Mapping Budget Processes in the Public Health Sector in Maharashtra

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Acronyms

ADHO	Additional District Health Officer
AG	Accountant General
ARC	Administrative Reforms Commission
AO	Administrative Officer
BAA	Budget Accounts and Administration
BEAMS	Budget Estimate, Allocation and Monitoring System
BDO	Block Development Officer
BDS	Budget Distribution System
BEAMS	Budget Estimate Authorisation and Monitoring System
CAA	Controller's Office of Accounts and Audit
CAFO	Chief Accounts and Finance Officer
CAO	Chief Administrative Officer
CAG	Comptroller and Auditor General
CEO	Chief Executive Officer
CS	Civil Surgeon
CSS	Centrally Sponsored Schemes
DAT	Directorate of Accounts and Treasury
DDO	Drawing and Disbursement officer
DH	District Hospital
DHO	District Health Officer
DHS	Directorate of Health Services
DLFAA	Directorate for Local Fund Accounts Audits
DMED	Department of Medical Education and Drugs
DMO	District Malaria Office
DPC	District Planning Committee
DPDC	District Planning and Development Council
DPO	District Planning Officer
DTO	District TB Office
Dy. Dir	Deputy Director
EOH	Extension Officer Health
ESIS	Employee State Insurance Scheme
FD	Finance Department
FW	Family Welfare
GB	General Body
GIA	Grants-in-aid
GOI	Government of India
GOM	Government of Maharashtra
GOIPC	Government of India, Planning Commission
GP	Gram Panchayat
GR	Government Resolution
HDI	Human Development Index
HLEC	High Level Expert Committee

MBM	Maharashtra Budget Manual
MGNREGA	Mahatma Gandhi National Rural Guarantee Act
MLAR	Maharashtra Legislative Assembly Rules
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MS	Medical Superintendent
MSACS	Maharashtra State AIDS Control Society
NIPFP	National Institution of Public Finance and Policy
NRHM	National Rural Health Mission
OE	Office Expenses
OTSP	Other Tribal Sub Plan
PHC	Primary Health Centre
PHD	Public Health and Family Welfare
POL	Petrol Oil and Lubricants
PRI	Panchayat Raj Institutions
PS	Panchayat Samiti
PSC	Planning Sub-committee of the Cabinet
RBI	Reserve Bank of India
RDD	Rural Development Department
RFA	Registry of Financial Accounts
RH	Rural Hospital
RRT	Rent, Rates and Taxes
RTA	Right to Information Act
SC	Sub Centre
SCP	Special Component Plan
SCSP	Scheduled Caste Sub Plan
SDH	Sub District Hospital
SOE	Statement of Expenditure
SOF	Statement of Finding
THO	*Taluka* Health Officer
TSP	Tribal Sub plan
ULB	Urban Local Bodies
ZP	Zilla Parishad

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EXECUTIVE SUMMARY

The budgetary processes in India are opaque and remain behind the extreme confidentiality of bureaucratic exercises. The Budget is an official policy document, which is indicative of the expenditure incurred and reflective of the policy priorities of the government. These documents accessed are not presented in a language and format that is user-friendly; the language used is too technical to understand making it difficult to comprehend. People, in general, consider the budget highly technical and very difficult, and only a miniscule proportion of the population understands the technicalities involved. Besides, the most crucial stage of the budget process, that of budget preparation does not allow any kind of participation by civil society organisations. In order to be conducive to public involvement, public understanding and involvement in the budget process is critical for ensuring that the Government is accountable to the public.

The objective of the study is to find answers to the basic questions of the budget process:

- How are decisions about resource allocation made?
- In the institutional structures and administrative processes governing resource, how does information flow?
- Who allocates the fund that reaches the frontline services units?
- Who at the regional and district level has discretionary power over the allocation/resources actually received by lower levels?
- Does actual expenditure match allocations – if not, what were the reasons and where were the cuts made?

The findings of the study outline budgetary processes; the range of issues discussed will help the reader understand all four stages of the budget process (formulation, approval, implementation and auditing).This information on the key actors in the system will not only hold them accountable, but also increase trust in them, which is the basis of civic participation.

Budget Formulation

The budget formulation stage takes place largely within the executive branch of the state. This part of the process usually starts with the 'Estimating Officer' who prepares the estimate based on the needs of the healthcare unit and administrative offices.

This study looked at budget processes related to health in two districts of Maharashtra and found that there was a significant variation in the way budget estimation was practiced at the level of Primary Health Centers (PHCs) in both the Districts. Procedures followed by the eight PHCs interviewed in the two districts varied a lot.

District A submitted the budget demand and two PHCs from one *taluka* (block) clearly mentioned that the budget estimates were prepared by them; on the other hand, two PHCs of another *taluka* were somewhat unclear on whether budget estimates were regularly

prepared. Estimates prepared by some of the PHCs were in a very different format. They showed no resemblance to the stipulated format.

In District B, all four PHCs in the two *taluka*s reported that they did not prepare either annual or revised budget estimates. It was observed that three of the four PHCs did not have any role in preparing budgets, and some even said that they had 'never' been involved in any sort of budget estimation.It was reported that budget estimation had been stopped from the preceding three to four years and replaced by only monthly salary demands. The staff at the facility level had no consistent information with respect to who prepared the budget for them. They assumed that the budget was prepared at the BDO or the DHO level; the BDO and THO clearly denied any role in the budget formulation of PHCs.

A high level of confusion regarding the exact role of the *Taluka* Health Officer in channelising the budget demands for all PHCs of the *taluka* was observed in the study. The fact that the THO is expected to serve as the official communication channel has been interpreted as the THO being relieved of his/her role with respect to the budget, leading to the current situation. Interestingly, THOs have a significant role to play under NRHM vis-a-vis budgets, but they do not have any relation with the state budget processes. It is thus quite essential that a *taluka* level authority ensures that all PHCs under her/his *taluka* prepare the budgets. Such an overseeing function will have a positive impact on budgetary processes.

The DHO in District A mentioned that only 20 percent to 25 percent of the PHCs in the District send their estimates. Repeated notices are sent to PHCs, but the PHCs do not send budget estimates. The District Health Officer's practical difficulty of not receiving budget estimates from the PHCs was observed in the study. The fact that despite repeated notices, many PHCs do not send budget estimates is a matter of serious concern, as it shows the general weakness of the budgetary mechanism and its control over frontline units.

Ambiguity about the role of the budget has resulted in the lack of budget estimate related data/information at the PHC, *Taluka* and DHO levels.

In the Hospitals Line, budget formulation is taken more seriously and all the facilities remain disciplined in preparing their estimates on time. It is assumed that the Civil Surgeon (CS), as administrative head of the District Hospital Line receives budget demands from all hospitals (RH, SDH, Cottage, Women's hospital). However, this is not the present case. The general perception is that the CS is the Controller of Health performance related activities or issues, while the Deputy/Joint Director is the Controller of Finance related issues in the case of the District. As a result, the hospitals send their budget estimates to the Dy. Director, at the regional level rather than to the CS. The CS's role is restricted to compiling the proposals for purchase of materials and supplies from the RH and forwarding it to the District Planning Committee (DPC).

The Deputy Director, Regional Office, is the grant controlling officer for the Hospital Line. The regional office vets the proposals received from the facilities' estimating officers; the actual expenditure of the current year and the preceding three years is considered vetting.

The vetting responsibility of the Controlling Officer has been guided by the role assigned under the Maharashtra Budget Manual.

The Deputy Director consolidates demands for each scheme from different sources into one single scheme demand/estimate booklet providing detailed explanations for all the estimates. This represents the demand of the region and is submitted to the relevant Line Department. This may include the Joint (Jt.) Director, Budget, Accounts and Administration (BAA).

The Joint Director, BAA functions under the DHS and performs most of the budgetary functions. The Jt. Director's office was originally known as the Controller's Office of Accounts and Audit (CAA). Budget estimates of the two lines, the PHC Line and the Hospital Line, as well as some other sources converge.

The Jt. Director, BAA scrutinizes estimates received from all DHOs, eight regional Dy. Director regional offices and other Bureau Chief offices that are assigned specific programs such as Malaria and TB. The Jt. Director follows certain norms for vetting and finalising estimates in the case of non-salary components of Grants–in-aid for the PHC Line schemes, for example, Petrol, Oil and Lubricants (POL) budget are based on the number of the facilities (PHC) in the district and the ceiling of consumption of 1000 liters per district.

The Finance Department is known for curtailing the demand estimate, as was seen in the case of the Primary Health Centre budget (code 2210 5041), where it was reduced by almost 9 percent in the salary component and 41 percent in non salary against what was proposed by the Health Department.

Budget Grant Distribution: Fund Flow

There was no uniformity in the information on allocation, cash flow, to the PHC in the two districts. In District A, the grant allocation letter is sent by the DHO to all the BDOs, THOs and MOs in the District. In District B, as in the case of PHCs who do not prepare the budget estimate, there is no cash flow intimation from the DHO. It was observed that the grant allocations are informed by the DHO only to the BDO, who is the disbursing officer. Some PHC respondents expressed this feeling saying that sending a demand made no sense since allocations are always lower than the demand.

The study found neglect of the budget and demands for the non-salary line items throughout the system. Based on the interview observations, while the salaries at the PHC level were being withdrawn based on 'guarantee', no such practice for demanding an additional grant in the case of non salary items was being followed.

For PHCs, receiving lower allocations than demand can undermine motivation. Some respondents expressed this feeling saying that sending a demand made no sense since allocations were always lower than demand.

Rural Hospitals, Sub-District as well as District Hospitals reported that the budget allotment to their facility happens through the online system, BEAMS (Budget Estimate Authorisation

and Monitoring System). Grants allotted to the facility for the entire year or the grants to be disbursed in the coming months are not displayed on BEAMS. Some reported grant allocation displayed month wise till December.

The budget is never fully revealed and the hospitals are often not informed of their budget grant for the full year and the first indication they get of their allocation is the cash flow. Funds are released by the higher level body when deemed necessary.

The service delivery unit/hospitals lack the information of fund flows and budget which is essential to understand their financial entitlements and also to safeguard against funds being pulled back by higher levels officials. In practice, the controlling mechanisms are implemented to curb the unevenness of expenditure, yet the rush of expenditure remains a problem due to weak information flow to the hospitals.

At the district and below the frontline (sub district, rural hospital) service providers are unable to use BEAMS, and are therefore unable to change the cash flow resulting in budgets getting lapsed or pulled back by the controlling officers.

According to the standing instructions by the Controlling Officer, expenditure has to incurred according to the monthly cash flow, which otherwise would lead to lapse or surrender,The Dy. Director, regional office uploads the grant and authorises to carry forward to the next month and Pull back grants if found unspent.

Methods adapted by both the Dy. Director and the regional offices were starkly different. In one case, grants unspent during a month were carried forward to the next month, whereas in the other, the grants were pulled back by the regional office. The Dy. Director can reallocate unspent funds to another RH under the same scheme line item. It was observed that the Dy. Director does not share information with the hospitals.

The rush of expenditure still exists, and the practice of receiving the budget allocation at the last moment (that is, 31 March closing month) has often resulted in grant surrender as there was no scope for incurring any expenditure.

The Jt. Director, BAA , reported significant delay in receiving supplementary grants (revised estimate demands); the budget authorised in the monsoon session, that is, mid July to mid August, is not received until October. Owing to the late release of grants, they remain un-spent.

The FD keeps control over the funds distributed to each administrative department, and the PHD, Secretariat does the same for funds distributed at the Directorate level. Periodicity of the release of the budget grant by the Finance and the PHD, Secretariat is not known.

Plan Budget

At the level of State Plan, Public Health Plan outlay for the year 2010-11 was Rs. 719.5 crores which was increased to Rs. 792 crores in 2011-12, of which Rs. 657.83 was budgeted (budget document) and there was a balance of Rs. 134 crores to meet the supplementary budget.

As a process of democratic decentralization, the District General Plan (at the level of District Planning Council) has been fixed at Rs. 3750 crore, later approved by GOI at Rs. 3905.24. District allocation based on a predetermined formula assigns weights to various factors, a district's total population (30%), rural population (20%), geographical area (30%) and Human Development Index (20%).

The District Collector is also the Controlling Officer for distribution of funds as well as re-appropriation of funds (with prior approval from the DPC) for the DPC schemes for that particular district.

Short supply of medicines at the state level is met by using the DPC plan fund for medicines. The CS demand for the medicine includes demand both for own institution (District Hospital) and also for all Rural Hospitals in the District.

In both the PHC and Hospital Lines, the Plan budget grant flows to the district through various channels, DPC and Health Line Department. The process seems complicated, because the information about expenditure data are scattered at the level of DHO, CS, DPC and tribal office. The DPC has information in terms of the outlay and expenditure for the General District Plan but, it was observed that information about outlays related to the district plan of Tribal Sub Plan and the Schedule Caste Special Sub Plan (SCP) budget of district plan are with the respective agencies. Adding to the complexity, the State health plan schemes data are scattered among the various line offices operating at the regional and district levels. No single document contains all the basic information for budget analysis.

Oversight- Internal and External Audit

Internal regular audit is done by the CAFO, Head of the Accounts and Finance Department in the ZP, once in a year. Rules guide the CAFO in his/her responsibility for the internal audit and periodic checking of account records. Many PHCs reported that most of the audit observations or issues/remarks raised are about the error in calculating salary increment payment, incorrect accounting and incomplete accounting in the cash book, errors in calculating leaves and privilege leave and its records. The issues are resolved by following the instructions of the internal auditor, making the necessary changes, updating the records and documenting the remedial action taken in the watch register[1]and settling the compliance in the form of responding to the objections raised by the internal audit.

In one *taluka* in District A, internal oversight/investigation teams visited the *Taluka* Panchayat Samiti (PS) office to compile accounts statement as there was no proper

[1]Register maintained to keep a record of issues raised by the auditor and the action taken to clear the objection.

reporting or delay in submission of statement to the ZP and also to investigate the reason for such delay or non-reporting.

The Researcher was unable to get internal audit tour details- number and the nature of the audit. However, the Audit report on local government[2], on a number of occasions had raised concern as 'Audit Para' about the weak or inefficient functioning of the internal audit system at the Panchayati Raj Institutions (PRI) (local bodies).

External audit for all the PHCs are done by the regional and district staff of the Directorate for Local Fund Accounts Audits (DLFAA), generally in the month of September and October. The Accountant General (AG) conducts the test audit usually held once in a five year period. Audits are mostly on accounting and the financial transactions at the level of PHC, THO and BDO.

As observed, the account and audit are a joint responsibility as it is the prevalent practice in India. Internal audit is a part of the Accounts Section in the government setup. As there is no segregation of duties and responsibilities, there is potential conflict of interest that might hamper the effective functioning of the Internal Audit. The oversight of Internal Audit is vested with the Controller of Accounts, who is also responsible for accounting and disbursement functions in the case of the Directorate of Health Services (DHS), Internal Audits.

Internal audit and the assessment of the health grant given to the ZP are done by the Jt. Director, Budget Accounts and Audit (BAA). The study observed delay in the internal audit. Audits for district Civil Hospitals for year 2004-05 have been completed in 2011-12; three district hospitals are selected for the audit for the financial year 2008-09. While the importance of internal audit is well recognised by the director, considerable delays happen due to insufficient human resources.BAA has the responsibility of internal audit, disbursement and accounting functions.

The study observed in both Districts A and B that the Zilla Parishad (ZP) publishes the Administrative Report mandated under the Maharashtra ZP and PS ACT. Along with other departmental information, it includes the section on audit notes with the replies thereto reported separately for ZP and PS. As observed, the scant information provided in this administrative report makes it impossible to correlate the objection raised, response for objection by official and the action taken in terms of remedial measures.

Rural Hospitals, District and Sub district Hospitals under the study reported that they undergo the statutory account audit by the Accountant General (AG). Medical store or equipment statutory physical verification is done by the Store Verification unit of the Directorate of Accounts and Treasury (DAT), Finance Department.

In District A, the internal audit and inspection of the RH are done by the District Civil Surgeon's office. With full staff support, the Chief Administrative officer (CAO),

[2]Fourth and Fifth Reports of the Comptroller and Auditor General of India on Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs) in Maharashtra.

Administrative Officer (AO) and a few accountants conduct the internal audit and investigations. In District B, internal audit and inspection of the RH in the district was reported to be usually conducted by the Dy. Director, Health Circle regional office (by the Grant Controlling Officer) and not by the district Civil Surgeon's (CS) office, as the CS was placed in the teaching hospital and did not have a separate office or full time officials.

As was observed in both the regional circle offices, the Dy. Director's office at the regional level plays an important role, apart from the responsibilities of fund distribution and controlling the expenditure to the DDOs, compiling the health indicators and submitting to concern higher authorities, Bureau Chief (program) , Jt. Director and DHS, obtains inspection and internal audit reports conducted by the subordinate CAO and administrative officers (AO) at Hospitals and PHC Line and updates by taking stock of observations/audit raised by external oversight agencies and submitted responses.

The Secretary, Public Health Department had constituted a team comprising the Asst. Director, BAA, Chief Administrative Office of DHS and a Pharmacist for conducting inspection on a regular basis through the year. This team was set up in the context of a misappropriation/irregularity that happened under the line item, 'Material and Supplies'- an excessive purchase/expenditure incurred than that proposed in 2008-09. The team is assigned to inspect store verification at the regional office of the Dy. Director's level, one district hospital in the jurisdiction of the Dy. Director, one SDH, RH, and one PHC level of that district.

The Finance Department, through its technical Directorate of Accounts and Treasury (DAT), controls and monitors all the receipts and payments/disbursements of the government. This is the built-in internal oversight/control system for the monitoring/control of expenditure.

At the district level, the District Collector has been assigned the responsibility for general administration and functioning of the treasuries under his/her jurisdiction, and reports to the Secretary, Finance Department. The Collector of the District does the routine inspection of the Treasury. If irregularities of any kind are brought to the notice of the Collector by the AG or identified during the inspection, the Collector personally conducts investigations which are reported to the AG and Secretary, Finance Department.

Internal audits are in the form of inspections, periodic meetings or monitoring through periodic progress reports. Internal audit with the scant information to the public about actions taken by the department makes it difficult for common people to abstract information about the amount of money forgone owing to irregularities and, lack of sight or misappropriation etc.

This study has tried to shed light on the complexity of the budgetary process of the State Government. The study has unfolded various intricacies involved in the budgetary process at different levels, starting right from the frontline service providers to the ministry level. The key issue of lack in transparency within all the administrative levels emerges as a major finding of this research.

CHAPTER 1

BACKGROUND, OBJECTIVES AND METHODOLOGY

Section I

While provisioning of health care in India is a joint responsibility shared by the State, Central and local Governments, health care delivery in specific, is for all practical purposes, the responsibility of state Governments. The states finance primary health care facilities, hospitals and insurance (Slim Haddad, Enis Baris, D. Narayana 2008). Thus, the primary responsibility of financing and provision of public health services rests with the state Governments. In a federal arrangement, the central Government plays an overseer role by providing directives and guidance through the formulation of national policies and sponsoring a number of programs through the provision of financial and other inputs. This intervention in the state subjects is through specially designed central schemes through which grants meant for the frontline service units are transferred to the state.

Institutional arrangements for health service provision are characterised by several administrative layers involved in the frontline provider supply chain[1]. The resource-flows to frontline service providers, through various hierarchical structures from the State capital to the division level and down to the district are diverse and complex.

In Maharashtra, health care was decentralised in 1961 and the schemes that have a bias towards district development have been transferred to the Zilla Parishads (ZP), the first tier of Panchayati Raj Institutions (PRIs) for implementation, maintenance and expansion. The expenditure on such schemes along with some incentives such as expenditure on supervisory staff at the district level is reimbursed by the Government to the Zilla Parishads (ZPs) in the form of grants. The state Government gives various grants to these bodies and these are shown in the state budget in their own respective departments.

At every district, there is a health department functioning within the folds of the Zilla Parishad. The department is headed by the District Health Officer (DHO) who is a Senior Medical Officer of the state Government on deputation to the ZP. He/She operates under the control of the Chief Executive Officer (CEO) of the ZP and for implementation related issues of various health programs, family planning, immunisation and welfare programs for pregnant women, explanations are sought from the District Health Officer (DHO) by the

[1] At the state level, Public health services are governed by the Ministry of Health and Family Welfare (MOHFW), through various departments, namely the Public Health Department, which includes Family Welfare, Medical Relief and Employee State Insurance Scheme (ESIS), and the Department of Medical Education and Drugs. Both these departments have technical wings called Directorate of Health and Directorate of Medical Education and Research, respectively. The Public Health Department has a Secretary-Public Health, a Commissioner cum Secretary-Family Welfare, and Commissioner for ESIS, and these have technical support from the Director for Health Services, Director State AIDS Society and Director Health System Development project. The Directorate of Health Services deals with "medical relief, control of contagious and communicable diseases, family welfare, maternal and child health, environmental sanitation and nutrition services and training of paramedical staff." Both the Secretariat and Directorate, as also the Commissioners of Family Welfare and ESIS have their own hierarchical structures from the State capital to the division level and down to the district. (CEHAT, 2005).

regional DeputyDirector[2]. The DHO is assisted by the Additional District Health Officer (ADHO); each one is in charge of a national health program, in the area of tuberculosis, leprosy and malaria. There are district level health officers for various programs which also function parallel to the DHO, ADHO and they have no formal links with the ZP. Another parallel network of the health line department is presided over by the Civil Surgeon (CS). The CS supervises and controls services provided by the rural hospitals, sub district hospital, women's hospital, district hospital, and his/her work activities are not linked to those of the ZP, except in the cases of epidemics or launching of national immunisation programs such as pulse polio.

State line departments have their own budgets at the district level and local Governments have their own budgets, and also there is a; a major part of healthcare funds come from Parastatals[3] and societies[4] that operate at the level of the districts, making it difficult to glean the total resource availability/fund flow at the district level. Districts have different budgets for funds coming from different sources; there is no institution or process in any state that compiles information that can be treated as the annual budget for a district (CBGA, 2011). At the district level, State budget allocations to the district are harder to access as there are no district-level consolidated budget documents.

Given the multiple sources through which funds flow in the district to the frontline provider, comprehensive health budget estimate and expenditure data, both with implementing executives and the local representatives, is fairly non-existent. The critical information about the roles and responsibilities at different levels needs to be made transparent when systems with complex divisions of labor operate. This is sound management practice, as well as important for public transparency.

The grassroots civil society groups found budget related issues too complex to understand and to substantiate arguments for demanding progressive changes and social justice, as there is no regular and comprehensive budgeting at the district level. In order to overcome these constraints, CEHAT intended to build the knowledge through the 'mapping of budget processes in the public health sector in Maharashtra'.

The present study diagnosed institutional structures and administrative processes governing resource and information flow in practice, accounting and oversight. This involved determining how the public hierarchy is structured, the roles and responsibilities of various administrative units, the allocation rules used by different resources at the various levels, and the nature of information flows including accounting, reporting and monitoring procedures. The project planned to carry out the following activities: (Also presented in Figure 1.1)

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[2] Deputy Director is a higher ranking officer of the health department posted at the divisional headquarters.

[3]Parastatals as they are often called, undertake some of the health programs such as malaria control program, HIV, National Programs which are funded directly by the State and from the Centre without the conventional route of budgetary processes, budget formulation, budget distribution and oversight.

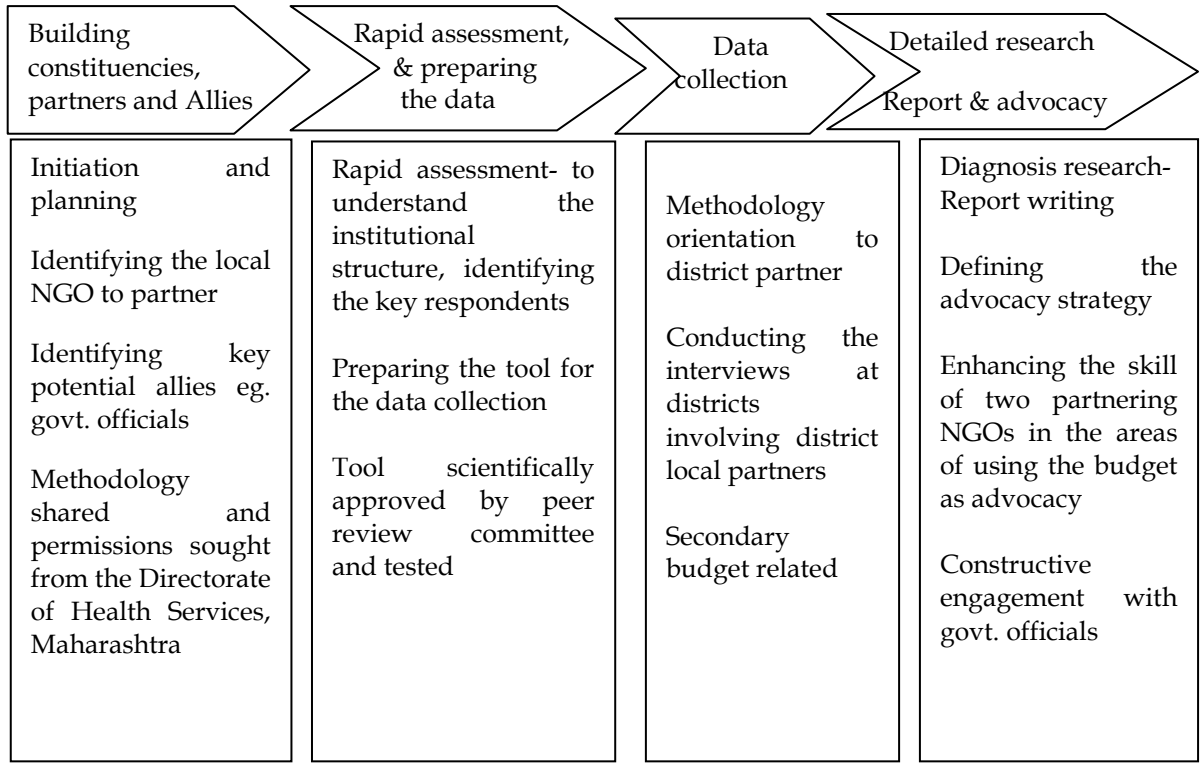
[4]Societies have been formed over the years as parallel bodies, ostensibly to minimise 'corruption', and also to help quick flow of funds for implementing the said programs. These direct transfer of funds (Off budget) to the district implementing agency, through the State Health and Family Welfare Society for implementing the NRHM makes it difficult to estimate the total spending at the district and also at the state levels.

I. Diagnosing institutional structures and administrative processes governing resource and information flow in budgeting practice, accounting and oversight, using Public Expenditure Tacking Survey tools.

II. Providing evidence-based recommendations to officials and decision makers, (key officials at different levels from the Planning, Finance and Health Departments; Local Representativesand State Health Resource Centres) and developing different advocacy strategies at various levels, so that these recommendations are taken up by those making decisions on allocation/expenditure/monitoring in various Government agencies.

III. Enhancing the capacity of partnering NGOs in observing and monitoring the action taken by the Government, local bodies and services providers, and exercising control over agents' behaviour.

