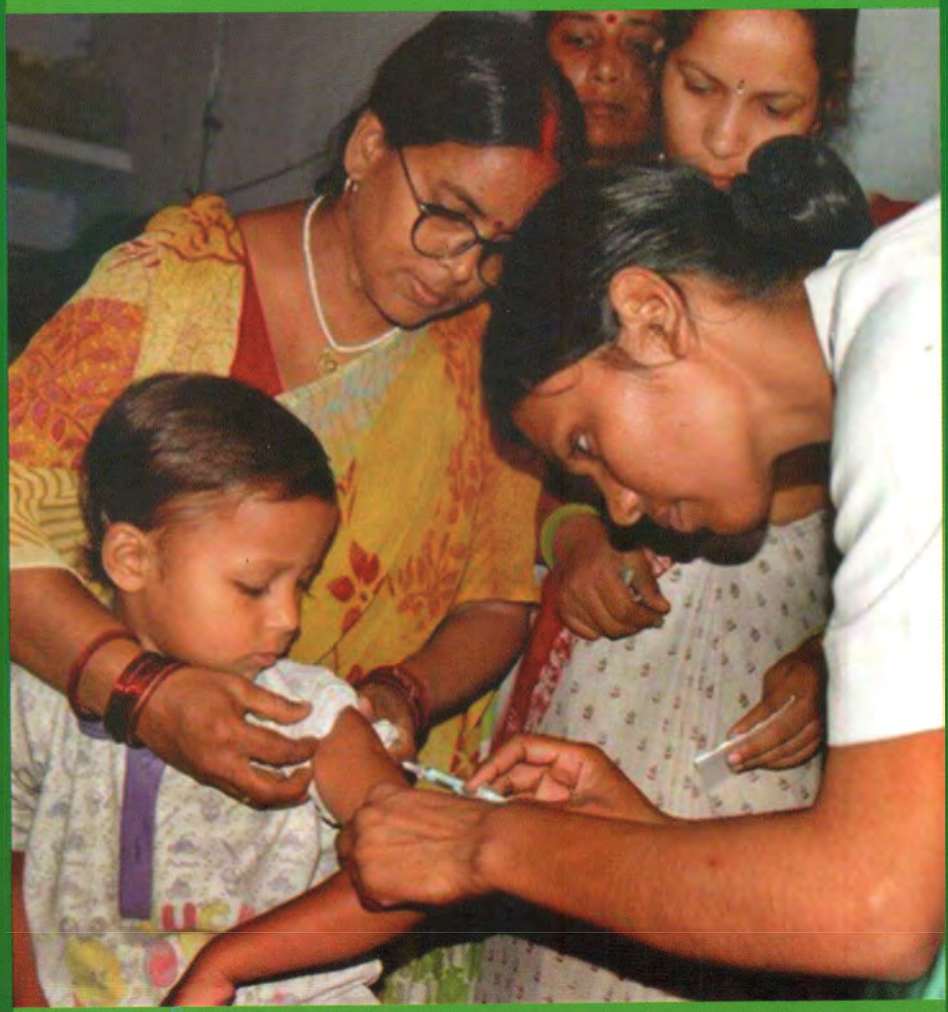
Budget for National Rural Health Mission in Odisha



Budget for National Rural Health Mission in Odisha

Odisha Budget and Accountability Center (OBAC)
CYSD
Bhubaneswar

Concept
Pravas Rajan Mishra

Research and Report
Surendra Sahoo
Basanta Nayak

Administrative Support
Prasanna Kumar Das

CYSD
E-1, Institutional Area
Gangadhar Meher Marg
Bhubaneswar 751013, Odisha, India
Tel: 91-674-2300983/2301725
Fax: 91- 674-2302226
Email: cysdbbsr@sancharnet.in
Website: www.cysd.org

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List of Important Abbreviations

ASHA	Acridated Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Sidha and Homeopathy
CDR	Crude Death Rate
CHC	Community Health Center
DHH	District Headquarter Hospital
FMG	Financial Management Group
GoI	Government of India
GoO	Government of Odisha
GKS	Gaon Kalyan Samiti
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
IPHS	Indian Public Health Standard
IDSP	Integrated Disease Surveillance Project
NRHM	National Rural Health Mission
NVBDCP	National Vector Born Disease Control Programme
NDCP	National Disease Control Programme
PIP	Project Implementation Plan
PHC	Public Health Center
PHC (N)	Public Health Center (New)
RKS	Rogi Kalyan Samiti
RCH	Reproductive Child Health
RNTCP	Revised National Tuberculosis Control Program
SHH	State Head quarter Hospital
SHS	State Health Society
SC	Sub Center
VHSNC	Village Health & Sanitation Committee
ZSS	Zilla Swastya Samiti

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Executive Summary

The report "NRHM Budget in Odisha" aims to understand the diverse dimensions of health care expenditure in Odisha under the national flagship programme for health i.e. the NRHM. It examines the different programmes and activities taken up under NRHM and the allocation of funds for these programmes. At the same time the report also tries to check the expenditure pattern of some of the activities undertaken by NRHM. The report aims to identify the values for money allocated for different activities under this national flagship programme. It also identifies a number of challenges faced at different levels to implement the programme and proper utilization of the allocated fund.

Increase in the demand for better health care system and to provide a better health care facility to the poor people, the Government of India has launched many programs in different times. The NRHM was launched in April 2005 to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the entire country especially to poor and vulnerable sections of the population. But financing these programmes has become a big issue since the inception of this program. At the same time the value of the money spent under this programme are not satisfactory.

Public spending on health constitutes a major part of the total health expenditure of the state. Basically the rural health care system is fully funded by the government where as part of the urban health expenditure is shared by the private sector. The increase in the health care infrastructure in the last few years evidences the increase in health care expenditure in the state. But while comparing the different health indicators with the national and international standard it shows a very de-motivating figure. As per Sample Registration Survey 2008, the CDR of Odisha in 2009 is 9.0 much higher than that of India with 7.4. Similarly Maternal Mortality in Odisha is a major concern. The reduction of women mortality – the number of maternal deaths per 1,00,000 live births is still an area of concern for government across the globe. In Odisha Maternal Mortality Ratio (MMR) in 2007-09 was 258 which is much higher than the national average of 212. Another important issue is high Infant Mortality Rate (IMR) in the state. Besides the above mentioned issues there are other health hazards which people of Odisha particularly in rural and hilly areas suffers.

NRHM is a central sponsored scheme under which the state receives huge quantum of funds. As per the NRHM framework, approved by Cabinet, the state contributes 15% of the total expenditure under the programme and the central government contributes the other 85%. The funds received by the States are disbursed to the District Health Societies in accordance to the requirements stated in the respective district Health Plan

(DHAPs). The districts disburse funds to the blocks which further disburse funds to various implementing units (CHCs/PHCs/ SCs/ VHSNCs) for programme implementation activities.

The study has attempted to examine the expenditure of the NRHM fund at the district level for which Koraput district was considered. As per the findings, the allotment to the district under the programme RCH-II which was Rs 202.34 Lakhs in the year 2006-07 got increased to Rs 536.19 Lakhs in the year 2010-11, at the same time the percentage of utilization of the available fund which was 48.45% in 2006-07 was increased to 71% in the year 2010-11. The study reveals that the government is very much concerned for providing more resources to the district under NRHM initiatives. But while looking at the percentage of utilization, it shows a very discouraging figure. In the year 2006-07only 6.44% of the available fund was utilized. It is also astonishing to know that in 2006-07 an amount of Rs 160 Lakhs was returned from the district to the OSH&FWS. The percentage of utilization of the allotted fund under the programme immunization was 87.22% in the year 2006-07 which has decreased to 19.45% in the year 2007-08. It again increased to 84.53% in the year 2009-10.

One of the major health sector reforms under the NRHM is increasing the functional, administrative and financial autonomy of the health institutions. Accordingly financial provisions have been made for these field units at different levels in the form of untied fund, annual maintenance grant (AMG) & RKS grant to undertake any innovative or responsive facility specific need based activity. Although utilization pattern of RKS fund varies from each other but priority has been given to the purchase of material. Similarly GKS funds are remaining un-utilized due to incapability of the GKS member.

The study concluded with the recommendations that more investment is needed in the healthcare sector in the state. Similarly, there is no dearth of opportunities to improve the health care services in the state with the available resources. The analysis of the available data, suggests that 1) the state needs to ensure 100% utilization of the available fund, 2) emphasis should be given for programmatic expenditure rather than management expenditure, 3) the state needs to ensure availability of health care facility within 5 kms from each community,4) needs to provide specific fund to GKS for providing transport cost to poor individual patients, 5) Ensure quick disbursement of the services 6) needs to provide training to the GKS member for proper utilization of fund.

