District Sector Fund Flow, Resource allocations and utilisation: Issues and Challenges in Odisha

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This policy paper attempts to examine the resource transfer processes and utilization of funds for health at the district level in two select districts of Odisha. The findings provide insights to improve the fund flows at the district level which is the main implementation unit for health services.

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Contents

1. Introduction

Budget preparation is an important health sector concern. More funds for health sector will not achieve universal health coverage (UHC) unless well-functioning financial management systems are in place and the funds are utilized efficiently. The way the budgets are formulated and budget allocations are made has a direct bearing on the performance of health sector (1).Understanding budget formulation process, prioritization, the level and nature of public expenditure, allocation and utilization pattern are crucial in order to increase efficiency of public spending. Though prioritization of expenditure is a political process rather than purely a technical exercise, understanding of these issues will help influence the process to enhance health system performance. In India, the annual budget for the union government is prepared by the finance ministry with support from other ministries and passes through –preparation phase, parliamentary approval, execution, and auditing. During preparation phase, the finance ministry makes consultations with different bodies – industry representatives, political parties, and civil society organizations to take their views on budget priorities. During this stage, the budget can be influenced by placing demands.

Current evidences on resource allocation and spending on national health mission (NHM) in India suggest wide gap between planning, release, and actual expenditure in backward districts. Higher proportion of NHM money is spent at the district level and higher devolution takes place for some specific programs – RCH flexi pool and mission flexi pool at the district and sub district level(2)(3). Further a study carried out in Uttarakhand found that top-down approach is followed instead of bottom-up approach as suggested by the NHM. This may imply that inputs from lower level are not taken as well as resource needs of the lower level facilities are not fulfilled (4). A recent study suggests huge underutilization of NHM money to the extent of 45% and is mainly due to higher share of the release of funds in the last quarter. In some states like Bihar and Maharashtra there is substantial delay in the release of funds from the state treasury to health societies. In contrast in Odisha more than 94 percent of funds are released in less than a month's time (5). Health being a state subject in India, resource transfer system from the state to health care providers, budget execution at the district and sub district level are crucial issues. These assume significance in strengthening decentralized planning at the district and execution process which leads to efficiency in public spending.

2. Research Methodology

2.1 Objectives of the study

(1) Examine the mechanisms/processes involved in budget preparation, budget disbursement and fund utilization at the district level
(2) Analyze the trend and pattern of public health expenditures in the two selected districts of Odisha during 2013-14 to 2017-18

2.2 Methodology and Data Sources

We used a mixed method approach – combination of quantitative and qualitative methods to critically investigate the above-mentioned research questions. We collected budget allocations, expenditure, and utilization data from the Integrated Financial Management System (IFMS), Odisha and from the district head quarter hospital (DHH), and community health centers (CHCs). The National Health Mission (NHM) data were collected from the state national health mission and DHH district national health mission. Analysis of budget allocation, expenditure, and utilization of different programs both for NHM and treasury were done for 5 years from 2013-14 to 2017-18.

In the study, we have followed public finance management (PFM) framework to understand the fiscal transfer system in Odisha(6). A standard budget cycle includes three distinct stages: budget formulation, budget execution and budget monitoring. Based on the above framework, qualitative interview with officials of both the department of health & family welfare, the department of finance, NHM staff and district program managers and other providers at the district and sub district level was conducted.
For this study, we selected two districts – Rayagada and Balasore. The two districts present diverse characteristics of Odisha. Balasore is a coastal district with more advanced health and development indicators, whereas Rayagada is a tribal and underdeveloped district with poor socio-economic and health indicators.

Table-1: Health infrastructure and expenditure in two districts

Indicators	**Rayagada**	**Balasore**
Total population (In Lakhs)	10.4(2.3%) *	25.3(5.5%)
Total health Facilities- Public	93(5.1%)	52(2.9%)
Doctors	108 (1.7%)	145(2.3%)
Total Beds	289	585
Beds for 10,000 population	3	2.5
Health Staff per 10,000 population	6.5(4.2)	3.6(2.1)
Total health expenditure in 2017-18 (INR in Lakhs)	6612	11146
Share of district in state health expenditure (%)	1.32	2.22
Per capita health expenditure (INR in Rupees)	619	440
*% in parenthesis indicates share in state total		