Figure 1.1: Approach Figure Approach and Methodology for the Project



Building Constituencies, Partners and Allies: For the project, local budget partners from two districts have been identified so that budget related issues are taken up by them to build pressure from the district and below. This involved generating awareness and identifying concerns on budget matters within the local constituency of the partnering organisation working in two districts. Teams from local partnering organisations were involved right from the initial stages of developing the instrument/protocol for the research study, as well as data collection. Partnering organisations were provided with a range of inputs; generating awareness and identifying concerns on budget matters, giving them orientation to acquaint them with the methodology to participate in the research study, and observations have been shared with them at the end of the fieldwork. During the process of data collection, members of the partnering organisations were familiarised with different offices and relevant budget documents, which could be useful to build strong budget advocacy efforts. A post-fieldwork workshop was organised to share and learn from each other's experiences.

Sufficient preparation has been done for building the constituency as well as identifying key potential allies such as key budget decision makers/shapers in the Planning Department and also in the Health Department. These are individuals/officers from the Rural Development Department, Health Department, Finance Department and Accountant General's office, whose interest is in governance. Some of these officials have guided and supported the study at different stages to help understand the budget decision-making process, review the tool and findings, help researchers access key budget documents and were even willing to help us achieve the project objective.

Rapid Data Assessment and Protocol: Prior to designing the instruments, a rapid assessment of budget decision making, fund flow process and budget data management was conducted. This was done for two reasons - one, to understand the structure of the system, identify the involvement of different offices in the process of budget-formulation, finalisation, vetting, approval and auditory mechanisms (internal/ external audit). Two, to verify the availability of data and its specific characteristics (variables, length, and so on), and to verify the consistency of data reported across various administrative levels. The process helped to understand and learn how to organise this uncoordinated and scattered data, the budget decision-making process and budget information. This rapid assessment was conducted using snow balling as a method. Based on proximity, non sample districts were selected for rapid assessment. These assessments lead to the development of protocol. This process has helped the researchers to identify and build contacts with potential allies in the Government setup, identifying windows for intervening in the budget process itself. On the basis of rapid assessment the draft protocol/tool was prepared, sent to five resource persons of whom two were domain experts. Later, the tool was scientifically approved by the Program Development Committee (peer review committee) of CEHAT and tested.

Study Methodology

The study has a diagnostic purpose, that is, to understand institutional structures and administrative processes pertaining to the budgetary processes in health. This involves determining how the public hierarchy is structured, the roles and responsibilities of various administrative units, the processes of budget planning and implementation, the allocation rules used at the various levels and the nature of information flows including accounting, reporting and monitoring procedures. Primary data was collected at public health centers, hospitals, administrative units at the district level (local Government), and the state/regional level authorities.

Literature on tracking surveys clearly state that they could be conducted for three different purposes: Diagnostic, Analytical[5] and Impact Evaluation[6]. (Turner et al, 2001; Reinikka, Ritva and Smith 2004). This study will be for diagnostic purposes and will seek to understand specific situations and identify specific problems without necessarily examining the reason for their occurrence or potential solutions (Reinikka, 2001). This tool could be useful for locating and identifying ineffective management and supervision systems (for example, fund flow management systems), as well as distributional issues (for example, allocative efficiency).

The focus of the present study is solely on budgetary processes, not assessing any of the other related aspects, such as, trend analysis of the allocation and expenditure, multilevel analysis to understand any significant effect to explore root causes for performance differences. The diagnostic study attempted to seek the answers for the following questions:

1. What are the multiple channels through which the funds flow from the district level to the frontline provider? What are the institutional structures and administrative processes governing resource and information flows in practice? What are the mechanisms of coordination that exist between these different channels and processes? What are the systems that exist to promote transparency and accountability?

2. What are the processes of budget allocations and how are the decisions on spending made? Does the state Government respond to the needs at the local level when allocating and distributing funds, or does it base fund allocation on its own supply of infrastructure and historical levels of spending? If this is so, does this mean that the flow of funds is not responding to the genuine demands of local communities for health services?

3. How much of the expenditure/allocation, through various budget items and programs made available by the Government actually reaches the District and filters down to the intended healthcare facilities, and whether this expenditure is as per the official rules and procedures. Do the regional and district administrations have discretionary power over the allocation/resources received by lower levels?

4. What advocacy strategies and mechanisms could be developed for improvement at different levels?

The core objective of the Study was to shed light on the institutional and administrative structure underlying health budget processes in Maharashtra, it used the tracking survey of the frontline healthcare facilities and programs which are specifically placed under the

[5]To pinpoint the causes of the problems identified in the public service provision system and to propose solutions to correct these deficiencies. For instance, the survey could be designed to try to determine factors explaining differences in performance among various types or ownership categories of schools or health facilities.

[6]To examine the impact of a specific Government program or reform put in place. For instance, repeated PETS were used in Uganda to evaluate the impact of an information campaign designed to reduce resource leakage in education identified by an initial tracking survey. The impact assessment showed that the information campaign had successfully improved resource flow, and revealed the efficacy of mobilizing civil society against corruption (Reinikka and Svensson, 2004)

Directorate of Health Services (DHS)[7] such as budget head which includes curative care, that is, district, sub district and rural hospitals and preventive and promotive program activities such as primary health centres (primary health units, mobile health units, allopathic dispensaries , mobile launch units). Thus, health budget tracking in this study is limited to processes involving flows from the state Government or local Government that is, budget formulation, budget distribution and oversight through the conventional route. There are some off-budget or outside the treasury - direct transfer of funds from the centre to the state and then to district societies/implementing agency/ frontline service providers which do not follow the conventional route. Some of the health initiatives such as National Rural Health Mission (NRHM), HIV Program, and some other National Programs follow such an off budget route. The present study is primarily concerned with the conventional route of budget and administrative processes, which follows the treasury routes shown in the state budget of their departments.

Sampling Strategy: Selection of Two Districts

In all there are 33 districts in Maharashtra, out of which two districts - one from the Vidharbha region and another from Marathwada region were considered for the study these districts have been chosen based on their development profiles. Maharashtra State is classified into five broad regional groups Konkan[8], North Maharashtra[9], Western Maharashtra[10], Marathwada[11] and Vidarbha[12]. This classification also brings out the regional differences very clearly. **Konkan** consists of Mumbai and other coastal districts with two major ports, one in Mumbai and another in Raigad district. **Western Maharashtra** districts, being in the narrow rain shadow area, receive lower rainfall; they have small landholdings, which are served by canals and wells. In general, Mumbai and Western Maharashtra dominate and determine the development parameters for the entire state in many ways: not only in terms of natural and economic conditions but also political, cultural and social. **North Maharashtra** region includes districts with forests, a large tribal population, with large landholdings and a high level of landlessness. **Marathwada** region is dry with low and uncertain rainfall, large landholdings and some landlessness. **Vidarbha** region has medium and large landholdings and a high level of landlessness.

Sample District A, from the Vidarbha region, is a tribal district, which has always remained in the news for malnutrition and child deaths. District B, has a predominantly dalit population and is known for discrimination against dalits on the basis of caste in all spheres of life, leading to social exclusion and economic exploitation. Another reason for selecting these two districts was that there should be a district specific NGO to partner in this study

[7]Under the Ministry of Public Health and Family Welfare Department (MoPHFW)., which also includes Family Planning and Immunisation, Employee State Insurance Scheme (ESIS), Food and Drug Administration, etc.

[8]Districts include Mumbai, Thane, Raigad, Ratnagri and Sindhudurg.

[9]Districts include Nandurbar, Dhule, Nasik, Jalgoan and Ahmednagar.

[10]Districts include Pune, Sangli, Satara, Kolhapur and Solapur.

[11]Districts include Aurangabad, Jalna, Parbhani, Hingoli, Nanded, Osmanabad, Beed and Latur.

[12]For administrative purposes, Vidarabha has been grouped into two, one part of Vidarbha, comprises Buldhana, Akola, Amravati, Washim and Yawatmal districts which are administered by the Amravati division and the rest comprising Nagpur, Wardha, Bhandara, Gondhiya, Chandrapur and Gadchiroli as Vidarbha–Nagpur division.Bhandara, Gondiya, Chandrapur and Gadchiroli districts have a large tribal population and forest cover.

and project, so that in the long term, the partnering NGO is involved in advocating for strengthening the budgetary support for the various programs within its constituency at the local level.

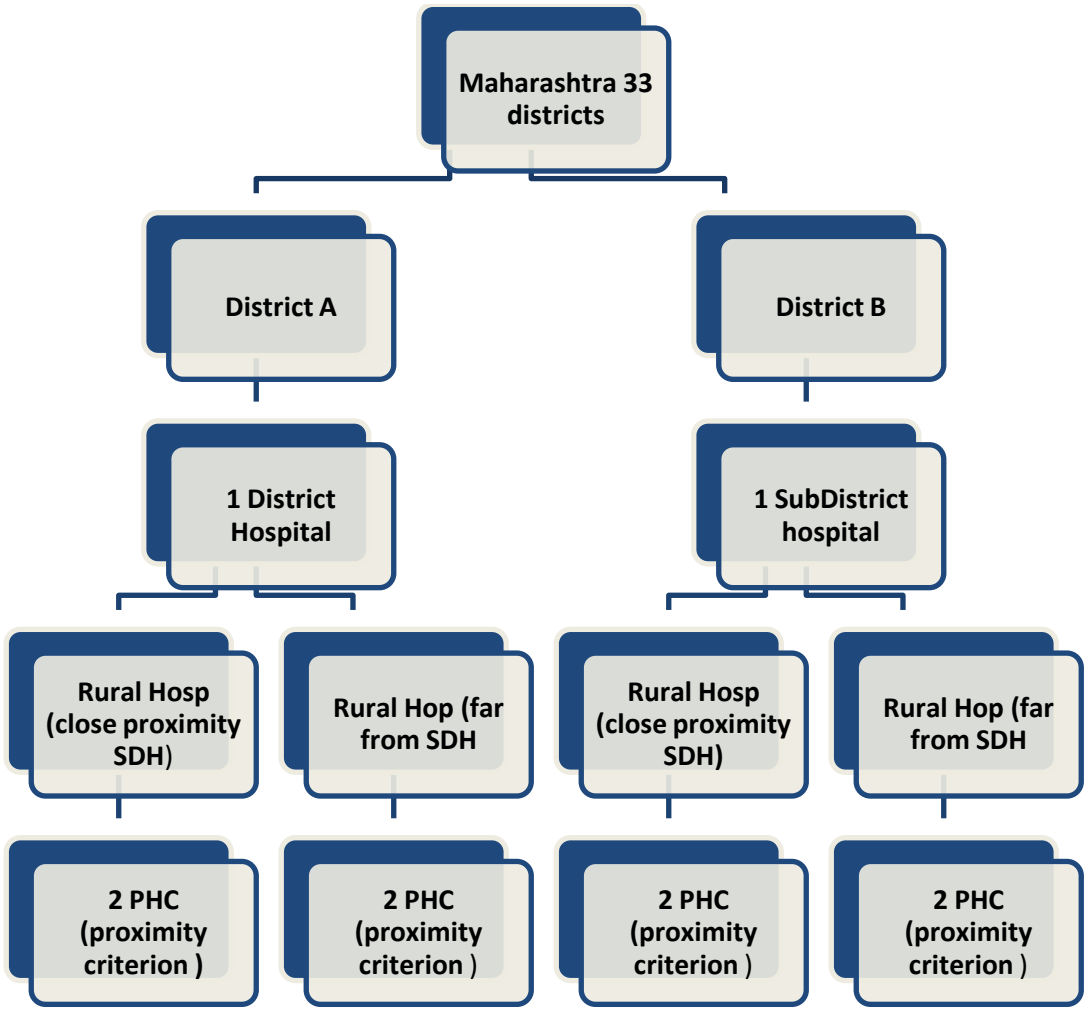
In the selected two districts[13], a tracking flow survey focused on the Primary Health Centres (PHC), selected Rural Hospital (RH)[14] , Sub-district hospital and District hospital (DH)[15]. From each district, one District Hospital (DH) was chosen for the tracking survey. In each district, two Rural/Cottage hospitals were selected. These selected two RHs were based on geographical stratifier, one RH situated close to the district headquarters and the other located distantly from the same. In each district, four PHCs were selected. These selected PHCs are associated with the above two selected RH. Similar geographical area stratifier was considered, one PHC situated close to headquarters, that is, a RH and the other located distantly from the same, also presented in Figure 1.2.

[13] District A has one district hospital and one women's hospital (373 and 189 beds), 4 sub district hospitals (3 SDHs with 50 beds and one SDH with 100 beds), 9 RHs and 56 PHCs. District B, has no district hospital; however, there are three sub district hospitals (SDHs - one with 100 beds and another with 50 beds.) The study has considered a sub district hospital with 100 beds. The total health care facilities available in District B area teaching hospital (733 beds), 3 sub district hospitals, 10 Rural Hospitals and 77 PHCs.

[14] Rural/Cottage hospitals are located in taluka headquarters and offer health care services to the population of the urban centres in which they are situated as well as those in the adjoining rural areas (one RH serves around 120000 population) , 4-5 PHCs are associated with one RH.

[15] DHs are core centres for referral medical care for the rural areas, apart from catering to the district town. The hospitals are mostly located at the district headquarters and called civil hospitals, that usually have 100-500 beds and the most basic specialties.

Figure 1.2: Sampling, Selection of Health Care Facilities



Data Gathering Tool: Method for Survey and Research Tools

Primary data was collected through semi-structured, in-depth interviews with frontline service functionaries of the hospital, key officials at the block and district levels of the relevant line departments and state administrative officers. The major categories of information in the interview guidelines were process of budget estimate/demand preparation and finalising, process of demand vetting and demand approval, allocation and fund flow, information flow and process, internal and external oversight mechanisms. Along with interviewing respondents, many documents relating to budgetary processes were reviewed at each stage. These secondary documents have provided deeper insights into the practical functioning of departments. The Interview Guidelines were prepared In English and Marathi (local language) (Annexure1.1(a & b) Interview Guidelines and Key Respondents list). A number of interviews were conducted with the officials.

The district fieldwork for the study was carried out in two phases in February and May-June, 2011. Front line healthcare service providers were covered first and then the key officials at the district level of the relevant line departments. During this visit, the District Health Officer (DHO) of both districts and a Civil Surgeon (CS) of the district were met and appraised of the study and were requested to inform the different Government facilities about the same. Regional health circle offices, Directorate of the health and State administrative offices that is Health department, Planning, Finance departments were done after completing the district fieldwork.

Secondary data such as Government Resolutions (GRs) and department circulars were collected. This was in the nature of information used by the different agencies for information flow, accounts and also for key administrative or decision making procedures.

As was frequently the case, keeping such records is contingent upon the motivation and the direction of officers in charge making it difficult to get similarly documented information from other healthcare facilities. Gaps in hospital level information were supplemented by information collected at the district, regional offices.

The Maharashtra Budget Manual, Maharashtra Zilla Parishads and Panchayat Samitis Act, Accounts codes were procured and referred to in order to arrive at a broad idea as to what guides budgetary matters and instructions for regulating the budgetary and accounting procedure.

Data Analysis

Most of the interviews where the participants gave explicit permission to record were electronically recorded. The data collected from the interviews were translated and transcribed and manually coded under broad themes using MS word. After the data had been arranged under different relevant themes, analysis was carried out manually by the team.

Literature Review

In terms of budget transparency, Maharashtra does not have a high ranking; it is seventh among ten states, according to the Study on Transparency in State Budgets in India. Out of eight parameters, four parameters score very low on the following counts: budget documents do not provide information on the district-wise break-up of the non-plan allocations and expenditures, no information on women's component plan or gender budgeting, no separate statement for the Scheduled Caste sub-plan, no complete information on funds received by the State from the Central Government or external agencies which are routed outside the State Treasury and not reflected in the budget; no release of any report on the steps taken to address audit observations, for example, in the Comptroller and Auditor General of India(CAG) reports, or information on revenues foregone due to tax concessions. While there is a large amount of data available in hard copy at the state level and an electronic version on the website with details of administrative departments and the various functions of the Government, it is not timely or sufficiently disaggregated to be useful. Nevertheless, the formats of reporting on budget estimate and expenditure are consistent with central Government standards, allowing comparability across the year and with other states in India.

The Structure of the Report

Chapter 1 gives a general introduction in Section I and in Section II, elaborates on the annual budget cycle. It gives a conceptual explanation of the terminology used as 'Budgetary Processes', of how the budget accounts are classified and accounted, and deals with some issues around such a classification.

Chapter 2 is devoted to the **Institutional Structure**, which explains the broader institutional and administrative structure guiding the health sector in the state. The structure entails multiple layers of governance and health service providers interacting with one another, and the entire chain ranges from the Ministry at the state level to the district and further below to the frontline providers, explaining the roles and responsibilities of each such key office or health service providing units involved in the budget for health services. This chapter specifically brings out the context in which the study is placed under the larger head of health budget processes.

Chapter 3 is concerned with **Budget Formulation** and deals with some of the basic procedures followed in budget formulation, the conceptual understanding as well as knowledge of some commonly followed and stipulated practices for budget formulation in the Health Department along with the findings relating to formulation of the budget from the budget tracking study.

Chapter 4 provides details on Fund Flow and Distribution, the area of budget execution, agencies and their role in the fund flow and budget control system and the devised mechanism of fund flow.

Chapter 5 helps understand the planning processes relevant to the whole annual exercise, state level allocation rules for the plan budget to the district and fund flow down to the districts and issues around tracking budget.

Chapter 6 provides insights into the internal and external audit and oversight and focuses on the type and the role of the internal and external audits agencies. The last Chapter concludes with Recommendations.

Section II

Introduction to Budgets

This section explains some crucial aspects of health budget making in Maharashtra and provides a useful context to understand the discussion in the following chapters.

In a federal arrangement like India, the central Government normally plays an overseer role by providing directives and guidance through the formulation of national policies and sponsoring a number of programs through the provision of financial and other inputs. However, the primary responsibility of financing and provision of public health services still rests with the state Governments. The budgetary process is carried out in accordance with the provisions of Article 112 of the Constitution of India. The budget cycle follows the financial year, which as per Government practice, is from 1st April to 31st March. Every year, the budgets of the frontline units and programs are prepared in such a manner that all the health care facilities send their requirements or demands to the Government, which in turn allocates grants to these units for incurring various expenditures. This study tracks the budgetary processes of the service providing units like PHCs, Rural Hospital and Civil Hospital. It is thus very important to explain, what the term, 'budgetary processes' precisely

means. Though the general reference to the term 'budget' is made singularly, there are various processes involved in any given budget. The four broad functional stages of the annual cycle of the budgetare - budget formulation, preparation of the budget estimates by the executive, budget approval debated and discussed in the legislature[16] before enactment, implementation of the approved budget by the executive authorities and finally, review by the executive and audit by an independent audit authority not subordinate to the executive. A diagrammatic representation of the process and the timeline follows are presented in Figure 1.3 Budget Cycle.

- **Budget Formulation:Preparation of the Budget Estimates by the Executive**

Every year, the budget preparation process begins six months prior to the beginning of the financial year. The demands from frontline units at the district level and below pass through various administrative layers reaching up to the ministry. Similarly, demands of various programs also reach the ministerial level. At each of these stages, some or the other processing on the budget is done, which may either include compiling budgets estimates and sending it further for vetting or approving the demands. This process of compilation and approval of the budget demands is broadly referred to as budget formulation or preparation stage. Since the budget estimation is done well before the beginning of the financial year, an account of the expenses is taken in between and it is estimated whether more funds are required. The budget revision is done thrice a year in Maharashtra and revised budget demands are submitted.

- **Authorisation/Enactment of the Budgetary Proposal by the Legislature**

The budget, Annual Financial Statement and the demand for grants of each department commonly known as the Budget, is placed before the legislature for debate, alteration and enactment. The processing of the budget proposals in the legislature involves general discussion, detailed discussion for consideration of the budget (voting of the demand) and approval of the proposed budget through the enactment of Finance Bill[17] and Appropriation Bill[18] and passing the budget law that becomes the basis for ministries/departments authority to collect tax revenue and spending targets (Karnik, SS). The Finance Minister presents the budget in his speech, which includes the new or fresh tax proposals for the year and impact on revenues, expenditure proposals in various sectors consistent with overall Government policies and financial and economic conditions of the state. This is followed by a general discussion of the budget proposals, which provides an opportunity to the legislature member to review the working and progress of the Government. The second stage of the discussion is consideration of department-wise demands for grants. After the demands are passed by the legislature, a bill is introduced to provide for the appropriation.

- **Execution of Budget: Distribution/Expenditure**

Once the budget demands are approved, the executive is authorised to spend money and to collect the revenue. The execution phase involves release of funds appropriated as per the Appropriations Act, the sanctioned grants of the budget, withdrawals of the grant and

[16] Parliament in the federal context and Legislatures in the state context.

[17] The financial bill containing tax proposals is passed in the Legislative Assembly and Council which enters into the statute as the Finance Act.

[18] The departmentwise demand grants seeking approval for withdrawal of money. The Appropriation Bill is put to the vote of the Legislative Assembly and Legislative Council and when the bill is passed by both the Houses, it becomes the Appropriation Act.

incurring the expenditure. Some authorities allot funds, some distribute them and the end users draw funds for usage or other expenses. Making day-to-day decisions on expenditure after the legislature has approved the budget is a key executive function.

The health and other state departments withdraw sanctioned grants of the budget, which are sent to the frontline units and programs for implementation. For this purpose, funds are routed from top to bottom and the route opposite to that of budget formulation is followed.

- **Oversight**

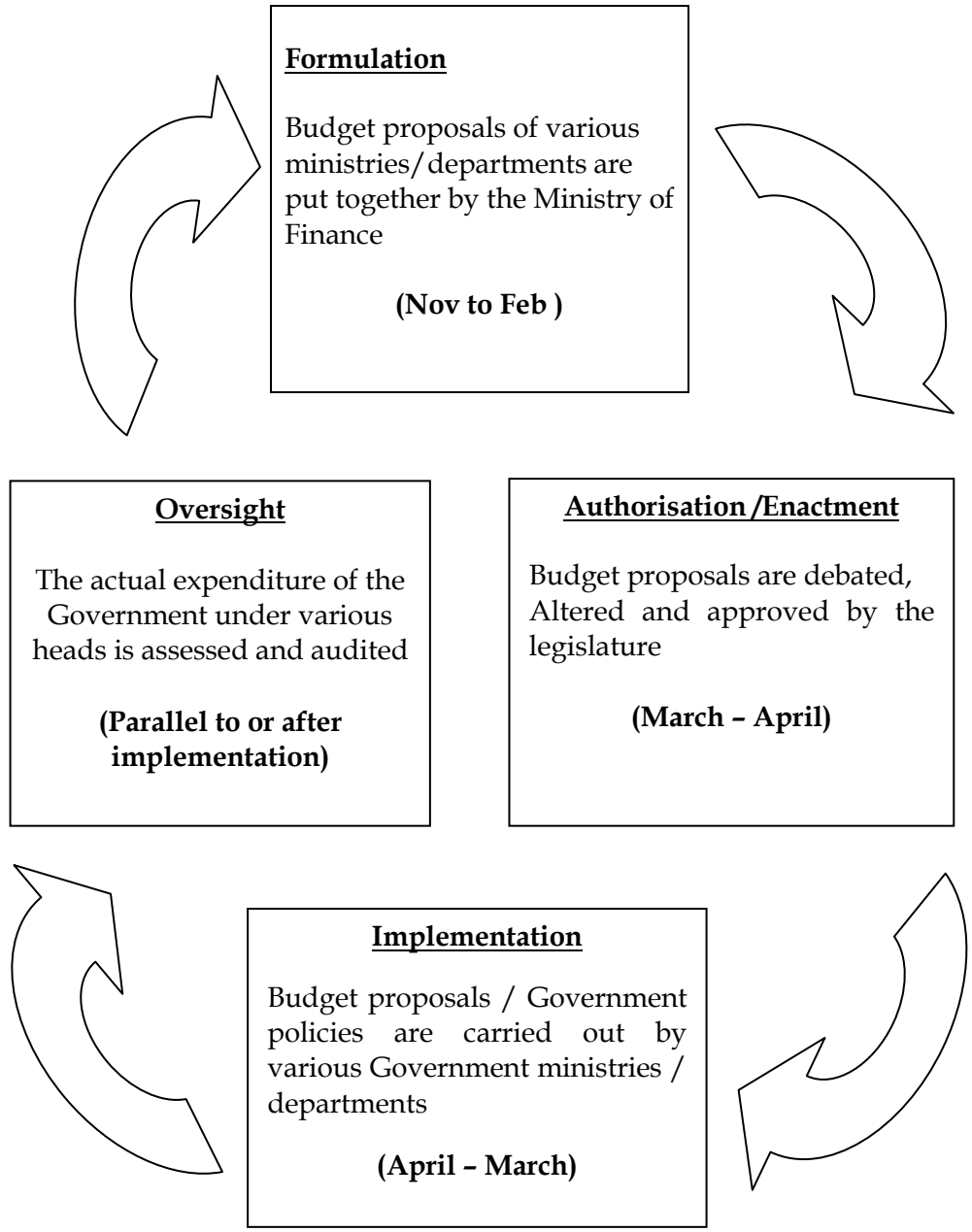
The Constitution of India envisages that the elected legislature exercises oversight functions over the Government, the making of laws, approval of the budget and monitoring of all Government actions (14th Report on Strengthening Financial Management Systems, Second Administrative Reforms Commissions, Government of India, GOI)[19].The process of preparation of the budget and its approval in the Legislature goes through legislative scrutiny and the Legislature exercises full control over the annual budgetary system through this oversight as an effective instrument of financial control of Government activities. To facilitate proper examination of different Demands for Grants leading to more meaningful discussion in the Legislature, Committees are constituted to scrutinise the budget estimates/demands for Grants of the concerned ministries/departments and present a report to both houses of the legislature. The legislature also exercises its control over the provision of supplementary or additional funds required in a particular year and for regularising any excess expenditure over the approved appropriations (Maharashtra Legislative Assembly Rules (MLAR)[20]. The Legislature also exercises its control over the post-budget evaluation of the budget implementation through various committees. These legislature committees call witnesses/administrator to answer their questions on matters related to the department's activities and report to the Legislature.

Having done the formulation or approval, distribution and revision of the budget for any year, it becomes very important to track details of funds and expenditures. This may include the following aspects: whether the expenditure has been incurred, if not, whether the funds have been surrendered to the Government, whether there are any irregularities or malfunctioning in the usage of public funds and so on. For this purpose, there are oversight and regulatory mechanisms built into the institutional structure of budgetary processes. These include roles like auditing, monitoring and controlling performed by either an internal department or by external oversight agencies. The Comptroller and Auditor General of India (CAG) constitutionally mandated external supreme audit agency conducts account and performance audits of Governments, local Governments (PRIs and urban bodies) and semi-government autonomous bodies and tables the reports in the Legislature and its committee for discussion and deliberation. With the laid legislative framework, the public administration of a state is subordinate to the elected bodies that govern it.