Introduction

Health care system is the formal structure to deliver health services in defined settings to a defined population, and whose finance, management, scope and content is defined by law and regulations. It is an important component for the development of human life in each society. It plays an important role in promoting, protecting and restoring population health. Existence of an organized health care system, which is easily accessible to the common people, is a key indicator of a developed society. In addition, good health contributes to economic prosperity through, improving education attainment and productivity. So it is the duty and responsibility of each state to provide an equitable resource for health care facility and services for the common people.

In Odisha the general condition of the people, particularly in rural areas, contribute to poor health condition and high rate of mortality. The mortality rate, considered as the major indicator of overall health status of a population, has declined with the advancement of science and technology. In spite of this, the state has experienced a significantly higher mortality rate than the national average. Despite gradual improvement in health status over many years, preventable mortality and morbidity in Odisha are high. The root causes of poor health continue to be poverty, social deprivation, lower levels of literacy, inefficient health systems and infrastructure for health care as well as control of diseases, particularly communicable diseases. Socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate geographic spread of service outlets and poor quality health care reduce access to and effectiveness of public services. So health system financing in Odisha is a crucial and critical component of public finances.

Public spending on health constitutes a major part of the total health expenditure of the state. Basically the rural health care system is fully funded by the government where as part of the urban health expenditure is shared by the private sector. Due to vast and diverse geographical area and poor lifestyle of the rural people the state government has to spend a huge amount on health and that too from the treasurer. During various time intervals, both the state and central government have implemented different health schemes for the rural people. Starting from the establishment of SCB medical college in 1944 till date, the health care system in Odisha has undergone a significant transformation. At present, there are 3 Medical colleges and hospitals, 32 District Headquarter Hospitals, 22 Sub-divisional hospitals, 231 CHC, 117 PHC, 120 other Hospitals, 1162 PHC(N) and 6688 sub-centers. The increase in the health care infrastructure evidences the increase in health care expenditure in the state. But while comparing the different health indicators with the national and international standards a dismal picture is depicted. Similarly the health care facilities are still far behind the

standards of the Indian Public Health Standard (IPHS). Below mentioned are some health indicators and their status in Odisha.

Table - 1 : Health Indicators of Odisha

S. No.	Item	Odisha	India
1	Crude Birth Rate (SRS 2008)	21.4	22.8
2	Crude Death Rate (SRS 2008)	9.0	7.4
3	Total Fertility Rate (SRS 2008)	2.4	2.6
4	Infant Mortality Rate (SRS 2008)	69	53
5	Maternal Mortality Ratio (SRS 2007-2009)	258	212

Source: Economic Survey 20010-11, Govt. of Odisha

Crude Death Rate (CDR) or Mortality rate is a statistical value that can be utilised to measure the decline of a population. CDR is measured by the rate of deaths among a population of 10000. As per Sample Registration Survey 2008, the CDR of Odisha in 2009 is 9.0 which is much higher than that of India with 7.4.

Similarly Maternal Mortality is one of the major issues in Odisha and its reduction is still an area of concern for government across the globe. Conceptually, maternal mortality is the number of maternal deaths per 1,00,000 live births. In Odisha, Maternal Mortality Ratio (MMR) in 2007-09 was 258 much higher than the national average of 212. Among the various causes for a high MMR, there are 6 critical causes i.e. hemorrhage, eclampsia (an acute and life-threatening complication of pregnancy), obstructed labour, sepsis (blood poising), complications arising out of unsafe abortion and pre-existing conditions such as anemia, and malaria. Most of these can be treated in hospital or first referral unit endowed with emergency facilities and skilled personnel. The third important health problem of the state is high rate of infant deaths. Infant Mortality Rate (IMR) continues to be the highest in Odisha among all the states. The rate of decline in IMR has been rather slow and this is a cause for concern. The above table indicates that in the year 2008, IMR was 65 almost 15 points higher than the national average (50). Low birth weight of the infants is one of the primary causes of infant deaths. Another reason for infant deaths is due to infections relating to the circulatory system. All these causes in broad sense reflect the lack of antenatal, natal and post-natal care. Particularly, in Odisha, three factors that are poor availability of professional attendance at birth, high percentage of low-birth weight babies and lack of professional post-natal care may explain the high level of IMR.

Besides the above mentioned issues, there are other health hazards which people of Odisha, particularly in rural and hill areas suffer. Among them, malaria is quite endemic in the four districts i.e. Kandhamal, Keonjhar, Sundergarh and Mayurbhanj. Similarly, tuberculosis (TB) and gastroenteritis remain major public health problems in Odisha. Though the case of fatality rate slowed down, still the prevalence rates have steadily increased. The aforementioned issues on the health status of people of Odisha give a clear picture at the macro level. But, at micro level, there are certain specific issues like institutional delivery, antenatal care, immunization, sanitation etc. which can provide a more vivid picture of the health status prevailing in the state.

In the context of the above issues, success of health sector plan in Odisha is basically centered and depends upon the successful implementation of the plans at the rural and tribal areas. Strengthening the available health care facility and increasing the access of such facility to the poor people are the key challenges. Similarly, effective implementation of the existing plans and increasing the community participation, public awareness on health, women and child health are some other key issues in health sector in Odisha. Health sector expenditure in Odisha has significantly increased in the last two decades with a consequent development in the health care facility and services. Though there has been an increment in the number of health care institutions in the state, but that does not help in the increment of the public health standards. One of the pivotal reasons for such poor performance can be attributed to financial insufficiency or less expenditure for the health sector.

1.1 Objectives and Methodology

Due to uneven resource distribution in budgetary provision, balanced health services are quite unhealthy. The most important cause for this unhealthy situation is lack of resources mobilization and proper utilisation. With the implementation of NRHM, the basic level of health infrastructure like CHCs, PHCs, and Sub centers are being revitalised through better human resource management including additional man power and better health infrastructures at all levels. Though there are more budgetary provisions under NRHM and Health and Family Welfare Department to improve the health status of the state, but it mostly depends upon the timely disbursement and proper utilization of the fund under different programmes. But, it is seen that the accessibility of the benefits, the utilisation of the funds and the quality of the services to the poor people is not satisfactory, which becomes a matter of concern in contemporary times.

Considering the above mentioned issue this study is an attempt to track the magnitude and intensity of budget benefits on NRHM. The study might come out

with pertinent issues and recommendations based on the analysis of secondary and primary data from different government health establishments and beneficiaries of the services.

Objectives

- To assess the implementation arrangement of different programmes under NRHM.
- To assess the resource disbursement to different tiers (from center to the ground through state and district) under NRHM.
- To assess the disbursement of states' contribution towards matching grants for NRHM.
- To assess the ground level accessibility of benefits from different community oriented programmes under NRHM.

Methodology

The study is aimed to be conducted in the state of Odisha. The data for the study covers the period of five years (2005-06 to 2009-10). Data is collected from both the secondary and primary sources of the state. The aggregate budget data is collected in the state level while at the district and block level data has been collected from three districts namely, Koraput, Keonjhar and Jagatsinghpur. Different health institutions and implementation agencies at ground level organizations have been randomly selected from the above three districts. The analysis covers three dimensions of the set objectives.

- First, the analysis examines the quantum of budget for different programmes under NRHM along with the state share of expenditure and its trend over the years.
- Secondly, the analysis captures the fund utilization pattern of selected activities and their relevancy. For this the Rogi Kalyan Samiti at block level and the Gaon Kalyan Samiti at village level are included in the study.
- Thirdly, the analysis will be made on the accessibility of benefits by the people at the community level.

Study Area

The study has been designed to be conducted in three districts such as Keonjhar, Koraput and Jagatsinghpur. The three districts have been chosen each from the three categories of districts like scheduled districts, partial scheduled districts and non scheduled districts in Odisha. The detailed study area is given in the following table.

Table - 2 : Sample of the study

Districts	Block	Panchyat	Village
KORAPUT	Potangi	Potangi	Bituguda, Girilguda, Karidi, Podalguda, Podapodar, Potangi, Siura
	Baipariguda	Baligaon	Atalguda, Badaatal, Baligaon, Cherka, Sindhigaon
KEONJHAR	Telkoi	Telkoi	Dandumunda, Halpodi, Ramachandrapur, Telkoi
	Banspal	Banspal	Banspal, Baragoda, Kankarei, Sapakanta, Tilapasi, Totadihi
JAGASTSINGHPUR	Biridi	Hajipur	Hajipur, Chandapur, Kamasasan, Kantapada
	Balikuda	Balikuda	Anjira, Balikuda, Balisahi, Bharioda, Nalio

National Rural Health Mission in Odisha

The National Rural Health Mission (NRHM) was launched in April 2005 to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the entire country especially to the poor and vulnerable sections of the population. The key strategy of the NRHM was to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, and provide an overarching umbrella to the existing disease control programmes run by the Ministry of Health and Family Welfare. The Mission seeks to initiate key changes in the health sector, varying from the encouragement and development of planning capacity and community participation to an emphasis on convergence with other indicators of a good' life - safe drinking water, sanitation etc. The long running disease control programmes have been brought under a more cohesive implementation structure and Indian Public Health Standards guiding infrastructure and facilities have been established.

