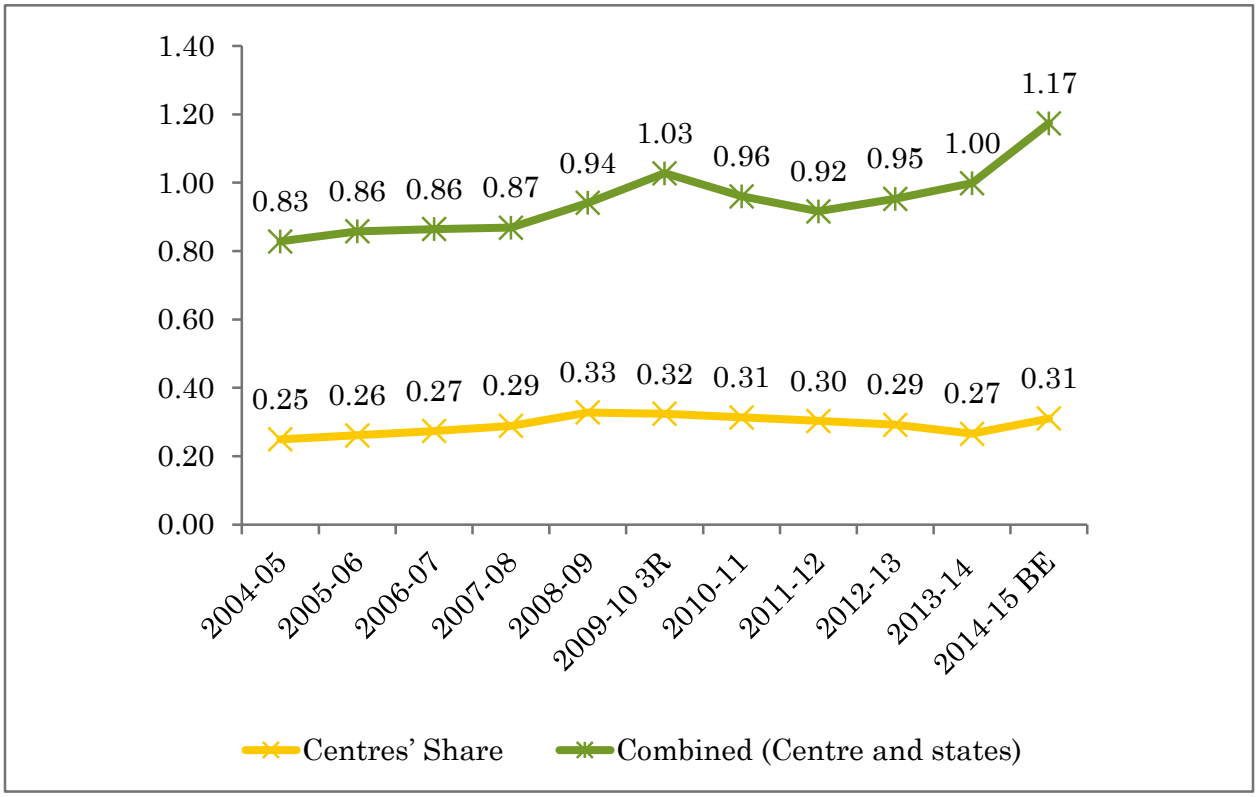
MATERNAL HEALTH BUDGETS IN INDIA: CASE STUDY OF JANANI SURAKSHA YOJANA (JSY)

Health budget in India

India's total spending on health is 4.2 percent of GDP of which public spending on health is just barely above 1 percent. Although the State and Union Governments' expenditure in absolute terms have increased in the last ten years, from 2004-05 onwards, a stagnation is observed in the Union Governments' spending on health. Presently, Union and State governments together spends only 1.2 percent of GDP on public healthcare. An increase to 2.5 per cent of GDP by 2017 anticipated in the country's 12th Five Year Plan, is itself one of the lowest proportions recorded anywhere in the world (Charts 1 & 2). The last ten years trend in budgetary spending both by the Union and State governments clearly indicates that health does not figure adequately in the priority list of the development agenda.