[19] www.arc.gov.in/14threport.pdf

[20] MLAR (rule no. 244-E) , eighth edition -2003, Maharashtra Legislature Secretariat

Figure 1.3: Budget Cycle



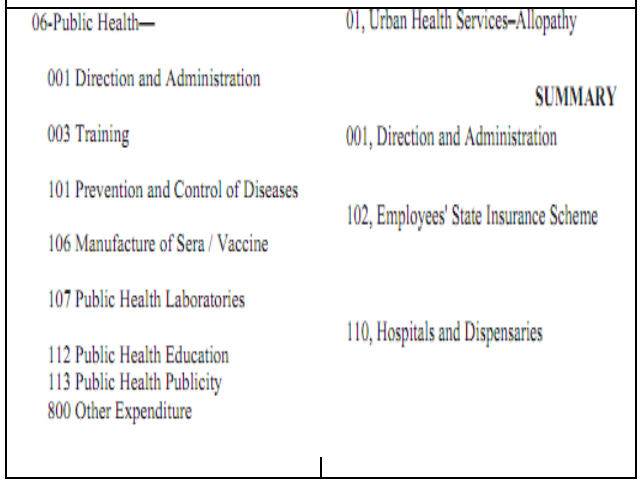
Budget Accounting Structure and Classification

The Central and State Governments keep accounts and follow the coding structure as recommended by the CAG. There is a well stipulated accounting structure followed by the Government to keep an account of every rupee that is received as receipts and expenditure incurred. While receipts are not discussed here, there is a six-tier hierarchical arrangement that deals with the expenditure side of the account. The main unit of classification in accounts is the major head which is divided into minor heads, each of which has a number of subordinate heads, generally known as sub-heads. The sub-heads are further divided into detailed heads. Sometimes major heads may be divided into sub-major heads before their further division into minor heads. Thus, the Sectors, Major heads, Sub-major heads, Minor head and detailed heads together constitute a six tier arrangement of the classification structure of Government Accounts and this classification is uniformly adopted by the Union Government and all the State Governments.

Explaining the classification of accounts with an illustration as shown in Figure 1.5, the scheme operates at the frontline service care facilities, that is, the Primary Health Centre (PHC) and Rural/District hospitals. Further, these schemes are dovetailed into minor heads, sub-major heads and major heads within the health sector. At the facility, 'detailed line item head', is termed as an object classification indicating the object or nature of expenditure on a scheme or activity in terms of inputs such as 'Salaries', 'Office Expenses', 'Supplies and Material' and so on. The detailed line item head is the lowest accounting unit under which transactions are recorded in the scheme/subhead.

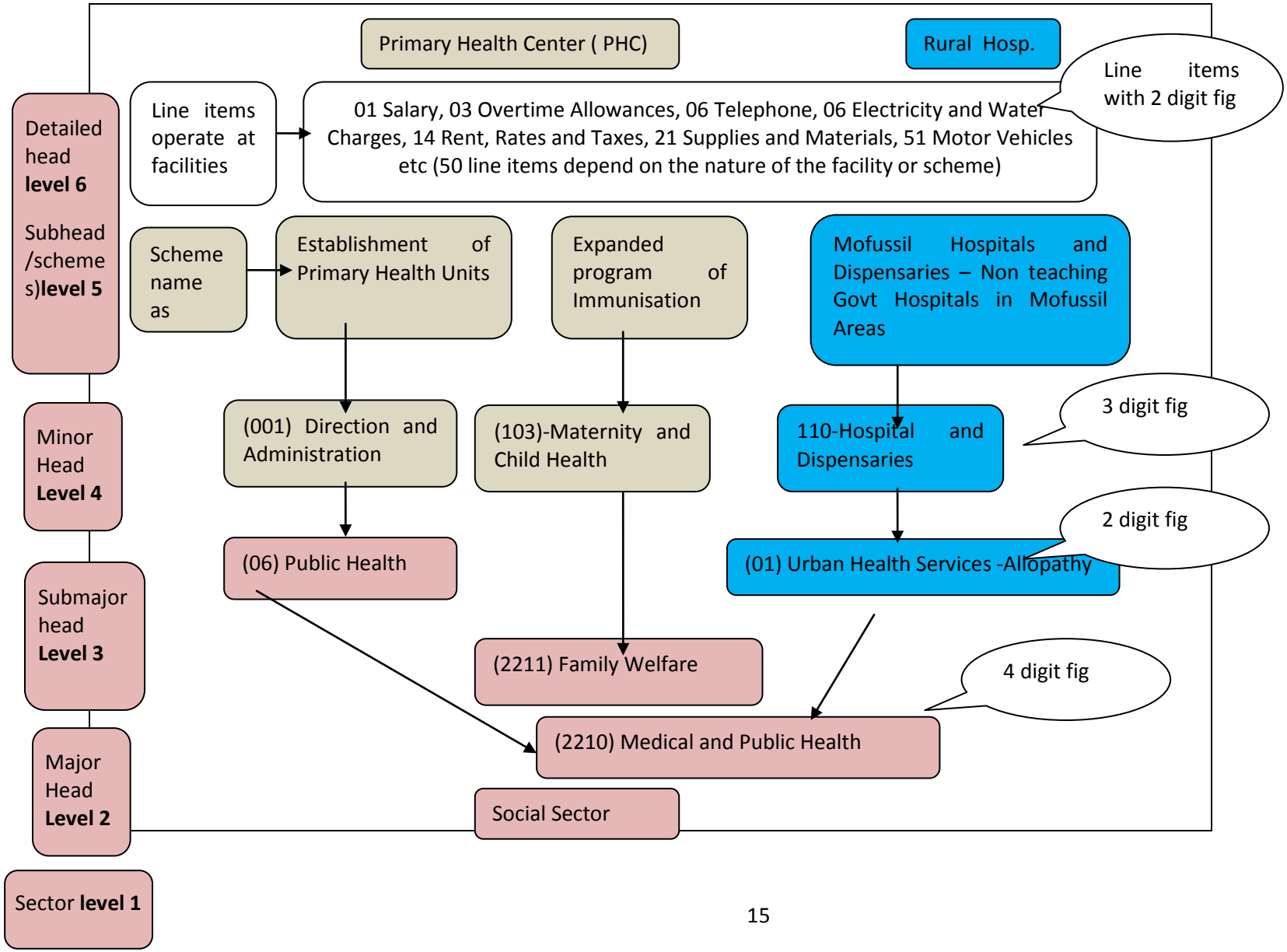
The minor head represents a definite activity, with information on the objective of the Government being achieved through that particular expenditure. It can be the scheme under the program. Schemes such as 'Expanded Program of Immunisation', 'Immunisation of Infant and pre School Children against Diphtheria and Tetanus and Expectant Mothers against Tetanus', 'Child Survival and Safe Motherhood Program' and 'Expansion of Medical Termination of Pregnancy Services' are the schemes under the minor head 'Maternity and Child Health' denoted by the three digit figure under the particular function of Family Welfare.

Figure 1.4: Minor head under submajor head



Submajor heads represent a group of allied functions under a major head. The submajor is denoted by a two digit figure; for instance, in Health 'Public Health' is a submajor head which includes a minor head like the program on 'Prevention and Control of Diseases', 'Manufacture of Sera/Vaccine' etc. Programs like 'Hospitals and Dispensaries', 'ESIS' and 'Direction and Administration' are included in the minor heads. Schemes such as 'Urban Health Services- Allopathy', 'Rural Health Service Services- Allopathy' are separately shown under all the relevant subheads with separate allocations. Also, as seen in Figure 1.4, minor head 001-'Direction and Administration' is common across the two sub heads thus indicating the nature of expenditure across the group.

Figure 1.5: Accounting Classification on Expenditure, an illustration



The functions of the Government discharged through the expenditure are denoted by the major heads, the first tier of the functional classification. Major Heads with the four digit numerical code correspond to different services such as 'Medical and Public Health' and 'Family Welfare'. Sector is the first level of classification. Functions of similar nature are grouped together; for instance the sectors include Social, Economic, General Services and Grants-in-aid. Social services include functional activities such as services on Education, Sports, Art and Culture, Health and Water Supply and Sanitation, Housing etc. Economic services are of a developmental nature and include services such as Agriculture and Allied Services , Rural Development, Special Programs for Hilly Areas, Irrigation and Flood Control, Energy, Industry and Minerals, Transport, Science; General Services comprise Administration of Justice, Administrative Services of Police, Jail, Treasury and Account Administration and Fiscal Services consist of Interest Payments and Debt Servicing.

Currently, the budgets as well as the accounts follow a uniform classification with a clear presentation of objectives and purposes of Government expenditure in terms of functions, programs and activities, bringing together all expenditures under appropriate subheads, functional (major), program (minor), and activity (subhead) irrespective of the organisation administering it. This grouping enables a clear understanding of the economic nature of the expenditure incurred; this has improved phenomenally over the year and provides a more meaningful classification of transactions for presentation and reporting of Government operation in terms of functions, programs and activities (High Level Expert Committee on Efficient Management of Public Expenditure, Government of India, Planning Commission (GOIPC), April 2010).

Plan and Non-Plan Budget

India follows a Plan based model of economy. The budgets or expenditures heads are broadly classified as Plan and Non-Plan and the distinction runs through all items of expenditure and there is a further division of expenditures into revenue and capital account. As the name suggests, the plan budget and expenditure encompasses all new expenditures envisaged in the Five Year Plans, which are included in the budget through the state Annual Plans. Non-plan expenditure is the expenditure incurred on administration, includes salary, maintenance of existing assets and so on. Further, the recurrent expenditure in maintaining the assets created under plan schemes enters into non-plan expenditure when the schemes are completed at the end of the Plan. The distinction has its roots in the plan model of development adopted by the country. The Plan resources primarily represent schemes that are largely controlled by the Centre - the Planning Commission and the line ministry of the Central Government. For a long time, ahigher plan expenditure was considered more desirable because it brought in development/investment funds. The non-plan expenditure is often viewed as obligatory in nature. The non-plan resources come mainly from the state's own resources, including some mandatory grants from the centre.

This intended purpose of the classification is no longer valid because a number of existing schemes and continuing expenditure continues to be under Plan. This classification has been criticised and questioned (for further reading[21]) in recent times; however, the distinction is

[21] High Level Expert Committee (HLEC) on Efficient Management of Public Expenditure set up by the Government of India, Planning Commission (GOIPC) on April 22, 2010 under the chairmanship of C Rangarajan; 4th Report on Strengthening Financial Management Systems, Second Administrative Reforms Commissions ,GOI ; Das-Gupta, Arindam.(2011). Public Expenditure Management Committee Report: A Critical Review. Economic and political weekly, vol. 46, no 43, p. 15-19.

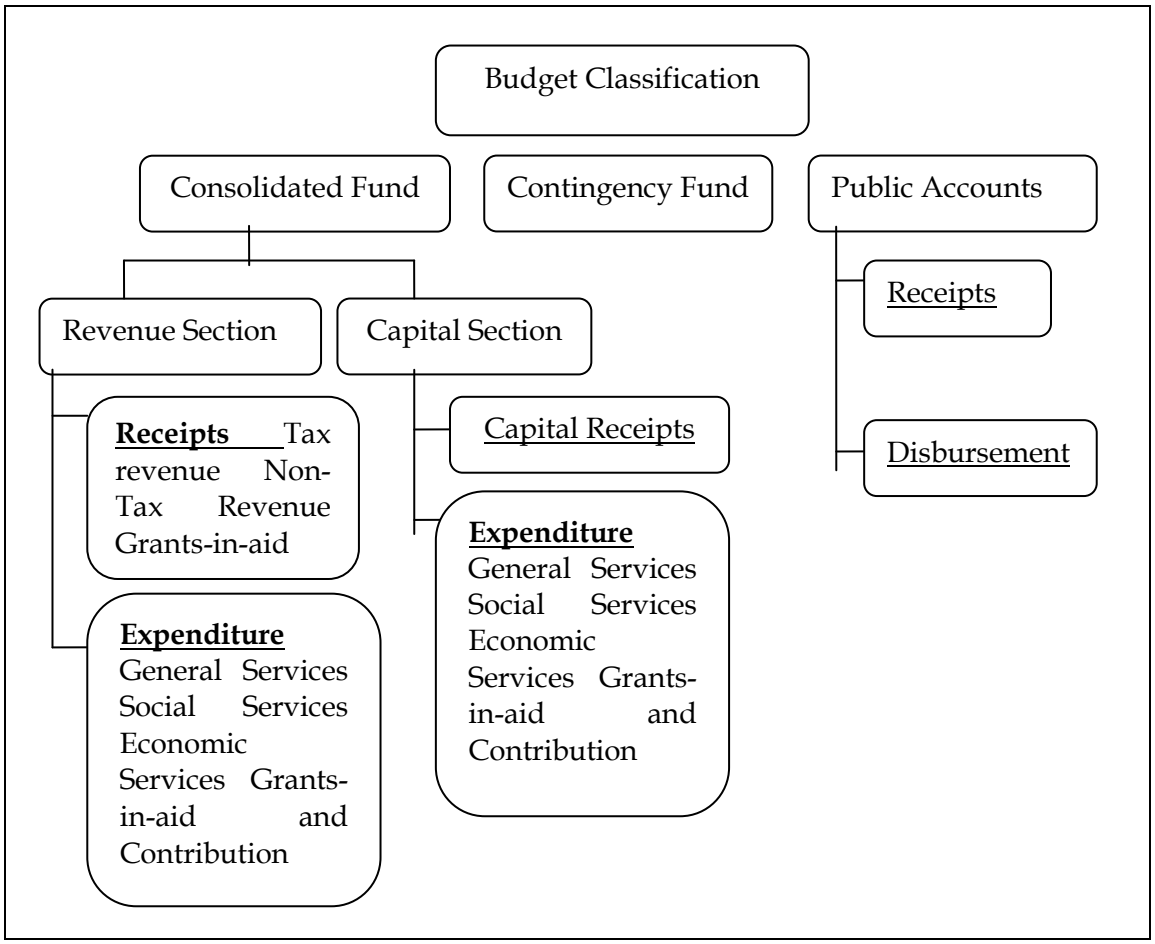
something which remains unique to Indian politics. As a former Home Secretary of the Government of India (Dr. Madhav Godbole) puts it,

"Just as not all Plan expenditure is, by definition, necessarily productive or developmental, not all Non-Plan expenditure is non-developmental and therefore of low priority. This classification has resulted in neglect of Non-Plan developmental expenditure, in particular" (Karnik S.S).

This points to the Government's increasing tendency to start new schemes, while neglecting the maintenance of existing capacity and service levels.

All budgetary transactions in India are classified into three funds - Consolidated Fund, Contingency Fund, and Public Accounts (Figure no.1.6). The Consolidated Fund consists of Revenue and Capital Accounts, which are further disaggregated into sectors and sub-sectors - budget classification is presented in Figure 1.5. Contingency Fund is provided for meeting unforeseen expenditure pending subsequent authorisation of the expenditure by the Parliament. The Third account is called the Public Account. This section records transactions relating to debt, deposits, advances, and remittances wherein the Government functions as a banker. For example, the money deducted from the salaries of employees as provident fund subscriptions gets credited to the Public Account (Receipt side) and all payments to employees out of their provident fund accumulations are debited to the Public Account (Disbursement side).

Figure 1.6: Basic structure of Government Budget/Accounts Classification



Revenue and Capital Classification

The Revenue-Capital classification has been incorporated since the inception of the budget (HLEC on the efficient management of public expenditure). Both the budget demand and account Revenue-Capital classification distinguish the nature of the expenditure incurred by the Government. The expenditure incurred by the Government with the object of either acquiring or creating assets of a material and permanent character or with a view to reducing recurring liabilities is booked as capital expenditure. Examples are construction of health facility buildings, purchase of equipment and machinery etc., in the account code this will be denoted by the numerical code '4' initial in major head (for instance, 4210 is capital expenditure for health). The expenditure on current consumption of goods and services of the Government departments, on activities of non-capital character, expenses on State administration, Legislature, debt servicing and interest payments, pensions, grants-in-aid to various institutions are booked as revenue expenditure. The major head with the initial 2 or 3 are revenue expenditure; in health, the numerical code is 2210 (medical and public health) and 2211 (family welfare) as also shown in Chart 1.5. This delineation between the revenue and capital in the budget provides a better understanding of the expenditure towards capital formation and towards current consumption (Pandkar and Raymus, 2007). Different numerical codes are allotted to the major head - first tier of the functional classification that defines the nature of the expenditure and thus follows uniformity in public sector finances across all states' (See Annexure 1.2 Coding Classification).

State- Central Schemes

In the federal system, many financial resources are transferred from the union Government every year to every state: share of states in the central tax; allocation in the form of grants and loans for new and targeted interventions for socio-economic development; Centrally Sponsored Schemes (CSS). The grants/transfers for CSS are meant to supplement the resources of the State Governments, who are responsible for the implementation of these schemes. CSS schemes are entirely funded or partly funded by the Union Government and the State Government contributes the remaining share. For example, the National Program for Control of Blindness is fully funded by the Union Government, whereas in the Tuberculosis Control Program, the State contributes a matching share of 50 percent and the Union Government provides technical support as well as cash and commodity assistance as per the approved pattern as shown inTable 1.1. Centrally sponsored schemes that are designed by the Union Government Health ministries, also provide directives and guidance for implementing the schemes.

Table 1.1: Entirely and Partially Funded Centrally Sponsored Health Schemes

	Annual Plan and Expenditure , 2009-2010 (schemes under Directorate of Health Services)												Rs. In Lakhs
Sr No	Name of Centrally Sponsored Scheme	Code No.		Sharing pattern (100 %, 75:25 , 50:50 etc.)	**Budgetary provision**			**Grants actually received**			**Expenditure**		
		Central Share	State Share		Central Share	State Share	Total	Central Share	State Share	Total	Central Share	State Share	Total
1	2	2a	2b										
1	National Tuberculosis Control Program	2210 0932	2210 5175	50%	100	100	200	521.1	47.26	568.35	521.09	47.26	568.35
2	Guineaworm Eradication Program	2210 0952	2210 5184	50%	2.00	2.00	4	0.67	0.67	1.34	0.45	0.00	0.45
3	National Malaria Eradication Program (GEN)	2210 0905	2210 5157	50%	400.00	400.00	800	169.1	169.11	338.22	169.11	143.85	312.96
	National Malaria Eradication Program (OTSP)	2210 3726	2210 3717	50%	89.60	89.60	179.2	0.00	89.60	89.60	0.00	35.06	35.06
	National Malaria Eradication Program (TSP)	2210 2873	2210 2864	50%	298.63	1012.71	1311.4	0.00	754.04	754.04	0.00	754.04	754.04
4	National Filaria Control Program	2210 0914	2210 5166	50%	100.00	100.00	200	89.6	44.39	133.97	89.58	35.96	125.54
5	National Program for Control of Blindness	2210 0235		100 %	140.45	0.00	140.5	31.6	0.00	31.66	31.66	0.00	31.66
6	Central Food Laboratory	2210 1008		100 %	70.00	0.00	70.00	70.0	0.00	70.00	60.35	0.00	60.35

Sources: Compiled from the secondary documents collected from the DHS office.

There are a number of Centrally Sponsored Schemes where State contributed matching grants, the percentage share of state contribution differ for the different schemes. It ranges from 25,33,50,75 to 80 percent. Such Schemes are National Filaria Control Program, BCG Vaccination and TB Control Program, National Malaria Eradication Program etc. The schemes for which funds are transferred from the Centre to the State for execution are treated as revenue expenditure irrespective of whether they are salaries and maintenance of

establishment or for creation of assets, and are booked as plan budget schemes. The State Governments also treat transfers of funds to local bodies (PRIs) and other implementing agencies in a similar way. The report on Efficient Management of Public Expenditure observes, "…because of such a classification, the picture of the resources being put for capital formation (asset) is not fairly provided".

The State health expenditure statement document is inclusive of all kinds of expenditure incurred for the purpose such as revenue and capital and plan and non-plan and thus provides a holistic idea of what is the total expenditure incurred on the program in one place. The expenditure statement provides details about such Centre to State transfer schemes separately. While assessing the expenditure statement, the major problem faced is to generating scheme wise information from the accounting classification due to the absence of a one-to-one correspondence with schemes and heads of accounts.

Flow of Funds: Treasury Mode and Society Mode/Off Budget

The flow of funds of the health sector CSS schemes from the Union to the State follows two methods - the treasury system/mode and the society mode. In the treasury mode, the release of CSS funds is reflected in the State budget. The State Finance Department, in consultation with the union ministries, gets the budget approval; the State Finance Department withdraws the grant from the Reserve Bank of India (RBI) and allocates to the State level implementing agencies. The concern implementation agency withdraws the fund for expenditure from the treasury captured as final expenditure in the State Annual Account prepared by the State Accountant General, whose reports are presented to the Legislature within the statutory period. The treasury mode follows uniform accounting codes and standards. This treasury system are perceived as stringent checks and auditing (of annual account) by the external audit agency, CAG.

Another method followed by the Central Government, started in the mid-nineties, is the direct transfer of funds required for the implementation of several central sponsored schemes to bank accounts of Implementing Agencies (societies, autonomous bodies, NGOs etc), set up at the State and district levels that maintain funds outside of the Consolidated Fund of the States, bypassing the state's normal arrangements for fund flow and implementation. This method of transfer is called the society mode of funds transfer (HLEC). In Health, one such program is the National Rural Health Mission[22] (NRHM), a central Governments flagship program. The society mode funds are not routed through the State Budget/State Treasury System. The society mode was adopted to address the concern of delay in receiving the resources by the frontline service delivery units. However, the CAG in its report perceived such off budget mode running the risk of improper utilisation of funds by these agencies and difficult to monitor the end use of direct transfer.

[22]The mission is an umbrella program subsumed various centrally sponsored schemes in Health and Family Welfare including the Reproductive and Child Health, National Disease Control Program, Programs for malaria, tuberculosis, *kala azar*, filaria, blindness and iodine deficiency and Integrated Disease Surveillance Program.

Health Budget Situation in Maharashtra

In Maharashtra, the health sector receives the CSS funds from both the funding mechanisms: treasury and off budget mode. Around 13 percent of the overall health budget is funded through centrally sponsored schemes/Central plan in the total health expenditure and external off-budget accounts amounts to Rs. 675.29 crore for NRHM, in 2010-11[23]. Some of the disease control programs are implemented by the societies constituted for the specific purpose such as TB control society, malaria control society and so on; schemes like Goitre Control Program, experimental projects-multi-purpose workers scheme etc., are funded through treasury mode. However, most of the State health policies are influenced by the Union Government through the fiscal leverage of the CSS. The Union covers the substantial part of the cost for the First Five Year Plan (usually five year), and the States are expected to cover all the costs thereafter (Monica Das Gupta et al, *EPW,* 2010).

The budget documents or the civil budget estimates, report the Budget Estimates for the year, the year preceding the budget and the actual outcome of the previous year's budget expenditures. The three departments, DOPHFW, Medical Education and Tribal department, show underspends on its budget, rather than overspends.

Table 1.2: Public Health Expenditure in Maharashtra, 2008-09 to 2011-12

		Rs. In Crores					
Year		**Public Health Dept.**		**Medical Education Dept.**		**Tribal Dept. (health major head)**	
		REV	CAP	REV	CAP	REV	CAP
2011-12	R. Estimate	3638.21	12.31	1389.79	62.25	133.97	24.19
2010-11	R. Estimate	3169.62	5.46	1301.03	34.37	105.50	13.07
	Actual Expn.	3020.49	19.99	1230.91	29.56	85.72	4.11
2009-10	R. Estimate	2706.77	18.68	1064.35	101.35	101.19	17.33
	Actual Expn.	2509.80	4.81	978.93	76.82	81.11	1.28
2008-09	R. Estimate	2182.56	6.33	735.82	118.03	123.43	18.04
	Actual Expn.	2168.38	5.12	740.31	116.63	84.39	4.44

Source: Civil Budget Estimate of the Respective Departments

Note: R. Estimate-Revised Estimate. Revised estimates are done through the supplementary budgets midway in the year; figures exclude debt major head includes loans to Government servants, loans for family welfare

The gap between the estimates and the actual expenditure shows the prudent and realistic economic assumptions in formulation of estimates. The various departments, especially tribal development, show persistent underutilisation. The State Accountant General, in his report, refers to underutilisation as 'savings'- surrender of unspent amounts from various grants to the Finance Ministry, and raises a caution about inadequate program management, budgetary control in the departments.

Our study focuses on the conventional route of budget and administrative processes which follow the treasury route, and are reflected in the state budgets of their departments or the transferred schemes to the ZP accounted in their budget/ accounts. Having explained the broad term used as 'Budgetary Processes' and account structure, the next chapter explains

[23]CAG Audit Report (State Finances) for the year ended 31 March 2011.

the institutional structures; the entire chain ranges from the Ministry at the state level to the district and further below to the frontline providers, explaining the roles and responsibilities of each such key office or health service providing units involved in the budget for health services. This elaborate explanation of the institutional structure is presented in the chronological as well as hierarchical orderthat follows the conventional route of budgetary processes. This will play an immense role in understanding the rest of the document.

CHAPTER 2

INSTITUTIONAL STRUCTURE

The key objective of this chapter is to outline the institutional structure of the public health services delivery system in the state of Maharashtra. The structure entails multiple layers of governance and health service providers interacting with one another and the entire chain ranges from the Ministry at the state level to the district and further below to the frontline providers. It is important to explain the institutional structure in order to understand the context for those levels. At each level, one or more key functional offices are involved in the budget for health services. The roles of each such key office or health service providing units at the various levels of governance have been delineated.

State Level

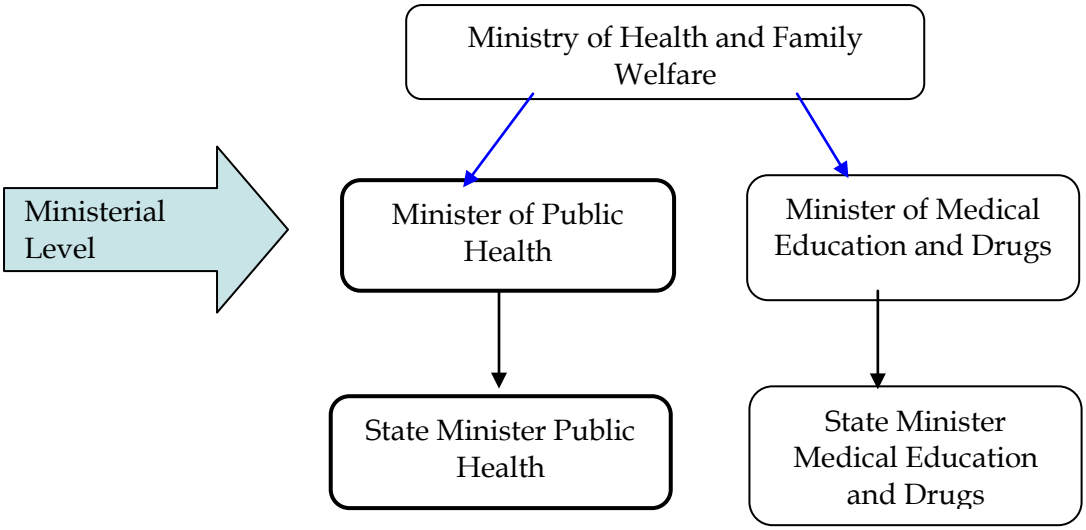
The state level structure governing the public health services can be broadly categorised into three levels - Ministry, Secretariat and Directorate. The ministry is the topmost authority and is supported by the administrative department at the secretariat level. Each administrative department is further supported by its directorate.