3. Key Findings

3.1 Budget formulation, Fund transfer and Resource Utilization process

Budget formulation at the district follows two distinct processes- 1. Treasury route 2. NHM route and each has a different process. Generally, the budget-making process for NHM starts in month of December for the next financial year after the state receives notification from the government of India (GOI). A consultation workshop is organized at the state level with participation of state and district level NHM officials from all the district of Odisha. The workshop aims at deciding the direction and pattern of the NHM budget. After that, the state provides a format in a soft copy with formula and target for the district and unit cost for each line item to prepare a health action plan for the district. Accordingly, each district prepares the district budget requirement following a participatory process involving district and block level officials. Though this process is largely called as bottom-up approach as the requirements are estimated based upon the needs from the village level, some of the block level officials are of the view that the consultation process at the ground has reduced due to the current practice of dependency on the health management and information system (HMIS) data. Most of requirements are estimated at the district level based upon the HMIS data and only the block level officials are consulted for validating any discrepancy. All the block plans are consolidated at the district level and sent to the state.

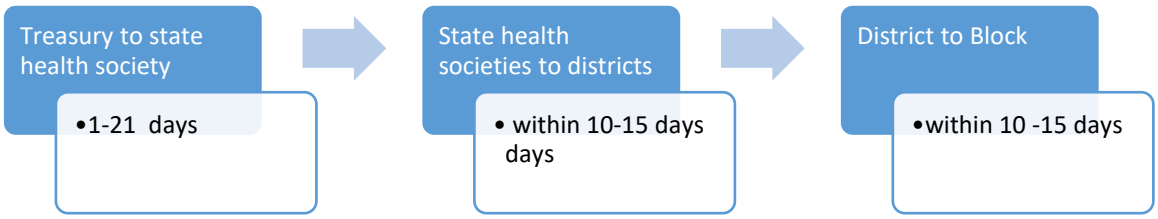
Five years back, the district adopted a bottom-up approach where the requirements were estimated based upon the needs from the village level. However, this has changed in the last two years where the district prepares the estimate based upon the last year's utilization – for instance on maternal health program, civil construction and others and submits to the state. After receipt of the expenditure, the district distributes the funds as per the last years' intake capacity to the block and block spends the amount accordingly. Now, we are only implementing whatever Program implementation plan (PIP) is coming from the district." – ***A block manager***

The state NHM office examines the district health plan and asks for clarifications and comments to the district and accordingly, the district reworks on the queries discussing with the block level officials and resubmits the final PIP to the state in the month of February and March. Finally, the state sends the PIP to the union government for approval. After receiving the approval from the GOI, the state sends the approved PIP to the District. During 2019-20, the approval was done in the month April and earlier it happened during July or August.

The fund disbursement process starts at this stage and the state sends a fund release letter to the district and after 10 days of the receipt of the letter, the actual fund is transferred to the account. After the district receives the funds, it verifies the unspent balances of different programs at the community health center level (block) and after adjusting the unspent balances, it transfers rest. The funds from NHM are transferred through the public finance management system (PFMS). There are multiple accounts in which

NHM funds are transferred for various health activities. For instance, in a district there are 15 to 17 accounts through which NHM funds are transferred to district.

Further the study suggests that the fund disbursement process has been quite easy after the introduction of PFMS software. After the receipt of GOI share in the consolidation fund of the state, the state takes on average 21 days to transfer money from state treasury to the state health society, the state health society transfer most of the funds to the district on the same day or within a maximum of 10-15 days of the receipt from the state health society. The district after receiving fund transfer it to the block within 10 -15 days.



Once the fund is disbursed to the blocks, the block level officials issue letter to the PHCs and SCs and subsequently release funds to the Primary health centers (PHCs) and sub-centers (SCs). Earlier, the blocks used to disburse funds to lower-level institutions on different activities. However, this has changed in the last 3/4 years where the funds are disbursed pool wise. Each month, the district program manager along with the accounts manager reviews the fund utilization status of the blocks and if there is low utilization for any program, they discuss these issues with the block level officials.

At the district level, the monitoring process for fund utilization is well laid down where the district program manager and block program manager along with the accounts and program staff review the progress and act where there are some deficiencies. As indicated by district level officials, the main reason for underutilization of funds is inadequate staff. Further, the new system of Aadhar based transfer to the beneficiary through PFMS further creates difficulty in fund utilization. Moreover, as per the government rule, the transferring bank should be State Bank of India (SBI). If SBI branch is not available then, any other nationalized bank is permitted. This creates difficulty in getting services on time from the bank as the bank is overburdened with many other works.

