Financing of the District Health Plan

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Current Approach to Financing:

What is acknowledged !!

- Budget received by state divided to districts
- Untied Grants at facility's discretion (AMG, RKS, Untied Funds)
- All other funds tied to specific programmes with rigorous guidelines- JSY, SNCU, ASHAs
- State budgets not part of plan.
- Funds sanctioned different from district plans.

What also may be happening ?

- Budget released to district separately, with separate sanction for each line item.
- Informal guidelines specify what is to be done with untied funds.
- Despite rigid guidelines on other "tied" items, re-appropriations occur.

Problems Faced in Financing-1

- Pile up of unspent funds at district level.
- Untied funds lie unspent in facilities which are marginally functional or non functional.
- Those facilities who do not spend, do not produce UCs on time and therefore next instalments cannot come – and this affects the facilities who need money.
- The pace of expenditure is set by the poorest performers.

Choked pipelines -2

- No clear operational guidelines for each programme available with the district.
- NRHM funds as an additionality in facilities:
  - Sub-centers by 50%
  - In PHCs by 20%
  - In DHs by 2%
- But case loads have increased much more in DHs and CHCs, and less in APHCs and minimally in sub-centers (JSY effect)

The Financial Achievement- Physical Achievements-Outcomes Relationship

- Loss of link between physical achievements and outcomes-
    - Mismatches: Infrastructure – HR – training – equipment – skills
    - Activity- outcome relationship (example: 100 ANMs trained- but no increase in SBA attended deliveries; 3 nurses deployed- but no increase in services)
  - Since Sanctions are by budget line- it results into fragmentation of both strategy and finances
- Sometimes even financial achievement and physical achievements links untraceable as in untied funds.

Not Merely a Management Issue- Also a Financing Issue

Addressing the Problems

- We have to repair the ship- when we are sailing it.
- Health System Can't be "closed for repairs."
- Has to be done within current context- of governance, of existing and potential capacities
- System is risk averse- cannot try major repairs.
- At best allows minimalist solutions . – small steps in the right direction are better than no steps at all.
- If we understand the solutions - then each small step can become the basis for major reform

But accepting the current mess is not an option. It prevents absorption of funds- and justifies privatisation of health care.....

How to get started

- STEP 1: Admit there is a problem!!! “Cannot wake the man who sleeps with eyes open”.
- STEP 2: Recognition of the two purposes of the plan. (i) as a tool to <u>bring resources</u> to the district. (ii) as a tool to <u>spend the resources</u> received by the district. : alignment of plan with sanctioned funds . (Can we have a base “strategic plan” from which we extract and submit annual plans?)
- STEP 3: Find out/communicate the resource envelope to plan
- STEP 4: Start with what can be done within current rules – let’s do it well- That would help expose the design issues.

Axiom: *If only 30% of the districts are doing it wrongly, it is an implementation problem. But if is 70% of the districts are getting it wrong- then it is probably a design issue- requiring policy intervention.*

Casting the district budget of NRHM
A budget page for each programme component:

- Every strategy is a composite of activities. Every activity needs a budget line. Text of the plan has to state activity with timelines and exact facilities (inputs/resources) and persons responsible.
- Then write the budget page for each strategy-
  - State Unit costs and Quantities,
    - How to define a unit cost: eg training costs calculated as per trainee or per batch
  - Match financial achievement with physical achievement and outputs.

Example : Child Health Budget

Activity/ Item	Unit Cost	Quantity	Total	Cross Reference No.
SNCU start up				
SNCU maintenance				
NBSU start ups				
NBSU maintenance				
New NBCs				
NRC start up				
NRC maintenance				
IMNCI Plus training package				
MO trg packages				
ASHA training package				
ASHA incentives				
BCC- Kit				

Arriving at Unit Costs eg IMNCI (to be prepared at state level)

Item	Unit Quantity	Rate per day	No of days	Total	Cr. Ref. No.(if.)
Trainers Fees and DA					
Trainers travel					
Trainees Fees and DA					
Trainees travel					
Training material					
Local travel/ stationary					
Total costs for 30 trainees				624,000	A.11
Unit cost per trainee to NRHM				20,800	
Supervision costs		1000	5		Unicef
Venue plus logistics manager(DTC)				10,000	State budget

Cross reference numbers relate to standard budget format.