In Maharashtra, public health services are governed by the Ministry of Health and Family Welfare (MOHFW) which is divided into two parts, 'Public Health and Family Welfare' (PHD) and 'Medical Education and Drugs'(DMED). Of the two departments, the former works on preventive and control of diseases, family welfare services and medical relief through Primary Health Centres (PHC), dispensaries , Sub Centre (SC), district, sub district, cottage, women and rural hospitals and Employee State Insurance Scheme (ESIS) hospitals and also specialist hospitals like TB Hospitals, ENT Hospital, Eye Hospital, Infectious Diseases Hospital and Cancer Hospital, whereas the latter oversees medical education, teaching hospitals which also provide some tertiary healthcare[24], research in the field of medicine as well as control of drugs and prevention of food adulteration. Figure 2.1, shows that both departments are headed by a separate minister; and each supported by a minister of state. Each part of the ministry is further supported by its administrative department[25]. Each such administrative department is headed by a Secretary. These secretaries for PHD and DMED function under their respective State Ministers.

[24]These are large 500-2000 bed hospitals that cater to not only their local areas but also the entire region around.

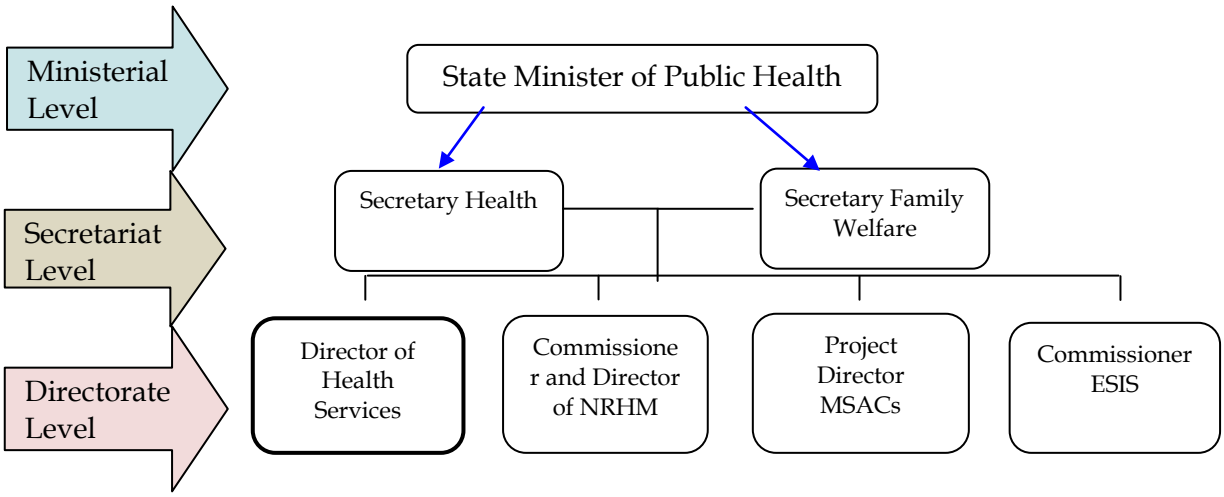
[25]The level at which these are placed is often referred to as the secretariat or 'Mantralaya' level, referring to a building in the state capital of Mumbai where the various administrative departments function.

Figure 2.1: Structure of Ministry of Health and Family Welfare



The present study focuses on tracking budgetary processes of public health care facilities, therefore the PHD is mainly relevant as services are catered through Civil hospitals, Rural and Sub-district hospitals and PHCs. The DMED cater services through the tertiary, that is, teaching hospitals located in Mumbai and other large cities like Pune, Solapur, Nagpur, Thane and Aurangabad. However, there are possible linkages in budget decision making across these two departments. The existing study does not explore the linkages and budget decisions. Figure 2.2 shows the remaining structure of the PHD and its directorate. As mentioned before, PHD being the administrative department is supported by its own Directorates for technical support.

Figure 2.2: From Ministerial Level to Secretariat and Directorate Levels



More on the Directorate Level

Of the four directors at the Directorate under PHD, 'health services' as understood in normal parlance are provided by the first three, while ESIS (Employee state Insurance Scheme) mainly deals with insurance. Further, MSACS (Maharashtra State AIDS Control Society) is specific to AIDS, whereas our purpose of tracking the budget is for regular or overall curative and preventive health care. This makes the first two directors, that is, those of NRHM (National Rural Health Mission) and Director Health Services (DHS) more relevant. The budgetary processes followed under NRHM and DHS are different. Although ample

literature discusses tracking NRHM fund flow[26], that of DHS remains neglected. Our study, thus, tracks the budgetary processes of the Director of Health Services (DHS).

The Director of Health Services is assisted by a team of Additional Directors, Joint Directors and Deputy (Dy.) Directors. Some of the Joint Directors are given the responsibility as Program Officers or Bureau Chiefs for different health programs and support services. The structure at the DHS level is wide and complex. For the purpose of our study, we can avoid getting into details of the same; however, for those interested in knowing the hierarchy at DHS, it is provided in Annexure 2.1.

While DHS, placed at the directorate level is a state level body, the hierarchical structure flows further down from the State to the division level and down to the district and below. We can now move forward to understanding structures at these levels.

Public Health Care Services under DHS

At levels of district, taluka and below, the public healthcare services are provided by various units. The nature of care provided depends upon the type of unit. At below the taluka level, Primary Health Centres (PHCs) and Sub Centres (SCs) serve the village level in rural areas. Rural Hospitals, Cottage or Sub District Hospitals as well as District Hospitals are located at the taluka and district levels. The SCs and PHCs provide preventive as well as some basic curative health care, and the hospitals serve as a referral point to patients from the PHCs.The facilities offered and capacities available at each of the service providing units mentioned above are given in detail below:

Primary Health Centres (PHCs) and Sub Centres (SCs)

Primary Health Centres (PHCs) are below the taluka level. Generally, one PHC serves a population of 30,000 in rural areas; in the case of hilly and tribal areas, one PHC serves a population of 20,000. Under each PHC are about four or five SCs. PHCs provide the first contact care to villagers. Generally, these facilities have six beds and a doctor, the Medical Officer (MO) heads the facility. PHCs and SCs implement all the national programs and schemes under Public Health and Family Welfare. The main focus areas at this level include preventive and control programs of malaria and leprosy. Surveillance of selected diseases, family planning services, immunisation such as pulse polio, ante natal care (ANC) and post natal care (PNC). PHC report the clinical services related to the THO and DHO. In the case of national programs such as malaria and TB, they also report to the line office at the district, for example, malaria related to the District Malaria office (DMO) and TB related the District TB Office (DTO) .

[26] Report of the Committee for finalising financial Guidelines and Framework for delegation of Administrative and Financial Powers under National Rural Health Mission March, 2007, GOI ; Kaveri Gill, *A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM):Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan*, Working Paper 1/2009 – PEO Planning Commission of India ,May 2009; Government of India, Guidelines on financial, accounting, auditing, fund flow and banking arrangements as approved by Empowered Program Committee of NRHM; No.107/FMG/2005-06, Date: 14th December 2006.

Rural and Sub-District Hospitals

The Rural Hospital (RH) at the taluka level is generally a 30-bed hospital that serves as a referral centre for associated PHCs. These hospitals are mostly located at the taluka (each District is divided into Blocks or taluka) headquarters serving the population from both urban and rural adjoining areas. Some of the Rural Hospitals with additional beds are upgraded to Sub District Hospital (SDH). The capacity of SDHs can vary from 50 beds to 200 beds. The SDHs provide some essential specialty services such as surgery, obstetrics and gynaecology paediatrics, ophthalmic to the population of that Sub District Hospital and the adjourning talukas. The frontline service providers at the taluka level, the RHs and SDHs, report to the Civil Surgeon at the District Hospital for technical issues such as services /performance related .

District Hospitals

At the district level, the District Hospital (DH) is the referral centre that forms the core of medical care provided by the MOPH. These hospitals are headed by a Civil Surgeon and are often referred as Civil Hospitals. They are mostly located at the district headquarters and usually have 100-500 beds with various specialties, such as medicine, surgery, obstetrics and gynaecology, paediatrics, radiology and pathology services. Some districts also have women's hospitals and cottage/other hospitals.

Overall, the PHCs and SCs are located in rural areas, whereas the hospitals (Rural, Sub district, and cottage) are located in taluka or urban areas. A particular facility, however, serve not only the population belonging to its location, but also those belonging to adjacent rural areas.

The healthcare facilities at the district level are divided into rural and urban areas and are managed by different authorities. The structure of healthcare provided and administration or control of both these lines are also very different. For our convenience, we have referred to them as 'PHC Line' and 'Hospitals Line'. The details of both are as follows:

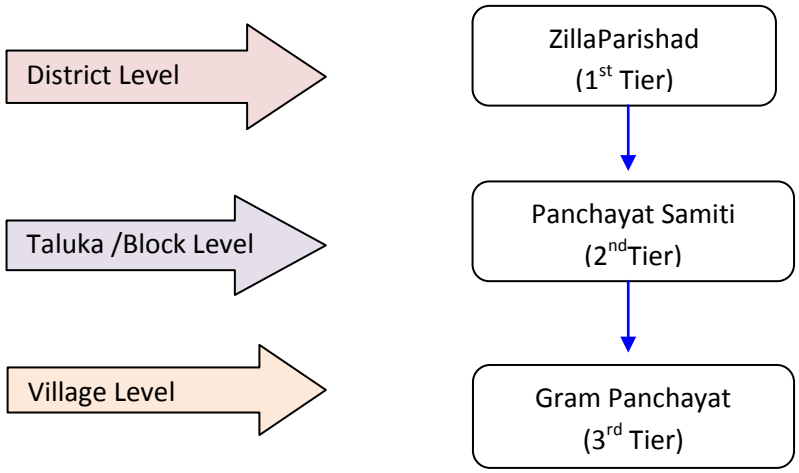
PHC Line

The PHCs and SCs mainly come under the fold of Panchayat Raj Institutions (PRIs).To understand the structure of PRIs refer to Box 2.1. In Maharashtra, there is a full-fledged health department within the folds of the Zilla Parishad (ZP).The health department at the ZP is headed by the District Health Officer (DHO), a senior medical officer of the state government with some public health training, on deputation with the ZP. The DHO looks after rural healthcare and program implementation and is supported by additional and assistant DHOs. The support staff also works exclusively for the rural areas administering the PHCs and SCs.

BOX 2.1: Panchayat Raj Institutions (PRI)

India, in its federal set up, is divided into 28 states and 7 union territories. Each state is made up into several districts, which total 640 nationwide. In order to decentralise governance in the country, the Indian Constitution was amended in 1992. As part of this change, the PRI institutions were intiated in rural India. Decentralisation of rural and urban areas is guided by the 73rd and 74thConstitutional Amendment Acts, respectively, which are landmarks in the history of Indian governance.

As part of the rural administrative system, the districts are made of multiple blocks or *'Talukas'*.. Talukas, in turn, are made up of several villages. The figure below shows the three-tier system of governance for PRIs. The Zilla Parishad (ZP), Panchayat Samiti (PS) and Gram Panchayat are the seperate governing bodies working at levels of District, Taluka and Village respectively.



One of the main implications of decentralisation is that resources from the central and state government, which are meant for programs falling within the jurisdiction of the PRIs will directly get allocated to them.

In addition to the DHO, the position of Taluka Health Officer (THO)[27] was created at the taluka level after NRHM came into existence. The main purpose of creating this position was to bridge the gap between the MO at PHC level and the DHO at the district level, since some districts contain a large number of PHCs. Maharashtra has 33 Districts with 1,816 PHCs., Although each district contains an average of about 55 PHCs, the range is wide: the lowest number of PHCs in any District is 24 (in Hingoli), while the highest is 103 (in Nasik). Given the large number of PHCs and talukas, in some districts, a taluka level authority is essential to bridge the gap between the DHO and MOs. Accordingly, there are additional DHO positions at the DHO office and the district may be divided amongst two or three ADHOs, and it is the same pattern at the Taluka level with additional staff where needed.

Aspects relating to health care provisioning are supervised by the THO, who is further assisted by a Health Supervisor and Health Assistant. Apart from that, the THO receives

[27]Under NRHM the THO is known as Block Medical officer (BMO) and has been provided with support staff to delegate the administrative and financial role and responsibilities.

support from the Extension Officer Health (EOH) mainly for administrative purposes. The THO reports back to the District Health Officer (DHO). The DHO and THO are heads of the Public Health Department at the district and taluka levels, respectively.

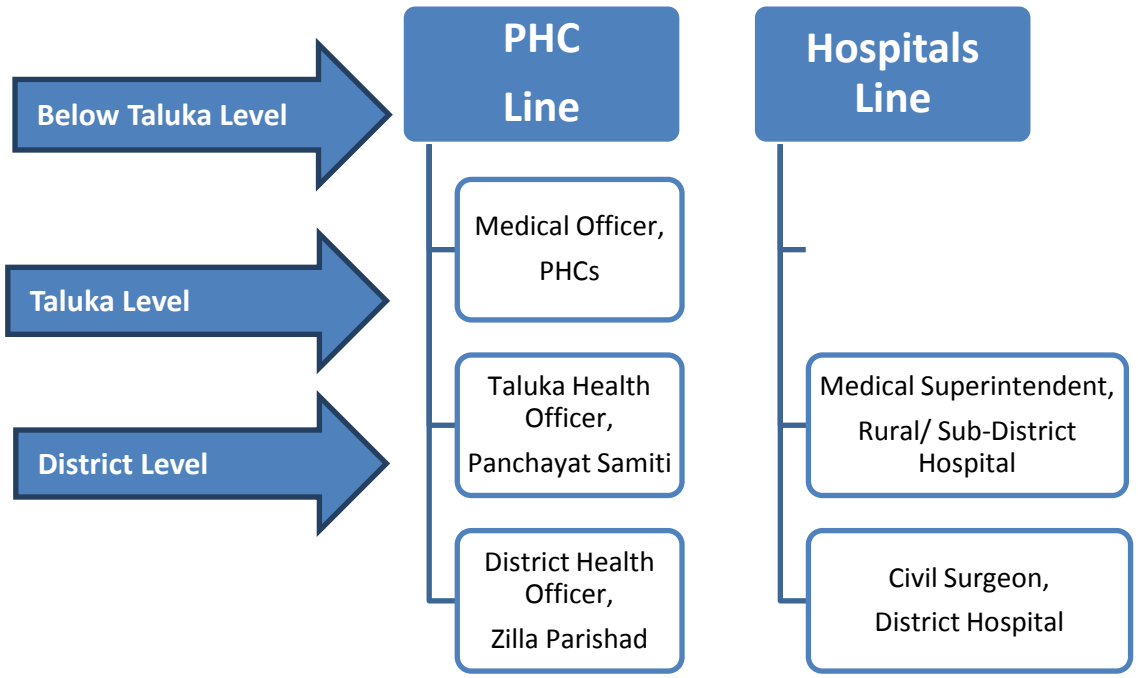
The entire link of MO at the PHC or below the taluka level, THO at the taluka level and DHO at the district level is what is referred to as the 'PHC Line'.

Hospitals Line

The Rural, Cottage or Sub-District Hospitals are all located at the taluka level; on the other hand, District Hospitals, as the name suggests, are located at the district level.

All the hospitals at the taluka level - Rural, Cottage or Sub-District Hospitals - are headed by a Medical Superintendent (MS) who reports the technical matters to the Civil Surgeon, who is a district level authority in charge of managing urban health. The Civil Surgeon is also the head of the District Hospitals and thus manages the technical control of the same. In fact, District Hospitals are often alternatively referred to as Civil Hospitals. All talukas or districts in Maharashtra do not necessarily have all the types of hospitals mentioned above.

Figure 2.3: Two Lines of Health Care and Technical Control

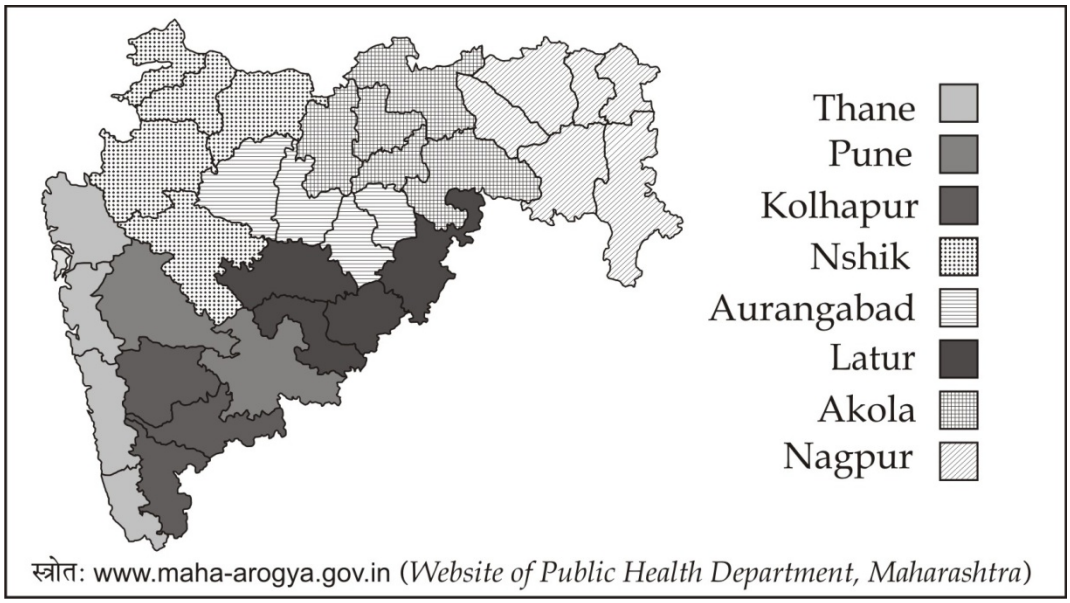


The two lines of healthcare have been clearly explained in Figure 2.3 above. At the district level, while the District Health Officer (DHO) looks at the preventive and disease control part of the healthcare of the district, the Civil Surgeon (CS) is responsible for looking into curative healthcare of the district. The crucial difference, however, is that the DHO is an officer of the ZP and, thus, has a formal role in PRI, the CS does not. The CS is directly linked with what is known as the 'state line department', that is, the state level structure of public health flowing down at the district level.

Convergence of the Two Lines: Deputy Director Health Services

There are 33 districts in the state of Maharashtra. It is difficult for a state level department to receive reports from the DHOs and CS of all 33 districts. The state is thus divided into eight regional level health circles (Figure 2.4). The number of districts in each circle ranges from the lowest of two under Pune circle to the highest of six under Nagpur circle.

Figure 2.4: Eight Health Circles/Regions of Maharashtra



स्त्रोत: www.maha-arogya.gov.in (*Website of Public Health Department, Maharashtra*)

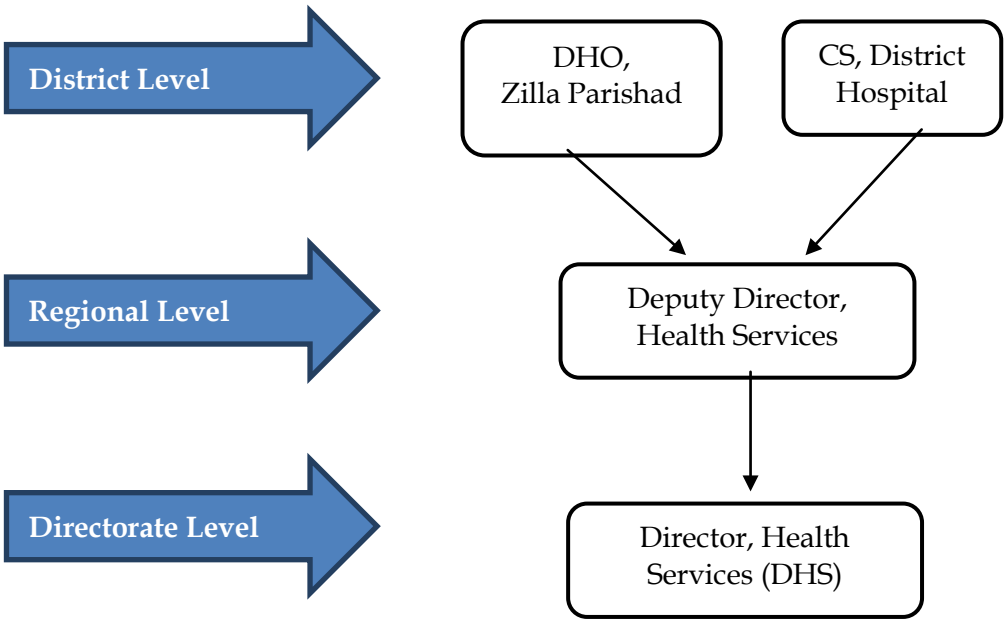
One Deputy Director (Dy. Dir.) heads each such circle. For reporting technical matters, aspects particularly relating to health care provisioning, the PHC Line and Hospitals Line converge at the regional or circle level. Both the DHO and CS report to the head of their particular region. The Dy. Director's office is alternatively referred to as the health circle office or regional office.

Convergence of Eight Regions: Director Health Services

All the DHOs and CSs respectively report the technical matters of the district's rural and urban health status to the Deputy Director at the regional level. All the eight Deputy Directors report the health status of their circles and thus the districts under them to the Director of Health Services (DHS) at the state level. This is shown in Figure 2.5 below.

One may recollect from our state level structure with three levels (Ministerial, Secretariat and Directorate) that DHS is one of the four directors supporting the Public Health Department (Refer to Figure 2.2 again to understand the precise structure). Thus, all the PHCs, Hospitals as well as the administrative offices supporting or controlling them are eventually connected to the office of DHS. Apart from providing care through PHCs and Hospitals, the DHS also carries out preventive and control programs for diseases like malaria, TB, BCG and Leprosy. These programs are headed by the state level bureau in charge or program officer, usually the Joint (Jt.) Directors, placed under the DHS. These authorities also provide technical reporting to the DHS.

Figure 2.5: District level Reporting at the Regional Level



Budgetary Processes at Various Levels

Given the focus of the study on budgetary processes at DHS, all the units in the line become very important. The reporting or controlling authorities may be slightly different from those explained in the section above. In terms of practically carrying out budgetary processes, there are some other offices or authorities that we have intentionally not referred to, for instance, those at the secretariat level; departments other than health like planning and finance also have a significant role to play. This section describes the role of each level of governance. There could be more than one office or frontline units operating, in health budget related matters. Figure 2.6 further delineates the relevant positions at each level. A brief introduction of their roles in budget formulation, distribution or oversight has been provided. This will serve as an introduction for the following chapters, which provide a detailed account of each stage of the budgetary process: budget formulation, distribution and oversight.

Below the Taluka Level

Primary Health Centers (PHCs)

At the time of Budget Formulation, the head of the facility, MO with support from the PHC clerk of PHC prepares the budget demand for the facility as well as SCs under his/her control and sends to the District Health Officer (DHO) at district level. As a part of budget distribution, PHCs receive grants from the Block Development Officer at the Panchayat Samiti (PS) or taluka level to incur expenditure on various items.

Taluka Level

Rural/Cottage/Sub-District Hospitals

During the budget formulation stage, all the frontline service providers at the taluka level, that is, Rural, Sub-district and cottage hospitals send their budget demands directly to the Dy. Director at the regional level. Similarly, at the time of budget distribution, these facilities receive grants from the same authority. However, as we have explained before, all these hospitals report to the Civil Surgeon for technical matters. The Dy. Director being the regional head also exercises some control over the technical aspects.

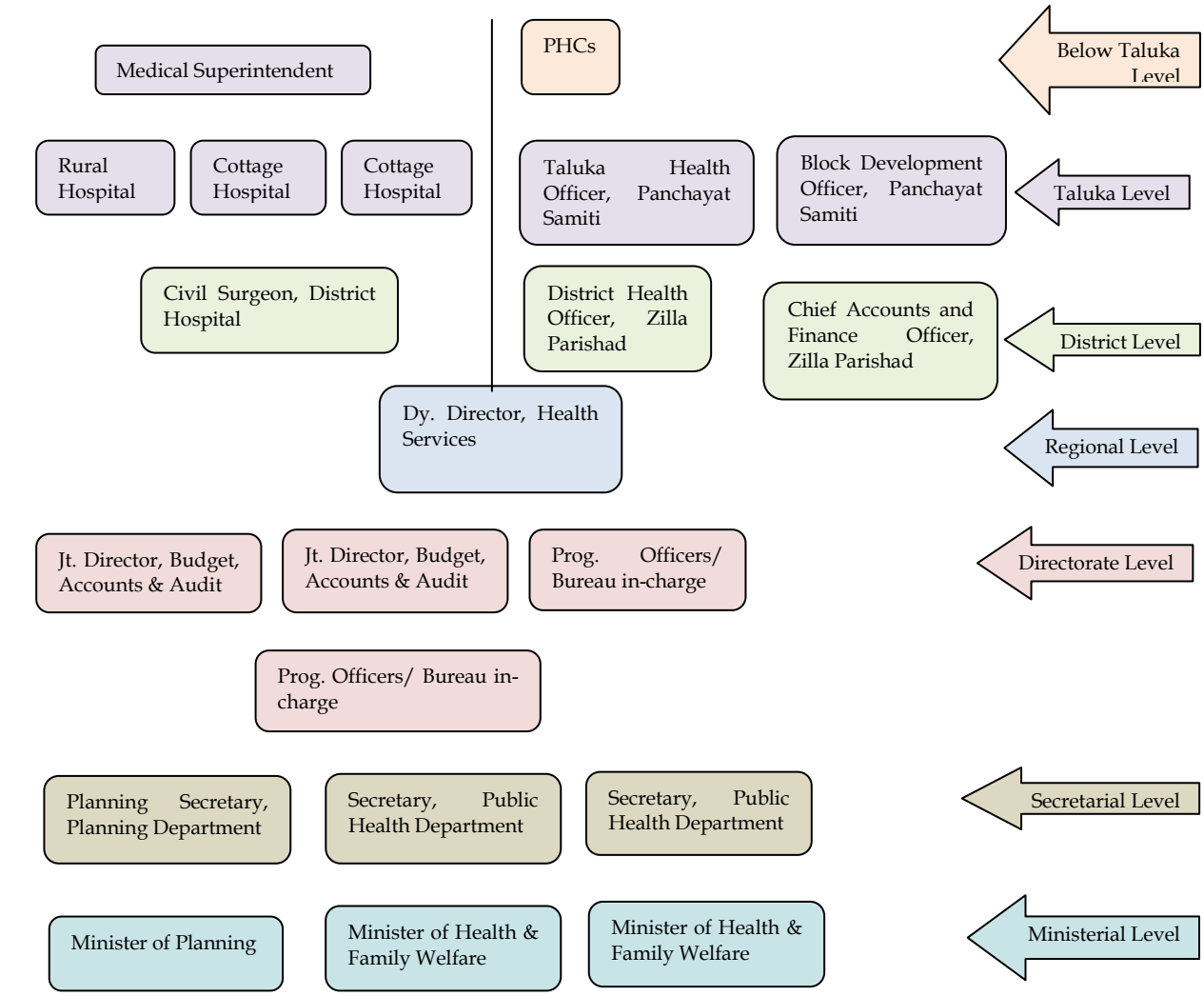
Block Development Officer (BDO)

The BDO is the administrative head of the Panchayat Samiti at the taluka level, a part of PRIs. Budget distribution to the PHCs is done by the BDO office; however, it does not play any in role in the formulation of the same. The position is vested in the administrative head for the taluka, who enjoys some financial powers.

