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Understanding India's Health Budgets

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The Government of Japan

Contents

Keywords

1. **Cess:** A cess is a tax-on-tax levied by the government for specific purposes. For example, since FY 2018-19, the Union government levies a 4 per cent health and education cess.
2. **Classification of Expenditure Budget:** The Expenditure Budget describes funds allocations for disbursement and spending to different ministries, departments, and schemes in a financial year. Expenditure can broadly be classified into two types i.e. revenue expenditure and capital expenditure.
   Revenue expenditure is recurring in nature and consists of expenditure on salaries, operations and maintenance, items like drugs and consumables, and interest payments Capital expenditure consists of creation of assets like health facilities, repayment of loans and advances, and public debt.
   For example, for the Union government, expenditure on the revenue component accounts for around 86-88 per cent, and the remaining 12-14 per cent is incurred as capital expenditure. Whereas, on average total state expenditure (including Union and State share) on revenue accounts for around 75-80 per cent and the remaining 20-25 per cent is incurred on capital account (excluding public accounts).
3. **Classification of expenditure by General, Social and Economic:** On the expenditure side of the budget, significant classifications are made on two fronts i.e. Revenue and Capital, and sector-wise classification of the expenses into Social, General, and Economic. These sectors have been defined by the CAG and include major heads as per its classification. Social services account for all major heads from 2202-2251 in the Revenue account and major heads from 4202- 4250 in the Capital account. The General services include the major heads 2011-2080 in the Revenue account and major heads 4046-4076 in the Capital account. The Economics services include the rest, i.e. major heads 2401-3475 in the Revenue account, and major heads 4401-5475 in the Capital account.
4. **Demand for Grants:** The Constitution requires that the estimates of expenditure from the Consolidated Fund of India be included in the Annual Financial Statement and voted by the Lok Sabha to be submitted in the form of Demands for Grants. The Demands for Grants are presented in the Lok Sabha along with the Annual Financial Statement. Generally, one Demand for Grant is presented for each department or ministry. Nevertheless, more than one Demand for Grants may be presented depending on the nature of expenditure. Each Demand for Grant initially provides the totals of 'voted' and 'charged' expenditure, along with the 'revenue' and 'capital' expenditure, and also the grand total of the amount of expenditure for which the Demand is presented.
5. **Voted Expenditure:** The expenditure estimates in the form of Demand for Grants need to be voted on by the Parliament and are counted as Voted Expenditure.
6. **Charged Expenditure:** Non-votable charges are called Charged Expenditures; and no voting takes place for the amount involved in these expenditures for their withdrawal from the Consolidated Fund of India. These are to ensure autonomy of Constitutional authorities from the legislature and are an example of constitutional safeguards. One major example in the context of health are grants under proviso to Article 275(1) of the Constitution, under which funds are allocated to areas with tribal majority, including funds for health. This is discussed more in chapter 4. Other examples include allowances and salary of the President and the Speaker of Lok Sabha.

7. **Budget Estimates (BEs):** These figures are the estimates put forth by the government for any department or scheme under various major heads for the upcoming financial year and approved by the legislature.
8. **Revised Estimates (REs):** After the initial estimate of expenditure for an ongoing fiscal year, the government modifies those estimates after six months of the fiscal year are over. These are called Revised Estimates.
9. **Actuals Expenditures (AEs):** These figures outline the actual expenditures by the government in a given financial year. Since actual expenditures can be assessed and audited only after the financial year has passed, these figures are released by the government with a time lag. Currently, they are released with a two-year lag.
10. **Revenue Receipts:** Revenue Receipts are money earned by the government which do not add to the government's assets or liabilities. For example, student fees for studying in medical colleges. However, not all receipts in the health sector are captured under revenue receipts in state budgets, like Rogi Kalyan Samiti user fees (see more here).
11. **Capital Receipts:** Capital Receipts are income through either sale of public assets or an increase in liabilities through loans or borrowings. For example, loans from the Union government to a State government for COVID-19 response.
12. **Committed Liabilities:** These typically include expenditure on salaries, wages and pensions, and interest payments on loans. State governments are obliged to pay them even if they face a resource crunch.
13. **Revenue Deficit:** Revenue Deficit is the gap between revenue components of receipts and expenditure, i.e. revenue disbursements and revenue receipts. This indicates the money the government needs to borrow to spend on non-capital components. A surplus arises if revenue receipts are more than revenue expenditures.
14. **Fiscal Deficit:** This is the gap between total expenditure requirements and total receipts, excluding borrowings. It shows the amount considered necessary by the government to meet its expenses and equals the money the government will need to borrow to meet its expenses. A large fiscal deficit means a large amount of borrowing.
15. **Primary deficit:** Primary deficit refers to the difference between the current year's fiscal deficit and interest payment on previous borrowings. It is an indication of the borrowing requirement of the government to meet expenditures.
16. **Establishment expenditures:** These are meant to cover the regular administration. It includes salaries, administrative costs, employee benefits, and costs of various facilities. For instance, for DoHFW, establishment expenditures include heads such as 'secretariat', direction and administration, central government health scheme, and the budgets for various union government hospitals.
17. **Non-plan budget:** Non-plan expenditure is what the government spends on the so-called non-productive areas, such as salaries, subsidies, loans and interest. Non-plan capital expenditure mainly includes defence, loans to public enterprises, loans to states, Union Territories and foreign governments.
18. **Plan budget:** Plan expenditures were funds set aside for productive purposes, like various projects of ministries. Plan expenditures were fixed post-discussion with the erstwhile Planning Commission. The Plan and Non-Plan distinction is no longer relevant, as the Planning Commission was dismantled and the last Five Year Plan ended in 2017.
19. **Grants-in-Aid:** Grants-in-Aid are payments in the nature of assistance, donations or contributions made by one government to another government, body, institution or individual. Grants-in-Aid are given by the Union government to state governments and/

or Panchayati Raj Institutions. The Union government also gives substantial funds as Grants-in-Aid to other agencies, bodies and institutions. Similarly, the state governments also disburse Grants-in-Aid to agencies, bodies and institutions such as universities, hospitals, co-operative institutions and others.

20. **Consolidated Fund of India:** The Consolidated Fund of India is mandated by the Constitution. It reflects all the revenues raised by the Union government, the loans taken by it, the advances received by it as well as the recoveries of loans. All the expenditures made by the government are incurred from the Consolidated Fund and no amount can be drawn from the Fund without due authorisation from the Parliament or the State assembly.
21. **Public Account:** Money which the government holds in trust makes up the Public Account. This is the money received by or on behalf of a state or the Union government. Funds under Public Account that do not belong to the government have to be paid back to the persons and authorities who deposited them and do not require parliamentary authorisation for withdrawal.

    Public Account funds which originate from the Consolidated Fund require due approvals from the Parliament. The first approval is for amounts to be drawn from the Consolidated Fund and remain in the Public Account for outlay on specific objects. The second parliamentary approval is needed for withdrawal from the Public Account for incurring expenditure on the specific object.

    Provident funds, small savings collections, the income of the government set apart for expenditure on specific objects such as road development, primary education, Reserve/ Special Funds, are examples of money kept in the Public Account.
22. **Contingency Fund:** The Contingency Fund of India is an amount positioned at the disposal of the President of India to facilitate the meeting of necessary unexpected expenditures by the government. Parliamentary approval for such unforeseen expenditure is obtained, ex-post-facto and an equivalent amount is drawn from the Consolidated Fund to recoup the Contingency Fund after the approval is obtained. For states, the Governor has to approve spending of state contingency funds. This includes expenditures for immediate relief to victims of natural disaster which are not envisioned in the plan and are met from this fund. For example, funds were drawn from state contingency funds for spending in response to the COVID-19 pandemic, which were approved post facto by the state legislature and reflected as Revised Estimates.
23. **Reconciliation statements:** This is an accounting process that compares different sets of budget documents to check that figures are correct. Under the Union budget, reconciliation between expenditure is shown in demands for grants, annual financial statements and expenditure profile statements.
24. **Drawing and Disbursing Officer (DDO):** This official is responsible for carrying out the functions of withdrawal of money from government accounts and making payments. The main function is to regulate government receipts and payments, incurring expenditure as authorised by the competent authority, and also keeping accounts of the office on behalf of the Head of Office.
25. **Utilisation Certificate:** This indicates how much has been spent under a particular budget head. It is used for reporting purposes as well as showing proof of spend, in order to obtain subsequent funds.

26. **General Financial Rules:** General Financial Rules (GFRs) are a compilation of rules and orders of the Government of India to be followed by all while dealing with matters involving public finances. These rules and orders are treated as executive instructions to be observed by all departments and organizations under the government and specified bodies except when mentioned otherwise.
27. **Public Finance Management System for CSSs:** This is a web-based online application to help the tracking and monitoring of the flow of funds and expenditure under Central Sector Schemes and CSSs by the implementing agencies, including Finance Commission Grants.
28. **Vote-on-Account:** A Vote-on-Account allows the government to meet its expenses in the period leading up to elections. It is passed without discussion, as opposed to a regular budget where the budget is passed only after discussions are held. A Vote-on-Account contains only expenditures and not receipts.
29. **Reappropriation accounts:** This refers to the transfer of savings within Revenue or Capital sections by the executive or a competent authority from one primary unit to another within a grant or appropriation before the close of the financial year to meet additional expenditure. It is only to be done when it's anticipated or known that funds will not be fully utilised.
30. **Supplementary budgets:** An additional Demand for Grant which is submitted for authorisation to the Parliament when the current allocations are insufficient or when a budget is required for a new activity. Such revisions may take place three times a year: during the monsoon session, winter session and the budget sessions of the parliament and legislative assembly sessions.
31. **PD Account:** Personal Deposit account are accounts that are maintained in the Treasury in the nature of dedicated bank accounts that are created as per rules wherein funds from the Consolidated Fund are transferred for the purpose of discharging certain functions/projects/schemes. For central schemes like the NHM, all funds for the scheme are transferred to the scheme's Personal Deposit (also called Personal Ledger) accounts for the purpose of scheme implementation. PD or PL account statements (not available in the public domain) provide accurate information on the fund-flow timelines.

The main objective of this primer is to offer the reader a way to understand and interpret India's Union and state health budgets.

Executive Summary

The budget is a vital tool for bringing policies into action. It supports the government in executing various programs and schemes in a methodical and strategic manner. Most importantly, it is the document that informs citizens of how taxes are collected and resources are prioritised and spent — how much and on what? But the process by which the budget is prepared and the details of the budget document itself, are not easily comprehensible. Many interested observers find it difficult to figure out the actual or budgeted expenditure on any particular subject of their interest.

One such subject is Health. The COVID-19 pandemic drew attention to India's health system performance, including health financing, service delivery, and pandemic preparedness. With increased resources flowing towards health and calls for even more funds, health budgets matter as never before.

In India, as in many countries, health budgets (or budget documents in general) have traditionally been viewed as an accounting or administrative document, instead of a strategic policy document. This is starting to change, and there is growing recognition that many aspects of the budgeting process are deeply embedded in India's health system performance. At the same time, India's 29 health budgets (Government of India plus 28 states) are complex, varied, and poorly understood. Thus, there is value in enhancing our collective understanding of how health budgets are formulated, executed, and evaluated; and in describing the implications of budget processes and structures for undertaking policy-relevant analysis.

Through this Health Budget Primer we seek to address this felt need for guidance in understanding the health budget process, actors, documents, terminology, and how to make sense of the budget itself. This is done by describing selected issues for addressing policy relevant questions based on budget documents, and by highlighting opportunities to enhance the transparency and policy content of health budgets. **The main objective of this primer is to offer the reader a way to understand and interpret India's Union and state health budgets.**

Chapter two of the primer aims to look at key building blocks such as the budget process at Union, State and Local Body levels. It provides an overview of the different stages in the budget cycle. Firstly, on how budget formulation or public funds are planned, approved, allocated and prioritised. Secondly, on budget execution or how budgets are spent and the timing of fund releases. Lastly, budget evaluation, or how public spending is accounted for, evaluated and fed into the next budget cycle.

This chapter further maps out the timelines of the budget process. There are several actors involved in the budget-making process including, for instance, the executive and legislature.

While the former do the heavy lifting and are involved in drafting the budget and allocating resources, the latter vote on the budget when tabled in Parliament or State Assemblies, and discuss new Acts and policies. The chapter also delves into some of the key documents you will come across when undertaking any form of budget analysis, such as the Annual Financial Statement and Detailed Demand for Grants providing sector specific budget-related information.

The third chapter focuses on centre-state fiscal relations and fund-flows with respect to the health sector. Funding for health primarily comes through the Union and state governments. Understanding the different sources of funding for health is useful while trying to trace the specific funds within the state budgets. For instance, most Union government spending on health is through Specific Purpose transfers, namely Centrally Sponsored Schemes (CSS) such as the National Health Mission, for which finances are shared between Union and state governments in fixed proportion. Funds are also spent through Central Sector schemes which the Union government funds unilaterally. However, state governments fund the bulk of health expenditure through their own resources to fund state plans for health and the state CSS share.

Chapter four provides detailed guidance on how health budgets can be analysed and interpreted. There are several ways in which health budgets can be analysed, but the approach depends on the objective and the purpose the analysis aims to serve. Budget analysis helps to understand government health priorities and funds allocated for the health sector. The budget can help evaluate sufficiency, efficiency of spending, changes over time, and distribution across facilities, regions, and populations. In practice, however, there are challenges in analysing budgets due to the way health budgets are designed. Some of these challenges include the unavailability of data in one document, the lack of disaggregated data, and differing figures across sources. This chapter also presents ways in which some of these issues can be resolved.

Chapter 01

Introduction

Highlights:

1. The government budget is a record of the revenues and expenditures of a government during a given period of time. It helps understand priorities set up by the government.
2. India is a federal country with an administrative set-up comprising three tiers of government — the Union government at the centre, the state governments, and local governments which include both urban and rural local bodies. Powers are divided across the Union and state levels of government via the Union list, State list, and the Concurrent list. Health is a state subject. These fiscal federal relations are reflected in government budgets.
3. Budgets have four key uses: as a policy and fiscal tool, as a planning tool, as an accountability tool, and as a tool for transparency.

How does one determine what the government thinks the priorities and needs of the country are?

Well, simple answer — through the budget. Governments around the world spend a lot of money on various things — to keep people safe, to keep them healthy, to educate them, to ensure people have jobs, etc. The budget of a country is a document that is of great interest to everyone. In India, it generates substantial discussion every year when it is released on February 1. On Budget day, you will hear different allocations being announced for different sectors. You may also see new schemes and initiatives being announced.

In particular on health, the Government of India spent ₹39.45 lakh crore in FY 2022-23, but only 2.2 per cent was on health (GoI, 2022). See Table 1.1 for more details.

Table 1.1: Union and State budget numbers — Overall and Health (₹ Lakh Crore)

	2020-21	2021-22 BE	2021-22 RE	2022-23 BE
Total Budgetary Expenditure (in ₹ lakh crore)	50.41	54.11	65.24	71.61
Expenditure on Health (in ₹ lakh crore)	2.66	2.73	3.50	4.72
Health Expenditure as percentage to total expenditure	5.3	5.0	5.4	6.6

Source: Economic Survey, 2021-22

In this primer, we are going to be looking more closely at the schemes and programs of the government specifically with respect to health. The guide will explore why looking at budgets is important and the building blocks that go into budgets — processes, terms, documents, and actors. It will then look at how we can read health budgets, and provide a 'how-to' on what questions can be asked and answered on health financing through budget documents. Finally, the guide will end with opportunities on how to improve transparency and readability of budgets.

As per the Economic Survey, 5.49 lakh crore (2.1% of GDP) was spent on health in FY 2022-23 by both Union and state governments.

India's federal set-up

India adopted a federal structure of administration when the Constitution was ratified in January 1950. A federal state is one which has a division of powers between central and regional authorities. The sphere of the different levels of government are pre-defined and limited.

In India, the founding members envisaged an administrative set up comprising three tiers of government — the Union government at the centre, the State governments, and local governments which include both urban and rural local bodies.

The legislative section was divided into three lists as determined in the Seventh Schedule of the Constitution of India: the Union List, the State List and the Concurrent List that specified the items on which the respective governing bodies could preside over (GoI, 1950).

The Union List has all items over which the Union government has exclusive legislative power and were determined keeping in mind questions of security, economies of scale, and those requiring uniformity of legislation. These items include defence, the army, international relations and other matters of national importance.

The State List, in contrast, are items of regional or local importance over which the states have exclusive legislative power. This is in line with first principles of fiscal federalism, that governments closer to people are more efficient and effective at solving problems such as the just distribution of income, allocation of resources, and economic stability. Consequently, the state list includes law and order, maintenance of the police force, agriculture, and others. **Health, as well, is a state subject.**

The Concurrent List enumerates items over which both the Union and the states can pass laws. These items include education (including medical education), family planning and population control, forests, and other such matters. The Eleventh and Twelfth Schedule of the Indian Constitution covers items that fall within the purview of Panchayats and Urban Local Bodies respectively (GoI, 1950).

