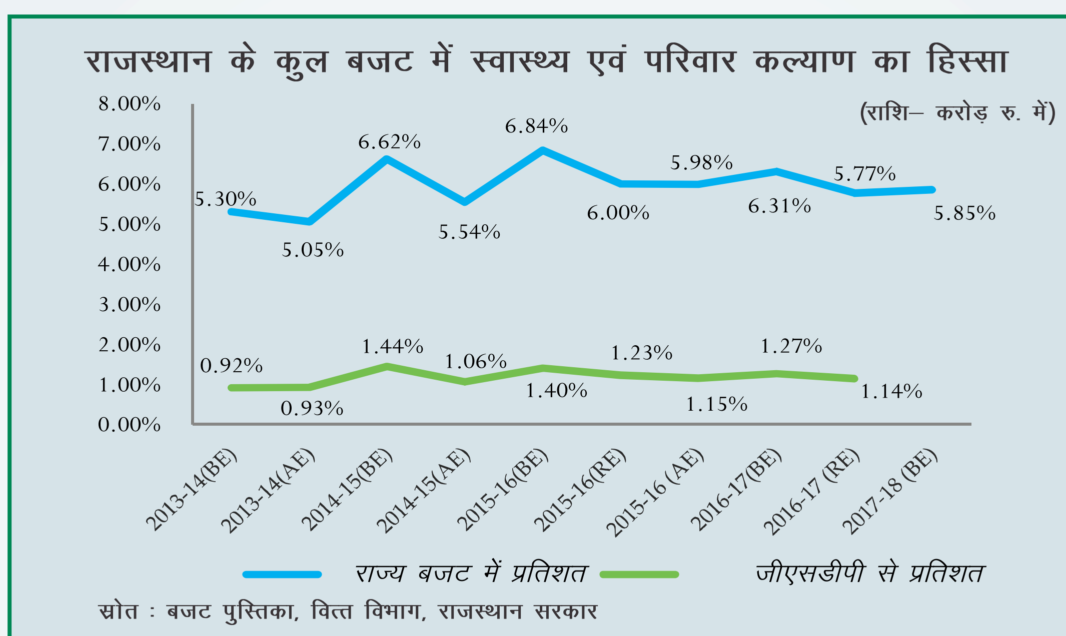
POLICY BRIEF

HEALTH BUDGET AND HEALTH SERVICES IN RAJASTHAN

Underutilization of funds and Ailing healthcare Infrastructure in Rajasthan



SUMMARY

This policy brief presents findings of a study of Health budget, health systems and human resource in health sector in Rajasthan. The study analyses public expenditure on health care and links it with the state of health care services, infrastructure, human resources and equipment at various points of service delivery such as, the District hospitals, Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub Centres (SCs). The study was conducted in four districts of Rajasthan- Barmer, Bharatpur, Chittorgarh and Jhunjhunu.

It is concluded that poor allocation in health budget in the state, under-utilization of the allocated funds, lack of human resource, gaps in the infrastructure and instrument and lack of transparency in the system are the major roadblock in the health service delivery in Rajasthan.

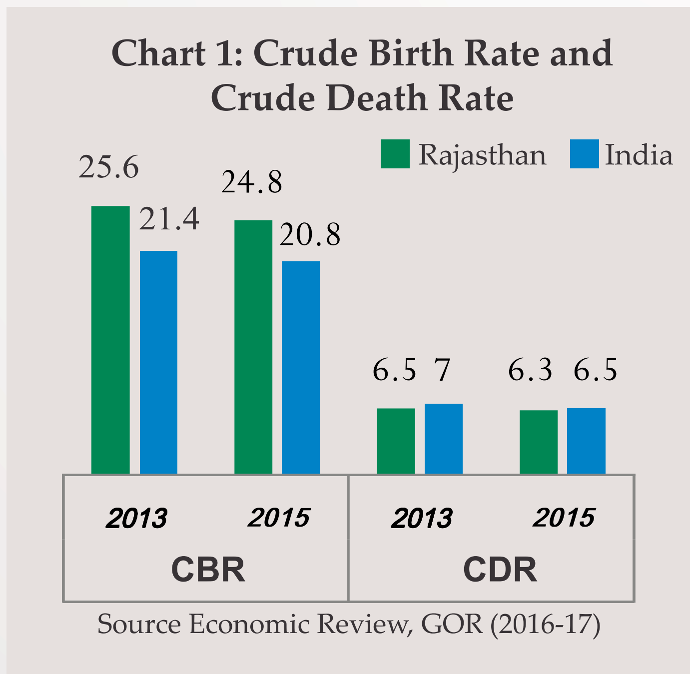
Background

Health is an important determinant of human development and it is directly related to the social and economic development of a society. In the federal arrangement of India, health is a subject in the state list of the Indian constitution (schedule 7, list II clause 6th), which means primary responsibility of health service lies with the state governments. However, central government also contributes in improving the public health system of the country by providing policy directions, initiating new schemes and sponsoring various existing schemes related to public health and family welfare.

