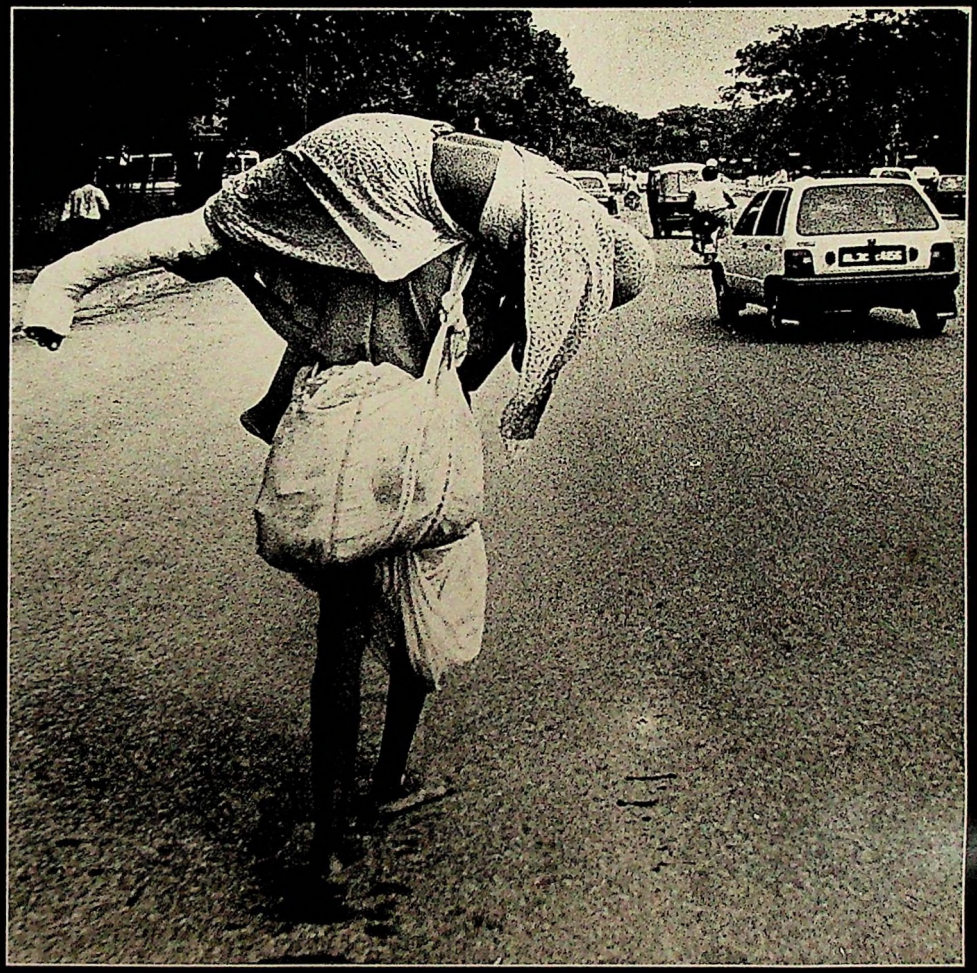
HEALTH EXPENDITURES IN INDIA



Wasting what we have got;
and running for more

Voluntary Health Association of India

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Wasting what we have got;
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By
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Voluntary Health Association of India

P R E F A C E

The considerable apprehension that we all had on the possible reduction of financial allocation for the social sector was put to rest by the very encouraging allocation of resources by the government in the recent budget. The present government's seriousness of purpose to strengthen this sector is also indicated by the fact that the country is willing to borrow money from International Institutions for this so-called "non-profitable" sector.

For some time now, VHAI was looking into the current pattern of external assistance to the health sector of this country and its utilisation. Unfortunately, the findings of the study have revealed some startling facts. Across the board we see extemely meagre utilisation of the assistance provided in the health sector. It is a matter of great shame and sorrow that on the one hand we find umpteen number of Primary Health Centres and other health infrastructure are defunct due to shortage of basic facilities and on the other, the valuable resources are being squandered away.

