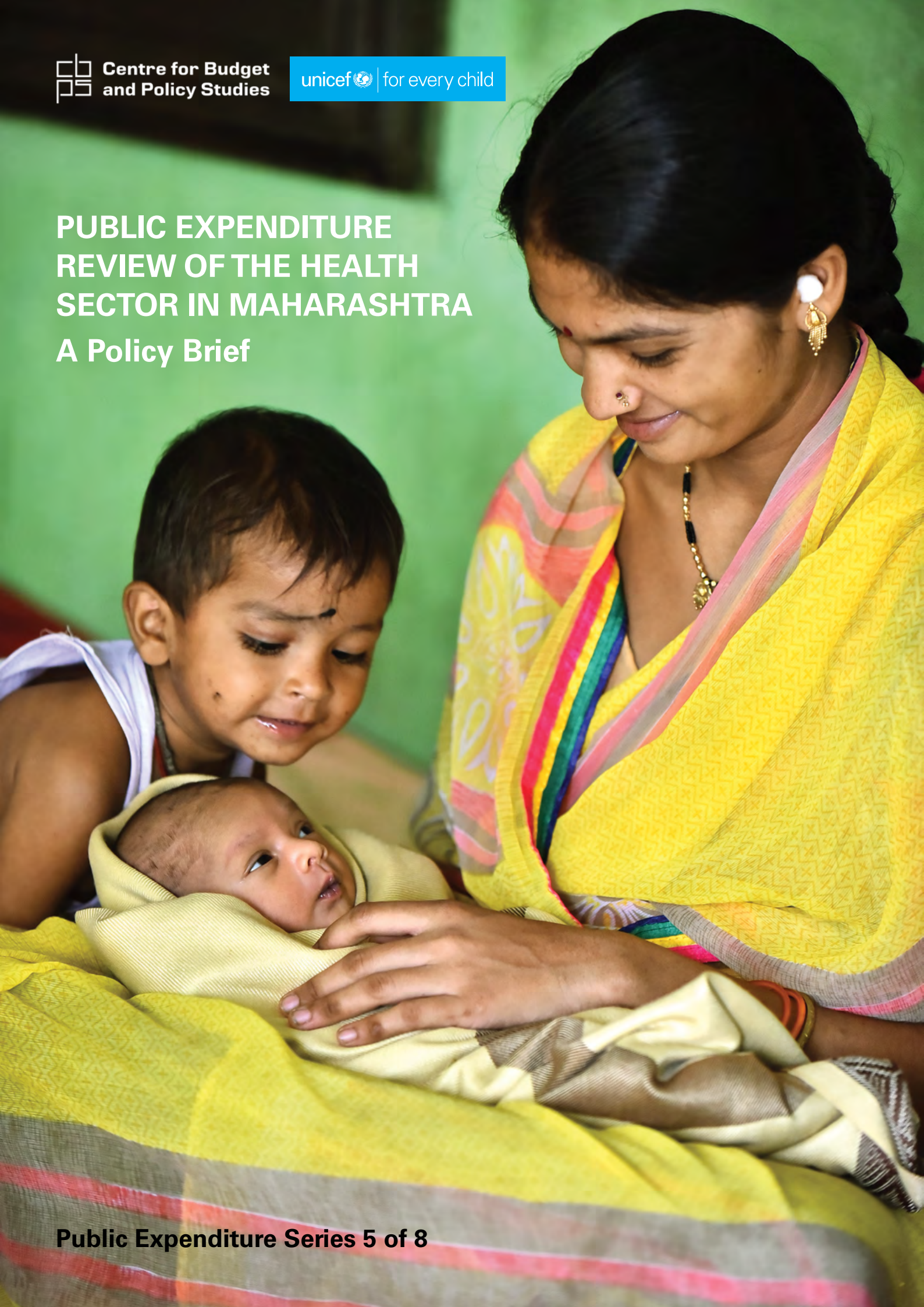


# **PUBLIC EXPENDITURE REVIEW OF THE HEALTH SECTOR IN MAHARASHTRA**

## **A Policy Brief**





# Introduction

Amongst India’s states, Maharashtra is the second most populous state and the third largest state in terms of geographic area. Maharashtra stands first in terms of Gross State Domestic Product (GSDP) and fifth in terms of per-capita income<sup>1</sup> among Indian states. Mumbai, its capital, is often referred to as the country’s financial capital. However, when it comes to health, it, surprisingly, has much poorer records when compared to states like Tamil Nadu or even Kerala that are comparable in terms of economic indicators even if not as advanced. This policy brief is based on a public expenditure review of the health sector (2012-13 to 2017-18) of the state<sup>2</sup>.

### Research Questions

The study sought to answer the following specific questions with respect to Maharashtra:

- 1

Is the health expenditure by the state government in line with its health needs or internationally recommended standards?
- 2

How do the changes introduced by the 14th Finance Commission (FC) translate to changes in policy and health expenditures?
- 3

What is the role/share of National Health Mission (NHM) in the overall state health expenditure?
- 4

How participatory and responsive is the development of the Gram Panchayat Development Plan (GPDP) at the Gram Panchayat (GP) level, particularly from the perspective of health?

population. Covering about 9.4% percent of the state population, the tribal areas report a high fertility rate and relatively higher incidence of malaria, sickle cell disease, and alcohol and drug addictions.