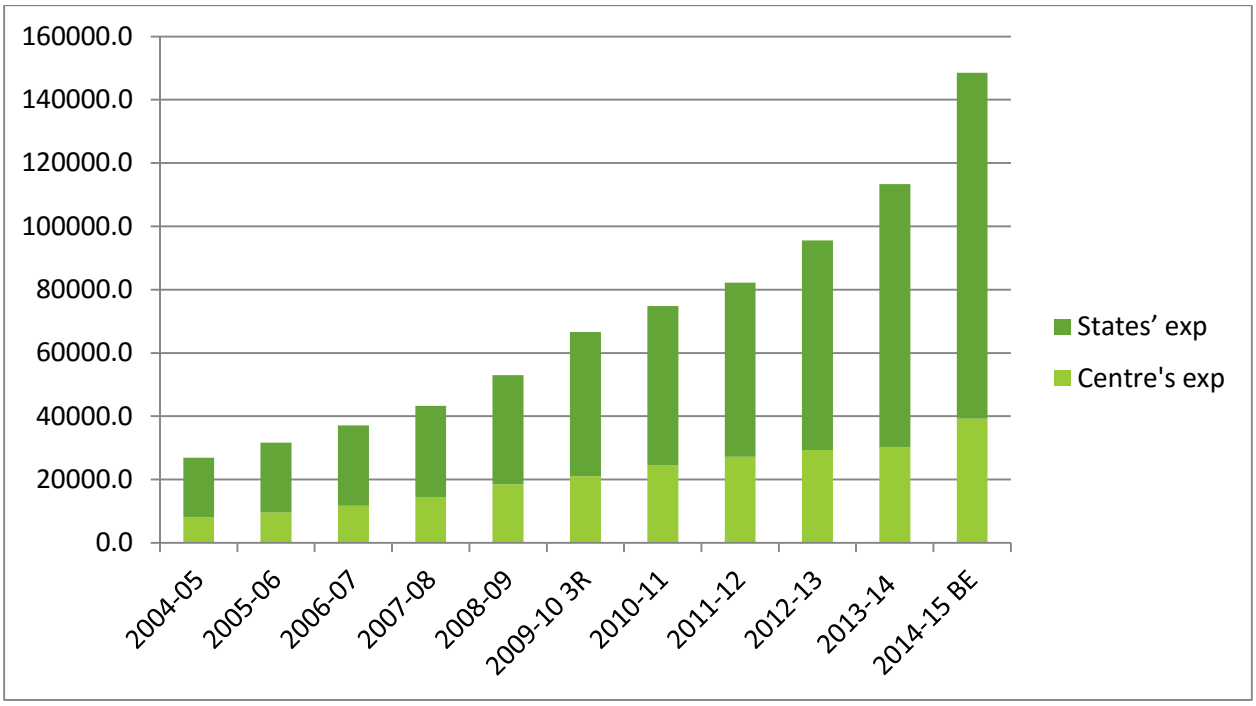
Chart 1: Trends in Budgetary Spending on Health as share of GDP (in %)



Note: State's Expenditure for 2013-14 is Revised Estimate and 2014-15 is Budgetary Estimate; GDP figures at current market price; $ Centre's expenditure on *Health and Family Welfare* refers to the expenditure by Ministry of Health and Family Welfare only. It doesn't include the expenditure of other Ministries. @ These figures may involve double counting of the grants-in-aid from Centre to States under *Health and Family Welfare*;

Source: Union Budget, Expenditure Budget, Vol-II, MOHFW, various years, GoI and RBI: State Finances – A Study of Budgets, various years.

Chart 2: Public Expenditure on Healthcare by Centre and States (in Rs. Cr)



Note: Union Government's expenditure on health covers expenditures by MOHFW only; Health expenditure data for general government for 2013-14 is Revised Estimates and 2014-15 is Budgetary Estimates Source: Union Budget ,Expenditure Budget, Volume II, MoHFW, various years and Economic Survey, various years, Govt. of India.

Outlays towards Health in the 12th Plan

The Government had committed to raising its expenditure on health from roughly 1 percent of the GDP to 2.5 percent of the GDP by the end of 12th Plan. The table above shows that for the four departments under the Ministry of Health and Family Welfare (MOHFW), the total 12th Plan outlay is Rs. 3,00,018 Crore (Table 2). The allocations in the four years of the 12th Plan when compared to the total recommended outlays, illustrate an under-allocation of funds by the Union Government. With the last year left of the Plan period, the allocations should have at least touched a 75 percent of the total recommended outlays, it is seen from Table 1 that only 40.2 percent has been allocated. With only the last year left in the Plan period, there remains a bleak possibility of fulfilling the recommended Plan outlay for health.