Taluka Health Officer (THO)

The THO mainly performs a supervisory role for the PHCs; however, the role of this officer in the budget formulation of PHCs is somewhat complicated and will be explained in detail in the following chapter. The THO reports to the BDO for administrative matters. Given the difference in functionality between the BDO and THO offices, the Extension Officer Health (EOH) acts as a mediator between the two. The EOH reports to the BDO and provides technical support to the THO.

Figure 2.6: Positions at each level



District Level

Chief Accounts and Finance Officer (CAFO)

The CAFO is head of the ZP Finance Department and reports to the Chief Executive Officer (CEO) of the ZP. The CAFO controls all the available funds at the ZP, that is, the grants received from various departments including health.The CAFO has an indirect role in the distribution of funds by transferring funds to the BDO, who then distributes them to PHCs. The CAFO does not, however, play any role in health budget formulation.

District Health Officer (DHO)

As part of budget formulation, the DHO consolidates demands from PHCs. Apart from grants to PHCs, the DHO is also entrusted with the responsibility of managing other schemes/programs for which the budget demand is differently prepared by her/his office. The collective demands are sent by the DHO to the section of Jt. Director, Budget Accounts and Audit functioning at the Directorate level, while budget grants/funds are routed through the Dy. Director level. Here again, one may note that when it comes to technical reporting, the DHO's immediate senior is the Dy. Director at the regional level; however, the

mechanism followed for routing budget is different. For administrative matters, the DHO functions under the control of the Chief Executive officer (CEO) of the ZP who is an IAS officer (bureaucrat).

At the time of distribution to the PHCs, though actual fund/grant transfer occurs through CAFO and BDO as mentioned above, the grant to be allocated to each PHC is decided based on the devised allocation by the DHO.

District Hospitals

As in the case of the frontline service providers at the taluka level, the district hospitals also send their budget demands to the Dy. Director at the regional level during budget formulation. Similarly, at the time of budget distribution, these facilities receive grants from the Deputy Director Health service, regional level.

Regional Level

Dy. Director Health Services

The administrative role of the Dy. Director's office is to collect budget demand/estimates of the Hospitals Line that is, RH, CH, SDH and DH. They vet the demand are as per the guidelines, consolidate the demands and send them to the Jt. Director, Budget Accounts and Audit at the Directorate level (DHS). Similarly, after receiving the budget grants from the Directorate level, this office distributes grants further down to the respective front-line units.

The Dy. Director office also functions as the controlling and monitoring authority for the grants distributed by her/his office. It performs tasks such as monitoring and controls budget grants given to the hospitals; the office has powers to re-allocate or withdraw grants once allotted in case they are not being used by facilities it also conducts the internal audit of only district hospitals.

Directorate Level

Director of Health Services (DHS)

The Director Health Services holds technical control over all the sub parts of DHS. All eight Dy. Directors from the regional levels report technical as well as administrative matters from their respective PHC Line and Hospitals Line to the DHS. In addition, Program Officers or Bureaus in-charge, such as those for blindness control or leprosy, report technical matters to this officer. The Director of Health Services is assisted by a team of Additional Directors[28], Joint Directors and Dy. Directors[29]. Some of the Joint Directors are given responsibility as Program Officers or Bureau Chiefs for different health programs[30] and support services (Annexure 2.1). The Bureau Chiefs function at the level of Jt. Director or Dy. Director placed under the Additional Director at the Directorate. Each program officer or bureau chief is

[28] At present there are two Additional Directors, one deals with Programs implemented with community participation, like family welfare and communicable diseases; while the other Additional Director deals with the programs implemented through health institution and training, like non-communicable diseases, hospitals, PHCs, etc.

[29] In the hierarchy, the Jt. Director is higher than the Dy. Director. At present, there are about 16 Jt. Directors in all working under the two Additional Directors.

[30] Family Welfare, Leprosy and TB, WBDCP-including Malaria andFilaria, Hospitals, PHCs-district level, Non communicable diseases, nursing, procurement.

assigned with the specific program, some offices of bureau chief have a line office down to the regional level assisted by the Asst. Director, and most of them have district level offices for each program. For instance, the Jt. Director, Malaria guides all the 33 District Malaria Officers (DMO) placed in the districts of Maharashtra. As for budget, the Bureau Chiefs prepare their annual budget and send it to the Jt. Director, Budget and Administration or Planning Section, for the non-plan and plan budgets respectively. Similarly, when funds are approved, they receive the same from the Jt. Director, Budget, Accounts section and send further to the district facilities of their program. Also, the Bureau Chiefs are entrusted with monitoring and oversight of the expenditure and activities of their district level facilities.

Of the wide structure at DHS, there are two very important wings/sections from the purpose of budget processes. These are the office of Jt. Director, Budget Accounts and Administration (BAA) and the planning cell of DHS, which respectively handle the non-plan and plan budgetary work. Budget proposals for various schemes come to them from different sources and the compilation of the entire state's demands is done at their level. These compiled state level demands are sent further to the Secretariat level from this section.

Given that the focus of the study is mainly on budgetary processes at DHS, these two units become very important. More information on these units is provided in the Box below 2.2.

Box. 2.2: Budget wing in Directorate of Health Services (DHS)

Jt. Director, Budget, Accounts and Administration

The wing of DHS responsible for budgeting and control is headed by a Jt. Director who functions under the DHS. The Joint Director is supported by an Asst. Director, Budget, Accounts and Audit. The Jt. Director and Asst. Director are both non-medical persons with a finance and accounts background, and are deputed from the Finance Department. This wing also functions closely with the Finance Department at the Secretariat level.

The office of Asst. Director performs most of the budgetary functions. It was originally known as Controller's Office of Accounts and Audit (CAA), however, following some recent changes, this section now deals with 'budget and audit' for health.

At the time of budget distribution, the Jt. Director, BAA office sends funds to all the estimating offices for plan as well as non-plan budget. Apart from budget consolidation and distribution, this section also has powers to reallocate or withdraw the allocated grants which cannot be done at the regional level; however, these powers are guided in the Maharashtra Budget Manual. Further, the section has also been entrusted with responsibility to conduct internal audit for all program officers, circle offices, civil hospitals and mental hospitals.

Planning Cell

The Dy. Director heading the planning cell functions directly under the DHS. This cell mainly deals with the proposals of new plan schemes or for continuation/discontinuation of the old schemes. For this purpose, the cell is closely linked with planning and public health department at the Secretariat level. The office basically consolidates budget demands or proposals from program officers and accordingly suggests or accommodates the new schemes for plan budget.

Apart from these, the cell assesses the implementation of programs/schemes at various stages to see the impact and suggest changes such as partial/complete closure of any program; assesses the need of further assessment of schemes and health programs and monitors the plan budget expenditure incurred by program officers and guides them for the same. It does not have any responsibility for audits.

Secretariat Level

Public Health, Finance and Planning Departments

During the budget formulation stage, the budget demands consolidated at the DHS level are sent to the budget wing of the Secretariat, Public Health and Family Welfare Department (PHD). The wing scrutinizes and consolidates the estimates received. These are sent further to the respective allied departments at the secretariat level. For the non-plan budget, discussion is held with the Finance Department, whereas the plan budget is discussed with the finance as well as the three departments dealing with the plan budget: Planning, Tribal and Social Justice. Of the budget estimate finalised at this level, the plan budget is sent for approval to the ministerial level,, while the non-plan budget is finalised by the Finance Department.

As part of distribution, the finance department allocates budget to the PHD, who in turn sends it to the Jt. Director, Budget Accounts and Audit for further distribution. The PHD has sole authority to reallocate funds.

Ministerial Level

After the meetings at the Secretariat level, each administrative department, including PHD, participates in the ministerial level meeting. Issues like additional budgetary provisions are discussed here. The Plan budget is put forth here for approval.

The proposed allocations are then put forth in the Assembly/State legislature. Here, the demands are converted into budget, the budget act is passed, and the budget estimates are brought out in a publication called 'white book'. This contains details of all the budget allocations for each department. The responsibility for distribution of funds as per the allocations mentioned in the white book lies with the Finance Department at the Secretariat level.

Having gone through different levels of the hierarchy, the following chapters deal with all the budgetary processes. Thus chapters 3, 4 and 6 respectively deal with budget formulation, distribution and oversight/audit. Each of these chapters will provide a broad conceptual understanding of the topic and then present the research findings that emerged as a part of Mapping of the budgetary processes.

CHAPTER 3

BUDGET FORMULATION

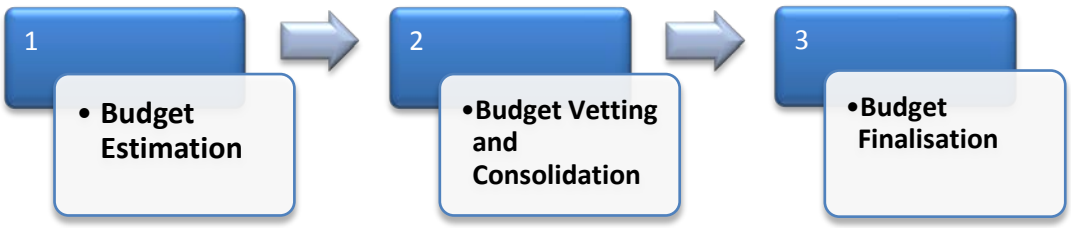
This Chapter brings out some of the basic procedures followed in budget formulation, which enhance the conceptual understanding of some commonly stipulated practices for budget formulation in Maharashtra and also the findings relating to formulation of the budget from the budget tracking study.

Budget Formulation Procedures

The drafting of the budget comprises of three steps as shown in (Figure 3.1)

- **Budget Estimation** envisages approximating the amount required to meet various expenditures. Frontline units prepare the budget estimates and submit them to their respective higher authorities for vetting and consolidation.
- **Budget Vetting and Consolidation** is then carried out at the various level and administrative heads. Vetting includes checking the estimates and their basis. Consolidation includes compiling demands received from multiple sources into one.
- **Budget Finalisation** The last link in formulation stage is finalisation, based on the collective demands and available resources in consultation with the Finance Department (FD). Following budget authorisation in the legislature, distribution begins.

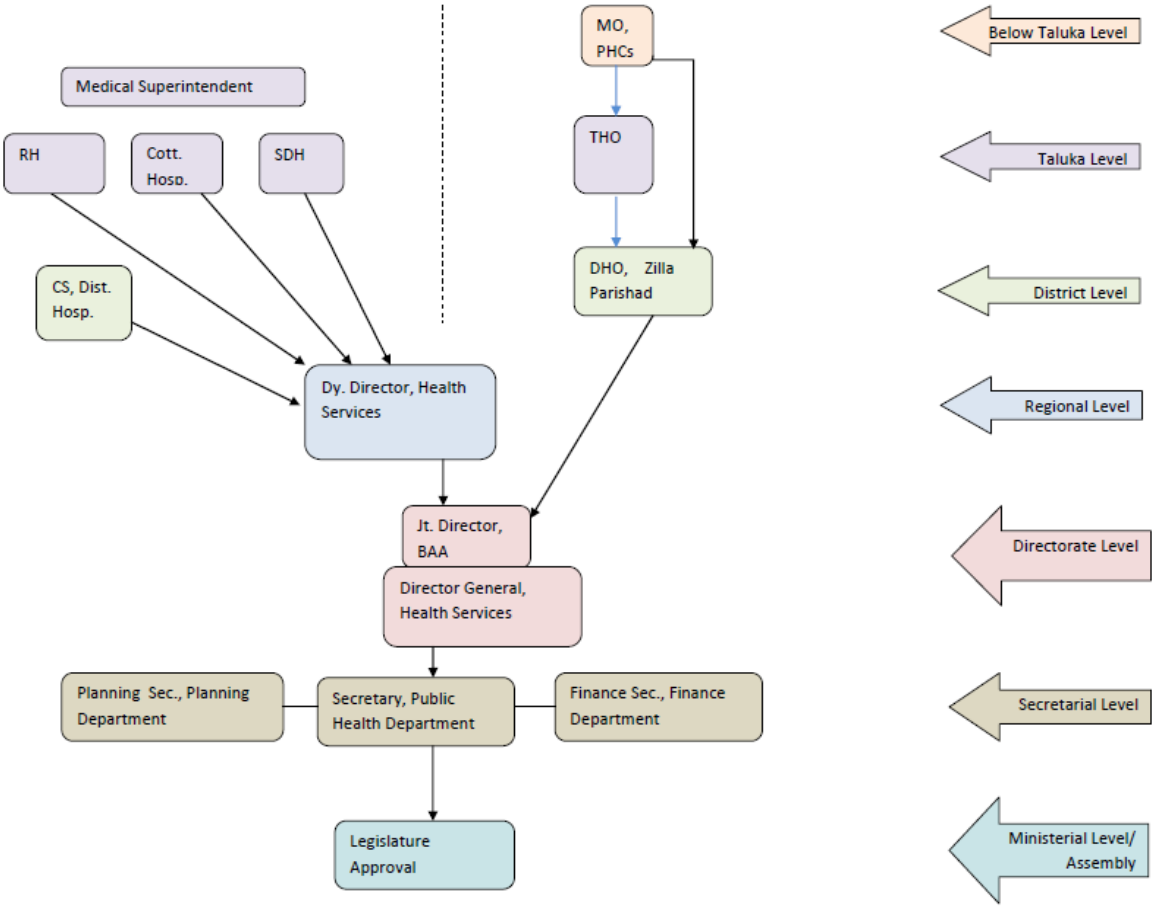
Figure 3.1: Steps in Budget Formulation



Flow of Budget Estimates

Figure 3.2 below, shows the flow of how budget formulation passes through several offices in the governance channel. To begin with, under the PHC line, all the PHCs of a district prepare budget estimates and send it to the DHO. Though there is THO at the taluka level, the post created to bridge a gap between rural PHC and district health office , there is no role for the THO in this formulation process . (This is discussed in the section on research findings.) Each DHO compiles the budgets of all PHCs of the respective district under her/his charge. Under the Hospitals line rural, cottage, sub-district and District Hospitals all send their budget estimates to the Dy. Director Health Services at the regional level. Here, the estimates are compiled from all the hospitals of the various districts falling under one region.

Figure 3.2: Flow Chart of Budget Formulation



Thus all the 33 districts compile demands of the PHCs, and all the 8 Dy. Directors do the same for various hospitals under their jurisdiction. After consolidating these budgets, the DHOs and Dy. Directors add the budget estimates of their own offices and send the collective estimates to the Joint (Jt.) Director, Budget, Accounts and Administration (BAA) at the directorate level. This section also receives demands from various program officers. The demands are compiled here for the entire state's budget under the head, '2210- Public Health Department' and is submitted to the Secretariat. Once again, this office adds its own budget to the consolidated demand.

The combined budget for the entire state is sent to the 'Public Health Department' in the Secretariat/Mantralaya .The Administrative Departments at the Secretariat level too add their estimates. This Department works in close association with the Finance Department in approving the demands. The demands for the entire state are compared with the available resources with the government. Based on these, the final budget allocations are determined. These demands are put forth in the Legislature/Assembly where the final approval takes place.

Figure 3.2 shows that the frontline units at the district, taluka and below taluka levels play a primary role in 'Estimation' and the authorities to which these are submitted - the DHO at the district level and Dy. Director at the regional level. The consolidation of the entire state's demands takes place at the Jt. Director, BAA at the Directorate level. These two levels are thus mainly involved in 'Vetting and Consolidating'. Finalisation of the Budget takes place

at the Secretariat and Ministerial levels. One can observe that the three steps brought out in Chart 3.1 follow a chronological as well as hierarchical order. As one moves along the governance chain from below the taluka to the ministerial level, the roles change from estimation to finalization, and the entire process in occurs about six months' time.

Of the three stages in formulation, some of the technical details relating to budget estimation are very crucial to understanding the entire formulation process, including the different types of estimates, annual timelines for preparation, and stipulated formats in which the estimates need to be prepared. These aspects are explained below.

Annual and Revised Budget Estimates

Budget estimation is essential as it forms the basis for vetting, consolidating and finalizing. Budget estimates for a particular year are based on the needs of the healthcare service providers and administrative offices. The process of preparing Annual Budget Estimates begins about six to eight months in advance of the following budget year.

The annual budget estimates prepared well in advance may require some changes during the course of the year, and hence there is a provision for revising the estimates. As part of this exercise, the frontline units as well as administrative offices like THO, DHO, Dy. Director are provided with the opportunity to submit 'revised estimates'. These may be based on the anticipated excess expenditures or savings during the year. Such revisions are also known as supplementary budget demands.

Time Line for Estimates

Every year, the estimates for following year are prepared by the PHCs, Rural, District or other Hospitals in the month of August; for example, estimates for fiscal year 2011-12 were prepared by frontline units in August, 2010.

In the state of Maharashtra the three revisions based on anticipated excess expenditure or savings are done after the fourth, eighth and eleventh months of the ongoing financial year. The first revised estimates will thus include the expenditure of the first four months, that is, April to July and based on this, the demands for the remaining eight months of the year are made. This four-monthly revision is thus done in August every year. Similarly, the eight-monthly budget is prepared in December based on the expenses of the period, April to November, while the eleven-monthly budget, which is the last revision, is done in March every year. It is thus a regular exercise of undertaking revision or review of the budget estimate during the course of the year. These revised estimates are backed by the supplementary demands authorised during the state legislature session held at different points of time. Supplementary budgets are presented in monsoon, winter and during the budget sessions (March-April) of the Assembly.

Notably, the annual budget estimate for the next financial year and four-monthly revised estimates are prepared in August every year. The activities pertaining to budget estimates are spread over the whole financial year.

Budget Estimating Formats

The Maharashtra Budget Manual (MBM)[31] has prescribed formats for preparing the Annual as well as Revised Budget Estimates. The Annual Budget format is known as *'Arthasankalpiya Andaj'* in Marathi (local language), and the revised estimate is referred to as

[31] The Maharashtra Budget Manual provides all budgetary matters and instructions for regulating the budgetary and accounting procedure. Section 30 provides the details.

'Sudharit Andaaj'. These formats are common for all the schemes of each department in the state, including health.

- **Annual Estimates**

The budget demand sheet for annual estimates is a 23 page booklet. On the first page, the instructions to fill the document are provided for the estimating officers and respective controlling officer to whom the estimate will be submitted. This includes title and code of the scheme, names of estimating as well as controlling officers and date of submission. In the next 12 pages of the booklet, a clear distinguished list of line items such as salaries, contingencies, wages, office expenses, electric and water bills and so on are listed one below the other. This is the most important part of the entire document and has been explained in Table 3.1.

As Table 3.1 shows, for each line item, the estimating officer has to fill various details. These include actual expenditure for the preceding three years (Columns 2, 3 and 4), annual as well as revised estimates of the current year (Columns 5 and 6), and finally, Budget Estimates for the following year (Column 7). The estimating officer is also required to provide a reason for increase/decrease in demand compared to the actual expenditure of the preceding year and estimates of the current year (Column 11). As in the example for travelling expenses mentioned in the table, there has been a consistent increase during the preceding three years, as well as the annual and revised estimates for the current year. The reason for increase in demand for the following year is provided as increase in rate (of Petrol and Lubricants). Likewise, in the case of salary, the reason may include increase/decrease in number of staff, change in pay scale and so on. Thus, it is expected that the estimates be prepared with great care and they should neither be underestimated nor inflated.

Although the budget estimates include 29 line items, not all of them are applicable to each estimating office/facility. Demands are made only for those line items applicable to the respective office. All the line item wise estimates in the document make for the total estimation of the sub-head. Demands for salaries in particular are to be made in a very detailed manner, including grade of employees, separate demands for temporary and permanent employees, and further basic pay, dearness allowance, house rent allowance and son on.

Apart from the details filled by the estimating officer, the budget booklet has a separate column for the controlling officer. The controlling officer, who is the immediate senior officer of the estimating facility's line office, has to check the demands made by the latter. This officer then puts the demand figure that she/he feels appropriate (Column 8). As mentioned before, this booklet is spread over about 12 of the 22 pages. The remaining pages are include an annexure with detailed description of the demands. The estimating officer prepares this sheet for each program or subhead that operates at the facility. The subsequent section in the box items the number of subheads (schemes) that are operated.

- **Revised Estimates**

The revised budget format is relatively simpler than the format of the annual budget. This is a smaller document with the first page mentioning details of the budget scheme/subhead. Table 3.2 provides an illustration of the four-monthly revised estimates.

For each line item, the estimating officer needs to put the Actual Expenditure of the preceding year in Column 3). Following this, based on the Grant allotted for the current year (Column 4), and actual expenditure incurred up to the current month (Column 5), the

estimated expenditure for the remaining part of the year is to be mentioned (column 6). The total revised estimate adding the grants already received for four months and estimated for the remaining eight months (summation of Columns 4 and 6) is to be calculated (column 7).

The next step is to calculate whether this revised estimate is higher or lower than the original estimate (Column 8). A justification for the increase/decrease needs to be provided (Column 9). If there are any pending bills from the first four months covered in the revision, these are to be attached along with revised estimates as an annexure.

The basic format for all three types of revised estimates is the same. In the case of eight-monthly or eleven-monthly revised estimates, Columns 5 and 6 vary in terms of date.

One may notice that the (illustrative) revised estimate in the proforma (Table 3.2, Column 6) is the four-monthly revised estimates explained above. Thus, every year, the estimating officers have to first prepare the four-monthly revised estimates, based on which the annual estimates for the following year are prepared. These are submitted together, for instance, in August 2012 the annual budget estimates for 2013-14 and the four-monthly revised estimates for 2012-13 are sent together.

Having explained the basic concept and sub-parts of budget formulation process as well as the formats and timelines followed in reality, we move forward to the findings that emerged as a part of tracking exercise.

Table 3.1: Illustration for Annual Budget Booklet: Estimates for FY 2011-12

Line items-code and title	Actual Expenditure			Budget Estimate	Revised Estimate	Budget Estimate, 2011-12				Reason demanding for more or less compared with last year actual exp to this year estimate
	2007-08	2008-09	2009-10	2010-11	2010-11	By Estimating Officer	By Controlling Officer	By Administrative Dept.	Finance Dept.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
01- Wages										
03– Travelling Expenses	1100	1450	1600	2000	2200	2500				Increase in rate
05– Petrol Oil and Lubricants	787	600	797.5	2000	2100	2400				Increase in fuel rate

Table 3.2: Illustration for Four-monthly Revised Estimate

Sr. No.	Line Item	Actual Expenditure 2010-11	Grant Received 2011-12	Actual Expenditure upto 4 months (31/7/11)	Estimated Expenditure for remaining 8 months	Total Revised Estimate of 2011-12 (4+5)	Increase (+) Decrease (-)	Reason
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1	Salary							
2	Wages							
3	Travelling Allowance							
4	POL							
5	Office Expenditure							

Source: The formats have been replicated from the specimen copies of 'Arthasankalpiya Andaj' and 'Sudharit Andaj'.

Research Findings on Budget Formulation

Figure 3.2 shows the expected movement of budget estimates; the practices followed in reality are often very different, as revealed by this study. Even when the actual practices do not differ from those stipulated, they provide significant insights into larger issues relating to the budget.

More specific findings are presented below; for convenience they are presented separately for two different lines of healthcare provisioning, the **PHC Line** and the **Hospital Line.** Budgets of both these lines converge at the Directorate level, with the Jt. Director, Budget Accounts and Audit.

PHC LINE

Findings are first presented for the PHCs below the taluka level, which are the frontline service providing units headed by MO, and then for the THO and the DHO, which are at the head of the Public Health Departments at the taluka and district levels, respectively.

PHC Level

PHCs being frontline units have to estimate the budget for their own facility. The budget heads applicable at the PHC level are mentioned in Box 3.1 below. The estimating officer for the PHC is usually the head of the institution and, in case of PHCs; it is the Medical officer (MO). In most cases, the clerks from PHCs prepare the budget under the guidance of MO. As for requirements for medicines and materials, the PHCs place a demand/requisition in the indent to the DHO; thus medicines and materials are received.

At the PHC level, the first step involved in the entire process of preparing budget estimates is that of receiving instructions from its line department head about preparing budget estimates. Though receiving instructions may seem a very simple stage in the entire process, it plays a very crucial role. Having received instructions, the next stage for PHCs is to prepare estimates. Finally, PHCs have to submit the estimates to the respective higher authority. Detailed findings of both the Districts involved in this study are presented below one after the other.

Eight PHCs in two districts were interviewed about the procedures followed and a significant variation in budget estimation practiced within the PHC line was observed. Broadly distinguishing the findings, PHCs from District "A" prepared annual as well as revised budget estimates, whereas those in District "B" did not prepare either. Given the stark differences, we have provided the findings of the two districts separately; however, for all the remaining levels, we have provided a combined set of findings for both districts.

Box 3.1: Budget Head at PHCs

There are numerous budget sub heads (schemes) under the health major head (revenue account 2210 and 2211 and capital account 4210 and 4211). From subhead description, it is difficult to identify the scheme that operates for primary health care delivery. The subhead descriptions in the budget document at the state level are different from those in the ZP budget documents, and thus make it difficult to relate the local (district) budget with the state budget. For '6- medical' is mentioned in the ZP budget documents, whereas 'mofussil hospitals and other medical services' are referred to in the state health budget document. There are three state administrative departments from which grants flow down to the PHCs, that is, Public Health and Family Welfare Department, Medical Education Department and in some cases, from the Tribal Development Department. The subheads reflected in their respective budget documents thus add to the complexity.

Scheme Subhead Code in figures - Subhead Name/Description

- 2210 5041 - 8- Public Health Primary Health Centre (PHC)
- 2210 4605 - Medical mofussil, also known as 6-medical
- 2210 4606 - 7-Ayurvedic
- 2210 4992 - Establishment of Primary Health Units (local sector)
- 2210 5012 - Mobile Health Services by launch (local sector)
- 2211 0149 - *Abhikaran* - Rural Family Welfare Centre and Health Centres
- 2211 0621 - Expanded Program of Immunization (local sector)

2210 4605 known as ' medical mofussil', and known as 6-medical in the local Zilla Parishad budget documents is reflected in the state budget Public Health Department as 'mofussil hospitals and other medical services (local sector)'.

2210 460 6 known as '7-Ayurvedic' in the budget estimate of the PHC and in the local budget documents of the ZP, is reflected in the budget documents of the Medical Education and Drugs Department under the head 'Grants to Ayurvedic and Unani Institutions'.

2210 499 2 is under the head 'Establishment of Primary Health Units (local sectors)' for those PHCs which have the Primary Health Units attachments to their PHCs (saproyojan).

2210 501 2 is known as 'Mobile Health Services by launch (local sector)' for special areas (difficult to assess, for example in Amravati District, the services are provided in the Melghate hilly areas).

2211 014 9 budget code for the ' Rural Family Welfare Centre and Health Centres' is basically for the sub centre attached to the PHCs .

2211 062 1 is the budget code for the 'Expanded Program of immunization-local sector'.

District A- Budget Estimates are Prepared
Of the two talukas in District A, both PHCs from one taluka clearly mentioned that budget estimates are prepared by them; on the other hand, the two PHCs of the other taluka were somewhat unclear on whether budget estimates are regularly prepared. The overall responses in the case of the latter were ambiguous and lacked uniformity in the answers provided by different respondents. Also, the MOs at these PHCs were not well informed about budgetary work.