**Poorer health indicators in urban areas:**

A total of 45.2% population in Maharashtra live in urban areas as per Census 2011, and around 23.3% of this population lives in slums. However, health indicators remain low. For example, Mumbai city was the third from the bottom when it came to MCHI. Poor quality of public facilities, high presence of private health care and high Out of Pocket Expenditure (OOPE) are key features of urban areas.

**High Out of Pocket Expenditure (OOPE):**

More than 71 % of the population preferred private hospitals for treatment, as per the National Sample Survey Organisation (NSSO) 75th round report (2017-18). It also showed that the average total medical expenditure per hospitalisation case in a rural private hospital in the state was Rs 23,821 (national average is Rs 27,347) while in urban it was Rs 42,540 (national average is Rs 38,822).

The current government health insurance scheme provides coverage only for secondary and tertiary care, and its access is highly dependent on availability of facilities/hospitals in the districts. Expenditure on medicines and diagnostic tests constituted the highest proportion of expenditure both for inpatient and outpatient care.

**High prevalence of Non-communicable diseases (NCDs):**

The top three causes of death (due to individual causes) in Maharashtra were ischaemic heart disease, chronic obstructive pulmonary disorder, and stroke in 2016<sup>4</sup>. Cardiovascular cause of death was seen in 70% of deaths for those over 40 years of age. These diseases require high hospitalisation expenditure as well as chronic treatment with high expenditures on medicines and diagnostics. Among those aged 15-36 years, the highest cause of death was suicide and violence, which calls for an investment in mental health.

**The Challenges**

The review was conducted vis-à-vis six major health and health care service-related challenges, identified through the analysis of literature and data-analysis. These are as listed below:

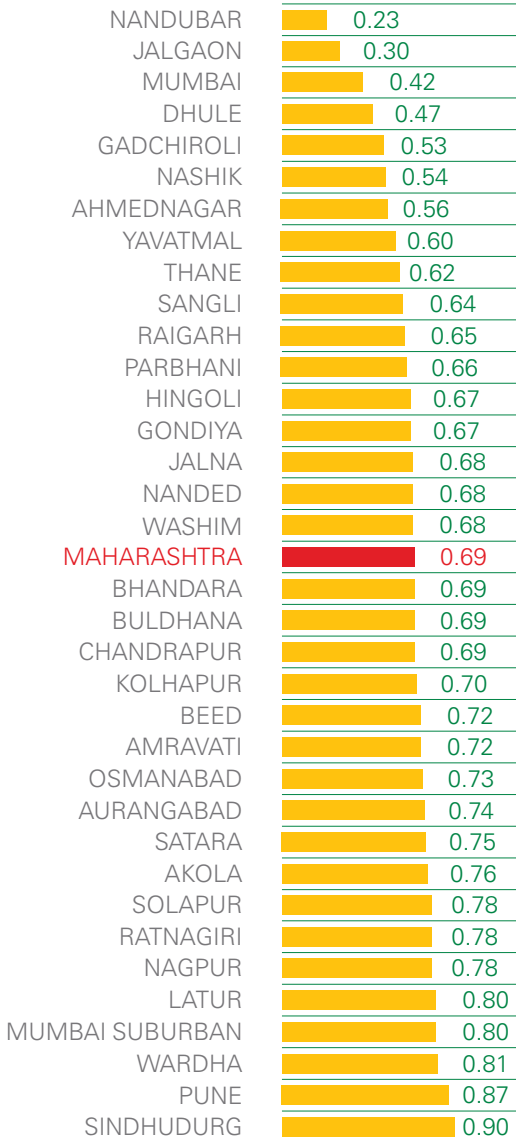
**Notable intra-state disparities in Maternal and Child Health Index (MCHI):**

In addition to having worse infant mortality rates, maternal mortality ratio and immunisation rates in comparison to states like Tamil Nadu and Kerala, the state’s inter-district variations in MCHI are also fairly high.

**Poorer health indicators in tribal-concentrated districts:**

Five of the bottom six districts showing poor MCHI have a high concentration of tribal

**Figure 1: Maternal and Child Health Index (MCHI) by District for Maharashtra (2015-16)**



Source: Maternal and Child Health Index (MCHI) calculated based on indicators obtained from NFHS-4 (2015-16) and HMIS (2015)<sup>3</sup>.

<sup>1</sup> The Economic Survey of Maharashtra, 2019-20. [https://www.maharashtra.gov.in/Site/upload/WhatsNew/ESM\\_2019\\_20\\_Eng\\_Book.pdf](https://www.maharashtra.gov.in/Site/upload/WhatsNew/ESM_2019_20_Eng_Book.pdf)

<sup>2</sup> The review included the analysis of state budget documents (2012-13 to 2017-18), National Health Mission (NHM) budget (2013-14 to 2017-18) and related documents, Gram Panchayat Development Plan (GPDP) budget documents accessed through a small fieldwork in Osmanabad and Nandurbar districts, and the budgets of Mira Bhayander Municipal Corporation, in addition to other relevant literature. A total of 124 interviews were conducted and 4 Focus Group Discussions (FGDs) were conducted between mid-March and mid-April 2019.