Table 1: Recommended 12th Plan Outlay vs. Budgetary Allocation in Health

Departments	Recommended Outlay in 12th Plan	2012-13	2013-14	2014-15 (RE)	2015-16 (BE)	Total Allocations for 4years of the 12th Plan	Allocation as share of Outlay (%)

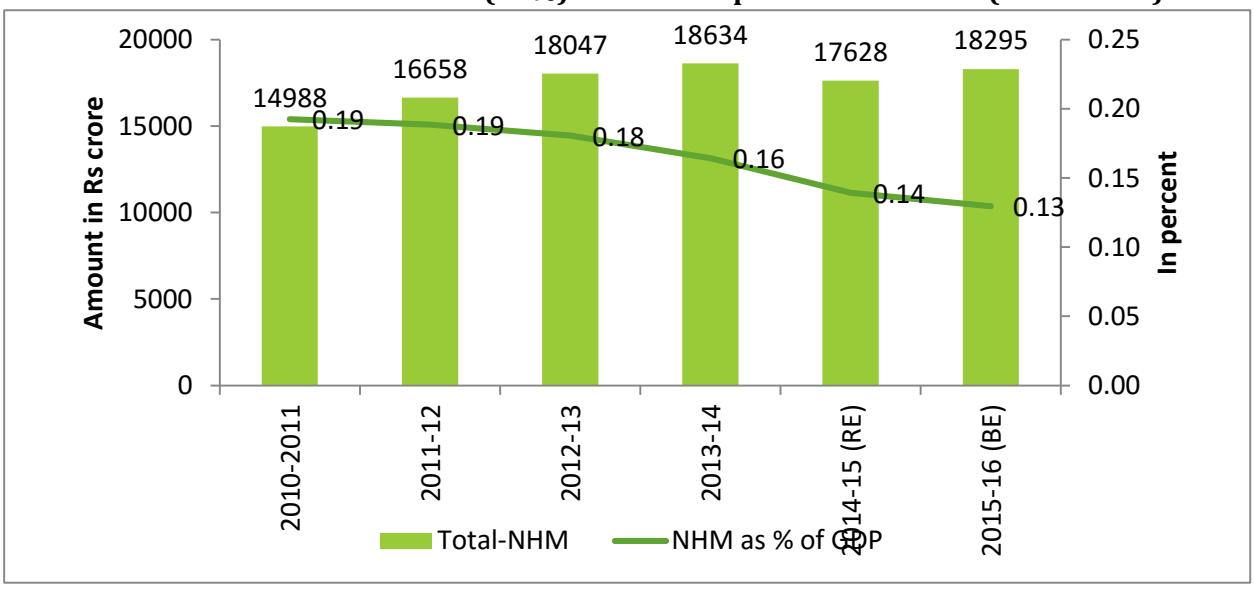
Dept. of Health and Family Welfare	268551	25133	27145.3	29042	29653	110973	41.3
Dept. of Ayush (became a separate Ministry in 2014-15)	10044	715	642.4	691	1214	3262.4	32.5
Dept. of Health Research	10029	720	874.1	932	1018.2	3544.3	35.3
Dept. of Aids Control	11394	1316	1473.1	1300	1397	5486.1	48.1
Total MOHFW	**300018**	**27885**	**29492.5**	**31274**	**32068.2**	**120720**	**40.2**

Source: Compiled by Author from 12th Plan Document and Union Budget Documents, various years.

National Health Mission (NHM)

In 2005, the Ministry of Health and Family Welfare (MOHFW) launched the National Rural Health Mission (NRHM), a landmark programme to provide universal quality healthcare in rural areas across the country. In 2013-14, the NRHM has been extended to include the National Urban Health Mission (NUHM) which has a directive to meet the health needs of the urban population with a special focus on the urban poor. The NRHM and the NUHM were together converted into the National Health Mission (NHM) with the objective of meeting the essential primary healthcare needs of households and reducing their out-of-pocket expenses.

Chart 3: Share of NHM in GDP (in %) and total expenditure on NHM (in Rs. crore)



Note: Since the year 2012-13, the NRHM has included the Urban Health Mission and is called the NHM. The figure reflects expenditure on NHM for these years.

Source: Union Budget, Expenditure Budget, Vol-II, MOHFW

With the roll-out of the NHM, some major interventions of the MOHFW, like the NRHM-RCH Flexi pool, the NUHM Flexipool, the National Vector Borne Diseases Control Programme (NVBDCP), the Routine Immunisation, Pulse Polio Immunisation and others, have been brought under its ambit. The pattern of allocation under NHM shows (Chart 3) that almost all of the total health budget is assigned for the NHM. Out of the total budget for NHM, a major part of it is allocated towards improving the reproductive and child health programmes in the health mission (Charts 4a and 4b).

