achieving health outcomes. This study aimed to examine various institutional features that affected the utilization of NHM funds following the reform related to the execution of the budget of the scheme. It also explored the developments in the administrative architecture which has emerged due to the reform, and has affected the utilisation of NHM funds. The study focussed on three selected States in India (Bihar, Maharashtra and Odisha) for deriving insights on the issues.

Our analysis suggests that the routing of funds through the State treasuries has had significant implications for utilization of NHM funds. The involvement of State treasuries has increased the accountability of States towards NHM spending. However, this has added an additional administrative layer in the fund flow process, and has created barriers in the fund flow due to complexities of States' administrative procedures for releasing funds. This has adversely affected the timeliness of availability of NHM funds for utilisation by implementing agencies. The file with the request for release of funds

has to pass through a minimum of 32 and 25 desks up and down the administrative hierarchy in Bihar and Maharashtra, and this has adversely affected the timeliness of availability of NHM funds for utilisation by implementing agencies in those States. On average, in the last two financial years, there was a delay of around 2 to 3 months in releasing NHM funds from State treasuries to implementing agencies in Bihar and Maharashtra.

The increased accountability of States towards NHM funding has also raised concerns of the Finance Departments about utilisation of funds. In Bihar, this has led to creation of additional bureaucratic structures in the process of fund release to implementing agencies. These additional structures have increased the time required for release of NHM funds. Part of the concern of the Finance Department arises from the fact that the NHM accounting methods are complicated, which reduces transparency in fund utilisation. Rigid budgetary structure, multiple budget heads and strict segregation of NHM budgets and releases for different components require separate financial reporting for each component. This has led to the creation of multiple bank accounts of implementing agencies at the State and sub-state level, translating into a complex financial architecture for NHM spending.

The volume of fund releases to implementing agencies has also reduced in the new financial architecture. In Maharashtra, a significant amount of NHM funds released by the Government of India to State treasury were not released to the State Health Society in the last financial year. As per the officials of the State, the non-receipt of NHM funds by the State Health Society (SHS) can be attributed partially to the management of State Finances by the Finance Department. This needs to be examined further. Moreover, apprehensions about releases in Maharashtra have led to fragmented procedures: the State share of NHM funds is claimed by SHS only after the GoI share is credited to the bank account of SHS. This has resulted in an inordinate delay in the receipt of the States' share by SHS. This is unlike Bihar and Odisha where both the GoI and the State share of NHM funds are claimed simultaneously for each instalment by SHS.

An important factor adversely affecting the process of release is the fact that the SHS is outside the administrative setup of the State Government. Integration of SHS with State administration will not only reduce the time taken for making funds available to implementing agencies, but can also bring about a larger degree of coordination between States' health expenditure and NHM spending. On the other hand, a drawback of such integration is that this will considerably reduce the flexibility which NHM funds have extended to health facilities in most States as utilisation of funds would then be affected by the rigidities of the State treasury system.

The complex and rigid administrative procedures in States needs to be simplified. Odisha has a relatively less cumbersome process for release of NHM funds, and is able to transfer funds to implementing agencies much faster than Bihar and Maharashtra. In addition to the involvement of various levels of administrative hierarchy in the release process, it may be noted that in Bihar, the issuance of two separate orders (sanction order and allotment order) for release of NHM funds takes up additional time, and these can be combined into a single order as is the case in Maharashtra and Odisha. Also, the requirement of an additional structure (Personal Ledger account) in Bihar for parking NHM funds before releasing to SHS needs to be re-examined. Notably, no such intermediate account exists in Odisha and Maharashtra. To increase transparency and address concerns of the Finance Departments of States about utilisation, the complexities in accounting methods and segregation of NHM budget into multiple budget lines need to be reduced. The segregated structure of NHM budget has also resulted in multiplicity of bank accounts reducing transparency. In this context, it may be worthwhile to create a single bank account under NHM at the State level from which all sub-State implementing agencies can directly draw funds.

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I. Introduction

Institutional structure for public fund flows has an important bearing on the effective use of budgeted resources. An understanding of this institutional architecture, including the rules and procedures that govern the release and utilisation of public funds, is essential for improved use of public resources.

This study aims to highlight issues related to execution of budgets and the institutional architecture associated with it in India's health sector. Specifically, we undertake an examination of funds under the National Heath Mission (NHM), to derive insights on the institutional features that affect the extent to which resource allocations for the health sector are optimally used for providing health services. NHM is the single largest scheme in India's health sector, and constitutes about a third of all Government health expenditures in the country. Till recently, studies on financing the health sector have primarily focussed on examining the effectiveness of alternative strategies for providing health services. However, potential gains through effective budget execution have been relatively less explored. A recent initiative has attempted to bring out the role of budgetary processes in determining the effectiveness of public spending on health.[4] With fiscal parameters constraining public spending on health in many developing countries like India, improved use of public resources can complement the Government's efforts in expanding the resource envelope for the health sector.

[4] Cashin et. al 2017

II. Structure for Fund Flows

India has a federal structure of government, wherein a number of schemes in various sectors (including the health sector) are initiated at the National level and implemented at the sub-national level. Till March 2014, bulk of the funds for these schemes was released by the National Government directly to implementing agencies without involving the treasury of the sub-National Governments. After March 2014, these funds have been released to the treasuries of the sub-National Governments, which in turn release them to State-level implementing agencies. The State-level implementing agencies further release funds to district-level, block-level and to lower level implementing units. Public funds therefore, have to flow through multiple levels of governments and administrative units before these can be spent for the designated goods and services.

Early case studies of selected schemes initiated by the National Government suggests that the nature of involvement of different tiers of Government and administration, and institutional features associated with them, have lowered the effectiveness of funds allocated to many of these schemes. Many schemes are decentralised in nature and the poor capacity for planning and implementation at the lower units of the decentralised structure has been argued to result in poor budget formulation and execution of these schemes. Further, in the decentralised structure, coordination between the lowest decentralised unit in States and the highest unit at the national level for planning and execution is often time consuming, and this delays the process of budget approval and execution of these schemes. Besides, the requirement of detailed documentation for release of funds across different levels of administration acts as a bottleneck for the flow of funds. This often results in lumping of releases towards the end of the financial year leading to low utilisation of scheme funds. Moreover, institutional gaps like the vacancies of staff at the lowest levels of the implementation units and improper planning across different components of budgets have been argued to lower the effectiveness of the resources allocated to these schemes.[5]

[5] These issues have been discussed in Gupta *et. al.* 2011, Barker *et. al.* 2014, Bhanumurthy *et. al* (2014)

III. The Objective

This study examines the extent of utilisation of funds under the National Health Mission and attempts to highlight some of the institutional structures that affect utilisation levels. Specifically, it first documents the utilisation of NHM funds in 29 States in 2015-16 and 2016-17 and then attempts to explore the institutional features that affect the utilisation in three selected States: Odisha, Bihar and Maharashtra. Two sets of institutional factors that affect utilisation are explored: (a) those affecting the timeliness of fund flows, and (b) other rigidities in the financial architecture.

The basic features of the National Health Mission (NHM) are indicated in Box 1.

Box1: Basic features of the National Health Mission (NHM)

The National Health Mission was initiated by the National Government in 2005 for selected interventions in primary and secondary health care services in States (sub-National Governments). The scheme is largely funded by the National Government, but implemented at the State-level through special purpose vehicles called 'Health Societies'. The 'Health Societies' have a decentralized structure with State, district and block level implementing units.

The funding for the scheme is shared between the National and sub-National Governments. At present, this sharing is in the ratio of 60:40. Both the National and State share of funds are released to State Health Societies (SHSs) through the State treasury. The SHSs then release funds to districts and lower level units for actual implementation.

Funds are released under four broad pools: (a) Flexible Pool for Reproductive and Child Health and Health Systems Strengthening (NRHM-RCH Flexipool), (b) Flexible Pool for Communicable Diseases (FPCD) (c) Flexible Pool for Non-Communicable Diseases (FPNCD) and (d) Flexible Pool for National Urban Health Mission (FPNUHM). In addition, the National Government also releases funds for selected maintenance of health infrastructure (called 'Infrastructure Maintenance Grant'), which are directly spent by the State Governments and not released to SHSs.

IV. Data and Methodology

The extent of utilisation of NHM funds is analysed here using the utilisation ratio. The utilisation ratio is defined as the ratio of actual expenditure to total allocation.

Data on actual expenditures (both aggregate and quarterly) have been compiled from the Financial Management Reports (FMRs) of States for the respective years.[6] For State-wise allocation under NHM, data have been compiled from the Record of Proceedings (RoPs) of each State provided by the Ministry of Health and Family Welfare.[7] These include the approvals made through supplementary RoPs as well. As FMRs for both the years excluded expenditure towards 'Infrastructure Maintenance' (IM), the allocations for IM were also netted out from total approvals to calculate the utilisation ratio. In other words, the utilisation ratios calculated here is net of the IM component.[8]

It is important to note that the approved allocation figures in RoPs are inclusive of both committed and uncommitted unspent balances available in States. It also includes the resources expected from State Governments in the form of matching contribution to the scheme. The utilisation ratio here therefore, reflects the utilisation out of all funds potentially available for the scheme.