Without putting the blame on any particular quarter we want to state as we have done before through various other well-researched documents that the time has come to clean up the Augean stables at the Ministry of Health & Family Welfare. A feeble Ministry cannot respond to the challenges of health care of 900 million people.

Alok Mukhopadhyay
Executive Director

Chapter I : Still a Long Way to Go

There is no doubt that the health of the people of India has been improving since the beginning of this century. The two most important indicators of health are the Expectation of Life at Birth (in years) and Infant Mortality Rate (Deaths per thousand Live Births). Both these indicators have shown a tremendous improvement during this century.

Table 1
Health Indicators 1901-1991

Year	Expectation of life at birth (Years)	Infant Mortality (per thousand live births)
1901	23.8	N.A.
1911	22.9	204
1921	20.2	174
1931	26.7	174
1941	31.7	161
1951	32.1	146
1961	41.2	N.A.
1971	45.6	138
1981	54.4	119
1991	61.1	86

*Source : **Health Information of India,** 1992, Ministry, of Health and Family Welfare, 1993. Tables 2.10, 2.11 & 2.04.*

The expectation of life has increased from 20.2 years in 1921 to 61.1 years in 1991. Similarly the Infant Mortality Rate has fallen from 204 deaths per thousand in 1911 to 86 in 1991. These are no small achievements.

However, there is still a long way to go. We are still far behind the world standards which have been shown in Table 2.

Table 2
International Comparison of Health Indicators, 1991

Country	Expectation of life at Birth in 1991, (Years)
India	61
Developing World	67
Developed World	77
China	69
U.S.A.	76

*Source : **World Development Report,** 1993.*

It will be seen that India is not only far behind the developed world but even in comparison to other developing countries.

Nearer home, Kerala has already achieved an Infant Mortality Rate of 17 deaths per thousand live births. The Infant Mortality Rate for the best and the worst states is given at Table 3.

Table 3
Estimated Infant Mortality Rates

State	Infant Mortality Rate, 1991 (Per thousand live births)	Expectation of Life at Birth, 1981 (Years)
Best States		
Kerala	17	68.5
Maharashtra	64	58.1
Punjab	66	62.8
Worst States		
Uttar Pradesh	105	46.8
Madhya Pradesh	120	50.2
Orissa	127	50.8
All India		
Average	86	54.4

*Source : **Health Information of India**, 1992, Table 2.05, 2.12.*

The Infant Mortality rate varies from a low of 17 deaths per thousand live births in Kerala to a high of 127 in Orissa—more than 7 times. Similarly, the Expectation of Life is at a low of 46.8 years for U.P. in 1980 against 66.5 years for Kerala. Thus, what has been achieved leaves no place for complacency. We need to go much faster.

Chapter 2 : Utilisation of Funds

We have seen that the health scene leaves much to be desired. On ther other hand, a scrutiny of various internationally funded programmes shows that the funds are not being utilised well.

THE WORLD BANK

The World Bank has emerged as a major lender in the health sector. The World Bank has two windows for lending. The International Bank for Reconstruction and Development (IBRD) lends at commercial rates of interest which the International Development Agency (IDA) lends at—concessional rates of interest. The typical IDA loan has 40 years maturity period and an interest cahrge of 0.75 percent. Bulk of the World Bank assistance in the health sector comes from the IDA window. Considering that the value of money would have depreciated to about 5 percent in 40 years and the loans would have to be repaid at that value, the IDA assistance is virtually like a grant.

The commitment and utilisation of assitance by the World Bank in Health Sector is given in Table 4.