Arriving at Unit Costs eg New Newborn Stabilisation Unit. (to be prepared at state level- caution this is only an example)

Item	Unit costs	Qty.	Total	Cr. Ref. No.(if .)
Infrastructure- minor civil works				A.9.3
Equipment				A.13.1
Drugs and supplies				A.13.2
Training of MOs/nurses				A.11
Additional nurses				B.10
Supervision costs				A.2
Total first year cost of new NBSU				
Unit costs of NBSU				

Cross reference numbers relate to standard budget format

Standard Budget Format-
--linked to strategies text and budget pages

Programme component – also major budget head	A	Minor Budget Head
MATERNAL HEALTH	1.	1.1 Operationalising facilities 1.2 Referral transport 1.3 Integrated outreach services 1.4.JSY 1.5 24-hour deliveries
CHILD HEALTH	2	
FAMILY PLANNING	3	3.1.Terminal/limiting methods 3.2 Spacing methods 3.3.POL for Family Planning 3.4 Repairs of laparoscopes
ARSH	4	
Urban RCH Tribal RCH Vulnerable groups	5 top 8	Usually no strategies are submitted here.- why?

Programme Component-	Budget Heads	Budget Heads
Facility Development	A.9. 1 to A. 9.5. A.10.	Infrastructure & HR 1. Contractual staff & services 2. Major civil works 3. Minor civil works 4. Operationalise infection (waste) management 5. Other activities 10. Institutional strengthening
	A.11, B12, B13.	Training
	A.13. & B 18	Procurement 1. Procurement of Equipment 2. Procurement of Drugs & Supplies
	B. 2; 3;4;5; 6; 19	2. Untied Funds/3. Hospital Strengthening/4. Annual Maintenance Grants/5.New Constructions, Renovations and setting-up/6RKS Corpus funds/19 support services
	B.11. B.14	Additional Contractual Staff: Incentive schemes

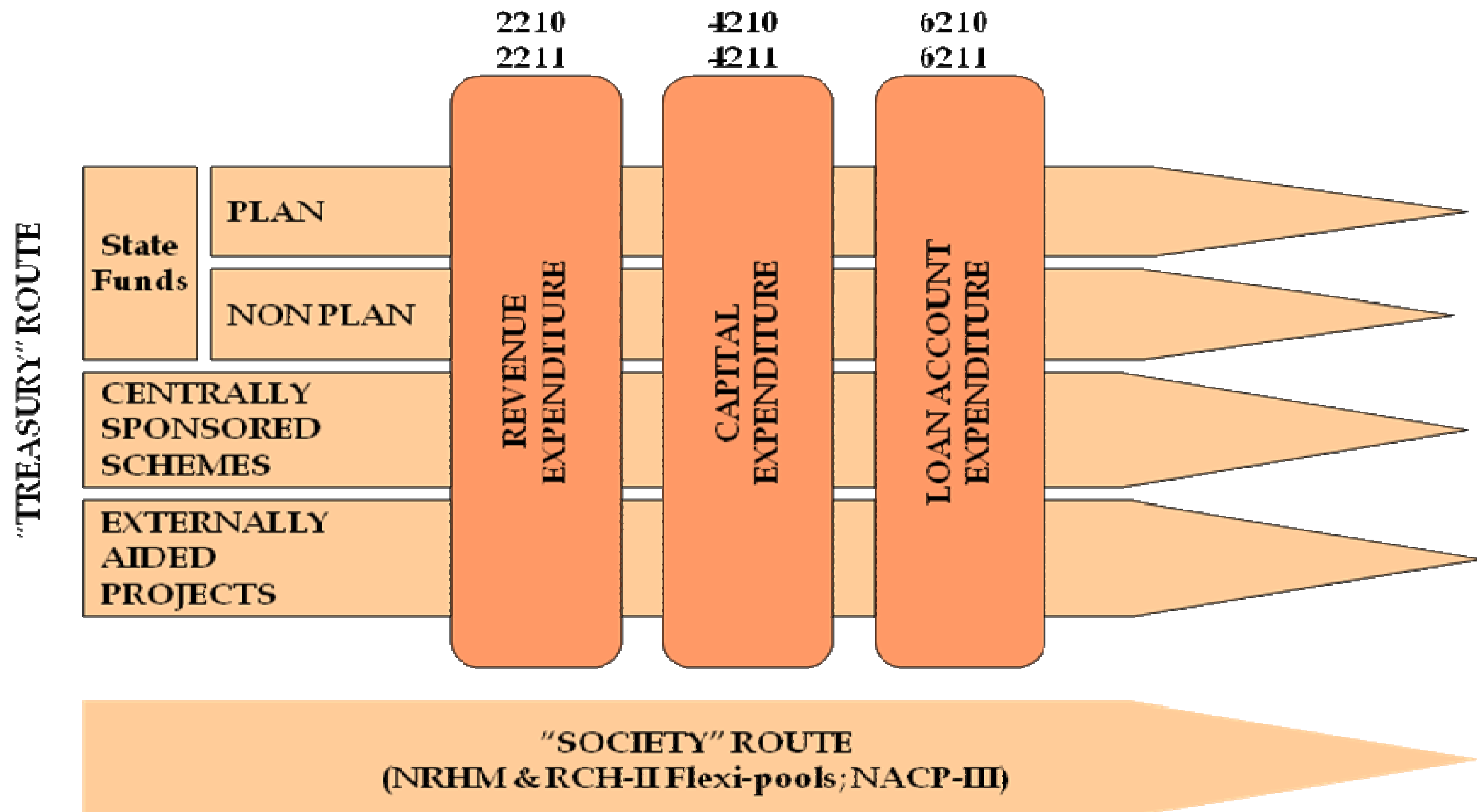
Standard Budget Format- Community Processes and management.

