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The National Health Mission (NHM) is the Government of India’s (GOI) largest public health programme. NHM consists of two sub-missions:

- National Rural Health Mission (NRHM)
- National Urban Health Mission (NUHM)

Using government data, this brief reports on the following parameters:

- Trends in allocations, release and expenditure for NRHM
- Coverage and progress in infrastructure and human resources under NRHM
- Allocations to the NUHM
- Progress in health outcomes

Cost share and implementation: As of 2012, 75% of the funds are to come from GOI and the rest from the states. Release of funds is based on state Project Implementation Plans (PIPs).


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HIGHLIGHTS

- Total public health expenditure (GOI and states) more than doubled between FY 2008-09 and FY 2014-15. However, as a percentage of GDP, expenditures in FY 2014-15 remained at 1.2% of GDP.

- GOI allocations for NHM stand at ₹18,875 crore in FY 2015-16, an increase of 1% over FY 2014-15. However, the NHM website reports that allocations to the NRHM have fallen 8% from ₹18,229 crore to ₹16,809 crore from FY 2013-14 to FY 2014-15. In 2013, GOI launched the National Urban Health Mission (NUHM). However, allocations for NUHM are low at 5% of total NHM approvals in FY 2014-15.

- There have been marginal improvements in health infrastructure. Between March 2013 and March 2014, shortfall in Primary Health Centres (PHCs) and Community Health Centres (CHCs) dropped by 1 percentage point each.

- The number of medical professionals fell between FY 2013-14 and FY 2014-15. The number of doctors at PHCs reduced by 7%, while the number of specialists at CHCs reduced sharply by 30%.

- India has made some progress in health outcomes. Infant mortality rates fell to 40 deaths per 1,000 births in 2013, as compared to 57 in 2006.

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SUMMARY & ANALYSIS

- There have been marginal improvements in health infrastructure. Between March 2013 and March 2014, shortfall in Primary Health Centres (PHCs) and Community Health Centres (CHCs) dropped by 1 percentage point each.

- The number of medical professionals fell between FY 2013-14 and FY 2014-15. The number of doctors at PHCs reduced by 7%, while the number of specialists at CHCs reduced sharply by 30%.

- India has made some progress in health outcomes. Infant mortality rates fell to 40 deaths per 1,000 births in 2013, as compared to 57 in 2006.
TRENDS IN GOI ALLOCATIONS FOR NHM

Allocations: Allocations to the MoHFW have increased by 54 percent from ₹21,680 crore in FY 2009-10 to ₹33,282 crore in FY 2015-16.

GOI’s allocations to health and family welfare account for 1.87 percent of total GOI allocations in 2015-16.

State governments contribute a significant portion to health financing. Public health expenditure by states increased by 72 percent between FY 2009-10 and FY 2012-13. Despite this increase, in FY 2012-13, public expenditure on health (GOI and states combined) accounted for only 1.3 percent of India’s GDP. This decreased marginally to 1.2 percent in 2014-15. This is considerably lower than most developing countries. For example, in 2010, Brazil spent 4.2 percent, South Africa 3.9 percent and China 2.7 percent of their GDP on public health care.

In May 2013, GOI launched the National Health Mission (NHM) — a comprehensive health scheme aimed at guiding states towards universal access to health care through strengthening health systems, institutions and capabilities. NHM consists of two sub-missions: a) National Rural Health Mission (NRHM) launched in 2005 and, b) National Urban Health Mission (NUHM) launched in 2013.

GOI allocations for NHM stand at ₹18,875 crore in FY 2015-16, an increase of 1 percent over FY 2014-15.

TRENDS IN ALLOCATIONS AND EXPENDITURES FOR NRHM

Allocations: In FY 2014-15, budget documents stopped reporting allocations for NRHM separately from total NHM allocations. However, according to the data available from the NRHM quarterly report, there was an 8 percent decrease in NRHM allocations in FY 2014-15, from ₹18,229 crore in FY 2013-14 to ₹16,809 crore. This is the first time that total allocations for the scheme have fallen since its inception in December 2005.

Total approvals under NRHM are based on PIPs, submitted by state governments and the total resource envelope available with GOI. This resource envelope includes estimates of the maximum amount of resources available, including GOI’s own funds, proportional share of state releases and uncommitted unspent balances available with the states.