Chart 4a: Component-wise break up of expenditure in NRHM, 2005-2015

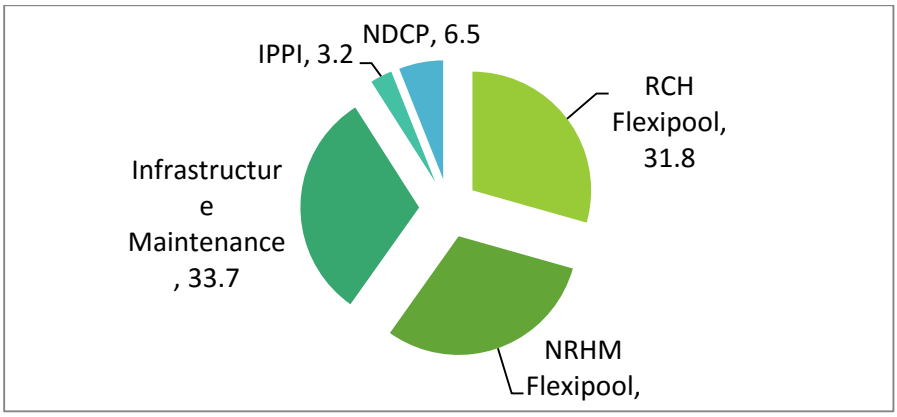
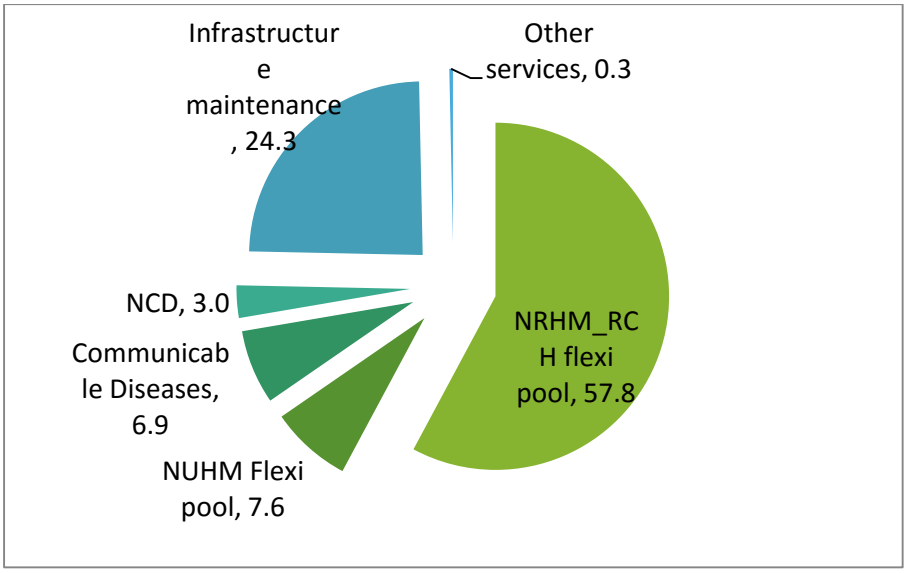


Chart 4b: Component-wise break up of expenditure in National Health Mission, 2015-16



Note: NRHM_RCH flexipool is inclusive of RCH-flexipool and NRHM-flexipool expenditures
Source: Ibid

These consistently higher allocations towards reproductive, maternal and child health initiatives under NHM stems from India's declaration at the London Health Summit, 2012 to adopt a holistic approach to provide a continuum of care in maternal and child health. The recent approach of RMNCH+A (reproductive, maternal, neo-natal, children and adolescent healthcare) adopted by the

MOHFW as a continuum of care for reproductive, maternal and child health strategy tries to capture the issue of adhocism in the supply side problems in the delivery of maternal health services.

Under this approach, NRHM and RCH II constitute main programmes to improve the quantity and quality issues in healthcare service delivery. Within this framework, the government also runs schemes such as *Janani Suraksha Yojana* (JSY) focusing on improving institutional delivery to impact the rates of IMR and MMR, *Janani Shishu Suraksha Karyakram* (JSSK) - cash-based free entitlement programme to improve IMR, MMR, and other 'mother & infant' health issues.