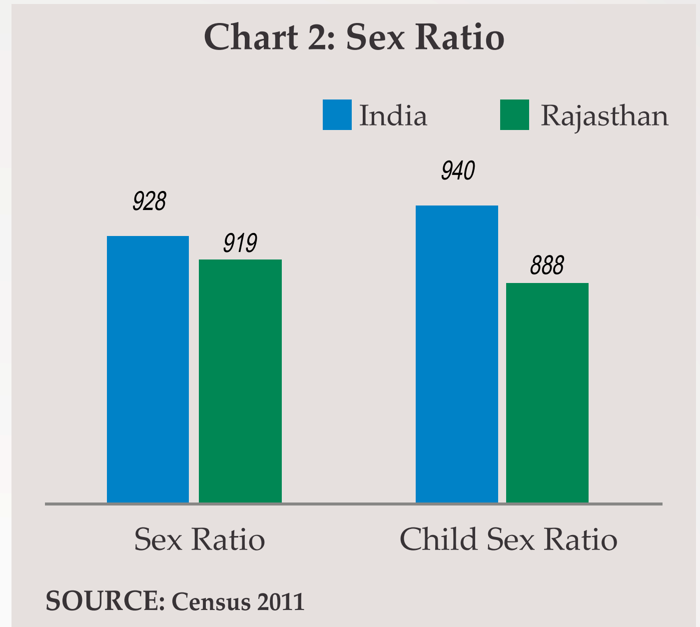
Public health scenario in Rajasthan is not appreciable because of several reasons such as poor health related outcomes of the state, poor infrastructure, lack of human resources, under-utilization of funds, transparency etc.

Status of Health in Rajasthan :

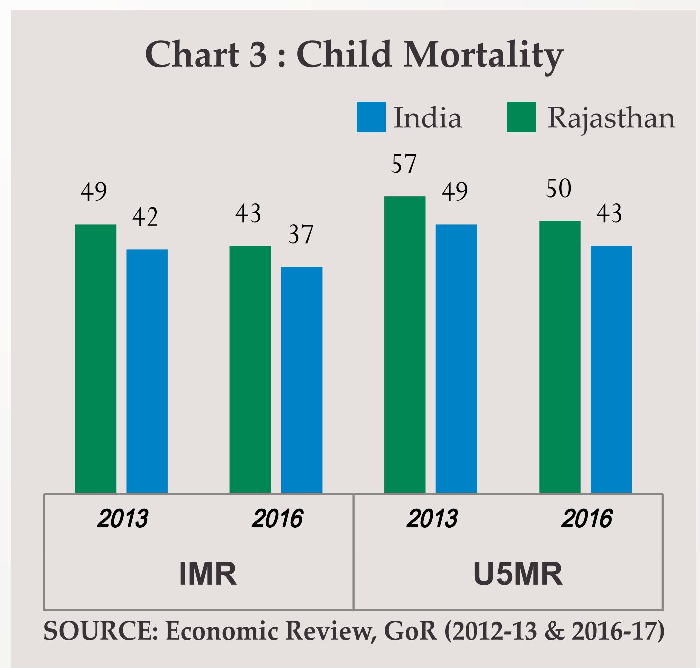
Important health indicators for Rajasthan aren't very satisfactory. The graphs below show the status of important health indicators in Rajasthan as a comparative as compared to the national average.



The above graph reveals the status of crude birth rate and crude death rate in Rajasthan. Even though there has been a positive change in both CBR and CDR in Rajasthan, it can be observed that in CBR Rajasthan is performingpoorly as compared to the national average. On the other hand, the CDR is better than the national average.



Both general Sex ratio as well as the Child Sex Ratio in Rajasthan, is lower than the national average.