Prgm component text – also major budget head		Budget Head s
Community Processes- ASHA	B.1.	ASHA
Community Process- VHSC	B.2.	Untied funds- VHSC component
Community Monitoring	B.16	Community Monitoring
BCC	A12. & B. 8	Under RCH and under NRHM
Referral Transport PPP/NGOs	B.11 B.9 , A 1.2. A 8.	PPP?NGOs Referral Transport
Programme management	B12;14; 17; A 12	Planning& Monitoring ,M&E, Programme management

Writing the budget- showing links

- For each of the components - Maternal health, child health, facility development, programme management etc- write a few pages of text describing the strategies and indicators and ending with a component budget page as discussed.
- Then fill in the standard budget format- using budget head numbers as cross reference numbers in the programme component budget page.
- Budgets of RCH and NRHM would necessarily be separate. The programme component texts could be the same- or different as per instructions….

Structure of Health Budget



Structure of Treasury Budget

Hierarchy/level	Budget Lines/Heads	Example (with code)
Level 1	Major head	Medical & Public Health – revenue expenditure head (2210)
Level 2	Sub-major head	Public Health (06)
Level 3	Minor head	Prevention & Control of Diseases (101)
Level 4	Sub-minor head	National TB Control Programme (04)
Level 5	Detailed head	Drugs & Medicines (60)

Treasury Route: Challenges

- Line-item budget (lack of flexibility)
- "Doctrine of Lapse"
- DDO (limits of financial powers)
- Separation of Expenditure with Authorization & Payment

Society Route

- Off-budget transactions (issue of accountability and transparency)
- Merger of Expenditure with Authorization & Payment

This needs:

- Accountability – more active participation of non-government members in the "Society" could help.
- Transparency – Concurrent Audits, FMRs in public domain (along with HMIS)

Differential Financing

WHY AND HOW

What is differential financing

- To fund according to
  - volume of services;
  - range of services,
  - quality of services
- .....Without losing sight of equity concerns
- How to address resource allocation
  - between public facilities.
  - between private facilities.
  - between service providers
  - between districts.