The choice of States for understanding institutional structures was based on the extent of utilisation of NHM funds in 2015-16 and 2016-17.[9] Odisha was taken up as a State which had one of the highest utilisation ratios in the country, whereas Bihar and Maharashtra were chosen for relatively poor utilisation: the utilised amount was less than

[6] Financial Management Reports (FMRs) are quarterly expenditure statements submitted by State-level implementing agencies (State Health Societies) to the Ministry of Health and Family Welfare. It indicates the quarterly expenditure against the allocation for each budget head under NHM.

[7] Record of Proceedings (RoPs) is the minutes of the meeting of the National Program Coordination Committee (NPCC) for NHM, which highlights the final approvals for NHM in each year.

[8] It includes the components RCH-Mission Flexible Pool, Flexible Pool for communicable Diseases and Flexible Pool for non-communicable diseases and NUHM.

[9] It was further narrowed down based on discussions with officials of the Ministry of Health and Family Welfare.

half the allocated funds in these States. The insights drawn with respect to individual States were based on unstructured interviews and data provided by officials of State Health Societies (SHSs), Department of Health and Family Welfare and the Finance Departments of the three States for 2015-16 and 2016-17.[10]

V. Utilisation of Funds under the National Health Mission

Utilisation of NHM funds appears to be remarkably low in both the years. On average, only about 55 per cent of the funds allocated to States were actually spent (Table 1). The utilisation ratio was marginally lower in 'high-focus' States than in 'non-high focus' States (among non-NE States).[11] In particular, Tamil Nadu, Kerala, Gujarat, Punjab, Madhya Pradesh and Odisha ranked at the top, while Bihar, Uttar Pradesh, Jharkhand, Maharashtra and Telangana stood at the bottom in fund utilisation in the two years (Table 1). In the high-focus north eastern States (with the exception of Assam and Arunachal Pradesh), the utilisation ratio was low in both the years (Table 1).

A component-wise examination suggests that utilisation of funds under the Reproductive and Child Health (RCH) Flexible Pools and Mission Flexible Pools (MFP) were higher than those of other components of NHM (Table 1). Also, on average, in most States, the utilization of funds under the RCH flexible pool (RCHFP) was higher than the Mission Flexible pool. The utilisation ratio of funds under the Mission Flexible Pool was particularly low in high-focus States; varying between 45 and 52 per cent (Table 1). In States like Uttar Pradesh and Jharkhand, the utilisation of funds under the Mission Flexible Pool was only around a third of the allocation (Table 1). The relatively low utilisation of funds in high-focus States under the Mission Flexible Pool, which primarily deals with strengthening of health systems, is again possibly a reflection of weak institutions in these States.

[10] State Health Societies (SHSs) are the State-level implementing agencies for NHM in each State. (Refer Box 1)

[11] 'High-focus' States are those which have low health achievements and receive a relatively higher focus under NHM.

The problem of low utilisation is further compounded by a disproportionately high share of expenditure in the last quarter of the financial year. On average, about 40 per cent of total expenditure in States was incurred in the last quarter (Table 2). Among the high-focus NE States, the share of expenditure in the last quarter was even higher; more than two-thirds of total expenditure. Notably, although Assam and Arunachal Pradesh had better utilisation ratios than other north-eastern States, bulk of the expenditure (more than 70 per cent) was incurred in the last quarter.

In 2014-15, the first year in which NHM funds were routed through the State treasury, the utilisation ratio was much lower in 'high-focus' States than 'non-high focus' States (Appendix Table 1). This could possibly be a reflection of relatively weak institutions in these 'high-focus' States, which hindered easy adaptability to the change in the mode of fund flows under NHM in that year.

The low utilisation of funds and the disproportionate expenditure in the last quarter of the financial year in States could be due to delay in flow of funds to implementing agencies, which limits the availability of funds for expenditure at specific points of time. Alternatively, the nature of budget planning or involvement of agencies may be such that it poses hurdles to spending the budgeted resources. The following sections look into these aspects in three selected States to gain insights into the issues related to utilisation.

Table 1: Overall and component-wise utilisation ratios under the National Health Mission (NHM), 2015-16 and 2016-17 (per cent)

States	2015-16							2016-17						
	Overall	Part I: (RCH/Mission FP, Immunization, NIDDCP			Part II (FP_CD)	Part III (FP_NCD)	Part IV (FP_NUHM)	Overall	Part I: (RCH/Mission FP, Immunization, NIDDCP			Part II (FP_CD)	Part III (FP_NCD)	Part IV FP_NUHM
		Total	RCH_ FP	M_FP					Total	RCH_ FP	M_FP			
High-focus States (Other than North-East)														
Bihar	51	53	65	35	40	16	29	44	47	61	32	36	17	30
Chhattisgarh	56	64	71	60	63	14	49	67	69	66	71	66	30	70
Himachal Pradesh	59	63	65	61	49	29	9	69	71	79	68	49	22	53
Jammu and Kashmir	58	73	80	66	65	29	83	56	61	72	49	40	7	51
Jharkhand	42	44	52	35	87	11	-	48	54	74	37	48	26	15
Madhya Pradesh	74	-			68	59	53	70	71	76	67	54	61	54
Odisha	75	81	84	80	64	44	64	69	71	88	60	64	40	
Rajasthan	58	59	69	54	48	65	44	57	59	70	52	53	53	55
Uttar Pradesh	45	45	61	37	45	27	48	45	44	56	37	57	37	55
Uttarakhand	62	67	75	54	12	12	71	58	70	71	65	49	11	60
Average	**54**	**59**	**71**	**50**	**52**	**33**	**50**	**54**	**55**	**66**	**47**	**52**	**35**	**58**
Non-high focus Large States														
Andhra Pradesh	67	75	83	71	54	37	25	71	74	74	73	63	68	55
Gujarat	75	72	72	71	84	98	76	83	82	89	78	95	73	84
Haryana	60	74	79	63	50	31	60							
Karnataka	55	67	67	65	72	45	23	40	36	55	24	72	48	69
Kerala	70	76	79	72	62	89	63	80	84	85	82	51	56	76
Maharashtra	44	49	65	39	65	41	21	45	48	54	45	60	37	21
Punjab	69	64	77	56	64	53	46	79	82	88	82	62	55	79
Tamil Nadu	74	49	60	44	74	71	67	80	82	80	88	56	86	78
Telanagana	30	36	63	20	29	14	5	33	36	51	25	24	10	28
West Bengal	45	59	58	60	49	12	10	62	68	76	64	64	18	38
Average	**56**	**58**	**67**	**52**	**61**	**42**	**32**	**57**	**61**	**69**	**56**	**60**	**46**	**47**
High Focus North Eastern States														
Arunachal Pradesh	73	99	75		37	13	71	63	62	56	67	72	48	
Assam	68	69	75	65	49	39	55	72	76	77	76	39	32	57
Manipur	51	64	53	74	29	41	29	30	36	49	27	19	6	16
Meghalaya	42	72	77	70	38	13	65	43	45	54	41	40	24	26
Mizoram	46	70	72	69	-	22	57	42	44	49	38	37	42	16
Nagaland	32	60	73	45	15	-	48	36	40	46	35	16	24	39
Sikkim	49	50	66	40	61	66	60	59	63	69	60	42	52	31
Tripura	47	47	60	41	36	36	25	53	53	63	48	98	39	28

Average	**60**	**69**	**73**	**66**	**44**	**35**	**57**	**57**	**64**	**68**	**61**	**41**	**31**	**40**
All States	**55**	**60**	**70**	**52**	**55**	**37**	**38**	**55**	**58**	**67**	**51**	**54**	**39**	**50**

Source: Actual Expenditures have been compiled from the Financial Management Reports (FMR) of States. Data on total budget have been compiled from the Record of Proceedings (RoP)/supplementary RoP and FMR of States. 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.

Note: RCH_FP refers to Flexible Pool for Reproductive and Child Health, M_FP refers to Mission Flexible Pool, FP_CD refers to Flexible Pool for Communicable Diseases, FP_NCD refers to Flexible Pool for Non-Communicable Diseases and FP_NUHM refers to 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. The FMRs of States included information on four components: NRHM-RCH Flexible Pool' and 'Flexible Pool for Communicable Diseases', 'Flexible Pool for Non-Communicable Diseases' and 'National Urban Health Mission' (NUHM). The figures in the above table include all these four components.

Utilization is calculated as actual expenditure as a percentage of total budget in respective parts.