- **Receiving Instructions for Budget Preparation**

It was observed that the instructions to submit the budget estimates were sent to PHCs by the DHO. The instruction mentions that all PHCs are required to prepare and submit budget estimates of their facilities within a stipulated time line. The letter is addressed by the DHO to the MO or at times sent to the THO and a marked copy (CC) to the MO. It includes other details such as timeline, format, the instructions as received by DHO from her/his administrative head, and so on.

Though the main method of conveying instructions is by sending a letter (hard copy), different mechanisms were reportedly used for transmitting the same information. In one instance, the instruction was received through email in which a scanned copy of the actual letter was sent as an attachment. Another source of instruction for preparing the budget was through the monthly meeting held at district headquarters, attended by the MO or clerk from the PHC. In some cases, it was observed that the letter is first sent to the THO through internal post (*Daak*) and further the PHC staff collects it from the THO office. In another instance, a PHC respondent mentioned that if the staff from the facility happened to visit the DHO office, they collect the letter directly. The PHCs are spread across the district and it seems that the appropriate mode of communication is chosen based on distance from the district as well as taluka headquarters or occasional meetings, etc.

- **Preparing Estimates: Different Formats**

When PHCs' budget estimates were reviewed[32] at the time of interview in District A; it was observed that budget estimates prepared by some of the PHCs were in a very different format. They showed no resemblance to the stipulated format.

Annual Estimates
On deeper enquiry, it was realised that the estimates submitted by some of the PHCs were different from the proforma because these PHCs only prepared the Annexure to be submitted with the estimates claiming the same to be their 'Annual Estimates'. A table referred to as 'Annexure A' (see Table 3.3) is prepared at the time of submitting annual budget estimates. One may recollect that this is a later part of the main budget estimation booklet explained earlier.

In cases where only the annexure is submitted, it serves the purpose of 'estimate'. This has a very important implication. If PHCs take into consideration only details of salary while preparing estimates, it means that the non-salary demands are completely neglected.

[32]Along with interviewing respondents, many documents relating to budgetary processes were reviewed at each stage. These secondary documents have provided deeper insights into the practical functioning of departments.

While some PHCs mentioned that they used the details of the annexure to arrive at the final budget estimates, they were unable to produce any of their previously submitted copy of estimates. (All PHCs are required to keep a record of their budget documents.) Besides, not all the PHCs that were interviewed shared their copy of estimates, making it difficult to say how many of them prepared it and in which format. It was thus difficult to infer whether these PHCs actually prepare their estimates in a budget booklet. However, preparing of the annexure table was something which was uniformly observed in the case of all PHCs.

Table 3.3: Annexure 'A' of the Budget Estimating Document

	पे बॅंड वेतन	ग्रेड वेतन	महागाई भत्ता	स्थानिकपुरक भत्ता	घरभाडे भत्ता	वंहतूक भत्ता	ठतर भत्ते	६वेवेतनआ .थकबाकी ४ थाहप्ता	एकूण
Name of the staff & Pay scale	Pay band	Grade Pay	Dearness Allowance	Compensatory local allowance	House Rent Allowance	Travelling Allowance	Other Allowances	4th installment Arrears of 6th pay revision	Total

Revised Estimates

Like the case with annual estimates, it was found that PHCs followed a different format even while submitting the demands for revised estimates. At the time of the four, eight or eleven monthly budget estimates, the frontline units provide information relating to the pending payment rather than revised estimates (See Table 3.4). This is called as demand for pending grants *(pralambit dayak che mahiti prapatra in marathi)*. Here again, one may recollect from our section on proforma that the pending bills are to be submitted along with the revised estimates. Though, it was observed that most of the PHCs have pending bills and it is useful for them that these can be recovered through placing demands in the revised budget, the very concept of 'revised estimate' has been completely missed in this process.

Table 3.4: Demand for Pending Payment

Sr. no	Budget head code	Line Items	Pending bill amount		Remark
			Year	Amount	

- **Submission of Estimates**

Once PHCs in District A prepare annual or revised estimates, in whichever format followed by them, the estimates are submitted in person to the DHO's office. In one case, it was observed that the PHC generally sent the budget estimates to the DHO in about ten days

after receiving the instruction. To make receiving convenient at the DHO level, all the PHCs of one taluka are allotted the same due date. However, as reported by the PHCs, this kind of timeline is not maintained strictly and some delays do occur.

As explained by the respondents from the PHC level, some amount of checking is done on submission. In case of any error, the DHO office also guides the PHC staff and asks them to prepare fresh estimates. Some PHCs send a copy of their estimates to the THO, while some do not.

Overall, while PHCs in District A prepare budgets, some of the basic mandated processes are not followed. However, if the unregulated manner of budget preparation in District A seems a matter of concern, the PHCs in the sample of District B showed no system of budget estimation whatsoever.

We now move forward to the detailed findings from District B.

District B- Budget Estimates not Prepared

In District B, all four PHCs in the two talukas reported that they do not prepare either annual or revised budget estimates. Three of the four PHCs said that they do not have any role in preparing budgets, and some even said that they have 'never' been involved in any sort of budget estimation. In contrast, the Extension Officer Health (EOH) interviewed in one of the two Talukas of this District mentioned that PHCs do prepare four, eight and eleven monthly revised estimates. As understood from an interview with a senior and experienced person, the budget used to be prepared by the PHCs, but in the last four to five years, this has been stopped. One practice followed by PHCs in this district, which may be seen as a substitute for placing a budget demand, is that of preparing monthly salary demands. Also, a respondent from one PHC mentioned that earlier they used to send letters demanding funds to the DHO, but this procedure was stopped. As the PHC respondent put it, "*The DHO never took it (budget demands) seriously, so we stopped sending it*".

- **Then who prepares the Budget Estimates for PHCs?**

When respondents from PHCs of this district were asked as to who prepares the budget for their facilities, those from two of the four facilities said that their budgets were prepared by the DHO. Respondents from the other two facilities reported that some exchange of information takes place between the BDO and the DHO, based on which the budget is prepared. Giving an example, one respondent said,

"At the Panchayat Samiti, the staff has a format called NAMUNA and they usually ask us details like how many employees were there till August, November and March and so on; accordingly they fill in the numbers."

The respondent in this case is referring to the stipulated budget estimate sheet for revised estimates. At the BDO level, there was a clear denial of having any role in the budget formulation of PHCs.

When another PHC was asked for its facility's information on budget heads 2210 and 2211, the respondent said that this was available with the CAFO office at the ZP. This information, according to the respondent, was published in 'some' document at the ZP level, which included taluka level information. Unaware of the name of the publication, the respondent further said that this document should also be available at the BDO office. The respondent also referred to Register no. 12 and no. 14 maintained at the BDO office, which include PHC level information for receipt and expenditure, respectively.

This shows that on the one hand PHCs in this district do not prepare budget estimates, while on the other; they assume that the budget is prepared at the BDO or the DHO level since they possess information regarding PHCs. In yet another instance, one PHC, which did not prepare budget estimates, mentioned that if they required any additional funds, they put the demand in the revised budget. In this case, the demand is put informally by informing the DHO. This shows that preparation of the estimate/demand is not very structured and systematic in practice and is not directed by defined guidelines.

- **Monthly Salary Demands: A Substitute for Budget Preparation?**

It was observed that the PHCs in District B prepare what is known as 'Monthly Salary Demands' after a particular month ends; that is, once the following month begins, the salary for the previous month is demanded; for instance, the demand for salary in June is put in the beginning of July. This is referred as 'June (salary) paid in July'. The monthly demands are accompanied with the details for each staff, including their salary, basic pay, deductions and so on.

Here again, the procedure followed for sending the monthly salary bills differed between both talukas of the district. In the case of one taluka, all the PHCs of the taluka came together in the THO office to prepare a collective demand for salary. Further, a single letter containing all PHCs' demands was sent from the THO to the DHO. One respondent mentioned that sometimes the demand is orally communicated to the THO who includes it in the letter. In the case of the other taluka, it was mentioned that the pay bill is submitted to the BDO of the Panchayat Samiti, who collects these bills for all PHCs in the Taluka and informs the DHO of the aggregated amount.

The pay bill is actually a document used as a part of the budget distribution process wherein at the end of the month, the PHC receives funds for the expenses it has incurred. In the absence of any mechanism for budget formulation, pay bill seems to be serving the dual purpose of budget formulation and distribution in the case of District B.

Not only do PHCs in District B show a lack of any system of budget preparation, they have different presumptions with respect to who prepares the budget for them. There are severe gaps in their understanding of budget preparation as a process. Both Districts A and B reveal a significant variation in budget estimation as understood in theoretical terms/approach of bottom to up formulation or as assumed at the state level administrative departments compared to that actually practised at the PHC level.

THO Level

As the head of the Public Health Department at the taluka level, the THO position is provided with the powers to supervise program implementation and management of the PHCs under the jurisdiction of the taluka/block. The THO post was created to bridge a gap between a rural PHC and the district health office. Panchayat Samiti's Extension Officer Health (EOH) provides support for the administrative responsibilities carried out by the THO. Some of the staff at the THO office receive salaries from the state budget and are booked under 2210 or 2211, while some staff receive it from NRHM. For the employees falling under state sector budget at the THO office, annual as well as revised budget estimates are prepared. Box 3.2 lists out the budget heads applicable for this purpose.

Box 3.2: Sub-heads reported to be operating at THO level Under the heads of 2210 and 2211

- 2210 5041 - 8- Public Health Primary Health Centre (PHC)
- 2210 0389- Districh Health Organisation(आरोग्य संघटना २२१००३८९)for EOH salary
- 2211 062 1 budget code for the ' Expanded program of immunisation-local sector'

22100389 -District health organisation budget is also known as the "Establishment Grants-in-aid" given to the ZP under section 183 of the Maharashtra Zilla Parishad and Panchayat Samiti Act, 1961. This includes salary, TA/DA and contingency of regular staff of the Zilla Parishad working in the THO office. They are Health Assistant, junior clerk and peon.

Whether the THO has any role in PHC budget formulation is perceived differently across the PHC line. The THO office also has some responsibilities relating to communication between the DHO and the PHC, as well as record keeping of PHC level information. These roles have an indirect bearing on the THO's role in compiling the estimate of the PHCs. It was observed that these roles were being carried out differently in different talukas.

- **Different Perceptions over THO's role in PHC Budgets**

Some PHCs send a copy of their budget estimates to the THO, but others do not, saying "*THO doesn't have any relation with that*". At the DHO level, procuring budget estimates from a taluka's PHCs is seen as the THO's responsibility. In one instance, in which some PHCs had not submitted their budget estimates, the DHO had written a letter to the THO saying that if the PHCs in their jurisdiction receive lesser grants, the THO office will be responsible.

Contrary to the perceptions at the DHO level, all the interviewed THOs in both the districts denied having any responsibility for collecting/compiling PHCs' annual or revised budgets. A respondent from the THO office said, "*There hasn't been any communication/order stating that the THO office should consolidate the budgets of all PHCs and send it further (to DHO*)". According to the THOs, while they have a significant role to play under NRHM, they do not have any relation with the state budget. One of them mentioned, "*Except the fact that some of the employees in the THO office receive their salaries under 2210 and 2211, we do not have much relation with the state budget*".

As observed from the Government Resolution[33], the Taluka Medical officer, is responsible for coordinating the official communication channel with the DHO and the PHC. This communication may involve implementation of various programs and informing its status to the BDO, DHO, etc. In his/her office, administrative responsibilities have to be carried out with the Panchayat Samiti Extension Officer Health (EOH[34]). The TMO office is also responsible for communicating the status of implementation of various programs to the BDO and the DHO. Though it is not specifically mentioned that the THO office should collect the budget estimates for all PHCs of a taluka, the fact that the THO is expected to serve as an official communication channel has been interpreted as ceasing the role of THOs to the budget as well.

[33] Public Health Dept/Maharashtra/2006/128

[34]EOH serves as a link between the Panchayat Samiti office and the THO

As observed in several cases, budget related communication to the PHC was directed through THO, which generally follows the hierarchical structure, at the time of formulation as well as distribution. Though the THO office functions as a communication or information agent in some cases, the practices are not commonly followed across talukas. In one taluka of District A, the PHCs mentioned that for all the important information pertaining to budget, the DHO sends a letter to the THO, who sends it further to the PHCs; no such practice was mentioned in the other talukas of the same district. Similarly in District B, the THO office in one taluka compiles the monthly salary demand for all PHCs and sends it to the DHO, while the other taluka does not report such a practice.

Except for some key health indicators and health service data, even information/data on staffing position-vacant and filled posts in the PHCs was not available. The centralised information/data pertaining to the PHC wise annual budget and revised estimates were not available at the THO office in any of the four talukas.

It can be seen that there are different roles of THOs observed not only among the two districts, but also among two talukas of the same district. There is considerable confusion about the exact role of the THO. The findings at the DHO level, discussed in the following section, show how important it is to address this issue.

One of the respondents at the THO level showed keen interest in the entire issue of collecting PHC budget estimates and provided some useful recommendations on how this can be achieved. He was of the opinion that all the estimates from a taluka's PHCs should be passed centrally through the THO office, and that one senior clerk and one junior clerk should be allotted to the THO office in order to carry out this work. The PHCs have newly appointed account managers under NRHM, and the earlier regular (ZP appointed) clerks do not have much role in NRHM finance. He suggested that instead of keeping different clerks at all the PHCs, additional assistants like Extension officer or senior clerk could be recruited to the THO office. The new officials could review if salaries were being processed and if leave records maintained. This way, the respondent maintained, '*Managing a taluka is not difficult*'. The respondent also mentioned that there was no time to monitor these things, because the work load of NRHM was very high.

The BDO made a suggestion for improving the administrative responsibilities of TMOs. Without any specific modifications in the actual GR, only priorities be given at the TMO level to re-orient his/her responsibilities for playing an active role in budget estimating and planning .

Though THOs are considered an official communication channel with the DHO and the PHC, the ambiguity surrounding the role related to the budget has resulted in the lack of budget estimate related data/information at the PHC, Taluka and DHO levels. In such a situation, budget estimation /preparation has not been done by considering the demand factor.

DHO Level

The DHO is head of the health department at the ZP level. As part of budget formulation, this office receives instructions from the Jt. Director, BAA at the Directorate level. The DHO further informs the PHCs and/or THO office regarding budget preparation as described above. Once budgets are prepared by PHCs and submitted to the DHO office, the role of the latter is to vet and consolidate. The combined district level demand is then submitted by the DHO to the Jt. Director, BAA. Apart from this, some schemes are implemented by the DHO, such as Student's Medical check-up in Ashram School, etc (detailed listing in Box 3.3).

These demands as well as those of the DHO office are added to prepare the consolidated demands of the district. Finally, the consolidated demands have to be submitted to the Jt. Director, BAA. In practice, however, most of the PHCs do not prepare budgets, and the DHO office has to take up the additional task of estimation for these facilities.

- **Receiving Instructions and sending them to PHCs**

The instructions received by the DHO office from the Jt. Director, BAA include guidelines, format, for estimation, timeline for submission and special instructions. Following receipt of instructions, the DHO sends instructions to all the PHCs in the district. These details have already been explained in the section on 'PHC Level' (refer to section 'Receiving Instructions for Budget Preparation').

- **Receiving Budget Estimates (or Not)**

As shared by the respondents at the DHO level, the budget estimates are not prepared by all the PHCs. Explaining the extent of this problem, a respondent of DHO office from District A mentioned that only some 20 percent to 25 percent of the PHCs in the district send their estimates. One of the officers at the DHO level who maintains a record, of which PHC has sent demands, shared that many PHCs from the district do not send any information or demands. Even the monthly demands for salary as mentioned in District B are not sent to the DHO office by all PHCs. Thus, in both the districts, the DHO office prepares the annual and revised estimates of PHCs.

Some Illustrations

Expressing anguish about the conduct of the PHCs, a respondent at the DHO level guided the study team to some correspondence from the DHO office. There were several letters from the DHO to the taluka level as well as to PHC level officers regarding the issue of not receiving budgets. These were tracked for one particular year to understand the cycle better. To begin with, the DHO had issued a letter of instruction to all MOs and THOs of the district for preparing annual estimates and four monthly revised estimates. In the case of one taluka, estimates were not received from any of the PHCs. In a letter to the BDO of this taluka, the DHO mentioned that since no estimates were received from either MOs or the THO in the taluka, the demands had been prepared and submitted by their DHO. The letter then specified that if the grants received were lesser than the requirement, the responsibility would be that of the BDO. In the two months that followed, there was another letter from the DHO to the BDOs of all the talukas. This letter brought out that excess grants had been spent by some PHCs who had not prepared demands at the time of budget formulation. The letter included a table containing taluka wise names of PHCs to whom this was applicable.

For the same year, the instructions for preparing the eight monthly revised estimates were sent to the MOs and THOs. As usual, the estimates were not received from all PHCs. The DHO sent a letter to all the THOs this time saying that approximate estimates had been sent by the DHO to the higher authority; and if actual expenditure were greater than the grant allotment, the responsibility would be that of the THO. This letter also provided a Taluka wise list of PHCs who had not sent estimates and further ordered that the MO or Clerk from these PHCs must visit the DHO office to provide an explanation for not sending estimates. The letters have proved to be very useful in understanding how difficult it is for the DHO office to get the budget estimates from PHCs and also how this has become a habitual approach.

As an example of how budgets are developed, one respondent mentioned that the DHO office had to submit its revised estimates to the Jt. Director, BAA in Pune by February 24, at the latest. At the time of discussion, by February 17, only one-fourth of the PHCs had sent their requirements. The respondent had thus prepared estimates for the rest of the PHCs.

- **Estimating Budget for PHCs**

The budget estimates are prepared for each scheme (sub head) in the prescribed format as mentioned in the budget manual[35]. The budget estimate is a time bound activity wherein the DHOs have to estimate demands for their districts for each subhead account, and submit to the higher authority following the timeline meticulously.

The budget estimates of PHCs prepared by the DHO office include salary and non salary components, which are recurring in nature. While preparing the estimates of salary component line items in the budget, the DHO office takes into account the salary scale, grade and cadre of the employees of the PHC. Also, a certain percentage rise is based on the increase in pay scale revision in the DA (Dearness Allowance) and TA (Travel allowance) over the preceding year's budget, on an approximate basis. To quote a respondent, "To give you an example, our overall budget is say, Rs. 17 crores, so for the next year we raise it by say some 20 percent as DA, TA etc. will increase".

For non salary line item components such as Petrol, Oil and Lubricants (POL), office electricity and phone bills, estimates are prepared based on the previous year's expenses. The secondary documents reviewed reveal that the budget for some non salary items is prepared such that a particular amount is arrived at based on previous expenses, and this is multiplied by the number of PHCs; for example, POL for one PHC is Rs. 25,000 and if the district has 50 PHCs, then the total budget accounted is a simple multiplication of the two. Another example for the line items, 'Material and Supply' [36]for estimating the medicines and other clinic related materials required at the PHC was done by applying the same rate to all facilities, that is, Rs.60,000 per PHC and Rs. 6000 per sub centre per year .

- **Preparing Budget Estimates**

Several budget heads are applicable at the DHO level, and PHC budgets are one part of it. Apart from preparing PHC budgets as explained above, the DHO office prepares other non-plan local sector budgets as well as plan budget estimates. The DHO has to prepare a budget for its own administrative office as well.

The DHOformulates the budget estimate under four broad categories: 'Purposive Grant' , 'Establishment Grants', 'Plan Grants' and 'Block Grants', under Sections 182, 183 and 187 of the Maharashtra Zilla Parishad and Panchayat Samiti Act, 1961, respectively. These budgets are meant for carrying out the activities of Primary Health Centres, Primary health units, Mobile health units, Allopathic dispensaries, and Mobile launch units in Panshet/Mulshi dam areas. The Budget heads are listed in Box 3.3 below.

[35] Under the Para/Section 137 ofMaharashtra Zilla Parishads and Panchayat Samitis Act, 1961; Maharashtra Zilla Parishads and Panchayat Samitis (budget estimates) rules 1966 and (GR, Finance Department GOM, sr. no. 1076/555/76/BUD-3, dated 11 November 1973)

[36]Under the sub head 'primary Health center 'or '8- PHC local sector'.

Box 3. 3: The Budget Subheads at the DHO Level

The comprehensive listing of the budget heads mentioned below has been compiled from different sources such as the hard copy collected at the time of field work from the PHCs, THO office and DHO office. The ZP budget estimate and annual account documents have been referred to for this purpose. It is possible that some budget heads applicable in practice may have been missed out in the list below, since no comprehensive list of all heads was available at any one place.

Under the plan budget schemes, Establishment/Maintenance/Construction of Health Institute and Strengthening of Primary Health Centers are a large part of the civil work. The expenditure of these said programs is partially taken care of by the Planning Department and Health Department and thus the estimates are prepared by the DHO and submitted to two different authorities (more details in Chapter 5).Thus, it is reported in two different documents.

The district DHO office consolidates the budget estimates of the following major head accounts pertaining only to PHCs wherein the DHO distributes grant to the PHCs.

- 2210-4965: Mofussil hospitals (६-वैद्यकिय मुफसल),
- 2210-4606 ayurvedic dispensaries (७-आयुर्वेद),
- 2210-389: District Health Committee (२-सा.प्र.६-स्वास्थ्य आरोग्य संघटना),
- 2210-5041 PHC (८-सार्व.आरोग्य; योजनेत्तर),
- 2210-0531 upgradation of PHC (प्रा.आ.केंददर्जावाढ),
- 2210-4992 Primary health mobile units (प्रा.आ.पथके).

Apart from above budget heads there are other budget heads at the DHO ZP level which are usually prepared in the form of revised estimates (four, eight, and eleven monthly) at the DHO level. This includes

2210-4983 Ex-District Local Board Scheme -Local Sector (भुतपुर्वस्था.मंडळाच्या योजना), 2210-5021 Student's Medical check-up in Ashram School (आश्राम शाळातील विद्या. तपासणी).Under Plan budget schemes2210-4876 Establishment/Maint/Construction of Health Institute (आरोग्य संस्थाबांधकामे), 2210-4885 Strengthening of Primary Health Centres (प्रा.आ.केंद्रबळकटीकरण), 2210- 4831 Training of Dais (दायीवैठकी), 2210-2935 Providing Special Health Facilities in Sensitive Tribal Areas (Including Mobile Health clinic) (संवेदनशिलआदिवासीभागाआरोग्य सेवापुरवणे), 2210-4849 Appointments of Volunteers as Pada Workers (पाडास्वयसेवक), 2210-4858 Medicinal Grants to High risk Mothers and Children of Grade III and IV (मातावग्रेड ३-४च्या मुलांनाऔपधोपचार),

For Construction and Maintenance purposes are 2210-9851 Construction of Sub-Centres(उपकेंदबांधकामे),2210-4742 Repairs and Maintenance of Primary HealthCentres/Subcentres (प्रा.आ.केंद्र/उपकेंद देखभालदुरुस्ती), 2210-4769 Strengthening of Primary Health Cetres (प्रा.आ.केंद्रबळकटीकरण), 2210-4751 Construction of Primary Health Centres(प्रा.आकेंद्रबांधकाम)

The DHO office also consolidates the budget estimates for Agency Schemes which fall under budget head 2211 (अभिकरण योजनाअतंर्गत) and are related to the Family Welfare (FW) Program which includes

- 2211-0051 Plan budget for District FW Bureau (जिल्हाकुटुंबकल्याणकेंद्र),100 % Central funded
- 2211-0541 Reproductive and Child Health Program(जागातीकबॅंकसहाय्यक प्रकल्प),100 CS
- 2211-0621 Expanded program of immunization -local sector(प्रतिक्षमतेचाविस्तारीतकार्यक्रम),Non plan
- 2211-0149 Rural Family welfare centres and Health sub-centres(ग्रामीणकुटुंबकल्याणकेंद्रे),Plan budget
- 2211-0612 Maintentence and petrol, oil,and lubricants of vehicles allotted to PHCs and Rural family welfare centre (परिवाहनकु.क वाहनासाठीइंधन),State Plan
- 2211-0597 Incentive for vasectomy operation(पुरुषनसबंदी).State Plan
- 2235 SavitribaiPhuleKanyaKalyanYojna(सामाजीकसुरक्षा व कल्याण-सावित्रीबाईफुले)State plan

- **Vetting and Consolidation**

At the DHO office, the accounts section looks after budget proposals of the PHCs, coordinating, collecting and compiling the proposals for budget heads applicable to the PHCs. When estimates are received by the DHO office, some amount of vetting is done by the accounts section. This includes checking the estimates and their basis. According to an example shared by a respondent from a PHC, the clerk at the PHC while preparing the budget estimate for vehicle allowance and washing allowance did so based on a rate of Rs. 75/- for each. At the time of checking at the DHO level, the rates were increased to Rs. 100/- and Rs. 150/- respectively. According to the respondent, this was very useful because otherwise they would have received lesser grants. If there is any error in estimation, the PHCs are asked to re-estimate the budget and submit it again. However, the DHO's role of vetting is reduced since very few PHCs actually prepare budget for themselves. In most cases, the DHO has to perform the task of estimation.

- **Submission of Estimates**

Once the scheme wise budgets estimates are prepared by the DHO, they are submitted to the various agencies directly; for example, the budget for the schemes related to the PHCs are sent to the Joint Director, Budget, Accounts and Audit who functions as a controlling officer[37]. As for the state budget, some budget estimates of major heads like those related to salaries of Class I and Class II officers go to the Dy. Director Health Circle. The scheme budget head related to Family Welfare is sent to the authority who acts as the controlling officer or to the agency from where they receive the grant.

It was observed while tracking the budget head of the PHC line, that annual and revised estimates are submitted personally by visiting the respective offices. At the Jt. Director, BAA's office, each circle/region is given a span of three to four days. The staff from DHO offices of the districts under each circle visit and submit their demands in the time frame stipulated. E-mail correspondence, courier or post are not accepted.

Scrutiny/vetting at the Jt. Director, BAA's office includes checking the assigned staffing pattern, sanctioned and filled posts, details for number of posts in various schemes

[37] The MBM guides that the budget demands prepared by the estimating officer need to his Controlling officer for vetting

recorded, verifying details with the supporting GR as well as the online portal of SEVAARTH web site[38] (government portal with statistical information on staffing position of permanent, temporary, vacant post, etc. assigned to DDO). Apart from these, checking the calculation of salaries and related items, provision made for the vacant post, etc. are also important. In case of non salary, pending bills of line items such as telephone, water charges, etc. the items are scrutinized. All the estimates are considered against expenditure over the preceding three years. Supporting the written statements, the signature of the CAFO is necessary along with a statement validating the authenticity of the expenditures made.

It has been observed, that despite repeated notices, the PHCs do not send budget estimates; that only 20 percent to 25 percent of the PHCs in the district submitted budget demands to the DHO office is a matter of serious concern. The DHO's practical difficulty in not receiving the estimates from the PHC or the THO office shows, a weak mechanisms of seeking the estimates and reflects poor control over the PHCs. The DHO office does not have disaggregated information for either PHC or taluka budgets. It is thus quite essential that a taluka level authority ensures that all PHCs under her/his taluka prepare budgets. In the current set up, however, neither the BDO nor the THO play this role. While the BDO's role is mainly related to distribution, the THOs have not taken this up despite being the head of the Public Health Department at the taluka level. While they have a significant role to play under NRHM, the THOs do not have any relation with the state budget.