In Odisha, the NHRM was launched by Chief Minister, Sri Naveen Pattanaik and Union Health Minister. Dr. Anbumani Ramadoss on 17th June 2007. It began with the objective to provide effective health care to rural and urban population throughout the state with special focus on the backward districts with poor human development and health indicators especially among the backward and marginalized groups like women and other vulnerable sections of the society.

The mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes:

- increasing public expenditure on health,
- reducing regional imbalance in health infrastructure,
- pooling resources,
- integration of organizational structures,
- optimization of health manpower,
- decentralization and district management of health programmes,
- community participation and ownership of assets,
- induction of management and financial personnel into district health system,
- operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.
- The Goal of the Mission is to improve the availability of and access to quality health care to the people, especially for them who reside in rural areas, the poor, women and children.

2.1 Key Programs under NRHM

NRHM is an integrated health scheme in the country, which constitutes different health plans. It is a combined and formal structure under which the health plans of the country are being implemented. It is the summation of the pre existing health plans along with some new initiatives undertaken to strengthen the health care system of the state. The following are the different programmes implemented under NRHM.

i) Reproductive Child Health (RCH)

The second phase of RCH program i.e. RCH - II has commenced since1st April, 2005. The main objective of the program is to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate. The objectives were set with a view to meet up to the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India. The major elements of RCH-II program are:

- Interventions to Promote Safe Motherhood,
- Essential Obstetric Care for All,
- Pregnancy and Delivery Services,
- First Referral Units (FRUs) for Emergency Obstetric Care,
- Management of RTIs/STDs, Infertility & Gynecological Disorders,
- Essential New Born Care, Prevention and Management of Vaccine Preventable Disease,
- Diarrhea Control Programme and ORS Programme,
- Prevention and Control of Vitamin A deficiency among children.

ii) NRHM Initiative

With the implementation of NRHM, some new initiatives, also known as the NRHM initiatives, have been introduced for providing effective health care facilities to the rural population with special focus on the backward districts of the state. Although several health plans was implemented before, but due to lack of proper management system the results were not impressive. There was no convergence between several schemes at the state and district level. So the NRHM has taken some new initiatives for better implementation of the existing health plans with some new innovatives. Under such initiatives, focus has been given to various strategic measures to ensure quality health services to the target community. The initiatives are discussed below.

a) Accredited Social Health Activist (ASHA)

In implementing NRHM, the sub-centre is the peripheral level of contact with the community under the public health infrastructure. To complement the work of ANM at the sub center level and to fill the gaps in the health care delivery system at the community level a new initiative termed as ASHA was introduced. The base level health workers in each village are called as ASHA. . The ASHA strengthens the link between the health sector and community by working towards catalyzing behavioral change in rural and tribal areas of the state. She contributes towards enhancing quality of life with focus on health nutrition, sanitation, drinking water etc.

b) Mainstreaming AYUSH

Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognized systems of medicine and have been integrated into the national health delivery system. The NRHM has taken steps to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. For mainstreaming AYUSH special measures have been undertaken under NRHM. The AYUSH medications are included in the drug kit of ASHA, the additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission are also included AYUSH formulations. At the CHC level, provisions are made for providing rooms for AYUSH practitioners and pharmacists under the Indian Public Health Standards (IPHS) model.

c) Provision of Untied Fund

Allotment of funds to the states/districts for implementation of any particular activity has traditionally been of tied fund. In order to undertake any innovative center specific and need-based activity at the Sub-Center/PHC/CHC level, there was a necessity of untied fund. To cater to this facility, provisions have been made under NRHM to allot some untied funds to the health institutions. These funds are specifically meant for the maintenance of the infrastructure and to undertake any center specific need based activity. The center has full autonomy for utilizing this fund.

d) Institutionalizing Hospital Management Society

Hospital Management Society/Rogi Kalyan Samiti (RKS) is a management structure consisting of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs. Under NRHM this management society has strengthened and given financial support for their business. It is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services at the center.

e) Mobile Medical Unit

Many areas in the State, predominantly tribal and hilly areas, lack basic health care infrastructure limiting access to health. Over the years, various initiatives have been taken to overcome this difficulty with varied results. Taking health care to the doorsteps is the principle behind this initiative and is intended to reach underserved areas. Under the NRHM, a new initiative has taken as provision of Mobile Medical Unit (MMU) in each District.

f) Strengthening of PHC/CHC/UGPHC

To minimize the patient load at the District Head Quarter hospital and to provide maximum quality of services at the PHC/CHC level, NRHM has taken initiatives to strengthen the PHC/CHC/UGPHC. Under these initiatives the PHC,CHC and UGPHC provisions are made for increasing the number of beds, upgrading the facilities, providing more staffs (doctor/ paramedics and management staffs).

iii) Immunization

Immunisation program is one of the important health initiatives for reduction of infant and child mortality. The objective of the immunisation program was elimination of Neonatal Tetanus, Diphtheria and Pertussis. Government is providing efficient and safe immunization services to all infants and pregnant women in the state. After the implementation of NRHM the pre-existing immunisation program was brought under the programme and emphasis is given for the successful management of the program. Specifically the ASHAs play an important role to popularize the programme at the community level and to cater the services.

iv) National Vector Borne Disease Control Programme (NVBDCP)

NVBDCP is the nodal agency for prevention and control of vector borne diseases like Malaria, Dengue, Lymphatic Filariasis, Kala-azar etc. In Odisha, NVBDCP deals with following diseases Malaria, Filaria, Dengu, Kala-zar. After the implementation of NRHM, the management of this programme was brought under the NRHM.

v) Revised National Tuberculosis Control Program (RNTCP)

Revised National Tuberculosis Control Program (RNTCP) is the state-run Tuberculosis Control Initiative of the Government of India. It incorporates the principles of Directly Observed Treatment Short course (DOTS) - the global TB control strategy of the World Health Organization . The Revised National TB Control Programme now

aims to widen the scope for providing standardized, good quality treatment and diagnostic services to all TB patients in a patient-friendly environment, in whichever health care facility they seek treatment from. Recognizing the need to reach to every TB patient in the country, the programme has made special provisions to reach marginalized sections of the society, including creating demand for services through specific advocacy, communication and social mobilization activities

vi) National Program for Control of Blindness

The programme was started in 1976 as a 100% centrally sponsored scheme. It aims to reduce the backlog of blindness through identification and treatment of the blind, to develop eye care facilities in every district, to develop human resources for providing Eye Care Services, to improve quality of service delivery and to secure participation of Voluntary Organizations in eye care.

vii) National Iodine Deficiency Disorder Control Programme (NIDDCP)

Iodine Deficiency is a major public health problem worldwide. About 1.5 billion people are at risk of Iodine Deficiency Disorders (IDD) and more than 70 millions are having Goitre and other IDD problems. Government of India (GOI) launched a 100% centrally assisted National Goitre Control Programme (NGCP) in 1962. The NGCP was renamed as National Iodine Deficiency Disorder Control Programme (NIDDCP) in 1992. This programme is also brought into the management of NRHM.

viii) Integrated Disease Surveillance Project

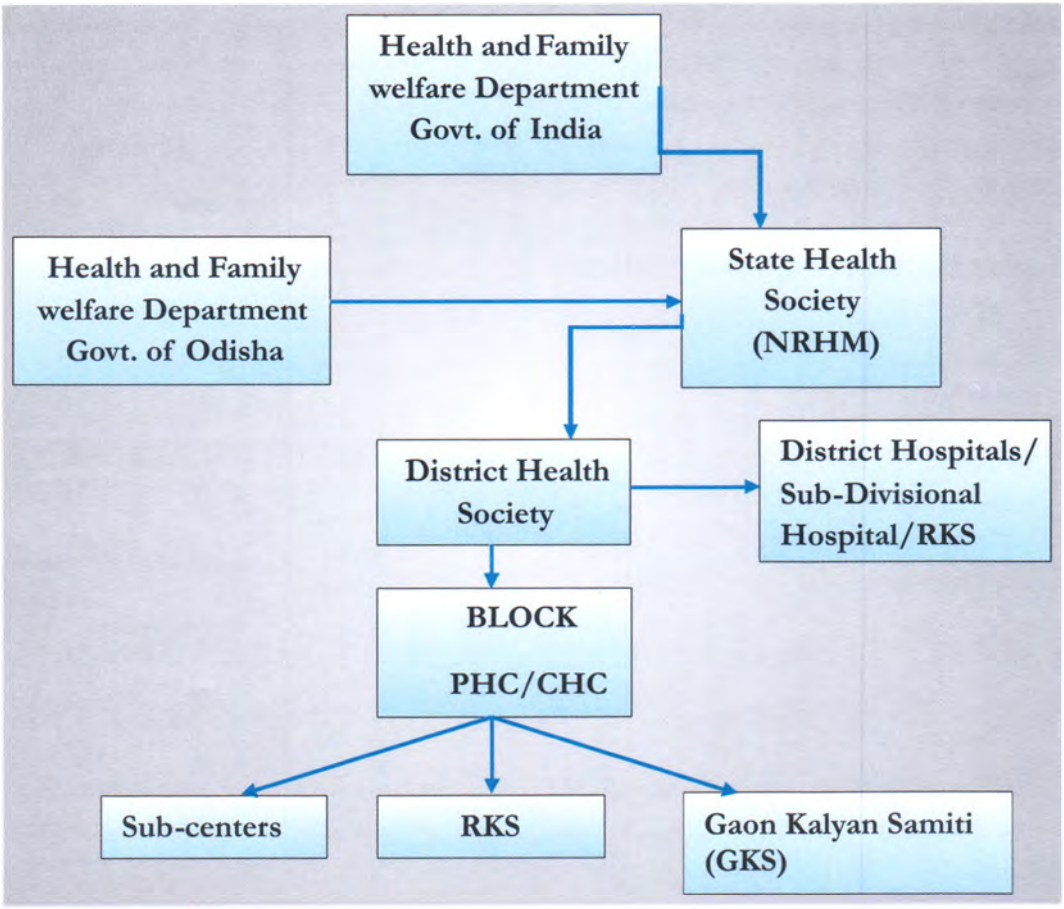
Integrated Disease Surveillance Project (IDSP) was launched by Health & Family Welfare Department in November 2004. It is a decentralized, state based surveillance program in the country and is intended to detect early warning signals of impending outbreaks and help in initiating an effective response in a timely manner. Major components of the project are : (1) Integrating and decentralization of surveillance activities; (2) Strengthening of public health laboratories; (3) Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team, other medical and paramedical staff; and (4) Use of Information Technology for collection, collation, compilation, analysis and dissemination of data.