Table 2: Cumulative expenditure in each quarter under the National Health Mission, 2015-16 and 2016-17 (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)	
	2015-16	**2016-17**	**2015-16**	**2016-17**	**2015-16**	**2016-17**	**2015-16**	**2016-17**
Bihar	7	9	26	29	54	44	100	100
Chhattisgarh	-	19	36	39	59	64	100	100
Himachal Pradesh	-	9	37	44	61	62	100	100
Jammu and Kashmir	-	14	33	35	52	60	100	100
Jharkhand	-	16	24	41	55	61	100	100
Madhya Pradesh	-	8	36	33	61	58	100	100
Odisha	-	9	36	35	60	61	100	100
Rajasthan	17	14	39	37	65	63	100	100
Uttar Pradesh	8	12	27	35	55	58	100	100
Uttarakhand	13	13	30	28	67	56	100	100
Average	**6**	**12**	**32**	**35**	**58**	**58**	**100**	**100**
Andhra Pradesh	-	11	26	32	72	58		100
Gujarat	-	11	28	31	53	55	100	100
Haryana	-	15	42	39	61	61	100	100
Karnataka	-	11	31	36	54	61	100	100
Kerala	-	14	36	33	60	64	100	100
Maharashtra	-	7	28	26	57	59	100	100
Punjab	-	17	40	37	64	62	100	100
Tamil Nadu	-	7	38	40	52	69	100	100
Telanagana	17	13	34	29	58	52		100
West Bengal	-	15	37	37	60	59	100	100
Average	**1**	**11**	**33**	**34**	**58**	**60**	**100**	**100**
Arunachal Pradesh	-	6	28	19	77	34	100	100
Assam	-	10	33	30	70	58	100	100
Manipur	7	18	31	47	56	68	100	100
Meghalaya	17	13	27	30	49	72	100	100
Mizoram	-	17	33	37	51	56	100	100
Nagaland	-	13	44	30	70	61	100	100
Sikkim	-	17	39	40	59	51	100	100
Tripura	-	14	37	28	63	61	100	100
Average	**1**	**11**	**33**	**30**	**67**	**57**	**100**	**100**
All States	**4**	**12**	**32**	**34**	**59**	**59**	**100**	**100**

Source: Financial Management Reports (FMRs) of respective States

VI. Timeliness of Fund Flows in the Selected States

In the last two financial years (2015-16 and 2016-17), there has been substantial delay in release of funds from State treasuries to bank accounts of State Health Societies in Bihar and Maharashtra. In both the States, about 80 to 85 per cent of all funds received were credited to the bank account of State Health Societies (SHS) with a time lag of more than two months (Table 3 and Table 4). In Bihar, the delay was particularly high in 2016-17. More than 80 per cent of all funds received in 2016-17 were credited to the bank account of SHS after a gap of 3 months (Table 3). Even in Maharashtra, about 14 per cent of all funds received in SHS account in 2016-17 were credited with a lag of more than 3 months (Table 4).

The substantial delay in release of funds from the State treasury to the SHS account has adversely affected the utilization of funds in Bihar. In 2016-17, the delay resulted in a situation where the first instalment of NHM funds reached the SHS only by the end of December 2016, leaving only the last quarter to spend the amount (Appendix Table 2). This could be partially responsible for the fact that about 56 per cent of all expenditure in the State in that year was incurred in the last quarter (Table 2). Notably, the first instalment (which was credited to SHS at the end of December) constituted nearly 80 per cent of all funds received in that financial year. The remaining 20 per cent of the funds received in that year was received only on 31st March, the last day of the financial year (Appendix Table 2). In general, no funds sanctioned since November 2016 could be credited to SHS account before March 2017 (Appendix Table 2). Even in 2015-16, about 45 per cent of funds were received in the last quarter, of which 18 per cent were credited only in March (Appendix Table 2). This again could be partially responsible for the fact that nearly half of all expenditure in that year (46 per cent) was incurred in the last quarter.

In Maharashtra too, the delays had adverse effects on utilization of funds. In 2016-17, about a quarter of the funds released to State treasury from the Consolidated Fund of India, could not be released to State Health Society. Also, as in Bihar, no funds

sanctioned since December 2016 for Maharashtra could be credited to the SHS account before March 2017 (Appendix Table 3). In 2015-16, it was worse; nearly a third of the funds released to SHS in Maharashtra were credited only in March 2016 (Appendix Table 3).

Unlike Bihar and Maharashtra, the time taken for release of funds from State treasury to SHS account in Odisha was much lower. In 2016-17, about 94 per cent of all funds received by SHS were credited in less than a month's time (Table 5). In 2015-16, this proportion was around 84 per cent (Table 5). Importantly, more than 90 per cent of the funds received by SHS in 2016-17, and 85 per cent in 2015-16 were credited to the bank account of SHS by end of December in that financial year (Appendix Table 4).

Table 3: Number of days taken to credit Central Share in SHS account of Bihar

Number of days	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*		
	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
2016-17						
0-7	658.2	85.6	5	-	-	
8-15	111	14.4	12	0.2	0.02	13
16-30	0.2	0.02	*	-	-	
31-90				121.4	15.8	72
90+				647.8	84.2	113
Total	**769.4**	**100**		**769.4**	**100**	
2015-16						
0-7	635.1	82.2	4			
8-15	127.6	16.5	12	5.2	0.7	9
16-30	10.3	1.3	*	127.4	16.5	21
31-90				398.6	51.6	65
90+				241.9	31.3	154
Total	**773.1**	**100**		**773.1**	**100**	

Source: Finance Department, Bihar for date of receipt of funds in the State treasury. State Health Society (SHS) for date of credit of funds to SHS account and date of Sanction Orders. The dates of Sanction Orders were also cross-checked with list of Sanction Orders provided by the Ministry of Health and Family Welfare.

*In 2015-16, Rs. 20.37 Crore received in the State treasury could not be credited to the bank account of SHS by the end of the financial year. It was adjusted in the next financial year. GoI refers to Government of India.

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

Number of days	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*		
	Amount credited (Rs. Crore)	Distribution (per cent)	Avg. no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Avg. no. of days
2016-17						
0-7	615.6	88.6	5			
8-15	76.1	11.0	12			
16-30	2.8	0.4	27	2.8	0.4	30
31-90				595.2	85.7	56
90+				96.5	13.9	148
Total	**694.5**	**100**		**694.5**	**100**	
2015-16						
0-7	756.1	99.4	2			
8-15						
16-30						
31-90	4.8	0.6	50	658.8	86.6	57
90+				102.1	13.4	152
Total	**760.9**	**100**		**760.9**	**100**	

Source: Same as Table 3. *Note*: *In 2015-16, Rs. 59.75 Crore received in the State treasury could not be credited to the bank account of SHS by the end of the financial year. It was adjusted in the next financial year. In 2016-17, the amount was about Rs. 242.4 Crore.

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

Number of days	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*		
	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days	Amount credited (Rs. Crore)	Distribution (per cent)	Average no. of days
2016-17						
0-7	445.3	85.2	4	14.8	2.8	0*
8-15	66.4	12.7	9	71.0	13.6	12
16-30	10.6	2.0	64	406.6	77.9	23
31-90				29.8	5.7	38
90+						
Total	**522.2**	**100**		**522.2**	**100**	
2015-16						
0-7	446.4	97.1	3	66.9	14.6	3
8-15	6.3	1.4	12			8
16-30	7.0	1.5	22	318.9	69.4	22
31-90				17.5	3.8	66
90+				56.4	12.3	98
Total	**459.7**	**100**		**459.7**	**100**	

Source: Same as Table 3. *Note*: *In 2015-16, Rs. 11.21 Crore received in the State treasury could not be credited to the bank account of SHS by the end of the financial year. It was adjusted in the next financial year. In 2016-17, the amount was about Rs. 0.14 Crore.

VII. Institutional Features Affecting Timeliness

The procedures for fund release from the State treasury to SHS in Bihar and Maharashtra is unduly lengthy (Appendix Figure 2 and 5). As indicated in the figure, there are a minimum of 32 desks in Bihar and 25 desks in Maharashtra (in contrast to 10 in Odisha) through which the file for release has to pass through before funds can be released to SHS. Bulk of the movement of file over multiple desks is up and down the hierarchical State administrative set up for issuing Sanction Orders (SOs) by State Governments for releasing funds to SHS.[12]

In Bihar, specific structures for fund flows have complicated the process. Unlike Odisha and Maharashtra, there is an additional layer through which funds are channelled in Bihar. Funds received in the Consolidated Fund of Bihar (State treasury) are first transferred to a Personal Ledger Account (PL account) before being credited to the bank account of the State Health Society (SHS) (Figure 3). The Finance Department of the State has imposed restrictions on the amount that can be withdrawn at a time by SHS from the PL account, and additional processing of papers are required for complete withdrawal of any instalment of funds at a time. This adds to the time taken for release of funds. Additionally, unlike most other States, every instalment of release of funds to SHS in Bihar requires the approval of the Minister of Health, which further lengthens the process.

In Maharashtra, the separation of the process for releasing the GoI and State share of NHM funds makes the process cumbersome. In Bihar and Odisha, for every instalment, the requisition letter sent by SHS to the Health Department (HD) includes the claim for corresponding State share against each instalment from the Centre. The sanction letters are also processed in those States taking into account the combined claim by SHS for the Central and the State share. In contrast, in Maharashtra, the SHS first submits a requisition to the Health Department only for the Central share sanctioned. The State

[12] Sanction Order (SO) is an approval letter issued by the State Governments for release of funds.

share is claimed only after the Central share in each instalment is credited to SHS account. This increases the number of iterations required for the release of funds. Further, funds are released to multiple agencies for different parts of the program. The State share towards NHM under tribal-sub-plan is treated differently and released directly by the Tribal Development Department to Zilla Parishads (ZP) at the district-level, unlike other grants, which are released to State Health Society. The requisition for release of the State share under tribal sub-plan is therefore submitted and followed up by each District Health Society to the Chief Executive Officer (CEO) of the Zilla Parishad (ZP) in the respective district. This adds to the complications in the process of release of NHM funds.

In contrast, in Odisha, certain institutional arrangements help to simplify the process and reduce the number of desks through which the file has to pass through for releasing funds to SHS. For example, the placement of a 'Financial Advisor' (FA), an employee of the Finance Department (FD) within the Health Department prevents the need for the file (with requisition for release) to move to FD for approval. On receipt of requisition from the SHS, the FA prepares the draft Sanction Order in consultation with the FD and forwards it directly to the approving authority (Health Secretary). This reduces the requirement for moving the file up through multiple desks in the administrative hierarchy within the Health Department. This is in contrast to Bihar and Maharashtra wherein the file with the requisition passes through various desks up and down the administrative hierarchy.

