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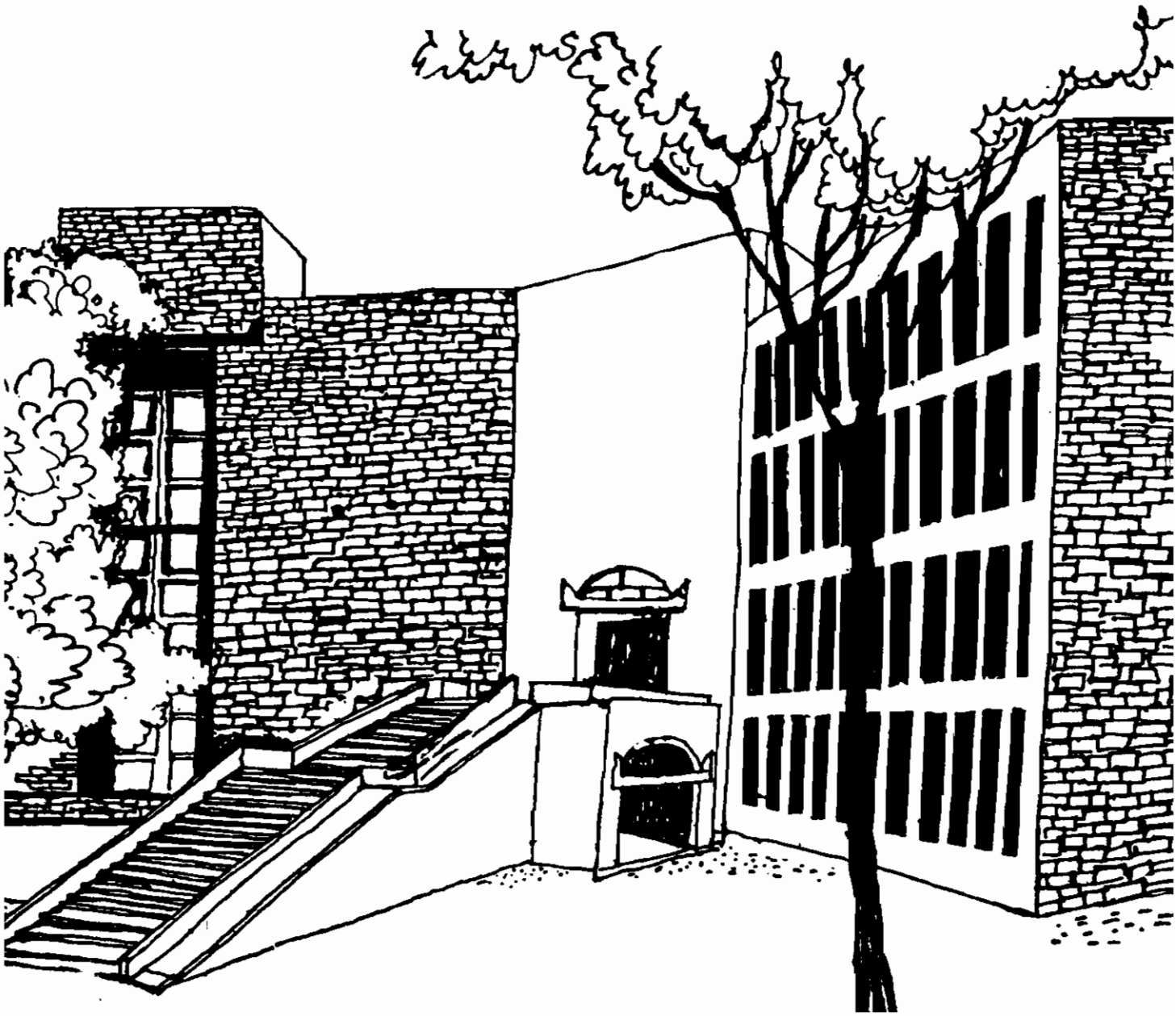

POLICY INITIATIVE OF CENTRE-SPONSORED PROGRAMMES IN THE HEALTH SECTOR AND ITS IMPLICATIONS FOR FINANCIAL AND OTHER RESOURCE FLOWS

By

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Policy initiative of centre-sponsored programmes in the health sector and its implications for financial and other resource flows

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Abstract

The central sponsored programmes (CSPs) have been one key policy initiative of the Government of India to support the health sector programmes directly, even though the health has remained the State subject. The Centre provides direct support to the States in meeting both recurring and non-recurring expenditure of programmes under this policy initiative. It was envisaged that the centralised focus would provide proper direction and thrust to specific health problems of national importance and management and implementation issues could be handled more effectively. The paper reviews the experience of CSPs using family welfare programme as a case study. It is argued that CSPs have prevented the policy makers to develop a sector-wide view of health programmes. The result is that there is less coordination across different agencies and stakeholders. Mechanisms of information sharing and coordination, pivotal from sector management viewpoint, between various programmes are almost non-existent at both macro and micro level. Through various policy instruments the centre has emphasised its role as major provider of services. There has been less clarity on the roles and responsibilities of the centre as financial intermediary for mobilising resources (e.g., interface of Centre and States with external agencies), allocating resources to states mostly as grants and systems of ensuring end use of resources. Where the CSP policy had envisaged protecting the funding and administering specific components of the health sector programme effectively, this policy has led to number of unintended consequences. There are no financial systems ensuring basic financial management discipline to handle the present day complexities of the programme management in many CSPs. These have created more fragments than integrated the process of management at the micro levels. No one assumes the risk of non-availability of key resources to implement the programme objectives effectively and States do not exhibit sense of ownership of these programmes. Changes and implementation strategies are generally top-driven which have aggravated the problems of programme management. The Centre tends to use uniform approach to manage the programmes despite the wide diversity at ground level conditions and variation in availability of necessary infrastructure. Criterion for allocating the resources lacks transparency not only from centre to states but also from states to districts and equity issues in resource allocation are not addressed. The CSPs have not helped the states to develop their capacity to manage the programmes and has displaced alternative sources of funding. Long-term sustainability of these programmes remains a major issue. Over the period the uncertainties in resource flows have grown considerably and have affected the programme implementation. Emanating from these, *by-passing* the State treasury has become one important character of these programmes in recent times. This is reflected through various policy instruments such as provision of kind resources (drugs and other supplies) directly by the centre to the implementing agencies in the districts and through the creation of registered societies. This paper attempts to describe recent developments in financial disbursement systems and development of new management structures and brings out number of important institutional issues, which need the attention of policy makers.

Policy initiative of centre-sponsored programmes in the health sector and its implications for financial and other resource flows

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1 Introduction

The central sponsored programmes (CSPs) have been one key policy initiative of the Government of India to support the health sector programmes directly, even though health has remained a state subject in India. In 1952 the Government of India implemented a policy initiative of directly supporting the health sector programmes in number of areas, which included family planning, malaria, leprosy, filaria. Other programmes such as tuberculosis, smallpox, goitre, trachoma etc., were added to the list of these programmes during 1960's. The National Family Planning (NFP) programme was the first to be supported as a part of this policy initiative. This was followed by creation of division named Department of Family Welfare in the Central ministry of health in 1966 and at this point of time this programme was converted into central sponsored programme. Under policy initiative of CSPs, the Centre provides direct support to the States in meeting expenditure, both recurring and non-recurring, on account of the programme requirements. There are some programmes where the States have to contribute matching grant. The implementation of the CSPs was done with the objective to give proper direction and thrust to selected health programme in India. This policy initiative had major implication for the availability of financial and other resources and overall management of these resources.

The overall budget allocations under these programmes are divided into two parts. The states receive financial allocations through the budgetary support from the Centre primarily to meet salary and other establishment expense. Other component is transferred to states in the form of kind resources. In implementing these programmes the Centre has used different policy instruments in transferring various resources to the States. This has resulted into number of mechanisms and processes in funds and other resource flows, which had significant implications for determining the ability of health sector programme managers to use the funds. These have also defined the scope and scale of how resources are used to meet the people's health needs. It is clear that over the period the dependence of States in implementing various components of these programmes have increased considerably. The funds flow mechanisms used in the process have raised number of questions. For example, since the Centre allocates the funds and other resources to implementing agencies directly, it is argued that the role of State administration in strategic management of these programmes has been neglected or undermined. As a result, at the state level and also at district level, the systems necessary to manage the resources and

programme outcomes remain less developed. This has affected the performance of the programmes.

It has been observed that the funds-flow mechanisms (the methods and processes through which the funds are transferred to implementing agencies) play crucial role in determining the performance of various components of the programme. These mechanisms significantly influence the availability of resources necessary to finance salary and non-salary components of the programme. The experiences with the funds flow mechanisms and their effectiveness in ensuring the availability of resources have been less encouraging. For example, various reviews identify the delay in transferring the necessary resources as major problem in implementing the programme. Because of the non-availability of funds on time, the areas such as medicine, maintenance and mobility (popularly called 3M problem in health sector) have not been managed effectively. It is in this background the need to strengthen the funds flow mechanisms have assumed considerable importance. There are four main types of initiatives required to strengthen the system and these are:

- clarity on mechanisms of funds transfer and remittances of funds as per line department's budget allocations;
- institutionalising appropriate authorities and responsibilities in the system with the objective that someone at the district level in the health bureaucracy assumes the risk of non-availability of resources and ensuring that funds are available when needed;
- well laid down policy guidelines on resource management practices including appropriate system of accounting, interacting with agencies outside the government and reporting of ways-and-means position to line department heads;
- ensuring end use of resources as per the programme objectives.

As a first step towards strengthening the system, it is advocated that health sector programmes should concentrate on developing an appropriate financial management system. It is argued that the present financial management systems of the government are not adequate to handle the present day complexities of the programme implementation particularly when there is considerable amount of interaction with agencies outside the government in implementing various components of programmes. In the absence of appropriate monitoring indicators, the processes and procedures in the government take considerable amount of time and this results into serious delays. Therefore, approaches have been suggested which link the funds disbursements with the performance of programmes by developing a set of indictors for this purpose.

There are number of technical, legal, treasury and institutional issues and options involved in strengthening the funds flow mechanisms and improving programme performance and most of these are complex and highly interrelated. Though the options of developing appropriate financial management systems are straightforward and well accepted by the policy makers but the present institutional complexities and recent developments in creating new institutional mechanisms (e.g., societies) pose lot of challenges, in the first instance, in effectively implementing the system, and secondly, making effective use of its existence.

The objective of this paper is to describe and understand the complexities of funds and other resource flow mechanisms in managing health sector programmes. The paper illustrates some of undesirable consequences of the current policy initiatives and existing mechanisms of funds remittance system and describes some practical options involved in strengthening and introducing the initiatives for improvement. This paper is divided into four sections. Section 2 describes the centre-state relationships in financing health sector programmes and the scenario of financing relationships between the government and its implementing agencies in the health sector and implications thereof. Section 3 discusses the issues in funds-flow and management implications arising out of the experiences in financial flows. The subsequent section describes various mechanisms used in funds flow at the state level. Section 4 presents recent initiatives to overcome some of the unintended consequences of the present system; and later sections discuss organisational and institutional imperatives for strengthening the systems.

2 Centre-state financing relationships

Health is primarily a state subject. Each state government makes budgetary allocations to health sector and it consists of consists of central plan, state plan and state non-plan components. These funds are made available to programmes and its implementing agencies through the state treasury. In government system there are laid down rules and procedures for disbursing and reimbursing the funds to its implementing agencies. The central plan component of the budgetary allocations is for programmes which are either directly financed and implemented by the centre (e.g., blindness programme) or for programmes called central sponsored programmes which are protected for financial allocations but implementation is the responsibility of states (for example, RCH programme). These allocations are generally shown as line item in the annual budgets of the state governments.

The sources of funding of central plan are either from central government's budgetary support or from loans and grants from various external agencies. For example, in financing the family welfare programme, the loan from World Bank and grants from other external agencies constitute a significant proportion of total support to states (e.g., the World Bank has contributed over $2.6 billion to central programmes since 1972). The financial resources received from external agencies are channeled through the Department of Economic Affairs (DEA), Government of India.

Till recently the State governments could not negotiate directly with the external funding agencies for loans or grants, particularly in the health sector. Most of these finances were mobilized by the Centre and later allocated to the States. The relationship between the Centre and the State regarding the use of mechanisms and terms on which these financial resources are transferred, are primarily guided by the recommendations of the Ninth Finance Commission. According to it, the entire external assistance (grants) received for external aided projects, in all cases, are to be passed on to the States implementing those projects. There are also programmes for which loans are raised by the Central government from agencies such as the World Bank and these are passed on to the States as grants. The Centre plays a role of financial intermediary in these cases. For example, the World Bank loan received for RCH programme is passed on to the states as grants.

There are three issues related to the center-state relationship in financing and implementation of health sector programmes. These are (i) structuring of health sector programmes and the role of the Centre and its relationship with the state; (ii) flexibility granted to implementing agencies and financial decentralisation; and (iii) mechanisms and processes used in transferring financial and other resource to implementing agencies.