Infant mortality rate (IMR) is calculated per 1000 live births and Under 5 Mortality Rate (U5MR) is calculated per 1000 live births. Both IMR and U5MR have improved significantly in Rajasthan but still are inferior to the national average.

It can be seen that in almost all the indicators Rajasthan is performing poorly when compared to India.

Research Methodology

Four districts were selected for the study- Bharatpur, Jhunjhunu, Chittorgarh and Barmer. In this study, the budget allocation and it utilization in health sector and status of health facilities at different levels have been analyzed:

1. Analysis of the Health Budget : We analyzed the trend of state health budget over the years along with an assessment of health facilities at different levels. The health budget data is analyzed to understand the trends of allocation, distribution and utilization towards health sector over the years, for which both medical & public health and family welfare (both capital and revenue expenditure) were taken into consideration.

2. Analysis of Health Facilities, services and human resource : One district hospital, two CHCs, 4 PHCs and 8 SCs are selected in each district to carry out health facility assessment in terms of available human resource, infrastructure and services that lay therein. We also tried to collect data on available budget and utilization at each level in these districts but we could not get except for one district. Exit interviews were also conducted with 487 patients at these health facilities to know their perception on quality of care.

Key Findings

The following are the key findings of the study-

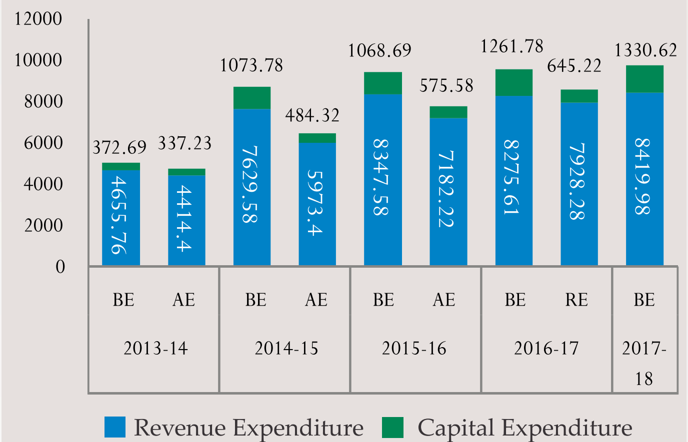
Analysis of State Budget-

1) Poor health Budget: The total health budget in is seen in chart 5. Though we can see that every year there is an increase in the health budget in nominal terms, it has not increased much in terms of percentage of the state budget.

Rajasthan spends around 4-6% of its total Budget on Health and Family Welfare. Over the years, there has not been a very significant increase in the allocation towards health when seen as the percentage of state budget. It has changed from being 5.30% in 2013-14 to being 5.85% in 2017-18, which is a marginal change of 0.55% with being close to 7% in 2015-16.

Chart 4: Health Budget in Rajasthan

(In Rs. Cr.)

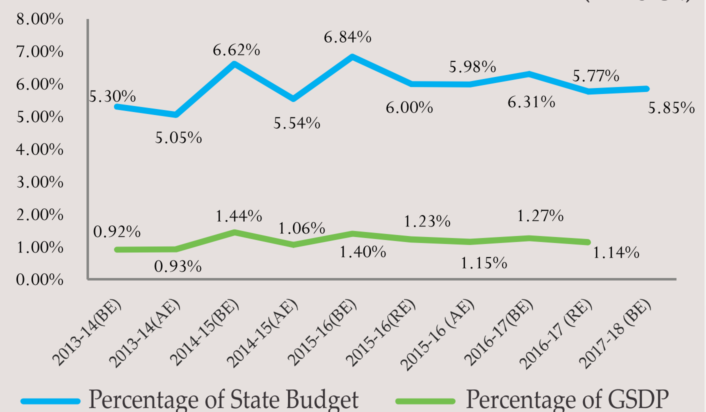


Sources : State budget books, Government of Rajasthan

On the other hand, as a percentage of GSDP the allocation towards health sector has increased from being 0.92% in 2013-14 to being 1.27% of GSDP in 2016-17. But this increase, even though marginal can be explained by the inclusion of centre's share of NHM budget in the state budget which earlier was transferred directly to the state Health Society by the Union Government.

Chart 5: Share of Medical Health and Family Welfare in Rajasthan

(In Rs Cr.)