Table 4

000 US $

Sl. No.	Lending Agency	Project	Year of Sanction	Total Committment	Utilisation 1991-92	Total Utilisation upto 31.3.92	Total percent Utilisation	Percent Utilisation per year
1.	IBRD	Industrial Pollution Control	1991-92	124,000	6,022	6,022	4.8%	4.8%
2.	IDA	Sixth Population Project	1989-90	87,200	4,387	19,027	21.8%	7.3%
3.	IDA	Seventh Population Project	1990-91	63,400	4,942	8,530	13.5%	6.7%
4.	IDA	Child Survival and Safe Motherhood	1991-92	160,900	13,146	13,146	8.2%	8.2%

*Source : **External Assistance 1991-92**, Ministry of Finance.*

It will be seen that the utilisation per year for World Bank Assistance has been in the range of 5-8 percent.

The IDA has sanctioned another loan for National AIDS Control Programme in 1992-93. The exact figures are not available but the total amount is reported to be in the range of US$ 100 million, or Rs. 320 crores. The utilisation of funds till January 1994 is given in Table 5. It will be seen taht only 3.4 percent of the money available was claimed from the IDA.

The result of the poor utilisation of funds is that the World Bank has been progressively reducing its committments to India (see Figure 1). The commitments were between US$ 2500 to 3000 million during 1984-85 to 1988-89. The utilisation (in all sectors) was only around 61 percent. Thus, the World Bank reduced its committments to around US$ 2000 million to match with the ability of the

Government to use the funds.

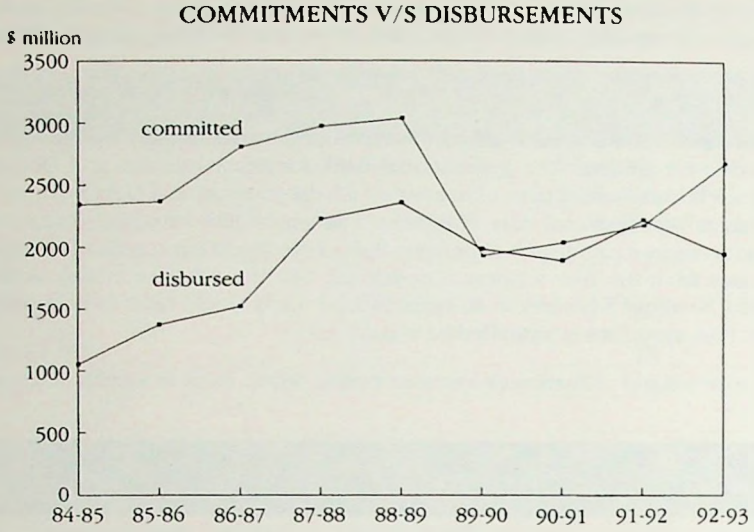

Table 5
National AIDS Control Programme

Sl. No.	Description	1992-93 Amount	1992-93 Percent	1993-94 (Upto January 1994-10 months) Amount	1993-94 (Upto January 1994-10 months) Percent
1.	IDA Commitment	70.0	100	73.0	100
2.	Grants Released to the States	11.43	16.3	2.9	4.0
3.	Expenditures reported	3.56	5.1	0.82	1.1
4.	Reimbursement claimed from IDA	2.35	3.4	N.A.	N.A.

As a result, according to Dr Anthony Mesham of World Bank, the undisbursed amount has marginally come down from US$ 14 billion 3 years ago to US$ 10 billion presently.

Needless to say, in comparison to the overall utilisation the utilisation, in the health sector was very poor. Taking the life cycle of a typical project at five years, the annual utilisation should be about 20 percent. Against this, the utilisation in the health sector was around 6-7 percent and in all sectors it was around 12 percent.

A result of this non-utilisation has been that India has the unique distinction of being the only country to be mentioned in the Annual Report of World Bank, 1993 where large loans

have been cancelled. To quote from the report: "The Bank is working closely with borrowers to ensure more timely project start-ups and has adopted a more pro-active stance towards project restructuring, cancellation and closure. This stance, for example, has resulted in recent, large cancellations of IBRD operations (fifteen projects valued at $ 850 million) and redeployment of IDA funds (eighteen projects valued at $ 379 million) in India" (p 124).