ix) National Leprosy Eradication Programme (NLEP)

NLEP was launched in 1983 with the objective to arrest the disease activity in all the known cases of leprosy. However coverage remained limited due to a range of

organizational issues and fear of the disease and the associated stigma. Districts were covered in a phased manner and all the districts in the country could be covered only by the year 1996. At this stage in view of substantial progress achieved with MDT, in 1991 the World Health Assembly resolved to eliminate leprosy at a global level by the year 2000. In order to strengthen the process of elimination in the country, the first World Bank supported project was introduced in 1993.

Figure - 1 : Implementation and Management structure of NRHM



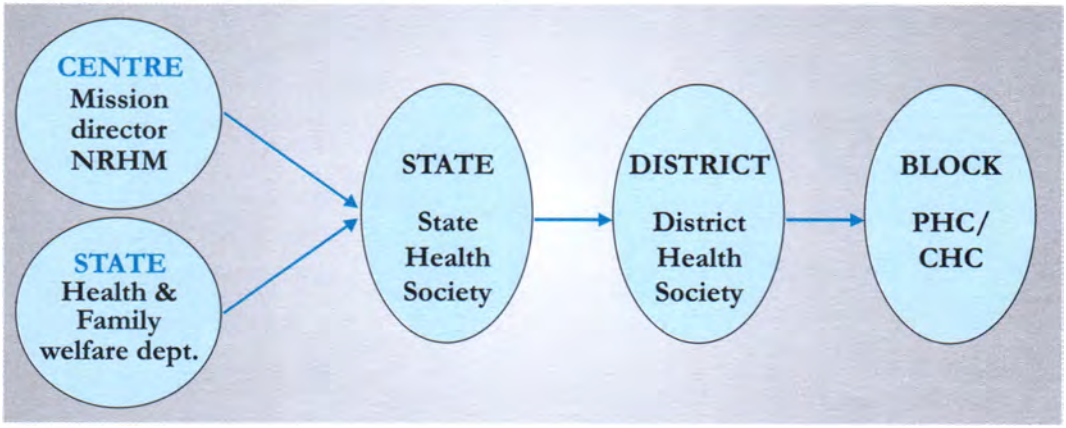
2.2 Funding Pattern of NRHM

NRHM is a central sponsored scheme under which the state receives huge quantum of funds. As per the NRHM framework, approved by cabinet, the state contributes 15% of the total expenditure under the programme and the central government contributes the other 85%. The framework also ensures that all along the state expenditure on health increases in real terms and there is no substitution of the state expenditure by central

expenditure. Though NRHM is an umbrella programme with various programmes under it with different budgetary requirements, the funds for entire NRHM are disbursed through pools for RCH, Additionalities under NRHM (Mission Flexipool), PPI and NDCPs. The funds from the Mission Flexible Pool are further divided into components to suit the requirements of the various programmes.

The funds received by the states are disbursed to the District Health Societies in accordance with the requirements stated in the respective district Health Plan (DHAPs). The districts disburse funds to the blocks which further disburse funds to various implementing units (CHCs/PHCs/ SCs/ VHSNCs) for programme implementation activities. Out of the total funds, approximately 10% of the total funds are spent at the state level, 20% at district level and 70% at the block level and below since most of the implementation activities take place at the lower level units. The fund flow process is explained below with the help of a flow diagram.

Figure - 2 : Fund Flow under NRHM



The fund flow mechanism of the NRHM is divided into two phases such as fund flow form center to state and fund flow from state to district and other implementing agencies.

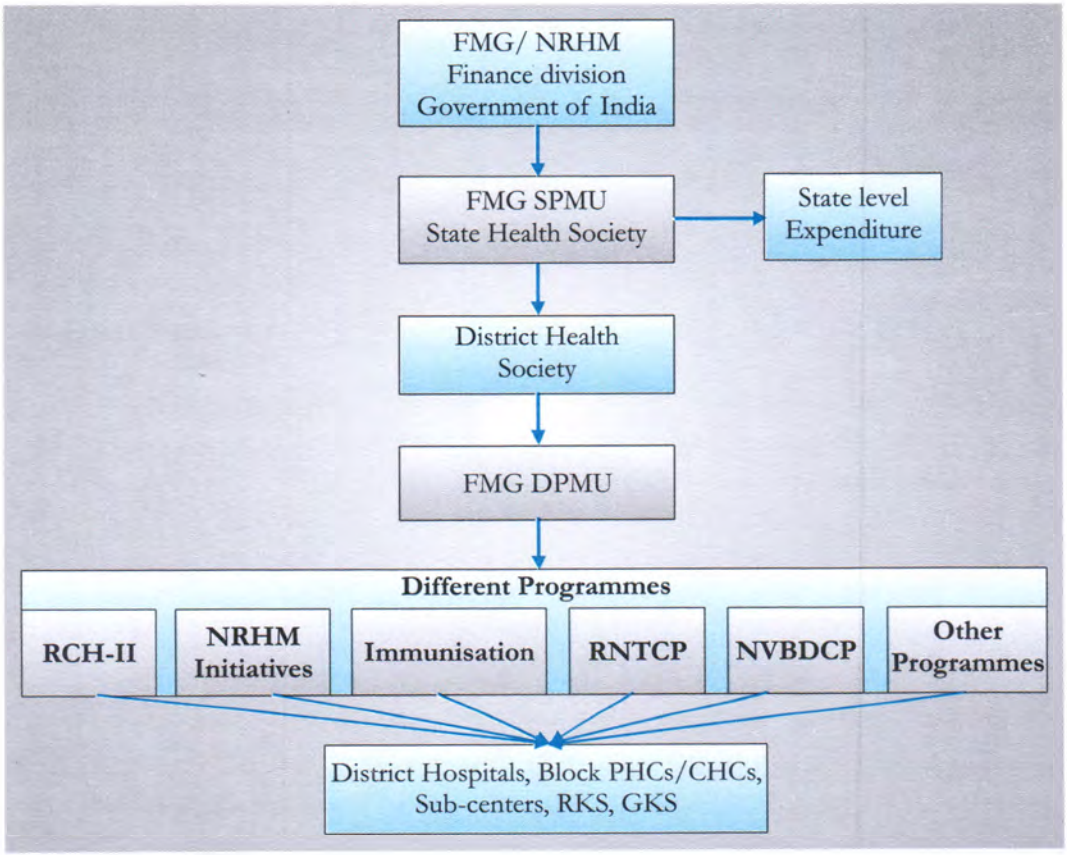
i) Fund Flow from Center to state

After the approval of the PIP of the states the FMG put proposal to GOI for fund release after due approval from Director Finance & Mission Director. FMG at the GoI level puts a proposal to the Integrated Finance Division (IFD) for fund release. After the sanctions are issued on the above proposal the funds are transferred to the SHS. At the same time the state also deposits the state share for NRHM in the account of the SHS, after which the funds get ready to be utilized by the SHS.

ii) Fund Flow from State to District/ Block

The mission direcctor NRHM is responsible for the utilisation of the money at the state and district level. As like as the central government transfer the fund to the SHS, the state government also transfer its share of expenditure. After receiving the funds from the Government of India and Governmnt of Odisha the SHS transfers the funds to the districts within 15 days. After adjusting the unspent balance of the previous years, the releases are made to districts as per the approved DHAPs. and. These funds include components like Untied Funds, Annual Maintenance Grants, grants for RKS to the VHSNC, Sub-Health Centres, PHCs, CHCs and Sub-district hospitals etc. SHS directly credit the bank account of each programme at the DHS level and not route it through the main account of DHS. The districts disburse the funds to the blocks as per their requirements, part of which are further disbursed to the implementing units including CHC/PHCs, SCs and VHSNCs.