Related Concepts

- Flexible financing – as opposed to rigid line-item budgets
- Output Based Budgeting (OBB) – financing related to volume/output
- Performance Based Financing (PBF) – may relate to output, outcome or certain benchmarks
- Results Based Financing (RBF) – financing the outcomes

Flexible Financing or Differential Financing

- Differential Financing fits into overall concept of Flexible Financing
- Differential Financing lays more emphasis on "customized allocation " of resources as against a "one size fits all" approach.

Differential Financing

- Financing different needs adequately- Essential to maintain quality of services – where volume of services is more….
- Rationalization of resources… free resources from areas of low needs and utilisation.

Challenges:

- What and where are the “needs”?
- How much is “adequate”
- How to finance? (funds flow mechanism)

Elements of Differential Financing

- Horizontal and Vertical differentials: ……..
- Cost Driver: (identify one service that is indicative of the entire package of services that would be consumed).
- Separation of "Institutional Overheads" and "Direct Operating Cost"(one is per facility- the other is per case load)
- Rates (based on volume), adjusted to quality (using inputs like certification/accreditation) and equity parameters (like inaccessibility measures)
- "Supply-side" vs. "Demand-side" financing (money following the patient).

Example: Differential Financing of RCH Services in a District

AN IMAGINED DISTRICT WHICH CHANGES TO A FULLY DEVELOPED FORM OF DIFFERENTIAL DISTRICT.

MODELLED ON DATA FROM UDAIPUR DISTRICT

District Profile

- Population – 30 lakhs (approx.)
- Total Institutional Deliveries (in govt. facilities) – 50,000 per year (approx.)
- Health Facilities – 562 Sub Centres, 70 PHCs, 18 CHCs, 3 District/Sub-District level hospitals :
- MCH Facilities identified – 8 level-III, 35 level-II, 54 level-I :
- these 97 out of 653 facilities (out of are providing 98% - about 49,000 – institutional deliveries.

Need for differential financing for RCH

- Workload of deliveries is distributed among SC-PHC-CHC-DH in ratio of 5%-20%-30%-45%
- Fund (for RCH) distributed in the ratio SC-PHC-CHC-DH in ratio of 39%-37%-22%-1%

Or in other words- 75% of deliveries are seen by CHCs and DH, but they get 23% of the RCH funds. Other RCH services get distributed in roughly same proportion.

JSY increased the number of cases in public hospitals – but it has done so very unevenly. Making differential financing essential

Re- allocation of Human Resource

Financing by Current Norms	Financing by Differential Financing Approach
All facilities equally developed with additional HR – as per MNH norms	Additional HR Prioritized – identified MCH facilities
	1. Prioritized based on MCH load 2. Re-locating existing contractual manpower 3. Ensure specialists at all MNH facilities

This would mean,for example ,that the 3 nurses paid for by NRHM would be prioritised only for those PHCs where there are deliveries – MCH facilities. If the delivery load is high they could get even more nurses . But if in many facilities there are already nurses but no deliveries(due to a CHC nearby for example) then they would have another defined package- e.g. school health to attend to.

– Re-positioning Untied Fund (Annual Maintenance Grant & RKS grant) as Institutional Overheads (given as pooled fund to district)

Financing by current norms	Financing by Differential financing approach
All SC – Rs 20,000 All PHC – Rs 1.75 lakhs All CHC – 2.25 lakhs Irrespective of case loads and outcomes	LEVEL I – Rs 50,000 LELEL II – Rs 2.5 lakh LEVEL III – Rs 8.5 lakh Other SC – Rs 15,000 Other PHC – Rs. 1.40 lakhs Other CHC – Rs. 1.50 lakhs

Cost heads	Level III	Level II	Level I
1. Building Maintenance	1.00	0.50	0.10
2. Supervision and QA	1.44	1.44	0.25
3. Equipment (annualized cost)	6.00	0.50	0.05
Total (rounded off)Rs in Lakh per facility per year)	8.50	2.50	0.50

Calculating and providing equipment cost

Financing by current norms	Financing by Differential financing approach
Equipment cost not included in overall budget and usually additional cost over are proposed. Each time there is a facility survey and a procurement and many mismatches in distribution	Inbuilt in the extra untied funds provided per MCH facility. Taken the total cost of equipment and assumed its replacement every four years. Or replacement of one fourth every year. Warehouse stocked with minor equipment.