2.1 Structure of health sector programmes and centre-state relationship

The Centre provides budgetary support to the states to finance and implement various national health programmes. For family welfare programme the centre provides 100 per cent grant to the states to implement the programme. In this sense the centre has 100 per cent control on the management of the programme. The evolution of the strategy to implement the programme has seen number of changes over the years. Many of these changes brought out new paradigms of implementing the programme. Many feel that not enough time was given to each new strategy to demonstrate its full potential and achieve effective results. This has resulted into too much of variability in performance and delays in translating the changed thinking into action.

The health sector in India has been artificially divided into what is known as national health programmes and other programmes. However, based on social concerns and epidemiology data, the MoHFW has been updating the list of national programmes from time to time. Many of the national programmes do receive financial support from external agencies. In case the financial assistance is received from external agencies for these programmes, the resources are transferred as 100 per cent grant to the states. However, other financial assistance received for programmes which are not designated as national programmes will passed on to the state as 70 per cent loan and 30 per cent grant. For example, any external assistance in the form of grant to upgrade the PHC facilities or primary curative services would not be recognised as national programme. In case States receive any grant, these would be passed on to the State treasury in 70:30 loan and grant ratio. The justification for doing this is to cover the foreign exchange fluctuation risk of overall portfolio of financial borrowing of the centre. It is argued that this policy works against the poor States if they want to use these sources to improve the health of most vulnerable groups of population. The loan burden makes many State treasuries, particularly poorer once, reluctant to use this support as this would be seen as creating future obligation to repay the loans and unfavorable to their State balance sheet. In the process the programmes most needed to uplift the socio-economic conditions of the community are likely to get lesser allocations. Recently there has been change in the thinking of the government in these areas and increasingly the ministry of finance allow the states to get these finances as grants on case to case basis.

With the emergence of non-communicable diseases, the governments' capacity to provide effective care to poor populations has not kept pace with growing demands. Many states are in need of additional resources to upgrade their health facilities. The growing epidemiological concerns of health transition are making resource allocation a difficult taks for the States. Increasingly the budget requirements to meet the demands arising out of new disease patterns are becoming difficult to meet. Many of these aspects are not recognised as part of national programmes and it forms part of State budgets. The needs of the States to strengthen their health facilities particularly primary-curative care requirements have also increased considerably. The poorer states have less capacity and capability, both management and financial, to handle many of these requirements. A new thinking is needed to handle these emerging issues. It requires sector-wide view focusing on roles of both private, public and external agency support in managing health sector. The implementation of CSPs has prevented programme managers to develop the mechanisms of implementing sector-wide initiatives and this policy initiative has reinforced the vertical character of the programmes from time to time. Since financing of the

programmes affect the performance, it is clear that the existing paradigm of national health programmes do not address many of the concerns adequately.

The other area closely related to the structure of the programmes is the financial management system for implementing the programmes. These concerns pertain to the financial structure used to finance the programme. The financial and kind resources are financed through different sources. The implementation strategy and use of mechanisms to transfer resources to these programmes are likely to be determined by these sources. It is observed that different components of the programmes in health sector have different financial structure. The way the programme's financial structure i.e., its sources and uses are designed would have significant implications for efficiency in allocating the resources in the system. For example, the financial structure of the family welfare programme has loan component and government budgetary support component. The loan component of this programme is passed on to the states as 100 per cent grants. On the other hand, the resources raised through the loan from World Bank to finance other health systems development aimed at strengthening the secondary care constitute borrowings of the State. All external borrowings are transferred to the states and they are charged rate of interest ranging between 12 to 14 per cent. The high rate of interest charged from the state on these borrowings is considered part compensation for the of the foreign exchange risk which the centre bears. The development of policy instruments and their use at the State level in these two programmes differ considerably and the responses of implementing managers are different. The programmes have also evolved different structure to implement the programme strategies. The way the programmes and projects are financed in the same sector have given rise to systems which see considerably less integrated.

2.2 Financial flexibility

The other issue in centre-state financing relationship pertains to flexibility in budget allocations. In most cases these programmes are 100 per cent controlled and monitored by the Central government. The experience suggests that over the years no attempt have been made towards implementing any meaningful financial decentralisation. The states implementing these projects have almost no flexibility in using different components of programmes to address the suitability of programme as per local community needs. Most of the strategic planning of resource allocation for these programmes is done at the MoHFW, GoI level. It is generally argued that inadequate flexibility in resource allocation at implementation level and top down approach of CSPs has seriously affected the performance of various programmes. The recent experiences in health sector reform suggest that more financial decentralisation in programme implementation has helped the

implementing agencies to target their clientele better and improve their performance. However, these reforms will need to put considerable emphasis on developing adequate systems to monitor and evaluate programme performance.

The need for providing adequate flexibility to implementing agencies in suitably adjusting budget line to meet specific needs at delivery level emanates from the fact that health needs should to be looked using integrated perspective. Also risks and epidemiology profile of communities differ. The present processes of financial allocation in health sector do not explicitly recognise these differences. The present policy views each national health programmes as vertical and forces to view the sector in a fragmented manner. The resources get allocated accordingly. This perhaps could be an effective strategy provided the allocation agencies have adequate information and data on health needs and risks. It is well recognised that government has not invested adequate resources and lack infrastructure in generating these data. Given the weak information systems, any attempt to allocate resources using this as basis would result into serious allocational distortions. For example, oversupply of some inputs and serious shortages of other inputs is commonly observed phenomenon at the PHC and rural hospital level. Following the allocation of resources based on CSPs paradigm, the allocation process does not consider sector-wide needs, invariably resulting into serious imbalances in the health delivery system. This has serious implications for the overall effectiveness of the healthcare delivery system. It is evident from the fact that the present allocations certainly do not produce the best health effects. What should be optimal service-mix of health services and input-mix for a community is difficult to assess from the top. What input-wise allocation of funds is required to produce satisfying mix of services can be effectively decided only after ascertaining requirements at the community level. The present allocation process imposes input-mix and consequently forces a type of service-mix on a health delivery system. This has many undesirable consequences affecting the programme objectives adversely.

The centre-state financial relations and treasury rules within the states also have implications for design and implementation of programme and therefore its performance. In many parts of the country, particularly in poorer states, the primary health care facilities are not functioning as desired (Rao 1987). A number of studies indicate lack of proper infrastructure, poor maintenance, lack of equipments and necessary facilities affecting the performance of the delivery system. There is serious mismatch of resources to sustain and deliver appropriate mix of health services. It is well recognised that within a limited amount of resources, it is not possible for any government to meet all health requirements of the community. However, it should be possible to optimise the use of resources provided the implementing agencies have flexibility in use of resources. Through an

appropriate planning system a satisfying mix of services can be made available from a given limited amount of resources. The main difficulty in achieving this is that the existing resource allocation does not adequately address the need for flexibility in budgeting process. However, this cannot be offered without adequately addressing the risks and responsibilities and appropriately strengthening the institutional system of the implementing agencies.

It is also observed that there are services, which remain under-funded since thin resource base is spread across programmes and their various components. Family welfare programme is interesting example to show how the resources were earmarked for different schemes numbering about 34 at one point of time (Bhat 1998). The financial allocations were earmarked for items such as eligible couple registers for recording information. However, the recent changes in the programme design have reduced the number of schemes but overall policy instruments of scheme-wise allocation have not changed. The spread of thin resource base results in poor quality of services. Many basic services are also not available. The present allocation mechanisms, which enforce that government will be providing everything, becomes a major obstacle to explore the options of developing community based mechanisms and role of non-governmental agencies. The poor in these situations have no options but to go to private providers who are not integrated with the public health delivery system. The private for-profit sector charges very high fee and these result into increase in financial burden, further aggravating the economic well being of vulnerable groups. The overall impact of an inappropriate resource allocation process is that the poor and vulnerable groups of population are affected adversely.

There are, however, questions on at what level in the health delivery system the flexibility in planning for resource allocation and deciding input mix could be instituted. The implications of the CSPs in terms of resource allocation and ability to address the needs of poor are less understood. Given the existing administrative set-up and ability to implement the input-wise allocation of resources, would the district be an appropriate unit at which sector-wide plan for health can be prepared and resources can be allocated. These need to be examined in evaluating the reform strategies.

The present policy framework in which the centre supports the health sector programmes of the states through policy initiatives of central supported programmes (central programmes and central sponsored programmes) does not adequately address the present day complexities of the health sector needs. It has created fragments, vertically dividing the programmes and having little coordination across different components from top to bottom. With the vertical division of programmes and use of different mechanisms of

transferring the funds, the system in its present form consists of many microstructures without having institutional mechanisms to coordinate their activities. This has resulted in very high transaction cost to implement the programmes.

The policy initiatives of central supported programmes were implemented with a view to protect the funding for programmes by allocating earmarked funds and directly influencing the allocations, reducing the risk of non-availability of funds, and effective administration of programmes. However, over the period, the implementation of these policy initiatives has resulted into number of unintended consequences. These emanate from the role the government assumes in supporting these programmes. The Centre assumes the role of a donor agency providing grants to states in these centrally supported programmes. The result is that these central driven initiatives have (a) displaced resources which could have otherwise been made available by the States; (b) affected the sustainability of programmes and is major issue in present day context; (c) created negative and uncertain implications for cash flows to various programmes and undermining the role of the States; (d) high cost of raising the financial resources and many times leading to high uncertainty; (e) delays in implementing various programme components; (f) financial management capacity of the States have remained less developed. It has also been observed that the centre lacks appropriate mechanisms to coordinate the programme activities at the national level. The sheer size of bureaucracy and level of channels through which the programme is implemented makes it difficult to manage the programme effectively. In the absence of adequate financial information system and performance indicators, the financial discipline remains inadequate resulting into inefficient use of resources.

The reform in this sector will need to focus on addressing number of management and institutional issues and ensuring that the implementing agencies do receive finances on time and funds are used appropriately for programme objectives. For this the development of appropriate financial management and disbursement mechanisms becomes imperative. The next part describes the issues in funds disbursements and later sections of the paper discuss the funds disbursement systems and implications in linking the disbursements with the performance.

3 Issues in funds disbursements

Though the financial rules and procedures are well defined, the delay in funds flow has been the general experience of managers in implementing health sector programmes and projects. This delay has been because of the involvement of number of levels in the government through which the disbursements are required to be processed. Recently this

has emerged as major cause of concern. Under the existing system of channeling the funds in health sector programmes, the financial resources are transferred to the State treasury and are made available to implementing agencies at district level or block level. In some cases there are implementing agencies outside the government where some components of the programme are being implemented through the NGOs or private sector. Because of the absence of private sector policy and how the interactions with the private sector are to be managed and implemented, the mechanism are less transparent and less obvious. Because of the absence of appropriate institutional mechanisms, these aspects further complicate the funds flow problem.

The releases of funds are primarily governed by the treasury rules described in the General Financial Rules of the state and central governments. It has been general experience that the release and disbursements take considerable amount of time and funds do not reach to implementing agencies when required. Considerable amount of time is lost in the process affecting the effectiveness of well-designed programmes. For example, the lack of funds at the Central and State level was identified as one of the major weaknesses of the National TB Programme (WHO, 1992). There is also evidence from number of other health programme initiatives (e.g., RCH programme) that timely availability of finances have seriously affected the programme outcomes. Besides these there are also number of financial management issues. We produce below selected examples, which describe the problems associated with the financial management of resources in health sector programmes.

3.1 Fragmentation of programmes and multiplicity of channels

The health sector programme and financial and other resource flows associated with its various schemes are highly fragmented. Figure 1 provides a broad description of funds and other resource (i.e., in kind) flow channels in FW programme in one selected state in India. The fragmentation occurs because of:

- sector is divided into programmes, programmes in schemes and schemes in components and each component and its sub-components is handled at different levels;
- there are resources which are transferred to states and in some cases state is by-passed and resources are transferred directly to the districts without coordinating and compiling information at state and district levels;