Sources : State budget books, Government of Rajasthan

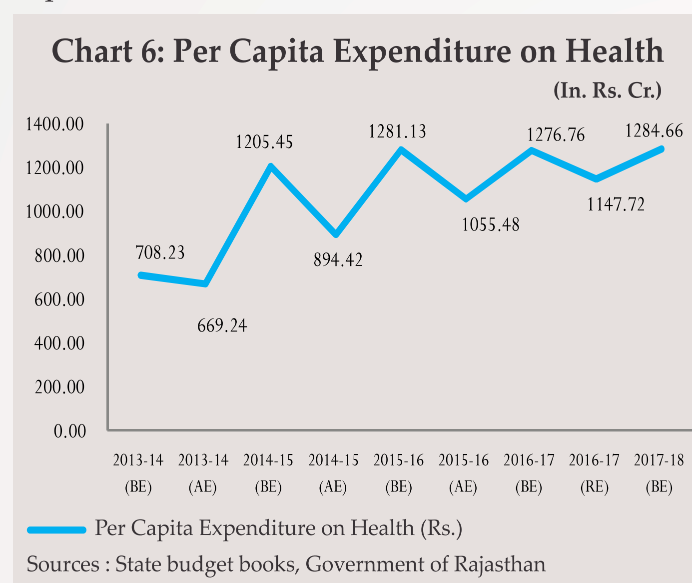
2) Low Per Capita Expenditure : The per capita allocation on health has almost doubled over the years from being Rs. 708.23 in 2013-14 to Rs. 1284.66 in 2017-18.

But if we examine the actual expenditure incurred per capita as compared to the budget allocation, the expenditure has not been very momentous and the actual expenditure has been lower than

the allocation for every year. In 2015-16, the expenditure incurred was Rs. 1055.48 per capita which is less as compared to the allocated Rs. 1281.13 per capita.

According to RBI data, Rajasthan is at the 17th position when it comes to per capita expenditure on health. Bihr, Andhra Pradesh, Jharkhand etc are among the states which are performing poorer in the aspect of per capita expenditure. On the other hand, states like Manipur, Uttarakhand, Himachal Pradesh etc are have better per capita expenditure on health.

Chart 6: Per Capita Expenditure on Health



Sources : State budget books, Government of Rajasthan

3) Poor Capital Expenditure: Capital expenditure ensures the construction of the new health centres and it is observed that it is significantly low despite the fact that the number of existing health centres in the state aren't sufficient to cater the health needs of all of its people.

The actual capital expenditure on health increased from 7.10% of total health budget in 2013-14 to being 7.42% in 2015-16, which shows a small increase of 0.32%. For Fiscal Year 2016-17, the budget estimate of capital expenditure on health was 13.23% of total health budget but it was reduced drastically in the revised estimate to 7.53%.

For the current year 2017-18, the capital expenditure remains 13.65% of total health budget. As compared to allocation in previous years and the current year, there has been a high increase in capital expenditure but the utilization of the fund is still under question.

4) Budget cut in various flagship programs: It can be observed that in the past 5 years there has been a cut in many schemes and programs of state and centre.

Table 1: Budgetary allocation under Major Schemes in Rajasthan (In Rs. Cr.)

Schemes Year	NUHM	NRHM	JSY*	JSSK*
2013-14 (BE)	-	1992.87*	217.11	137.89
2013-14 (AE)	13.06	1599.53*	179.97	96.33
Utilization (%)	-	**80.26%**	**83%**	**70%**
2014-15 (BE)	290.13	1830	194.08	161.82
2014-15 (AE)	75.55	1129.08	183.6	126.95
Utilization (%)	**26%**	**62%**	**95%**	**78%**
2015-16 (BE)	290.13	1834	201	148.99
2015-16 (AE)	81.16	1643.04	177.84	94.91
Utilization (%)	**28%**	**90%**	**88%**	**64%**
2016-17 (BE)	117.51	1622.61	203.58	164.31
2016-17 (RE)*	70.5	1415.49	188.32^	126.55^
Utilization (%)	**60%**	**87%**	**93%**	**77%**
2017-18 (BE)	90.48	1525.21	-	-

Source: State budget books, Government of Rajasthan
*FMR of Rajasthan Government
Note: The NHM's FMR (March 2017) shows that for the year 2015-16 the unspent amount was Rs. 399 crore.

In 2017-18, the budget allocation towards NRHM has declined by 6.39% and for NUHM the decline in allocation was even more significant at 29.87%. For JSY and JSSK the budget allocation has more or less been the same.

Table 2: Budgetary allocation under State sponsored Schemes

(In. Rs. Cr.)