Figure - 3 : Fund Flow Hierarchy NRHM



Findings and Observation

3.1 Health expenditure in Odisha

The three major sources to finance Health care expenditure in the state are expenditure by the state government, by the central government and by the private sector. The public expenditure (Expenditure by both state and central government) contributes the maximum to the total expenditure, specifically the health care expenditure in the rural areas are fully financed by the government. Scrutiny of the health care expenditure in Odisha, can be observed in two ways i.e. expenditure before the implementation of NRHM and expenditure after the implementation of NRHM.

Table - 3 : Health care expenditure in Odisha

	Before Implementation of NRHM					After implementation of NRHM				
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11(RE)	2011-12(BE)
Total Health Expenditure*	534.43	606.96	676.27	537.15	659.66	742.02	923.72	1280.92	1541.19	1451.66
Growth Rate		11.95	10.25	-25.90	18.57	11.10	19.67	27.89	16.89	-6.17
As % of GSDP	1.08	0.99	0.88	0.64	0.66	0.58	0.65	0.79	0.83	NA

**Total health expenditure includes expenditure incurred by the state budget and expenditure incurred outside the state budget by the government.*

Source : Odisha budget at a glance.

The above table shows the total health expenditure in the state (before and after implementation of NRHM). Total health expenditure of the state which was Rs 534.43 Crore in 2002-03 has reached to Rs1451.66 Crore in 2011-12(BE). From the above table it is observed that the total health expenditure in the state has an increasing trend, after the implementation of the NRHM. But while looking at the total health expenditure as percentage of GSDP it was found that there is no improvement in the health expenditure. Total health expenditure as percentage of GSDP which was 1.08% in 2002-03 has reduced to 0.83%. Similarly the health expenditure as percentage of GSDP shows an enhanced figure before the implementation of NRHM.

Similarly trends in health expenditure also show an uneven growth. From 2002-03 to 2006-07 the average growth rate was only 3.72% and after implementation the average growth rate became 13.88%. But in the last year there was a decrease in the health expenditure of the state.

Expenditure under NRHM

NRHM is a major source of finance for the health care expenditure in Odisha. Under NRHM huge fund have been flowing from the central government to the state. The following table shows the amount received by the state government under NRHM from 2005-06 to 2010-11.

Table - 4 : Total Receipt and expenditure by State health society under NRHM

Proposed Budget Vs Actual expenditure in the state. (Rs in Lakhs)						
	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Proposed Budget/Budget	13060.17	20569.1	39343.72	47082.74	55139.2	61388.52
Receipt	12681.55	15299.58	29001.11	32580.48	37229.68	41775.64
Receipt as % of Proposed budget	97.10	74.38	73.71	69.20	67.52	68.05
Actual Expenditure	5037.82	8847.34	15984.14	23573.07	46762.01	46847.42
Expenditure As % of Proposed Budget	38.57	43.01	40.63	50.07	84.81	76.31

Source: Mission director, NRHM, Govt. of Odisha

It is clear from the above table that in the year 2005-06, the state government has received an amount of Rs 1268.55 lakhs under NRHM, which has increased to Rs 45354.24 lakhs in the year 2010-11. But while examining the utilization of the amount receipt by the state government it was found that in the year 2005-06 only 39.73% of the total receipt was spent. The utilization was increased to 72.35% in the year 2008-09. In the year 2009-10 and 2010-11 the utilization exceeded the allotted amount of the concerned year. It shows that in the last two years more expenditure was made by the state. While calculating the average expenditure of the NRHM fund received by the state it was found to be 86.35% of the total receipt.

Table - 5 : State share of expenditure for NRHM

Share of NRHM fund between central and state government (Rs in lakhs)				
	Government of India Release	Government of Odisha Release	Total	Growth rate
2005-06	12681.55 (100%)	0	12681.55	
2006-07	15299.58 (100%)	0	15299.58	17.11
2007-08	25216.76 (86.95%)	3784.35 (13.04%)	29001.11	47.24
2008-09	27536.73 (84.52%)	5043.76 (15.48%)	32580.49	10.99
2009-10	31129.67 (83.61%)	6100.01 (16.38%)	37229.68	12.49
2010-11	35375.63 (84.68%)	6400.01 (15.31%)	41775.64	10.88

Source: Mission director, NRHM, Govt. of Odisha

The distribution of fund between the state government and central government plays an important role. If the state will not give the state share of expenditure for CSP then the central fund could not be utilized. So it is necessary for the state government to provide adequate share to the central sponsored plans. It is well-known that as per the NRHM framework, approved by Cabinet, the state contributes 15% of the total expenditure under the programme and the central government contributes the other 85%. From the above table it is observed that the beginning two year of the programme there was no state share of expenditure for the NRHM. It is because of the plan was launched two years after the launch of the NRHM by the central government. In the year 2007-08 the state government was able to give only 13% of the total expenditure under NRHM. Similarly in the year 2009-10 the state share of expenditure has marginally increased to 16.38%. Although the state is capable of giving its share of expenditure for NRHM

programme but the absolute expenditure under NRHM is not adequate. The growth in the total expenditure under NRHM shows a fluctuating figure. In the year 2006-07 the growth rate was 17.11% which was increased to 47.24% in the year 2007-08 and it again fell to 10.88% in the year 2010-11, which is not at all a good indicator for equitable health expenditure in the state.

3.2 Expenditure under different component of NRHM in Koraput district

The study tried to examine the expenditure of the NRHM fund at the district level for which Koraput district was considered to be studied. Three major components of the NRHM such as RCH-II, NRHM additional ties and Immunisation were experimented and analyzed. The following table depicts some of the findings.

3.2.1 Expenditure for RCH-II

Table - 6 : Expenditure for RCH in Koraput district

Expenditure for RCH-II in Koraput District (Rs In Lakhs)					
	Receive during the Year	Previous year Balance	Total fund In Hand	Expenditure during the Year	Percentage of Utilisation
2006-07	202.34	31.03	233.37	113.06	48.45
2007-08	274.50	120.30	394.80	190.23	48.19
2008-09	495.32	204.57	699.88	389.55	55.66
2009-10	326.40	305.32	631.72	430.20	68.10
2010-11	536.19	201.52	737.71	525.05	71.17

Source: District Health Society, NRHM, Koraput

From the above table it can be clearly observed that although the allotment of funds is increasing constantly but the percentage of utilization does not have positive indications. The allotment to the district under the RCH-II programme which was Rs202.34 Lakhs in the year 2006-07 was increased to Rs 536.19 Lakhs in the year 2010-11. Similarly, the percentage of utilization of the available fund which was 48.45% in 2006-07 was increased to 71% in the year 2010-11. While on one hand the district is lacking huge health care facility due to high tribal population and high MMR and IMR, so high, on the other hand the government is not able to spend the allotted money under the programme RCH-II which is an important matter of concern.

3.2.2. Expenditure for NRHM Initiatives

Table - 7 : Expenditure for NRHM Initiatives in Koraput

Expenditure for NRHM Initiatives (Rs In Lakhs)					
	Receive during the Year	Previous year Balance	Total fund In Hand	Expenditure during the Year	Percentage of Utilisation
2006-07*	251.44	54.47	305.90	19.71	6.44
2007-08	265.72	126.20	391.92	81.96	20.91
2008-09	528.50	309.96	838.46	138.08	16.47
2009-10	888.18	700.38	1588.56	899.22	56.61
2010-11	0.00	0.00	0.00	650.04	

*In the year 2006-07 an amount of 16000000 was returned to OSH&FWS
Source: District Health Society, NRHM, Koraput

The fund under NRHM initiatives (additional programmes under NRHM) is mainly meant for development of infrastructure, improving health care access, institutionalizing hospital management (GKS and RKS), and ASHA in each village. But while experimenting the financial allotment and expenditure of the fund under NRHM initiatives in the district it was found that the allotment under this programme has increased to Rs 888.18 Lakhs in the year 2009-10 which was only Rs 251.41 Lakhs in the year 2006-07. It shows that the government is very much concern about providing more resources to the district under this programme. But while looking at the utilization of the above said allotted fund it shows a very discouraging figure. In the year 2006-07only 6.44% of the available fund was utilized. It is also astonishing to know that in 2006-07 an amount of Rs 160 Lakhs was returned from the district to the OSH&FWS. Though the percentage of utilization has increased to 56.61% in the year 2009-10 but still the figure is not very good. A huge amount of the funds are remaining unutilized every year. It is putting direct impact on the successful implementation of the other health care programmes in the district.