According to Dr Mesham, the major difficulty in disbursements in the health sector was that the State Government not understood the procedures for claiming reimbursement have. The World Bank had been dealing with the Ministry of Health and Family Welfare (MHF), which, in turn, was communicating the procedures to the states, obtaining expenditure statements and submitting to the Bank. Somehow, the process was not being understood by the States, leading to poor disbursements. Reportedly, under pressure from the Bank, the Ministry of Health and Family Welfare has recently agreed that the Bank may lend directly to the states.

THE UN SYSTEM

Two agencies of the UN system having significant presence in the Health Sector are The United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF).

The UNFPA mainly funds programmes in the area of family planning and welfare. It held a mid-term review of its programme for India 1991-95 in May 1993 with the Ministry of Health and FAmily Welfare. According to the report submitted to the MHF for the review, the overall performance of MHF appears to have been quite reasonable in 1992 with nearly 87 percent utilisation of the Programme Allocations. However, there still were some projects which had been lagging behind. The details of some of such projects is given in Table 6.

Table 6
UNFPA : Slow Moving Projects

Sl. No.	Programme	Allocation 1992	Actual Expenditure 1992	**Percent Utilisation**
1.	Monitoring Sterilisation	65	43	66
2.	Centres of Excellence	220	83	**38**
3.	FW Area Project - HP	1935	1326	68
4.	Study Tours	90	18	**20**
5.	Population Education - Higher Education	77	49	64
6.	Programme Development Mission	6	1	**17**
7.	Women Development (Haryana)	3	2	67
8.	Total Slow Moving	2396	1522	63
9.	Total, All Projects	11700	10259	88

Although UNFPA assitance gives a better picture, it has to be seen under the backdrop of reducing committments from the UNFPA. In 1990 the UNFPA allocation for India was US $16.3 million. In view of the poor utilisation, UNFPA reduced its allocation to $ 11.2 million

in 1991 and $ 11.7 million in 1992. Moreover, UNFPA revises its allocations every six months and provides more money to fast moving projects and takes away from slow moving projects.

IMPLEMENTATION PROBLEMS

While each project has a specific set of problems, there are many problems which are common to all projects. These are refelcted at various stages such as project documents preparation, project implementation and mid-course correction. The main prblem areas are given below:

1. There is a considerable gap between the signing of a project document and its actual implementation. This gap ranges anywhere between six months to five years.

2. At the time of implementation, all project components are not given equal importance. Certain components get more preferene than others.

3. Projects initiated by a particular person get affected if continuity in leadership is not available. A new incumbent often would like to substantially or totally change the project components.

4. Projects initiated by the *centre* are often given to the state governments for implementation whether the states are interested or not. *State government* preferences do not always match with Central Government priorities.

5. Too many projects sponsored by different donor agencies in a particular geographical area often make it difficult for the state governments to absorb funds and to cope up with workloads.

6. Major projects, often measured in terms of budgetary allocations overshadow the minor projects if taken up in the same state either by the same donor agency or by different donor agencies.

7. *Inter-sectoral* activities which call for coordination between various departments and agencies often encounter difficuties in implementation. In most cases, it requires herculean efforts to bring these departments together.

8. Organisation structures and mechanisms created for speedy implementation of project components, at times, become major hindrances. Too many committees, lack of clarity on roles, functions and decision-making authority, and separate officers make the project activities look different from mainstream activites.

9. While all major projects have components of personnel to administer the project, posts do not get filled in because of cumbersome rules, and at times due to blanket ban on recruitment. What has been agreed at the time of project agreement is often over-ruled later because of promulgation of general rules applicable to all departments.

10 Flow of financial resources is a major problem. Though budgetary sanctions are accorded to all activities int he beginning, specific sanctions are required to spend money on each activity. This results in considerable delay in flow of resources. Implementing agencies in health and family welfare departments have hardly any authority or flexibility. Given this, in recent times, state governments and donor agencies have, more often than not, created flexible mechanisms outside the formal government structures to ensure regular and timely flow of funds.