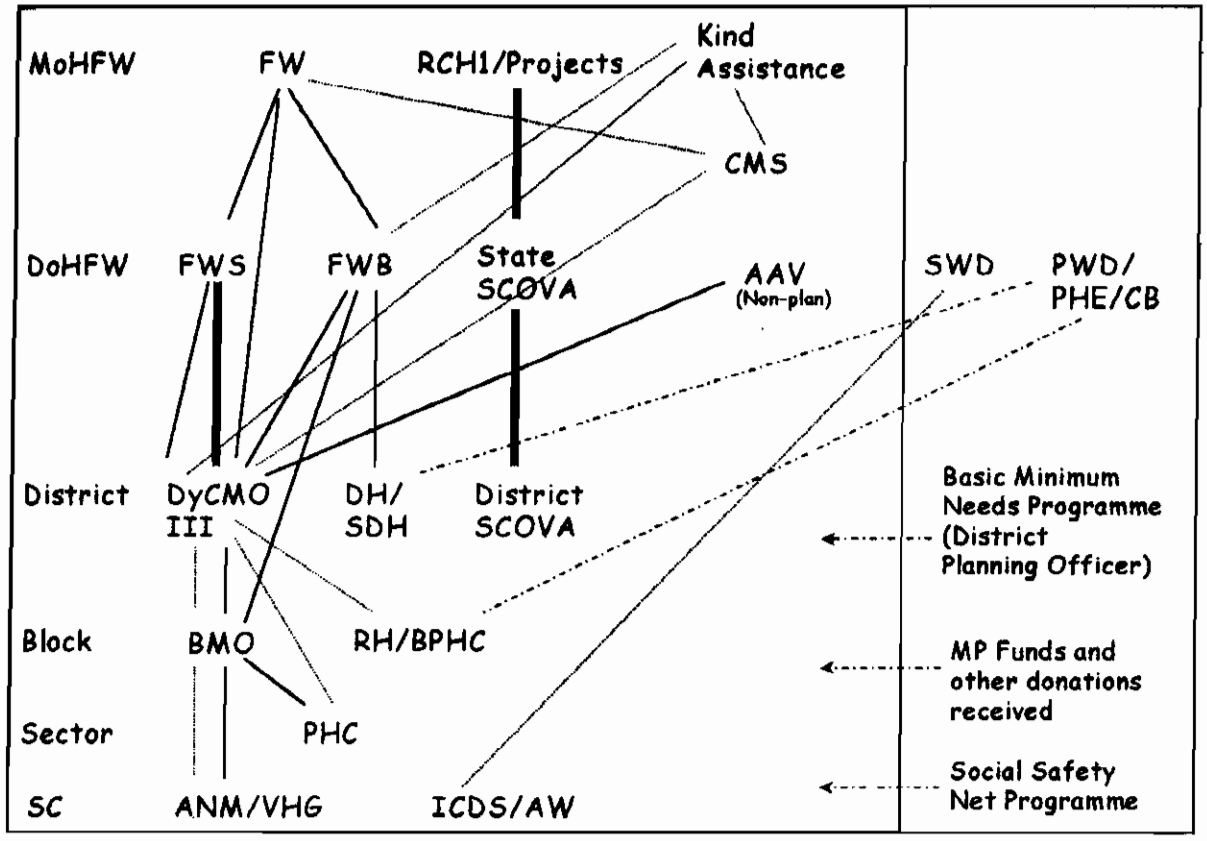

Figure 1: Complexity of resource flows in Family Welfare Sector

- Allotment of funds through government treasury (referred as paper allotment and indicated by ———— line in the figure)
- Funds (cash) transfer through PL Account or direct cash withdrawals (indicated by ▬▬ hard line)
- Resources Flow in Kind (indicated by ..... dotted line)
- Resources flow from departments other than DoHFW (indicated by – – – broken line)

MoHFW	Ministry of Health and Family Welfare, Government of India	PWD	Power and Works Department
FW	Family Welfare	PHED	Public Health Engineering Department
RCH1	Reproductive and Child Health Programme	CB	Construction Board
CMS	Central Medical Store	Dy CMO	Deputy Chief Medical Officer
DoHFW	Department of Health and Family Welfare	DH/SDH	District Hospital/ Sub-divisional Hospital
FWS	Family Welfare Secretariat	BMO	Block Medical Officer
FWD	Family Welfare Directorate	RH/BPHC	Rural Hospital / Block Primary Medical Centre
SCOVA	State Committees of Voluntary Action (registered society)	PHC	Primary Health Care Centre
		ANM	Auxiliary Nurse-Mid-wife
AAV	Accounts, Audit and Verification	VHG	Voluntary Health Guide
		AW	Aanganwadi Worker
SWD	Social Welfare Department	MP	Member of Parliament (other public representative

- this gets further complicated because different remittances mechanisms and criteria are followed for different schemes in allocations at various levels (at centre, state and district levels);
- programmes are is managed through a structure divided into offices which are physically dispersed having little exchange of information and coordination between them; and
- different monitoring and evaluation requirements for different schemes.

The direct implication of the existing processes and systems is that states lack complete and systematic information on what resources are available to them to implement the programmes.

3.2 Delay and arrears

There are number of instances of delay in making the funds available to various implementing agencies in the health sector. For example, the reviews of various national health programmes (TB, RCH etc.) have identified the delay in funds disbursement as one of the reasons of poor performance. As a result number of programmes have made changes in implementing strategies, which *inter alia* focus on strengthening the funds flow up to the level of sub-centres and involving non-government sector. The performance of these changes is yet to be examined. However, recent experiences do not demonstrate that recent changes in the management structures of these programmes through creation of societies have produced significantly better result. For example, in one of the states, which set-up the state and district society to channel the RCH funds experienced the delay of 262 days from the date the centre decided to release the funds (see Table 1).

Table 1
Time delay in allocation of funds in RCH1 Programme in one of the backward district

	Dates	No of days	Cumulative days
GoI decides to release the funds	31-Mar-98	0	0
DoHFW received communication	28-Apr-98	28	28
Cheque received by DoHFW	17-Jun-98	50	78
District receives communication	06-Oct-98	111	189
District receives cheque	23-Nov-98	48	237
Funds not used till	17-Dec-98	25	262

The above table indicates that the remittances of the RCH1 funds took about 262 days in getting it deposited to district society bank account. At district level no guidelines

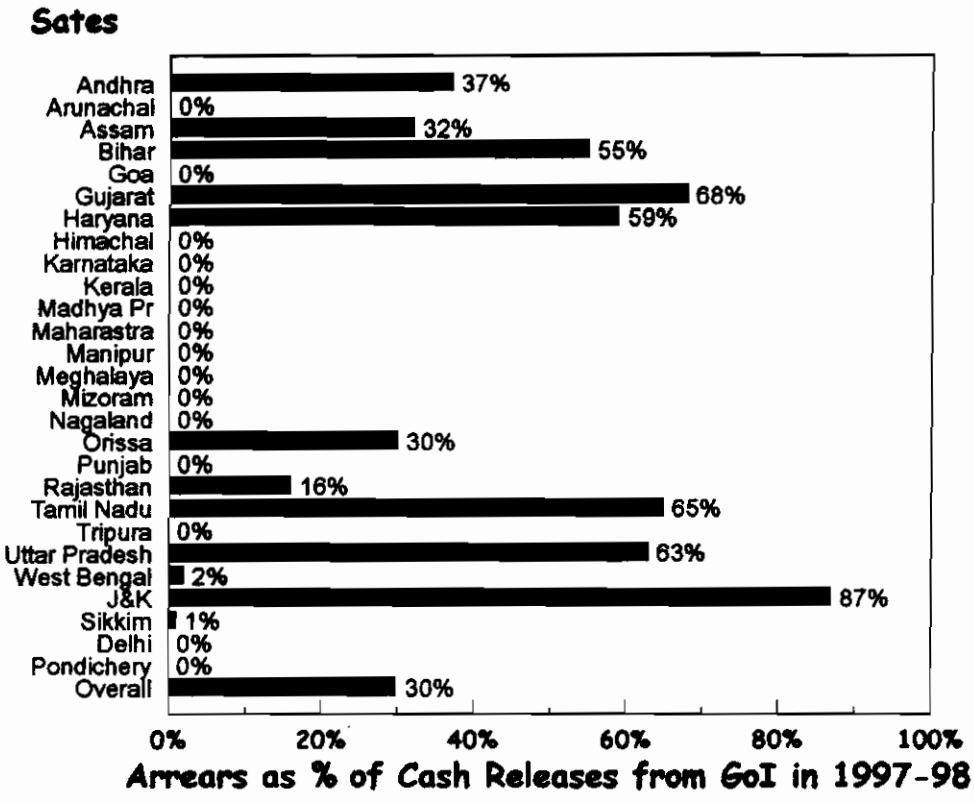

Figure 2

were available to utilise these funds. This would have caused further delays in making funds available for use. The timely availability of funds is other major concern. This is reflected by the fact that there are significant in number of cases. For example, in case of Gujarat there are arrears to the extent of 68 per cent of total cash releases for family welfare during the year 1997-98 (see Figure 2 below and Appendix 2). The all-India average for this worked out to be about 30 per cent for the year 1997-98.

3.3 Under-utilisation and under-funding

There are also experiences that funds allocated for different programme components and its sub-components are many times under-utilised and these go unnoticed. This is because of inadequate financial management information system. At different levels the programme managers do not have any idea of the extent of under-funding, making it difficult to manage the programmes. For example, the utilisation pattern of different schemes in the family welfare programme in one state in India provides the following scenario on utilisation (see Figure 3). The utilisation differs across different schemes.

State and district health administration do not maintain these records systematically and at times it is difficult to monitor the utilisation of different schemes.

In the process the utilisation information of many components is less systematic. There is also a problem of inadequate information on the extent to which the different schemes are under-funded. One can see from the utilisation data that there are components, which are over-utilised. This over-utilisation is direct outcome of inadequacy of the system to highlight the under-funding problem. Many times one finds that over-utilisation result into to arrears and are carried forward for number of years. How far the policy intervention of CSPs has achieved the objective of protecting the funding of programmes and its sub-components is also not clear. Given the financial performance in implementing the programmes it is, however, obvious that the centre's initiative of defining the scale and scope of financial allocations for the programme and its various sub-components have not produced intended results. It is also observed that the salary expenditure crowd out the spending on many other important components of the programme.

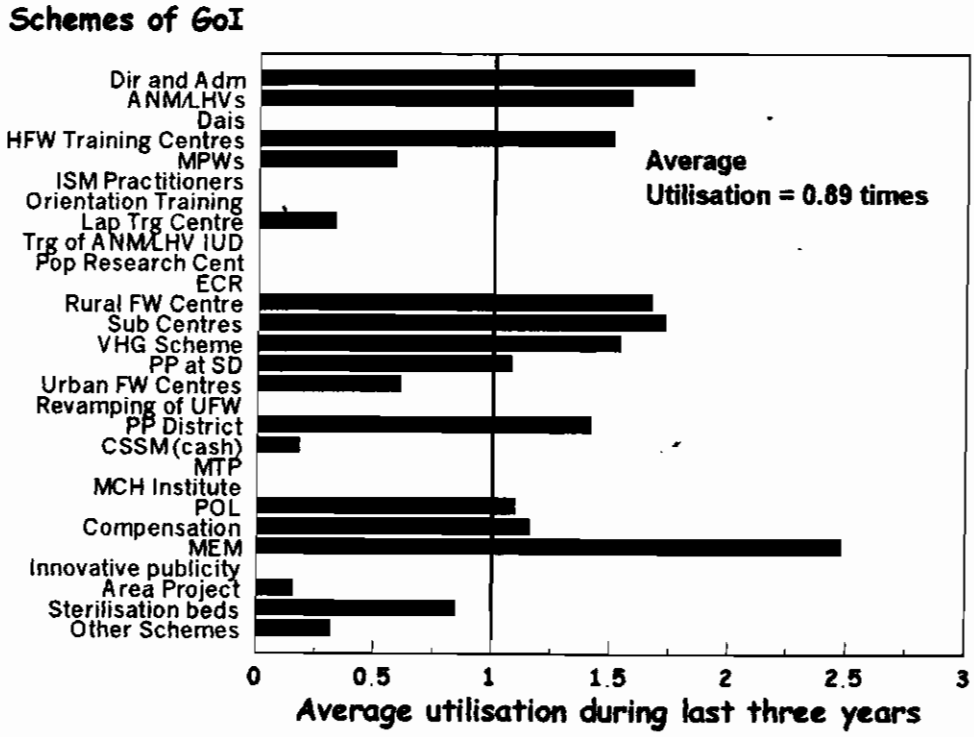

Figure 3

3.4 Lack of proper procedures for spending the money

Over the period the interaction with the agencies outside the government has become inevitable in managing the various components of the programmes effectively. The processes, procedures and financial rules of the government have not kept pace with these developments. At the implementation stage there is considerable amount of confusion at different levels about the way the implementing agencies are expected to interact with the agencies outside the government and how funds are supposed to be spent. This results into considerable delays in achieving the programme objectives. It has been observed that this problem arises because there are no clear guidelines for these interactions and programmes do lack adequate financial management systems. During various training programmes and discussion with various implementing managers, one experiences lot of tension and conflicting views on public-private interaction. These add to the confusion. It is very important that the government evolves policy on public-private interaction and lay down clear guidelines and processes needed to implement many of these initiatives. In absence of these guidelines the implementing agencies would find less utilisation of available resources and some time under-utilisation of allocated funds. For example, in one district because of lack of these guidelines, RCH1 funding was still not used after 275 days after the disbursement of funds. Many districts are still in the process of evolving these mechanisms and guidelines for spending the funds. It was also observed that districts lack appropriate financial management system and skills to handle many of new challenges. The systems also lack flexibility in using the resources to address the local level needs. For example, in one district where most of the sub-centres are rented ones, RCH1 funds earmarked for minor works was seen problematic to utilise. This is one of the problems when funds are allocated without considering the ground-level realities. The systems of transferring the funds do not address these aspects and many of the management issues in implementing the programme are not addressed appropriately.

3.5 Share of kind resources and information gaps

One of the important components of programme support to districts and below district is transfer of resources (drugs and medicines) directly from the centre and state level agencies to various implementing agencies (see Table 2).

Table 2 Kind Assistance in FW programme for a State (Rs. in lakhs)			
Year	Cash	Kind	Percent
1994-95	4910.10	1537.41	24%
1995-96	6253.18	1936.60	24%
1996-97	7046.22	1909.68	21%
1997-98	5201.99	2505.16	33%
Total	23411.49	7888.85	25%

For example, Table 2 suggests that in family welfare programme on an average about 25 per cent of total allocations have come in the form of kind resources over the period of last four years (Bhat 1998). During one of the recent surveys, it was found that districts do not maintain records of these resources systematically. For example, it was not possible to get information on resources received in kind at state and district levels. It was, however, possible to prepare the following statement from several invoices and bills of receipts about the amount and quantity of kind resources received at one district level (see Table 3 below).