It is important to recognise that releases to district-level implementing agencies are affected by the delay in receipt of funds at State Health Societies. In Bihar, around 78 per cent of all funds transferred to districts under the RCH-Mission Flexible Pool in 2016-17, were released after the SHS received the first instalment of funds at the end of December (Appendix Table 5). Bulk of the releases to districts were made two days after the SHS received the first instalment of funds in December, thereby indicating a strong association between receipt of funds in SHS account and release of funds to district-level health societies. In Maharashtra too, about 63 per cent of all releases to districts in 2016-

17 were made after funds were received by the SHS. More than a third of these were released after the receipt of first instalment of funds by the SHS (Appendix Table 5). In Odisha, the association was even stronger. About 81 per cent of funds transferred to districts under the RCH-Mission Flexible Pool were released after a day of receipt of funds in SHS account in that year (Appendix Table 5).

Notably, part of the delay in crediting funds to SHS account in Bihar and Maharashtra is on account of delay in approval and release of funds from GoI. In 2016-17, in both the States, the first sanction order was issued in the month of September, nearly 6 months since the beginning of the financial year. In Bihar, part of this was due to a delay in finalization of the Program Implementation Plan (PIP) and the approval of the NHM budget of that year. In Maharashtra however, although the NHM budget was approved in June, the issuance of sanction order for the first instalment was delayed due to the State's inability to meet various conditions required for the release of funds in that instalment. Notably, in most major States, the NHM budget was not approved before June, the end of the first quarter in the financial year.

VIII. Other Rigidities in the Financial Architecture

Structuring of NHM budget into more than a 1000 budget lines, and limited flexibility in the use of funds across different flexible pools poses a hurdle in utilisation. Even within the same 'Flexible pool', budgets are often strictly segregated. Under the flexible pool for communicable diseases, funds for disease control programs like the Revised National Tuberculosis Control Programme (RNTCP), National Vector Borne Disease Control Programme (NVBDCP) and National Leprosy Eradication Programme (NLEP) are earmarked and sanctioned by separate divisions within the Health Ministry and released separately. With separate budgets, releases and requirement of maintenance of accounts for individual disease control programmes, limited flexibility in using budgets across different heads exist even within the same pool.

The segregation of funds within the NHM budget and the requirement of separate financial reporting for each programme have complicated the implementing structure resulting in reduced transparency in utilization of funds. The reduced transparency has resulted into delays in fund releases in States like Bihar. A typical example of this is the existence of multiple bank accounts in implementing agencies which cater to different programmes under the scheme. Data provided by SHS in Odisha and Maharashtra suggest that the main (group) bank account of SHS is further subdivided into 8 to 9 sub-accounts to ensure segregation of funds under different programs. 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. 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.

The mode of State's contribution of their share of funding to NHM also adversely affects utilisation in States like Maharashtra. As noted earlier, in Maharashtra, the State share is not simultaneously released with the Central share from the State treasury unlike Bihar and Odisha. The request for release of State share by SHS is initiated only after the Central share is credited to the bank account of SHS. This results in inordinate delay resulting in either receipt of funds in the fag end of the financial year or non-receipt in the form of State share. In 2016-17, of the funds that were received in SHS out of GoI releases in that year, only about half the State share due was credited to the bank account of SHS. Besides, bulk of these (about 56 per cent) was credited only in March 2017, leaving little room for spending the amount in the financial year. Moreover, as the requests for State share are usually initiated after the receipt of Central share, on average it takes about 4 to 5 months to receive the State share from the date of issue of the Sanction Order by GoI. The situation is worse if one considers the fact that about a quarter of NHM funds received in State treasury of Maharashtra from GoI was not released to State Health Societies within that financial year, which implies that the contribution of State share was even lower.

The existence of SHS outside the administrative boundary of the State Governments has further added complexities. Being outside the State administration, NHM Funds can be released to State Health Societies (SHS) only in the form of Grants-in-aid (GIA), which in turn can be released only on issuance of a Sanction Order by the State Government.[13] Much of the time consumption in the release process of States is in the issuance of Sanction Order. 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 Sanction Order 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. These are withdrawn by a Drawing and Disbursing Officer (DDO) in the Health Department. (Box 2) Even in a relatively better performing State like Odisha, a significant number of days (nearly a week) are consumed in submission of bills even after the Sanction Order is issued.

Box 2: Withdrawal of NHM funds from State Treasury

Withdrawals from State treasuries are done by Drawing and Disbursing Officers (DDOs). DDOs are officers authorized by administrative departments with the concurrence of the Finance Department along with the Auditor General (A.G.) to withdraw funds from the State treasury under various budget heads. Health Societies implementing NHM in States (SHSs) are outside the administrative set-up of the State Governments and therefore, officers of SHSs cannot withdraw funds directly from State treasuries. An officer of the Health Department in each State is designated as the DDO for withdrawing NHM funds and disbursing it to SHSs. The State Health Societies are dependent on the designated DDO in the health department for submission of bills for withdrawal of NHM funds.

Utilisation can also be adversely affected by factors unrelated to the financial architecture. Deficiencies of physical inputs (like lack of human resources) in State health systems

[13] Grant-in-aid is a transfer of funds from the State Government to local Governments or implementing agencies for the purpose of funding a specific program or project.

pose major constraints in utilising 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 utilisation of funds under the Mission flexible pool in better performing States is higher than the poor performing States.

IX. Discussion

The routing of NHM funds from GoI to implementing agencies through State treasuries (since April 2014) has important implications for utilization of NHM funds. The involvement of State treasuries in processing NHM funds has increased the accountability of States towards NHM spending. However, this has added an additional administrative layer in the fund flow architecture, and has engulfed the fund flow process with complexities associated with States' administrative procedures for fund release. This has adversely affected the timeliness of availability of NHM funds for utilisation by implementing agencies. In the last financial year, bulk of the NHM funds released by GoI to Bihar was available for spending only in the last quarter, and this possibly contributed to the fact that more than half the NHM expenditure in the State was incurred only in the last quarter. In both Bihar and Maharashtra, no funds sanctioned since the end of the third quarter (December) could be released to implementing agencies before the last month of the financial year, leaving little room for effective utilisation.

The volume of fund releases to implementing agencies has also reduced in the new financial architecture. In Maharashtra, about a quarter of funds released to State treasury by GoI (and the corresponding State share) were not released to State Health Society. Of the GoI funds that were released by the State treasury, more than half the corresponding State share was not received by the SHS within the financial year. Further, due to apprehensions about releases, it has been a practice of the SHS to claim the State share only after the GoI share is credited to its bank account. This meant that the State share was received with an inordinate delay (a lag of 4 to 5 months) after the GoI release. More

than half of the State share was received by SHS only in the last month of the financial year. This has severely reduced the timely availability of funds to implementing agencies. Discussions with State officials suggest that the management of State finances by the Finance Department have a bearing on non-release of funds to implementing agencies, and this needs to be examined further. Similarly, in Bihar, the creation of a separate Personal ledger account for NHM funds within the State treasury and imposition of restrictions on the amount of funds that can be withdrawn from that account has implications for utilisation. Although the restrictions on the volume of fund withdrawal from the account have been repeatedly waived by the Finance Department on special request from the State Health Department, this has added complications and lengthened the process of fund release. As per the Finance Department, the creation of an additional account was required to deal with issues related to utilisation of NHM funds and their documentation by SHS.

The need for an additional account for SHS in Bihar arises from the fact that accounting methods under NHM are complicated. This reduces transparency in fund utilisation. Rigid budgetary structure with more than a thousand budget heads and strict segregation of NHM budgets and releases for different components require separate financial reporting for each component. This has led to the creation of multiple bank accounts of implementing agencies at the State and sub-state level. Releases to District Health Societies are made separately from each of the bank accounts of SHS. District Health Societies in turn release funds from multiple bank accounts to lower level implementing units or health facilities for different programmes. With increased accountability of the State towards NHM spending (due to channelling of funds through State treasury), the State Finance Department has been concerned about utilisation of NHM funds. Although the Public Financial Management Systems (PFMS) was introduced to increase transparency in fund flows of Centrally Sponsored Schemes like the NHM, till recently, this was inadequate to deal with the concerns of the Finance Department about utilisation of NHM funds.

The existence of SHS outside the administrative structure of the State Governments has also added complexities in the process of fund release. Being outside the State administration, NHM Funds can be released to State Health Societies (SHS) only in the form of Grants-in-aid (GIA), which in turn can be released only on issuance of a Sanction Order by the State Government. 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 Sanction Order is required for release of funds. Much of the time in the release process is spent in the issuance of Sanction Order. In addition, being outside the States' administrative setup, NHM grants cannot be withdrawn directly by SHS from the State treasury as they are not a part of the State administration. The SHS is dependent on a Drawing and Disbursing Officer (DDO) in the Health Department for submission of bills to the State treasury on behalf of SHS for release of funds.

Keeping these in view, the following options need be considered:

Integration of SHS with State administration: The process for release of NHM funds to SHS is time consuming primarily due to the fact that SHS is outside the State's administrative setup. As pointed out by some State officials, if SHS was brought within the administrative setup of States, the need for a separate Sanction Order for release of funds to SHS could be done away with. Correspondingly, the time required for processing the sanction order (which consumes bulk of the time taken for release) could be curtailed significantly. The integration of SHS with the State administration could also mean that the parallel implementing machinery of NHM will cease to exist, and this will potentially bring about a greater degree of coordination between the States' health expenditure and NHM spending. With States now contributing nearly half the NHM programme funds (40 per cent) and recommendations for increasing States' contribution to the scheme over time, the integration of State and NHM expenditure is likely to bring about several gains.