<sup>3</sup> The state has 35 districts. Of these, Mumbai district is completely urbanised. In order to facilitate comparison between districts, the Maternal and Child Health (MCH) indicators form National Family Health Survey (NFHS)-4 (2015-16) and Health Management Information System (HMIS) (2015) have been used to construct a Maternal and Child Health Index (MCHI). Mothers who had at least four antenatal care visits (%), institutional births (%), children aged 12-23 months who are fully immunised (BCG, measles, and three doses each of polio and DPT) (%), children under 5 years who are stunted (height-for-age) (%), children under 5 years who are wasted (weight-for-height) (%), non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%), Infant Mortality Rate, under-5 mortality rate, and Maternal Mortality Ratio (MMR) were the indicators used to construct the MCHI. This was used to rank the districts.

<sup>4</sup> Indian Council for Medical Research (ICMR), Public Health Foundation of India (PHFI), & The Institute for Health Metrics and Evaluation (IHME), (2017). India: Health of the Nation's States–The India State-level Disease Burden Initiative. [https://www.healthdata.org/sites/default/files/policy\\_report/2017/India\\_Health\\_of\\_the\\_Nation%27s\\_States\\_Report\\_2017.pdf](https://www.healthdata.org/sites/default/files/policy_report/2017/India_Health_of_the_Nation%27s_States_Report_2017.pdf)





### Shortfall in the number of public health institutions and staff:

Going by the existing population norms for availability of respective health care facilities, in 2014-15, there was a 22% shortfall in the number of Sub-Centres (SC), 18% shortfall in number of Primary Health Centres (PHC), and 35% shortfall in the number of Community Health Centre (CHC) in Maharashtra<sup>5</sup>. More than 560 rural PHCs, out of a total of 1,811, had no lab technician or pharmacist. There was also a shortage of specialists in CHCs.



### Trends and Patterns in Public Expenditure

1

#### High growth in real health expenditure yet lower than comparable states

The total expenditure on health<sup>6</sup> increased from Rs 6,773 crores in 2012-13 to Rs 14,534 crores in 2017-18 registering a Compounded Annual Growth Rate (CAGR) of 12% in real terms. Total Health Expenditure (THE) as a percentage of Total State Expenditure (TSE) increased from 4.3% in 2012-13 to 5.1% in 2017-18. As a result, the per-capita health expenditure also registered an increase Rs 677 to Rs 1,349 in 2017-18 in nominal terms.

In 2015-16, Maharashtra's public expenditure on health was Rs 12,066 crores, which was highest amongst the group of major non-EAG (Empowered Action Group)<sup>7</sup>. Among Maharashtra, Karnataka, Tamil Nadu, and Kerala, Maharashtra had the lowest per capita expenditure at Rs 1,011 that year. The state also had the lowest health expenditure as percentage of Gross State Domestic Product (GSDP) amongst the four states (0.60%)<sup>8</sup>.

2

#### National Health Mission (NHM) occupies 20% of the Total Health Expenditure (THE), and Reproductive and Child Health (RCH) covers almost 90% of the NHM expenditure

The NHM contribution to the state health expenditure has been increasing and it now

comprises 20% of THE. Amongst the four flexible pools of NHM, the highest expenditure was under RCH accounting for an average of 89.3% of the total expenditure followed by Communicable Diseases (CD) at 5.7%, Non-communicable Diseases (NCD) at 0.8% and National Urban Health Mission (NUHM) at 4.1% of the total expenditure, during 2013-14 to 2017-18. At the aggregate level, both the budget allotted and expenditure incurred under NHM have grown but the average growth in the allocations has been much higher (13.3%) than the average annual growth rate for the actual expenditure (4.5%), indicating potential for improvement in the utilization rate. The average utilization ratio of five years was 61.6%.

If we look at schemes, Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojana (JSY) together accounted for 96% of maternal health expenditure, which remained stagnant at around Rs 117-118 crores in five-year period. Janani Shishu Suraksha Karyakram (JSSK)<sup>9</sup> comprised 60% of maternal health expenditure but its utilization decreased from 66.7% (2014-15) to 44% (2017-18).

The most utilized component was referral transport at 42%, followed by drugs and consumables at 26%, expenditure on diets at 15%, and diagnostics at 13%. Janani Suraksha Yojana (JSY) expenditure remained stagnant with an average utilization of 82% with higher institutional delivery expenditure in rural areas as compared to urban areas. The biggest expenditures under JSY were on institutional deliveries (58.3%), followed by incentives to Accredited Social Health Activist (ASHA) (37%).

3

#### Share of expenditure on personnel declined as did the utilisation rate for allocations meant for specialised staff

The share of expenditure on personnel decreased from 60.3% in 2012-13 to 48.5% 2017-18 in state budget, which is not necessarily a bad sign as it indicated an

increase in the share of non-personnel heads. But the fact that the utilization of allocations made for human resources also declined, from 83.7% in 2013-14 to 66.6% in 2017-18, is not a welcome trend and it reflects shortage of staff—this was confirmed by the field visits to PHCs in Osmanabad and Dungarpur where nurses, multi-skilled workers, lab technicians, and accountants were short in supply. If the expenditure on ASHA were separated, the utilization rate for human resources would go down to 58% in 2017-18.