Source : **UNFPA Mid-term Review Report.**

Thus, the allocations for slow moving projects are gradually brought in tune with the actual speed of expenditure. The importance of this fact is that if the utilisation was better, UNFPA may have been willing to allocate yet more funds.

The major problem faced by UNFPA was that the money had to often go through five accounts to reach the actual user. For example, the money for school education project was paid by UNFPA to the MHF, which paid to Ministry of Human Resources, whcih paid to NCERT, which paid to the State Councils of Eduation Research and Training who were to actually spend the money. The result was that often the State Councils were starved of funds despite UNFPA having paid to MHF. On one occasion the retirement of one person at NCERT and the delays in appointment of the replacement had blocked the process for many months.

UNFPA has also not been able to obtain audited expenditure statements of the monies paid by it. This was causing difficulty. Since all the money was first going into the Central Government kitty, it could not be audited by and 'external' auditor.

In fact, one wonders if there is a need for a nodal ministry. In the above example, MHF came into the picture only because it was the nodal ministry for UNFPA although the entire project was being handled by the Education Ministry. The only explanation seems to lie in the fact that MHF would not like to part with its 'influence' over UNFPA funds.

The result of this situation is that most MCH/FP projects are behind the stipulated time schedule. UNFPA has suggested that it would like to drop "all projects pending for more than 2 years"; and it has sought the assistance of MHF "to create a more responsive flow of financial resources" (p 1-2 of Mid-term Review Report).

The various problems of implementation outlined by the Review are given in the **box**. The UNFPA report goes on to mention that "there are several reasons for low expenditure levels on projects: 1) New projects that are supposed to commence in 1992 could not begin due to delays in government clearances; 2) Amount of expenditure incurred on on-going projects was much less than estimated levels due to slow progress in implementation." Thus, the situation continues to be bleak if one looks at what could have been achieved by a little more attention on the part of the Government of India.

The other important UN agency in the Health sector is UNICEF. Unfortunately, UNICEF office was tight-lipped about discussing the problems. However, Health Ministry sources provided a statement of the budgets and utilisation for the major UNICEF Scheme—The Expanded Programme for Immunisation (EPI). UNICEF has an accounting system wherein the unutilised budget of one year is automatically carried forward and added to the budget for the next year. Hence, if some money allocated for 1991 was ultimately utilised in 1993, it would appear in the budget of 1991, 1992 as well as 1993. Precisely for this reason, the figures give a correct picture of the funds available in any particular year whether by way of carry forwards or fresh allocations.

Table 7 UNICEF : Funds Utilisation EPI					
Sl.No No.		Year	Budget Amount	Utilisation Amount	**Utilisation Percent**
1.		1991	38,784	18,302	**47.2**
2.		1992	44,458	25,622	**57.6**
3.		1993	30,731	17,913	**58.3**
4.	Total	1991-93	113,973	61,837	**54.3**

It will be seen that the utilisation of UNICEF funds has been in the range of 50-60 percent only.

BI-LATERAL FUNDS

A large part of foreign funds comes through bi-lateral arrangements. The Aid and Accounts Audit Division of Department of Economic Affairs publishers annual statistics of External Assistance. The last year for which they are available are 1991-92. The details of projects in the health sector are given in Table 8. All figures relate to grants, not loans.

The average rate of utilisation for 1991-92 was 7.8 percent for UK, 10.7 percent for Denmark, 24.5 percent for USA, 29.7 percent for Japan, and 64.0 percent for Norway. It must be metnioned that these percentages have been calculated on the basis of total undisbursed funds available as at 1.4.1991. This would include the amount to be utilised in subsequent years. However, since break-ups for the amount budgeted for 1991-92 were not available, the total amount has been used to calculated the percent utilisation. Nevertheless, they do give us an overall feel of the situation.