3.2.3 Expenditure for Immunization

Table - 8 : Expenditure for Immunization

Expenditure for Immunization (Rs In Lakhs)					
	Receive during the Year	Previous year Balance	Total fund In Hand	Expenditure during the Year	Percentage of Utilisation
2006-07*	28.54	3.01	31.55	27.52	87.22
2007-08	20.69	4.03	24.72	4.81	19.45
2008-09	14.45	19.91	34.37	19.57	56.94
2009-10	58.41	25.03	83.44	70.54	84.53

Source: District Health Society, NRHM, Koraput

Immunization, a major component of the NRHM intervention, plays an important role in child health and is one of the major contributors for minimizing the child and IMR. After the implementation of the NRHM the pre existing immunization programmes got a new dimension with the new manpower support of the NRHM. Specifically the ASHAs are the key person for popularizing the immunization in the community. The allotment of funds under this programme for Koraput district is continuously increasing after the implementation of the NRHM in the district but still there is a problem in the expenditure of the available fund. The percentage of utilization of the allotted fund was 87.22% in the year 2006-07 which has decreased to 19.45% in the year 2007-08. It again increased to 84.53% in the year 2009-10.

3.2.4 Expenditure pattern for different component of RCH fund

Utilization of funds under different centrally sponsored schemes is a critical issue so as for NRHM is concerned. While at times it remains unutilized, some time there is improper utilization of the fund. To analyze the expenditure pattern of the NRHM fund the study has considered the expenditure of funds under RCH-II in Koraput district. The following table shows the utilization pattern of the RCH fund during 2006-07 to 2010-11 in Koraput district.

Table - 9 : Utilisation of RCH fund In Koraput District

	Expenditure during the years (As % of Total RCH-II)				
Activity	2006-07	2007-08	2008-09	2009-10	2010-11
Maternal and Child health	81.91	64.20	55.28	69.04	56.78
Family Planning	6.42	17.43	21.60	18.40	15.10
Adolescent Health and gender	0.00	0.00	0.00	0.00	0.12
Urban Health	0.00	0.00	0.00	0.00	0.09
Tribal Health	0.00	2.82	0.13	3.21	0.53
IEC/BCC/Training	0.40	1.56	1.16	1.58	3.04
PPP/NGO	0.00	0.26	0.00	0.00	0.22
Infrastructure and Human resource	3.96	6.02	18.70	1.90	13.34
Institutional Strengthening	0.00	3.18	0.81	2.08	0.35
Programme Management	1.87	3.24	2.32	3.80	10.43
Untied fund for RCH -II	0.00	1.29	1.29	0.00	0.00
Augmentation of Society	5.44	0.00	0.00	0.00	0.00
Total	**100**	**100**	**100**	**100**	**100**

Source: District Health Society, NRHM, Koraput

From the above table it is clear that there are four major sources of fund utilization under RCH such as maternal child health, family planning, infrastructure development and project management. The highest percentage (56.78% in 2010-11) of the RCH-II fund is utilized for maternal and child health over the years. The main activity under maternal child health are JSY and child health programme. Similarly family planning programme is also given emphasis under these initiatives. Under family planning, financial assistance is given as compensation for sterilisation and UID receptors. Expenditure for programme management which was within 4% of the total expenditure till 2009-10 was increased to 10.43% of the total expenditure in the year 2010-11.

Increase in the expenditure for management after five years of implementation of the programme is not a good indicator. On the one hand NRHM is campaigning for 100%

institutional delivery but on the other hand there is a decline in the expenditure for JSY (Annex Table: - 7) fund which shows a contradictory factor. The above table also reveals that spending for tribal RCH is very nominal. Koraput is a tribal district but the expenditure on tribal specific component is very low.

In the year 2009-10 expenditure for tribal specific programme was only Rs 262664/- which is only 0.53% of the total expenditure. Similarly the, there is no expenditure under untied-fund for RCH-II in the last two financial years i.e. in 2009-10 and 2010-11. So it can be clearly concluded from the above analysis that during 2010-11 emphasis has been given on infrastructure development and programme management rather than programmatic expenditure.

3.3 Utilization pattern of RKS Grant

One of the major health sector reforms under the NRHM is increasing the functional, administrative and financial autonomy of the health institutions. Accordingly financial provisions have been made for these field units at different levels in the form of untied fund, annual maintenance grant (AMG) & RKS grant to undertake any innovative or responsive facility specific need based activity. For this purpose PHC(N)s are provided with Rs.25,000/- per annum as untied fund and Rs.50,000/- as AMG . **PHC/CHC/UGPHC/AH** are provided with Rs.50,000/- per annum, Rs.1 lakh as RKS grant and Rs 1lakh as AMG. Similarly every sub-divisional hospital & district headquarter. hospitals are provided with an annual corpus grant of Rs.1 lakh &Rs. 5 lakhs for RKS grant respectively. The RKS in the concerned institution is responsible for managing all these three funds.

Table - 10 : Utilisation of RKS fund by Telkoi CHC

Items	Fund Utilisation (As Percentage of Total Exp.)		
	2008-09	2009-10	2010-11
Construction and Repair	52.73	30.15	28.86
Office material	4.52	2.40	7.25
Meeting and Awareness	1.76	8.35	8.53
Sanitation work	0.76	1.85	4.12
Remuneration	1.65	13.03	11.65
Purchase of material	38.58	43.48	33.89
Others	0.00	0.74	5.69
Total	100	100	100

To examine the fund utilization pattern by the RKS, two RKS was taken into the study, such as Telkoi CHC of Keonjhar district and Potangi CHC of Koraput district. Utilization pattern in this two RKS vary from each other. Table:-10 shows the utilization

pattern of the RKS fund of Telkoi CHC. From the table it is observed that more priority has been given to the purchase of material (33.89% in 2010-11) which includes electrical fittings, medical instrument, generator, furniture etc. The second priority area is construction and repair for which 28.86% of the total expenditure was done. Besides, 11.65% of the total expenditure is meant for providing remuneration to the workers. Expenditure for sanitation takes the last priority in the expenditure table.

Similarly in Potangi CHC a major part of the total expenditure is meant for the purchase of materials that is 42.92% of the total expenditure. From the analysis it is clear that as all the funds managed by the RKS are flexi-pool funds, so there is no uniformity in the expenditure of these funds. So it is not possible to uniformly measure the expenditure pattern of the funds. Sanitation was given less priority during 2008-09 and 2009-10 as there was no expenditure for the same. The data also reflects that 17.99% of expenditure in 2010-11 was done for office stationary, printing and computer consumable which looks very irrelevant. Similarly less expenditure is also made for meeting and building awareness.

Table - 11 : Utilisation of RKS fund By Potangi CHC

Items	Fund Utilisation (As Percentage of Total Exp.)		
	2008-09	2009-10	2010-11
Construction and Repair	0.72	4.17	17.52
Office Stationary	9.49	22.86	17.99
Meeting and awareness	0	0.63	7.84
Sanitation	0	0	4.36
Remuneration	3.05	3.51	7.42
Purchase of material	86.73	57.90	42.92
Others	0	10.94	1.95
	100	100	100

3.4 Utilization pattern of GKS Grant

As per the norm of NRHM an untied amount of Rs.10,000 is provided every year to the GKS. The GKS utilizes this fund for the village level public health activities like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc. The untied grant is a resource for community action at the local level and shall only be used for community activities that involves as well as benefits more than one household. The GKS also supports the poor individuals of the village at the time of their health need. The intention of this untied grant is to enable local action and to ensure the public health activities at the village level.

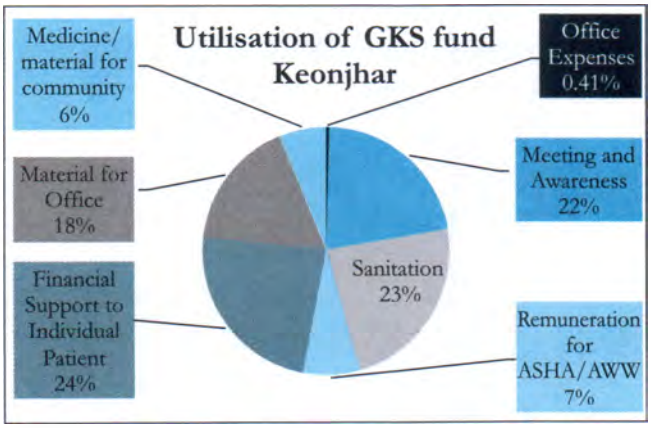
To analyze the expenditure of the GKS fund in the studied area two dimensions of the expenditure i.e. percentage of utilization of the total fund and the utilization pattern were taken into consideration. From the table no. -12 it is observed that Keonjhar district is quite efficient in utilizing the money where as Koraput district shows a very

dissatisfying status. As most of the GKS in the studied area were constituted in the year 2008-09, hence, the utilization of the allotted fund is not quite up to mark. In the year 2008-09 for Keonjhar district the percentage of utilization was only 44.73% and for Koraput and Jagatsinghpur district the percentage of utilization was only 8.42% and 53.33% respectively. But in the succeeding two years both Jagatsinghpur and Keonjhar districts showed an improvement in the utilization of the GKS grant. But in Koraput district, major part of the GKS fund remains unutilized. In 2009-10 and 2010-11 the utilization was only 36.53% and 52.45% of the total fund respectively. The main reasons behind the poor and improper utilization of the GKS fund in Koraput district constitute the incapability and lack of skills and training of the GKS members to spend the grant.