The drawback of such integration however, is the fact that the flexibility which NHM funds extended to health facilities in most States would be reduced to considerable extent as utilisation of funds would then be affected by the rigidities of the State treasury system. In the present setup, while the complex administrative procedures of State Governments delay the receipt of NHM funds by implementing agencies, but once released, they are not bound by the rigidities of the State treasury system. NHM funds have extended appreciable flexibility to spending in health facilities, and a reduction of this flexibility may not be desirable.

Till the feasibility of such integration is explored in details, steps need to be taken up to reduce the time taken for release of funds to SHS through some of the following measures:

Simplification of the release process: The process for release of funds to SHS needs to be simplified significantly. A comparison of the release process in the three States suggests that in Odisha, only about 10 desks were involved in the process of release in comparison to a minimum of about 25 desks in Maharashtra and 32 in Bihar. Correspondingly, the time consumed in the release of funds to SHS from the Sate treasury in Odisha was substantially shorter (less than 25 days as compared to 2 to 3 months in Bihar and Maharashtra). It is important to note that in Odisha, a single nodal officer (the Financial Advisor and his section) prepares the draft Sanction Order on receipt of the request for release from SHS, and sends it directly across the competent authority for approval. This is unlike Bihar and Maharashtra, where the file has to move through several desks up and down the administrative hierarchy in the State leading to major delays.

The process is particularly cumbersome in Bihar, wherein even the approval of the Health Minister is sought for every release, unlike Odisha and Maharashtra. Besides, in Bihar, two orders are required for release of funds of SHS: the Sanction Order and the Allotment Order. In states like Odisha and Maharashtra, these are combined into a single Sanction Order which simplifies the process. The same should be considered in Bihar.

The creation of an additional account in Bihar (PL Account) for parking NHM funds before releasing to SHS also consumes additional time. In both Odisha and Maharashtra, no such intermediate accounts exist between the State treasury and SHS, and the need for such an account in Bihar needs to be re-examined.

Greater transparency in accounting and utilisation: Discussions with officials of the Finance Department suggested that with increased accountability of States for NHM spending, there has been a rise in concern over utilisation issues of NHM funds. Multiplicity of bank accounts and complex accounting structures has resulted in lower transparency in utilization of NHM funds. The reduced transparency has posed hurdles in NHM fund release to SHS causing delay. It is therefore, important to simplify the accounting and banking structure of NHM to improve transparency and reduce delay. In this context, it may be worthwhile to create a single bank account under NHM at the State-level from which all sub-State implementing agencies and health facilities directly draw funds. Such central bank accounts have been used in other schemes like the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) and Pradhan Mantri Awas Yojana (PMAY).

The NHM budget is also relatively rigid with a large number of budget lines. This complicates the fund flow structure reducing transparency and effectiveness. A relatively flexible budgetary structure will not only have a significant bearing on improving utilisation and effectiveness of NHM funds, but also contribute towards greater complementarity with health spending by States. Further, annual planning of NHM budgets has to be linked with a medium term expenditure framework for better translation of expenditure into the targeted outputs.

Examining State financial management issues in Maharashtra: Apprehensions about whether or not funds will be released by the State Government have complicated procedures in Maharashtra. The State share of NHM is requested by SHS only after the GoI share is credited to its bank account. This has led to extraordinary delays in receiving State share by SHS (a lag of 4 to 5 months). Notably, in Bihar and Maharashtra, both the GoI and

the State share are claimed simultaneously for each instalment. Even with respect to GoI share, a significant part received by the State treasury is not released to SHS within the financial year. This pending amount is not negligible: nearly a quarter of GoI releases to State treasury were not received by the State Health Society in the last financial year. As per the officials of the State, the reason for non-receipt of a substantial sum of NHM funds from State treasury and apprehensions about releases can be attributed to management of State Finances by the Finance department. This needs to be examined in details.

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Appendix Tables

Appendix Table 1: Overall and component-wise utilisation ratios under the National Health Mission (NHM), 2014-15 (per cent)

States	Utilisation Ratios				
	2014-15				
	Overall	**Part I**: RCH FP/Mission FP/Immunization/NIDDCP			**Part II** FP for Communicable diseases
		Total	RCH Flexible Pool	Mission Flexible Pool	
High-focus States (Other than North East)					
Bihar	50	52	56	40	41
Chhattisgarh	57	59	64	56	36
Himachal Pradesh	71	72	72	75	45
Jammu and Kashmir	60	60	61	61	43
Jharkhand	35	36	42	27	-
Madhya Pradesh	76	77	89	65	72
Odisha	69	72	76	70	73
Rajasthan	69	69	77	65	54
Uttar Pradesh	42	41	66	27	45
Uttarakhand	66	67	75	58	53
Average	**54**	**54**	**66**	**45**	**46**
Non-high focus Large States					
Andhra Pradesh					
Gujarat	54	53	69	43	67
Haryana	82	84	88	77	54
Karnataka	65*	65	63	67	53
Kerala	66	67	82	55	47
Maharashtra	65	77	70	81	56
Punjab	50	50	65	41	48
Tamil Nadu	83	84	74	90	54
Telanagana					
West Bengal	44	45	56	32	46
Average	**62**	**65**	**68**	**63**	**54**
High Focus North Eastern States					
Arunachal Pradesh	38	41	53	35	22
Assam	48	49	65	34	45
Manipur	46	48	44	52	28
Meghalaya	38	42	38	47	33
Mizoram	41	40	44	35	45
Nagaland	36*	45	55	33	-
Sikkim	26	65	74	58	39
Tripura	84*	86	67	98	64
Average	**48**	**49**	**60**	**40**	**36**
All States	**56**	**58**	**66**	**52**	**48**

Source: Actual Expenditures have been compiled from the Financial Management Reports (FMR) of States. Data on total budget have been compiled from the Record of Proceedings (RoP)/supplementary RoP and FMR of States. Total budget includes both committed and uncommitted unspent balances in each year and the expected contribution of the State and the Centre.

Note: Expenditures under 'Infrastructure Maintenance' (IM), have been excluded from the above analysis. In 2014-15, FMRs of States provided information for only two components: 'NRHM-RCH Flexible Pool' and 'Flexible Pool for Communicable Diseases'. The figures of 2014-15 in the above table therefore, include only these two components.

Utilization is calculated as actual expenditure as a percentage of total budget in respective parts. * Data on Committed unspent balance was reported as zero and hence, needs to be treated with caution.

Appendix Table 2: Receipt of different instalments released by GoI during the years 2015-16 and 2016-17 in Bihar

Release Towards	Date of Sanction Order (SO)	Date of receipt in SHS Ac	Share of total receipts from GoI (per cent)
2016-17			
NRHM-RCH Flexible Pool	2nd Sept, 2016	26th Dec, 2016	78.9
RNTCP	7th Nov 2016	31st Mar, 2017	2.8
IDSP	29th Nov, 2016	31st Mar, 2017	0.3
NVBDCP	9th Dec, 2016	31st Mar, 2017	2.3
NRHM-RCH Flexible Pool	13th Jan, 2017	31st Mar, 2017	15.8
Total			**100**
2015-16			
NRHM-RCH Flexible Pool	24th June, 2015	11th Sep, 2015	48.6
		29th Dec, 2015	3.8
		25th Jan, 2016	22.4
RNTCP	29th June, 2015	11th Sep, 2015	1.8
		25th Jan, 2016	1.0
NUHM	8th July, 2015	15th Dec, 2015	2.1
NVBDCP and Flexible Pool for NCDs	30th Sep, 2015	16th Feb, 2016	2.0
NPCDCS	21st Oct, 2015	31st Mar, 2016	0.05
IDSP	9th Dec, 2015	16th Feb, 2016	0.2
NVBDCP	15th Dec, 2015	18th Mar, 2016	0.6
NVBDCP	11th Feb, 2016	19th Mar, 2016	1.6
NVBDCP	24th Feb, 2016	31st Mar, 2016	15
NRHM-RCH Flexible Pool	29th Feb, 2016	31st Mar, 2016	0.9
Flexible Pool for NCDs	25th Feb, 2016	**Not received@**	
NLEP	22nd Mar 2016		
Total			**100**

Source: State Health Society, Bihar

@ Some of the funds credited to the State treasury could not be credited in SHS bank account within the financial year. It was adjusted in the next financial year.