The share of expenditure on human resources in National Rural Health Mission (NRHM) was 25% of the total on an average during this period<sup>10</sup>. The expenditure on ASHA averaged at 31% of this over these five years. The utilizations for expenditure on ASHA was at an average of 89.5% for five years. Allocations to positions of Additional Nurse Midwife (ANM) and paramedical staff also showed good utilization. However, poor utilization of allocations was observed for specialists and medical officers under NRHM.

The existence of vacant positions has an adverse impact on the quality and reliability of service delivery and, to an extent, explains why people prefer private health care facilities.

4

#### Expenditure on infrastructure increased with an emphasis on new constructions

The share of capital expenditure in THE increased from 13.3% in 2012-13 to 15.2% in 2014-15 before decreasing to 13.9% in 2017-18. This averaged at 14.2% in the five-year period. Under NRHM, strengthening of hospitals, i.e. mainly upgradation of PHCs, CHCs and DHs, saw an initial boost in 2013-14, followed

by a steep decrease in allocations as well as expenditures in later years. This expenditure decreased from Rs 10,929 lakhs in 2013-14 to just Rs 494 lakhs in 2017-18. Increasing priority was given to new constructions of PHCs and sub-centres, which saw increasing allocations as well as expenditure from 2015-16, with high utilization rates in the following years, i.e., 2016-17 (118%) and 2017-18 (99%).

Untied grants under NRHM serve as a discretionary support grants for health facilities and saw 91% utilization in rural areas (NRHM); however, its utilization rate was very low at only 4% under NUHM in urban areas in 2017-18. On the other hand, in the same year, NUHM<sup>11</sup> showed 120% utilization in the infrastructure strengthening head with emphasis on construction and renovation of new PHCs.

5

#### No clear pattern or trend emerged for allocation and utilization for services that make health care affordable or free (Insurance, free services, and prevention)

The state budget consisted several insurance schemes: Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY)<sup>12</sup>, Employees State Insurance Scheme (ESIS), Rashtriya Swasthya Bima Yojana (RSBY)<sup>13</sup>, and cashless medical insurance scheme for members and ex-members of Maharashtra legislature. State's expenditure on insurance showed an increasing trend from 7.8% of total state health expenditure in 2012-13 to 10.8% in 2016-17. However, there was a steep decline in its share (1.7%) in 2017-18<sup>6</sup> in total expenditure due to decrease in MJPJAY expenditure, which was integrated with the Pradhan Mantri Jana Arogya Yojana (PMJAY).

In NHM, the free drug scheme had the highest expenditure under procurement of drugs from 2014-15; however, utilization under the scheme was haphazard showing alternate years of increase and decrease. The field visits indicated that there was a shortage of medicines in certain areas. The free diagnostics scheme is yet to gain momentum in the state.

<sup>5</sup> Rural Health Statistics 2014-15. (2015). [https://wcd.nic.in/sites/default/files/RHS\\_1.pdf](https://wcd.nic.in/sites/default/files/RHS_1.pdf)

<sup>6</sup> This includes all the expenditures incurred on health and family welfare through the state budget (public health and other departments, healthcare facilities, programs, training, drugs and consumables, asset creation, personnel, insurance, and medical charges, etc.), and the National Health Mission (NHM) through the State Health Society (SHS).

<sup>7</sup> Empowered Action Group (EAG) States are the eight socioeconomically backward states of India: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal, and Uttar Pradesh which lag behind in the demographic transition and have the highest infant mortality rates in the country. Non-EAG states are the states that are not classified as EAG.

<sup>8</sup> National Health Profile 2018. [http://www.cbhidghs.nic.in/Ebook/National%20Health%20Profile-2018%20\(e-Book\)/files/assets/common/downloads/files/NHP%202018.pdf](http://www.cbhidghs.nic.in/Ebook/National%20Health%20Profile-2018%20(e-Book)/files/assets/common/downloads/files/NHP%202018.pdf)

<sup>9</sup> Janani Shishu Suraksha Karyakram (JSSK) offers free delivery related services (drugs, diagnostics, hospitalisation, diet, and free referral transport) to all mothers in public health facilities and free childcare till one year of age.

<sup>10</sup> National Health Mission (NHM) total does not include infrastructure maintenance (IM) component. Human Resources (HR) only includes NRHM as that under NUHM and IM was unavailable.

<sup>11</sup> Details are only available for 2017-18.

<sup>12</sup> As of 2018, this scheme has been integrated with the Pradhan Mantri Jana Arogya Yojana (PMJAY). This may be the reason for decrease in expenditures in 2017-18.

<sup>13</sup> It is not available in the state since 2013-14.



Janani Sishu Suraksha Karyakram (JSSK), which provides free delivery care and infant care to all mothers at public health facilities, shows an increase in allocations but stagnant expenditures. Prevention measured by expenditure on IEC/BCC (Information Education and Communication/Behavioural Change Communication) under NRHM showed a marked decrease in utilization from 81% in 2013-14 to 26% in 2017-18, against increasing allocations. Under NUHM, IEC/BCC showed 32% utilization in 2017-18.

6

Increasing allocations but stagnant expenditure for child health

There was a wide gap between allocations and expenditures within child health as seen from the utilisation rate—it saw a sharp fall from 96% in 2013-14 to 45.7% in 2017-18. Although child health saw increasing allocations (average 24% annual growth rate), its expenditures remained almost stagnant (annual growth rate of 3%).