Schemes Year	Bhamasha Medical insurance scheme*	CM free Medicine Scheme	CM free Diagnostic scheme
2013-14 (BE)	-	258.91	158.56
2013-14 (AE)	-	162.97	102.16
Utilization (%)	-	**62.94%**	**64.43%**
2014-15 (BE)	-	299.56	131.52
2014-15 (AE)	-	245.04	85.44
Utilization (%)		**81.80%**	**64.96%**
2015-16 (BE)	213.76	367.42	131.22
2015-16 (AE)	213.45	363.46	111.83
Utilization (%)	**99.85%**	**98.92%**	**85.22%**
2016-17 (BE)	431	360.36	129.457
2016-17 (RE)	163.40	300.36	117.06
Utilization (%)	**37.91%**	**83.35%**	**90.42%**
2017-18 (BE)	N.A.	415.99	131.06

Source : Budget Books for different years
*The data was received from the Dept. of PH&FW and for 2016-17, the data is up to Dec. 2016

On the other hand, the allocation towards CM Free Medicine Schemes and CM Free Diagnostic Scheme has seen an increase in allocation by Rs. 55.63 and Rs. 1.61 Cr. respectively in 2017-18 as compared to 2016-17 (BE).

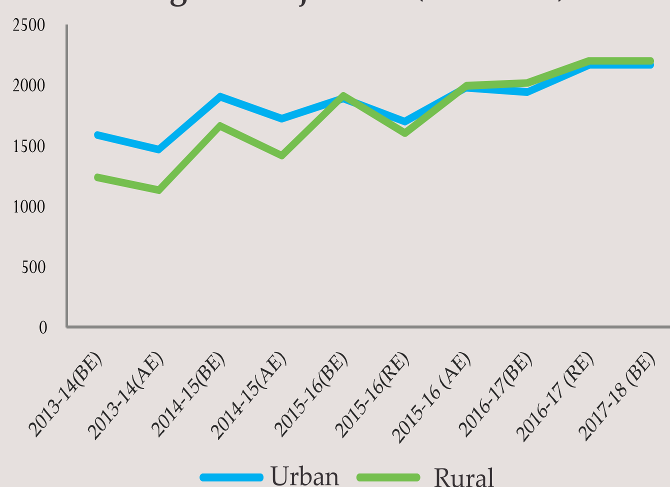
Bhamasha Medical Insurance Scheme was started in 2015 and has seen almost doubled increase in allocation from being Rs. 213.76 Cr. in 2015-16 to Rs. 431 in 2016-17.

5) Under-utilization of funds: As the chart previously showed, almost every year the actual expenditure has been lower than the budget allocated for department of Public Health and Family Welfare. In 2015-16 the percentage utilization of the budget estimate was only 82.39%. In the same year the percentage utilization of medical and public health was 83.19% of the budget estimate whereas it was 80.69% for the budget estimate of family welfare.

Also, different schemes such as National Rural Health Mission (NRHM), National Urban Health Mission (NUHM), Chief Minister-free medicine and free diagnostic schemes etc., are not able to utilize 100% of the funds allocated under their respective heads and the percentage utilization of these schemes are at a disappointingly low level. The actual expenditure data for JSY and JSSK (two schemes under NHM) shows that out of the total allocated funds, 77% in JSY and only 38% in JSSK has been utilized. (See table: 1)

6) Rural Urban Division of the Budget: In Rajasthan more than 75% of the population resides in the rural areas and therefore development medical facilities in the rural sector is of the utmost importance.

Chart 7 : Rural Urban Distribution of Health Budget in Rajasthan (in Rs. Cr.)



Sources : State budget books, Government of Rajasthan

But, as we can see from the graph above, the allocation towards both urban and rural sector is almost equal. The budget should be allocated according to the population so people residing in rural areas are able to receive the entitled benefits. Doing so will also reduce their Out of pocket expenditure which is incurred due to travel to get proper treatment in urban areas, bringing down the overall expenditure on health.

HEALTH FACILITIES RAJASTHAN

7) Infrastructure in Health Sector : The quality of infrastructure in India is a far cry from what it should be. In Rajasthan, the infrastructure that is there is not up to the mark.

The Indian Public Health Standard (2012) states,

that there should be at least one district hospital in the district (therefore, 33 in Rajasthan). Other than that, it specifies that there should be one sub-centre per 5000 people, one PHC per 30,000 people in hilly/tribal areas and one per 50,000 people in plain areas and one CHC per one lakh people.