In the present era of computerisation and internet, the records (demand estimates) are difficult to assess on paper and are not readily available. Except for a small number of PHCs, the maintenance budgets are non-existent or minuscule. None of the computer applications, MS Excel or Word, are used for preparing the estimate or for record keeping at all levels (PHC, THO and even the DHO).

Having looked at the findings of the PHC Line in detail, we now move to the Hospital Line.

HOSPITALS LINE

As part of budget formulation in the Hospitals line, the facilities from the taluka and district levels - the Rural, Cottage, Sub-District or District Hospitals- all submit their budgets to the Dy. Director at the regional level. The processes followed by all hospitals are more or less similar and have thus been combined under one group called frontline units. The findings have been presented in the following order.

- Frontline units
- Dy. Director

Frontline Units

Of the various frontline units included under the Hospitals Line, the Rural Hospitals (RH), Cottage Hospital and Sub-District Hospitals (SDH) are placed at the taluka level and are headed by a Medical Superintendent (MS). The District Hospitals (DH) on the other hand, are headed by a Civil Surgeon (CS). The Medical Superintendents and the Civil Surgeons being heads of the institutions are also the budget estimating authorities. Here, again, in most of the cases, the clerks of the facilities are more directly involved with the task of estimation under instructions of the head of the institution.

[38] https://sevaarth.mahakosh.gov.in/

For the frontline units, the processes involved in budget formulation are similar to those of PHCs. These include receiving instructions to prepare the budget and then estimating the demands. The submission of estimates in this case is made to the Dy. Director, except for some RHs where submission is made to the Civil Surgeon (CS).

For all the facilities interviewed in the Hospitals Line, the annual and revised budget estimates are regularly prepared in both the districts. Further, the various procedures relating to formulation as mentioned above are largely common for all types of facilities. The findings have thus been brought out collectively for all types of facilities.

- **Receiving Instructions for Budget Preparation**

All the hospitals generally receive letters of instructions for preparing budget estimates from the Dy. Director. However, at times the DH receives the letter first and sends it to SDHs and RHs. Sometimes these facilities also receive instructions during the monthly meeting held at the Civil Surgeon's or the Dy. Director's office. In one case, the RH used to receive the letter through e-mail and, according to a respondent, this practice started last year. The letter includes the common instructions such as format, time line for submission and any special instruction.

Preparation of Budget Estimates

It was observed that budgets are prepared by all the facilities regularly and in the stipulated format. While all the facilities have to prepare the annual and revised budgets for their own offices, the CS office is additionally involved in preparing the plan budget (the details of which are brought out in Chapter 5). Also, in the month of August, all the facilities prepare four monthly revised estimates for the current year and then the annual estimates for the following year. The budget heads applicable to RHs and SDHs are brought out in Box 3.4 below.

Box 3.4: Budget subheads examples applicable to RHs and SDHs

- 2210 0413 - Upgradation Of Primary Health Centres into Rural Hospitals (Non plan budget)
- 2210 05311 - Up-gradation Of Primary Health Centres into Rural Hospitals (state plan budget under Minimum needs programs)
- 2210 0146 - Mobile ophthalmic unitfor the Sub district hospitals.

In addition to those mentioned above, SDHs have budget heads like

- 2210 0315 - Hospital and Dispensaries, cottage hospitals
- 2210 0462 - Up-gradation of Rural/cottage Hospitals (MSDP).

Of the total, around 50 line items that are applicable will differ for each hospital. Budgets are thus prepared by the facilities for those line items applicable to them. The respondents from facilities have shared details of how they actually prepare estimates. These are very useful in understanding the processes adopted in undertaking estimation.

An example shared by one RH respondent, the estimating officer first begins with getting the information of

Staffing positions in the facility. Particularly, for estimating annual budgets, salary calculations, information is sorted under heads and sub-heads. Details of all the working staff in the facility have to be provided along with the estimates. These also include details of the total posts sanctioned, filled and vacant. These details are put in an annexure in the budget estimate document. For items such as office expenses, electric and phone bill or POL, estimates are generally raised by 10 percent -15 percent (based on increase in fuel rate and increase inflation) over the previous year's expenditure. Items like rent and tax do not change every year.

Box. 3.5: Estimating officer proposed budget for year 2012-13

दोन अंकी संगणक संकेतां सह उद्दिष्टे		मागील तिन वर्षाच्या खर्चाच्या प्रत्यक्ष रकमा			अर्थसंकल्पीय अंदाज	सुधारीत अंदाज	प्राक्कलन (एस्टिमेटींग)
1		2008-09	2009-10	2010-11	2011-12	2011-12	2012-13
०२ मजुरी							
०३ प्रवास खर्च		125	150	70	76	76	76
०४ अशासकिय सदस्यांना प्रवास भत्ता/							
०५ कार्यालयीन खर्च		175	143	40	45	56	56
०६विद्युत दूरध्वनी,पाणि					45	96	96
०६ पेट्रोल,तेल व वंगण		60	85	23	14	24	24
०७ भाडेपटटी आणि कर		60	60	115	8	120	70
३० मोटर वाहने		25	20	0	0	0	10
५१ आहार खर्च		100	125	26	0	72	75

Note: screenshot from the budget estimate of RH, on the right column are the line items. On the Row are the Actual of proceeding three year, followed by budget and revised estimate of last year (2011-12) and estimate proposed by the Estimating officer for the FY 2013

As observed in the case of one DH, the most significant budget head for the District hospital is **2210 0146 -**Mofussil Hospitals and Dispensaries– Non-Teaching Government Hospitals in Mofussil Areas. In one case it was observed that in the annual budget estimate proposed by the estimating officer, the reason/justification provided for the demand was "Previous pending bill and current requirement". The pending bills included domestic travel bills, Rent, Rates and Taxes (RRT), Diet expenses, publications, and material and supplies. In other cases, the domestic travel bills were pending since 2007-08 in one hospital, whereas in a number of hospitals' budget estimates, previously pending bills were included as 'arrears of past years'. An example of this is provided in Table 3.5 below. The budget booklet has such annexure formats wherein the estimating officer has to provide the details.

The broad definition on the estimate are demands based on the needs of the front line as the **annual estimate**, and **revised estimate** as the anticipated revision during the course of the financial year. As observed that these estimates are based on arrears of the pending bill, and this is due to accumulation of the pending bill was lesser allocation against the approved budget. The grant distribution authority (controlling officer) tends to control the expenditure by approving less against the budget, releasing a lesser grant against the approved grant, thus giving scope for reappropriation. Table 3.5 illustrates table is the excellent case wherein how most of the line items were approved less against the estimate and expenditure

incurred was either less or what was provided to them. The process of budget allocation and decisions on spending are almost entirely top-down, and the hospitals depend exclusively on the Controlling Officer at the regional office and the DHS.

Table 3.5: Annual Estimate based on Pending Bill and Current Requirement

Sr. no	Line item details	Budget estimate by estimating officer 2010-11	Approved budget 2010-11	Actual exp 2010-11	Approved budget 2011-12	Reason for demanding more or less in the budget estimate 2011-12
1	2	3	4	5	6	7
		Rs. In thousands				
1	Salaries	152335	172949	168633	86700	Pending bill details enclosed & current requirement
2	Wages	500	600	572	50	Pending bill details enclosed & current requirement
3	Overtime allowance		109	101	45	
4	Office expenses	3000	2204	21423	1011	Pending bill details enclosed & current requirement
	electricity ,					Pending bill details enclosed & current requirement
	telephone,					
	water charges					
	Total	18000	21423	21423	635	
5	Travel Allowance		874		76	Pending bill details enclosed & current requirement
6	POL	500	346	346	90	प्रलंबीत व पुढील कालावधीकरीता आवश्यक
7	RRT	900	687	687	372	रुपये १.३६ चे देयक कोषागारात सादर
8	Publication	120	05	5	01	पुढील कालावधीकरीता
9	Advertisement	30	28	24	15	प्रलंबीत व पुढील कालावधीकरीता
10	Minor work	150	20	20	&	पुढील कालावधीकरीता
11	Vehicle repair	400	20	20	09	प्रलंबीत व पुढील कालावधीकरीता
12	Diet	4500	3098	3098	525	प्रलंबीत व पुढील कालावधीकरीता
13	Stipends		285	253	-	प्रलंबीत व पुढील कालावधीकरीता
14	Material and supply	10000	9998	9325	957	प्रलंबीत व पुढील कालावधीकरीता
	Total					

Note: Read Marathi content asPending bill details enclosed & current requirement

- **Submission of the Estimates**

As mentioned before, at the District Hospital there are a large number of sub heads applicable. A detailed list of this is provided in Box 3.6 below. Thus, submission of the budget subhead estimates is also made to different authorities. Some these are submitted to the Dy. Director, while others to the various program officers or Bureau in-charge[39] that designated controlling officers for that scheme. For example, the budget estimate of sub head 2210-0146 is submitted to the Dy. Director, Regional Health Circle and also to the Jt. Director– programs (Blindness Control Program). The submissions of estimates are made to the controlling office from whom the grant will be allocated to the facility.

Box 3.6: Budget Subheads Scheme Code under the Major Head 2210-Public Health applicable to DHs

2210-0146 -"Mofussil Hospitals and Dispensaries– Non-Teaching Government Hospitals in Mofussil Areas

2210-0146 -(Blindness Control Program) "Mofussil Hospitals and Dispensaries– Non-Teaching Government Hospitals in Mofussil Areas

2210 0413 i.e. "Upgradation of Primary Health Centres into Rural Hospitals" Non plan budget

2210 462 4 PH –"Upgradation of Rural/cottage Hospitals- under Maharashtra Health System Development Project"

2210 010 1 PH (02- urban) District Medical Officer

2210 105 3 PH "Establishment of Public Health Transport Organisation" non plan

2210 280 1 TD- under Tribal Area Sub Plan schemes-State Plan Scheme " Upgradation of Primary Health Centres into Rural Hospitals

2210 131 1 (jeevan dai)

2211 017 6 Urban Family Welfare Centre– which is 100 percent a Centrally Sponsored Scheme

[39] The Bureau Chiefs function at the level of Jt. Director or Dy. Director placed under Additional Director at DHS level. The program[39] bureau chief are assigned with the specific program and each office of bureau chief has line office down to the regional level assisted by the Asst. Director and further down to the district level offices for each program such as District Malaria Officers (DMO), TB etc. The designation of Bureau Chiefs varies from program to program, and further depending upon a Bureau Chief's designation, they are assisted by Dy. Director or Additional Director. While for the implementation of the programs, there are district level offices for each program which coordinate with the Bureau Chief, e.g. there is Jt. Director Malaria and Filaria at the DHS level and at each district, there are District Malaria Officers (DMOs). Further, the final implementation of the program may be done by the frontline units, in coordination with the district level offices. As for budget, the Bureau Chiefs prepare their annual budget and send it to the Jt. Director, Budget and Administration or Planning Section of health in DHS, respectively for non-plan and plan budgets. Similarly, when funds are approved, they receive the same from the Jt. Director, Budget, Accounts section and send them to the district facilities of their program. Similarly, on receiving funds, the Bureau Chiefs route the same to the implementing bodies and monitor the expenditure of their district level facilities, for example, the Jt. Director, Malaria shall undertake the audit of DMO.

2211 060 3 School Health Check-up treatment and Operation of Students I to IV (non plan)

2211 061 2 "Maintenance and Petrol, Oil and Lubricants of Vehicles allotted to Primary Health Centres and Rural Family Welfare Centres which is the state plan scheme

2235 238 6 "Savitribai Phule Kanya Kalyan Yojana"

The remaining frontline service providers, RH and SDH, send their budgets demands directly to the Dy. Director. In the case of one RH, the MS was not authorised as the DDO; in this case, the budget was submitted to the Civil Surgeon. A respondent from another RH said that the Civil Surgeon was not aware about the budget estimate demand forwarded from the RH to the Dy. Director. Facilities submitting their estimates either to the Dy. Director Health Circle or the CS, do so by personally visiting their office.

Submitting Estimates to the Civil Surgeon

The Civil Surgeon as the head of the district, who supervises the curative health care service in the district, does not play any role in collecting the budget estimates of the RH/cottage /SDH /women hospital or compiling the same. RH/cottage /SDH /women hospital send it (budget) to the Dy. Director rather than to the CS. It was understood that the CS collects budget demands only for such RHs in the district where the MS of RH does not have Drawing and Disbursing powers and the grants are distributed to the RH by the CS's office. The CS does not receive the budget demands; this has a link with distribution mechanism. Some of the RHs do not have what is known as 'Drawing and Disbursing' Powers, which includes the authority to withdraw grants[40]. They thus withdraw funds from the Civil Surgeon. In all other cases, where the facilities had Drawing and Disbursing powers, they send budgets to the Dy. Director since the latter is the budget controlling authority. Since the RH in this case receives budget grants from the CS, the latter becomes the controlling authority and thus it is a different route for submitting budget estimates. A respondent maintained,

"The *Civil Surgeon is controller of health performance related activities or issues, and the Deputy/Joint Director is controller of finance related issues in case of this district.*"

Demands other than Budget: Medicines or Equipment

For bio-medical equipment, medicines or other relevant machines like generators, the RH puts demands to the CS, who sends it to the Dy. Director, and medicines are supplied to Rural Hospitals and other health care institutions. The respondents specified that all other proposals apart from the budget are sent by the RH to the CS. As per the MS in one RH, he personally makes these demands to the Civil Surgeon who posts it to the Deputy Director along with others' demands; further the Health Department at the Directorate level is informed and finally the required equipment is purchased in bulk and distributed according to the demand. For medicines, the RH submits its budget estimate to the Civil Surgeon, while the procedure remains the same as explained above. One district has a mechanism in place to conduct a district level meeting where all RHs in the district discuss their needs and exchange medicines and equipment in case of shortage.

It was assumed that the CS receives the budget demand from all hospitals (RH, SDH, Cottage, women's hospital) which is not the present case and he/she is not the controlling

[40] MS is not registered with the Finance Department and the Treasury to withdraw budget grants and to deposit revenue receipts. More on this will be covered in the chapter on Distribution.

officer of the District. Ultimately the CS does not have the budget and expenditure details of all these hospitals under his/her jurisdiction. It is was observed that the Civil Surgeon plays an important role in compiling the wish list of all the RHs and puts forth the collective demand (proposals for purchase of materials and supplies) to the District Planning Committee (DPC), local authority for District Plan budget wherein the demand is approved and grants are disbursed by the District Collector (more analysis and findings in a separate chapter on Plan Budget).

It can be seen that in the Hospitals line, budget formulation is taken seriously and all the facilities remain disciplined in preparing their estimates on time. It has better mechanisms for coordination and control.

Dy. Director Health Service

The Dy. Director Health Services is the head of the Public Health Department at the regional level. Hospitals controlled by the Dy. Director's office can be broadly grouped into three types: District Hospital and Women's Hospital; Sub-district Hospital; and Rural Hospital and Cottage Hospital. The Regional office deals with the non plan budget (recurring expenses which include line items, Salary, Wages, Office expenses, POL, etc) of all these facilities in the region and also has an important role in the plan budget processes; the Regional Officer attends all the DPC meetings along with the DHO, with the CS as the representative of health line department (more details in the chapter on the Plan budget).

The different processes involved in budget formulation at the Dy. Director's level includes receiving instructions from the Jt. Director and further instructing hospitals under the region regarding the same, collecting and vetting the estimates received from the facilities, and consolidating the demands and submitting them to the Jt. Director, BAA. Some of the budgets which belong to other programs, such as blindness or leprosy, are sent to the respective program officers or bureau chiefs.

- **Receiving Information and Informing Further**

The eight Dy. Directors of the different circles receive information regarding budget formulation from the Jt. Director, BAA office. Each of the eight Dy. Directors then sends out letters with instructions for budget formulation - timelines for which the budget estimates and revised estimates are to be submitted by the estimating officer of the frontline services of the Hospitals line. Receiving the letter as well as sending out the letter to facilities, happen generally in the month of July. The instructions received from the Jt. Director provides the timeline stipulated for receiving budget estimates from the circles, and accordingly, each circle level office provides a timeline to the frontline units controlled by it. There could be specific instructions from time to time, which need to be followed.

- **Vetting on received Demands**

The regional offices vet the proposals they receive from the facilities' estimating officers. This includes determining conforming whether the instructions for estimation have been followed, the documents contain the necessary details, the summation figures are correct, and salary details are checked such as whether HRA is taken accurately according to the location, whether is DA is calculated as per the instructions and so on. Apart from this, at the time of vetting for annual estimates, the actual expenditure of the current year and the preceding three years is considered. The vetting responsibility of the controlling officer has been guided by the role assigned under Para 34 of MBM.

The budget booklet, as mentioned before, has a separate column for the estimates of the controlling officer. The officer generally relies on the annexure details for salary and non-salary items provided at the end of demands, capacity of the facility as known to the controlling officer, etc. Also, as respondents from the Dy. Director mentioned, they generally do not cut the demands unless they are unreasonable. The final amount approved by the controlling officer is put in what is known as 'column 8' of the booklet (as shown in Table 3.1). This shows that this figure of estimation is put by him/her as 'controlling officer' (responsibility assigned under the Para 34 of MBM).

The role of Dy. Director in budget formulation is limited. As a respondent put it,

"*We only consolidate demands coming from facilities and send it further*".

This office functions more as an intermediary agent which collects demands from frontline units, consolidates them and sends it further to the Jt. Director, BAA where the entire state's demands are gathered.

- **Consolidating and Submitting Estimates**

The MBM also advises that the consolidations of estimates are to be made scheme wise. Demands received from different hospitals are consolidated scheme wise (subhead/scheme) by the regional office. Thus, depending on the schemes and budget heads allocated to different facilities, the Dy. Director's office consolidates demands for each scheme from different sources into one single scheme demand/estimate booklet providing a detailed explanation for all the estimates. This represents the demand of the region and is submitted to the relevant line department. This may include the Jt. Director, BAA.

The budget estimates of the two lines we observed are further submitted to the Jt. Director BAA. Here, the budgets for the two lines as well as some other sources converge for the entire state. We can now move forward to the findings at levels of directorate and further.

Jt. Director, Budget, Accounts and Administration

This section is part of the Directorate of Health Services and works on budget, accounts and audit (internal oversight). The budget demands, only of budget head 2210- Public Health Department, are compiled here for the entire state. The budgets of all programs of the department, from national programs to all preventive and control programs and curative aspects, come to this section for formulation and compilation.

The various roles performed by this section include receiving instructions from the Director Health Services/Public Health Department regarding budget preparation and sending the information further to the various heads of offices. The Jt. Director, BAA office receives and vets the estimates from the various offices. The demands from multiple sources [41]are compiled and submitted to the Administrative Department, Secretariat (Public Health and Family Welfare Department). At times, if a particular line item does not fit into an existing budget head, for example, line item for contractual services of security guards, then this

[41] From program in-charge or Bureau Chiefs which include Joint Director or additional directors–of malaria, filarial and water borne diseases; TB BCG leprosy program; Dy. Director of public health laboratories, Dy. Director transport, Dy. Director for publicity and IEC, and 8 Dy. Directors and 33 DHOs .

section liaises with the Health and Finance Department at the Secretariat for creating additional heads.

- **Sending out Instruction for Budget Estimates**

This section receives Instructions from the Public Health Department at the Secretariat level regarding budget preparation.

As mentioned before, the Jt. Director, Budget and Admininstration circulates letters with instructions on how to proceed with the preparation of estimates. For the estimation of the annual budget for the forthcoming financial year, the letters are sent from this office by the month of July. These letters are sent to all the respective heads of offices, which include the eight regional Dy. Directors and DHOs of all the districts.

The letter/circular lays down a detailed time-table with the dates for submission for each level of the office (Annexure 3.1). The circular clearly states that the budget preparation for the forthcoming financial year is a time-bound activity and the timeline must be adhered to meticulously. The guidelines also state the details to be considered at the time of estimating and the annexure statements required. For example, in case of non plan expenditure the annexure includes– number of staff at a particular office, relevant GRs, salary details, office expenditure and verification of the electricity and telephone bills. Following instructions from this section, the respective Dy. Directors and DHOs pass on instructions to the frontline units under their control.

- **Scrutiny and Checking of Estimates**

The office of Jt. Director, BAA compiles the budget estimates submitted by different offices for the entire state. As mentioned in previous sections, all the frontline units like PHCs and Hospitals send their demands to their respective line head, DHO and Dy. Director, respectively. The demands received by this section come from all the 33 DHOs and eight Dy. Directors[42].The estimates received from the DHOs of 33 districts are scrutinised by this section, whereas the budget estimates received from the eight regional Dy. Director Health circle offices and the other bureau chief offices have already undergone some scrutiny when they were received from their line offices. The role of CAA (office of Asst. Director) office in this case is more of checking whether the instructions for estimation have been followed. The scrutiny of the budget demand considers how much is demanded against the previous three years' expenditure, checks for extraordinary demands, for instance, a demand for high grants despite low spending in the past, and look for the justification mentioned by the controlling officer or estimating officers .

Scrutiny of Estimates from DHO

The scrutiny of budget estimates for the PHC line schemes, that is, budget estimates received from the DHO includes verifying the number of vacant and filled positions with GRs of Rural Development Department (RDD), Secretariat, and detailing the staffing position for each department of the ZP. The large proposition, as reported by the respondent is around 85 percent, the salary line items of the budget estimate under the Grants-in-aid sub head/scheme of the PHC line are taken care of in this scrutiny. (Check)

A respondent at CAA level said,

[42] This also includes the demands of about 16-18 Program Officers/Bureau Chiefs, which do not form a part of our tracking exercise as mentioned in chapter 1.

"In case of salary grants-in-aid for any subhead/scheme of PHC that goes to the Zilla Parishad, the administrative department of these ZPs is the Rural Development Department (RDD), which issues a circular with the details of the staffing position for each departments of the ZP. This GR guides us for scrutiny and accepting the budget estimate proposal received from the DHOs and also for verifying the number of vacant and filled positions. Whatever positions are there for the current year, we ask for the budget; in case there is any decrease in the staff position, we have to give clarifications and if it increases then the related Government Resolution (GR) is checked with the budget requisition. This is because the salary component forms about 85% of the sanctioned grants and the remaining 15 % of the funds has to accommodate all other non-salary expenditures."

The Jt. Director follows certain norms for vetting and finalising estimates in the case of non-salary components of grants–in-aid for the PHC line schemes. For line items such as Petrol Oil and Lubricants (POL), the budget is based on the number of the facilities (PHC) in the district and the ceiling of consumption of 1000 litres per district. If District 'A' has 79 PHCs, the budget estimate is calculated as 78 PHC x (1000 litres x Rs.70 per litre) = Rs. 54.60 lakhs. For line item Motor Vehicle, it is Rs. 7,500 per PHC in the tribal and hilly areas and Rs. 5,000 per PHC for non tribal PHC. For line items Office Expenses (OE), for incurring telephone expenses, it is Rs. 8,500 per PHC with a telephone connection and Rs. 5,000 per PHC without a telephone connection. In case of line item, 'Material and Supplies' the estimates are guided by the allocation rule; for example, a PHC in the tribal and hilly area will formulate the estimate of Rs. 1.60 lakhs for Material and Supplies, Rs. 1.20 lakhs for nontribal areas and Rs. 12,000 per sub center.

While it scrutinizes demands, the section usually does not curtail any grants demanded with the fear that the Finance Department may curtail the demand. As a respondent puts it,

"*If we do any curtailment and further the finance department also curtails demands, then very little amount is sanctioned for facilities. This may become insufficient for routine expenditure*".

Table 3.6 is an example of the budget estimate proposal compiled for budget head of 2210 scheme for Primary Health Centre (PHC) under budget head 2210 5041- 8- public health for 2011-12. The subsequent section shows the approved budget against the proposed demand.

- **Consolidating Demands and Submission to the Public Health Department**

Having received the budget estimates, the most crucial work performed by the BAA section is that of scheme wise consolidation of proposals received from all the different sources. All the various demands mentioned above are compiled by this section and sent further to the administrative department, the Public Health Department at the Secretariat. These demands, in the form of multiple copies, are consolidated into one budget estimate by the BAA section. Likewise, different budget estimate booklets are prepared for each individual scheme. There are about 55 non-plan schemes in all, including state as well as local sectors. For each scheme, demands come from multiple sources like the DHO, Dy. Director or Program Officers.

Table 3.6: Consolidated Estimate proposed for Zilla Parishad Scheme for Primary Health Centre (PHC) under Budget Head 2210 5041- 8- Public Health for the Year 2011-12 (Figures in Rs. Thousands)

sr.no	Dist. ZP	salaries	wages	Overtime allowance	Phone, electric &water	tic travel expenses	office expenses	rents, rates & taxes	computer	परिरक्षण	POL	Motor Vehicles	supplies and materials	Diet	Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	1 to 13
1	Thane	329998	3618	1231	1310	1877	390	0	0	29	3021	316	0	0	341790
2	Raigad	194726	1700	439	874	3035	369	44	0	0	1800	188	0	0	203175
3	Ratnagiri	182734	3557	100	2462	5000	910	0	0	335	2814	335	0	0	198247
4	Pune	261118	5413	263	5369	2664	3236	96	0	0	7800	650	0	96	286705
5	Solapur	258419	0	2000	1000	3500	1500	200	0	120	2000	400	0	0	269139
6	Satara	276815	13180	150	500	4200	800	250	0	0	760	290	0	0	296945
7	Nashik	435984	576	2200	2472	4500	1674	10	0	0	3914	645	0	1000	452975
8	Dhule	173127	0	100	1200	2700	700	0	100	0	1000	300	0	0	179227
9	Nandurbar	413407	540	535	0	2044	535	300	200	0	2320	635	0	1000	421516
10	Jalgaon	367260	300	500	100	4000	770	0	0	0	2232	1920	0	30	377112
11	A'nagar	307481	115	0	960	2100	2000	0	0	0	2500	900	0	400	316456
12	Kolhapur	233364	2216	650	500	5000	1080	0	0	500	2117	550	0	0	245977
13	Sangali	167112	2000	650	1600	3000	0	0	0	0	650	300	0	0	175312
14	Sindhudurg	144781	0	500	1500	3500	1000	0	0	400	2090	1000	0	0	154771
15	Aurangaba	178417	2412	25	600	3000	1300	50	0	10	1500	300	0	0	187614
16	Jalna	151697	2016	1598	730	2500	852	0	0	0	629	200	0	0	160222
17	Parbhani	101845	1000	60	400	1000	650	50	0	0	1550	155	0	0	106710
18	Hingoli	73643	550	110	110	700	300	0	0	0	1230	110	0	0	76753
19	Latur	172072	900	2220	1000	3000	1200	0	0	138	1840	230	0	0	182600
20	Nanded	250865	1600	800	1200	10000	1600	250	0	0	3000	400	0	0	269715
21	Beed	149772	827	200	900	2500	470	50	0	300	1850	250	0	0	157119
22	Osmanaba	184163	1373	850	840	1500	630	1000	0	0	1680	525	0	0	192561
23	Akola	90161	0	90	120	960	240	0	0	0	442	72	0	0	92085
24	Washim	69161	0	0	0	700	650	0	0	0	560	350	0	0	71421
25	Buldhana	251852	2538	275	598	1500	900	210	0	70	2158	275	0	0	260376
26	Amravati	229090	2340	540	952	5000	1072	120	0	0	3080	870	0	100	243164
27	Yawatmal	255935	400	30	500	2000	650	0	0	300	1100	250	0	0	261165
28	Nagpur	86181	500	600	1000	2000	1000	100	0	250	1500	300	0	0	93431
29	Bhandara	146871	2500	0	850	1700	900	70	0	330	1000	190	0	30	154441
30	Gondiya	165606	6154	450	2000	2600	1700	150	0	150	1700	250	0	550	181310
31	Wardha	118988	0	220	500	1500	100	200	0	0	500	135	0	0	122143
32	Gadchiroli	289604	600	300	700	3500	1239	100	0	40	900	350	0	500	297833
33	Chandrapu	181426	1589	278	1857	2362	1160	40	0	0	2610	310	0	500	192132
	DHS	0	0	0	0	0	0	0	0	0	0	0	177994	0	177994
	Total	6893675	60514	17964	34704	95142	31577	3290	300	2972	63847	13951	177994	4206	7400136

A justification has to be provided by each of the estimating authorities for each deviation in grants demanded compared to actual expenditure of the preceding year. For example, if the previous year's salary was Rs. 1 lakh and the current year's demand is Rs.3 lakhs, the estimating officer needs to provide explanations; for instance, he can explain that five posts which were vacant the previous year were filled. Estimating officers must justify each deviation. At the time of total consolidation, the Jt. Director, BAA office must explain the deviation in total; for example, the previous year's expenditure was Rs.1 crore, but the

current demand is 2 crores, because in total 200 posts were vacant which have been filled, or the pay scale has been revised, or increase in DA, and so on.