Immunisation was responsible for 54.7% of child health expenditure. Although immunisation received increasing allocations, its utilisation decreased from 95% in 2014-15 to 64.6% in 2017-18. Rashtriya Bal Swasthya Karyakram (RBSK) constituted 20.4% of child health expenditure with average utilisation of only 53%. The third highest average expenditure on children was on Rashtriya Kishori Swasthya Karyakram (RKSK) at 8.3%. Utilisation under RKSK has not kept up with its allocations—it was at 93% in 2013-14 and went down to 25.9% in 2017-18.

7

Tribal Sub-Plan (TSP) expenditure appears to be substituting regular health expenditure in tribal districts

Tribal Health expenditure reduced from 6.2% to 5.2% of THE from 2012-13 to 2017-18. Among the expenditures incurred under Tribal Sub-Plan (TSP)<sup>14</sup> for the Department of Public Health and Family Welfare, the highest average expenditure was under grants-in-aid to various tribal districts. The second major expenditure incurred was on NHM, followed by establishment /maintenance /construction of health institutes. If we look only at scheme specific allocations<sup>15</sup>, we see that 95.89% of allocations under TSP at state level went towards NHM. At the district level, TSP



allocations suggested high allocations for health schemes in tribal districts (Figure 2).

Nandurbar got the largest scheme-linked allocation in the district, but allocations did not necessarily mean expenditures. In 2019, field visits in the district showed vacancies in health posts as well as shortage of medicines in the PHCs visited. An analysis of outlays within Maharashtra Plan Schemes Information Management System (MPSIMS) in 2017-18 in Nandurbar showed that 93% of funds for schemes at district level were allocated through TSP, while in Gadchiroli this was 73%, and it was 53% in Thane. Thus, funds under TSP appeared to substitute regular state funds for health schemes in tribal districts even though TSP funds are meant to be an addition to state funds.

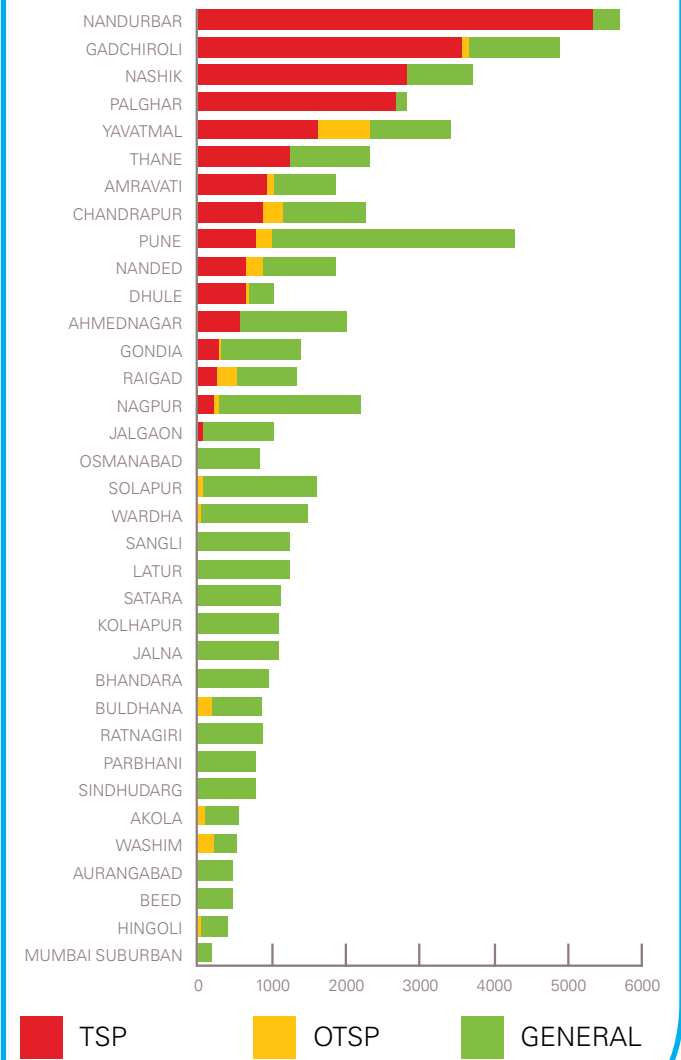
Due to universality of schemes like JSSK, JSY and immunization, MCH provisions were available to tribal populations. Tribal specific expenditure was visible for malaria and health insurance schemes. However, no funding provisions were discernible for tribal specific health concerns like sickle cell disease, alcohol and tobacco dependence, and improved IEC/BCC to counter cultural beliefs and illiteracy.

<sup>14</sup> In view of the special needs of tribal population, the concept of drawing up a TSP (Tribal Sub-Plan) accounting for all the flows of funds invested in the Integrated Tribal Development Project (ITDP) was started from 1975-76. Thane, Raigad, Nashik, Dhule, Nandurbar, Jalgaon, Ahmednagar, Pune, Amravati, Yavatmal, Nagpur, Gondiya, Chandrapur, Gadchiroli, and Nanded are the 15 districts with a TSP component.