Interventions for improvement of Maternal and Child Health

In view of the consistently higher IMR and MMR figures (Tables 2 and 3), along with the increasingly disturbing dynamics of the declining child sex ratio and persistent malnutrition, the 12th Plan recommended special interventions under NRHM and an impact assessment of existing schemes.

Table 2: Maternal Mortality Ratio (MMR) in major states of India

India & Major States	2010-12	2011-13	Drop in MMR (2010-12)–(2011-13)	% decline in MMR (2010-12)–(2011-13)
India Total	**178**	**167**	**11**	**6.2**
Assam	328	300	28	8.5
Bihar/Jharkhand	219	208	11	5.0
Madhya Pradesh /Chhattisgarh	230	221	9	3.9
Odisha	235	222	13	5.5
Rajasthan	255	244	11	4.3
Uttar Pradesh/ Uttarakhand	292	285	7	2.4
Andhra Pradesh	110	92	18	16.4
Karnataka	144	133	11	7.6
Kerala	66	61	5	7.6
Tamil Nadu	90	79	11	12.2
Gujarat	122	112	10	8.2
Haryana	146	127	19	13.0
Maharashtra	87	68	19	21.8
Punjab	155	141	14	9.0
West Bengal	117	113	4	3.4

Source: Registrar General of India (SRS Estimates)

Table 3: Infant Mortality Rate (IMR) in major states and UTs in India

States	Infant Mortality Rate (as per SRS)			Annual decline (%) over previous year	
	2011	2012	2013	2012	2013
All India	**44**	**42**	**40**	**4.5**	**4.8**
Andhra Pradesh	43	41	39	4.7	4.9
Assam	55	55	54	0.0	1.8
Bihar	44	43	42	2.3	2.3
Chhattisgarh	48	47	46	2.1	2.1

Gujarat	41	38	36	7.3	5.2
Haryana	44	42	41	4.5	2.4
Jharkhand	39	38	37	2.6	2.6
Karnataka	35	32	31	8.6	3.1
Kerala	12	12	12	0.0	0.0
Madhya Pradesh	59	56	54	5.1	3.6
Maharashtra	25	25	24	0.0	4.0
Odisha	57	53	51	7.0	1.9
Punjab	30	28	26	6.7	7.1
Rajasthan	52	49	47	5.8	4.1
Tamil Nadu	22	21	21	4.5	0.0
Uttar Pradesh	57	53	50	7.0	5.7
West Bengal	32	32	31	0.0	3.1
Arunachal Pradesh	32	33	32	-3.1	3.0
Delhi	28	25	24	10.7	4.0
Goa	11	10	9	9.1	10.0
Himachal Pradesh	38	36	35	5.3	2.8
Jammu and Kashmir	41	39	37	4.9	5.1
Manipur	11	10	10	9.1	0.0
Meghalaya	52	49	47	5.8	4.1
Mizoram	34	35	35	-2.9	0.0
Nagaland	21	18	18	14.3	0.0
Sikkim	26	24	22	7.7	8.3
Tripura	29	28	26	3.4	7.1
Uttarakhand	36	34	32	5.6	5.9
A & N Islands	23	24	24	-4.3	0.0
Chandigarh	20	20	21	0.0	-5.0
Dadra & Nagar Haveli	35	33	31	5.7	6.1
Daman & Diu	22	22	20	0.0	9.1
Lakshadweep	24	24	24	0.0	0.0
Puducherry	19	17	17	10.5	0.0

Source: Sample Registration System (SRS), Registrar General of India.

The new schemes included the *Janani Suraksha Yojana* (JSY) and the *Janani Shishu Suraksha Karyakram* (JSSK), two major interventions under Reproductive Child health (RCH). Apart from these, nutrition interventions in the form of Indira Gandhi *Matritva Sahayog Yojana* - a Conditional Maternity Benefit (IGMSY-CMB) by Ministry of Women and Child Development, have been launched to reduce the mortality rates among women and children and provide health and nutrition facilities to pregnant and lactating mothers free of cost. In addition to the IGMSY, the SABLA and ICDS are also part of the RMNCH+A approach and hence are included in the maternal health nutrition initiatives. Given this, in 2012-13, the Union Government's allocations for the JSY and JSSK were Rs. 2,050.8 and

Rs. 357 crore respectively, which together constitutes only 13 percent of the total NRHM allocation. Under IGMSY, Rs. 400 crore has been allocated in 2014-15(BE), a 33 percent increase over 2013-14(RE) (Table 4).