Supervision and Quality Process

Financing by current norms	Financing by Differential financing approach
Costs of supervision and quality process are over and above these untied funds	Two supervisors-one for clinical quality and another for support services

Un-tied Funds- Re-positioned as Operating Costs

Financing by current norms	Financing by Differential financing approach
Untied funds used largely for maintenance Not included are: Costs of Drugs and supplies- may come from state budget - Costs of diet, laundry, hygiene and sanitation, security - not provided for. OOP (out of pocket payments) – Rs 500 to Rs 1500 by patients are paid on these heads even in public health facilities.	An untied fund paid to facility based on number of deliveries handled- but paid for covering the operational costs of entire range of services Payment rates per delivery would be Level III – Rs 1,500 Level II – Rs 550 Level I – Rs 225 This is for drugs and supplies, diet, sanitation, laundry, security. Comfortable and safe- helps meets quality standards. No Out –of –pocket payments- whether they go to public or private facility. Share of state could be worked out.

Operational Costs	Level III			Level II			Level I		
Cost of consumables for..	No.	Unit Rate	Total	No.	Unit Rate	Total	No.	Unit Rate	Total
Deliveries:									
Normal Del	200	200	40,000	400	200	80,000	200	150	30,000
Complicated	60	400	24,000	70	300	21,000	0		0
LCS	70	3000	210,000	0		0	0		0
Other RCH Services:									
Safe Abortion	25	300	7,500	25	300	7,500	0		0
Female Sterilization	150	300	45,000	150	300	45,000	0		0
Male Ster.	50	50	2,500	50	50	2,500	0		0
Sick Newborn care	50	400	20,000	100	200	20,000	0		0
AN/PN complications	50	1000	50,000	50	100	5,000	0		0
TOTAL	**330**		399,000	**470**		181,000	**200**		30,000
Cost of consumables per Delivery			**1,209**			**385**			**150**
Diet, Laundry, Hygiene, Security per delivery			300			150			75
Direct Operating Cost per delivery			**1,509**			**535**			**225**
Rounded off (Rs.)			**1,500**			**550**			**225**

Transport Costs

Financing by current norms	**Financing by Differential Financing Approach**
Rs 250 paid to ASHA, irrespective of distance travelled	1. Actual reimbursement – from home to hospital and drop back 2. No referral transport – Rs 250 of JSY 3. Rs 1000 per level III delivery, Rs 500 per level II delivery and nil at level I

Levels	**Average radius of catchment area (KMs)**	**Rate (Rs per KM)**	**Cost for 2 Trips**	**Rounded off**
Level II	15	10	300	500
Level III	35	10	700	1000

Provider Incentive

Financing by current norms	Financing by Differential financing approach
No provision for provider incentives	Provider Incentives (shared with RCH team) Rs 500 per delivery at level III Rs 100 per delivery at level II Rs 50 per delivery at level I

Current Financial Package (existing norms)-

Levels of Health Facilities	HR cost (additional for RCH)	Training (@ 15% of total HR cost)	UF + AMG + RKS grants	Total per facility (Rs.)	No. of Facilities In sample district	Total (for all facilities at the level)
Sub Centre	1,20,000	36,000	5,000	1,61,000	562	Rs. 9.05 crores
PHC	9,60,000	2,29,000	35,000	12,24,000	70	Rs. 8.56 crores
CHC	19,44,000	5,99,000	37,500	25,80,500	20 (18+2SDH)	Rs. 5.16 crores
District Hospital	19,44,000	5,99,000	50,000	25,93,000	1	Rs. 0.26 crores
TOTAL						Rs. 23.03 crores
JSY						Rs. 10.00 crores
GRAND TOTAL						**Rs. 33.03 crores**
Rest of Untied Grants(all of untied grants is not for RCH alone- this is the rest)						Rs. 2.29 crores

Financial Package -based on differential costing
(in the imagined district)