Under treasury route, the funds are transferred to the drawing disbursement officers (DDOs) at the health care institutions and most of the funds are related to salary and administrative expenditure. There are various drawing disbursement officers (DDOs) at the health care institutions who receive the funds directly under various accounts heads – medical public health, family welfare either in revenue or capital heads. Once the budget is approved by the state legislature, the funds get transferred to different directors- for instance, director of health services, director of family welfare, director medical education and training and others. These directors then transfer funds to the respective DDOs at the district level under various accounts heads.

3.2 Health expenditure variations in the two districts

The findings suggest that overall, share of health expenditure in total state health expenditure of Balasore which also has more health care institutions was more than Rayagada. For instance, it was 2.2% of total state health expenditure in Balasore compared to 1.3% in Rayagada in 2017-18 (**Fig 1.1)**. However, the per capita health expenditure of Rayagada was INR 619 which is 40% more compared to INR 440 in Balasore in 2017-18. This is accounted by the lower population in Rayagada, which is only 41% of Balasore population. In absolute terms, the health spending has gone up in both the districts during the study period. In Balasore district, this increased from INR 790.5 million in 2013-14 to INR 1114.6 million in 2017-18, a 41% increase during this period. In Rayagada it increased from INR 431.8 million to INR 616 million during the same period accounting for 53% increase thus 12% higher in Rayagada than Balasore **(Fig 1.2)**.

Figure 1.1: District's share in state total in Balasore and Rayagada (NHM plus treasury)

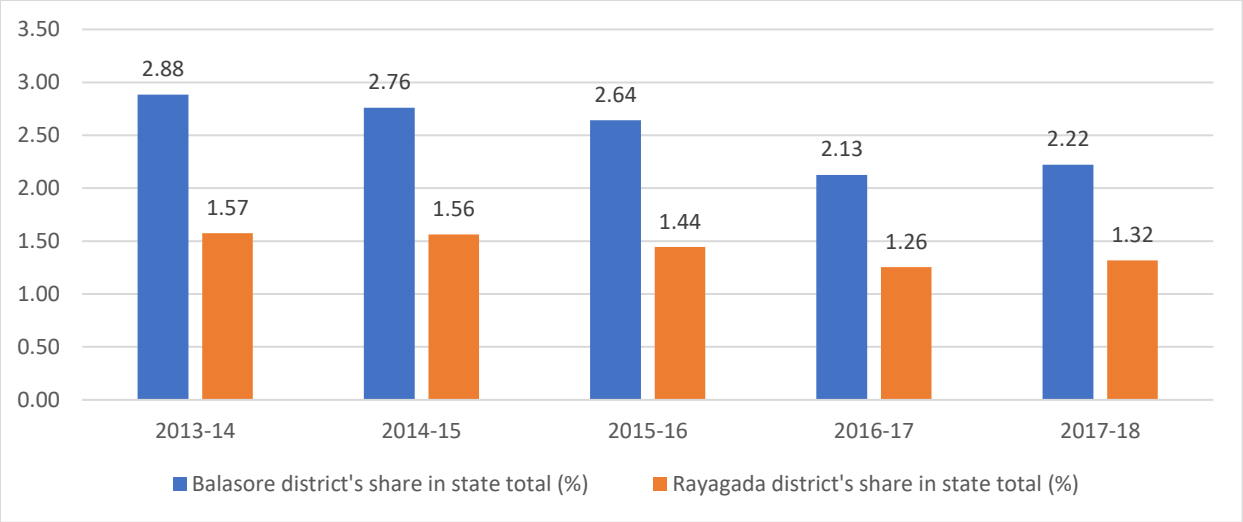
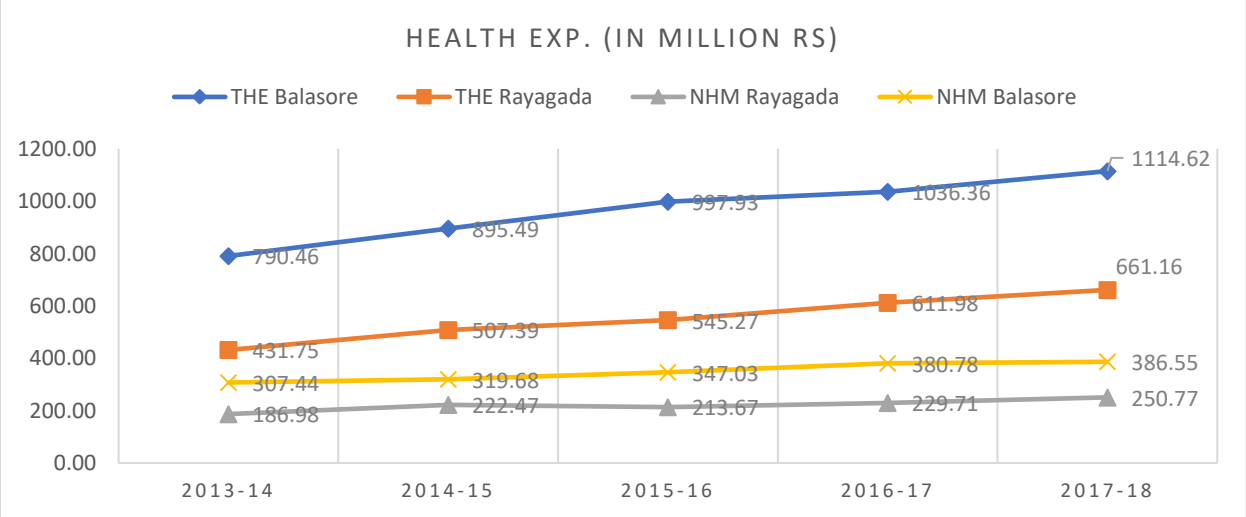