Table 3 Estimates of drugs and medicines delivered in kind to one district, 1997-98		
Date	Details	Amount (Rs.)
08-Oct-97	ORS	143820
08-Oct-97	Tab Cotimoxazole	71910
08-Oct-97	Tab Folic Acid and Forte Sulphate	96008
27-Jan-98	Vit A	218260
Total for which value in known		**529998**
28-Jan-98	Direct supplies of Mytholorg injection (495x10) Provident Iodine ointment (495x5)	na
18-Mar-98	Direct supplies from CMS: Stool container (200 pieces); Cotton bandages (50x5); Menodzole tab (30000x5); Paracetomol (20000x12); Cotton (60x8, 30x1); Plastic bag (20000x7); Immunisation card (4000x25)	na

It can be observed that resources received in kind for which monetary value were available totaled about Rs. 530,000 in one district. The total kind allocations to the state were Rs. 25 crore during that year and this district represented about 4 per cent of state's population. If one uses the number of sub-centres as the basis of allocating kind resources, the district would have received Rs. 114 lakhs of kind resources. The

kind resources for which value could be ascertained represented only less than 5 per cent of total expected allocations.

3.6 Uneven and irregular flows

The policy initiative followed in the past has also resulted in considerable amount of uncertainty and unevenness in the flow of resources. Table 4 illustrates the flow pattern of cash flows pertaining to five family welfare schemes for which cash remittances are received and deposited in a bank account (see Figure 4). The account opened with the balance of Rs. 35,000 in the fiscal year 1997-98. First cash remittance in this account was received in the month of July 1997. This constituted about 1% of the total cash flows remitted to this account during the year. For first six months one observes that there were no other cash flows received. The major cash remittances were in October and November. Most of these cash remittances are for compensation and PPI programme.

Table 4
Month-wise cash flow remittances to support five schemes of family welfare programme in one district during the year 1997-98 (Rupees in '000)

Month	Amount	Percent
Opening balance	35	
April		0.00%
May		0.00%
June		0.00%
July	24	1.21%
August		0.00%
September		0.00%
October	403	20.33%
November	460	23.21%
December	265	13.37%
January		0.00%
February	435	21.95%
March	395	19.93%
Total	1982	100.00%

Cash recepits credited to PL Account to Support (MEM, Compensation, Drugs and Medicine, PPI and CSSM) in a District, 1997-98

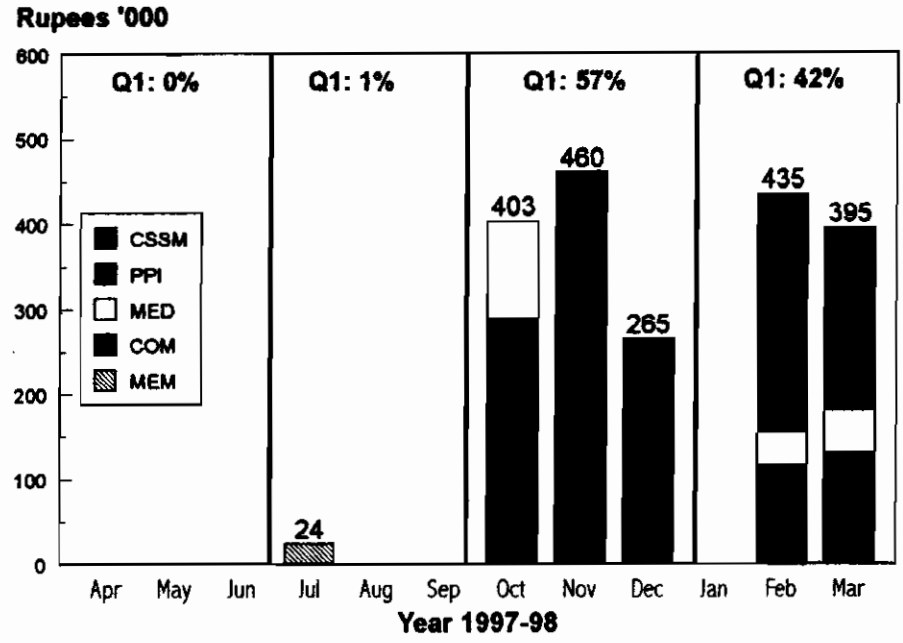

Figure 4

The cash flow remittances to districts are highly variable. It was also found that mechanism of transferring funds from centre to state and then state to districts adds to further delays. The mapping of funds transfer from centre to state does not exactly match with transfer of funds from state to districts. A comparison was made between the cash releases made by the GoI and cash remittances received by the district. Table 5 presents information about the quarter-wise release of funds for three schemes of family welfare and cash flow remittances to a selected district.

Table 5
GoI Funds Release to a State and cash releases to one district

Mass Education & Media	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
GoI releases to DoHFW	175	175	175	175	700
Cash remittances to District	0	24	0	0	24
Share in total scheme resources					3.43%
Compensation					
GoI releases to DoHFW	16252	16252	12804	10761	56069
Cash remittances to District	0	0	553	245	798
Share in total scheme resources					1.42%
CSSM					
GoI releases to DoHFW	2450	2450	2450	2450	9800
Cash remittances to District	0	0	40	215	255

The data suggest significant variation in two patterns and indicating treasury and systemic delays. One can also observe a variation across schemes in terms of proportion of funds transfer to a district. It also suggests that different criteria are used in allocating funds to districts under different schemes.

The above example shows that intra-year cash flows are highly uneven and irregular in case of selected FW programme components. The story is not different for inter-year flows i.e., over the period. Like intra-year experiences, the programmes also experience financial flows that are not regular and consistent. Table 6 illustrates inter-period allocations in a selected district.

Table 6
District: Health Sector Expenditure (Rs. '000)

	1996-97	1997-98	% change
Pulse Polio Imm. (IEC and Mobility Support)	562	866	54.09%
Public Health	6166	7260	17.74%
Health	14833	13924	-6.13%
TB	1490	1677	12.55%
Leprosy	1820	3988	119.12%
Blindness	295	435	47.46%
Malaria	246	543	120.73%
Kind assistance (Health)	5082	5739	12.91%
FW	22327	25832	15.70%
Kind assistance (FW)	4465	5166	15.70%
ICDS: allotment on referral	578	0	-100.00%
ICDS: value of medicine kits	698	698	0.00%
PWD/RD/R&B	831	923	11.07%
Red Cross/other donations	1000	1120	12.00%
Total	60394	68171	12.88%
Per Block (Rs. '000)	4646	5244	12.88%
FW per SC (Rs. '000)	26	29	12.93%
Total per capita (in Rs.)	40.26	45.45	12.88%
FW per capita (in Rs.)	18.71	21.13	12.93%

- Kind assistance for Health and FW has been assumed to be 20% of total support
- Donations were assumed to be about Rs. 10 lakhs per annum
- The allotment for the year 1997-98 for ICDS was assumed same as previous year.
- User Fees Collection is about Rs. 3 lakhs per annum

The district health finance information about programme specific expenditures at district level shows considerable variation in expenditure from year to year. It can be observed that there are changes to the extent of 120 per cent in allocation of resources to programmes. Some of these variations are because of delays and previous year allocations. It was observed that the delayed allocations create considerable burden on implementing agencies to spend the funds in the shortest possible time. This information also raises number of questions about the capacity of health departments and management issues in implementing the programme effectively.

These problems, as discussed above, raise lot of questions about the programme implementation and management capacity of the health departments. One can find that there are both systemic (institutional) and treasury management reasons for these problems. Fragmentation of sector, financial management practices at treasury and institutional level, lack of responsibility and who assumes risk of non-availability of funds, and capacity to handle the new tasks arising out of growing complexity of system are some of the institutional and systemic issues.

In sum, the effect of these systemic and treasury problems is:

- inadequate information on total resources available to implement the sector programme at different levels (centre, state and district);
- lack of clarity on financial management (e.g., purchase and payments) procedures and how these are expected to be implemented at different levels;
- less systematic recording and reporting of financial and other resource information;
- impossibility of linking the performance of the programme with the use of resources and ensuring end use of resources; and
- difficult to observe under-funding, over- or under-utilisation of funds for specific purposes.

Based on the above, it is suggested that an appropriate funds flow system should ensure that:

- mechanisms of funds transfer are clear (which account and where) and remittances takes place and information about it reaches line departments without delay
- funds are remitted as per line department's budget allocations or funds are made available when needed
- designated officer of line department is able to make or arrange payments to providers of service or suppliers within a reasonable time

- line department follows appropriate system of accounting which facilitates the systematic recording of resources received and spent and ensures financial propriety and treasury rules of the government
- reporting of ways and means position to line department heads enabling them to identify under-financing, under- and over-utilisation of resources
- funds are protected from diversion and end use of resources as per objectives of the programme are ensured

The financial management practices and treasury rules are also significantly influenced by the two important factors: one, mechanisms that are used in remitting funds and second, criteria that are used to allocate resources.

4 Mechanisms of funds flow

The mechanisms and processes used in transferring the funds and other resources would have significant bearing on the performance of programme objectives and the outcomes that it intends to achieve. There are five mechanisms presently available for channeling the government financial resources to districts for implementing various components of the health sector programmes and we discuss the implications of these on performance. These mechanisms are:

- Allotments through treasury
- Withdrawal of cash by designated officer of line department from State treasury
- Transfer of funds through cheque and utilisation of funds through bank account: (e.g., PL Ledger account)
- Letter of credit (LC)
- Funds transferred through cheque to State or district society

4.1 Allotment of funds through treasury

The annual budget of the State government provides the budget allocations to various line departments. The funds allocated are released to the district treasury in installments (generally quarterly installments). The state finance department decides how much of funds would be transferred to district treasury at the end of each quarter. These allotments are done through the letter of allotment and this transfer is referred as "paper allotments". The allotted funds remain with the district treasury but are placed at the disposal of the concerned line department. The experiences in many states suggest that district health authorities managing health programmes do not maintain systematic record of all allotments. In order to find what are the total allotments in a

given period, one has to refer to different files, which keep copies of these allotment letters, though not systematically.

Authorised line department officer (designated as Drawing and Disbursement Officer, DDO) have the option to draw the cash in advance against these allotments or use the services and submit the bills to the treasury for payments to third party. The DDOs draw the money from the Treasury under the system called Advance Contingency Bill system. Under this system the officials are required to submit the expenditure statements generally within two months of the withdrawal of funds. Given the lack of appropriate accounting systems and personnel to handle accounting of expenditures, and also the risks involved, it is generally observed that cash withdrawal system is not preferred. This also increases the workload of DDOs. The DoHFW has also experienced that there is considerable delay in submitting the utilisation or expenditure certificates for the amounts withdrawn. In the absence of proper financial management systems and capacity to handle the risks, the DDOs generally do not prefer direct withdrawal of cash.

The second method of submitting the bills for direct payment to third party is the most preferred method to handle the paper allotments. Under this systems the DDOs submit the bills to treasury for payments. The treasury office, after scrutinising the bills and ensuring the funds to be paid are within the allotted budgets, issues cheque in favour of the third party. The treasury can also withhold the release of funds if the accounts of treasury and line departments do not reconcile. Many times because of the general squeeze in state finances, the payment is also withheld. In case the concerned line department is not in position to use allotted funds by year-end 31st March, the unutilised portion lapses.

4.2 Withdrawal of cash by DDOs from State treasury

The transfer of funds through paper allotment from state to district generally takes considerable amount of time. In cases where these delays are long and there is an urgent need of funds, the state line departments may allow the concerned DDO to draw the cash from state treasury and use these funds to meet the obligations. Under this mechanism the concerned DDO will be required to submit the expenditure statement within the two months of taking advance money. This method is used in very rare circumstances. It has also been experienced that this method is also subject to problems of not submitting utilisation certificates on time and the settlement of the accounts of withdrawn money gets delayed. Since the risk of carrying the money are

too high and DDOs are not permitted to operate bank account for settling transactions, this is least preferred method by the DDOs. Also, ensuring proper compliance and monitoring of end use of funds utilisation is problem. In the absence of any proper system and financial controls, there are also questions of financial propriety.

4.3 Decentralisation of financial rules to operate separate account

Given the difficulties of time delays in transfer of funds through treasury and the procedures of government system in utilisation of the funds, the line departments have experienced considerable difficulties in implementing programmes and schemes. To ensure smoother and quick flow of funds, an alternative mechanisms has been adopted in number of states which decentralises the financial powers by allowing the line departments to operate separate bank account. This enables the designated line managers to issue cheques. Under this system, the funds are transferred from general treasury pool to this account and the designated officer is required to maintain a ledger account, cash book and cheque book and is authorised to issue cheques. For example, this system is known as Personal Ledger Account (PLA) in West Bengal. The accounts maintained by the treasury and the line department are regularly reconciled to ascertain the financial position. The treasury does not monitor and control the individual expenditures. It is considered that under this system the funds are protected from diverse use i.e., other than the stated objectives of the specific ledger account. However, funds from multiple sources can be remitted to PLA. For example, the funds for MEM, Compensation, Drugs and Medicine, Pulse Polio and CSSM were remitted to one single PLA in West Bengal at district level. In this case, the district is supposed to maintain separate books of accounts for each source. In West Bengal the DoHFW used this mechanism to transfer the funds of extra-budgetary support provided through the World Bank loans to implement the State Health Systems Development Project (SHSDP). For example, the DM operates PL account on behalf of District Health Committee (DHC) implementing the SHSDP.