Components	Levels of Health Facilities			Costing unit
	Level-III	Level-II	Level-I	
1. Human Resources for Health (HRH)	25.5 lakhs	12 lakhs	1.5 lakhs	per facility#
2. Untied funds towards equipment, supervision and infrastructure Maintenance	8.5 lakhs	2.5 lakhs	50,000	per facility
TOTAL Fixed cost (per facility : 1+2, rounded off)	**34 lakhs**	**14.5 lakhs**	**2 lakhs**	Per facility
3. Referral Transport	1,000	500	0	per delivery
4. Operating cost	1,500	550	225	per delivery
5. Provider incentive	500	100	50	per delivery
TOTAL Variable Cost : or Untied funds- 2 (per delivery: 3+4+5)	**3,000**	**1,150**	**275**	per delivery

[1] One lakh (1,00,000) = 0.1 million

Financial Implications

Financing by Current Norms	Financing by Differential Financing Approach
Rs 33 crores including JSY funds Rs 23 crores excluding JSY funds (Excluding equipment costs)	Rs 25.5 crores including JSY funds Rs 16.8 crores excluding JSY funds (Including equipment costs)
PLUS Capital expenditure of Rs 30 crores	PLUS Capital expenditure of Rs 6 crores

Current Expenditure in Udaipur district, would become less in our Imagined district – but at the same time… in this district we would now be providing universal access with quality care- free transport, no out of pocket Expenses on drugs, diet and cleanliness and security etc.

Differential Financing: Implementation Issues

Financing Mechanisms- 5 options.

- Differential Untied Grants (to facilities/districts/ blocks)-
- Rajasthan Swasthya Bima Yojna, MMJRK or Deen Dayal Upchaar Yojna mechanism- a govt organised adminstrator- makes User Charges (notional) – for per case payments to facilities (pay for 100 deliveries at a time).
- "Health Funds" for districts and blocks- GOI proposal to make a % of untied funds available as a district pool- to give to facilities per case-
- Insurance payments (RSBY in Kerala)
- Service Vouchers (Chiranjeevi type)

Differential Financing: Pre-requisites

- Database of disease (morbidity/mortality) profile by health facility and regions
- Detailed costing (by services, procedures, levels of facility and regions)
- Reliable and timely HMIS, disaggregated at facility and department (within facility) level
- Different financing mechanism for "per-facility" and "per case" transfers
- TPA-type agency/cell at the district level

What we would like to see : futuristic

	RCH services	Trauma and Surgical Care	Communicable Disease and Poisioning	Non Communicable disease
Sub-center A	Level- 1 center	nil	Nil	nil
Sub-center B	Non- del.	Nil- school health +++	Level -1	Level 1
Sub-center C	Level-1	nil	nil	nil
PHC - A	Level- 1	nil		
PHC- B	Level -2	Pack A	Level- 2	Level- 1
PHC- C	Non MCH	Pack A	Level -1	Level-2
CHC- A	Level 2	Pack A	Level- 2	Level-2
CHC -B	Level 3	Pack B	Level-3	Level- 2
DH	Level 3	Pack C	Level- 3	Level- 3

Limitations of Differential Financing

- Less available leverage within current system

  Untied funds around 6% of NRHM funds, which is around 20% of state health funds

  - High proportion of committed expenses in public health system (salaries-80%, fixed overheads for building maintenance and utilities, etc.)
- Definition of "cost driver" – more general the cost driver (like say OPD), less accurate the unit cost estimations
- Might lead to targeted interventions (TI) as against universal healthcare (UHC) approach. Danger that those diseases not on a package would not get provided.

Making a start……

1. Untied funds to facilities- could be made on a differential basis.
2. Part of the untied funds to facilities which are pooled and placed with the district health society.
3. The Deendayal Upchaar Yojana- or similar mechanism could be oriented for this role and it could also handle the pooled untied fund.
4. Private sector partnerships could be made on this basis.

Let us think about it.. Change does not occur in a day..

This is not such a strange concept. Every private sector chain of services- or even a wholesaler of for example a variety of cool drinks supplying a chain of retail Outlets, always organises his supplies to match needs. The financing of public Health systems needs to become responsive to needs- if it must be efficient!!!

Thanks!!!