These rules and the way they play out have changed with time. The economic reforms of 1991 ushered in an era where states had relatively more autonomy than before. As states became key players in social sector expenditure and gross fixed capital formation, the fiscal authority and division of the shared pool of resources also began to undergo changes.

The main avenue where these fiscal federal relations are reflected are government budgets. This primer focuses on the first two levels of government, in the context of health budgets — the Union government, and the state government. India's federal set-up, with 28 states and 8 union territories, implies there are no less than 37 health budgets.

Why are budgets important?

What is a Budget?

The government budget is a record of the revenues and expenditures of a government during a given period of time. Ex ante, it shows what the government intends to do during that period and how it intends to finance these activities. Ex post, it shows what the government actually did and who had to pay for it and in what form (Von Hagen, 2007). Budgets set priorities for the country, and give direction to the activities of the government and the economy through various policies. Budgets are thus visioning documents.

Why are budgets important for the government and citizens?

Budgets have four key uses.

Budgets are a policy and fiscal tool and are used by governments to indicate intent and address macroeconomic concerns and challenges — is growth slowing down and should the government invest more? Is growth picking up and are the right sectors being targeted to keep it going? The budget addresses all this. Similarly, while keeping policy in mind, the budget is also used to match receipts with expenditure thereby seeking to ensure growth and stability. Governments cannot spend more than the money they have. Of course, governments can borrow to spend, but the budget is what indicates how much one can borrow. Therefore, the budget has to be prepared in a way that balances growth and stability of the economy.

Budgets act as a planning tool. They are used for prioritising activities to meet longer term strategy. Allocations in the budget every year are meant to be a part of medium or long-term plans. In fact, state budgets, which are usually made after the Union budget, depend crucially on finances from the Union. So, states can use the Union budget while making their plans. Citizens can use budgets for designing interventions and for proposing changes to the way things are done. For example, health insurance companies can work in line with existing provisions in health insurance schemes regarding coverage, and hospital owners and administrators can make decisions of empaneling their hospitals with these schemes.

Budgets serve as an accountability tool. Budgets can indicate the extent to which the government is able to allocate resources for fulfilment of its promises. We can also find out what the government is prioritising across sectors and even within a sector, and if the needs of the people are met, especially those related to basic welfare rights such as healthcare. In fact, governments at the Union level can even use state budgets to monitor activity at the state level, and vice versa. In a federal structure, budgets are thus important in keeping different authorities in check.

Finally, budgets are an important tool for transparency. Citizens pay taxes and cesses on formal income every time they buy goods and services, and the government uses those for various goals and outcomes. Citizens' money goes as taxes into the coffers of the government, and from there as expenditures.

The next chapter will look at some of the building blocks of the budget — the processes, the actors involved and key budget documents.

Chapter 02

Budget building blocks: Processes, actors, types, and documents

Highlights:

1. The budget cycle has three phases: formulation, execution, and evaluation. The Union budget is released on February 1, followed by state budgets which are usually released by April 1. The process for creating both is similar.
2. There are several key actors involved through the budget cycle, across different levels. These include parliamentary actors, including the executive, legislature, the Finance Commission, Departmental Standing Committees, and the CAG. Central ministries and agencies include the MoF and health-specific ministries and agencies such as the MoHFW and the NHA. State actors include departments of health, State Health Societies, State AYUSH Societies, and district level officials. Non-government actors include Civil Society Organizations and external institutions who may provide loans.
3. Line item budgeting is the mainstay of Indian budgeting.
4. India follows a six-tier hierarchical structure which includes major heads, sub major heads, minor heads, sub minor heads, detailed heads, and object heads. The major heads for health expenditures are 2210, 2211, 4210, 4211, 6210, and 6211.
5. The key budget documents include the Annual Financial Statement, Expenditure Budget, Department-wise budgets, Receipt budget, Budget at a glance, Budget highlights, and the Economic Survey. There are differences between Union and state budget documents, and there are differences across state budget documents as well.

The budget cycle: A framework

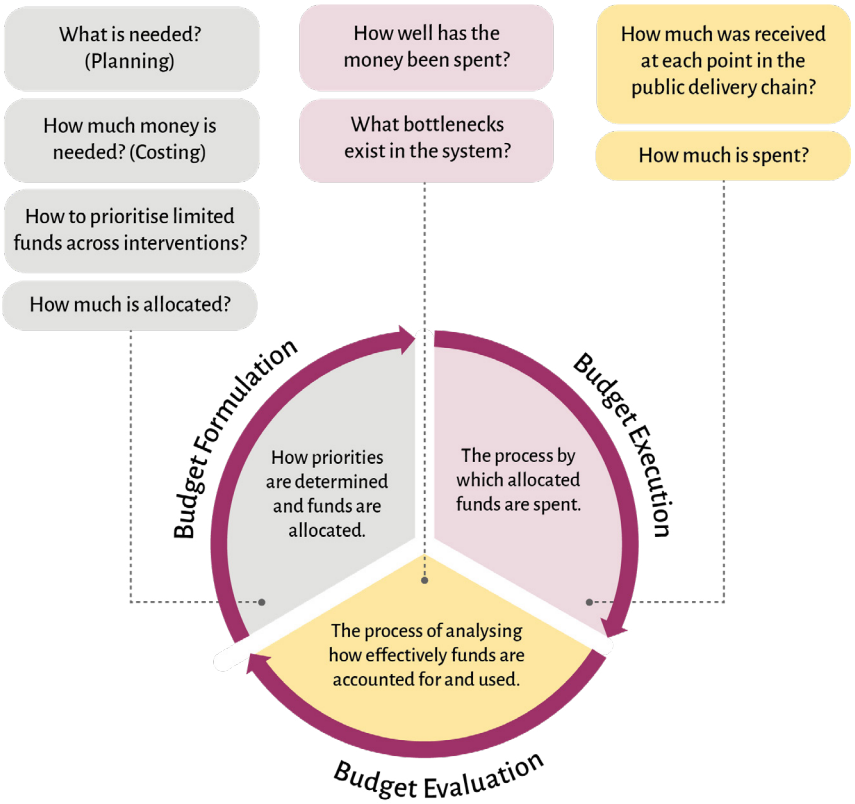
When thinking about budgets, it is important to think about what generally happens before and after the budget is announced. One way of doing this is through the budget cycle.

There are three stages in the budget cycle. These are:
(1) **Budget formulation** refers to the process of creating budgets, ranging from planning, approvals, and allocations. It seeks to answer a basic set of questions: what is needed, how much money is needed, how to prioritize limited funds across interventions, and finally, how much is allocated.;

(2) **Budget execution** refers to the process by which allocated funds are spent including fund-flow processes and the amount and timing of funds released. It seeks to answer two questions: how much was received at each point in the public service delivery chain, and how much was finally spent.

(3) **Budget evaluation** refers to the process of analysing how effectively funds were accounted for and used, including audits. It also aims to look at what bottlenecks exist in the system. (Kapur and Shukla, 2021).

Figure 2.1: The Public Finance Management Cycle



Source: Kapur and Shukla (2021).

Below we describe the budget-making process, timelines and actors involved in each of these phases.

Budget formulation/preparation

August

The Union budget preparation procedure starts at the end of August or the first half of September, with the Budget Division (part of the Department of Economic Affairs in the Ministry of Finance or MoF) issuing the Budget Circular to all Union ministries and departments.

September
Budget circular issued

The circular provides detailed instructions on preparing the estimates of receipts and expenditures and the formats in which they are to be presented. This is when the Department of Expenditure holds discussions with financial advisors of various stakeholders after which estimates are finalised. In this case, these stakeholders are ministries/ departments such as the Ministry of Health and Family Welfare.

October

November/ December
Discussions on inputs on expenditures

In November/December, the Finance Minister has a series of discussions with sectoral representatives, including social sector experts, industrialists, and economists to get their inputs and prospects on expenditures.

January
'Blue sheet' presentation

In January, the Budget Division presents a "blue sheet" to the Finance Minister, which has broad numbers on expected revenues, expected expenditures, and borrowing requirements of the Government of India (Open Budgets India).

Approval of first tentative budget

Post that, the Finance Minister meets with officials from the Revenue Department and prepares the revenue receipts. Once the broad numbers are decided, the Finance Minister goes to the Prime Minister for the first round of consultation. The Council of Ministers approves the tentative Budget in the second half of January. If there is a conflict between any ministry/department and the MoF with regard to any allocation in the Budget, the matter is resolved by the Union Cabinet, and the budget document is printed.

February
Union Budget presented in Lok Sabha

Until 2016, the Union Budget of India was presented in the Lok Sabha on the last day of February. However, from 2017 onwards, this was shifted to the first working day of February. This change was done to facilitate faster approvals of funds to states, in order to bring greater efficiency to implementation. The overall process however remains the same.

Budget enactment and execution

Budget Enactment begins with the presentation of the budget document in the Parliament. The budget presentation starts with the Finance Minister delivering the budget speech in Lok Sabha on February 1. After the Finance Minister's budget speech in the Lok Sabha, the

'Annual Financial Statement' (details below) is tabled in the Rajya Sabha.

The budget is said to be passed once the Appropriation Bill and Finance Bill are passed. The Finance Bill gives the government legal authority to raise resources, mainly through taxation. On the other hand, the Appropriation Bill gives the government lawful authority to incur expenditure as stated in the budget and approved by the legislatures. As per the Constitution, no expenditure can be incurred from the 'Consolidated Fund of India' without the authorisation of the legislature and passing of the Appropriation Bill. It thus provides legal effect to the demands that the House has voted on.

March

After the Lok Sabha has passed the budget, it moves to the Rajya Sabha. The Rajya Sabha does not have the power to amend or reject the budget, but it can only make suggestions to the Lok Sabha within 14 days. It is up to the Lok Sabha whether to accept or reject the Rajya Sabha's suggestions. When both Houses have passed the budget, it goes to the President for approval, after which it is deemed final and is published in the Gazette of India.

April
Audit begins

After this, the Union government implements the budget proposals, i.e. raising resources and incurring expenditures as proposed in the budget, the MoF allocates the approved funds to many controlling officers. They check if work is done according to the approved budget, monitor that various ministries and departments do not incur expenditure further than their sanctioned limit, and if funds are disbursed to execute schemes and programs.

Budget legislative review/audit

Even though the audit phase is the last stage, it is essential for the entire budget cycle. The Comptroller and Auditor General of India (CAG) audits the government's expenditure and revenue and checks whether the appropriate procedures and rules were followed while collecting taxes. CAG administers matters referring to the departmentalisation of accounts of the Union government. It is responsible for auditing all the central expenditures as well as state budgets and submitting audit reports to the President for placement before the appropriate legislature.

Until next FY

Source: Open Budgets India; Overseeing Public Funds, PRS (2019)

CAG audits are usually of 3 types:

i. A financial audit to determine that financial statements are accurate;
ii. A compliance audit to check the extent to which laws and regulations have been respected, and;
iii. A performance audit to examine the performance of key programs.

For instance, in 2017, the CAG did a performance audit of Reproductive and Child Health under the National Health Mission. More recently, in August 2022, a performance audit was conducted of procurement and supply of drugs in the Central Government Health Scheme of the Union government (CAG, 2017; CAG, 2022).

State budgetary process

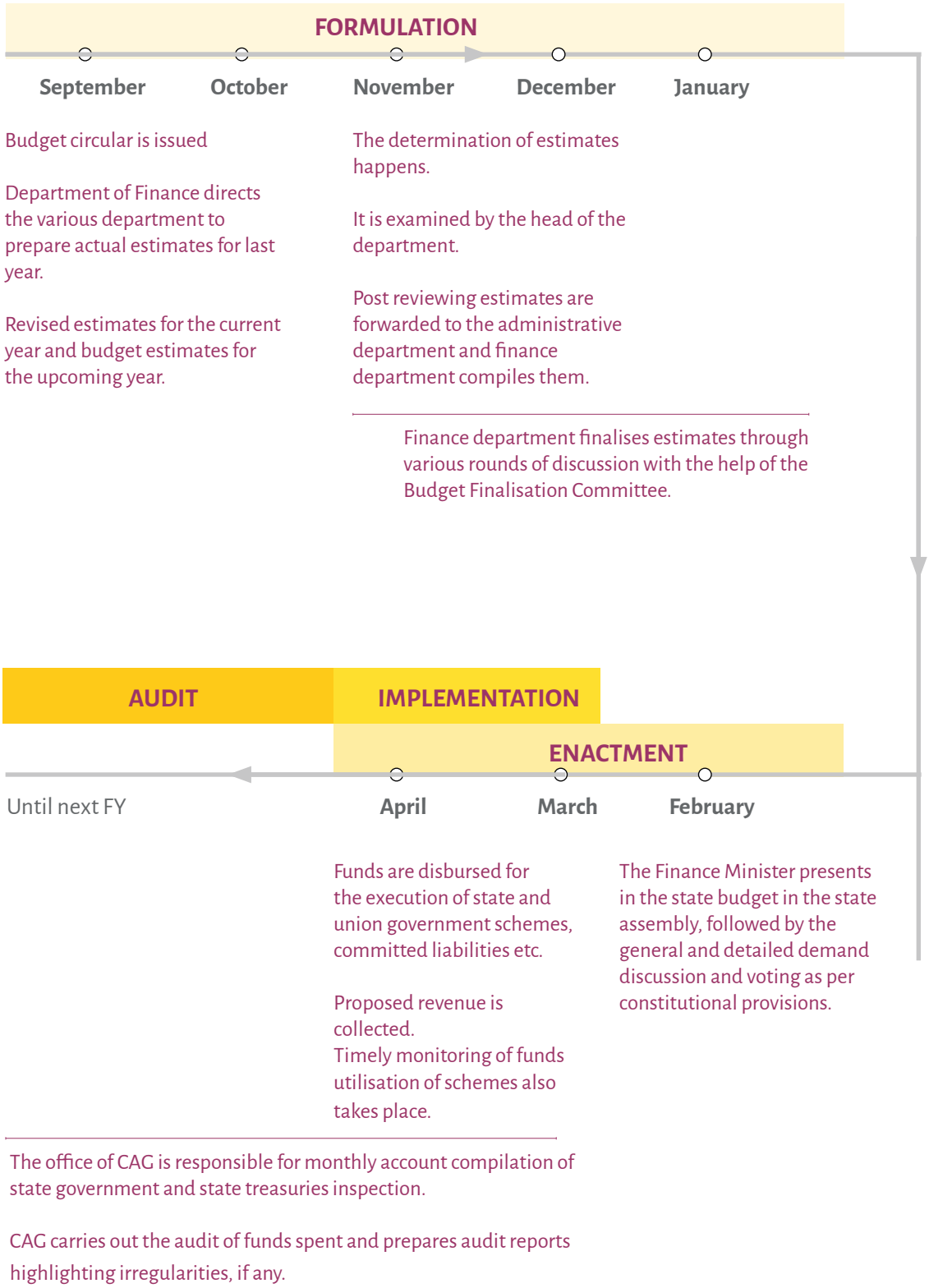
The structure of the state budgetary process follows more or less the same process of formulation as the Union budget. As with the Union government, the Constitution of India directs that no disbursement can be incurred from the State Consolidated Fund without the mandate of an Appropriation Act. To obtain approval from the state legislature, a statement of projected receipts and expenditures for each financial year, known as the Annual Budget, must be put before the state legislature.

An efficient procurement system is critical for execution of health budgets. Typically, state health budgets have included procurement of capital projects, drugs and consumables, and a range of non-clinical support services. Funds for such procurement are transferred by the Health department to the agencies entrusted with such a mandate. For realistic assessment of expenditure, it is important to identify agencies responsible for such procurement and get their receipt and expenditure statements.

State Finance departments prepare their budgets, which are released after the Union budget. Budgets are usually released by April 1. There are, however, some exceptions to this rule when, for instance, the state/Panchayati Raj Institutions (PRIs)/civic bodies are going for elections. In such cases, a vote-on-account is presented to the legislature which includes the authorisation of expenditure till a certain date and the audited actual expenditures.

The budget at the state level is made by different departments of the state government, each of whom are responsible for a specific area/sector, such as agriculture, health, and education. Each department's budget is called a Demand for Grant that has a unique serial number for each department. The numbering system varies among states. For example, the Demand for Grant for the Department of Health in Bihar is Demand number 20 and Karnataka is 22. The Finance Department then reviews and consolidates the departmental budgets to finalise the overall state budget, and the Legislative Assembly passes it.

Figure 2.2: Budget Cycle Timelines



Local body budgetary process

Most local bodies do not have a detailed budgeting process. In 2015-16, the Union government started a process for the preparation of Gram Panchayat Development Plan (GPDP) — an annual plan for each panchayat where Gram Sabha residents determine where the funds should be spent, within the resource envelope communicated by the State government. GPDPs are now mandated and are to be based on a participatory process inviting the Gram Sabha, and convergence with schemes related to the 29 subjects listed in the Eleventh Schedule of the Constitution. There are also some states where local bodies make budgets. These are described in the box below.