In FY 2014-15, GOI approved 69 percent of the total funds proposed by states.

Releases: There has been a decrease in the proportion of allocations released by GOI. In FY 2009-10, 99 percent of allocations were released. This dropped to 88 percent in FY 2012-13. In FY
NRHM allocations in FY 2014-15, according to quarterly report

2013-14, this dropped to a further 86 percent. As of September 2014, halfway through the financial year, 61 percent of allocations for FY 2014-15 had been released.

Fund releases have also slowed down in FY 2014-15. In FY 2013-14, 46 percent of allocations were released in the first quarter and 66 percent in the first half of the year. This has decreased to 29 percent in the first quarter and 61 percent in the first half of FY 2014-15.

Expenditure performance: As with releases, expenditure as a percentage of total releases (including state share) has dropped. In FY 2009-10, over 100 percent of total releases (GOI and state share) were spent. This dropped to 84 percent in FY 2012-13. Till December 2013 (the latest year for which state shares are available), 63 percent of the total releases were spent.

TRENDS IN STATE-WISE ALLOCATIONS AND EXPENDITURES

To address regional imbalances in health outcomes, NRHM identified a set of 18 ‘high focus’ (HF) states with the poorest health indicators. These states received 62 percent of the total GOI allocations for NRHM in FY 2014-15.

Proposed vs approved allocations: There are state-wise variations in the proportion of proposals approved. Jharkhand and Tamil Nadu had the lowest approval rate with 56 percent of proposals being approved in FY 2014-15. In contrast, 85 percent of funds proposed by Punjab were approved and 86 percent for Haryana.

Releases: Till FY 2013-14, once approved, funds for NRHM were released directly by GOI and state governments to autonomous implementing bodies known as State Health Societies (SHS). In FY 2014-15, a new fund flow mechanism was introduced. Under this system, GOI allocations are first released to the state treasury. The money is then routed by the state health department to the SHS. Since the start of the Twelfth Five Year Plan (FYP) in 2012, funds are to be shared by GOI and states in a 75:25 ratio.

Overall, state releases have been lower than their required share. In FY 2013-14, till December, Bihar released 65 percent less than its required share. Similarly, Andhra Pradesh released 49 percent less than its required share.

Expenditure performance: There are significant state variations in expenditures as a proportion of total approvals (GOI and state shares). In FY 2013-14, Jharkhand and Bihar spent 61 and 73 percent of total approvals, respectively. Chhattisgarh and Haryana, on the other hand, spent 93 percent.

73% of Bihar’s approved allocations were spent in FY 2013-14.
Most states have shown improvements in expenditure performance between FY 2012-13 to FY 2013-14. For instance, expenditure in Chhattisgarh increased from 65 percent in FY 2012-13 to 93 percent in FY 2013-14. Similarly, expenditures increased in Gujarat from 75 percent to 89 percent. Expenditure performance, however, decreased in West Bengal from 98 percent to 89 percent during the same period. Since releases from GOI are largely high and timely, low expenditures are likely a consequence of poor state capacity.

There are 5 main components for which funds are allocated under NRHM. These are:
- Reproductive, maternal, new born and child health services (RCH Flexi Pool),
- NRHM Mission Flexi Pool or funds for strengthening health resource systems, innovations and Information, Education and Communication (IEC),
- Immunisation including the Pulse Polio Programme,
- National Disease Control Programme (NDCP) and,
- Funds for infrastructure maintenance

Allocations: In FY 2014-15, 38 percent of total NRHM funds were allocated to RMNCH. This was followed by 34 percent for Mission Flexi Pool and 16 percent for infrastructure maintenance. Disease Control Programme had a 7 percent share of total allocations, and funds for immunisation constituted only 4 percent.

In FY 2014-15, GOI’s NRHM allocations saw some cuts relative to previous years. These cuts were visible in allocations for infrastructure maintenance, which decreased by 31 percent from ₹4,788 crore in FY 2013-14 to ₹3,315 crore.