Table - 12 : Utilisation of GKS fund

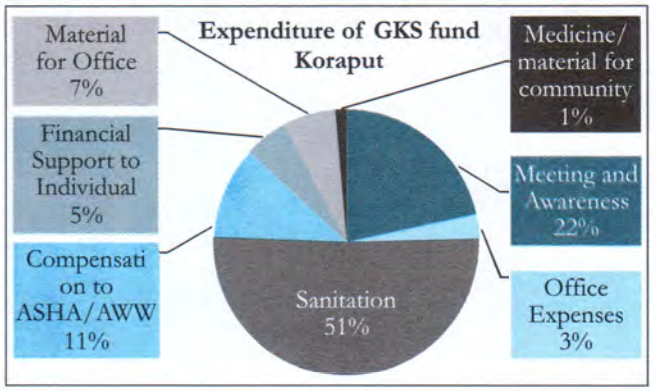
Utilisation of GKS fund (Aspercentage of allotment)			
District	2008-09	2009-10	2010-11
Keonjhar	44.73	102.51	121.53
Koraput	8.42	36.53	52.45
Jagatsinghpur	53.33	89.43	105.30

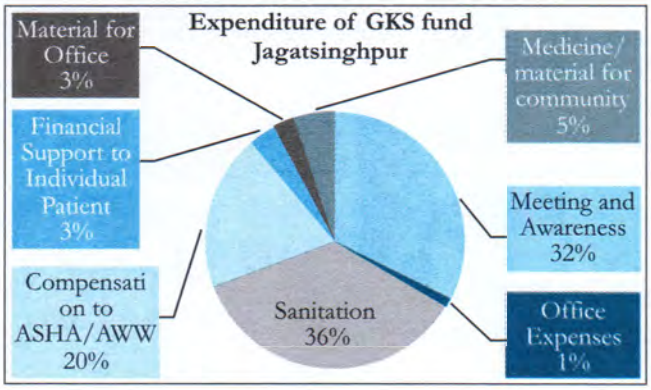
While analyzing the utilization pattern of the GKS grant in the three studied districts, the data shows a varying pattern of expenditure in different districts. In Keonjhar district (Annex-Table:- 4) priority has been given for sanitation facility and for financial support to poor individuals in terms of transport fees. Next to this a major amount is also spent for sanitation work in the village. From the fig:04 it is clearly seen that in 2010-11, 21.88% of the total expenditure was for the meeting and awareness in the community, 23.36% for sanitation, 23.53% for individual support and 17.42% for purchase of materials.



In Koraput district more priority has been given for sanitation facility and awareness programmes. (Annex-Table:- 5) In 2010-11 out of the total expenditure

51.09% was for the sanitation programme in the community. Next to sanitation a major part (21.58%) was spent for meeting and awareness programmes. Similarly another major part that is 11.18% of the total expenditure was done for compensation to ASHA and AWW.





Similarly, in Jagatsinghpur district, sanitation and awareness programmes have been prioritized, (Annex-Table:- 6) During 2010-11, 35.6% and 32.36% of the total amount were spent for sanitation and meeting/awareness programme respectively. Less priority has been given for financial support to poor patient (3.32%) where as 19.81% of the total expenditure was for compensation to ASHA and AWW.

The above analysis clearly indicates that sanitation programme is the main thrust area of expenditure of GKS fund for all the three district where as meeting and awareness programme is the second priority for the GKS. In Keonjhar district financial support to poor individuals, specifically for travelling to the hospitals, is a major area of expenditure. Another key observation found in the study that, although there is no restriction for the GKS to mobilize local fund for GKS but there is no such evidence found in the study. The GKS members should be trained well enough to mobilize resource for the GKS.

3.5 Public awareness on different programmes under NRHM

The success of any programme largely depends upon its utilization and its benefit to the public. There is a need of creating public awareness about the programme for greater acceptance. To measure the awareness level of the people about different components of NRHM, the study included some of the public opinions in the three studied districts.

Table - 13 : Awareness level; of the people about NRHM

Awareness level ➡	Good (In %)			Average (In %)			No Response (In %)		
District	Jagatsinghpur	Keonjhar	Koraput	Jagatsinghpur	Keonjhar	Koraput	Jagatsinghpur	Keonjhar	Koraput
RCH	82.09	12	9.17	17.91	68	75.83	0	20	15
JSY	100	42	51.67	0	42	40.83	0	16	7.5
NDCPs	4.48	12	18.33	80.6	30	54.17	14.93	58	27.5
Immunisation	95.52	45	50	1.49	45	46.67	2.99	10	3.33
GKS	97.01	50	29.17	0	28	55.83	2.99	22	15
RKS	1.49	4	0.83	38.81	0	15.83	59.7	96	83.33
ZSS	23.88	0	0.83	47.76	0	5	28.36	100	94.17
Janani Express	74.63	40	44.17	17.91	41	48.33	7.46	19	7.5
ASHA	98.51	95	45.83	0	5	54.17	1.49	0	0
NRHM	77.61	54	45	22.39	28	35.83	0	18	19.17

Among the three studied districts, awareness level of the people of Jagatsinghpur district is higher where as the awareness level of the people of the Koraput district is very much less. Awareness about the Immunisation, GKS, Janani express and ASHA shows a good figure in the studied area where as awareness about RKS and NDCPs shows a very negative response. Under NRHM a measureable amount is spent for creating public awareness through mass media, leaflets, posters and wall paintings, at the same time ASHAs are also given training for creating awareness in the community but still the people in the tribal areas are not aware about different programmes and facilities. There is need of greater emphasis on crating public awareness in the tribal districts.

3.6 Access to service delivery

In order to know the effectiveness of the programme it is very much necessary to measure the accessibility of the facility given under the programme. While tracking the distance between the service delivery point and beneficiary it was found that Koraput district suffers than the other two districts. From the table- 14 it is clear that in Jagatsinghpur district 100% of the people are getting the facilities within 5kms whereas in Keonjhar 58% people are getting the facility within 5kms, 34% people are getting facility in within 5-10kms and 8% people are travelling more than 10kms accessing the health care facility. In Koraput district the situation is very poor, only 45.83% people are getting the facility within 5kms and 31.67% people are

Table - 14 : Distance of Service delivery point

District	Distance		
	0-5 km	5-10km	More than 10km
Jagatsinghpur	100.00	0.00	0.00
Keonjhar	58.00	34.00	8.00
Koraput	45.83	31.67	22.5

getting the facility within 5-10kms, whereas 22.5% people have to travel more than 10kms to get the facility provided under NRHM. So it implies that there is a need to take necessary steps to facilitate accessibility of the services to the people in the tribal areas.

Similarly immediate release of the incentives to the beneficiary under different programmes such as JSY, compensation for sterilization,treatment of TB etc is also another issue. Under JSY the beneficiaries are getting Rs 1400/- for institutional delivery, for sterilization and treatment of TB the beneficiaries are getting Rs 600/- and Rs 250/- respectively. While analyzing the time duration for getting the financial benefit the following data was found.

Table - 15 : Time spent to access financial incentives in different program

	Time spent to receive financial incentives						
District	On the same day	1 week	2 weeks	3 weeks	1 month	More than months	Missing
Jagatsinghpur	71.64	28.36	0.00	0.00	0.00	0.00	0.00
Keonjhar	70.00	12.00	0.00	2.00	0.00	6.00	10.00
Koraput	63.33	15.00	0.83	13.33	5.00	2.5	0.00
Total	67.60	17.07	0.35	5.92	2.09	4.02	4.02

From the above table it is clear that more than 65% of the beneficiaries are getting the benefit on the same day of their claim. In Jagatsinghpur, 71.64% of the beneficiaries are getting the benefit on the same day where as the other 28.36% of the beneficiaries are able to get the benefit within one week. In Keonjhar district 70% of the people are getting the benefit on the same day, 12% of the beneficiaries are getting the benefit within one week and 6% people are getting the benefit past a month. Unfortunately, 10% of the beneficiaries claimed to have missed to get the benefit. In Koraput, 63.33% get the benefit on the same day, 15% within one week, 13.33% people are getting the benefit within two to three weeks and 5% people are getting the benefit within a month where as 2.5% claimed that they had to wait for more than a month for getting the benefit.