Box 2.1: Budgets made by Local Bodies

Urban Local Bodies: Budget Cycle (Karnataka and Tamil Nadu)
The ULB's Budget Cycle begins with the preparation and publication of the Annual Performance Report of the previous year (published in September/ October of each year). The first round of public consultations towards finalising the Budget, are held in November when the Annual Performance Report is discussed. The second round of public consultations is organised in December; the draft budget is outlined based on it and submitted to the Commissioner, who then finalises the budget. The budgets are initially made at the Unit Office level and consolidated at the department and ULB levels. The budget document is submitted between January and February to the Municipal Council. Following discussions, the Council approves the budget. This process is supposed to be completed by March 31.

Rural Local Bodies: Gram Panchayat (Karnataka and Tamil Nadu)
Towards the end of January, the Panchayat Secretary prepares the budget for their Gram Panchayat. They place the budget proposal before the Gram Panchayat between February and March, and the Gram Panchayat General Body approves the budget. Once the General Body passes the budget, it is approved by the Gram Panchayat officials. Following this, the President and Secretary of the Gram Panchayat approve and sign the budget document. The budget approved by the Gram Panchayat is sent to the Block level. The Block Panchayat office receives all the Gram Sabha budgets, and the Block Executive Officer approves these documents by April, which is the final budget of the Gram Panchayat.

Source: Centre for Budget and Policy Studies. 2013.

As can be seen, there are several actors involved in the budget-making process. Let's take a quick look at some of the key ones.

Overview of key actors and their role in health budgets

Parliamentary

Executive
The Executive is involved in drafting the Union budget and doing the heavy lifting of allocating resources and deliberating over them before the budget is proposed. The responsibilities of the Executive concerning the budgetary process involve budget preparation, budget execution, and accounting and reporting to the legislature, the general public and own use.

Legislatures
Legislatures, or elected assemblies for the Union or states, have the authority to make laws. These include voting on the budget when it is tabled in the Parliament, and discussing and voting on new Acts and policies. An example of the latter is the 'Right to Health' bill in Rajasthan. Legislatures which approves the annual budget respectively, as the Constitution clearly vests 'the power over the purse in the hands of elected representatives'.

Finance Commission
The role of the Finance Commission – constituted every five years as per the Constitution – is primarily twofold. One, to remedy the vertical fiscal imbalance by deciding the share of Union and states in the divisible pool of tax revenue. Second, to address the 'horizontal imbalance' arising from limited capacities of some states to generate suitable resources independently. In other words, the Finance Commission is responsible for determining the tax devolution formula between the Union government and states. It can also recommend grants to states for health-related activities. These affect both the Union and state budgets. It is up to the Union government to accept or reject these recommendations. For example, in 2021 the 15th Finance Commission recommended funds specifically for the health sector.

Departmental Standing Committees
Parliamentary Departmental Standing Committees consist of Members of Parliament and are permanent regular committees across both houses of Parliament. They are responsible for looking at specific sectors. They are appointed or elected by the House or nominated by the Speaker and work under the direction of the Speaker. They present reports to the House or to the Speaker and the Secretariat. For instance, health matters are taken up by the department related Standing Committee on Health and Family Welfare of the Rajya Sabha. It handles matters related to AYUSH as well.

Comptroller and Auditor General of India (CAG)
Mandated by the Constitution, the CAG reviews the funding of the government, and thereby provides independent review that public funds collected are used effectively and efficiently.

[1]At the Union level the legislature is called Parliament and at state level state legislative assembly.

At the Union level, Pay and Accounts Offices keep line item wise accounts of all the transactions involving the Consolidated Fund of India, Contingency Fund of India, and Public Account of India. These monthly accounts are reviewed and analysed and presented to the Finance Minister. Similar arrangements exist at the state level for compilation of accounts. Treasuries where all financial transactions take place maintain initial books of account. They render these accounts along with all vouchers and *challans* to the State Accountant General, who compiles the accounts for the state government.

Central ministries and agencies

In addition to the above, there are government actors, including various ministries, which make estimations of how much they will require in the upcoming year, and the bureaucracy which does the legwork when it comes to implementing recommendations, gathering data, and drafting the budget.

Ministry of Finance (MoF)
The Ministry of Finance plays a crucial role in approving demands for grants by various ministries, including MoHFW. All ministries, including MoHFW, place their demands with MoF, who have to carefully balance many competing priorities. With the abolition of the Planning Commission, the distribution of resources across sectors/ministries rests with the MoF.

There are also some health-specific ministries and agencies that play a role in budgeting:

- **MoHFW:** The Ministry consists of two departments, for which budgets are made i.e. the Department of Health and Family Welfare, and the Department of Health Research. The Ministry is in charge of various health-related initiatives of the Union government through the policy cycle, from formulation and execution to evaluation. During the budget preparation phase, officials at MoHFW prepare estimates for what is required for various programs, and place the same before the MoF. Once allocations are made, they are responsible for various parts of implementation, including releasing funds and providing technical assistance and direction to states governments and other health related entities. They also monitor progress on health outcomes and fund utilisation.

- **National Health Authority (NHA)**: The NHA is the apex body responsible for implementing India's flagship public health insurance scheme, the Pradhan Mantri Jan Arogya Yojana, at the national level. Its role is to design strategy, build technological infrastructure, and implement the Ayushman Bharat Digital Mission to create a National Digital Health Ecosystem. The NHA is an attached office of MoHFW, with full functional autonomy.

Similarly there are other ministries/agencies that play a role in health budgeting. For instance, the Ministry of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy). Previously part of MoHFW, in 2014 it was carved out as a separate Ministry

[2]Projected Demand from Rajya Sabha Committee Reports, and allocations for Union Budget of India.

to revive knowledge of traditional Indian systems of medicine and ensure the optimal development and propagation of these systems of healthcare. The Ministry of Tribal Affairs provides financial assistance to state governments and other ministries through Grants-in-Aid to fill critical gaps in health and nutrition for tribal areas; or the Ministry of Social Justice and Empowerment which provides such grants to fill critical gaps, including for healthcare.

State actors

The majority of India's health spending is funded at the state level. Here too, legislatures, the executive, line departments, and agencies play a critical role. Their functions are similar to their corresponding bodies at the Union level. Below is a short description of the relevant actors at state level.

Departments of Health at state level
The departments of health at the state level are responsible for discharging health-related initiatives within the state. These include both state schemes and programs, and Centrally Sponsored Schemes (CSSs). The department handles budgeting and fund-flows for state schemes, making proposals to the Union for CSSs, and subsequent implementation. The department generally contains several directorates or commissionerates for distinct activities.

State Health Society
SHSs are in-charge of receiving, managing, and disbursing funds to various implementing agencies, such as the Directorate of Public Health and Family Welfare, or the Directorate of Medical Education. SHSs are also responsible for the creation of Programme Implementation Plans for the National Health Mission.

State Health Agencies (SHA)
SHAs are autonomous (usually) registered societies under the aegis of the state Department of Health and Family Welfare, entrusted with the responsibility of administering and implementing the GoI's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). SHAs submit their budget estimates to the state health department and also to the Government of India. The annual budget of the SHA for AB-PMJAY is a subset of the overall health department's budget.

State Ayush Societies (SAS)
These are societies created to implement the National Ayush Mission, similar to SHSs. Regarding budgeting, their work includes the preparation of State Annual Action Plans, execution of the approved State Annual Action Plan including release of funds, and review of detailed expenditure.

District officials
Officials at the district level contribute to creating plans and budgets for the district they are in-charge of. These plans and budgets are aggregated while creating state level plans. The exact process differs across states. In some states, officials at the district level create detailed

plans and budgets, and in others, they may provide a list of requirements only with state level officials fleshing out the details. The office of the Chief Medical Officer of the District is meant to prepare district budgets based on estimates received from all health facilities within the district, like the PHCs, CHCs, and sub-divisional hospitals. District hospitals are also meant to prepare their individual estimates. However, this process too varies from state to state.

Non-government actors

There are also non-government actors who primarily suggest or make recommendations for specific policies and certain allocations including Civil Society Organizations (CSOs) and individuals — industrialists, academicians, farmers lobby, industrial lobby, media, etc. However, this phenomenon is mostly seen at the Union level.

Table 2.1: Actors involved in the Budget Cycle

	Actors and Activities
Budget Formulation	· MoF: Allocates funds based on priorities. · Other line ministries: Prepare budgets for recurrent establishment expenditure (including salaries) and programs and schemes. · Legislatures: Budget approval. · State Societies: Prepare Programme Implementation Plans and budgets for approval. These are submitted directly to the GoI and the aggregate estimates feed into the state budget of the health department. · State Health Agencies: Prepare estimates for the health insurance programs that feed into the state budget of the health department. · District officials: Meant to prepare plans and budgets to be used for the state health budget. They are also meant to prepare plans and estimates for CSSs (like the NHM) that are submitted to State Societies. However, this process varies across states. · External agencies and CSOs: Support budget making,
Budget Execution	· Union line ministries: Release funds to states, implement schemes. · State line departments: Release funds to districts, implement schemes. · District officials: Scheme implementation, requisite spending, and release of funds to block and facility levels. · Health facilities: Implement schemes, use budgets for managing operations. · External agencies: Provide technical support in policy and systems strengthening and provide implementation support as required.
Budget Evaluation	· Line ministries, government agencies, parliamentary standing committees: Evaluate scheme progress. · CAG: Conducts audits. · External agencies and CSOs: Conduct external evaluations of programs and finances.

India's budgeting system

There are different types of budgeting done across countries. Some of the common approaches include line item wise budgeting, zero budgeting, and performance budgeting, or sometimes a mix (Shah, 2007).

Line item budgeting: The mainstay of Indian budget-making

The traditional form of budgeting is when budgets are arranged by 'line items'. When budgets were first brought to legislatures, every separate piece of spending in the form of inputs got approved in all its details. So, for instance, if you wanted to build a sub-centre, a line item budget would have all the different components from the costs of the building, human resources, equipment, electricity, etc. This is exactly what India does.

This type of budgeting is often preferred for two reasons. First, after the initial exercise of creating line items, the template tends to be relatively standardised and previously approved items are effectively already present for reapproval. Also, anytime a new programme or project is started, a new line item can be added. Second, it is believed that this approach leads to increased process-oriented accountability since every input needs to be accounted for. Thus, for administrators, by focusing on the inputs in which money is allocated (such as equipment) and the process of disbursement, line items provide a degree of control. This control emphasis developed as a response to problems of financial irregularity in governments.

However, input-based line item budgets (also known as object-based budgeting) has disadvantages, and most middle and high income countries have moved away from it. One shortcoming is that decision-making is reduced to changes in various inputs such as "personnel, equipment, maintenance, utilities, or transportation — that make up programs rather than looking at programs (or sub programs) as wholes" (Fölscher, 2005). In the health sector, ultimately we are more interested in service delivery for specific conditions than the number of doctors or medicines paid for. As Mikesell, an expert in government finance explains, traditional budgets emphasise control of fund use and have not been structured to facilitate resource allocation decisions (Mikesell, 1995).

Thus, while the line item approach facilitates control, it also thwarts the development of a results-oriented accountability, in which the following kinds of questions are relevant:

What is the government doing with the money it receives?

What are the goals of government interventions?

Is the government reaching its goals, or at least moving toward their achievement?

These questions relate to how money is being used for services, an issue that the line item budget does not adequately address.

Budget accounting classification and coding

Given that India follows line item based budgeting, it's useful to look at how budgets are organised. The budgetary system in India follows a six-tier hierarchical structuring comprising:

- Major Heads which are a four-digit Code that correspond to 'Functions' of the government.
- Minor Heads, which are subordinate to the major head, are three-digit code which identify the 'Programme' undertaken to achieve the objectives of the function.
- The Sub Head (two-digit code) below the minor head (three-digit code) represents various schemes or activities under the programme.
- The Detailed Head is termed as object classification. The detailed classification of account heads in government accounts and the order in which the major and minor head appear in all the account records is prescribed by the Union government from time-to-time on the advice of the CAG.

If one looks at the broad classification of the first digit of the four-digit Major Code one can indicate whether the major head is a Receipts Head or Revenue Expenditure Head, or Capital Expenditure Head or Loans and Advances or it pertains to Public Account.

- If the first digit is '0' or '1', the Head of Account will represent Revenue Receipts.
- If the first digit is '2' or '3' it will represent Revenue Expenditure.
- If the first digit is '4' or '5' it will represent Capital Expenditure.
- If it is '6' or '7', it represents Loans and Advances Head; (4000 for Capital Receipt) and;
- '8' will represent Contingency Fund and Public Account — (8000 for Contingency Fund).

Receipts are classified according to their nature and source.

Expenditures are classified in two ways. First, using the accounting head classification, expenditure is distinguished according to the function, programme, and their economic nature using a fifteen-digit numerical code. Second, expenditure is also classified into revenue and capital expenditure.

Table 2.2: Types of Budgeting

6 tier classification (15 digit codification)			Examples: Maharashtra
Major Head	XXXX	Functions	2210- Medical and Public Health
Sub Major Head	XX	Sub Functions	01-Urban Health Services- Allopathy
Minor Head	XXX	Programs	110-Hospitals and Dispensaries
Sub (Minor) heads	XX	Schemes	01-Mofussil Hospitals and Dispensaries
Detailed Head	XX	Sub Schemes	01-Non-Teaching Government Hospitals in Mofussil Area
Object Head	XX	Object of Expenditure	01-Salaries

Below are some examples of common health related major heads for receipts as well as capital and revenue expenditure. However, as will be described in Chapter 4, this list is not exhaustive and does not capture all health expenditures.

Table 2.3: Common Health Related Major Heads

Revenue Receipts for Health	Revenue Expenditure for Health	Capital Expenditure for Health
0210- Medical and Public Health	2210: Medical and Public Health	4210: Medical and Public Health
0211- Family Welfare	2211: Family Welfare	4211: Family Welfare
1601- Grants for Health from Union to States are accounted under this head like NHM, health sector grants, etc.		6210: Loans and Advances for Medical and Public Health
		6211: Loans and Advances for Family Welfare

Source: (CGA, 2022)

In order to ensure a level of standardisation across line departments and across states, the CAG provides a detailed guideline/handbook on the classification of expenditure (CGA, 2022).

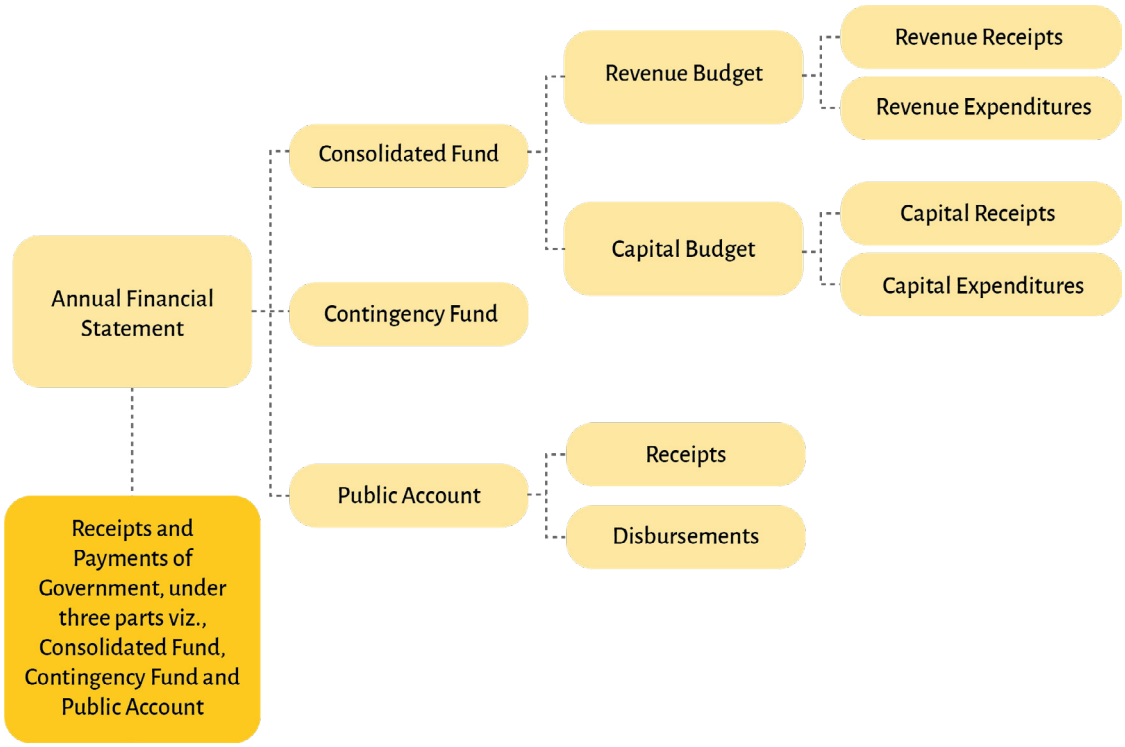
Key budget documents

Finance and health department websites of the Union and state governments may include a complex set of budget documents, at times with varying titles for documents across states. The main documents are described here, and a glossary of terms is included in the appendix.