Only 60% of flexi pool proposals were approved in FY 2014-15

<table>
<thead>
<tr>
<th>Component</th>
<th>% of approved funds in FY 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCH Flexi Pool</td>
<td>38%</td>
</tr>
<tr>
<td>Mission Flexi Pool</td>
<td>34%</td>
</tr>
<tr>
<td>Immunisation</td>
<td>4%</td>
</tr>
<tr>
<td>Diseases</td>
<td>7%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>16%</td>
</tr>
</tbody>
</table>


Note: This data pertains to 20 major states of India
Gaps between amounts proposed and final approvals give a sense of GOI prioritisation across activities, particularly when there are budget cuts. In FY 2014-15, while states proposed nearly twice the total resource envelope available for RCH Flexi Pool, only 81 percent of proposed funds were approved. Similarly, less than 60 percent of funds proposed for Mission Flexi Pool were approved.

There are state-level differences in the pattern of investments across components. Tamil Nadu and Bihar allocated half their total funds to the RCH Flexi Pool, while allocating 22 percent and 26 percent of funds to Mission Flexi Pool. In contrast, Maharashtra and Uttar Pradesh allocated more than 30 percent of their funds to Mission Flexi Pool.

Himachal Pradesh and Jharkhand had the lowest approvals under RCH Flexi Pool, at 59 percent and 65 percent respectively. Despite the fall in infrastructure maintenance funding, Himachal Pradesh continued to be the state which spent the highest proportion of funds on infrastructure maintenance.

There are state-wise differences in expenditure of funds across various components. In FY 2013-14, while Tamil Nadu spent 96 percent of approved funds under the Mission Flexi Pool, Uttar Pradesh spent only 38 percent. Similarly, Maharashtra spent nearly all allocations for the National Disease Control Programme, as compared to Uttar Pradesh and Bihar, which spent 17 percent and 25 percent, respectively. All states spent more funds for infrastructure maintenance than their approved allocations, with Uttar Pradesh spending twice its allocations.

% of total all allocations spent in FY 2013-14

- Uttar Pradesh: 162%
- Bihar: 145%
- Maharashtra: 130%
- Tamil Nadu: 100%
- RCH Flexi Pool: 99%
- Mission Flexi Pool: 89%
- Immunisation: 77%
- NDCP: 96%
- Infrastructure maintenance: 71%

96% of Tamil Nadu’s funds were spent for Mission Flexi Pool in FY 2013-14.

The rural health care system in India has three tiers: a) Sub-Centres (SCs), b) Primary Health Centres (PHCs) and, c) Community Health Centres (CHCs).

SCs are the focal point between the community and the primary health care system. According to the guidelines, 1 SC has to cater to 5,000 residents in the plains and 3,000 residents in hilly regions. 2 community health workers staff each SC.

The PHC is the first point of contact with access to a qualified doctor in rural areas. They also provide pharmaceutical and laboratory services. Each PHC should serve 30,000 residents in the plains, and 20,000 residents in hilly, tribal or difficult areas.

CHCs are larger referral centres for patients from PHCs requiring specialised medical services such as surgery, gynecology or pediatric services. There must be 1 CHC for every 1,00,000 residents in the plains, and one for every 80,000 residents in tribal and desert areas.

Between 2005 and 2014, the number of SCs, PHCs and CHCs has increased by 4 percent, 8 percent and 60 percent, respectively.

The number of facilities required by norms has also increased due to population growth. Thus, while shortfall (difference between number required as per norm and facility present) in CHCs has reduced by 17 percentage points, shortfalls in both PHCs and SCs have increased by over 6 percentage points.

There are also year-on-year variations. Between March 2013 and March 2014, the number of CHCs increased by 3 percent, PHCs by 2 percent and SCs by less than 1 percent. This represented a 1 percentage point decrease in total shortfalls for PHCs and CHCs, which stood at 23 percent and 32 percent as of March 2014.

There are state-wise variations in the shortfall of CHCs and PHCs.

As of March 2014, Bihar had a 91 percent shortfall in CHCs and 39 percent shortfall in PHCs. In contrast, Jharkhand had a higher shortfall for PHCs with 66 percent fewer PHCs and 22 percent fewer CHCs than required.

No new facilities were constructed in Jharkhand, Maharashtra, Uttar Pradesh and West Bengal in FY 2013-14, despite significant shortfalls at all levels.

On the other hand, Goa, Himachal Pradesh, Jammu and Kashmir, Kerala and Mizoram have met their requirements for health facilities at all levels.