Appendix Table3: Receipt of different instalments released by GoI during the years 2015-16 and 2016-17 in Maharashtra

Release Towards	Date of Sanction Order (SO)	Date of receipt in SHS Ac	Share of total receipts from GoI
2016-17			
NRHM-RCH Flexible Pool	21st Sep, 2016	29th Oct, 2016	68.4
	21st Sep, 2016	9th Dec, 2016	7.1
Flexible Pool for NCDs	30th Sep, 2016	24th April, 2017	3.7
RNTCP	11th Nov, 2016	1st Feb., 2017	6.2
		2nd Mar, 2017	0.6
NVBDCP	9th Dec, 2016	26th April, 2017	0.7
		24th April, 2017	0.1
NUHM	26th Dec, 2016	20th April, 2017	1.9
		24th April, 2017	6.9
IDSP	19th Jan., 2017	24th April, 2017	0.3
NRHM-RCH Flexible Pool	28th Feb., 2017	24th April, 2017	4.1
Total			**100**
2015-16			
NRHM-RCH Flexible Pool	15th Sep, 2015	20th Oct, 2015	52.1
		5th Dec, 2015	6.2
		28th Dec, 2015	7.8
RNTCP	29th Sep, 2015	28th Dec, 2015	1.5
		29th April, 2016	2.3
Flexible Pool for NCDs	30th Sep, 2015	29th Feb., 2016	2.5
		11th Mar, 2016	0.4
		29th April, 2016	0.3
NVBDCP	8th Oct., 2015	29th Feb., 2016	0.5
		11th Mar, 2016	0.1
		29th April, 2016	0.1
NLEP	7th Dec, 2015	29th Feb., 2016	0.3
		11th Mar, 2016	0.04
		29th April, 2016	0.03
NCD	25th Feb., 2016	29th April, 2016	0.5
NRHM-RCH Flexible Pool	26th Feb., 2016	31st Mar, 2016	23.2
		29th April, 2016	2.4
Total			**100**

Source: State Health Society, Maharashtra

@ Some of the funds credited to the State treasury could not be credited in SHS bank account within the financial year. It was adjusted in the next financial year.

Appendix Table 4: Receipt of different instalments released by GoI during the years 2015-16 and 2016-17 in Odisha

Release Towards	Date of Sanction Order (SO)	Date of receipt in SHS Account	Share of total receipts from GoI (per cent)
2016-17			
NRHM-RCH Flexible Pool	2nd June, 2016	27th June, 2016	61.6
NVBDCP	22nd June, 2016	27th June, 2016	10.0
RNTCP	29th June, 2016	27th July, 2016	1.6
NUHM	9th Sep, 2016	8th Nov, 2016	1.7
NLEP	10th Oct, 2016	3rd Feb, 2017	0.4
NUHM	5th Dec, 2016	29th Dec, 2016	0.8
Flexible Pool for NCDs	8th Dec, 2016	3rd Feb, 2017	1.9
NRHM-RCH Flexible Pool	9th Dec, 2016	29th Dec, 2016	12.4
Flexible Pool for NCDs	20th Jan, 2017	28th Feb, 2017	1.9
NUHM	31st Jan, 2017	28th Feb, 2017	0.8
NRHM-RCH Flexible Pool	8th Feb, 2017	4th Mar, 2017	2.2
IDSP	23rd Feb, 2017	27th Mar, 2017	0.3
RNTCP	28th Feb, 2017	27th Mar, 2017	1.6
NVBDCP	29th Mar, 2017	31st mar 2017	2.8
NLEP	23rd Mar 2017	Not Received@	
Total			**100**
2015-16			
NRHM-RCH Flexible Pool	9th June, 2015	27th June, 2015	64.8
RNTCP/IDSP	29th June, 2015	27th July, 2015	3.0
NVBDCP	6th July, 2015	19th Aug 2015	1.5
NLEP	31st July, 2015	8th Oct 2015	0.2
Flexible Pool for NCDs	30th Sep 2015	4th Nov 2015	2.3
NRHM-RCH Flexible Pool	17th Dec 2015	23rd Dec 2015	14.6
NRHM-RCH Flexible Pool	17th Dec 2015	29th Mar 2016	7.0
NUHM	22nd Dec 2015	29th Mar 2016	5.3
NVBDCP	28th Dec 2015	29th Mar 2016	0.8
IDSP	31st Dec 2015	29th Mar 2016	0.4
NVBDCP	15th Dec 2015/30th Mar 2016	Not received@	
Flexible Pool for NCDs	25th Feb 2015		
NLEP	31st Dec 2015/22nd Mar 2016		
Total			100

Source: State Health Society, Odisha

@ Some of the funds credited to the State treasury could not be credited in SHS bank account within the financial year. It was adjusted in the next financial year.

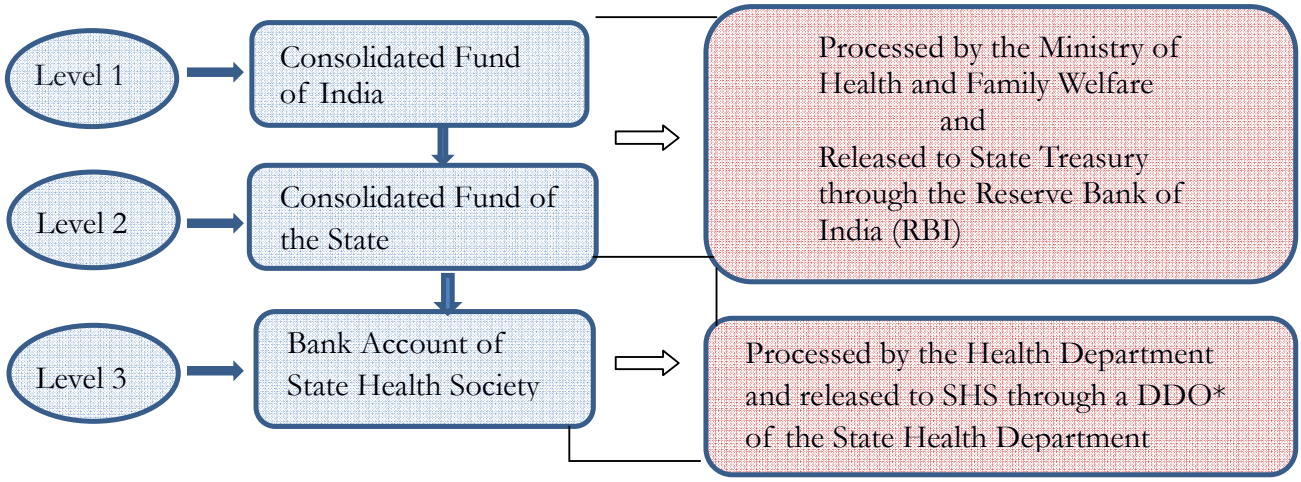
Appendix Table 5 Association of releases to districts with receipt of funds at SHS

	1st instalment received	
Bihar	In SHS	26th Dec
	Date of release to districts (63 % of all releases after receipt of first instalment at SHS)	28th Dec
Maharashtra	In SHS	29th Oct
	Date of release to districts (63 % of all releases after receipt of first instalment at SHS)	10th Nov
Odisha	In SHS	27th June
	Date of release to districts (81 % of all releases after receipt of first instalment at SHS)	28th June

Appendix: Features of Fund Flows to State-level Implementing Agencies

A. General Features

Appendix Figure1: Flow of Funds to State Health Societies under the National Health Mission



The NHM is administered through the State Health Societies and this section focuses on the general process of release of funds to these societies at the State-level:

Releases from the Consolidated Fund of India: Releases from the Consolidated Fund of India are processed by the Ministry of Health and Family Welfare. The process for release begins with the issuance of Sanction Order (SO) for specific programmes. Bulk of the Sanction orders (SOs) is issued in two instalments in each programme.[14] For the first instalment (which is usually the largest amount released in the financial year), the Sanction Order is processed only if two conditions are met by States (i) have submitted the financial management Report (FMR) and the provisional fund utilization certificate (UC) for the previous financial year, and (ii) have contributed the required State share in the previous financial year and there are no arrears on this account. For the second instalment, SOs are issued if States submit (i) audited UC and audit report of the previous year, and (ii) FMR for the previous quarter.[15] For each instalment, the issuance

[14] Infrastructure maintenance and kind grants are exceptions to this rule.

[15] Interestingly, Sanction orders are issued by multiple units within MoHFW. For National Urban Health Mission (NUHM) and Disease Control Programmes for Communicable Diseases like the Revised Tuberculosis Control Programme (RNTCP), National Leprosy Eradication Programme (NLEP) and National Vector Borne Disease

of a Sanction Order is followed by an advice to the Reserve Bank of India (RBI) for credit of funds to the respective State accounts. On receipt of this advice, RBI informs the Finance Department (FD) of the respective States about the credit of NHM funds.

Releases from the Consolidated Fund of the State: NHM Funds are released to State Health Societies (SHS) from the State budget in the form of Grant-in-aid (GIA). For releases of GIA, a sanction order has to be issued by the State Government, following which, a Drawing and Disbursing Officer (DDO) in the Health Department withdraws funds from the State treasury and releases it to SHS.

The SHS initiates the process for the issuance of sanction order. On receipt of information on GoI Sanction Order, SHS submits a request to the Health Department for release of NHM funds.[16] Following the request from SHS, the Health Department of each State processes the file (in consultation with the Finance Department) and issues the Sanction Order for release. The DDO in the Health Department of the respective States who has been delegated the responsibility of withdrawing funds on behalf of SHS then prepares the necessary bills and submits to the State treasury for release. The treasury in turn credits the requested amount to the bank account of State Health Society by way of e-transfer (as in Odisha and Maharashtra), or issues a Demand Draft in favour of the State Health Society (as in Bihar).

The details of the processes in the three States are discussed in the following section.