Annual Financial Statement (AFS)

The AFS is a crucial summary document and shows estimated receipts and expenditure of the Government of India for a financial year, say 2022-23, in relation to estimates for 2021-22 and the actual expenditure for 2020-21. The receipts and disbursements are shown under three parts in which government accounts are kept viz (i) the Consolidated Fund, (ii) the Contingency Fund, and (iii) the Public Account. The AFS differentiates the expenditure on the Revenue account as of the expenditure on other accounts, as is mandated in the Constitution of India. The government budget thus includes the Revenue Budget and the Capital Budget. The estimations of receipts and expenditure included in the AFS are for expenditure net of refunds and recoveries.

Figure 2. 3: The Annual Financial Statement



Source: (Union Budget)

Expenditure Budget

These documents present detailed information on the expenditures of the government. Sectors, ministry, and scheme-wise details are provided. It contains the budget estimates for each department and ministry.

Department-wise budgets

A sub-component of the Expenditure Budget, department-wise budgets as the name suggests reflect the revenue and capital expenditure of various ministries/departments in a financial year. The details about both capital and revenue expenditure are further given in two separate categories: charged and voted expenditure as per the requirement of voting in the Lok Sabha. At the Union level, since FY 2017-18, broad details of expenditure under Central Sector Schemes/Projects, Centrally Sponsored Schemes, Establishment Expenditure are also covered.

Receipt Budget

These documents present comprehensive information on the money raised by the government by way of tax and non-tax receipts, capital receipts, and borrowings.

Box 2.2: FRBM Documents

FRBM Documents: In order to regulate fiscal management, the Union government introduced the Fiscal Responsibility and Budget Management Bill in December 2000. The Act and corresponding Rules were brought into force on 5 July 2004, and most state governments have enacted similar legislations. Under this Act, the government must follow sound fiscal policies and set limits on the size of the budget deficits. It requires measurable goals for decreasing the growth of debt, deficit and guarantees in a time-constrained way and requires a series of improvements in fiscal transparency and medium-term fiscal planning to improve budget management.

Budget at a Glance
This is a document like an executive summary that explains all broad aggregates and estimates in a form that is easier for readers to comprehend. It shows all receipts, expenditures, fiscal deficit, revenue deficit, and primary deficit of the Union and state governments.

Budget Highlights
These documents show the salient points of the entire budget, across sectors, and may run into several pages. Not all states have this as a separate document.

Economic Survey
This is an annual document published by the Ministry of Finance. This document assesses the development of the Indian economy over the past financial year looking at the performance of key development programs, highlights of GoI policy initiatives and economic forecasts in the short to medium term. State governments also prepare their economic surveys and are published on the states' Department of Finance websites along with other budget documents.

Differences between Union and state budgets
The majority of Union and states documents are identical. Like the Union budget, state budgets also have an AFS, Budget Summary/Highlights, Budget at a Glance, Receipt Budget, etc. Yet, they have some crucial differences. For instance, the Union budget document does not have a detailed Demand for Grants like state budgets. Instead, it only provides ministry/department-wise expenditure details. Moreover, unlike the state budget, it does not include major head and minor head wise expenditure details.

Differences across state budgets
There are also differences in budgets across states. They may vary in terms of different languages or formats used. For instance, budget documents are only available in Hindi for states such as Rajasthan, Bihar, and Madhya Pradesh, whereas they are in English and the regional language for West Bengal, Odisha, and Maharashtra. For most states, budget documents are in PDF format (in some cases scanned PDF documents like in Bihar), but for Odisha and Sikkim, documents are also available in Excel format.

Generally, many states such as Karnataka, Gujarat, Madhya Pradesh, and Maharashtra, put up their detailed Demand for Grants department-wise whereas some states such as Bihar and Rajasthan combine the details by broader categories, either by revenue and capital expenditure or through a classification of expenditure on general, economic, and social services.

Apart from this the number of documents prepared also differs across states. For example, Odisha has a Nutrition, climate, and Sustainable Development Goal (SDG) budget. Tamil Nadu, Karnataka, Andhra Pradesh and Odisha have separate Agriculture Budgets (Mukherji, Shine Jacob, and Sanjeeb, 2022). Bihar has a separate Gender budget and Child budget, and is one of the few states to publish this. As of 2021, 11 states prepare outcome budgets, but there are variations both in format and the number of departments that contribute to the process (Mahendru, 2021).

Also worth noting are the variations in terms used to publish documents. For example, the West Bengal budget portal states "Civil Budget Estimate" on its budget page but the linked file is the AFS. Similarly, for Rajasthan, the budget portal has a "Summary Volume" document but it too has details which are basically covered under the AFS document. So, headings can be misleading.

Chapter 03

Resource Flow and Fiscal Architecture from Union to State

Highlights:

1. For States, over 50% of health funding is from States own revenue (including both tax and non-tax revenue).
2. For the Union government, the primary mechanism are Centrally Sponsored Schemes such as the National Health Mission (NHM), Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) and Central Sector Schemes (CS) such as the Pradhan Mantri Swasthya Suraksha Yojana and Family Welfare Schemes. In FY 2022-23 BEs, CSSs constituted 55% of total Union government expenditure on health and CS constituted 19%.
3. CSS and CS schemes are also an important source of State health expenditure as they form non-wage funds directed for a specific purpose.
4. Understanding fund flows is critical to analysing health budgets. CSS funds flow through independently created societies and flow through the society to implementing agencies. State budgets (Excluding CSSs) funds flow through the state treasury via Drawing and Disbursing Officers (DDOs) to implementing agencies.
5. The fund flow mechanism for CSSs changed in 2014-15 which impacts comparability of total state health expenditure pre 2014 and post 2014.

Major sources of health funding for states

Based on the institutional architecture described above, the following are the main sources for funding health:

Union

Most of the Union government expenditure on health is through Specific Purpose Transfers. Specific Purpose Transfers are given to ensure minimum standards of public services, at least in principle. Thus, they are meant to equalize expenditure levels so that a child born in Bihar or Kerala should both receive comparable services that meet minimum standards. There are two types: Centrally Sponsored Schemes (CSS) and Central Sector schemes (CS).

CSSs which are designed and implemented by Union government ministries in areas of national priorities to support state-level expenditure. CSSs involve financial participation from both the Union and state governments in a fixed ratio and generally cover subjects in the State or Concurrent lists. CS schemes are fully funded and implemented by the Union government. They mainly cover subjects on the Union list.

In 2022-23, for instance, 55 per cent of Union government financing for health was driven by CSSs and 19 per cent by CSs. Similarly, over the last five years, more than 70 per cent of Union government financing for MoHFW is through CSSs and CS schemes.

Table 2.4: Common Health Related Major Heads

	2017-18	2018-19	2019-20	2020-21	2021-22 RE	2022-23 BE
CS as a share of Total MoHFW Spending	12%	11%	13%	29%	18%	19%
CSS as a share of Total MoHFW Spending	60%	60%	59%	49%	59%	55%

Source: (Union Budget)

State

The primary sources of health expenditure in states is through their own resources (including both tax and non-tax revenue). Between 2014-15 and 2020-21, the majority of the large states have derived on average more than 50 per cent of funds through states' own resources (Kapur A., Irava, V., Pandey S., and Ranjan, U. 2020). Spending on health by states is through

state health schemes and state shares in CSSs for health through their own resources. It is also worth noting that committed and establishment expenditures account for a sizable portion of state resources.

In addition, several Finance Commissions have given money specifically for health. The 15th FC has provided a sum of ₹70,051 crore over the period FY 2021-22 to FY 2025-26 as health grants for local bodies, meant to improve health systems and reduce the crucial gaps in the healthcare system at the primary healthcare level. They remain, however, a small proportion of overall government allocations for healthcare. For instance, the FC grant for FY 2021-22 BEs was only 2.8 per cent of the total expenditure by both the Union and state governments on healthcare. Some of the recent health grants by FCs are described in Appendix Table 1.

Budgets for Union Territories are mentioned in the Union budget. Therefore, the money is directly sent from the Finance Ministry and relevant line departments at the Union level to the Union Territory.

Given the importance of Specific Purpose fund transfers in financing health, the next section looks at a few important CSS and CS for health.

Centrally Sponsored Schemes for health

Two important CSSs for health are the **National Health Mission** and the **Pradhan Mantri Jan Arogya Yojana**. Both are described briefly below:

National Health Mission

The National Health Mission (NHM) is the Union government's flagship CSS aimed at meeting health requirements by providing accessible, affordable, and quality healthcare in rural India by strengthening health systems, institutions, and capabilities.

In order to provide flexibility to states to meet their needs within the national framework, NHM adopted a flexible financing model. Accordingly, NHM constituted six flexible pools (or flexipools) under which funds were disbursed for specific activities. In principle, states are free to choose activities within a defined pool of funds.

The six flexipools are as follows:

1. Reproductive and Child Health (RCH) Flexipool which funds maternal and child health, family planning, and the Janani Suraksha Yojana (JSY). This now also includes the erstwhile Immunisation Flexipool for financing routine immunisation and pulse polio immunisation, and the Iodine Deficiency Disorders Control Programme (NIDDCP
2. Health System Strengthening (HSS)/NRHM Mission Flexipool (MFP) for untied funds, annual maintenance grants, and hospital strengthening.
3. NUHM Flexipool which addresses healthcare needs of the urban poor with a special

focus on vulnerable sections.

4. Communicable Diseases (CD) Flexipool for financing the National Disease Control Programme (NDCP). This includes programs such as the Revised National Tuberculosis Control Programme (RNTCP), National Vector Borne Diseases Control Programme (NVBDCP).
5. Non-Communicable Diseases (NCD) Flexipool for financing programs such as the National Programme for Control of Blindness (NPCB), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), and the National Tobacco Control Programme (NTCP).
6. Infrastructure Maintenance (IM) funds, which are allotted for paying salaries, capacity building of front line workers and other functionaries, and health facilities.

In addition, since FY 2018-19, NHM has expanded the existing performance-based financing model under the scheme wherein 10 per cent of the earmarked resource envelope for a state was to be disbursed conditional on a state's performance on a set of agreed indicators. This was increased to 20 per cent of the resource envelope in FY 2018-19.

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is a health insurance scheme aimed at providing access to public and private inpatient secondary and tertiary care to poor and vulnerable families, and reducing catastrophic out-of-pocket expenditures arising out of serious health episodes. The scheme expands the previous Rashtriya Swasthya Bima Yojana (RSBY) launched in 2008 and is designed to provide cashless cover to households based on a robust IT system. The scheme is managed by the NHA within the MoHFW and implemented by state health agencies.

PMJAY, however, differs from RSBY by including tertiary care, expanding the coverage amount to ₹5 lakh (from ₹30,000), and extending coverage to more than 10 crore identified target households (irrespective of size). This makes for over 500 million people. For both schemes, funds are shared between the Union government and the states in a 60:40 ratio. For North Eastern Region (NER) states and Himalayan states, the ratio is 90:10. Union Territories are fully funded by the Union government.

Central Sector schemes for health

Pradhan Mantri Swasthya Suraksha Yojana: The scheme was launched with the objective of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and to also augment facilities for quality medical education in the country. It aims to set up government medical facilities and colleges, similar to the All India Institute for Medical Sciences (AIIMS).

Family Welfare Schemes: These provide for Swastha Nagrik Abhiyan (SNA), population research centres, health surveys and research studies, procurement of contraceptives for social marketing and free distribution, training of doctors in no scalpel vasectomy/ recanalisation technique, etc.

Budget execution: Flow of funds from the Union budget to the state budget and autonomous bodies

Pre-2014, there were two ways in which finances were transferred from the Union to the states i.e. the Treasury route and the Society route. Non-Plan transfers like Finance Commission grants were transferred to the states through the Treasury route. However, for several CSSs, independent autonomous societies were created for implementation and funds were transferred by both states and the Union government directly through the Society. As a result, money did not flow through the state budget. From the year 2014-15, even CSS funds started flowing first through the Treasury which were then sent onwards to the Society. This was a move to increase expenditure accountability.

Below is a brief description of these two main mechanisms of fund transfers.

Treasury route

The process of fund transfer starts when the RBI is intimated to transfer the funds to the State government. Once the State government and the State Accountant General (AG) receives a clearance memo from the RBI to confirm the fund transfer, the Finance Department of the state approves and sanctions the budgetary allocation/withdrawal, and the concerned department/agency withdraws funds. The system ensures that the expenditure is routed through the Treasury and is captured by the AG office through vouchers received for the same.

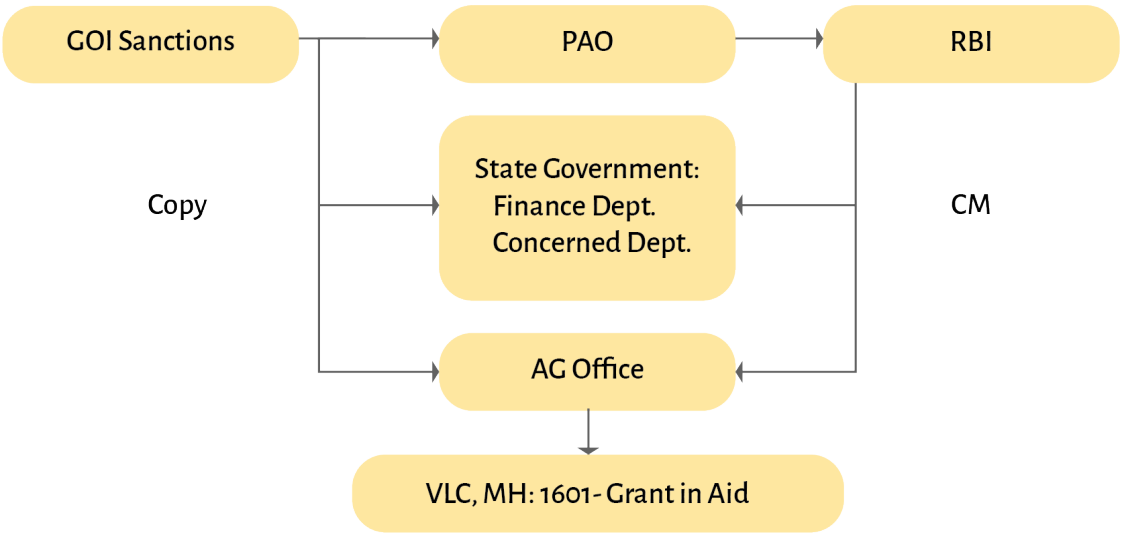
In India's context, state and district Treasury systems form the structure of the public finance machinery within a state. The State government's Finance Department uses administrative control over the whole Treasury Department, which is generally divided into the district treasuries, sub-treasuries, and special treasuries. This is supported by a set of gazetted officers, known as Drawing and Disbursing Officers (DDOs), who have the authorisation to draw bills and make disbursements on behalf of the government at local administration levels. These DDOs are based in the facilities, various districts and the State government's headquarters. The significance of these treasuries can be understood by looking at the annual volume of financial transactions they handle.

Accountability under the Treasury mode accounting system is a robust system that tracks down expenditure to the object level, as vouchers for each transaction are available with the Treasury/AG. The expenditure, as compiled by the AG, goes through a process of validation and is audited by the CAG. However, there are also drawbacks. For instance, the transfer to states by the Union, and to implementing agencies by states is immediately booked as final expenditure regardless of actual utilisation. Moreover, tracking Union releases is also tricky since scheme expenditure is often not disaggregated by components when funds are released. Finally, the lack of uniform fund-flow processes across states, different terminologies and budget heads make it difficult to track fund releases.

Society route

Unlike the Treasury route, in the Society route, once funds are sanctioned and released by concerned administrative ministries, these are credited directly to the bank accounts of concerned agencies i.e. District Rural Development Agencies, Societies, Autonomous Bodies, or NGOs. Till 2014, the agencies to which funds flowed directly from the Union government were PRIs, ULBs, societies/autonomous bodies at state level, central autonomous bodies, NGOs, etc. Collectively, these bodies are known as Implementing Agencies (IAs). Funds are released by these first-level recipients to their constituents at the district, block or Gram Panchayat levels.

Figure 3.1: Release of Funds through State Budget (Treasury Route)



Source: Report of the High Level Expert Committee on Efficient Management of Public Expenditure, GoI 2011. Available online at: https://niti.gov.in/planningcommission.gov.in/docs/reports/genrep/rep_hle.pdf'.
Note: CM: Clearance Memo; PAO: Pay and Accounts Office; RBI: Reserve Bank of India; AG: Accountant General ; GoI: Government of India; VLC: Voucher level computerisation; MH: Major Head.

The Society mode has been stated to have several issues. First, the expenditure is monitored by the concerned Union ministry/department and the audit is conducted by chartered accountants. Second, in contrast to the Treasury mode, the tracing of fund release and utilisation ends at the state level and actual release and utilisation information till the last mile are maintained by the autonomous societies separately.