The bi-laterial donor agencies are virtually disgusted with the state of affairs. In the opinion of one donor, the situation in India was "the worst that I have seen".

The main problem repeated by the donors was that it took a tremendous amount of energy to get anything done through the Health Ministry. In the words of one donor, the MHF was the bottleneck between the donor and the state governments, which were the actual user of the funds. According to him, "the relationship between the MHF and the state governments is no mystery. The MHF wants to control the funds. The state governments incur the expenditures and submit statements to the MHF. The Health Ministry consolidates them and submits to the Donor. The Donor gives money to MHF which, in turn, re-imburses the state government. The whole process gets stuck in the bureaucracy. We want to release money to the states directly but the govenment would not let us."

Then there are problems at the level of sanction also. Here the Department of Economic Affaris (DEA) of Ministry of Finance comes into the picture. Any foregin assistance proposal from MHF has to be routed through the DEA. Thus, initiation of a project requires yet another stage. The state concerned approaches the Donor for funds and prepares a scheme. It sends to MHF, which sends to DEA for approval. The whole process takes anywhere from 6 months to five years! This can be seen most visibly in the bi-lateral grants fro USA. Most projects have been negotiated and re-negotiated for over 3 to 4 years (see Table 8).

Table 8
Bi-lateral Grants in Health Sector, 1991-92

U.K.

Sl. No.	Scheme	years of Sanction	Amount Authorised upto 31.3.92	Amount Utilised upto 31.3.91	Amount Available in 1991-92*	Utilised in 1991-92	
						Amount	Percent
1	2	3	4	5	6	7	8
			MILLION POUNDS				
1.	Orissa Family welfare II	1990	18.0	0.2	17.9	1.4	7.8
	Sub Total U.K.	18.0	0.2	17.9	1.4	7.8	

DENMARK

Sl. No.	Scheme	years of Sanction	Amount Authorised upto 31.3.92	Amount Utilised upto 31.3.91	Amount Available in 1991-92*	Utilised in 1991-92	
						Amount	Percent
1	2	3	4	5	6	7	8
			MILLION D KR.				
1.	National Programme for Control of Blindness I & II	NA	205.0	92.5	42.5	0.5	0.5
2	Health Care and Family Welfare Project, New Delhi I & II	NA	14.8	10.6	4.2	0.0	0.0
3.	Health Care Project M.P. I & II	NA	250.4	188.0	62.4	13.8	22.1
4.	Health Care Project T.N., I & II	NA	223.3	152.0	71.3	18.7	26.3
5.	National Programme for Eradication of Leprosy	NA	81.5	28.6	52.9	0.0	0.0
6.	Health Care & Family Welfare Project, Chandigarh, I & II	NA	11.8	7.2	4.6	0.0	0.0
	Sub Total Denmark		786.8	478.9	307.9	33.0	10.7

Presumably this figure includes amounts to be spent on subsequent years. However, since no break-up of amount budgetted for 1991-92 has been give separately, the total figure of balance amount avatlable has been given.,

U.S.A							
Sl. No.	Scheme	years of Sanction	Amount Authorised upto 31.3.92	Amount Utilised upto 31.3.91	Amount Available in 1991-92*	Utilised in 1991-92	
						Amount	Percent
1	2	3	4	5	6	7	8
			MILLION US$				
1.	Family Planning Communication & Marketing Grant	1983	17.5	3.0	14.5	1.2	8.3
2.	Bio-medical Research Support	1985 1987- 88	9.3	0.9	8.4	0.0	0.0
3.	Contraceptive Development and hiproductive Immunology	1985 & 88	3.2	0.2	3.0	0.01	0.3
4.	Child Survival and Health Support	1986 1988 & 89	41.1	22.2	18.9	8.0	42.3
5.	Vaccine Immunodia-gnostic Development	1989	4.0	0.3	3.7	0.2	5.4
6.	Private Voluntary Organisation for Health	1987	6.5	0.5	6.0	0.4	6.7
	Sub-Total U.S.A	81.6	27.1	40.0	9.81	24.5	