B. Unique Features: Bihar

The process of release of funds from the State treasury to SHS in Bihar is shown in Appendix Figure 2. As indicated in the figure, there are a minimum of 32 desks through

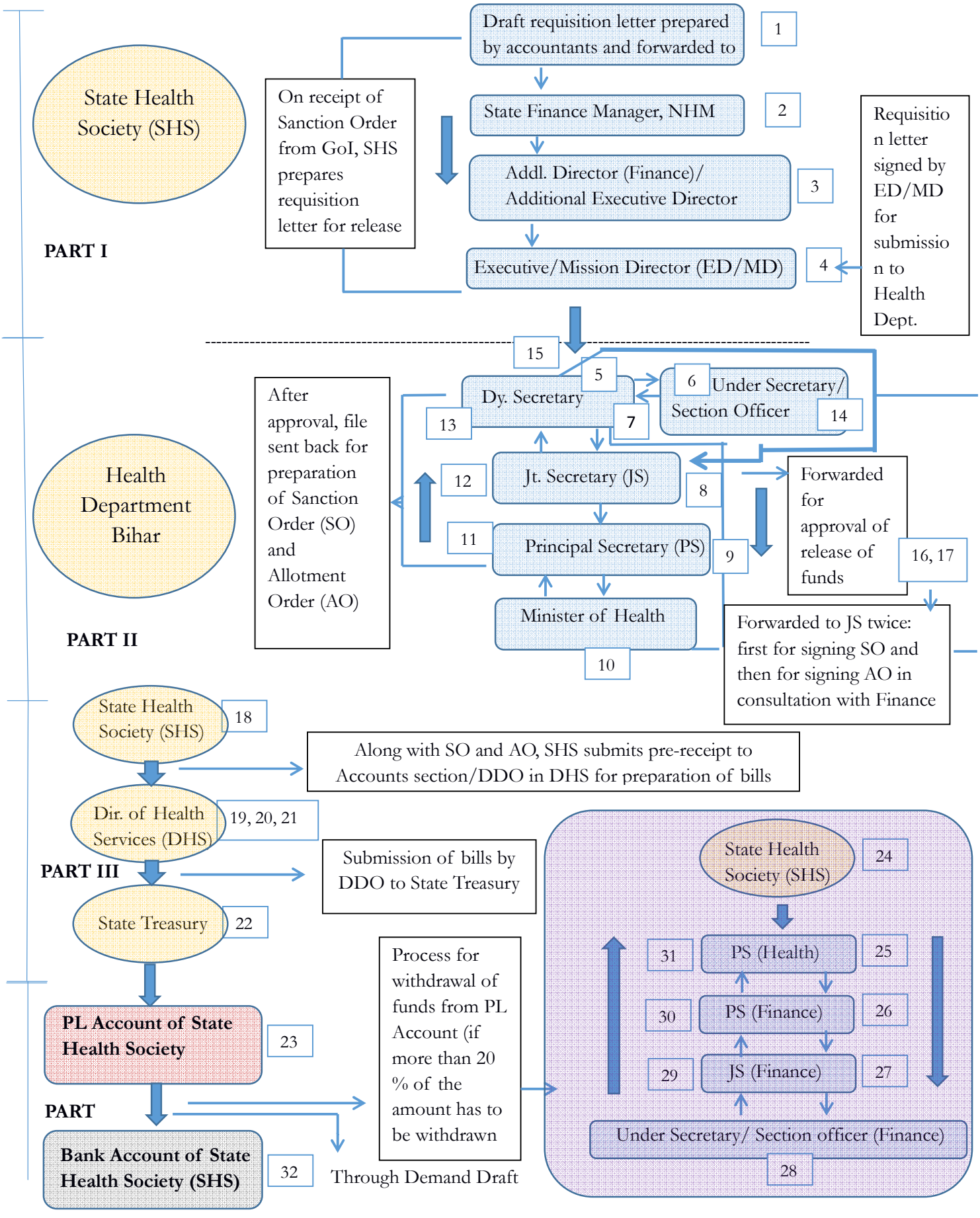
Control Programme (NVBDCP), sanction orders are issued by the individual disease control divisions, while for the remaining components of NHM, Sanction Orders are issued by the NHM (Finance) division within MoHFW.

[16] The Department of Health and Family Welfare here refers to the *Health Department* in Bihar and the *Public Health Department* in Maharashtra.

which the file for release has to pass through before funds can be released to SHS. Bulk of this is within the Health Department. The requisition from SHS is received by the Deputy Secretary (DS) in the Health Department, who then sends it up the hierarchy to the Health Minister for approval (Appendix Figure 2). Notably, unlike most other States, every instalment of release of funds to SHS in Bihar requires the approval of the Minister of Health. Following the approval from the Minister, the file is sent back to DS through the Principal Secretary for preparation of Sanction order. The prepared sanction order is then sent up the hierarchy again to the Joint Secretary (JS) for signing. This is followed by an allotment order, prepared by the section under DS and sent up to JS for signing. The sanction and the allotment order together constitute the sanction for release of funds in Bihar.[17] Once the sanction and allotment orders are issued, the SHS sends a request to the Directorate of Health Services (DHS) for submission of bills to the State treasury for release of funds

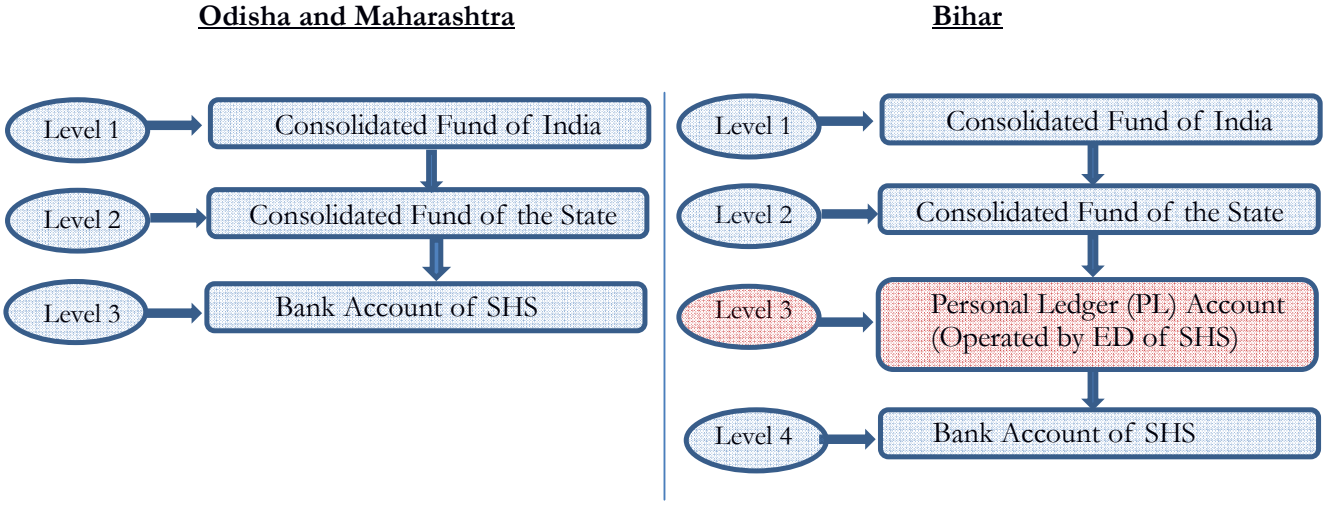
[17] This is unlike Odisha and Maharashtra where a single order is issued as sanction for release.

Appendix Figure 2: Process for release of NHM funds from State treasury to State Health Society in Bihar



Importantly, unlike Odisha and Maharashtra, there is an additional layer through which funds are channelled in Bihar. Funds received in the Consolidated Fund of Bihar (State treasury) are first transferred to a Personal Ledger Account (PL account) before being credited to the Bank account of the State Health Society (SHS) (Appendix Figure 3).[18] In other words, funds have to flow through an additional account, which exists between the Consolidated Fund of the State and the State Health Society (Appendix Figure 3).The issuance of sanction and allotment order in Bihar is only to release funds to the PL account of the State Health Society.

Appendix Figure 3: Flow of Funds to State Health Societies in Selected States



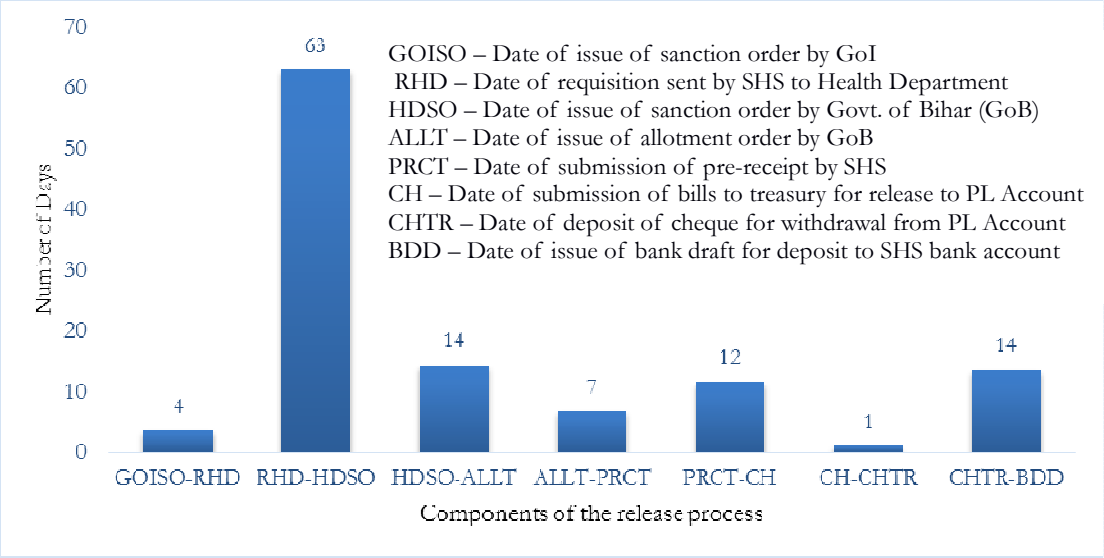
*Source:*Officials of the Finance Department and State Health Society, Bihar

Till recently, as per the notification of the Finance Department, only 20 per cent of the funds deposited in the PL account could be withdrawn by SHS at a time. However, in 2015-16, with special request from the Principal Secretary (Health), the Finance Department had allowed SHS to withdraw significantly larger proportion of funds against each instalment received in the PL account. In 2016-17, the Finance Department

[18] PL account is an account of the State Health Society within the State treasury. It is used for depositing funds that are received by the State Government for transfer to the State Health Society. Unlike the treasury where unutilized funds lapse at the end of each financial year, funds deposited in the PL account lapse only at the end of three consecutive financial years.

had allowed 100 per cent withdrawal of each instalment under special request from the Principal Secretary (Health).[19] Although the restriction on the upper limit of withdrawal of funds from PL account was waived by FD for every instalment, and was not implemented in practice, the need for special request for waiver in each instalment lengthened the process of withdrawal of funds.