The PL Account system has also faced the difficulty of not receiving the funds on time. For example, in West Bengal, the month by month receipts of cash flows under this mechanism suggest that there is literally no cash flows occurring during the first six months of operations to implement family welfare programme (see Table 4 above). About 60 per cent of the cash flows take place in third quarter and remaining during the last quarter. This raises serious management questions in implementing these programme components.

The PLA mechanism of channeling funds has become quite controversial in some states during the recent times. One of the major objections of the Accountant General (AG) has been about the resources going out of state treasury system as soon as funds are transferred to PL Account. It is argued that this adversely affects the ways and means position of the state. Also, there is no audit and monitoring procedure to keep track of utilisation of funds from this account. There is no reporting systems whereby the funds received in accounts and utilisation are constantly reported to state finance department or AG office. Reconciliation of what was received and what has been spent is less systematic and raises problems of verification of accounts and authenticity of each transaction. As a result questions of financial propriety are generally raised about the utilisation of funds from this account. From this viewpoint, institutionalising this type of system is therefore discouraged and resisted at different levels.

4.4 Decentralisation of financial powers - Letter of Credit (LoC)

To overcome the difficulties of PL Account, another mechanism used for making funds available for use is through the process of decentralising the financial disbursement powers to line departments. This method of funds transfer is based on banking principles of sanctioning a limit to the concerned line department. The designated line department managers can use the treasury bank account and permitting her/him to issue treasury cheques. At regular intervals generally after each month the accounts of treasury and line departments are reconciled. The advantage of this mechanism is that the line departments can use the funds without compromising on the ways and means position of the State since under this system the total budgeted allocations remain within the government treasury system till they are spent. There is also no uncertainty in transferring the funds once the allocations are finalised.

The designated officer of the line department is authorised to issue treasury cheques to make payments. This mechanism has all the other advantages of the PL Account system without compromising the state treasury's ways and means position. The designated office of the line department is having a limit to use the funds. This limit is conveyed to the bank and designated officer having state treasury account through mechanism called Letter of Credit (LoC). The line department is expected to maintain the account of all expenditures and send the statement of expenditure for previous month to the AG Office by the 5th of every month. The AG Offices uses this information to reconcile the expenditures and work out the funds position of the line department under LoC system.

Most of the states in India have used this mechanism for PWD departments. This was done to ensure work does not get delayed because of the delays in treasury payment system. It is increasingly felt that other departments such as health and family welfare which has considerable amount of interface with outside agencies to implement health programme should also have this type of facility. This mechanism of funds flow system uses the government system and it ensures that government accounting and auditing procedures is followed. There have been recent initiatives to use this mechanism in health sector. For example, the SHSDP in West Bengal has been recently allowed to operate the LoC to implement the World Bank financed project at the State level.

4.5 Setting-up of State and district level societies

Under the general financial rules it is not permissible for officers of line departments to operate bank accounts. However, in past the bank accounts have been used to channel the extra-budgetary funds from UNICEF for the pulse-polio programme. In this case the external agency would issue a cheque to the State FW Directorate which in turn would remit these funds through cheque to Chief Medical Officers. A separate bank account was supposed to be opened for this purpose at the district level. However, some state governments felt that this method was not in line with the treasury rules of the government and instructions were issued to close such accounts.

To avoid the problems of time and systemic delays in channeling the funds for various health sector programmes, the MoHFW has instructed State governments to set a "Society" at the state and distract levels for implementing number of national health programmes. For example, for the RCH programme the funds are now channeled through RCH Society set-up at State and distract level in number of states. The funds for RCH programme are directly transferred to state society, which in turn transfer the funds to district societies. From project management viewpoint, the roles of societies are expected to be different at state and district levels.

At state level, the role of the society is primarily to be a conduit for routing funds without going through the state treasury. It also monitors the utilisation of funds by the district societies by ensuring sound financial management practices in implementation of programmes. This would include the areas such as payment to outside parties, payments to people on contract basis and financing of NGOs and private providers. The role of the societies at the district level is to undertake expenditure for programme implementation at the district, to manage financial

resources effectively for achieving programme objectives, develop plan and receive funds from state society and spend as per the plan.

The creation of societies under the Societies Act provides implementing agencies separate legal entity and they can operate their own bank account. Having their independent existence, the societies through their management structure (e.g., governing body, management committees) can better address the concerns of all stakeholders who facilitate the planning process considerably. This is likely to strengthen the overall financial management.

The effectiveness of these societies in channeling the funds and strengthening the ability of the implementing agencies to implement the programme is yet to be experienced. The development of these societies is in infancy stage and has yet to take roots. A visit to number of these societies at State level will reveal that many of these agencies have yet to start the process of developing and institutionalising appropriate management systems. However, the experiences in funds flows suggest that in the initial stage the setting-up of societies have not completely reduced the problem of delay. For example, the funds release for the new RCH programme through societies indicates the delay of 262 days in one district (see Table 1 above).

The institutionalisation of new mechanism, called Society, has also brought with them many new management challenges. There is considerable amount of confusion as the people managing these societies are also part of the government and reconciliation of treasury rules and society financial management practices are yet to take place. There is lot of confusion at the implementation level and also considerable amount of reluctance at the level of managers to deviate from government treasury rules. Very little training and capacity building has been done to make the implementing managers aware of the new concepts and their implications. Many feel that this new approach of managing the financial resources may not produce desired results. Their effectiveness, however, depends on the development of capacities these societies would require to handle new management challenges. The society concept will have considerable amount of flexibility to develop and institutionalise planning and budgeting systems, financial accounting systems, contacting systems, involving NGOs and private providers through contracting mechanisms, use of imprest system to manage cash requirements better. However, this will be possible only if there is adequate top management support and appropriate policy reform initiatives, which would facilitate these areas, are taken at the State department level. The leadership role of the Centre would be key in ensuring that these are carried out effectively.

5 By-pass mechanisms: issues and prospects

The recent development in creating alternate management structures outside the government through the creation of societies (mostly government societies) is an attempt to address *inter alia* the issues pertaining to various funds flow problems (see Figure 5). In a number of centrally sponsored projects, the society set-up is required as a conduit to channel the funds and to implement the programmes (see Mechanism II in Figure 5). In most externally supported projects, the society set-up has become one important requirement. The state treasury is bypassed with the objective to ensure that the funds reach the designated implementing agencies on time. Less attention is paid to strengthen the management structures of these new institutions and one finds that systems and procedures required for effective functioning of the programmes are not in place in most cases.

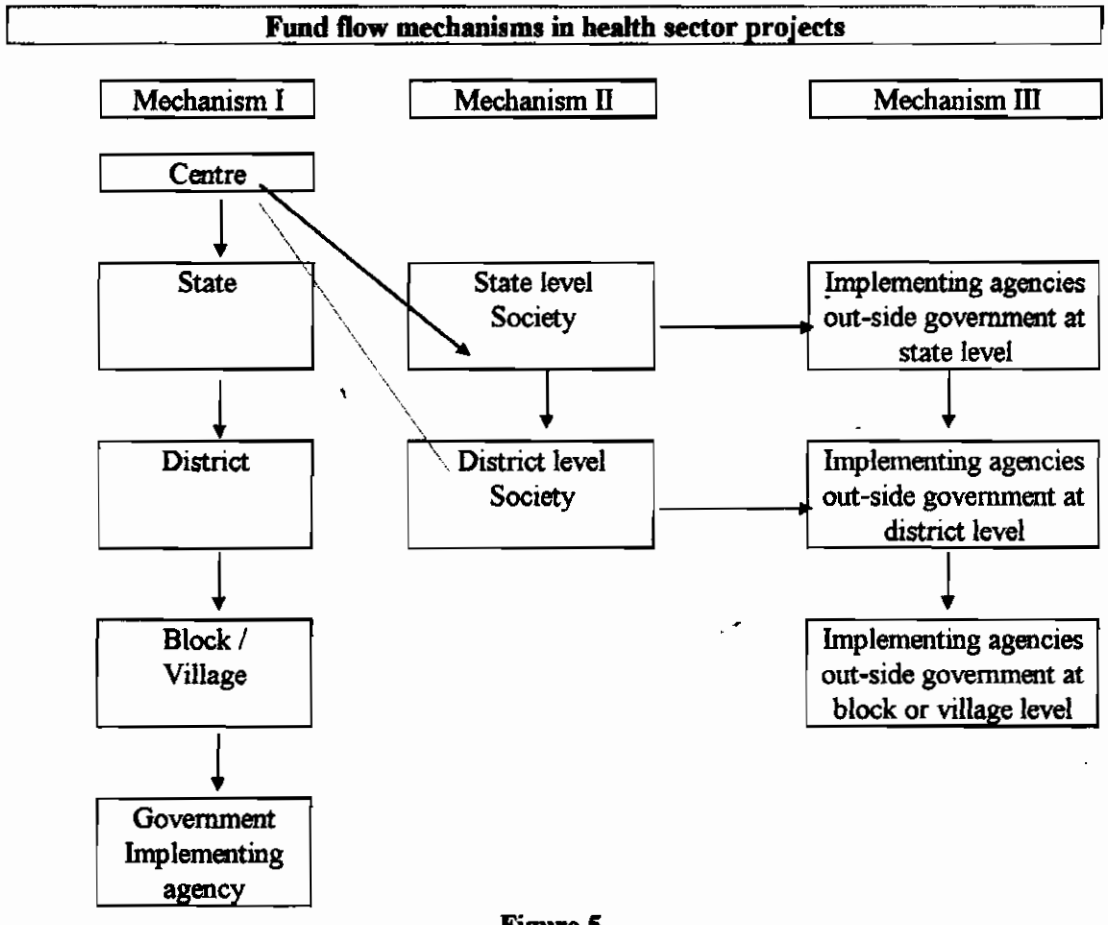

Figure 5

Most of the health sector programmes use districts as a unit of implementation centre. For effective implementation and smooth financial flows, district level societies have

also been set-up and they receive funds from State level societies or in some cases directly from the centre. One of the roles envisaged for the State level societies is also to provide adequate training and technical support to district level societies.

It has been the general experience that district or block level government agencies are not in position to handle all the load of delivering health care programmes. Invariably, a number of projects envisage involvement of NGOs or other private providers in implementation of programmes. The contracting out of services becomes an important activity of the state or district level societies. These societies are expected to develop the procedures and systems to handle these tasks more effectively, some of these tasks may take longer if implemented through the government departments. The capability to handle these new tasks requires strengthening of the management systems and capability. These new management structures aim at strengthening the management, technical and training capacities, promoting integration, involving non-government sector and having appropriate management structure to ensure delivery to the periphery. In this regard there are number of concerns which are primarily related to management and linking performance with disbursements.

5.1 Management concerns

In most of the programmes of the government the disbursements and reimbursements are based on the fulfillment of the following three submissions:

- audited accounts,
- utilisation certificates or expenditure statements, and
- activity report.

Generally the submissions for the funds reimbursements contain the information on physical achievements of the programme. The physical achievements as described in activity report are sent to the technical wing (e.g., directorate of health services) of the health ministry for examination and to certify the expenditures incurred. Based on the reports submitted to the technical wing, it makes recommendations for further disbursements. However, no attempt is made at any stage to relate and monitor the activities performed for the expenditures incurred. The disbursements and reimbursements in most cases are budget driven. The previous experiences with the disbursements suggest that the procedure of verification and subsequent release of funds takes about 45 days to 60 days within the ministry and has to go through number of levels within the ministry to ensure compliance of government procedures. In

number of cases the funds have not been disbursed to projects for long periods because of procedures delays.

The creation of NMS such as societies is likely to make this task more difficult and complex. There is growing recognition at the level of disbursing agencies to relate the expenditure and disbursements with the performance of programmes and activities.

In the absence of appropriate systems the delay in transferring the funds to various implementing agencies may increase. Therefore, for the programmes and projects implementation under NMSs such as societies, the overall review and monitoring of the project performance becomes quite critical.

Some attempts to strengthen these structures are worth noting. In number of cases the monitoring and a designated committee, for example, project steering committee, have been constituted which plan and follows-up the programme performance and evaluation periodically. This committee generally has a representation from a wide range of organizations including the central government, state government, NGOs, health institutions and other major stakeholders. The constitution and registration, which defines governance system of these new management structures, is generally carried through a prevailing legal framework. Important for their set-up are two important documents viz., memorandum of association (MA) and articles of association (AA) which define the objectives of the organisation and its governance system. Most of these societies are set-up in such a way that they function within government framework constituting a governing body, which would have overall responsibility of its functioning. The details of its governance mechanism are described in detail in memorandum and articles of association. Generally the executive committee is entrusted with the role of day to day management of these NMSs and the governing body handles all strategic decisions. For effective implementation of the programme, the societies need to ensure managerial and operational flexibility, involvement of various stakeholders, appropriate systems of planning, budgeting, contracting procedures and recruitment etc. Many have concerns and are skeptical about the government-managed society's ability and leadership to carry forward many of these processes to manage the activities of the programme effectively.