*Source : **External Assistance** 1991-92, Aid Accounts and Audit Division, Ministry of Finace.*

JAPAN							
Sl. No.	Scheme	years of Sanction	Amount Authorised upto 31.3.92	Amount Utilised upto 31.3.91	Amount Available in 1991-92*	Utilised in 1991-92	
						Amount	Percent
1	2	3	4	5	6	7	8
1.	Regional Cancer Centre Madras	1988	641.0	609.8	34.2	34.2	100.0
2.	Regional Cancer Centre (Grand Aid)	1989	616.0	13.0	603.0	154.8	25.7
	Sub Total Japan	1257.0	622.8	637.2	189.0	29.7	

NORWAY							
Sl. No.	Scheme	years of Sanction	Amount Authorised upto 31.3.92	Amount Utilised upto 31.3.91	Amount Available in 1991-92*	Utilised in 1991-92	
						Amount	Percent
1	2	3	4	5	6	7	8
1.	Family Welfare PP II	NA	215.0	170.7	44.3	33.2	74.9
2.	Eradication of Leprosy	NA	10.0	2.4	7.6	0.0	0.0
	Sub Total Norway	225.0	173.1	51.9	33.2	64.0	03.03.94

Chapter 3 : Suggestions

It is too much to expect this quick study to be able to come to any 'conclusions'. However, this much can be stated that a problem does exist. The main difficulty seems to be that health is a state subject under the Constitution. Thus, all programmes relating to health have to be implemented by the state governments, or at least have their positive concrurence and support. However, the international donor agencies have to primarily deal with the Central Ministries of Health and Finance. In the words of Mr. R.K. Ahooja, former Jt. Secretary in Ministry of Health, "the donors have no direct access to the state governments." Thus, "the states do not understand the procedures." This was the same remark as made by Dr Anthony Mesham of the World Bank. The result is that the International Health Division of Ministry of health is overburdened with getting the communicaton established between the State governments and donors. The whole system gets slowed down here. The norms are set by the Central Ministries and the State Governments have no say in it. There is no flexibility at the state level. Any problem has to be sorted out with the donors only through MHF, and gets stuck there. One of the donors explicity stated that the problem was that MHF was unwilling to relinguish its influence and control over the funds.

The second major problem duly emphasised by Mr. Som Nath Som, Advisor (Health) Planning Commission, was that according to the procedures set by MHF, the State governments had to first incur an expenditure from their own funds and then seek re-imbursement from the donors. Often the States have had a problem of liquidity. They do not have the funds to spend initially. Then, due to inadequate understanding of the procedures often the expected re-imbursement does not take place due to non-adherence to the norms. This makes the States hesitant to put in their own money. As a result the money available from the donors does not get utilised.

Dr Bharat Jhunjhunwala did his Ph.D in economics from University of Florida in 1973. He taught at the Indian Institute of Management, Bangalore from 1973 to 1979. In this period he lived in a slum for two years and was active in the Trade Union movement. He has been a free-lance consultant since then. Presently, he is editing Legal News & Views, a journal which aims to assist the NGOs.

The Voluntary Health Association of India (VHAI) is a secular, non-profit federation of over 3000 organisations working in the field of health and community development. VHAI strives to make health a reality for all, especially the unreached and the oppressed.

VHAI fulfills these objectives primarily through training and by providing information to the target groups. In support of its objectives, VHAI also develops and distributes appropriate educational aids to the organisations serving at the grassroots. Linking up these organisations through its newsletters and journals also constitutes an important activity of VHAI.

VHAI researches into and campaigns on relevant and important health issues to ensure that a people-oriented health policy is brought about and effectively implemented. VHAI also works to sensitise the large public towards a scientific attitude to health.

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