Table 4: Union MWCD and MoHFW Expenditure on schemes related to maternal health (and nutrition)
(in Rs crore)

Year	RGSEAG- SABLA	IGMSY-CMB Scheme	JSY	ICDS
2010-11	329.51	116.2	1618.4	9,763
2011-12	593.75	289.8	1552.9	14,266
2012-13	503.63	82.07	1640.0	15,712
2013-14	548.33	270.0	1762.8	16,432
2014-15 R.E.	630.00	360.0	2039.8	16,520
2015-16 B.E.	10.00	438.0	N/A	8,754
Addl. Allocations in Union Supplementary Budget 2015-16	400.00	-	N/A	3,600
Total 2015-16 BE	410.00	438.0	-	12,354

Source: Expenditure budget, Vol. II, MoHFW, MWCD, Govt. of India.

It is evident from the table above in terms of allocations, JSY has been the most important programme related to the improvement of maternal health indicators in India in the last decade. Since the launch of JSY, there has been a considerable improvement in the rates of IMR and MMR, as shown by Tables 2 and 3 earlier. In addition, there has also been a significant improvement in institutional delivery among women due to the launch of this programme. However there have also been criticisms raised by women's reproductive rights groups in India in terms of the rigidities associated with the guidelines of JSY that tended to exclude women not having access to institutional delivery and the benefits of the programme due to several reasons. In this paper, the focus would be mainly to understand JSY, its objectives, guidelines and how the scheme has played out in terms of budgetary allocations at the state level. Certain important, yet to be addressed concerns have also been flagged at the end.

Janani Surakhsha Yojana-Objectives and Guidelines

The JSY is a Centrally Sponsored Scheme which is being implemented with the objective of reducing maternal and infant mortality by promoting institutional delivery among pregnant women from Below Poverty Line (BPL) families. Under the JSY, eligible pregnant women are entitled for cash assistance irrespective of the age of mother and number of children for giving birth in a government or accredited private health facility.

The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu and Kashmir. While these States have been named Low Performing States (LPS) under the scheme, the remaining States/UTs

have been named High Performing States (HPS). The scheme also provides performance based incentives to women health volunteers known as ASHA (Accredited Social Health Activist) for promoting institutional delivery among pregnant women. The ASHAs are expected to assist ANM in early registration, identification of complicated pregnancies, providing atleast three antenatal care, do post delivery visits; organising appropriate referral and arrange for transport for pregnant mother in case needed. The cash entitlement for JSY is as follows:

Cash Assistance for Institutional Delivery (in Rs.)

Category	Rural Area		Urban Area	
	Mother's package	ASHA's package*	Mother's package	ASHA's package**
LPS	1400	600	1000	400
HPS	700	600	600	400

*ASHA's package of Rs. 600 in rural areas include Rs. 300 for ANC component and Rs. 300 for facilitating institutional delivery

**ASHA's package of Rs. 400 in urban areas include Rs. 200 for ANC component and Rs. 200 for facilitating institutional delivery

Cash assistance for home delivery

A recent component of assistance for BPL pregnant women, who prefer to deliver at home has been introduced in the design of the scheme. BPL pregnant women preferring to deliver at home are entitled to a cash assistance of Rs. 500 per delivery regardless of the age of pregnant women and number of children.

Direct Benefit Transfer under JSY

The mode of payment in JSY has been converted recently into Direct Benefit Transfer (DBT) in order to improve coverage, control leakage of funds and improve efficiency in delivery mechanism. It has been rolled out in 43 districts with effect from January, 2013 and in 78 districts from July, 2013. Currently efforts are being made towards the extension of DBT mode of payment throughout the country in all States/UTs in all districts. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their bank accounts**.**

Beneficiaries and Budgetary allocations under JSY

The number of beneficiaries increased manifold since the launch of JSY. Table 5 below gives an account of the increases in the last three years in the number of beneficiaries. The fact that the number of beneficiaries under JSY has increased manifold i.e. from 7.38 lakh beneficiaries in 2005-06 to 104.39 lakhs in 2014-15, itself is an indicator of high awareness levels among the pregnant women about the scheme. Also the fact that about 9 lakh ASHA workers get performance based incentives under JSY for motivating pregnant women to give birth in a health facility is an indication of high awareness about the scheme. Further, out of the total JSY beneficiaries reported in 2014-15, a large majority of (nearly 87%) beneficiaries belong to rural areas. However, the numbers of beneficiaries have remained at this level for the last few years and the initial momentum of increase in institutional deliveries may not hold true for the current period.