The fund flow mechanisms and financial management of resources are important aspects, which would need special attention and strengthening in case of these new management structures. The total funds requirements of the state-level implementing agency will depend on its activity plan. The activity plan depends on projected

activities and plan of its various constituents who are involved in implementation process. For this purpose the implementing agency needs to institute appropriate systems of accounting and budgeting. These societies would need to develop appropriate guidelines for expenditure. The societies would be required to hire the services of an external, private registered chartered accountant to get its quarterly/annual expenditures audited as part of requirement for ensuring financial propriety. The auditors' statement will identify the actual expenditure incurred by the project and certify that the expenditure was incurred in accordance with the terms and conditions of the rules of the society. In addition to this there will be government audit also.

For replenishment of funds, implementing agencies would be required to furnish up-to-date statement of expenditure periodically, may be at the end of each quarter. The societies are required to follow a specific set of guidelines about reporting of their expenditures. The following points are considered important in developing an effective mechanism for funds disbursements:

- timely submission of reports; deadlines need to be defined about the submission of reports (delay in submitting the reports are clear signs of non-functioning of management systems)
- clearly defined guidelines for examining/evaluating and seeking clarifications from the implementing agencies about the reports submitted;
- clearly defined deadlines for next installment of funds disbursements

The management structures of these programmes being outside the government also need to consider number of imperatives for their effective functioning. For example, at the disbursement level, the need for linking the funds disbursement with the performance of the project is considered important. The direct transfers of funds are likely to give rise to number of concerns pertaining to planning, monitoring, evaluation and control. Most of these concerns pertain to management issues in releasing the funds and the disbursing authorities would like to assure the following:

- do these new management structures have adequate accounting and management systems in place to ensure the compliance of basic treasury rules as they are ensured when fund are channeled through government treasury system
- since the funds are now directly going to the new management outfits, how to ensure that funds are utilised as per the suggested or agreed upon activities;
- in most projects and programmes, financial requirements would have significant component (in many cases 60 to 80 per cent) for recurring expenses, how to ensure

the funds are used effectively and efficiently; important concern here are to link the funds disbursements with the performance

- will there be adequate pressures on the staff to systematically plan for activities and make qualitative assessment of their activities; it has been experienced that the recurring expenses generally put considerable amount of pressure on disbursing funds even if the performance targets have not been achieved.
- what should be the system of releasing the funds for capital expenditure;
- do the societies have systems in place that minimise the cross-use of funds, which are allocated to specific set of activities;
- how to take care of working capital requirements of the project; does the advance payment of funds adequately take care of these requirements; what should be the level of advance funding to the implementing agencies in the beginning and at later stages; should the first installment of funds released be up-front loaded to adequately take care of working capital requirements of funds.
- in case of multiplicity of sources of funds (for example, government and external agencies) would linking of grant funds against achievement of certain performance indicators be desirable; what are conditions for satisfying fundamental requirements of funds being additional to the existing programme.

In case the project has large component of funds proposed to strengthen the systems and developing appropriate practices of implementing agencies, monitoring of such expenditures becomes critical. These expenditures are difficult to monitor as there are no definite relationships between resources spent and outputs. It is also difficult to measure and quantify the impact directly of such expenditure on programme performance.

The monitoring and evaluation of project performance are quite critical from viewpoint of project implementation and ensuring that goals of the project are achieved. For example, it has been observed in recent times that GoI is generally unwilling to pass funds to societies at the State level if they have not developed systems of accountability and these systems ensure that the funds would be used as intended.

As per the existing systems of funds flow mechanisms the implementing agencies are required to maintain accounts for reimbursable expenditure in accordance with agreed upon rules. Some of these rules are well defined in government procedures. The implementing agencies are also required to provide quarterly expenditure reports to the funding agency. As discussed above there should not be any confusion about the formats and systems, which will be followed and they should be spelled out adequately to avoid any delays and confusion in disbursement process. The staff should be provided with adequate information and training on the objectives, contents and

purpose of the agreed upon formats. As of today there are serious information gaps on the procedures that would be followed in using and disbursing the resources. The reporting relations and information requirements at different levels are not clear. Following a well-designed system of submitting expenditure statements as discussed above do not adequately respond to issues such as linking the performance with disbursements as raised in this section.

6 Linking performance with disbursements

As discussed above there are major concerns about linking the performance of the programme with funds disbursement. In this section we discuss the disbursement systems and examine their implications. There are three broad approaches, which are being followed by the disbursing agencies in various health programmes. These are:

- Expenditure-based disbursement (EBD) systems
- Performance-based disbursement (PBD) systems
- Activity base planning, budgeting and accounting (ABD) systems

Two programmes of the MoHFW have envisaged to implement the performance based disbursement (PBD) system. These projects are: RCH Programme of MoHFW supported by World Bank and Innovations in Family Planning Services (IFPS) Project in UP supported by USAID. The National Polio Surveillance Project has proposed to use "Activity Based Budgeting and Accounting System" to monitor the flow of funds to the various surveillance units all across the country. We discuss the salient features of these approaches in this section.

6.1 Expenditure-based reimbursement systems

Under this system of reimbursement, funds are released on submitting the expenditure statements or utilisation certificates. The implementing agency are required to submit audited expenditure statements, which ensure the authenticity of financial transactions. The system requires that vouchers for all transactions are kept as records and are subject to verification at any point of time. Under this system the programmes are also required to submit various output indicators. The relationships between outputs and inputs are generally difficult to spell out. Before spending the funds the project or programme may have agreed upon budget and broad output indicators.

The major problem in this system is the delays in releasing the funds to implementing agencies. Since there are no clear guidelines on how to establish the relationship between resource use and performance of the project, the delays are inevitable. The general tendency to get it approved at different levels in the ministry is guided by whether expenditure deadlines have been met. The risks of financial flows are not with the implementing agencies and the accountability of implementing agencies is not clearly specified.

This type of system of funding would be suitable where the technical relationships between inputs and outputs are very clear and there is no ambiguity in measuring these relationships. Under these conditions the setting of standards is easy and can be used effectively to evaluate performance. However, in most situations the relationship between resource use and outputs or programme performance is not clear or cannot be established, there is a need for an alternative system.

As against the system of disbursements based on utilisation certificate or expenditure statements, there is growing recognition to link the performance of the programmes with the disbursement procedures.

6.2 Performance-based reimbursement systems

Under this system the reimbursements are linked to the meeting certain pre-agreed milestones or benchmarks agreed upon before hand between the financing agency and implementing agency. The process of developing these indicators evolve:

- benchmarking of various tasks
- developing set of verifiable indicators for each benchmark, and
- budgeting amount of funds for each benchmark

Over the years assessing performance of health care delivery systems in many countries has given rise to number of approaches. Besides appropriateness review, peer review and outcome assessment, benchmarking is used quite often in health care in assessing and comparing performance of delivery system in many developed countries. The concept of benchmarking had its origin in corporate sector and was popularised by Xerox company. The benchmarking generally involves a process in which the standards of products, services or practices and their performance are defined and redefined on continuous basis following internal or external processes.

The internal process of benchmarks involves identifying internal functions, activities, milestones or tasks and they are used as basis for comparison. This method has been found useful in first time integrated delivery systems with multiple, diverse component entities.

The second approach of benchmarking is external or competitive benchmarking. Under this approach the standards for products, services and practices and their performance are defined against organisation's toughest competitor or organisations considered as industry leaders with the objective to surpass them within defined time-frame.

The internal system of benchmarking attempts to institute a management control system that monitors the performance and effectiveness of the health delivery system. The new projects where it is difficult to define the performance targets, benchmarking helps to define the milestones that are planned to be achieved. It creates pressure on programme implementers to define strategies and develop detailed work-plan to achieve the milestones.

The process of defining benchmarks involves the following:

- defining objectives and sub-objectives
- defining scope of activities
- developing benchmarks and arriving at value attached to it
- developing detailed work plan of activities to achieve the objectives
- determining criteria or indicators to measure or compare performance
- defining valuation criteria (whether within budget, evaluating technical progress and technical importance)

As discussed above there are presently two programmes of the MoHFW which have proposed to use the different variants of this system. These programmes are: Innovations in Family Planning Services (IFPS) programme in Uttar Pradesh supported by USAID and RCH programme supported by World Bank

6.2.1 IFPS Project

The USAID supported project in UP on Innovations in Family Planning Services (IFPS) project uses Performance Based Disbursement (PBD) system in which the disbursements are made against verifiable achievements for which a set of indicators

are developed (USAID, 1997). These indicators are agreed upon between MoHFW and USAID and project partners. These are discussed with project partners and agreed upon in advance. The objectives of developing the benchmarking system for this project were as follows:

- focus on results rather than inputs (different from traditional system of reimbursing based on expenditure statements)
- developing appropriate funding mechanisms based on verifiable indicators (developing state based society and directly channeling the funds to the society)
- strengthening the system of management of funds by shifting monitoring role to the implementing agencies rather than to be monitored by the MoHFW or USAID
- shifting the risks of ensuring financial flows to the implementing organisation

Till the end of 31 July 1997, the project had evolved 53 benchmarks. Since the inception of the project in 1993, the project has achieved 31 benchmarks. The experience in implementing PDB system has provided number of interesting insights into the financial management of projects and problems in implementing PBD systems. These are discussed later in this section.

6.2.2 RCH programme

The RCH programme implemented with the support of World Bank has introduced the concept of PBD for the first time in 1997. Under this programme, the annual work programmes and budgets would be reviewed and appraised based on critical performance benchmarks. The system of PBD as proposed involved the following two stages: one, defining the scope of activities to be monitored; and second, development of critical benchmarks. The scope of activities to be monitored under the programme is as follows:

- establishment of monitoring system
- timeliness of reports and critical actions
- training
- IEC
- availability of supplies
- provision of services
- timely completion of construction

- local community involvement

For each of these activities the RCH programme implementation strategy has developed broad benchmarks for the first two years of programme (Department of Family Welfare, 1997). These benchmarks are as follows:

- project management office in place through out the period
- expenditures vs. allocated budgets
- balanced expenditure in each category of expenditure
- availability of data as per agreed formats of reports
- households survey in 20% districts
- training of trainers and establishments of systems of proficiency certificates for these trainers

These benchmarks are expected to be reviewed periodically. It has been agreed upon that States, which would fail in achieving the critical benchmarks, would be recommended remedial actions within a time frame. And failure to implement the remedial measures would result in reduction or withholding of funds.

Benchmarking has a potential problem of making the project under-capatalised at least at the time of the start of the project. The project may not have adequate capital (long-term or working capital) to sustain its operations. The programmes can take care of this problem by assigning higher values to initial benchmarks. For example, in the beginning of the IFPS project implementation of some of the benchmarks were valued higher than what it could have cost the Society to achieve them. As a result significant amounts of funds were provided to the project in initial years. The project's experience in implementing the PBD system has provided number of insights in implementing this system and these are as follows:

- Projects generally take longer time to get started. It is possible that the during initial periods the project may result in significant pipeline of obligated funds which remain unutilised and ambitious schedule of activities and benchmarks plan lag behind.
- It is generally difficult to establish the relationship between achievement of benchmark, actual expenditure and the value of each benchmark achieved.
- Like the start date, there are delays in completing the activities of the project on time. Generally there is considerable gap between the initiation of activities and its completion as envisaged under the benchmark.
- It becomes difficult to monitor the financial progress of the project and on-going achievements of activities of the project. For example, in ongoing activities for

which money has been spent but the activity has not been completed, the PBD system will suggest non-completion of benchmark against the money spent. Appropriate monitoring systems are required to be developed to ensure better information on performance of programme activities. For example, the IFPS project suggests monitoring systems based on accrual concept for overcoming some of the problems in monitoring performance of the on-going programmes.

- The amount of funds released for a particular benchmark is linked to duration of that benchmark. For benchmarks of longer duration, the project may create huge reserve of funds. The guidelines and what flexibility the implementing agencies would have for use of funds need to be clearly defined.

- Analysis should not only be based on funds released but also examination of commitments. For example, the funds release show larger balances but most of these funds may have been committed. All commitments should be taken into account while evaluating the performance. At times the overall picture (when commitments are considered) may indicate a deficit situation, whereas based on expenditure analysis there may be impression of surplus situation. The assessment of financial progress on expenditure lines alone may seriously affect the sustenance and momentum of project performance and achievement of results.

- The PBD process involves considerable forward planning. For example, in case of the IFPS project benchmark negotiations took 12 to 18 months from initiation to finalisation which suggests the development and finalisation of benchmarks is comprehensive and involved process. The development, finalisation and reimbursements are based on extensive discussions among various stakeholders.

In real life situations given the complexity of health care delivery systems and level of developments of skills within the implementing agencies, it may not be possible to implement the PBD systems as described above. One of the possible approach at least in the beginning stages of programmes implementation could be to follow a hybrid system: one component based on PBD system and other on existing system. The time duration of the benchmarks could also be made short not like 2 years in RCH programme. We have found that it has resulted in considerable amount of delay in disbursing the funds to the implementing agencies. Under the PBD systems of funds disbursement, the Centre need to consider change in their role as different what exists today. The experiences also suggest that it is difficult to sequence the benchmarks. For example, the benchmarks that are proposed to be discussed in future or those under consideration, the activities would not start unless up-front commitment is made towards the funding. The reviews suggest that this may affect the momentum of the project particularly if the project is complex one.