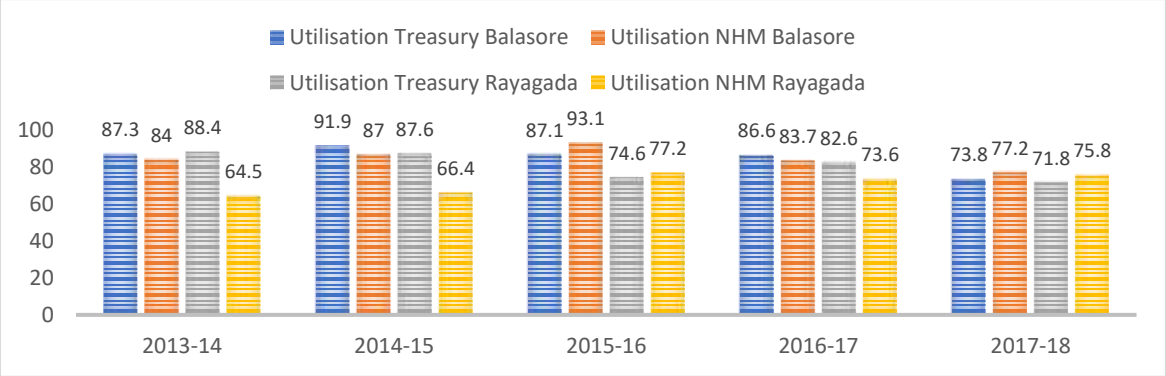
Fig 1.2: Health Expenditure in Balasore and Rayagada (in Million)



Share of utilization of resources to allocated funds

It is further observed that districts have not utilized resources fully. In Balasore, the utilization of funds from treasury was 73.8% in 2017-18 compared to 71.8% in Rayagada. Similarly, the utilization for NHM specific funds was 77% in Balasore and 75.8% in Rayagada. Overall, the utilization declined in both the districts during 2013-14 to 2017-18. However, the decline was more (11%) in Balasore as compared to 2.8% in Rayagada. Further, analysis showed that there was a decline in utilization of treasury expenditure in both the districts (13.5% in Balasore and 16.6% in Rayagada) but increase in utilization of NHM fund from 64.5% in 2013-14 to 75.8% in 2017-18 contributed to lower overall decline in utilization in Rayagada as presented in **(Fig 1.3)**. This shows the absorption capacity of fund utilization under NHM has gone up in a backward district of Rayagada.

Fig 1.3 Fund Utilization pattern in Balasore and Rayagada (%)



It was further observed that on an average around 14% of total funds under NHM from the previous year is carried forward and gets added to the fund release of the next financial year of the district in each year. This backlog unspent balances further accumulates to the current underutilization of resources of the district. For instance, during 2017-18, balance from the previous year was 52.38% of total receipt under NCD and this was 53.6 % under NUHM. Similarly, this was 24% under NRHM additionalities in 2013-14 which reduced to 13% in 2017-18. Therefore, while examining underutilization of the current financial year, it is important to examine what percentage of total resources gets accumulated from the previous financial year. This accumulated fund from the previous year further adds to the problem of underutilization of funds in the district and reduces the resources that would have been available to the district had the funds been spent and not carried over to the next year.