The quality of health infrastructure in PHCs continues to be low. The Indian Public Health Standards (IPHS) set measures for the quality
of health infrastructure in all PHCs, CHCs and government hospitals. As of March 2014, only 21 percent of PHCs across India were functioning according to IPHS, up from 18 percent as on March 2013 and 15 percent as on March 2011.

Most PHCs also lack basic infrastructure. As of March 2014, 31 percent of PHCs did not have a labour room, 5 percent were functioning without electricity and 8 percent without regular water supply, these numbers remaining nearly unchanged since March 2013.

HUMAN RESOURCES

Doctors in PHCs: Between 2005 and 2014, the number of doctors at PHCs increased by 35 percent. However, this increase could not keep pace with population growth. Between March 2013 and March 2014, the number of PHCs functioning without doctors more than doubled from 1,072 (4 percent of total PHCs) to 2,225 (9 percent of total PHCs). The total number of doctors in position also fell by 7 percent from 29,562 in March 2013 to 27,355 in March 2014.

The proportion of vacant posts grew in the same period from 22 percent to 26 percent.

There are significant state-wise differences. As of March 2014, Chhattisgarh had a shortfall of 51 percent in required posts for doctors in PHCs and 49 percent of the existing posts were also vacant. Similarly, PHCs in Gujarat had a 23 percent shortfall in doctor posts and a vacancy rate of 41 percent.

Similarly, while West Bengal had filled all required posts in PHCs in 2013, the number of doctors in position fell by 1,070, causing the shortfall against norms to stand at 22 percent in March 2014.

Specialists in CHCs: Specialists at CHCs comprise of surgeons, paediatricians, physicians, obstetricians and gynaecologists.

The total number of specialists employed at CHCs reduced by 30 percent between March 2013 and March 2014; falling from 5,805 to 4,091.

As of March 2014, shortfall in the number of specialists against the norms stood at

Between March 2013 and March 2014, the number of PHCs functioning without doctors more than doubled from 1,072 to 2,225

<table>
<thead>
<tr>
<th>State</th>
<th>Doctors required in PHCs</th>
<th>Doctors present in PHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uttar Pradesh</td>
<td>3,497</td>
<td>2,209</td>
</tr>
<tr>
<td>Karnataka</td>
<td>2,333</td>
<td>1,955</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>2,082</td>
<td>2,111</td>
</tr>
<tr>
<td>Bihar</td>
<td>1,883</td>
<td>2,521</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>1,611</td>
<td>2,596</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>1,369</td>
<td>2,139</td>
</tr>
<tr>
<td>Odisha</td>
<td>973</td>
<td>1,305</td>
</tr>
<tr>
<td>Gujarat</td>
<td>889</td>
<td>1,158</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>999</td>
<td>1,157</td>
</tr>
<tr>
<td>West Bengal</td>
<td>711</td>
<td>909</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>783</td>
<td>383</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>571</td>
<td>489</td>
</tr>
<tr>
<td>Haryana</td>
<td>454</td>
<td>454</td>
</tr>
<tr>
<td>Punjab</td>
<td>441</td>
<td>427</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>372</td>
<td>330</td>
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<tr>
<td>Uttarakhand</td>
<td>257</td>
<td>168</td>
</tr>
<tr>
<td>Sikkim</td>
<td>54</td>
<td>24</td>
</tr>
</tbody>
</table>


Note: All figures as of March 2014
81 percent — 9 percentage points worse than March 2013 and 35 percentage points worse than 2005.

❖ Further, the number of posts sanctioned for specialists falls short of the required norms. Against 21,452 required specialists, only 11,463 posts or 53 percent have been sanctioned as of March 2014.

❖ Variations exist across states. The fall in the number of specialists over March 2013 to March 2014 is driven by decrease in the number of specialists in the states of West Bengal and Uttar Pradesh. The number of specialists in these states decreased by 89 percent and 72 percent, respectively.

❖ Only two states, Karnataka and Jammu and Kashmir had at least half the required specialists in position.

11,463 posts or 53 percent have been sanctioned as of March 2014, against 21,452 specialists required

NUHM

❖ The National Urban Health Mission was started in May 2013 with the objective to meet health care needs of the urban population. The mission focuses on the urban poor, by providing essential primary health care services and reducing their out-of-pocket expenses for treatment. The sub-mission covers all state capitals, district headquarters, and towns with a population exceeding 50,000.