Fund-flows for CS vary based on the size of the specific scheme. For instance, if the CS scheme's annual outlay is more than ₹500 crore and does not involve state agencies, it can be implemented directly to the level of the beneficiary or vendor account from the Union government level. However, if there are other agencies at the state level who are involved, the concerned ministry/department needs to designate an autonomous body to implement the scheme who in turn may transfer funds to implementing agencies. For CS schemes with an annual outlay of less than ₹500 crore, the implementation can be through scheduled commercial banks (GoI, 2022).

For the purpose of tracking CS and CSS funds, the Union government has implemented the Public Finance Management System (PFMS) which is a web-based online application to help tracking and monitoring fund-flows and expenditures under CS schemes and CSSs by implementing agencies, including Finance Commission Grants. From October 2017, GoI has made it mandatory to use PFMS for all such schemes. This should make the tracking of health expenditure across states easy. Unfortunately, however, the PFMS is not publicly available.

In 2021, as part of PFM reform, the Finance Minister announced the launch of a Single Nodal Agency (SNA) Dashboard. Under the revised model, each state recognises and designates SNA for every scheme and thereby all funds for the state in a specific scheme will be attributed to this bank account, and all expenditures will be done by all other Implementing Agencies engaged from this account.

The dashboard is meant to allow tracking fund releases, disbursement, and monitoring for CSSs. Through greater visibility of funds till the last mile, the SNA model allows for greater efficiency in CSS fund release, utilisation, tracking of funds, and eventually a pragmatic and just-in-time release of funds to states, which is expected to contribute to better cash management of the government.

Details of fund release process for two key CSSs: NHM and AB-PMJAY

Process as envisaged by NHM

NHM advocates an annual, decentralised, and aggregative planning and budgeting exercise to determine the targets and resource requirements for implementation. Each state is obligated to prepare its State Programme Implementation Plan (SPIP) by aggregating individual district plans, which themselves are to be an aggregation of their respective Block plans. But Block plans are not prepared in many states. Also, while the recommended process requires planning to start at the village level, this is rarely implemented in practice.

The SPIP includes the amounts proposed by the state under various budget heads. These are then submitted to the MoHFW for appraisal and approval. These are appraised during National Programme Coordination Committee (NPCC) meetings, following a discussion between officials from the State and Union governments. Once approved, these are known as Record of Proceedings (RoPs). Till FY 2021-22, RoPs were made for each year. However, for FY 2022-23 and FY 2023-24, a combined RoP has been prepared.

NHM funds continue to flow from the Union to the facilities through several intermediaries.

Union government to State Treasury

The process described here is post FY 2014-15, wherein funds are first transferred to the state Treasury which in turn disburses the funds to the SHS. With the introduction of the Single Nodal Account (SNA), at the start of a financial year, the Ministry is to release up to 25% of

the amount earmarked for a state for a CSS. Subsequent instalments also require the release of the stipulated state share and utilization of at least 75% of funds released (Department of Expenditure, 2021). Once the State Treasury receives funds, it is expected to deposit its matching contribution within 15 days.

At the state level, funds are released from the State budget in the form of Grants-in-Aid. A government order has to be issued towards this release by the State government, following which a DDO in the Health Department withdraws funds from the State Treasury and releases them to the SHS.

NHM has directed states to maintain their NHM funds in a three-tier system. Funds from the Union government are credited to the SHS Group Bank Account (Tier 1), following which funds are transferred to the Flexible Pool accounts (Tier 2) and then to the Programme accounts (Tier 3). The Union's share is meant to be released in May and October.

SHS to District Health Societies (DHS)

After retaining some share for its own expenditure, the SHS disburses funds directly to the bank account of each programme at the District Health Society (DHS). According to the guidelines, the releases made to districts should be as per the approved District Health Action Plans (DHAPs) after adjusting for unspent balances from the previous year. States are meant to release funds to the districts within 15 days of receipt of funds from the Union government. For this purpose, some states like Bihar prepare a detailed disbursement schedule (like the state ROP) where allocations for each programme and budget line are split across districts based on the approved DHAPs. Others do not follow this process.

DHS to Facility

At the district level, a part of the funds earmarked for district expenditure is segregated and the rest is released onwards. For instance, funds at the district partly flow from the DHS to district administered hospitals and programs, with the remaining amount being released to the Block. Funds from the Block office flow to Block-level facilities such as Community Health Centre (CHC) and Primary Health Centre (PHC). At times, CHCs can also intermediate in the fund-flow to PHCs, SCs and Village, Health, Sanitation, and Nutrition Committees. (VHSNCs). Each intermediation also entails procedural formalities which tend to vary in each state. Districts are meant to release funds immediately after receipt from the SHS to the blocks and similarly blocks to the implementing units.

Fund-flows for AB-PMJAY

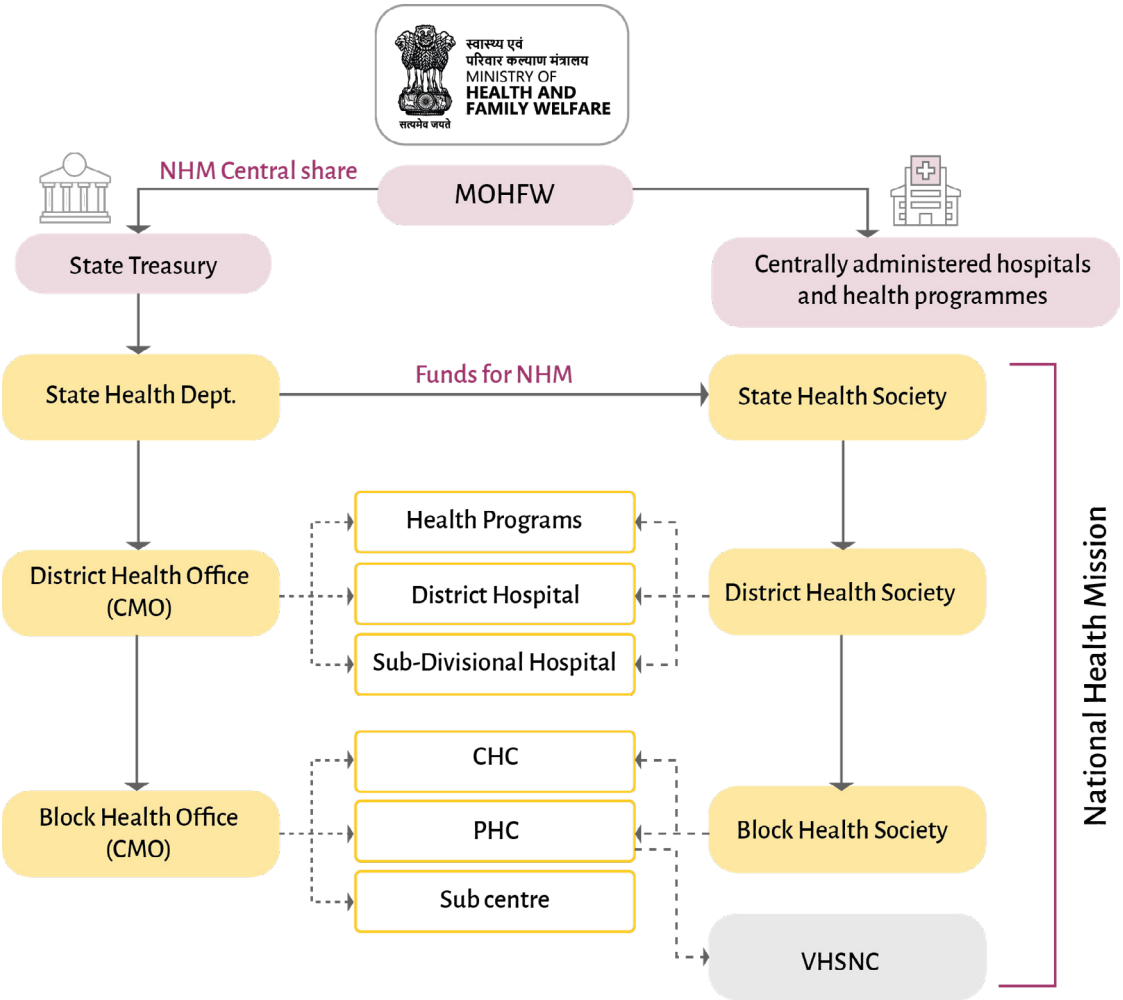
AB-PMJAY is demand-based, and funds flow based on claims made to empanelled hospitals. However, a notional allocation is made in the Union budget based on an estimated premium per household (originally ₹1,052), and the Union government does not co-finance expenditures if they exceed this limit (states must fully cover any difference).

Funds released (including premiums and administrative expenses) are deposited in designated escrow accounts of both Union and state governments. While state governments

are to release their share of the premium in advance, the Union government must release it within 21 working days from the receipt of a completed proposal from states. Upon receipt of GoI's share, states are to release funds to implementing agencies and for reimbursement of medical claims within timelines that are indicated by the Government of India.

For states implementing AB-PMJAY in Trust Mode (i.e. no insurance company) or states implementing AB-PMJAY in Mixed Mode with regard to Trust Component of Mixed Mode: Grant-in-Aid are released, preferably in two tranches of 50 per cent each (around the month of May and October), subject to proportionate upfront release of the state share and utilisation of earlier released Grant-in-Aid, if any. The annual payable Grant-in-Aid in case of Mixed Mode is computed for the premium payment as per the applicable insurance contract signed between SHA and the insurance company. Further, the computation of payable treatment cost of NHA's Share-for-Claim payment under Trust Mode will be done from the leftover funds with revised beneficiary base (excluding null data records).

Figure 3.2: NHM Release Framework



Source: Adapted from NHM guidelines and circulars detailing stages in fund-flows. Note: CMO stands for Chief Medical Officer; BMO for Block Medical Officer; CHC for Community Health Centre; PHC is Primary Health Centre; VHSNC is the Village Health Sanitation and Nutrition Committee.

Chapter 04

Analysing Health Budgets

Highlights:

1. There is no single, comprehensive database of budgets for health-related schemes that exists. Thus, for a detailed budget analysis and given the lack of standardisation across budget formats in states, it is critical to look at multiple documents to understand the range of the budget.
2. Information may be available for the same datapoint across multiple documents. However, it is advisable to use the same data source. The most reliable data sources are state budgets and finance accounts, as they are audited by the CAG, but these numbers are available with a two year lag. For schemes, detailed analysis is only possible via scheme specific documents such as Record of Proceedings for overall NHM approved budgets and Financial Management Reports for NHM expenditures.
3. Analysing MoHFW budgets to estimate overall allocations or spending on health is not sufficient for identifying and collating health budgets and expenditures. Because several other departments are engaged, it is necessary to go beyond health-related major heads. A full analysis preferably requires scanning across multiple major heads till the minor level to comprehend the entire amount of money spent on or allocated for health.
4. Understanding and analysing municipal budgets is critical, yet municipal budgets are rarely made public, and there is little standardisation across municipalities, making analysis difficult.
5. Health expenditures analysis can be done by economic classification, for doing so there is need to look at object head level data and NHM detailed FMR by budget line items. It identifies expenditure incurred in form of salaries, capital expenditure, interest payment, etc.
6. The health budget can also be analysed by level of care (primary, secondary, and tertiary) using the NHSRC budget tracking toolkit.
7. It is also possible to analyse the equity of health expenditures in the context of specific groups, such as tribal populations. One method is to conduct a tribal-sub-plan (which mandates spending for tribal communities) analysis using detailed demand for grants under the state budget,

The previous chapters introduced the key budget building blocks and gave an overview of inter-governmental fiscal flows. This chapter provides guidance on how to analyse health budgets to answer a range of policy and health financing questions.

Budget analysis and review helps us understand how the government plans to implement programs from both receipt and expenditure perspectives. It explores the degree of (mis) alignment between public policy, stated objectives, and real goals. This is especially important in the health sector in view of its importance to the common citizen. Budget analysis also helps explore the efficiency and equity of public policies, programs, and expenditures. There are numerous ways by which one can analyse budgets, and selecting a specific approach depends entirely on the objective and purpose of the analyses. Five key methods of analysis are mentioned below:

First, budgets help examine overall government health priorities. Allocations for a particular sector or scheme or even a particular group (tribes, minorities, etc.) can be benchmarked against total funds allocated for a given financial year or even as a proportion of the gross domestic product (GDP). Often priorities stated either in electoral promises or finance speeches can be compared with the actual proportion of money allocated to a specific sector or scheme.

Second, similar analysis can also be done within the health sector to evaluate both prioritisation within the sector and the changes over time. This can help identify the extent to which, for example, primary care is prioritised and how those priorities have shifted over time, using time series data.

Third, the efficiency of spending can be analysed — how the money was spent, was it spent the way it was planned, did inputs correspond to outputs, and so on. This can include budget execution, or the (in)consistencies regarding the amount of allocated funds versus revised and actual expenditures.

Fourth, analysing adequacy or the extent to which the allocations made are related to the needs on the ground or the total costs to cover all eligible citizens under the programme. One essential concern while budgeting is equity both based on geography as well as from the viewpoint of marginalisation and exclusion. The analysis responds to whether the funds allocated or spent under any sector are adequately distributed - across geographic regions and populations.

Fifth, analysing outcomes helps evaluate the progress and accomplishments in a specific sector. It helps analyse the government's commitments and evaluates the progress over time in the respective sector/sectors. It links budgets with outputs and outcomes and thereby supports the examination of return on investments.

While each of these methods can be applied, in practice there are challenges in undertaking these analyses due to the way health budgets are designed. This chapter looks at some of these challenges in greater detail and proceeds to provide tips on how to undertake different types of health budget analysis. The contents of this chapter are structured in a question-answer template to make it useful for practitioners. There are 25 questions structured

under four categories: (a) preparing for budget analysis; (b) identifying and collating health budgets and expenditures; (c) analysing health expenditure; and (d) equity of spending.

PREPARING FOR BUDGET ANALYSIS

What are the budget and expenditure documents that I need to have before starting any analysis?
Should I use data from different sources?
Is the Demand for Grant a reliable source for expenditure in major CSS such as NHM and AB-PMJAY?
I am undertaking analysis in June 2022. Can I get audited expenditures for FY 2021-22?

IDENTIFYING AND COLLATING HEALTH BUDGETS AND EXPENDITURES

How should I calculate the total health budget and expenditure?
How do I identify scheme allocations and expenditures?
Can I study local government budgets?
Can I analyse constituency-wise budgets?

ANALYSING HEALTH EXPENDITURE

How should I analyse health expenditures by economic classifications?
How should I analyse health expenditures by levels of care: primary, secondary, and tertiary care?
How should I determine capital investment for health?
How should I unpack fund-flows from the Union government versus states' own expenditure?
Will using assumptions in CSS's centre-state ratios be accurate?
How should I calculate health budget utilisation rates?
How should I interpret and understand NHM expenditure?
How do I analyse health budgets by districts?
How do I analyse budgets by levels of health facilities?
What are the challenges in an inter-state comparison of health budgets?
Are there any constraints in time series analysis of expenditure data?
Can I compare BE, RE and Actuals?
Is it possible to assess spending with reference to outputs and outcomes?
Do all states produce Outcome Budgets? Are they reliable?

BUDGETS FROM AN EQUITY PERSPECTIVE

How do I determine budgets by specific population groups? Say tribal communities
The Union and some state governments produce Gender Budget Statements. What are they and how can I use them for health budget analysis?
The Union and some state governments produce Child Budget Statements. What are they and how can I use them for health budget analysis?

Preparing for budget analysis

1. What are the budget and expenditure documents that I need to have before starting any analysis?

While the answer to this depends on the scope and scale of your analysis, let us assume that a comprehensive review and analysis of the overall government health budget and spending is planned. The following documents are required:

Table 4.1: List of documents required for Budget Analysis

No.	Document	What does the document contain?	Where can I access the document?
1	Demand for Grant for Health & other related departments	BE, RE and Expenditure data	Usually on the Finance Department website. Few states like Tamil Nadu have a separate portal for their budget.
2	Annual Financial Statement	BE, RE and Expenditure data for all government accounts (including all departments)	Usually on the Finance Department website. Few states like Tamil Nadu have a separate portal for their budget.
3	NHM PIP	Project implementation plan and detail proposed budget for the NHM	NHM GoI website
4	NHM ROP	Proposed and approved budget amounts for each budget line.	NHM GoI website
5	NHM FMR	Only source for detailed budget line wise expenditure under the NHM.	Not accessible in the public domain, except for Rajasthan. Can be accessed through RTI application.
6	State Finance Accounts	Has details on audited Actual expenditure data and also has a breakup of expenditure for CSSs by centre and states	CAG website
7	State Treasuries	Head-wise real-time expenditure and BEs/ REs. Can also has information by schemes or by Drawing and Disbursing Officers (DDOs)	Usually there is a separate website that has the Treasury data often called IFMS or Integrated Finance Management System. Not all states have this information in the public domain. Some states that do include it are Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Telangana, and Uttar Pradesh (Acharya, 2018).

2. Should I use data from different sources?

> ★ It is advisable to use the same data source across all your analysis rather than using multiple data sources.