3.3 Differences in expenditure profile of the two districts

The findings further suggest changes in the share of union government in the total district sector spending. Earlier, the union and state government shared resources at 75:25 ratio for health which has been changed to 60:40 since 2015-16. This change in the share of the union government is reflected in the district spending pattern. For instance, the share of union government was 29% in Balasore and 32.48%

in Rayagada in 2013-14, which has declined to 21% and 23% respectively in 2017-18. Under National Health Mission, the expenditure is mainly for reproductive child health (RCH), maternal health, immunization programs, communicable and non-communicable diseases. A major share of NHM expenditure was on RCH and NMH additionalities (80%). The share of communicable diseases was only 1.6% of total health expenditure in Balasore whereas this was a little higher at 4 % in Rayagada. Similarly, the share of non-communicable diseases (NCDs) was less than 1% of total health expenditure of the district. The analysis showed that communicable and non-communicable diseases not only had least priority at the district level, these two items also witnessed low utilization of resources. For instance, in Balasore, the utilization for NCD was 36% compared to 32% in Rayagada in 2017-18. Further, immunization programs also noticed perceptible decline in utilization in both districts during study period. The fund utilization of only 50% on immunization in Rayagada, a backward district is a matter of concern.

Many block level officials pointed out that fund utilization for certain programs especially, NCDs was affected due to shortage of staff at the block and below. The Auxiliary nurse midwife (ANM) is not able to screen NCD patients at household level due to multiple responsibilities. Moreover, those who are screened do not get required services at PHCs and CHCs due to lack of diagnostic services to test and identify the disease.

In this study, we combined the family welfare, national leprosy eradication program, national vector borne program, national tuberculosis control program and all NCD program routed through both NHM and treasury to define them as public health activities. The expenditure on public health activities constituted 6% of total district health expenditure in Balasore and 7.37% in Rayagada during 2017-18. Moreover, it is also observed that there has been a decline in utilization in both the districts against the resources allocated. Total utilization was 63% in Balasore compared to 58.4% in Rayagada

Rogi Kalyan Samiti (RKS) is also called a hospital development committee, receives fund from various sources which includes user fees, untied fund, fund for NIDAN[1], First Referral Unit (FRU) grants for outpatient (OP) and Inpatient (IP) admissions. Apart from this, they also receive fund from external sources like donation and corporate Social Responsibility (CSR) activity. Recently, the state government has withdrawn users' fees from the hospitals. The study suggested that though RKS provides autonomy to spend the money as per the local requirement, there has been a lesser utilization of resources. This is more in an underdeveloped district of Rayagada. Fund utilization is delayed primarily, as meetings do not take place on regular intervals especially, at the block level because of different priorities of political executives who are the members of the RKS.

[1] This scheme aims at providing free diagnostic services at all public health care institutions in Odisha. The state government has partnered with private laboratories to provide free of cost Pathology tests, digital X-Ray, CT scan and MRI to the people under this scheme.

4. Recommendations

This study analyzing district sector resource allocation and spending in Odisha provided many useful insights for improving district level spending for health programs in Odisha.

4.1 Inclusion of health care needs based on disease burden and district characteristics like backwardness/aspirational districts. Resource allocation decisions are based on health care institutions which is normally determined by population norm. This leads to higher share of resources to the developed district (which has more health care institutions) compared to a backward district. This study recommends for inclusion of health care needs, disease burden and backwardness indicators for allocation of resources to the district rather than population norm. Though this is followed by NHM resource allocation, NHM funding only reflects one fifth of total spending of the district.

4.2 Address manpower and capacity constraints to avoid under-utilization of specific program funds. Overall, the under-utilization of public resources, has a major bearing on the delivery of services. The study shows that there has been a huge underutilization of resources in both treasury and NHM streams. It is also noticed that NCDs get least priority in the district sector spending. Further, in many of the critical programs related to NCDs and communicable diseases, underutilization of resources is large. When the burden of NCD is growing, the low utilization of resources is major concern. This study suggests that the utilization of spending should be increased substantially in NCDs and communicable disease programs with provision of adequate manpower and planned activities.

4.3 Increase resource allocation for public health activities. Higher investment is required on public health activities as the study suggests only 6% of district funds is towards this currently.

4.4 Scale-up the pilots on virtual accounts being undertaken for NHM fund management. Multiple accounts on various programs at district level led to administrative problems and further evidence is needed to show whether the pilots being undertaken to improve the financing system through National financial accounting and management software (NFAMS) leads to increase in efficiency in the system. Experimentation is needed in one district to understand the integration of resources for better pooling to avoid fragmentation of resources at the district level

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