❖ Implementation of NUHM rests with urban local bodies. States have flexibility to constitute Urban Health Societies, or include members from local bodies into the existing District Health Societies. In seven major cities: Delhi, Mumbai, Chennai, Kolkata, Bangalore, Hyderabad, Ahmedabad; the Municipal Corporations are responsible for its implementation. 22 percent of NUHM funds are allocated to these 7 cities and 78 percent to the remaining urban population.

❖ While the scheme was started in 2013, funds allocated under NUHM are low.

❖ In FY 2014-15, only ₹1,128 crore was approved (including state shares) for 20 major states. This represents only 5 percent of the total NHM budget for these states.

❖ As with NRHM, not all funds proposed by states under NUHM were approved in FY 2014-15. Only 48 percent of the proposed funds were approved in FY 2014-15.
India has made some progress in meeting its Millennium Development Goals (MDGs). Maternal Mortality Ratio (MMR), calculated through 2004-06 was 254 per 1,00,000 live births. This has improved to 167 in 2013.

Similarly, Infant Mortality Rate (IMR) has improved from 57 in 2006 to 40 in 2013.

There are, however, state-wise variations. IMR in Madhya Pradesh and Odisha dropped from over 65 in 2009 to 54 and 51 in 2013, respectively. Kerala had among the lowest IMR, but it has not decreased since 2008.


Source: Time series data on CBR, CDR & IMR. Available online at: https://nrhm-mis.nic.in/Part%B0%20Demographic%20and%20Vital%20Indicators/Times%20Series%20data%20on%20CBR%20CDR%20IMR%20and%20TFR.xls Last accessed on February 19, 2015
In FY 2014-15, only ₹1,126 cr were approved (including state shares) under NUHM for 20 major states. This represents only 5% of the total NHM budget for these states.
Allocations to the MoHFW have increased by 54 percent from ₹21,680 cr in FY 2009-10 to ₹33,282 cr in FY 2015-16.
This section offers some practical leads to accessing further, more detailed information on the Union Government’s health sector budget. Reader patience and persistence is advised as a lot of this information tends to be dense and hidden amongst reams of data.

<table>
<thead>
<tr>
<th>DATA SOURCES</th>
<th>USEFUL TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Union Budget, Expenditure Vol.2</strong>&lt;br&gt;Available online at: <a href="http://www.indiabudget.nic.in">www.indiabudget.nic.in</a>&lt;br&gt;Last accessed on February 28, 2015</td>
<td>Provides total ministry-wise and department-wise allocations as well as disaggregated data according to sectors and schemes FY 1998–99 onwards. The data has both revised estimates and budget estimates and should be calculated according to the major-head and sub major-head. For health and family welfare, the heads are 2210 and 2211.</td>
</tr>
<tr>
<td><strong>Bulletin on Rural Health Statistics in India, 2014</strong>&lt;br&gt;Available online at: <a href="https://nrhm-mis.nic.in/Pages/RHS2014.aspx">https://nrhm-mis.nic.in/Pages/RHS2014.aspx</a>&lt;br&gt;Last accessed on February 19, 2015</td>
<td>Information on PHCs, CHCs, sub-centres, doctors, nurses, and specialists.</td>
</tr>
<tr>
<td><strong>NRHM, Health Management Information System (HMIS) Portal. Quarterly MIS Reports</strong>&lt;br&gt;Available online at: <a href="http://nrhm.gov.in/component/content/article.html?id=405">http://nrhm.gov.in/component/content/article.html?id=405</a>&lt;br&gt;Last accessed on February 19, 2015</td>
<td>Information about progress of NRHM, expenditures and releases, status of public healthcare facilities, and so on.</td>
</tr>
<tr>
<td><strong>Time series data on CBR, CDR &amp; IMR</strong>&lt;br&gt;Available online at: <a href="https://nrhm-mis.nic.in/Part%20B%20Demographic%20Vital%20Indicators/Times%20Series%20data%20on%20CBR%20CDR%20IMR%20TFR.xls">https://nrhm-mis.nic.in/Part%20B%20Demographic%20Vital%20Indicators/Times%20Series%20data%20on%20CBR%20CDR%20IMR%20TFR.xls</a>&lt;br&gt;Last accessed on February 19, 2015</td>
<td>Contains information on vital demographic indicators over time.</td>
</tr>
</tbody>
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Photo: **Centre for Science and Environment**