<sup>15</sup> As expenditure data under Tribal Sub-Plan (TSP) is unclear in the state budget, we undertook analysis of data available through Maharashtra Plan Schemes Information Management System (MPSIMS) website. The data consists of department outlays on schemes only, hence we cannot discern the use of TSP funds for non-programme allocations.



Figure 2. Scheme Outlays under District Plan in Maharashtra 2017-18



Source: Consolidated from MPSIMS <https://mahades.maharashtra.gov.in/MPSIMS/userLogin.do#>

8

Low expenditure on Disease Control Programmes

Expenditure on CD increased from 2.4 % of THE in 2012-13 to 3.7% in 2017-18, while that of NCD increased from 1.2% to 1.8% in the same period. Malaria Programme comprised 43% of communicable disease expenditure followed by the tuberculosis programme at 29%. Mental health programme comprised of 68% of NCD expenditure and National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases, and Stroke (NPCDCS) comprised an average of 18% expenditure. Given that NCD is a major challenge and mental health issues need greater attention, the health expenditure priorities do not seem to match the challenges.

9

Urban expenditure on health trends and patterns not clear

The urban health expenditure covers 33% of THE. Of this, human resources accounted for 51 % of urban expenditure within state budget, followed by grants-in-aids for government run hospitals and research institutions accounting for 29%. However, state health institutions (i.e., tertiary care hospitals, medical colleges, and speciality hospitals) located in urban areas do not necessarily serve only residents in the areas where they are located as they are accessed by people all over the state.

National Urban Health Mission (NUHM) received, on an average, 10.3% of the total NHM allocation but was responsible only for 4.1% of total average NHM expenditure from 2014-15 to 2017-18. Analysis of the allocations for 2017-18 in MPSIMS under the state plan shows an allocation of 56.9% (Rs 2,60,064.29 lakhs) for urban specific schemes. These included allocations for NUHM, major constructions, national AIDS control programme (for Mumbai), and urban family welfare centres. National Health Mission (NRHM + NUHM) formed 12% of total urban scheme allocation indicating that major share of health expenditure in urban areas came from non-NUHM sources. Expenditures under RCH and other disease programmes was undertaken under NRHM and, therefore, cannot be separated for urban areas. National Urban Health Mission (NUHM) was still in its infancy, field interviews showed untied funds were underutilised and community processes like Mahila Arogya Samiti (MAS) had not yet taken off.



Analysis of the municipal corporation health expenditure showed a focus on maintenance and running of public facilities and implementation of health schemes, mainly immunization. These expenditures do not figure in state budget, underestimating urban health expenditures. The only major health scheme specifically for urban areas appeared to be the AIDS Control Programme (for Mumbai) and Urban Malaria Scheme.



### Governance and Budgeting Practices

1

**14th Finance Commission's (FC) recommendations did not have a negative impact on health expenditure though the total social sector expenditure declined**

Health expenditure as a proportion of Social Services Expenditure (SSE) also increased over the years from 10.61% in 2012-13 to 15.21% in 2017-18. However, the expenditure on the SSE as a proportion of TSE decreased from 40.5% in 2012-13 to 33.33% in 2017-18, reflecting perhaps a lower priority towards other social sectors The implementation of the 14th FC recommendations in 2015-16 did not affect the health expenditure adversely in Maharashtra, but the share of total social sectors like education, nutrition, and sanitation, etc. showed a decline, which has an indirect effect on health .



2

**Fragmented Budgeting practices makes it difficult to estimate public expenditure on Urban Health**

The municipal expenditure on health does not figure in in State budget and the Financial Management Review (FMR) for NHM does not separate RCH between urban and rural; these make it difficult to estimate the entire health expenditure in urban areas.

3

**Schematic approach and focus lead to diffused accountability in rural areas**

The allocations coming to a district were split across departments and schemes i.e. state general funds, NHM, TSP, Scheduled Castes Sub-Plan (SCSP), Other Tribal Sub-Plan (OTSP)<sup>16</sup> and so on, to account for several Centrally Sponsored Schemes (CSS). Currently, accounting for these schemes is mainly through utilization of money rather than through actual change in health indicators.

As of now, other than the health insurance scheme, which is developed by the state, most other programmes are developed at the centre, leaving little room for state specific issues. A long-term goal in the state's health expenditures was not visible at any level in the state but it rather followed the centre's direction. Hence, although health is a state subject, the autonomy of the state was not visible in terms of determining its own priorities.

4

**Fund Flow delays and Utilisation in National Health Mission (NHM)**

Maharashtra receives one of the largest shares of the NHM funds, but its average five-year (2013-14 to 2017-18) utilisation was at 61%<sup>17</sup>. A major reason for lower utilization rates were the delays experienced in the receipt of funds from the union government. In 2017-18, Maharashtra received only 44% of the total allocation for NHM by the third quarter of the financial year. It took an average of 145 days for the transfer from the state treasury to the State Health

Society (SHS) to happen in 2016-17, whereas it should have happened in 15 days as per guidelines<sup>18</sup>.

The disbursement of funds currently follows a hierarchical path where funds are first transferred to the SHS, from where it goes to districts, and then to the sub-district levels. Our field interviews with PHC accountants showed that the first instalment of funds for 2018-19 reached them only by June or July instead of April, and the second instalment reached them only by December, highlighting a delay of minimum 60-90 days. Other field insights showed that the need for utilisation certificates even for small expenditures occurring in PHCs

as well as the shortage of accountants and clerks led to delays.