As far as possible state budgets and finance accounts are the most reliable data source as the same are audited by the CAG.

There are differences across different data sources specifically with respect to the quantum of expenditure incurred on CSSs. As can be seen in Table 4.2, a comparison of NHM expenditure in 2019-20 for Andhra Pradesh, Bihar, and West Bengal from five different sources which include data from Finance Accounts, State Budget, NHM FMR (audited), Parliament question, and RTI, found significant mismatches.

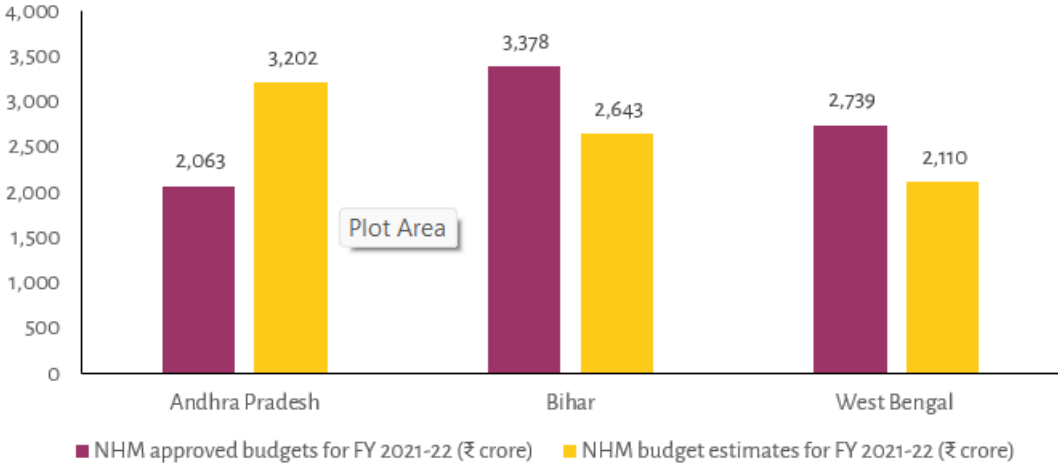
Table 4.2: As per Finance Accounts State Budget, NHM FMR (audited), RTI, Parliament question Expenditures in 2019-20 (in ₹ crore)

State	Finance Accounts	State Budgets	NHM FMRs	Lok Sabha	RTI
Andhra Pradesh	1,253	1,253	1,320	1,820	1,332
Bihar	2,283	2,367	2,434	2,842	2,434
West Bengal	2,880	2,667	1,612	2,340	1,612

Source: Compiled by authors from various documents and Right to Information Act responses.

Another challenge with respect to using different data sources are the differences in terminologies. **Approved budgets as given in NHM RoPs or FMRs do not match NHM allocations in state budgets.** For instance, in FY 2021-22, Andhra Pradesh's budget estimates for NHM were 55 per cent more than the budget approved for NHM from the RoPs. Whereas for Bihar and West Bengal, budget estimates were lower than the approved budget for NHM by 22 per cent and 23 per cent, respectively. Using different sources of financial data are generally not advisable and this is a clear example of why!

Figure 4.1: NHM Approved vs NHM Budget Estimates



3. Is the Demand for Grant a reliable source for expenditure in major CSS such as NHM and AB-PMJAY?

No, the Demand for Grants may not always be a reliable source for CSS expenditure. For example, AB-PMJAY funds for treatment may not show in the Demand for Grants, as Union shares of funds are transferred directly to escrow accounts, bypassing the state Treasury. But there are also states like Madhya Pradesh where Grants-in-Aid for AB-PMJAY are reflected under Revenue Receipt and Detailed Demand for Grants as well.

A similar issue arises for NHM. Since funds are transferred out of the Health department via the state Treasury to the autonomous implementing agencies like the State Health Society (SHS), all such funds transferred are treated as expenditure in the Treasury records. In reality, however, these funds may not be spent at the last mile in the same year. This results in large unspent balances with the SHS. Given that funds do carry over from year-to-year with the SHS, it may also mean that previous years' "expenditures" are actually undertaken this year, resulting in higher expenditure shown than allocations or releases.

> ★ Therefore, at the time of analysis, it is important to look at the NHM budget, release, and expenditure data from the SHS accounting records rather than relying on the figures in the health Demand for Grants.

4. I am undertaking analysis in June 2022. Can I get audited expenditures for FY 2021-22?

No, audited expenditures are only available with a lag. While calculating health spending as a percentage of GDP, REs and BEs typically provide a higher figure than Actuals, which are audited and final. For example, in 2019-20 BEs, this figure stood at 1.6 per cent, while it was 1.5 per cent in the REs, and 1.3 per cent in Actuals. This is linked to misestimations of revenues and expenditures in the budget, and this can translate to miscalculations of progress towards targets. Thus, where possible, Actuals and audited expenditures should be used to calculate progress towards targets.

> ★ Until audited figures are available, figures should be taken with a pinch of salt.

Identifying and Collating Health Budgets and Expenditures

5. How should I calculate the total health budget and expenditure?

The first question you should ask is: Am I looking at expenditure on health by the Health Department or expenditure on health by the State government, including health expenditure that may be incurred by other departments?

★ Studying just the budgets of the Ministry of Health and Family Welfare is not sufficient to determine the total allocations or spending on health.

Several other departments are also involved in implementing schemes/programs to attain health-related goals. An indicative list is given below.

Table 4.2: As per Finance Accounts State Budget, NHM FMR (audited), RTI, Parliament question Expenditures in 2019-20

States	Department
Andhra Pradesh	Labour Department
Chhattisgarh	Labour Department
Himachal Pradesh	Scheduled Caste Department, Tribal Welfare Department,
Karnataka	Labour Department
Maharashtra	Tribal Welfare Department, Social Justice and Special Assistance Department and Planning, Public Works Department District-wise Detailed Budget Estimates of Expenditure
Madhya Pradesh	Bhopal Gas Tragedy, Relief and Rehabilitation Department Labour Department
Odisha	Finance Department Labour Department
Telangana	Scheduled Caste Department, Tribal Welfare Department,
West Bengal	Labour Department

A second question is how to find out the health expenditure through other departments?

The first step is to- look at the Annual Financial Statement (AFS).

Usually the AFS lists BEs, REs, and Accounts figures by major heads, and in many state AFS under each major head, you will find the list of department names (or Demand for Grant numbers) through which budgets are allocated for that major head.

But don't look at health-related major heads only. While most health expenditures are under the major heads 2210 (Medical and Health), 2211 (Family Welfare), 4210 (capital expenditure for Medical and Health) and 4211 (capital expenditure for Family Welfare), certain funds released for health are not reflected in these budget heads alone. For instance, some funds are released specifically for health under 2225 which is the major head for Welfare of Scheduled Castes, Scheduled Tribes, Other Backward Classes and Minorities. These health funds are under the minor head 282. Another such major head code is 2235, which is the overall head for Social Security and Welfare. Bihar's AB-PMJAY insurance scheme is booked here under minor head 110.

While most states organise their DFG by line departments, some organise them by major heads (e.g. Rajasthan). The estimation of TGHE should thus include the following major heads though there will be state variations. Major heads other than 2210, 2211, 4210, and 4211 should be included when the budget line explicitly includes reference to a health department intervention aimed at health or family welfare. Illustrative examples from different state DFGs of allocations under the health department are as follows:

- Major head 6210: Loans for Medical and Public Health
- Major head 6211: Loans for Family Welfare
- Major head 7610: Loans to Government servants: Rs 64.43 crores were allocated under this for BE 2022-23 and the total figure under the Public Health Department's DFG would include this as well.
- Major head 2012: President/Vice President/Governor/Administration of Union Territories: Tamil Nadu DFG for Health.
- Major head 2215: Water Supply and Sanitation: Tamil Nadu DFG for Health.
- Major head 2251: Secretariat-Social Services –Maharashtra and Odisha DFGs for Health.
- Major head 2252: Secretariat-General Services – most health department's Demand for Grant will have allocations under this major head. These are for secretariat administrative services and are not treated as health expenditure.
- Major head 2217: Urban Development - Health Sector grants to Municipal Corporations under 15th FC are allocated under this head for Himachal Pradesh.
- Major head 2059: Public Works – usually this code includes expenditure on construction and maintenance of office and other buildings – example, the Demand for Grant for Health and Family Welfare for Himachal Pradesh includes allocations under MC 2059.
- Major Head 2515: Other Rural Development Programs in West Bengal
- Major 2235: Himachal Pradesh that includes medical reimbursement for freedom fighters (2235-60-200-10) under the major head 2235 Social security and welfare

Thus, a complete analysis ideally requires scanning through several major heads till the Minor level to understand the total quantum of money spent or allocated for health.

As mentioned in chapter 2, funds for procurement of capital projects, drugs and consumables, etc. are transferred by the Health department to the agencies entrusted with such a mandate.

For a realistic assessment of expenditure, it is important to identify agencies responsible for such procurement and get their receipt and expenditure statements.

Relatedly, a common mistake is to focus on NHM allocations or expenditure alone. However, in many states NHM forms an important but relatively smaller proportion of the total health budget. For instance, in FY 2019-20, NHM accounted for 31 per cent of the total health budget in Bihar, 25 per cent in West Bengal, and 17 per cent in Andhra Pradesh.

Thus, for a comprehensive picture one needs to look at the entire quantum of funds allocated and spent on health, not just NHM.

It is important to note that expenditure is also spread across levels of government. Apart from the Union and state governments, local governments also spend on healthcare, which should be considered. See question 8 for more details. If the exercise aims at looking at overall health spend, then private expenditure will have to be included as well. This includes money spent by individuals and households (including out-of-pocket), companies and organizations, and donors and charitable organizations. Such complete information is available in the National Health Accounts that the MoHFW publishes periodically. This, however, provides information at the national level only.

National Health accounts has information at the national level on private health expenditure.

6. How do I identify scheme allocations and expenditures?

It is challenging to identify health-related schemes just by looking at the budget code description at the sub-major or minor head level.

> ★ Given the lack of standardisation across states, to identify scheme expenditure one needs to scan sub-minor head (level 4) or detailed/schemes expenditure head (level 5).

For example:

- In Karnataka, NHM scheme expenditure is a sub-component of other expenditure minor heads, categorised under the 'Rural Health Services — Allopathy' sub-major head within major head 'Medical and Medical Public Health' (2210).
- For Andhra Pradesh and Telangana, it falls under different sub-heads such as 'Other Services and Supplies', 'Special Component Plan for Scheduled Castes', 'Tribal Areas Sub-Plan' all of which come under 'Family Welfare' major head (2211).
- There is no NHM in these two states under the major head Code 2210.
- Detailed Demand for Grants in states such as Punjab do not even have scheme level bifurcation for NHM or other schemes.

7. Can I study local government budgets?

Local government budgets are rarely online. Some local bodies have budgets. However, municipal budgets are rarely available publicly and there is no standardisation across municipalities so analysing these is very difficult. It is virtually impossible for Panchayats to make budgets since they don't know how much money is being spent in the Panchayat. The fact is that most money is spent by line departments and Panchayats spend very little, and that they don't know when states will send them funds, if at all.

A study in Karnataka found that 30 Gram Panchayats (GPs) in the Block Mulbagal received ₹6 crore collectively, but state line departments and parastatals received ₹174 crore. Only 3 per cent or 20 lakh was planned and spent by each GP, and the rest by line departments or parastatals. In fact, it is not only that GPs had very limited discretion over funds spent in their area, they also didn't know what these other line departments and parastatals were spending on, as this information is rarely collected at GP level. Even if this information was available, it is rarely shared with GPs (Iyengar et al., 2016).

8. Can I analyse constituency-wise budgets?

There have been some attempts at categorising budgets by constituency, which are not yet in the public domain. This would require Block-wise budget and expenditure data. While Block-wise RoPs are rarely available for NHM, it can, in theory, be done for expenditure. However, this information is not available in the public domain and would need to be individually collected from state governments. In brief, constituency-wise budget analysis is not easily done.

Analysing health expenditures

9. How should I analyse health expenditures by economic classification?

An important question in many health systems is whether there is an input mismatch that is a hindrance to service delivery. For example, staff without drugs, hospitals without staff, or inadequate maintenance. Budget analysis can help explore this issue.

1. The economic classification identifies the type of expenditure incurred, for example, salaries, goods and services, transfers and interest payments, or capital spending.

2. For economic classification, one needs to look at the object head level of data from the state budget. In addition, one should analyse the NHM detailed FMR and pull out relevant budget line items.

   Most of the NHM budget line descriptions clarify the nature of expenditures (salaries or transport or drugs, etc.). The state budget and the NHM estimates for each such economic category have to be added to arrive at realistic estimates by economic classification. The latest NHM major line items follow the six components of NHM mentioned in chapter 3. Things like human resources, however, are spread across components. For instance, human resources are a part of Health System Strengthening separately for urban and rural areas. While undertaking this aggregation exercise, to avoid duplication, one must remove all NHM related budget lines from the Demand for Grant. See Appendix Table 2 for more details on NHM classification.

3. Each state government has its own object head classification structure and this is usually available in the state budget manual.

4. Using details of object head, the items under revenue expenditure can be classified as wage and non-wage revenue expenditure.

5. For analysing wage and non-wage expenditure: For this, one can pick out all the object heads that are salaries to arrive at the wage component under an activity/programme/function. Similarly, the non-wage components can be categorised by examining the items of object heads individually. Wage components include expenditure on salaries, travel expenses, wages, and allowance, whereas all other object heads are considered non-wage. Both wage and non-wage components, when added up together, provide the total revenue expenditure under each activity or programme or functional areas (Salaries, Monitoring and Evaluation, Drugs and Consumables, Administration, etc.). Remember to check the NHM FMR for budget lines under the NHM that have similar expenditure items.

Note: It is generally desirable to have an adequate share of non-wage components so that there are enough resources for drugs and consumables at sub-centres (SCs), primary health centres (PHCs) and community health centres (CHCs). In comparison, a higher wage component would mean that the health sector is spending a substantial chunk only to meet the salary requirements of the personnel such as doctors, other staff.

10. How should I analyse health expenditures by levels of care: primary, secondary, and tertiary care?

1. The Budget Tracking Toolkit published by the National Health System Resource Centre (NHSRC) can be used for classification of health expenditure into primary, secondary, tertiary, etc. based on accounting codes (NHSRC, nd).

2. Using the example from Rajasthan's health budget, the NHSRC toolkit tries to present a methodology to classify sub-minor head descriptions into levels of healthcare (primary/secondary/tertiary/administration).

3. There are three important things to note while using the NHSRC budget classification.

   a. First, there is an element of subjectivity associated with the classification given the challenges of how budget codes themselves are structured. For instance, all NHM expenditure under the toolkit is booked as Primary Healthcare. While NHM plays a vital role in facilitating access to primary healthcare, it also has components such as secondary and tertiary care programs and Human Resources for Health and Medical Education which are not a fit for the primary care category.

   b. Second, since the toolkit uses the Rajasthan health budget, it isn't always possible to classify expenditure across states using the same methodology given the lack of standardisation in budget formats. As previously mentioned, there is no standardised format that is maintained by states at the sub-minor head level and even minor heads may have differences. For example, in Madhya Pradesh and Chhattisgarh, sub-minor heads only state if the budget item is general, tribal sub plan, scheduled caste sub plan or it is CSS, or state plan. Thus, one would still need to look at the detailed description, to classify expenditure items into primary, secondary, tertiary, etc.

   c. Third, for some schemes, even the descriptions are not self-evident. For example, the Chief Minister Maternity benefit Scheme, NHM, Ayushman Bharat, Atmanirbhar Swasth Bharat Yojana, CM Health Insurance Scheme, etc. do not tell us enough to know how the scheme can be classified. Thus, this would require spending some time to understand the state-specific health sector schemes.

11 How should I determine capital investment for health?

1. One would think a breakdown of expenditure into revenue and capital would be easy, especially since you have in the Accounting classification clear demarcation by code of Revenue (major heads 2210 and 2211) versus Capital (major heads 4210 and 4211). Unfortunately, it is not straightforward.

2. All money that is given as a Grants-in-Aid including CSS is booked as Revenue expenditure, even if it is for building a capital asset. Thus, for instance, the entire NHM expenditure would be booked as revenue expenditure in the Union budget. However, there are clearly items in the 2022-24 NHM RoPs that are for the creation of assets. These include the repair and renovation of facilities for newborn care, equipment for various types of care and treatment, etc. These should ideally be booked as capital expenditure.

3. Moreover, even terminologies can be confusing at times. For instance, NHM has a line item called infrastructure maintenance — in reality this is not for physical infrastructure but actually to meet salary, capacity building, and facility-related needs within the NHM.

4. A proper classification of revenue and capital expenditure thus requires either going into the details of the nature of expenditure or ensuring adequate caveats to account for this subjectivity in classification.

★ Dont just go by revenue capital classification in the state budget. Look at the details of the nature of expenditure.