CONCLUSION

Equitable health care expenditure is a critical issue in Orissa. After the implementation of the NRHM the quantum of fund has increased and all health programmes in the state have been brought under one management for better service delivery. The health institutions such as PHC, CHC and sub-centers have got financial autonomy in terms of untied fund for reasonable local level expenditure. The study analysis shows some of the complex issues in the context of the socio-economic and geographic condition of the state.

In spite of higher healthcare expenditure in the state the growth rate of health budget in the state is not satisfactory. The state expenditure on health as percentage of GSDP is very less as compared to the requirement to meet the MDGs. Another problem in health care expenditure in the state is underutilization of the available fund. On the one side the state has a shortage of fund for health sector and on the other side a huge amount of the available fund remains unspent, which is a matter of concern. Similarly the state needs to minimize the management expenditure and maximize the programmatic expenditure.

The study reveals and reinforces the fact that in tribal areas the poor people are not able to reach the service delivery point (PHC/CHC) due to poor financial condition. They are not able to bear the travel cost. As there is no provision of ambulance at PHC level the GKS fund is the only source to provide support for village to hospital mobility. Such situations ask for added specific financial provisions within GKS fund for providing financial support to the poor people of the village. Similarly quick delivery of the services is another aspect of better health care system which needs to be addressed by the state by appointing more number of staffs in the health institutions. Specifically the financial incentives given to the beneficiary under different programmes is often delivered late. Although there are systems for quick delivery of the financial support but they lack proper functioning. The government should ensure the releasing of money to the beneficiary on the same day.

The GKS funds are remaining unspent due to the inefficiency of the GKS members. There is a need for extensive and continuous training to the GKS members; especially in the tribal areas. Along with training on health, hygiene, different schemes given by the government etc, the training should also focus on how to manage the GKS, maintaining records and mobilizing local fund for GKS.

There is a dearth of health personnel like doctor, staff nurse, paramedics etc, at different levels in the state. It leads to delay in providing service, poor quality of service, and under utilization of the available fund. The state should give effort to address this issue of staff shortage. The PHCs, CHCs need investment for modernization/up gradation to meet the standards of IPHS. Similarly popularizing and practicing AYUSH, one of the main objectives of NRHM, is still far from the target. The people are not aware about the AYUSH, and the facility that it provides.

No doubt to say, after implementation of NRHM the health care facility in the state has substantially changed, specifically health care management has seen an immense development. But looking at the health status of the people and available healthcare facility in the rural and tribal areas there is need for more public investment in health sector in the state.

Annexure - I

Table - 1 : Fund Utilisation by RKS, Telkoi CHC, Keonjhar

Utilisation of RKS fund by Telkoi CHC RKS (In Rs.)			
	2008-09	2009-10	2010-11
Construction and Repair	87391 (52.73%)	74980 (30.15%)	89865 (28.86%)
Office material	7490 (4.52%)	5964 (2.4%)	22585 (7.25%)
Meeting and Awareness	2915 (1.76%)	20758 (8.35%)	26570 (8.53%)
Sanitation work	1256 (0.76%)	4590 (1.85%)	12840 (4.12%)
Remuneration	2740 (1.65%)	32409 (13.03%)	36262 (11.65%)
Others	0	1850 (0.74%)	17720 (5.69%)
Purchase of material	63945 (38.58%)	108140 (43.48%)	105520 (33.89%)

Table - 2 : Fund Utilisation by RKS, Potangi CHC, Koraput

Utilisation of RKS fund By Potangi CHC RKS (In Rs.)			
	2008-09	2009-10	2010-11
Construction and Repair	650 (0.72%)	11982 (4.17%)	41321 (17.52%)
Office Stationnary	8550 (9.49%)	65698 (22.86%)	42446 (17.99%)
Meeting and awarene	0	1800 (0.63%)	18500 (7.84%)
Sanitation	0	0	10294 (4.36%)
Remunation	2750 (3.05%)	10080 (3.51%)	17500 (7.42%)
Others	0	31438 (10.94%)	4600 (1.95%)
Purchase of material	78119 (86.73%)	166439 (57.9%)	101245 (42.92%)

Table - 3 : Amount received and spent by GKS

Amount received and Spent by the GKS (In Rs.)									
	2008-09			2009-10			2010-11		
District	Number of GKS got fund in the studied area	Amount Received	Amount Spent	Number of GKS got fund in the studied area	Amount Received	Amount Spent	Number of GKS got fund in the studied area	Amount Received	Amount Spent
Keonjhar	10	100000	44729	10	100000	102509	10	100000	121533
Koraput	6	60000	5050	11	110000	40180	11	110000	57697
Jagatsinghpur	3	29816	15900	7	100000	89430	7	70000	73710

Table - 4 : Utilisation of GKS fund Keonjhar District

Items	Amount of expenditure (In Rs.)		
	2008-09	2009-10	2010-11
Office Expenses	1612 (3.6%)	3038 (2.96%)	496 (0.14%)
Meeting and Awareness	9500 (21.24%)	21400 (20.88%)	26587 (21.88%)
Sanitation	21150 (47.28%)	31680 (30.9%)	28389 (23.36%)
Remuneration for ASHA/AWW	3350 (7.49%)	4050 (3.95%)	8950 (7.36%)
Financial Support to Individual Patient	3903 (8.73%)	15760 (15.37%)	28600 (23.53%)
Purchase of Material for Office	3900 (8.72%)	21462 (20.94%)	21175 (17.42%)
Purchase of medicine/material for community distribution	1314 (2.94%)	5119 (4.99%)	7336 (6.04%)
Total	44729 (100%)	102509 (100%)	121533 (100%)

Table - 5 : Utilisation of GKS fund Koraput district

Items	Amount of expenditure (In Rs.)		
	2008-09	2009-10	2010-11
Office Expenses	900 (17.82%)	4707 (11.71%)	1750 (3.03%)
Meeting and Awareness	1400 (27.72%)	14700 (36.59%)	12450 (21.58%)
Sanitation	1600 (31.68%)	16773 (41.74%)	29475 (51.09%)
Remuneration for ASHA/AWW	1150 (22.77%)	3250 (8.09%)	6450 (11.18%)
Financial Support to Individual Patient	0	750 (1.87%)	3050 (5.29%)
Purchase of Material for Office	0	0	3800 (6.59%)
Purchase of medicine/material for community distribution	0	0	722 (1.25%)
Total	5050 (100%)	40180 (100%)	57697 (100%)

Table - 6 : Utilisation of GKS fund Jagatsinghpur District

Items	Amount of expenditure (In Rs.)		
	2008-09	2009-10	2010-11
Office Expenses	1100 (6.92%)	1200 (1.34%)	820 (1.11%)
Meeting and Awareness	5950 (37.42%)	31630 (35.37%)	23850 (32.36%)
Sanitation	4150 (26.1%)	27450 (30.69%)	26300 (35.68%)
Remuneration for ASHA/AWW	2750 (17.3%)	13050 (14.59%)	14600 (19.81%)
Financial Support to Individual Patient	500 (3.14%)	5250 (5.87%)	2450 (3.32%)
Purchase of Material for Office	1150 (7.23%)	9450 (10.57%)	1900 (2.58%)
Purchase of medicine/material for community distribution	300 (1.89%)	1400 (1.57%)	3790 (5.14%)
Total	15900 (100%)	89430 (100%)	73710 (100%)

Table - 7 : Utilisation of RCH fund In Koraput District

Items	Amount of expenditure (In Rs.)				
Activity	Exp. during 2006-07	Exp. during 2007-08	Exp. during 2008-09	Exp. during 2009-10	Exp. during 2010-11
JSY	9261453	12068840	21285254	25039436	20835972
Others Maternal Health	0	104740	93068	2822054	6179970
Child Health	0	39900	157100	1839537	2796093
Compensation for Sterilization/UID acceptor	0	28080	29940	7840110	7461874
Provision of equipment to SCs for IUD	0		504340		
NSV Camp	0		33797		28200
Tribal RCH				1380343	262664
Others Family Planning	726228	3287581	7845736	73540	437270
Adolescent Health and gender	0	0	0		65380
Urban Health	0	0	0		49500
Tribal Health	0	536169	50997		14590
Training	32000	175645	62570	166055	1237070
PPP/NGO	0	49250	0		113000
Infrastructure and Human resource	447485	1144510	7282746	815715	7004709
Institutional Strengthening	0	604825	314331	893357	181416
IEC/BCC	12898	121540	389811	514135	360453
Programme Management	211296	616014	904920.5	1635384	5476687
GIS and Public health	**0**	0	0		
Untied fund for RCH-II	0	246301	501510	0	
Augmentation of Society	615123				
Total	**11306483**	**19023395**	**38954611**	**43019666**	**52504848**

Annexure- II

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Budget for National Rural Health Mission in Odisha

Odisha Budget and Accountability Centre
E-1, Institutional Area, Gangadhar Meher Marg
Bhubaneswar - 751013, Odisha, India
Tel: + 91 674- 2301725, 2300983, Fax: + 91 674- 2301226
E-mail: cysdbbsr@sancharnet.in, info@cysd.org

www.cysd.org