Field investigations also showed that at the district level, even though a part of THE, NHM stood out due to its very detailed budgeting processes. Despite that it is only 20% of THE, considerable time and energy was spent on its planning and execution, often rendering other district/block expenditures invisible in this process. Assessing the expenditure under NHM in the state was challenging as a comprehensive audit would imply an audit of all the health societies created at different levels under the programme, where interest accrued is a major component.

### Proportion of Average Annual Allocation and Corresponding Utilisation Ratio from 2013-14 To 2017-18) for Selected National Health Mission (NHM) Components in Maharashtra

National Health Mission (NHM) Component	Average Annual Allocation Rs (in Lakhs)	Average Annual Expenditure Rs (in Lakhs)	Proportion of total NHM Expenditure (%) 2013-14 to 017-18*	Average Utilization Ratio (%) 2013-14 to 2017-18 *
Human Resources under National Rural Health Mission (NRHM)	33252	33019	17.4	69.5
Procurement under NRHM	24306	13315	10.7	56.3
Child Health under NRHM	22224	12397	9.7	60.4
National Urban Health Mission* (NUHM)	22194	5442	4.1	26.5
Maternal Health under NRHM	21865	12603	10	58.5
Accredited Social Health Activist (ASHA) under NRHM	12010	10706	8.3	89.5
Untied Funds/Annual Maintenance Grants /Corpus Grants to Hospital Management Society (HMS)/ Rogi Kalyan Samiti (RKS) under NRHM	9896	9043	7.2	91.7
Revised National Tuberculosis Control Programme	7693	5760	4.5	76.7
National Leprosy Eradication Programme	1119	769	0.6	68.0
National Vector Borne Disease Control Programme	1102	537	0.4	54.1
National Programme for Control of Blindness**	1028	578	0.4	58.2
National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke**	698	352	0.3	50.7
<i>National Health Mission Total</i>	<i>211885</i>	<i>127562</i>		<i>61.4</i>

Source: Audited Maharashtra Financial Management Report, 2013-14 to 2017-18. This does not include Infrastructure Maintenance Component.

\*Proportion of allocation and utilisation is an average for five years. \*\*From 2014-15 for four years. \*\*\*From 2016-17 for two years.

<sup>16</sup> Other Tribal Sub-Plan (OTSP) is meant for tribal areas outside of the tribal districts while Tribal Sub-Plan (TSP) focuses on districts designated as Tribal districts.

<sup>17</sup> This does not include analysis of the infrastructure maintenance component.

<sup>18</sup> Centre for Policy Research. (2019). BUDGET BRIEFS, National Health Mission Gol, 2018-19. <http://nhm.gov.in/nrhm-in-state.html>.

5 **Third level government still not an active partner in public health systems**

Decentralisation in health care in terms of engaging the Panchayati Raj Institutions (PRIs) was not very evident in Maharashtra, as seen from the field data. Although GPDs were developed by various GPs, there was no evidence of good coordination between health department and PRIs.

Allocations to health projects in GPDs were largely related to sanitation projects focusing on drinking water, storm water drains, and solid waste management. Projects relating to women and children largely focused on improvement, upgradation and provisioning of services such as drinking water, toilet, compound wall, and augmenting nutrition efforts in anganwadi. While these are important and contribute to better health, it is also important to engage PRIs in health care management and priorities—this was not very evident.

Municipal corporation budget analysis revealed that they served mainly as a conduit for government schemes and did not seem to engage in any health planning of their own.

6 **Health expenditure is not necessarily gender responsive**

Health expenditures directed towards women were mostly for maternal care. Under family planning too, despite higher compensations for male sterilisation, the expenditures leaned heavily towards female sterilisations. Low utilisation of spacing methods when combined with lack of facilities for medical termination of pregnancies<sup>19</sup> at PHCs shows low reproductive choices for women. Decreased funding for adolescent health programmes is also concerning as these are important platforms for mentoring young women and men on reproductive and sexual health.

Measures for prevention and early detection of NCDs in women, especially breast and cervical cancer as well as mental health disorders like depression, were not visible from the analysis. As already seen IEC/BCC received low priority under NHM.

Poor access to health care for tribal population and urban poor was felt more among women in these populations who also faced the double burden of discrimination due to gender. Fear



of higher expenses, lack of transport, and a lack of knowledge delayed seeking of health care. What emerged is that gender was not an obvious area of concern while determining the priorities.

**Long-term Policy Implications**

1 **Universal Health Care needs greater attention**

The ongoing COVID-19 pandemic has laid bare the paucity of infrastructure and resources required to fight a disease at a large scale in every state but since Maharashtra is dealing with a very large number of cases, the gap has been even more visible. Shortage of hospital beds, paramedical staff, Personal Protective Equipment (PPE), and ventilators, at the time of utmost need, has resulted in an increase in short-term health expenditure. While the state focuses on fighting the pandemic, lack of facilities as well as fear of infection result in side-lining of other life-threatening health conditions that require urgent medical treatment like heart conditions, cancers, and even pregnancy. Now, more than ever, the need for Universal Health Coverage (UHC) has been felt as the pandemic has resulted in loss of livelihoods, and this will make health seeking an expensive affair.