Table 5: State-wise and year-wise details of number of beneficiaries under JSY (2012-13 to 2014-15)

Name of States	2012-13	2013-14	2014-15
Assam	421359	451748	448143
Bihar	1829916	1695843	1531020
Chhattisgarh	277653	290276	321762
Jharkhand	282169	283562	249455
Jammu and Kashmir	127041	143129	116642
Madhya Pradesh	979822	1010824	942644
Odisha	547648	530089	498046
Rajasthan	1072623	1106262	1090012
Uttar Pradesh	2186401	2388204	2325010
Uttarakhand	89506	95344	100261
Sub Total	**7814138**	**7995281**	**7622995**
Andhra Pradesh	341041	383135	261558
Goa	1387	1100	828
Gujarat	308880	253005	277433
Haryana	61902	44076	45742
Himachal Pradesh	13626	15766	16182
Karnataka	407611	383251	411423
Kerala	116816	138527	114677
Name of States	2012-13	2013-14	2014-15
Maharashtra	364039	403405	345761
Punjab	79511	96873	103423
Tamil Nadu	358224	457770	470003
West Bengal	659996	363655	491356
Sub Total	**2713033**	**2540563**	**2674038**
Andaman and Nicobar Islands	298	366	398
Chandigarh	449	899	1713
Dadra and Nagar Haveli	786	1203	1241
Daman and Diu	Not implemented	245	107

Delhi	21722	12096	13723
Lakshadweep	494	992	1000
Pondicherry	3728	3754	3527
Sub Total	**27477**	**19455**	**21709**
Arunachal Pradesh	12200	11827	12906
Manipur	18145	17064	21667
Meghalaya	21082	20151	43334
Mizoram	12057	12871	5605
Nagaland	17609	13390	16430
Sikkim	2668	2383	2278
Tripura	18682	15502	17943
Sub Total	**102443**	**93188**	**120163**
Grant Total	**10657091**	**10648487**	**10438905**

Source: press release, 31 July, 2015, Press Information Bureau, Government of India, Ministry of Health and Family Welfare

In terms of allocations, the details of funds allocated/released under JSY during the last three years are given below in Table 6. It is clear from the table below that utilisation for high focus or low performing states are better than that for the others. The NE states also fare well in terms of fund utilization for the programme.

Table 6: Statement Showing SPIP Financial Approval and Utilisation under JSY (Rs. In Crore)

States/ UTs	2012-13		2013-14		2014-15	
	SPIP Approval	Utilisation	SPIP Approval	Utilisation	SPIP Approval	Utilisation (upto 31.03.2015)
High Focus						
Bihar	244.29	299.18	354.35	314.24	387.15	296.90
Chhattisgarh	61.82	47.56	70.88	43.95	60.07	52.95
Himachal Pradesh	2.33	1.26	2.11	1.24	2.27	1.28
J & K	20.57	22.40	22.40	26.44	28.12	21.67
Jharkhand	89.25	59.33	89.71	62.41	86.41	62.40
Madhya Pradesh	191.41	175.05	210.25	193.32	189.80	171.55
Odisha	110.24	99.81	120.06	98.28	98.28	97.83
Rajasthan	181.42	161.81	217.11	179.97	194.08	183.64
Uttar Pradesh	521.90	428.02	471.24	445.79	509.21	441.72
Uttarakhand	13.51	14.77	15.39	16.28	19.07	19.48
Sub Total	**1436.73**	**1309.20**	**1573.49**	**1381.91**	**1574.46**	**1349.42**