6.3 Activity-based planning, budgeting and planning systems

As different from PBD and benchmarking exercise, an alternative to consider is a bottom-up approach focusing on detailed planning of activities for the project and accordingly preparing the plans and budgets for financial allocations. It is also important that the activities of the project are elaborately defined and a comprehensive accounting system is in place which is able to record and process financial information.

Activity based system is an integrated approach which tries to address the use of resources in relationship to performance; and activities in relationship to the programme objectives and its impact. This relationship can be described with the help of following diagram (see Figure 6).

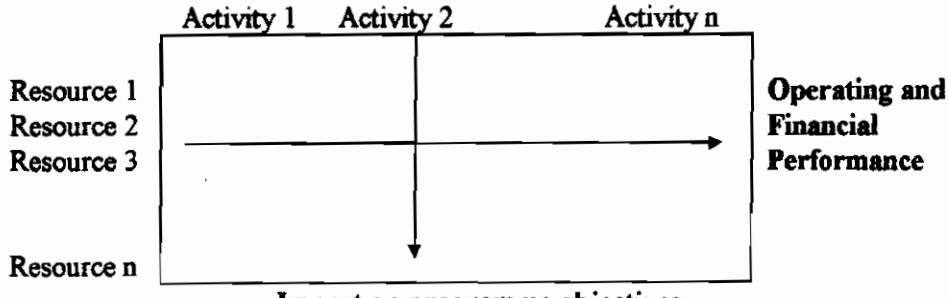

Figure 6

The system helps the implementing agency to establish clear relationship between resources use and performance on the one hand and activities and impact on programme objectives on the other. Figure 6 depicts the relationship between resources and activities. Resources in traditional sense are as inputs in the programme implementation (see Figure 7 below). In activity-based system the resource uses are classified as per the activities rather than on the basis of their functional classification (see Figure 7 below).

The activities of the programme are directed towards creating the impact and achieving programme objectives. The activity-based information system emphasizes relating the activities with the programme performance objectives. This helps to focus on relating the activities with impact on the one hand and resource with efficiency on the other. This system attempts to help the implementing agency to strike an optimum balance between the mix of activities that are not only economically efficient but also have maximum impact on programme objectives achievements. For example, under this system it is possible to identify the activities that do consume more resources but have less impact on programme performance. The information and system requirements of

this system are quite significant. Under this system funds are disbursed based on optimum mix of activities. The National Polio Surveillance project (NPSP) has proposed to use a variation of activity-based budgeting and planning system in their surveillance programme. It would be interesting to see the experience in implementing this system.

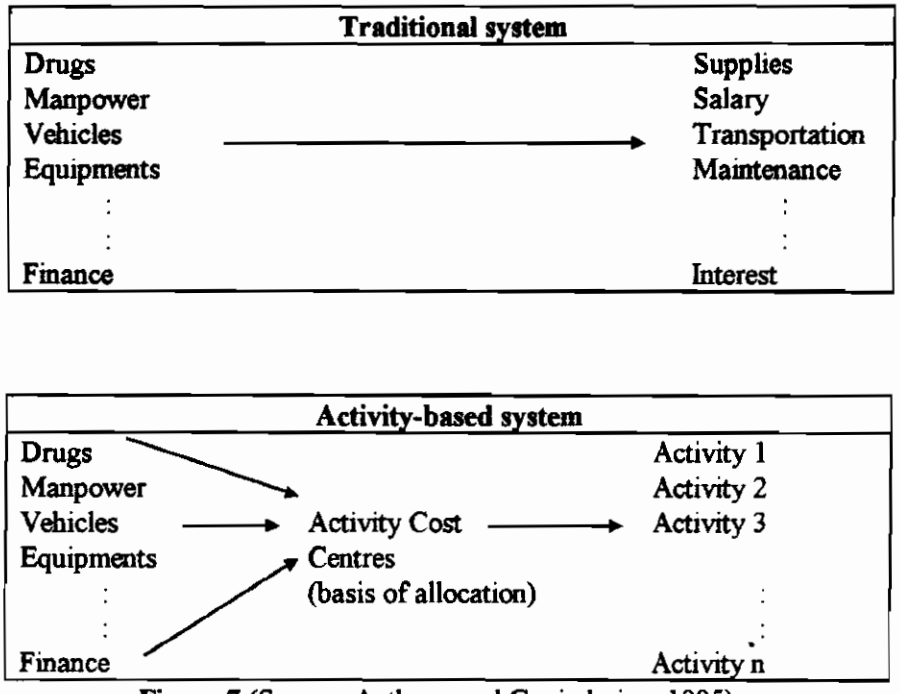

Figure 7 (Source: Anthony and Govindrajan, 1995)

Table 7 describes these three systems of disbursements comparing them on various dimensions.

From financial management viewpoint, the following factors need to be considered in designing and implementing any of the reimbursement system as discussed above:

- district based implementation would involve number of constituencies and stakeholders, coordination at different levels and complexities involved in implementing the project would be high;
- high percentage of recurring expenses and its implication for release of funds overlooking the performance;
- implementation through existing government manpower resources suggesting capacity building requirements are considerably high;
- management systems and capacities within the state and district level implementing agencies are inadequate.

Most projects in India at present are not in a stage where the financial flow risks (i.e., non-availability of funds in required quantity and at desired time) can be effectively transferred to the project implementation unit i.e., state or district level society. This would require that adequate capacities, systems and procedures are in place. Developing capacities in this respect would form important component of overall implementation plan.

Table 7
Comparison of three disbursement systems

	Expenditure-based Reimbursement	Performance Based Disbursements	Activity Based Budgeting and Accounting
Focus	on spending and meeting expenditure targets; no objective system to relate performance with expenditure	develop indicators of performance; use of benchmarking process and linking disbursements based on meeting these benchmarks	Comprehensive, focuses on total programme in an integrated manner; process of linking activities with performance and attempts to achieve optimal results
Suitability	where clear relationships exits between inputs and outputs and can be arrived at technically	more suitable where funds are provided as an additional component and benchmarks can be developed	activities are clearly defined and well designed management information and control system in place
Training requirements	not significant	could focus on specific components of PBD system	highly intensive in accounting, budgeting and financial management systems
Impact indicators	difficult to relate expenditures with performance and therefore difficult to assess programme impacts in health sector programmes	easy to relate with programme performance and difficult to make impact assessment; however physical targets also form part of impact assessment	information system provides appropriate data base to relate the resources with performance and activities with impact.
Management Information System	expenditure tracking important and information system designed to generate expenditure reports	needs information system to track completion of benchmarks and expenditure incurred on completing these benchmarks.	Activity tracking system and resource use forms important component of information system and has to be comprehensive and important to be integrated
Planning	budget based and expenditures are budgeted in advance; expenditures are incurred as per budgets	define scope of work and benchmark; need to have detailed work plan for each benchmark and budget for each work-plan; expenditures are incurred as per the agreed work-plan; strategic planning forms an important component of overall planning system	relationships between resource-activity; resource-efficiency; activity-performance and activity-impact are clearly defined; activity based costing, setting of standards and drawing optimum fit between activity and resources

7 Implications and future tasks

The Centre and the State governments have evolved or are in the process of evolving new management structures to ensure the smooth flow of funds to various health sector projects and programmes. The predominant form of these new structures is in the form of government societies. As discussed in previous sections these societies have been created as financial conduit for programme implementation and financial flows. In the process these structures by-pass the government treasury. Some national health programmes have created or are in the process of creating independent management structures such as project management units to manage the operations of the programme. Most of these developments are in nascent stage. In order to ensure that programmes are successfully implemented, considerable amount of work needs to be done to strengthen the financial systems of these new management structures. The development of appropriate monitoring system and performance indicators is an integral part of the whole process.

Some of the basic financial management systems required in programmes and projects that would be required are as follows:

- planning and budgeting system
- financial management system
- contracting system and
- cash management system.

Besides this these agencies will be required to develop financial authorisation norms, internal control checks and norms that will ensure accountability of funds.

At present most of the implementing agencies do not have capacity to handle these tasks. Under the proposed management structure paradigm, linking of performance with disbursements; or linking of activities with disbursements becomes imperative. At the same time it appears that creating more accountability for funds management would become necessary for successful implementation of programmes. The development of capacities needed to handle the new tasks will take some time. Appropriate training programmes and capacity building programmes will be required to strengthen the management aspect of these programmes. The existing training programmes offered to health professionals in management and related areas do not have clear focus on these aspects. Management training programmes offered by various training institutes in the country emphasize developing personal inter-personnel

management skills. The development of new programmes will need to give appropriate thrust to other functions of management and should emphasis to develop functional areas such health finance. A review of these programmes is necessary in view of the developments in funds disbursement systems and implications of setting-up new management structures. In case the implementation agencies follow the strategy of phasing out the implementation of performance or activity based disbursement systems, the time should be used to build capacities of new management structures to ensure institutionalisation of appropriate systems.

It should also be noted that the capacity and system requirements of new management structures would vary from situation to situation. Each project while working out the mechanism to implement any disbursement system needs to consider the conditions within which the project will be implemented.

While designing the financial management systems it should be ensured that the new systems help the implementing agency to guide them to work out most appropriate and suitable activity plan and reporting system adequately highlight the performance of programme or project. In this case the activity mix and performance indicators would be an important outcome of financial management and reporting system (see Figure 8).

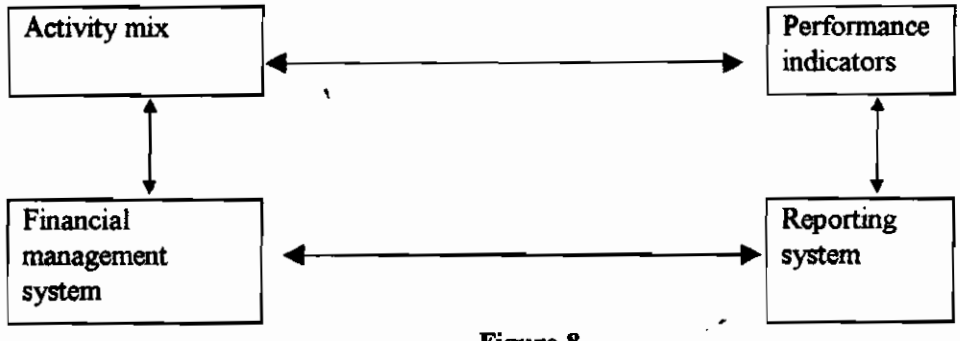

Figure 8

This, along with the development of capacities, should be achieved through instituting the development of following systems in phased manner:

- cash flow planning system
- activity based budgeting
- strategic planning system
- benchmarking of performance indicators

In the initial stages of the project, the linking of funds flow with performance indicators should recognise the difficulties and constraints as described in this paper. It should be acknowledged that when programmes are going to be implemented through entirely newly established structures, the tasks of developing the systems from zero-base pose considerable amount of difficulties and change management is major challenge. It is also time-consuming process. Right from the beginning, it would be difficult for the programmes to benchmark the performance and link the disbursement of funds with meeting any of the benchmarks.

Attempts to strengthen the financial management systems of the project should take these constraints into account. An appropriate strategy would be to benchmark the **procedures, practices and processes** in the initial stages of the project implementation rather than performance of programme. Most of the procedures, practices and processes need to be adequately spelled out. Adequate care needs to be taken in ensuring that meeting of these benchmarks is properly evaluated before linking it with funds disbursements.

8 Summary and conclusion

The central sponsored programmes (CSPs) have been one key policy initiative of the Government of India to support the health sector programmes directly, even though health has remained a State subject in India. The family planning programme was the first programme to be supported as a part of this policy initiative. Later on a number of new programmes have been added to this list and these are described as national health programmes of the government of India. The centre provides direct support to the states in meeting both recurring and non-recurring expenditure of programmes under this policy initiative. The implementation of the programme remains the responsibility of the state. It was envisaged that the centralised focus would provide proper direction and thrust to specific health problems of national importance and management and implementation issues could be handled more effectively.

Most of the programmes under the CSP policy initiative have also received financial support from number of international external agencies. The kind of financial structure and technical characteristics of the programmes has triggered the need to have separate management structures, giving them a character, which is essentially vertical in its approach. Also, many of the policies and procedures followed under these programmes have been influenced by the requirements of the external agencies. With

little coordination across different agencies and lack of sector-wide focus has led to differences in management approaches in implementing the programmes and these differences across number of health sector programme initiatives persist. There has been no uniform approach in addressing the management issues that has arisen out of interaction with the number of diverse stakeholders in the sector. Also, the government lacks having adequate and appropriate polices to address growing complexities in managing the programmes.

The experience suggests that there is very little coordination between these programmes and what is happening with other activities in the health sector at district level or at state level. Mechanisms of information sharing and coordination, pivotal from sector management viewpoint, between various programmes are almost non-existent at both macro and micro level.