<sup>19</sup>This is as seen in field visits to Primary Health Centres (PHC) in Nandurbar and Osmanabad.

2 **High potential for increasing expenditure on health**

Although the state increased its allocations to the health sector after the implementation of the 14th FC recommendations, it still occupies only 5.1% of total state expenditure, which is much lower than the level recommended by the National Health Policy, 2018 (8%). Considering that its fiscal deficit is well within the limit of 3% set by the Fiscal Responsibility and Budget Management Act<sup>20</sup>, it has the potential of adequately addressing its health sector needs.

3 **High potential for health sector reforms**

The state also has the potential for initiating systemic reforms that makes health sector planning and budgeting processes much more participatory and comprehensive by making the exercise less fragmented, and we have made suggestions for the same. This, we think, would also improve the efficiency and effectiveness of the public expenditure. This also implies that the NHM's role can go beyond monetary contribution if the experiences are used to enable process-reengineering reforms.

4 **Need for responsive health sector responses to specific urban, tribal and gender needs**

We also argue for strengthening UHC through a variety of measures such as making the health planning more responsive to specific issues of respective population groups such as tribal and urban poor, and also strengthening the gender budgeting processes. We recommend that comprehensive primary care machinery that focuses on both prevention and cure at minimal or no cost to users is critical for improving health indicators of the state. This takes into account the health indicators in the state that point towards the need for greater attention to tribal areas, urban areas, NCDs, and gender gaps.

5 **High potential for more active engagement of third tier governments in both rural and urban areas**

The third-tier government bodies in both rural and urban areas can be important partners in this reform process and play a significant role through participation in the process of

comprehensive planning and monitoring of the health sector interventions. This is especially important in view of the higher levels of funds being made available to these bodies by respective FCs.

**Suggestions for Immediate Action**

1 **Setting a state health goal with development of district and sub-district level plans with budgets:**

The state should set a long-term health goal and tune all health expenditures towards it. All districts and sub-districts must develop an integrated annual health plan and budget, where allocations from all sources including the health department (through treasury), NHM (other CSS), and TSP are brought together in a single document marked by sources, expenditure heads, and proposed quarterly spending. Even if the money were to flow through separate schemes and departments, the presence of a single health plan and expenditure document with scheme/department wise attribution would help in developing a holistic understanding and execution.



2 **Understanding and addressing fund flow delays and low utilizations:**

The state government could consider direct disbursement of NHM funds to each level from the SHS, where the funds are released directly to the Taluka Health Officer from the SHS instead of it going through the district first.

<sup>20</sup>The Fiscal Responsibility and Budget Management (FRBM) Act (2003) mandated states to eliminate the revenue deficits and to keep the fiscal deficit below 3% of the Gross State Domestic Product (GSDP), which is reviewed annually and targets are set for ensuing financial year with respect to revenue and fiscal deficit.



### 3 Access to and affordability of health services:

Working towards improving affordability, accessibility, and availability of health services to all—i.e., UHC should be the goal of the state. Increasing allocations for tribal population or providing tertiary health coverage are all piecemeal solutions that only provide a temporary band aid. The state's fiscal capacity suggests that it possesses resources to push towards UHC but lacks the political will for the same.

### 4 Reprioritising health expenditure to suit the needs in tribal areas:

Increasing tribal health allocations to match the proportion of tribal population in the state is essential. However, more efforts should be made in undertaking tribal-specific measures to match their health care needs.

### 5 Creation of urban health plans in tune with urban health conditions:

Currently, no special schemes for urban areas exist even though literature suggests that problems of cities are very different from that of villages. While strengthening of public health services should remain non-negotiable, exploring innovative public-private partnership routes to expand the reach of public health care services may be a good idea in urban areas, especially in cities such as Mumbai. COVID-19 experiences should inform this plan. This could include compulsory provisions for universal admissions in private hospitals in times of disasters and pandemics, ceiling on fees for services charged, and a number of other such measures that make private health facilities also more accountable and people-oriented even during normal times (e.g., free Out Patient Department (OPD) facilities up to a particular limit for one household for all residing in a defined radius).

6

### Make data available to enable more responsive GPDs and enable urban local governments to be more proactive in health planning:

There should be proactive utilization of funds available under FC grants by the health department as a source of additional income in undertaking health related expenditures at the GP level. This will require coordination between the health department and Panchayati Raj department. The urban local governments also need to be enabled to become more active in and accountable for urban planning.

7

### Address Gender Concerns:

A compulsory gender review of proposed plan and budgets at various levels could be institutionalised to prevent women from being seen only as a reproductive tool and to strengthen the gender responsiveness of the health sector interventions and spending. Training at all levels, including GPs and other local government bodies, should have a gender focus to enable more gender-responsive planning and monitoring of fund utilization.

The Brief has been prepared by Gayathri Raghuraman, Madhusudhan B.V. Rao and Jyotsna Jha. In addition to these three, Mithila Abraham Sarah and Puja Minni from CBPS were also part of the study team that conducted the research. Acknowledgements are due to Soumen Bagchi, Anuradha Nayar and Khanindra Bhuyan from UNICEF for their comments.

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