12. How should I unpack fund-flows from the Union government versus states' own expenditure?

1. There are several sources of funding for health — including CSS, State Plan, Central Assistance, and Grants under Article 275(1) of the Indian Constitution.[5] Since money is pooled into the Consolidated Fund, determining the source of funding within the state budget is difficult. In the case of CSS and state plans, sources are to some degree identifiable via coding patterns across states and their descriptions. But for Central Assistance and Grants under Article 275(1) for health or any other department, such identification is difficult.

   To get a break-up of health expenditure across two broad sources, a breakdown of CSS expenditure is needed as it is shared between Union and state governments.

[5]Article 275 (1) covers grants from the Union to certain states, charged on the Consolidated Fund of India for the purpose of promoting the welfare of Scheduled Tribes in that state or improving the level of administration in Scheduled Areas.

Some state budgets in India provide a break-up of CSS expenditure into Union and State government shares since funds are released to the implementing societies created for each scheme, through the state Treasury route. Once funds reach the implementing society's account, they are then spent from a common pool. As a result, not all states maintain separate records for expenditures corresponding to the amounts released by the Union government and the state and it becomes difficult to distinguish between the expenditures.

13. Will using assumptions in CSS's centre-state ratios be accurate?

Using assumptions on CSS ratios does not always work. For CSS, Core Schemes are funded by the Union and State government based on the ratio of 60:40 for general category states, and for the 8 North-Eastern and three Himalayan states, the ratio is 90:10. But, in practice these ratios differ, with the differences mostly driven by state shares.

For instance, in FY 2018-19 and 2019-20 for Rajasthan under NRHM, around 50 per cent of expenditure came from state fund expenditure, whereas in FY 2020-21, only 32 per cent came from state fund expenditure. Similar trends can be seen in Haryana. In FY 2018-19 and FY 2019-20, around 50 per cent of NHM expenditure came from state funds, whereas in FY 2020-21, about 60 per cent of expenditure came through state sources. This is partly due to the fact that since expenditure for CSSs are carried over from previous years, expenditure incurred in a given year could include unspent balances from previous years. For some schemes, states also put in additional shares to increase coverage under the scheme. Differences also arise due to delays in release of money or because of a failure to submit utilisation certificates to GoI or other procedural delays at different levels.

Finance Accounts provide some details: Since assumptions of the fund sharing ratio aren't always accurate, a useful data source to determine centre versus state finances for health are the Finance accounts of different states certified by the CAG. For many states, they provided a breakup of Union and states shares for CSSs (which may also account for unspent balance).

Finance accounts provide some details for many states on the breakup of Union and state shares for CSSs

14. How should I calculate health budget utilisation rates?

A common focus of budget analysis is to compare actual expenditures with the original budget. Many health systems struggle to spend the full quantum of resources allocated each year, for many reasons including late fund release from the Treasury, slow procurement processes, weak capacity to follow budget rules in a timely manner, or other reasons that cause poor fund absorptive capacity.

1. For the Treasury route (state budget), the utilisation can be presented as the share of actual expenditure to the original Budget Estimate. This ratio shows how credible the Budget Estimates are. However, if you want to find the utilisation for the most recently completed financial year, you may use the share of Revised Estimate to the original Budget Estimate as the Actual expenditure will be available only with a lag of two years.

2. Looking at Actual expenditures for a particular scheme or component such as NHM and comparing this with funds available provide some useful insights.

   Actual expenditure under a scheme is typically available only from the scheme's financial management reports. NHM budgets are usually divided into committed and uncommitted unspent money. Committed unspent funds refer to expenditures for activities approved during the previous years which are under implementation, while uncommitted funds refer to the activities approved during previous years but not yet undertaken. Committed amounts can be found in the RoP.

3. For schemes, expenditure can be looked at in three ways: a) expenditures as a proportion of approved budgets; b) as a proportion of total budget available; and c) as a proportion of funds available.

4. Approved budgets (under the NHM) don't account for committed liabilities, and therefore utilisation against NHM approved budget might be an overestimate. Approved budgets and the total budget available don't account for money that is actually released to states. It is possible that the budget is high, and expenditures are low if funds aren't released to states, for whatever reason. Fund release data for some schemes like NHM is available and can be compiled through sanction orders (available here for NHM). Aggregated data may not always be available, especially for state shares.

5. Thus, the best indicator of spending under schemes is the proportion of expenditure out of funds available, which account for funds that are with the state at the start of the financial year, and funds released.

   This accounts for all the funds that a state department has at its disposal to spend and bank interest accrued. The authentic source for expenditure and funds available

within a financial year is the statutory audit reports of the implementing agencies that are not available in the public domain. Data on state releases for CSSs like NHM are available via sanction orders, but are not always available in the public domain.

6. While a significant part of the problem of low utilisation is due to state capacity and administrative inefficiencies, a simplistic explanation also lies in the peculiarities of government planning, budgeting, and fund-flow cycles. This brings us to our next question.

15. How should I interpret and understand NHM expenditure?

The NHM is the single largest component of Union government expenditure on health, and a major source of funds for states to strengthen health outcomes. Analysing NHM budgets and expenditures is often a key priority, but there are many challenges in doing so.

1. The single most useful document for determining state and union NHM priorities to some degree are the RoPs.

Since RoPs contain both the proposed and approved budgets, the differences between the two give a sense of these centre-state differences. For details on expenditures, the only source are FMRs. These, however, are not in the public domain and thus need to be collected. One of the means of gathering such information is by filing requests under the Right to Information (RTI) Act, 2005.

2. Under NHM, states have a large number of line items and sub-components to choose from, that reflect their needs and plans to spend. These are reflected in the SPIP, mentioned above. Each item is discussed in the NPCC, and final approvals are listed in the RoP. The extent to which state proposals and thereby their needs and priorities are accepted can be determined by comparing the proposed and approved budgets. This comparison also tells us how much the NPCC amends budgets, if one compares components. This analysis can also indicate the extent to which states have the flexibility to implement their own state-specific plans and the extent to which states can negotiate these with the Government of India.

3. NHM allows for more detailed component-wise analysis.

As previously mentioned, the availability of detailed documents under NHM allows for a more thorough analysis of NHM budgets. For instance, component-wise approved budgets and expenditures highlight which components are prioritised in the NPCC meetings, where there is representation from Union and state governments. Just remember though to not just go with the NHM classification, but to also look at the line item wise details. Studying component-wise trends in NHM provides a window into cross-state priorities.

4. The merit of looking at NHM details also comes from the fact that a bulk of regular state health expenditure (excluding CSS) is on salaries and wages, leaving little else to study. An analysis of public spending by detailed heads in 2016-17 suggested that overall, a higher share (which accounted for more than two-third of expenditures in the state, other than NHM) of public expenditure was tied to payments to employees in the form of salaries, wages and medical reimbursement (Chaudhary and Dubey, 2020).

5. Other useful NHM documents include the FMRs as mentioned above and **Statement of Expenditures (SoE)**. SoEs are annual statements of expenditures under different heads. They are generated at the sub-district levels — for Blocks, Community Health Centres (CHCs), Primary Health Centres (PHCs), etc. These are then compiled at the district and state levels.

6. NHM also has a **Statement of Fund Position (SoFP)** which provides details of the opening and closing balances of cash and bank deposits along with funds received and expenditure incurred for a particular period under various heads. These are meant to be generated by both the State Health Society (SHS) and the District Health Society (DHS) on a monthly basis. SoFPs are required to be submitted with the FMRs and duly reconciled with them. The SoFP thus provides a consolidated tracking statement of the fund-flows and expenditure.

7. Finally, **Utilisation Certificate (UC) and Audited Balance Sheet** are a final certificate of expenditure of the grants received during the year. They are meant to give a descriptive account of the nature and purpose of the grant sanctioned, along with the actual spent and unspent balances. All Grants-in-Aid sanctioned and released by GoI to the SHS in a particular financial year are indicated in the UC of that financial year. UCs are produced at all the implementing levels. At the end of the year, detailed balance sheets are audited by Chartered Accountants.

16. How do I analyse health budgets by districts?

India's 700+ districts have an average population of almost 2 million people, and this "third tier" of government is a growing focus in the policy landscape. The 15th Finance Commission recommended significant funds for both rural and urban local bodies, and NITI Aayog has initiated programs with a strong district focus. In this context, understanding district health budgets could offer important insights. But this is not easily done.

District' budgets don't really exist. The district administration is absolutely vital in India with the district magistrate or collector being a linchpin for the administration of programs. Therefore, studying district budgets is essential as well. Despite the importance of the district administration, most states don't have a district budget except for Maharashtra (known as district books) and Karnataka (division-wise budgets). So, what can be done?

1. Treasury data can provide some estimation of district-wise expenditure.

The only way to estimate district expenditure overall is through the treasuries (district or sub-treasuries) and district autonomous implementing agencies or societies. There are multiple DDOs in a district. One thus requires information on which DDO pertains to which district to be able to map expenditure to districts. Health expenditure estimation at the district level thus requires collating DDO wise information under each budget head and can be used to derive more precise estimates of public spending

Not all Treasury data, however, is online. As of 2018, though 10 states provide access to Treasury information in the public domain which include states such as Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Telangana and Uttar Pradesh (Acharya, 2018).

2. CSS funds may need to be added separately.

It is also important to note that not all CSS money is reflected at district level and below in disaggregated form — this means that at the district level or below, one can't specify whether money was used to buy books or repair a school building or build a health centre. Funds from Member of Parliament Local Area Development or MPLAD and Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) often get excluded from state budgets and state treasuries but show up directly in district treasuries as the money is routed directly to district without booking it at the state-level. Thus, getting accurate district estimates may require adding in district-wise scheme data.

3. **A lot of the expenditure is booked centrally and does not flow through to state budgets.** For instance, drugs are often procured centrally either by the Union government and sent to states or by states who send them forward to districts. Even at the DDO level, centralised state procurement would reflect in the expenditure under specific DDOs in either in the capital city or divisional headquarters thereby making it appear that that district has undertaken a lot more expenditure, which isn't the case. For instance, if a state procures stethoscopes and distributes them across districts, the expenditure will show up only in the specific DDO where the procurement occurred. Ideally, one would then need to identify and apportion this centralised expenditure across districts.

17. How do I analyse budgets by levels of health facilities?

A common question for health budgets is how much is spent on primary care – where health interventions are more likely to be cost-effective – compared to hospital care, which can help mitigate the financial consequences of high-cost health episodes. A

granular analysis can help in the examination of primary, secondary and tertiary care. However, existing budget structures are not conducive to doing so.

1. There is no one single facility-level comprehensive plan and budget. The budgets are fragmented by financing streams and schemes (like the NHM, state budget).

2. In rural areas, these are Sub-Centres (SCs) at the lowest level; above which are Primary Health Centres (PHCs), and Community Health Centres (CHCs). Correspondingly, in urban areas, there are urban PHCs and urban CHCs. Then there are Sub-Divisional Hospitals (SDHs), which are the First Referral Units for SCs, PHCs, and CHCs (which may also function as FRUs in certain areas). For higher levels of care, there are District Hospitals and Medical Colleges. Budgets for these facilities can indicate amounts being spent on primary, secondary, and tertiary care.

3. It is extremely challenging to estimate a health facilities budget and expenditure, except for large state-level general or specialty hospitals or teaching hospitals or autonomous medical institutes. The challenges are on account of:

    - Not all expenditure for the health facility is incurred at the facility level.
    - For example, in most states salaries are disbursed centrally and facilities only submit monthly payrolls. Most of the medicines, consumables and supplies are centrally procured at the state level.
    - Many a time, we see huge backlogs in payment of electricity bills as bills are either not generated in time or there is a shortage of funds.
    - Repair and maintenance of civil infrastructure is either handled by the PWD or through agencies procured by the health department either at the district or the state level.

4. Some line items in state budgets and NHM indicate clearly which facility a particular item is targeted towards, but this is unclear for others. For example, the FMR line item "Operationalization of 24-hour services at PHCs" is clearly for Primary Health Centres. However, it is unclear which facility "Other construction/ Civil works" is aimed towards.

In brief, facility-wise budget analysis can be very challenging.

18. What are the challenges in an inter-state comparison of health budgets?

State-wise comparisons of health budgets are among the most common priorities for analysts, but some caveats should be considered before attempting to do so.

1. Any accurate study of health finances requires time and patience. In the six-level classification of accounts, while budget heads are relatively standardised till the minor head level, i.e. most states follow the same coding and classification under health, several differences come up below the minor head. For example, in Madhya

Pradesh and Chhattisgarh, Special Component Plan for Scheduled Castes and Tribal Area Sub-Plan is classified under the heads 0702 and 0703 whereas for the majority of states it is under 789 (Special Component Plan for Scheduled Castes) and 796 (Tribal Area Sub-Plan).

2. Moreover, budget structures vary across states in terms of different languages or formats. For example, in states such as Madhya Pradesh, Bihar, and Chhattisgarh, budget documents are in Hindi only and published in PDF format. In the case of Bihar, several PDF documents are scanned, which makes converting them into machine readable formats tougher. Odisha and Sikkim stand out. In Odisha, documents are available in both English and the regional language (Odia), and in both PDF and excel formats. In Sikkim too, Excel workbooks are available for most documents.

3. Differences also exist in how this information is organised. For instance, instead of detailed Demand for Grants, Haryana classifies expenditures by Revenue and Capital expenditure heads. Similarly, Rajasthan goes a step further by classifying Revenue expenditure in general, social, and economic services.

4. Thus, collating health finances across states requires spending some time to understand the data structure format, and may often require us to go down till the 5th accounting head to ensure comparability across states.

19. Are there any constraints in time series analysis of expenditure data?

Several caveats should be considered when attempting to analyse budget trends over time. Among the most important are as follows:

1. When comparing allocations and expenditure trends, it is important to remember the changes in fund-flows mentioned in Chapter 3. These changes mean that analysing health expenditures time trends prior to 2014 is complicated.

2. Since money for CSSs were routed off-budget, these are not reflected in state budgets prior to 2014. For comparability then, they would ideally need to be included but there is no one clear data source for the same.

3. Since funds for CSS like NHM are pooled into a 'revolving' fund, expenditure incurred in a year can be based on allocations for the previous year and unspent funds, and not necessarily funds only for the current fiscal year.

4. For states too, budget formats do change year on year, though not frequently. The removal of the plan and non-plan distinction in 2017 for instance, meant significant

changes in reporting styles of budgets across states. Once in a while, states may change the object code number and one should be alert to this possibility especially when undertaking analysis over longer time periods.

5. Most studies on time trends have thus looked at changes in health budgets from 2014 onwards to ensure comparability. However, in case you do need to look at it prior to 2014, funds routed directly to key CSSs like NHM would need to be added back for comparability. A useful source for this are the Finance Accounts which are audited expenditure, and thus provide the most accurate estimation of expenditure.

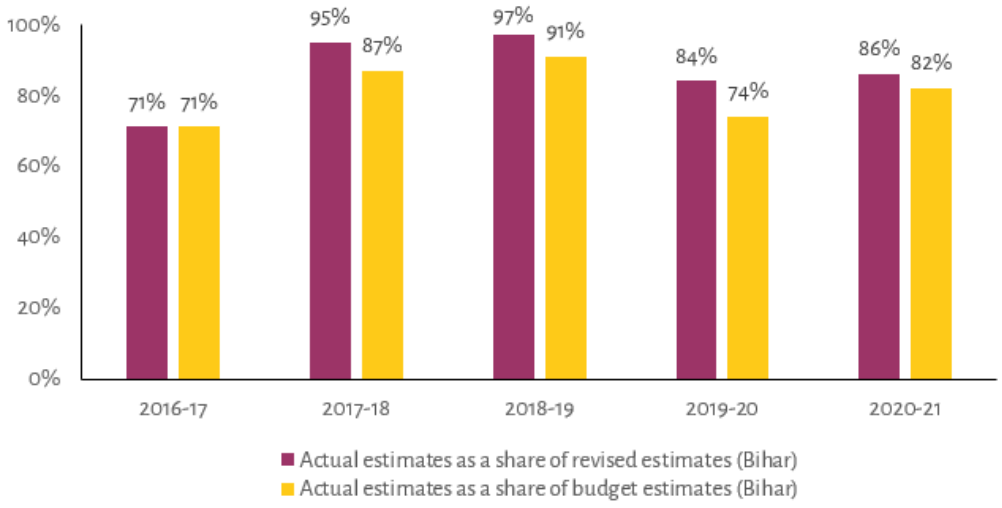
20. Can I compare BEs, REs, and Actuals?

As described earlier, budget documents include budget estimates (BE), revised estimates (RE), and actual expenditures. A comparison of these numbers within a specific year or over time can yield valuable insights related to overall budget performance, but some caution is also warranted. As always, it is important to be clear about the analytical objective and major caveats.

BEs reflect the original budget policy intent, while actual expenditures present reality, and therefore the gap between them is of interest. REs offer an update of BE during the interim period when actual expenditures are not yet available. For the reasons mentioned earlier, actual expenditures may only reflect when resources were transferred from the Treasury system to a state health society.