Table 3: Health Infrastructure in Rajasthan

Medical Institution	Number	Population per Institution
Hospitals	114	601302.08
CHC	579	118391.08
PHC (Rural)	2079	24771.69
Dispensaries	194	353342.46
PHC (Urban)	52	990391.38
Sub Centres	14407	4758.00
Aid Post (Urban)	13	3961565.54
Beds*	47241	1451.04

Source: Economic Review (2016-17), GoR (Population- Census 2011)

From the above table we can see that Rajasthan is not able to fulfill the norms only in the case of CHCs and PHCs. Other than that, Rajasthan fulfills the basic infrastructure requirement under IPHS.

In the study conducted in four districts, it was found that 50% of the district hospitals don't have functional CT scanner and 75% don't have the facility of endoscopy. Other than that, in 81.2% PHCs there isn't any equipped Operation Theatre to conduct sterilization operations.

8) Huge Gaps in human resources: In terms of human resources, the state of appointment of medical health workers as compared to the sanctioned posts in Rajasthan is really disappointing. (Table: 4)

According to the Rural Health Statistics of India, Rajasthan has performed very poorly with having 31.51% of its health staff posts vacant.

Currently, out of total 1566 sanctioned posts for specialists at CHCs appointment has been done for only 526 posts which leads to a significant gap of 1040 specialists at the CHC level in Rajasthan. Among the specialists, 172 posts out of 271 of obstetricians and are lying vacant at the CHC level. Other than that, 140 posts out of 229 sanctioned posts are lying vacant for pediatricians along with 386 vacant posts out of 561 posts of Physicians. Moreover, Pharmacists and Radiographers at the PHCs and CHCs level are also not appointed as per the sanctioned numbers. There are only one-third of specialists present at CHCs as opposed to the sanctioned posts for them. Other than specialist, there are a large number of posts vacant for Radiographers at CHCs (70.14%), Health assistants both male (71.11%) and female (47.04%) at PHCs etc.

The below table reflects the status of human resource across different health facilities in Rajasthan.

Table 4: Medical Health Staff in Rajasthan (as on March 2012 & March 2015)

Posts / Year	Sanctioned		Vacant		% of Vacant	
	2012	2015	2012	2015	2012	2015
Health worker (Female)/ANM at Sub Centres & PHCs	14348	21704	*	5705	*	26.29
Health Worker (Male) at Sub Centres	2217	2388	625	546	28.19	22.86
Health Assistant (Female)/LHV at PHCs	1369	2160	*	1016	*	47.04
Health Assistant (Male) at PHCs	252	180	51	128	20.24	71.11
Doctor at PHCs	1824	2807	69	395	3.78	14.07
Total specialists at CHCs*	298	1566	150	1040	50.34	66.41
Q Radiographers at CHCs	208	767	*	538	*	70.14
Pharmacist at PHCs & CHCs	362	1282	*	615	*	47.97
Laboratory Technicians at PHCs & CHCs	1818	3425	*	1495	*	43.65
Nursing Staff at PHCs & CHCs	5628	13435	*	4185	*	31.15
Total Staff	**28324**	**49714**	**895**	**15663**	**3.2**	**31.51**

Source: RHS 2012 & 2015
(*Specialists include Obstetrician & Gynaecologist, Paediatricians, Physicians and Surgeons)

When we compare it to the 2012 data, we see that the situation has worsened over time. The number of sanctioned posts has increased drastically by 21,390 mainly due to increase in sanctioned posts of Female health workers/ANMs at sub-centres and PHCs and nursing staff at PHCs and CHCs. But the government has not been able to hire in

keeping with the increase in the number of sanctioned posts. Therefore, the number of vacant posts has increased drastically from being 3.2% of the staff to now being 31.51% of the total staff.

Table 5: Lack of Human Resource in SCs and PHCs

Health Facility	Human Resource	Number	Percentage
Public Health Centers (Total - 2083)	Without doctors	176	8.45%
	Without Lab Technician	690	33.13%
	Without Pharmacists	1580	75.85%
	Without Female Doctors	251	12.05%
Sub Centers (Total - 14407)	Without health worker Female/ANM	3086	21.42%
	Without health worker Male	10276	71.33%
	SC without both	2762	19.17%

Source: RHS 2012 & 2015

There are about 8.45% of PHCs that are working without doctors and 12.05% working without female doctors. There are 19.17% of SCs which are working without health worker. The below table reflects the status of lack of human resource in PHCs and SCs.