Appendix Figure 4: Average delay in various components of the process of release for NHM funds in Bihar in 2016-17 (number of days)



Source: State Health Society, Bihar

An examination of the average number of days consumed in various parts of the process for release of NHM funds in 2016-17 suggests that most of the time was consumed in issuing the sanction order (around two months). This was primarily on account of the large number of desks through which the file had to pass through for approval (including the office of the Minister of Health). Interestingly, even between the issuance of the sanction order and the allotment order (both of which are issued by the same unit of the health department), there was a gap of about 14 days on average. Similarly, nearly half a month was required for withdrawal of funds from the PL account even after the funds

[19] An examination of the receipts and payments from the PL account (information provided by the Finance Department), shows that all funds deposited in the PL account in 2015-16 and 2016-17 were withdrawn by SHS.

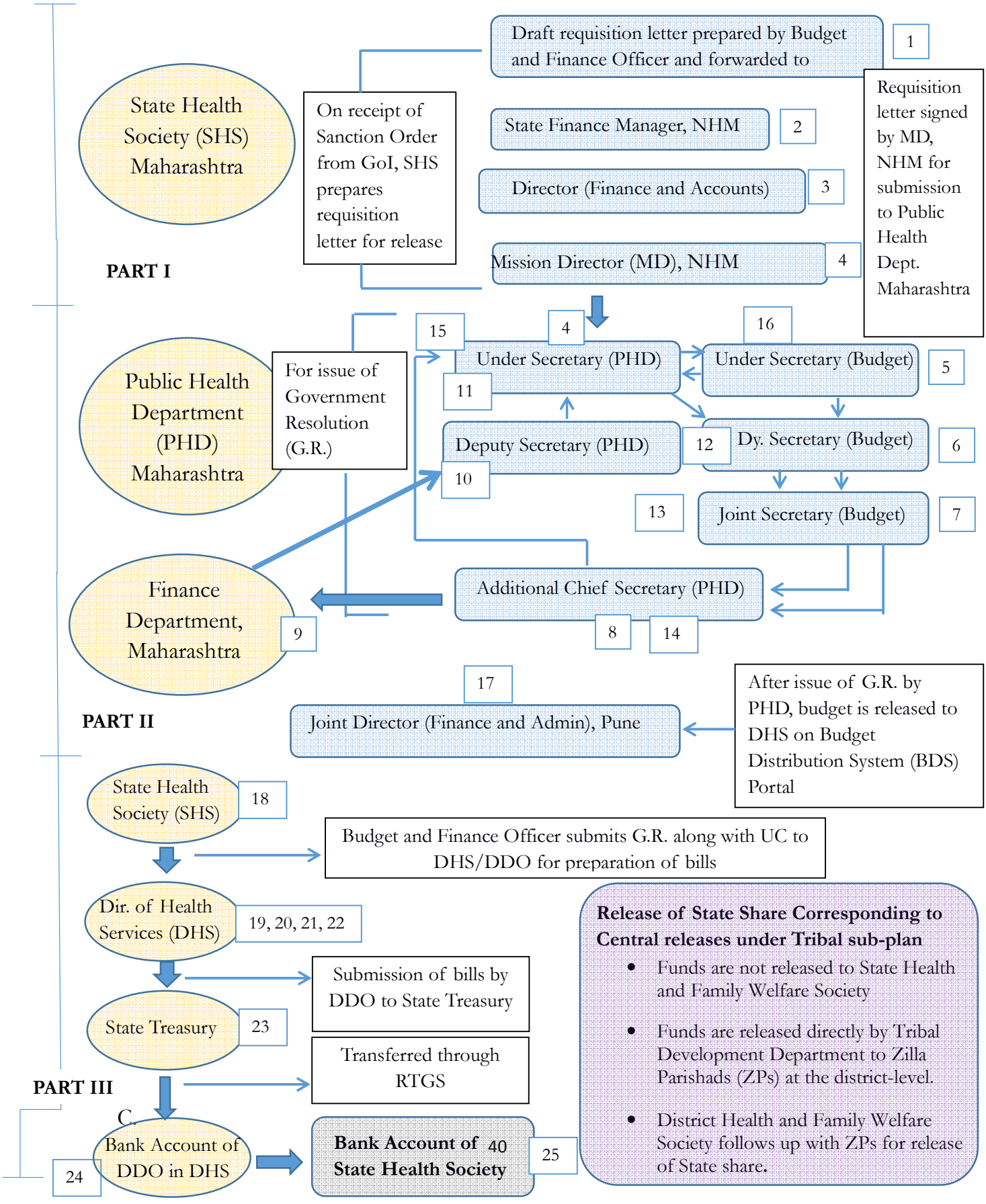
were available in that account. This delay can be largely attributed to the restrictions on the withdrawal of funds from the PL account, and the need for additional processing of papers for withdrawing the complete instalment of funds at a time. It may be recalled that if more than 20 per cent of the funds deposited in the PL account had to be withdrawn at a time, the Principal Secretary Health had to make a special request to the Finance Department for allowing complete withdrawal of funds. This required the file to be processed by another seven to eight desks, leading to the consumption of about 14 days on average for withdrawal of funds from the PL account.

Unique Features: Maharashtra

In Maharashtra, there are at least 25 desks through which the file for release has to pass through before funds can be credited to the bank account of SHS (Appendix Figure 5). As in Bihar, most of these are within the Health Department. Till 2015-16, the process for release of NHM funds was even lengthier. The request for release used to be processed by 13 different units within the Health Department as the NHM budget is spread out over 13 different budget heads in the State budget. Besides, the Planning Department was also involved in processing the file (in addition to Finance and Health Department). Since 2016-17, the process has been relatively simplified. The file for release is now processed only by the Health and the Finance Department and request for all programmes are processed by a single section within the Health Department. Despite the simplification, the process remains cumbersome. The file with the request for release of funds by SHS is placed on the desks of multiple officers in the hierarchy of the Health Department and the Finance Department (Appendix Figure 5). Within the Health Department, the movement of file happens multiple times along the hierarchy for approval and signing the Sanction Order (known as 'Government Resolution' (G.R.) in Maharashtra).

The separation of the process for release of the GoI and the State share of NHM funds in Maharashtra further complicates the process. In Bihar and Odisha, for every instalment, the requisition letter sent by SHS to the Health Department includes the claim for corresponding State share against each instalment from the Centre. The sanction letters are also processed in those States taking into account the combined claim by SHS for the Central and the State share. In contrast, in Maharashtra, the SHS first submits a requisition to the Health Department only for the Central share sanctioned. The State share is claimed only after the Central share in each instalment is credited to SHS account. This increases the number of iterations required for the release of funds.

Appendix Figure 5: Process for release of NHM funds from State treasury to State Health Society Maharashtra



D. **Unique Features: Odisha**

In Odisha, the process for release of funds is relatively simple. There are only about 10 desks through which the file with the requisition for release has to pass through before funds can be credited to the bank account of the State Health Society (Appendix Figure 6).

Certain institutional arrangements help to simplify the process for release in Odisha. First, the placement of a 'Financial Advisor' (FA), an employee of the Finance Department (FD) within the Health Department prevents the need for the file (with requisition for release) to move to the Finance Department for approval. The 'Financial Advisor' in the Health Department clears issues with the FD without having the file to move to FD. This speeds up the process. Secondly, unlike Bihar and Maharashtra, the file does not move back and forth in the chain of hierarchy within the Health Department. On receipt of requisition from the State Health Society, the FA checks with the FD and sends the file to the relevant section in the Health Department for preparation of the Sanction Order. The draft Sanction Order is then forwarded to the Secretary of the Health Department for approval, from where it is passed on to the DHS for preparation and submission of bills by the DDO. In other words, the file with the requisition from SHS is moved up only once after clearance by FA and preparation of Sanction Order by the relevant section in the Health Department. Thirdly, the draft sanction order prepared by the relevant section is sent directly by the FA to the secretary, and does not pass through the entire hierarchy within the Health Department. This is in contrast to Bihar and Maharashtra wherein the file with the requisition passes through various desks up and down the hierarchy within the Health Department.

Appendix Figure 6: Process for release of NHM funds from State treasury to State Health and Family Welfare Society in Odisha