Through various policy instruments the centre has emphasised its role as major provider of services. There has been less clarity on the roles and responsibilities of the centre as financial intermediary for mobilising resources (interface with external agencies), allocating resources to states mostly as grants and ensuring end use of resources. The view of the centre as provider of services (different from financial intermediary of the programme) has primarily influenced the development of systems, implementation structures and various policy measures in implementing the programmes. These views and policy instruments used over the period has undermined the capability of the States to manage and implement the programmes and these had unintended impact on the state's ability to implement and manage the programmes.

There is less clarity on the implications of this policy instrument and what happens when loan funds are transferred to states as grants. Where the CSP policy had envisaged to protect the funding and administer specific components of the health sector programme effectively, their implementation has led to number of unintended consequences. There are no financial systems ensuring basic financial management discipline to handle the present day complexities of the programme management in many CSPs. With the inclusion of many new programmes over the period, the policy has created more fragments than integrated the process of disease management at the micro levels. No one assumes the risk of non-availability of sufficient resources to implement the programme objectives effectively and states do not exhibit sense of ownership of these programmes. Changes and implementation strategies are generally top-driven which has aggravated the problems of programme management. The centre

tends to use uniform approach to manage the programmes despite the wide diversity at ground level conditions and variation in availability of necessary infrastructure. Criterion for allocating the resources lacks transparency not only from centre to states but also from states to districts and equity issues in resource allocation are not clear. The CSPs have not helped the states to develop their capacity to manage the programmes and has displaced alternate funding which otherwise could have been made available to these programmes. Long-term sustainability of these programmes remains a major issue. Over the period the uncertainties in resource flows have grown considerably and have affected the programme implementation. The artificial division of the health sector programmes and its components create serious distortions and undermine the capability of the states in number of areas. It also prevents the sector managers at the centre to have a sector-wide view and allocate resources accordingly.

Difficulties have been handled in an ad hoc manner, without having any policy frame. Emanating from this, *by-passing* the state treasury has become one important character of these programmes in recent times. This is reflected through various policy instruments such as provision of kind resources (drugs and other supplies) directly by the centre to the implementing agencies in the districts. The states are by-passed. There are no plans made at the State level for these allocations and state administration and implementing agencies generally do not have adequate and systematic information on total resource availability, making difficult to manage and assess the programme performance.

Similarly, as per the recent changes the funds are now transferred through state level and district level societies. The policy frame for the functioning of these societies is not clear. As a result one finds that these societies lack adequate financial management and reporting systems to ensure end use of resources.

Many of these interventions have had adverse influence on various implementation strategies such as development of implementation guidelines and performance evaluation systems, which has remained top-driven. Inappropriate and inadequate monitoring mechanisms for performance evaluation are an obvious outcome of these policies because it would have meant centre evaluating its own performance.

Criteria for allocating resources in compartmentalised and earmarked manner are significantly input driven and lack process element. Thin resource base is spread so scarcely to various requirements that most of the time nothing is achievable in the

process. Salaries most of the time crowd-out the other uses such as maintenance of facilities and equipments, adequate support for mobility of personnel and medicine.

Financial management function of these programmes has remained unattended. Funds flow uncertainty from external agencies, dwindling government budgetary support, processes and mechanisms followed in the government to transfer resources have resulted into serious delays, increasing arrears indicating deferment of committed and essential expenditures. These are some of the major undesirable outcomes of the policy initiatives in the past. This policy initiative has reinforced excessive dependence of State on Centre for funds and other kind resources, making implementing agencies less concerned as a result of fewer stakes in strategic management of the programmes.

The present structure of ministries of health does not have adequate institutional mechanisms to address these problems. The entire fragmented structure of the different components of the programme remains less integrated with the overall strategy and structure of the health bureaucracy in the country. The reporting relationships in the health bureaucracy are diffused adding to the complexity of managing the programmes. For example, the bifurcation of technical and non-technical wings in the secretariat on the one hand and health, family welfare and systems of medicine on the other adds considerable amount of confusion in defining these relationships and responsibilities between state and district level agencies and relationship of state vis-à-vis with the centre. These have considerable implications for programme management. The CSPs are less and inadequately integrated with the overall structure of health departments in the state.

The most undesirable consequence of this intervention has been Centre's failure in ensuring that administrative levels in the state assume the risk of non-implementation of various programme components or assume the risk of non-availability of key resources and responsibility of its implications. In the absence of these, the treasury rules and other systemic problems have seriously affected the availability of finances and other resources, adversely affecting the motivation of the personnel in implementing the programmes. Increasingly, the financial management dimension is becoming important to ensure the better performance of these programmes.

This paper has made an attempt to understand financing issues of health sector programmes in general and have brought out number of important institutional issues, which need the attention of policy makers. The mechanisms and processes used in transferring financial and other resource flows to implementing agencies do have

significant implications for determining the ability of health sector programme managers to use the funds and determine how resources will be used to meet the people's health needs. The recent experiences in programme implementation have highlighted delays and other institutional problems as major obstacles in ensuring the availability of funds. There are four main types of initiatives required to strengthen the system and these are: (a) clarity on mechanisms of funds transfer and remittances of funds as per line department's budget allocations; (b) making funds and other resources available when needed; (c) well laid down policy guidelines on financial management including appropriate system of accounting, reporting of ways and means position to line department heads and contracting out of services; (d) ensuring end use of resources as per the programme objectives. The paper has discussed the implications of setting-up societies and using them as conduit of transferring financial and other resources to implementing agencies.

References

1. Anthony, Robert N. and Vijay Govindarajan. 1995. Management Control Systems. Richard D. Irwin, Inc., 1995.

2. Bhat, Ramesh. 1999a. "Health financing issues and context for programme of work in health financing and economics: Orissa Health Sector reform project," Report prepared for British Council, New Delhi, March 1999.

3. Bhat, Ramesh. 1999b. Strengthening the systems and mechanisms of funds-flow in health sector in India, Health Sector Group Report submitted to the Health Sector Group, DFID, New Delhi, March 1999.

4. Bhat, Ramesh. 1998. Financing of family welfare programme in West Bengal. Report submitted to the Health Sector Group, DFID, New Delhi, India. November 1998.

5. Department of Family Welfare. 1997, Reproductive and Child Health, Project Proposal and Implementation Plan, Volume I, Government of India.

6. EC Preparatory Mission for Health and family Welfare Sector Development, Sector investment Programme in Health and Family Welfare, India, Final Report, InDevelop Uppsala AB, April 1997.

7. Mavalankar DV. 1996. "Can PHC System in India Deliver Emergency Obstetric Care: A Management Perspective on Child Survival and Safe Motherhood Programme." *Social Change*, September-December, 1996, Vol.26, Nos.3-4.

8. Mavalankar DV. 1998. Management constrains for operationalization of Reproductive Health Programme Interventions in PHC system in India. (Unpublished).

9. Planning Commission, "Approach paper to the Ninth FiveYear Plan," 1997-98, pp 87.

10. Rao, K. Sujatha. 1997. *" Financing of Primary Health Care in Andhra Pradesh,"* Report prepared for World Health Organisation.

11. USAID, Innovations in Family Planning Services Project, Midterm Assessment Report, September 1997.

12. WHO, India: Tuberculosis Programme Review, WHO September 1992

13. World Bank, "Measuring the achievements and costs of Reproductive Health Programmes," Report of a meeting of the Working Group on Reproductive Health and Family Planning, June 24-25, 1996.

14. World Bank, 1995. "India: Policies and Finance Strategies for Strengthening Primary Health Care Services." Report No. 13042-IN, Population and Human Resource Division, South Asia Country Department II, The World Bank, Washington D.C.

15. World Bank, India: New Directions in Health Sector Development at the State Level: An Operational Perspective. (Report No.15753-IN), Feb. 11, 1997.

16. World Bank, India's Family Welfare Programme: Towards a RCH Approach, Report No. 14644-IN, June 1995.

17. World Bank, World Development Indicators, Washington DC. 1998.

Appendix 1

Characteristics of funds flow mechanisms	Mechanisms of funds flow in health sector				
	Paper transfer	**Cash withdrawal**	**PL Account**	**Letter of credit**	**Society bank account**
Clarity of mechanisms of funds transfer at all levels	• funds are transferred to treasury as per government financial rules • no ambiguity in where to transfer and how • clarity of process at all levels • information passed on through allotment letters	• funds transfer mechanisms are same as in paper transfer	• line department operates bank account with the permission of AG and DoF • funds are remitted to this account • supposed to have information at all levels but problems surface number of time between agencies sending the cheque and line department	• funds remain in treasury • designated officer of line department issued a letter of credit defining limit up to which he use the treasury cheques • allowing use of treasury cheques goes through long procedure of approvals from AG, DoF • once approved this mechanism is quite efficient	• mechanism very clear at all levels • each society has its own bank account and funds remitted to this account • concerns since the system by-passes the treasury and need approval at various levels to transfer funds to society • setting-up of society takes time and requires backing of government policy
Frequency of cash flows and ensuring whether funds are available when needed	• generally quarterly allotments • most of committed expenditures are transferred through this mechanism • no mechanism in place to assure funds are available when needed	• quarterly allotments • suitable for small amount transactions	• no fixed pattern of remitting funds (irregular supply of funds) • most of non-recurring and contingent expenditure are transferred through this account - serious effects on performance of programme	• allotments and further amounts sanctioned after reconciling the funds availability and expenditure • funds are generally available when needed	• the society is supposed have its own budget and activity plan and funds are supposed to flow as per this plan • initially because of procedural delays and establishing back-end systems in the government, inordinate delays have been experienced in getting funds
Payment procedures and delays	• advance cash withdrawal mechanism available, but least preferred • bills submitted to treasury for payments • delays take place either allotment not received or government's overall budgetary position • no time limits set for payments to third party and inordinate delays experienced and suppliers or providers of service reluctant go through this mechanism	• designated line officer can draw the funds from treasury • funds are used to pay for services or goods • statement of expenditure submitted within two months of advance	• payments through cheque • delays take place because of irregular supply of funds • in most cases the rules and procedure for payments are not spelled out • not a well accepted system	• payment procedures are straight forward as the designated officer has the authority to issue treasury cheques • supposed to follow treasury rules • in most cases the rules and procedure for payments are not spelled out • well accepted system	• society is expected to lay down payment policy and procedures • many societies in the process of institutionalising these systems • supposed to have considerable amount of flexibility in handling various types of payment procedures (e.g., direct payment to suppliers, contacting out of services and payments to NGOs etc.)

Accounting system and treasury rules	• government treasury accounting system and ensures propriety of government treasury rules • no accounting system maintained at the line department level • funds remain within government treasury till used	• designated officer who takes advance responsible for maintaining record of expenditure • no system of accounting is required (for example financial management practice of maintaining of Imprest System would have most suitable)	• maintains bank account • no specific accounting system in place • no procedure for cash advances and imprest type of accounting system • funds go out of the treasury system when funds remitted therefore affecting states treasury ways and means position	• maintains accounts as per treasury rules • funds remain within treasury till used	• society would generally follow a mercantile system of accounting • institutionalisation of sound financial management practices such as planning and budgeting system, activity plans, cash management system, imprest accounting system are possible and project management gets strengthened
Reporting on utilisation of resources and information system	• no system of reporting except expenditure statements means of verification • aggregate allotments and utilisation of funds not known	• no period reporting of these expenditures • advances are settled directly with the treasury	• no systematic way of reporting on utilisation	• recording and reporting of expenditures every month to AG and treasury • reconciliation of all expenditures • funds position related to that account known every month	• regular recording and reporting of operational and financial performance • development of appropriate financial management controls possible • ways and means position of the society known at regular intervals • funds go out of treasury once transferred to the society
End use of resources	• most funds are committed in nature e.g., salaries no need for verification for end use of funds and • expenditure as per the budget allocations • funds lapse if not used within fiscal year	• no mechanism in place to ensure end-use of resources • bills only evidence and settlement based on expenditures	• lack of systemic recording of outputs and therefore lack mechanisms of end use of resources; many times cheque issuing authority not dealing with the programme implementation • PPI programme having high visibility ensures proper utilisation • funds do not lapse if not utilise with one fiscal year	• designated officer directly dealing with the output and better judge to make payments • no systems of monitoring outputs of designated officer giving way to perverse incentives • funds lapse if not utilised within fiscal year	• activity plan becomes guide for spending resources • effectiveness of resources used depend on the efficiency and adoption of new financial management systems • most society functioning within government set-up, institutionalisation of new initiatives is taking considerable amount of time

Appendix 2
Arrears as percent of current years cash budget support for family welfare programme to states in India 1997-98 (Rs. Lakhs)

State	Total support	Arrears	Current support	Percent
Andhra Pradesh	8838.71	2373.40	6465.31	37%
Assam	3284.70	795.45	2489.25	32%
Bihar	9894.51	3525.17	6369.34	55%
Gujarat	9446.00	3817.69	5628.31	68%
Haryana	3521.84	1306.85	2214.99	59%
Orissa	4821.63	1107.99	3713.64	30%
Rajasthan	7299.73	997.96	6301.77	16%
Tamil Nadu	10835.89	4255.62	6580.27	65%
Uttar Pradesh	19276.48	7457.73	11818.75	63%
West Bengal	5201.99	99.38	5102.61	2%
Jammu and Kashmir	1873.62	871.43	1002.19	87%
Sikkim	218.87	2.33	216.54	1%
Overall	84513.97	26611.00	57902.97	46%