It was observed in the study that 50% of the district hospitals don't have eye specialist and there isn't any trained medical officer for sterilization in six out of eight CHCs. Also, in 87.5% of CHCs there is not one single trained medical officer for conducting abortion.

Trained empanelled medical officer for sterilization isn't available in any of the PHCs. In 90% of the PHCs there isn't any medical officer who is trained to carry out either emergency obstetric care or RTI/STI.

Other than that, male health workers and sweepers aren't available in 96.9% and 81.3% of the SCs respectively. Delivery services and referral slip for critical pregnancy cases aren't available in 62.5% of the sub centres.

9) Lack of Transparency: Even after having a letter from the health directorate all important data couldn't be gathered from the health facilities we intended to study. This reflects the lack of transparency at the district, block and below level.

Policy Recommendations

1) It is important to increase the amount allocated towards public health and family health so that more human resource can be placed at the CHC, PHC and SC level, better infrastructure can be developed and more equipment can be provided to the centres. The recently approved National Health Policy (2017) also emphasizes on increasing the budget expenditure on health.
2) It is important to increase the amount of capital expenditure under public health and family welfare so that new buildings can be constructed and old buildings can be repaired or maintained properly to ensure quality healthcare service delivery.
3) It is important to ensure the effective and efficient utilization of funds especially since the overall health budget is insufficient. One of the main reasons of under-utilization of funds is the delay in release of funds to districts and below level health facilities. It is crucial to improve the planning process of the fund flow to these societies and facilities by mentioning in advance, the dates and amount of funds to be released.
4) It is also recommended that human resources, infrastructure and equipment gaps should be reduced by sufficient allocation and proper utilization of funds. This will help in reducing the pressure on district and state level hospitals and dispensaries. It will also help in reducing the out of pocket expenditure of patients who travel long distances to receive even primary and secondary healthcare services.
5) Considering the traffic of people who seek tertiary care compared to those who seek primary and secondary care, it is important that we re-evaluate the distribution of health budget between rural and urban areas and increase facilities in rural areas.
6) To ensure better health service delivery it is also important to keep checks and balances on the amount being utilized under various schemes and services. To maintain the transparency it is very important to make the documents related to planning, budgetary allocations and expenditure available at the district and block level for public access.

Notes:

Crude Death Rate (CDR): The number of live births occurring among the population of a given geographical area during a given year, per 1,000 mid-year total population of the given geographical area during the same year.

Crude Birth Rate (CBR): The total number of deaths per year per 1,000 people.

Sex Ratio: The ratio of males to females in a population.

Child Sex Ratio: The number of females per thousand males in the age group 0–6 years in a human population.

Infant Mortality Rate (IMR): The number of deaths of infants under one year old per 1,000 live births.

Under Five Mortality Rate (U5MR): Probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.

Budget Estimate (B.E.): Estimate of Government spending on various sectors during the year, together with an estimate of the income in the form of tax revenues.

Revised Estimate (R.E.): Each year after six months of the presentation of the budget by the government i.e. in the month of September-October, analysis of income and expenditure is done by the departments on the basis of which the government revises the previous budget estimates which are known as revised estimates and are presented in the next year's budget.

Actual Expenditure (A.E.): Expenditure done by the government in a year is known as actual expenditure.

A combined effort of People's Budget Initiative (PBI) and Jan Swasthya Abhiyan (JSA)

Jan Swasthya Abhiyan (JSA): JSA India is a group of various organizations which conducts research, analysis, advocacy, lobbying etc on various issues related to Health. It is a part of international group named "People's Health Movement".
www.phmindia.org

People's Budget Initiative (PBI): People's Budget Initiative (PBI) is a civil society coalition, which promotes the inclusion of people's movements, grassroots organisations and NGOs in the policy processes that determine the priorities underlying government budgets in India.
www.pbiindia.net

Partner organizations

Budget Analysis Rajasthan Centre (BARC): BARC is a unit of Astha which works on budget and policy issues.
www.barcjaipur.org

Prayas, Chittorgarh: Prayas (Endeavour) is a voluntary organization working for social, political and economic development in Chittorgarh district of Southern Rajasthan.
www.prayaschittor.org

Jan Swasthya Abhiyan
People's Health Movement-India

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