Nevertheless, a comparison of Actuals with BEs available in the state budgets can give a sense of expenditure capacity. For instance, actuals for the Health Ministry were lower than the REs between FY 2016-17 and FY 2020-21. This gap is even more acute for some states. For instance, in Bihar for the health sector, only 86 per cent of the BEs were spent in FY 2020-21 and 84 per cent in FY 2019-20. When compared with REs, the gap was at 82 per cent and 74 per cent, respectively. Many states exhibit similar patterns.

Figure 4.2: Differences between BEs, REs, and Actuals



However, since actual expenditure data are released with a two year lag, as mentioned above, it is difficult to know in real time what the total quantum of money is being spent on health is, and whether expenditure was as per needs. Moreover, since a large part of the funding is tied to wages and salaries and money unspent in non-CSS components must be returned, a better understanding of state capacity comes from looking at scheme expenditure.

21. Is it possible to assess spending with reference to outputs and outcomes?

In an ideal world, it would be useful to look at return on investments or the extent to which finances are allowing us to meet our goals or targets. These may include service delivery outputs, specific health outcomes, or other indicators. Some examples of health sector targets are:

- Reducing the number of people who suffered from various ailments, such as the number of children who are stunted or underweight, the number of people who suffered from COVID-19, etc.
- The number of people treated under a scheme such as AB-PMJAY.
- The number of facilities created in an area, and their quality.
- Reducing the amount of out-of-pocket expenditures by people and households.
- Reducing inter-district variation in health outcomes.

Unfortunately, the lack of disaggregated data often precludes detailed analysis. While correlations can be calculated for budgets and outcomes, more robust methods require disaggregated data (especially below the state level) which are often not available. Some of these causal analyses could include the use of regression models that use outcomes or health status as the dependent variable, and budget related figures as independent variables. However, given that most data are only available at the state-level and not below, a small sample (there are only 36 states and UTs) precludes robust causal analysis.

Ideally, financing analysis should be combined with other methods and data sets to answer the question at hand. This could include studying processes and understanding fund-flow impacts on service delivery.
Moreover, in the absence of accurate outcome indicators, fiscal targets can be compared with financial indicators such as the progress towards spending 2.5 per cent of GDP and the extent of reduction in out-of-pocket expenditure available in the National Health Accounts (NHA).

About the NHA: Currently, in India, NHA estimates are arrived at using NHA guidelines which were developed based on the System of Health Accounts (SHA, 2011) framework and classification codes adapted according to the country's health system context (keeping with international standards for systematically tracking health spending). National Health Accounts (NHA) estimates currently provide expenditures incurred for the consumption of healthcare services and goods in a country in a year. It provides the flow of funds on sources of these finances, financing through which money is channelled, and functional categories under which the consumption of these healthcare goods and services takes place. All healthcare expenditures are included regardless of how or by whom the service or good is funded or purchased or how and by whom it has been provided (NHSRC, 2016).

NHA tracks the flow of funds from Union, state and local governments, external donors, non-profit institutions serving households, social health insurance and households (including voluntary prepayments). These funds are further tracked based on the healthcare financing schemes, revenues of healthcare financing schemes, healthcare providers and functions. Thus, as the report states, it provides "overall estimates for health financing by sources of financing, by schemes that manage the funds, by providers of healthcare and by types of care, policy interpretations of the data will follow, including estimation of expenditures by diseases, age and gender in the coming year"(NHSRC, 2016).

Refer to question 22 for Outcome Budgets below.

22. Do all states produce Outcome Budgets? Are they reliable?

Outcome budgeting refers to creating budgets with specific outcomes as their basis, and linking the two, as mentioned in Chapter 2.

1. The Union government and only 11 state governments currently produce Outcome Budgets. The process was started in 2005 at the Union government level, wherein against budget outlays different departments are expected to submit the quantifiable targets and achievements under various schemes. Even across the 11 states, not all departments submit their outcome statements.

2. However, the quantifiable targets that are put in the Outcome Budget Statement are physical output targets, like number of hospital beds constructed, number of medical colleges and seats increased. These are at best outputs and cannot be termed as measuring outcomes. Further, the targets and achieved output numbers submitted

by the line departments are not subject to any verification systems and hence may only be as (un)reliable as the department's management information system.

For further reading on Outcome Based Budgeting, readers may refer to Outcome Budgeting in India: The Efforts being made at the Union and State Levels published by the Centre for Budget and Governance Accountability (Mahendru, 2021).

Budgets from an equity perspective

23. How do I determine budgets by specific population groups? Say tribal communities?

Equity across social groups

A fundamental question about budgets and expenditures in the health sector is whether the resources primarily benefit poor and vulnerable populations, or if they are largely captured by the better off. This is commonly explored via "benefit incidence analysis", which combines budget analysis with household survey data. For example, survey findings can tell us which socioeconomic groups (rich, poor, middle class) seek what type of healthcare services (outpatient, inpatient) at which types of government facilities (primary health centre, district hospital, medical college), and how often. This can be combined with budget data on government spending at those facilities. The earlier questions in this chapter covering expenditures by level of care or type of facility are relevant for benefit incidence analysis, and highlight specific challenges. The design of survey questionnaires also has implications for doing this analysis. Further insights can be found in previous benefit incidence studies in India (Bowser et al., 2019).

It is also possible to analyse the equity of health expenditures in the context of specific groups, such as tribal populations.

1. To recognise the gap in the status of the tribal population vis-à-vis the normal population, the Government of India introduced the Tribal Sub Plan (TSP) that mandates spending on tribal communities at least in the proportion of their share of population in an area. TSP was visualised as an additional spending over and above the regular programmatic spending in the tribal areas by departments and ministries.

2. TSP is also referred to as the Schedule Tribe Component (STC) or Development Action Plan for Development of Scheduled Tribes (DAPSTs) (PIB, 2021). The MoHFW provides assistance to state governments and other ministries through Grants-in-Aid for health and nutrition. The DoHFW has a total of six schemes, which,

cumulatively, need to have a ("prescribed") earmarking of funds at 8.6 per cent under STC (MoTA; STC-MIS; NITI Aayog).

3. Spending on Tribal Health can be analysed in various ways. This can be in absolute terms, or as a share in total health expenditures. The latter measures the extent to which the health of tribal communities is prioritised within health budgets. Per capita expenditure on Tribal Health, similarly, looks at spending per member of tribal communities.

Tracing TSP funds

4. Tracing funds for each scheme under TSP is difficult, as data at the Union level aren't available typically. From documents like the FMR, line items cannot clearly be demarcated for TSP spending.

5. One way of analysing TSP funds is by using state budgets. This can be collected from the detailed Demand for Grants and collected till the detailed head level. This is the fifth level (major head, sub-major head, minor head, sub-minor head, and detailed level head). The major heads are 2210, 2211, 4210, 4211, 6210, and 6211, the same for health budgets. An example is shown here:

Table 4.4: Tribal Sub Plan major and minor heads

Budget Code level	Major Head	Sub-Major head	Minor head	Sub-minor head	Detailed Head
Code	2210	01	001	102	7476
Code description	Medical & Public Health	Urban Health Services - Allopathy	Direction and Administration	Tribal Areas Sub-plan	Divisional Joint Director Office

6. As previously mentioned, line items from all departments should be considered, as healthcare expenditure (major heads mentioned above) can be across departments. For example, in Chhattisgarh, expenditures can be found under the Public Health and Family Welfare department, the Medical Education department, and the Public Works department.

7. To track TSP funds, it is useful to look at all the different sources of finances including Central Sector Schemes, and CSSs in addition to states' own budgetary resources, including state schemes.

24. The Union and some state governments produce Gender Budget Statements. What are they and how can I use them for health budget analysis?

In 2005, for the first time the Union budget released the Gender Budget and 36 central ministries and departments opted for gender budgeting. As of September 2022, 17 states regularly publish gender budgeting documents.

The gender budget is an exercise that applies a gendered-lens to the allocation and tracking of public funds. The focus is on improving women's welfare through government policies. Gender budgeting is an important method for achieving gender mainstreaming so as to ensure that health benefits reach women as much as men, and tell us what amount of total health budget is spent towards women healthcare under different schemes by the Ministry of Health and Family Welfare.

At present in India, the Gender Budget comprises two parts: Part A encompasses schemes that allot 100 per cent of the funds for women. Part B consists of schemes that allocate at least 30 per cent of funds for women. The exact method of how departments make these distinctions however is unclear. For instance, expenditure on Research Studies by ICMR under the Department of Health Research is featured in part A of the FY 2022-23 Union Gender Budget even though there is no clarity as to how it has 100 per cent women beneficiaries or how it contributes to women empowerment. In Meghalaya, under Part A for health, only women health-related schemes such as Incentives for maternity benefits and ASHA, Schemes for Auxiliary Nurses and Midwives training, etc. are considered. But women and child related schemes such as Women and Child Hospital are also included in Part A (GoM, 2022). So the distinction at the state level is also not very clear.

Use gender budget statements with some caution as the exact method of how departments make distinction's unclear. Instead: look at specific health related schemes targeted towards women

The present segregation into parts A (100 per cent) and B (30 to 99 per cent) also means that schemes that earmark less than 30 per cent of their funds for women are excluded from the Gender Budget.

Despite this caveat, It may be useful to look at the allocation of health in the Gender Budget to get a sense of what proportion of the total health budget is for women responsive schemes. In the Union budget, between FY 2020-21 and FY 2022-23, around 18 per cent of the total gender budget allocation has been towards health, and which is almost entirely coming from part B.

Moreover, if one wants to look at gender budgets specifically for health, one would need to look at the specific health schemes which are targeted towards women.

25. The Union and some state governments produce Child Budget Statements. What are they and how can I use them for health budget analysis?

Child Budget Statements published by the Union government (since 2008-09) have always included child-focused budgetary provisions under both "Schemes Expenditure" and "Establishment and Committed Expenditure" heads. For Child Budgeting in the Union government, the number of Demands for Grants captured in the Statement has increased from just eight in 2008-09 to 25 in 2020-21. Currently, 13 states regularly publish Child Budgeting documents.

This falls in statement No. 12 (i.e. Schemes for the Welfare of Children) of the Union Budget thereby recognising that children under 18 years of age constitute a significant percentage of the Indian population. It reflects the Budget provisions of schemes that are meant for the welfare of the children. The provisions in this statement indicate educational outlays, provisions for the girl child, health and other provisions for child protection.

Out of 25 Demands for Grants, the health proportion in the total child budget is very small, at around 4 per cent (between FY 2020-21 and FY 2022-23). Under the Department of Health and Family Welfare, the majority of allocation for child budget happens under NRHM - RCH Flexible Pool component. For further information, see here.

Concluding Thoughts

The objective of this primer has been to offer the reader a way to understand and interpret India's Union and State health budgets. It has emerged from the need for better guidance to help a range of interested audiences to understand the health budget process, actors, documents, terminology, and how to make sense of the budget itself. The aim is to enhance our collective understanding of how health budgets are formulated, executed, and evaluated and to highlight the implications of budget processes and structures for undertaking policy-relevant analysis.

The first part of the primer offered an overview of key budget building blocks, including a description of the budget cycle, key stakeholders and the array of budget-related documents. The second part provided a detailed "Q&A format" approach to describe how India's health budgets can be analyzed and interpreted. Budget data can be used to help evaluate the adequacy of spending, efficiency, long-term trends, and the distribution of health resources across facilities, regions, and populations. But careful analysis is required to do so.

Going forward, there is scope to strengthen India's budget structures at both the Union and state levels to facilitate policy-relevant analysis. This could include revisiting the classification of heads of accounts, strengthening information systems, enhanced budget transparency, standardization of formats across states, and other areas. In the digital age, mobilizing large volumes of information to serve the social interest is both an opportunity and challenge, but in the health budget context this goal is within reach and offers the promise of a stronger Indian health system for all.

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Appendix

Appendix Table 1: Health Specific Grants Recommended by Recent Finance Commissions

Finance Commission	Time Period	Amount In ₹Crore	Description	Sub-Major head
12th Finance Commission (CGD and AI, CPR, 2015)	2005-2010	5,887.08	Under 12th FC Health-specific transfers known as "equalisation grants for health" to seven states. The goal was to reduce inequality in per capita expenditure across these states, which had the lowest health indicators. The grants bridged only up to 30 per cent of the gap in per capita expenditure after controlling for revenue capacity, tax effort, and health expenditure preference. Conditionality was related to spending on health at the state level	Odisha Jharkhand Bihar Uttar Pradesh Uttarakhand Assam Madhya Pradesh
13th Finance Commission (CGD and AI, CPR, 2015)	2012-2015	5000	As a performance incentive to states that reduced their infant mortality rate based on data from the Sample Registration System. The allocation formula took into account the relative improvements from the median and used a weighted average to calculate the share of the funds going to each state. However, it did not consider population or state health expenditure while calculating the weights.	Because of the design, the 13th Finance Commission formula led to a situation where a handful of states captured a large share of winnings, with 65 per cent of allocations going to states that accounted for less than 10 per cent of India's total population.

15th Finance Commission[6]	2021-2026	Health grants : 70,051 Sector-specific grants for Health: 31,755 States specific grants : 4,800	Health grants under local bodies meant to improve health systems and reduce the crucial gaps in the healthcare system at the primary healthcare level. FC also recommended allocations not be on a per capita basis for states or for local governments but based on the MoHFW proposal. 15th FC keeping the current pandemic in mind also recommended separate sectoral grants for the health sector to state governments which are meant for critical care hospitals and public health laboratories to build resilience in surveillance and fight communicable diseases, epidemics, and pandemics in the future. Responding to a state government proposal to state specific grants for improving health infrastructure, FC also recommended state specific grants for health to support states build resistance against future pandemics by constructing critical care hospitals and public health labs.	All states covered under Health grants and sector-specific grants. State specific grants Bihar, Haryana, Rajasthan and Uttar Pradesh.

Appendix Table 2: Major heads in the latest RoP (2022-23 and 2023-24)

FMR Code	Component
RCH	**Reproductive and Child Health (RCH)**
RCH.1	Maternal Health
RCH.2	Pre-Conception (PC) and Pre-Natal Diagnostic Techniques (PNDT) Act

[6]Report of Fifteenth Finance Commission for 2021-26.
Available online at: https://fincomindia.nic.in/ShowContent.aspx?uid1=3&uid2=0&uid3=0&uid4=0

RCH.3	Child Health
RCH.4	Immunisation
RCH.5	Adolescent Health
RCH.6	Family Planning
RCH.7	Nutrition
RCH.8	National Iodine Deficiency Disorders Control Programme
NDCP	**National Disease Control Programme (NDCP) Flexi Pool**
NDCP.1	Integrated Disease Surveillance Programme
NDCP.2	National Vector Borne Disease Control Programme
NDCP.3	National Leprosy Eradication Programme
NDCP.4	National Tubercolosis Elimination Programme
NDCP.5	National Viral Hepatitis Control Programme
NDCP.6	National Rabies Control Programme
NDCP.7	Programme for Prevention and Control of Leptosprirosis
NDCP.8	State specific Initiatives and Innovations
NCD	**Non Communicable Diseases (NCD) Flexi Pool**
NCD.1	National Programme for Control of Blindness and Vision Impairment
NCD.2	National Mental Health Program
NCD.3	National Programme for Healthcare for the Elderly
NCD.4	National Tobacco Control Programme
NCD.5	National Programme for Prevention and Control of Diabetes, Cardiovascular Disease, and Stroke
NCD.6	Pradhan Mantri National Dialysis Programme
NCD.7	National Programme for Climate Change and Human Health
NCD.8	National Oral Health Programme
NCD.9	National Programme on Palliative Care
NCD.10	National Programme for Prevention and Control of Flourosis
NCD.11	National Programme for Prevention and Control of Deafness
NCD.12	National Programme for Prevention and Management of Burn Injuries
NCD.13	State specific Programme Interventions
HSS.U	**Health System Strengthening - Urban/NUHM Flexipol**
HSS(U).1	Comprehensive Primary Healthcare
HSS(U).2	Community Engagement
HSS(U).3	Public Health Institutions as per IPHS norms
HSS(U).4	Quality Assurance
HSS(U).5	Human Resources for Health (HRH)

HSS(U).6	Technical Assistance
HSS(U).7	Access
HSS(U).8	Innovation
HSS(U).9	Untied Grants
HSS	**Health System Strengthening - Rural**
HSS.1	Comprehensive Primary Healthcare
HSS.2	Blood Services and Disorders
HSS.3	Community Engagement
HSS.4	Public Health Institutions as per IPHS norms
HSS.5	Referral Transport
HSS.6	Quality Assurance
HSS.7	Other Initiatives to Improve Access
HSS.8	Inventory Management
HSS.9	Human Resources for Health (HRH)
HSS.10	Enhancing HR
HSS.11	Technical Assistance
HSS.12	IT Interventions and systems
HSS.13	Innovation
HSS.14	Untied Grants
-	**Infrastructure Maintenance**

Source: NHM RoPs, available online at: https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1377&lid=744.