NE						
Arunachal Pradesh	1.42	1.09	2.18	1.13	1.82	0.85
Assam	81.07	87.88	92.45	94.76	104.94	90.57
Manipur	1.69	1.69	2.17	1.88	1.97	2.29
Meghalaya	2.14	1.57	3.79	0.72	3.68	2.35
Mizoram	1.39	1.17	1.70	1.72	1.88	0.70
Nagaland	1.82	1.89	2.06	1.53	1.76	1.21
Sikkim	0.44	0.29	0.51	0.28	0.31	0.27
Tripura	2.82	2.04	3.13	2.36	2.92	2.52
Sub Total	**92.80**	**97.62**	**108.00**	**104.36**	**119.29**	**100.75**
States/ UTs	**2012-13**		**2013-14**		**2014-15**	
	SPIP Approval	**Utilisation**	**SPIP Approval**	**Utilisation**	**SPIP Approval**	**Utilisation**
Non-High Focus States						
Andhra Pradesh	31.79	28.47	45.47	36.76	25.10	30.19
Telangana					22.83	18.72
Goa	0.12	0.10	0.12	0.08	0.12	0.04
Gujarat	50.54	46.63	35.02	33.06	35.80	34.85
Haryana	6.30	5.04	5.92	7.14	4.33	7.11
Karnataka	42.45	41.37	66.20	54.15	65.85	55.00
Kerala	12.13	12.08	16.08	13.77	13.13	13.72
Maharashtra	30.23	34.62	44.82	45.14	52.64	45.91
Punjab	8.07	7.66	10.43	11.79	11.09	13.67
Tamil Nadu	35.72	28.64	36.02	37.92	52.44	45.30
West Bengal	60.16	59.04	74.44	36.97	59.67	60.46
Sub Total	**277.51**	**263.64**	**334.52**	**276.78**	**343.01**	**324.99**
Small States/UTs						
Andaman & Nicobar Island	0.11	0.06	0.06	0.07	0.07	0.05
Chandigarh	0.08	0.05	0.06	0.06	0.06	0.07
Dadra & Nagar Haveli	0.13	0.12	0.14	0.16	0.22	0.23
Daman & Diu	0.06	0.00	0.04	0.01	0.03	0.02
Delhi	1.85	1.40	2.24	0.63	2.30	1.18
Lakshadweep	0.06	0.08	0.08	0.09	0.07	0.09
Puducherry	0.34	0.25	0.35	0.25	0.30	0.23
Sub Total	**2.62**	**1.96**	**2.97**	**1.27**	**3.06**	**1.88**
Grand Total	**1809.67**	**1672.42**	**2018.97**	**1764.33**	**2039.81**	**1777.04**

(1) Note: Above mentioned expenditure figures are as per FMR and hence provisional. (2) SPIP-State Programme Implementation Plan.

Source: press release, 31 July, 2015, Press Information Bureau, Government of India, Ministry of Health and Family Welfare

BROADER CONCERNS FOR MATERNAL HEALTH

This clearly shows that while for low performing states, the guidelines still have scope for improvement in indicators, in order to meet the targets for attaining globally comparable levels of IMR and MMR, there needs to be changes made in the scheme guidelines for high performing states. This has been an evolving process and has been observed from the changing guidelines to include women delivering at home which has been a major factor for inclusion in JSY. Removal of age restrictions on mothers and restrictions on number of children has also helped in increasing beneficiaries as well as greater utilisation of funds leading to a positive impact on the outcomes. However, maternal and reproductive health of a woman is not only about delivery. It is intrinsically linked to the overall health and nutritional status of a girl child from the time she is born. Thus while JSY is acclaimed as a grand success, ensuring proper food security and secure livelihoods also need to be linked to maternal and reproductive health outcomes.

There have also been several criticisms of the programme. First and foremost the problems linked to exclusion of women in remote rural areas residing in difficult terrains, who find it impossible to commute for delivery at the designated health facilities. While guiding principles for such cases have been included for delivery at home, yet for there needs to be more mobile vans or other modes of mobile delivery facilities which would be able to reach the women on time.

A more recent concern that has been highlighted with regard to increase in institutional deliveries has been about the behavior mooted towards pregnant women in the health centres. This concerns lack of proper infrastructure as well as caste oppression for poor, dalit and adivasi women who are not provided with beds during labour. A lot has been reported about the rough and insensitive behavior in rural areas towards women in labour, to the extent that women have had to be taken to private facilities nearby for better treatment. Studies have pointed towards infrastructural deficiencies in terms of lack of beds and related requirements as well as shortage of human resources creating pressures on the existing staff at the health centre leading to such unwarranted situations.

Apart from this, reports of fund misappropriation by the ASHAs through maintaining false rosters of pregnant women have also come into light under JSY. Such discrepancies point towards a more serious concern about how to treat the health workers who are the foot soldiers of service delivery. While increasing remunerations is an important and viable alternative, improving overall work conditions as well as not overburdening ASHAs with loads of responsibilities is also the need of the hour.

Finally it is also important to note that while a major part of NHM goes for RCH activities, it should not only focus on Institutional deliveries but needs to recognise associated activities related to maternal health and bring it under the fold of RCH activities. Those could well be related to improving infrastructural and human resource needs as well as nutritional needs, quality of care including extension of post natal period of care.

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