The consolidated estimates are sent to the Administrative Department at the Secretariat level, that is the Public Health Department around 15th October for further scrutiny.

Public Health Department (PHD) and Finance Department, Secretariat Level

As part of the budget formulation process, the Secretariat level plays a crucial role. The flow of instructions to start the budget preparation process begins from this level. The finance department informs each administrative department to begin with procedures for budget estimation and accordingly, each administrative department informs its directorate to do the same. On the other hand, once all the demands have been prepared, they are consolidated at the Directorate level and then submitted to the Administrative Department at the Secretariat level. This is where the crucial role of the Administrative Department comes into play. One may remember from the flow chart on budget preparation that the finalisation of budget occurs at the Secretariat and Ministerial levels. The non-plan budget is finalised at the Secretariat level, whereas for the plan budget, Ministerial level discussion also takes place (this will be covered in detail in the plan section).

As we have seen so far, in case of non-plan and plan budget (salary and non salary line items) for DHS, both the lines of frontline service (the PHC Line and Hospitals Line) submit budget estimates to their respective line department heads. Vetting and consolidation of these estimates is done at various levels, and the Jt. Director, BAA level consolidates demands for the entire state for the DHS. These are then submitted to the Public Health Department (PHD) at the Secretariat level. The PHD receives budget estimates from all the four directorates including DHS in the same budget format for each scheme. From the PHD, these demands are forwarded to the Finance Department (FD) in a duplicate copy. This submission of demands for the annual budget of the forthcoming fiscal year occurs around the first week of November; for example, demands for annual budget 2011-12 are sent to the FD in November 2010. In case, the PHD feels the need to make any additions/deletions or any other alteration, a statement giving the justification and recommendations as enclosures is forwarded to the FD along with the estimates. Like the PHD, every Administrative Department at the Secretariat level sends its budget demands to the FD.

Under the administrative control of the Principal Secretary, Finance Department, various sections deal with the budget processes. Two main sections of the FD include the Budget Cell/Wing and Expenditure Cell/Wing. Both these cells have further sub units denoted by numbers, and each unit is assigned with two to three state administrative departments. The budget estimate of the Public Health Department and the Medical Education Departments are sent to Budget Cell no. 9 in case the scheme is of revenue account; that is, a non plan regular existing scheme. If the scheme is new and has to be considered afresh, it is received by Budget Cell no.3.

After receiving the estimates of the proposal from all the Administrative Departments, the FD scrutinizes them and makes modifications where necessary after due consultation with the concerned administrative departments. The expenditure estimates from all the Departments are then consolidated to arrive at the figure of total estimated expenditure under non-plan budget for the entire State. This figure appears in the Civil Budget Estimate (also called White Book) Part II and is treated as the final approved budget. This includes major head-wise detailed statement of expenditure which is tabled in the Legislative Assembly for final authorisation. Whatever budget the house approves, is presented in the form of an Appropriation Bill produced in the White Book/civil estimates.

Having seen the proposed estimate by the PHD to the Finance Department (Table 3.6), it will be interesting to see the finalised budget of the same year. Authorisation or approval of the budget happens in the Legislative Assembly during the budget session, which usually happens in March. For the year 2011-12, it can be observed in the civil budget estimates/White Book of the Public Health Department (Annexure 3.2a), that the budget estimates for the Primary Health Centre (PHC) under budget head 2210 5041 (Rs. 558 crores for Salary and Rs. 29.73 crores for non salary line items) were reduced by almost 9 percent and 41 percent, respectively . This is how the budget is finalized. (Annexure 3.2b gives the details district wise information for the reader, this disaggregate information is not available in the civil budget estimate. the table is reproduces from the data available during the field work.)

To conclude, Budget formulation is a time bound activity, where the demands/estimates from frontline units and programs at levels of district and below pass through various layers of institutional and administrative structures reaching up to the ministry. At each of these stages, some processing on the budget is done. It may include vetting and compiling budgets of various health facilities, districts or regions and sending it further or it may involve approving these demands. The number of issues identified at each level, at the PHC, and the theoretical approach of bottom to up formulation actually does not hold as differences exist in each district. At the level of the DHO, the estimate prepared is incremental and not according to need but on allocation rule. At the level of district, the estimates are sent to a number of designated controlling officers, from whom budget grants are received, thereby adding to the complexity.

Once the budget demands are approved, the funds are sent to the frontline units and programs for implementation. For this purpose, funds are routed from top to bottom and the route opposite to that of budget formulation is followed. Here, there are some authorities who allot funds, some who distribute them below and the end users draw funds for usage during health service provisioning, which is covered in detail in next chapter on distribution: Fund Flow.

CHAPTER 4

BUDGET GRANT DISTRIBUTION: FUND FLOW

As part of budget formulation, the process moved from governance layers of below taluka to the ministerial level. The order is reversed at the time of budget distribution. Once the budget is approved by the Legislature, the flow of budget distribution then begins from the Finance Department at the Secretariat level. Funds pass through the same multiple layers of governance that we have seen in earlier chapters before it finally reaches the frontline units of hospitals and PHCs. The following section describes the broad flow of budget distribution and mechanisms used for the same.

Flow of Funds: Budget Distribution and Authorisation

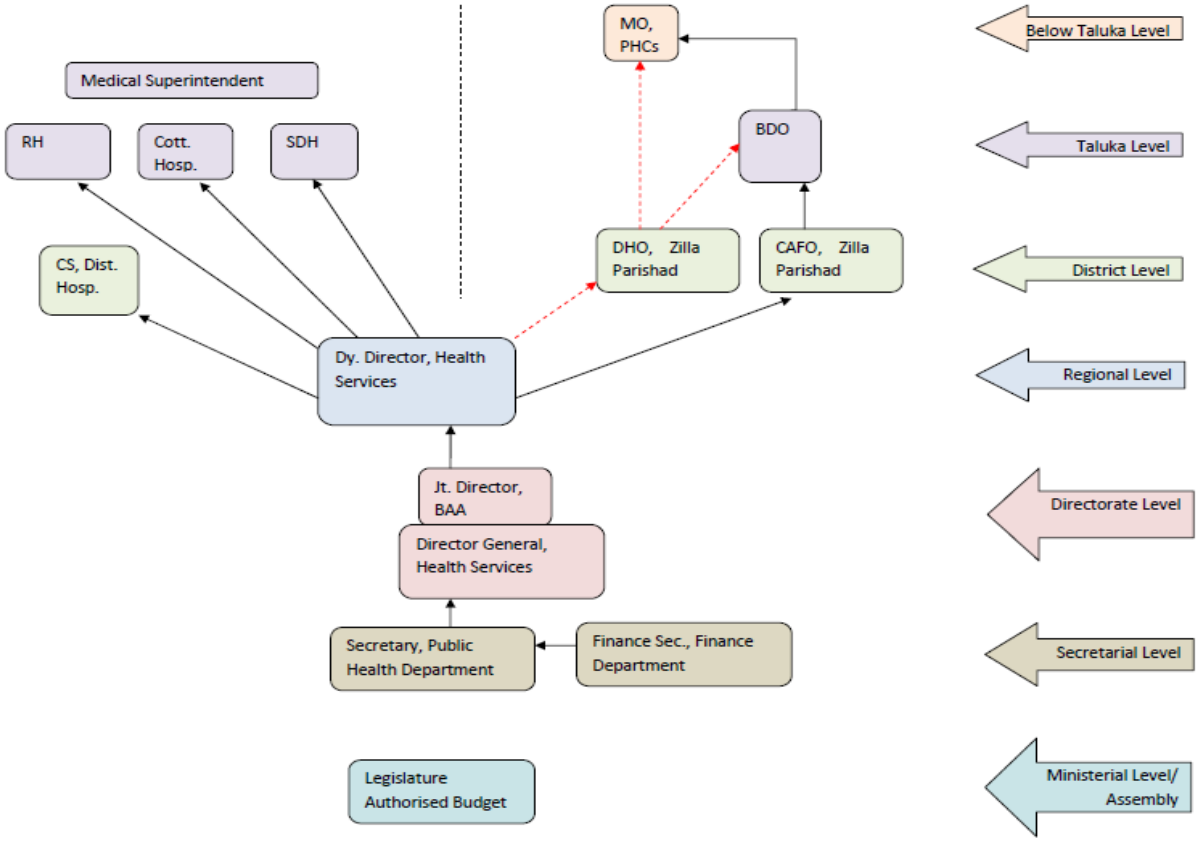
The broad flow of budget distribution is explained in figure 4.1. To begin with, FD distributes funds to the various administrative departments including the Public Health Department (PHD). The PHD has its Directorate and one of the four Directors is the DHS. The grants pertaining to the DHS are transferred by the Public Health Department to the Jt. Director, BAA office. This way, the PHD becomes the controlling authority over the DHS and the Jt. Director, BAA. Another side of the same coin is that at the time of transferring grants, the PHD also provides authorisation to the Jt. Director, BAA to further distribute funds. Likewise, each controlling authority provides authorisation to the next level of governance which enables them to distribute grants further or incur expenditure as the case may be.

Going to the next link, the Jt. Director, BAA distributes funds to the eight Dy. Directors[43] and gives them authorisation. The Dy. Directors further distribute grants to the various frontline units in the Hospitals Line as well as to DHOs in districts under their region. Thus, the Dy. Director becomes the Controlling Officer for the facilities to which she/he distributes grants.

The heads of the frontline units have what is known as 'Drawing and Disbursing' power for their own facilities. This allows them to withdraw funds allocated to their facility and incur expenditure against the same. While this is true for the Hospitals Line, one can see that the flow for the PHC Line is somewhat different.

The distribution from the Dy. Director to the PHC line is complicated. As shown in Figure 4.1, the red dotted line shows the flow of *information* of how much grants have been allocated; whereas the funds are actually *distributed* through the channel shown by the simple black line. How the two are different from each other will be brought out in detail in the research findings.

[43] The Jt. Director, BAA also distributes funds to the Programme Officers/Bureau in Charge



Mechanisms for Budget Distribution

Multiple mechanisms are involved in the actual distribution of grants, such as on-line fund transfer, devising allocations or what is known as 'Cash flow' and treasury and banking systems through which actual withdrawal is made. These mechanisms are explained briefly below:

- **On-Line Fund Transfer: Budget Estimate, Allocation and Monitoring System (BEAMS)**

In Maharashtra, there is a system of online allotment of grants through an on-line portal referred to as BEAMS or Budget Distribution System (BDS)[44]. Both Non plan and Plan budget grants are allotted on BEAMS. The allocations are made scheme wise and bifurcation of line items details like salary, wages, electric and telephone expense, travel expense, office stationery, taxes rent rate, material supply, and POL (Petrol/Oil /Lubricants) are also provided.

BEAMS not only provide information on grant allocation to each office/facility, but also authorises them to withdraw the allocated amount. Each Controlling Officer is given a unique 10 digit code to carry out the operations on BEAMS. For example, the Dy. Director receives grants from Jt. Director, BAA on BEAMS. The amount of allocation is checked by the officer using the 10 digit code. This officer further devises allocations for the various hospitals in the region, which is again put up on BDS using the code. Similarly, all the hospital heads check the grants allotted to them and further withdraw the same from the government treasury.

[44]Web-site available at: https://beams.mahakosh.gov.in

- **Cash flow**

While the BEAMS are used for actual transfer of funds, each Controlling Officer who has to distribute funds to multiple offices or frontline units has to devise allocations. This is referred to as 'cash flow'. For example, the Jt. Director, BAA distributes funds to the eight Dy. Directors at the regional level through BEAMS. Now, each Dy. Director has to further distribute these funds among the various hospitals in the region. They first devise an allocation in this regard depending on the availability of funds and demands from hospitals, after which this is uploaded on BEAMS and the facilities can view the funds distributed to them.

In the example mentioned above, cash flow on BEAMS also provides authorisation for withdrawal. In case of PHC line where BEAMS is only available till the Zilla Parishad level, one can notice separation of cash flow and authorisation. Here some departments are solely provided the information on cash flow, while the actual authorisation to withdraw funds lies with others. This can be seen in the chart above, where the dotted red line shows flow of information/cash flow, whereas the black line shows the flow of actual funds (Figure 4.1).

Treasury and Banking System

BEAMS facilitate online distribution from the state to the district level and down to the hospitals. Actual withdrawal of grants is supported through the Treasury. Treasuries at the district and sub district levels are institutions from which field-level officers physically 'draw' funds allotted to them by the government and accept receipts of government payments. In fact, for each Drawing and Disbursing Officer (DDO), the initial four of the 10 digits code of BEAMS actually identifies the treasury to which she/he is associated. In withdrawing funds from the Treasury, the frontline units have to produce their actual bills to claim expenditure. These bills have to be authorised by their respective sanctioning authority and only then does the Treasury pass the claim for expenditure. The functioning and administrative accountability of the treasuries are covered in some detail in Chapter 5 on oversight.

The entire process of budget distribution is closely linked with the controlling mechanism, each officer who passes on grants to the level below or subordinate level of governance becomes the controlling authority primarily responsible to keep track of the expenditure through the grants distributed by her/him and authorised to reallocate grants.

As mentioned in the earlier chapter, presentation of the budget of the state government is a constitutionally mandatory function of the Governor of the state. This function is discharged by order and in the name of the Governor by the Finance Department (FD) of the State (S.S Karnik). As the FD manages the finances of the state, it plays an important role in estimating the availability of resources like revenue through taxation, contribution from the central government, etc., and it also functions as the ultimate controlling authority.

In its dealings with funds distribution of the entire state, the FD makes the first release of funds based on 'Vote on Account' authorised by the Legislature (before the new fiscal year starts, this is, before 31 March) to incur the expenditure. This is mainly so because the final authorisation of the state budget happens by the end of May or the beginning of June. One may note that the new financial year has already begun and the procedure of finalising the budget is still going on, hence the initial distribution works as a provision for expenditure during these two months. The second release of budget grants is done around the first or second week of June; the month wise cash flow allocations are available online till

December. The percentage of funds to be distributed up to December is generally reported between70 percent to 80 percent. For example, if the limit has been pegged at 70 percent, then of the approved annual outlay to PHD, 70 percent of the funds will be released for the period April-December and the remaining 30 percent during January-March.

Overall, it can be seen that as a part of budget distribution, several sub-parts or steps like Controlling and Authorising grants, Drawing and Disbursing, etc. are involved at various levels of governance. Unlike the case with budget formulation, the sub-parts of the distribution process do not necessarily follow a chronological or governance level based order. In budget distribution, processes like authorisation, control, drawing and disbursing occur at various levels and are all continuous processes. The discussion below presents the research findings from the frontline service provider to the source of fund providers. For consistency, the two categories, the **PHC Line** and the **Hospital Line** are followed in this chapter as well.

PHC LINE

PHC Level

Having estimated budgets as a part of the formulation process, the PHCs are allocated a certain amount of grants. It is important to make a distinction between allocation and actual allotment/disbursement. The DHO determines how much allocation should be made to the PHCs in the district, but the actual disbursement or release of funds to the PHCs is done by the BDO of the Panchayat Samiti. In order to get these funds from the BDO office, the PHCs have to provide pay bills and salary details to the former. There is some amount of checking that is performed at the BDO level, after which the PHCs receive funds.

Thus, at the PHC level, the steps involved in the distribution process are receiving grant allocation, preparing bills to claim expenditure and submitting these bills; finally on the BDO's authorisation of bills, actual funds are received. Findings relating to these aspects are as follows:

- **RECEIVING GRANT ALLOCATION**

The indication of the funds allocation by DHO to all the PHCs are brought out through what is called known as 'grant allocation letter' also known as 'cash flow' (tartudichepatra/anudanvitran in Marathi). The letter includes PHC wise monthly allocations scheme /subhead as well as line items.

Information on Allocations

PHCs being the ultimate users of the resources allocated by DHO, it is natural that they must possess information on the allocations made to them. Based on the interviews conducted at the PHC level, the facilities in District A receive the grant allocation letter from the DHO, whereas those in District B do not.

In District A, the grant allocation letter is sent by the DHO to all the BDOs, THOs and MOs in the District. One PHC mentioned that it receives the letter monthly via e-mail by around the tenth of every month, while the letter is received by post in some other cases. In District B, based on the secondary documents collected from the BDO level, it was observed that the grant allocations are informed by the DHO to the BDO. This implies that neither the DHO nor the BDO sends this information to the PHCs. It was surprising to know that the DHO sends a letter to the BDO marking a copy to the THO, but does not inform PHCs about the same.

Problems faced on not receiving Information

One may recollect from the chapter on formulation that in District B, the PHCs do not send their demands to the DHO. In this case, the reverse effect can be seen in the case of the DHO not sending grant allocation information/cash flow. Overall, this might result in a mismatch between what was demanded and what was supplied, which may lead to inefficient allocation management. The facilities running health services neither demand their requirements nor are they informed of how much funds they have for incurring expenditure. This shows that the procedures followed for formulation also have a direct bearing on the distribution. On the contrary, in District A, although PHCs do not receive the full amount that was demanded, the overall payment is based on the estimates submitted, and they regularly receive information on allocations.

This highlights several aspects: how funds and other resources are being allocated without the knowledge of the particular facility which is supposed to use them; how PHCs have to remain at the mercy of BDO's office to get information on funds meant for their usage; and how they remain uninformed of allocations despite the funds being allocated by their own line department.

Quoting instances from the PHCs wherein they receive the grants/funds and assets without prior information. In the respondent's words, "*We got a grant of Rs. 9,000 and have no clue about what is it meant for! Later we got to know that it is meant for travel allowance, only if I go to the BDO office, or if they inform us, we get to know the details*". In another interesting incident, while the interview was being conducted in a PHC, a new computer arrived in a courier for which neither the PHC nor the THO office had any information. When asked why they do not approach the DHO to know the allocations, most respondents showed reluctance reflecting the stringent hierarchical structure among other things. As a respondent from one PHC said, "*We do not have the right to ask this. The DHO is the boss.*"

PREPARATION and SUBMISSION: SALARY BILL and PAY BILL

This step of withdrawal in the distribution process is followed commonly across all PHCs in both the districts. In order to claim funds for expenditure incurred during the month on salary and non-salary, the salary bill and pay bills, respectively, are prepared after each month is over. The core idea being that after the expenditure/activity has incurred during a month, the expenditure will be reimbursed.

The study observed that all the PHCs prepare the bills in the prescribed format with the relevant supporting documents. They prepare the salary and pay bills as guided by the Zilla Parishad and Panchayat Samitis' Acts and account code[45]. In case of the salary bill, the details of staff of the PHC (excluding the Medical Officer) are submitted in what is known as 'Form no. 26'(Pagar bill namuna in Marathi). Details of employees mainly include the basic salary, allowances such as Travelling Allowance (TA), Dearness Allowance (DA), and House Rent Allowance (HRA) together making the gross salary. From the gross salary, the deductions applicable like insurance, loan, leave, etc. are calculated further. Once deductions are taken out from the total gross payment, the net payment is arrived at. A report of deductions is sent to the concerned department of a particular service provider, for instance the insurance company or the bank. This exercise of calculating net salary and sending a report of deductions is done for each staff member of the PHC. For non salary line

[45] Rule prescribed under the rule book of Zilla Parishad and Panchayat Samitis' Account code 1968 under Sections 69 and 79.

items such as contingency and other charges, Petrol Oil and Lubricants (POL), and Office Expenditure (OE), all the expenditure details are filled in another format called 'Form no. 26' *(akasmit kharchahce* bill *namuna* in marathi). The relevant invoice/receipts of bills are attached with the form.

- **Actual Receipt of Funds at PHCs**

The grants received by the PHCs are common; the grants are released by the BDO for salary as well as for the non salary line items. PHCs in District A, receive the cheque in favour of the Drawing Officer (MO of the PHC) through the BDO drawn on the concerned bank which maintains the BDO's funds. The cheque is enchased in the PHC account in a bank located in the vicinity of the facility and distributed to its staff. A list of account numbers of the staff along with their net salary amount after deduction along with the copy of grant allocation/monthly cash flow information letter for grants are informed to the bank to credit. Some PHCs in District A reported that PHCs have biometric machines (fingerprint time attendance system) and that it is mandatory to attach the summary statement of attendance along with the pay bill and other details.

In District B, the same procedure was followed earlier, whereas now instead of the PHC staff collecting the cheque first and then submitting it for clearance in their bank, the cheque goes directly to the manager of the bank with PHC's accounts.

It was reported that the salary receiving procedure is very long and tedious. Maharashtra ZP & PS, Account code 1968 Rule 70 guides that the pay bill should be finalised not more than five days before the last working day of the month in which the salary is earned. The salary should be received no earlier than the first working day of the month following the month for which it is due. In practice, it was observed that in most PHCs of the sample, the PHC staffs receives their salaries by the 12th-15th of the month; while there were two cases where the PHC staff received their salaries by the fitfth or the sixth of the month. Irrespective of when they receive their salaries, it takes about 10-12 days to complete the entire procedure of bill preparation, submission, scrutiny and authorisation to actually receive the salary.

The Case of Lower Allocation than Actual Demand

It was observed that if the grants allocated to the PHCs turn out to be less than the actual requirement, then in case of salaries, the PHCs can receive the full entitlement from the BDO. For example, Rs. 20,000 was demanded for the salary bill and only Rs. 15,000 was allocated by the DHO. The PHC brought this to the BDO's notice, put in a claim and withdrew the entire salary grant of Rs. 20,000. Exercising such an option, however, is not possible for non-salary items.

Such allocation of grants lower than required is also called as grants in 'minus'. The withdrawal of the shortfall for salaries is known as that on 'guarantee' basis. When such withdrawal on guarantee takes place, the PHC must keep a record that funds received were less for a particular month. It also has to follow up with the DHO for the difference; for example, a PHC brings to the notice of the DHO that the salary bill was Rs.20,000 and that allocated in cash flow was only Rs. 15,000, thus there was a shortage of Rs.5,000. The DHO staff makes note of this and releases the salary bill the following month with the difference from the preceding month added to it.

The study found neglect of budget and demands for the non-salary line items throughout the system. Based on the interview observations, while the salaries at the PHC level were being withdrawn based on 'guarantee', no such practice for demanding additional grant in

the case of non-salary items was being followed. Some respondents also mentioned that withdrawal for non-salary items was not always done on a monthly basis, as these bills were submitted when informed by the BDO or the DHO. Respondents said that this was mainly because the withdrawal of non salary items was based on the available allocations with the BDO.

In the case of one PHC, it was observed that the PHC had asked for allowances for TA bill and miscellaneous office expenses at the end of March 2011, and also included pending demands of 2008-09 and 2009-10. According to the respondent, the demands were always partly met. Some PHCs had also reported that most of the non salary items, such as POL and Miscellaneous Expenses were now being taken care of from NRHM funds. For example, one PHC's need for POL funds was met from NRHM funds, since they received only about Rs. 10,000 from the regular budget at the end of March for the full year; another PHC had no grants for Miscellaneous Office Expenses from the DHO office, so the facility used Rs. 25,000 from NRHM

During field work, it was observed that the way in which the PHCs demanded grants in the letter was not systematic. It only stated the cumulative shortfall of the preceding three years and did not specify the extent of shortfall year wise. For PHCs, receiving lower allocations than demand can undermine motivation. Some respondents had expressed this feeling when they said that placing a demand made no sense since allocations were always lower than demand.

Accounts and Budget Record

The respondents were asked which were the key budget or expenditure records in the PHC to which they had easy access, and most of them replied spontaneously that it was the Cash Book and Pay Bill Register. All the PHCs reported that the Cash books are considered the most important, used for recording the accounts transaction. All the receipts received and all the payments made by cash or cheque are recorded in the Cash book. The receipts received mainly include funds received from the BDO for salary or non salary disbursement. The cash withdrawn from the bank is recorded here. Cash books must be maintained in chronological order as and when the transaction takes place. The Pay bill register includes details such as month of salary, name, designation, pay and allowance grants for each employee and authorised deduction. It also includes the loans and advances to be recovered from the salary of each employee. Most of the respondents reported that these are used for scrutiny and audit by the oversight (auditors) agencies and validation with the balance as per the banks and registers maintained by the Panchyat Samiti (PS) as their expenditure.

In District B, PHCs who did not prepare budget estimates and did not receive the cash flow intimation, kept records of all expenditure transactions in Register No. 14, which was mandatory. In District A, one sample taluka recorded the transaction in Register No. 14, whereas, the other taluka did not. The Senior Assistant (clerk), who was well informed about the mandated account records to be maintained, was asked why the Register was not being maintained. The respondent mentioned that the BDO (Panchyat Samiti) received monthly expenditure details from all PHCs and such a Register was maintained at the BDO level as well. On further questioning, the respondent said that Register '14' was not checked by oversight authorities like the THO or BDO and audit agencies.

The researcher realised during the interaction with the senior accountants at the BDO office, that the PS (2nd tier of PRI) had to record all the receipts or grants received and expenditure or disbursement incurred by them in Registers 13 and 14 respectively in accordance with

the accounting rules under the Zilla Parishad and Panchayat Samitis' Account code rules. Maintaining Register no. 14 was a practice started in the PHCs long ago wherein registers were provided as stationery by the PS which has been stopped. Besides, there was no clear rule or mandate for the PHCs to record the expenditure in Register 14 for accounting purposes.

The senior or Junior Assistant was well informed about the accounts and had been given additional charge of 2-3 other PHCs. The Assistant visited the other PHCs three-four times a month to carry out basic administrative tasks. It was noted that there were a number of vacant posts of Senior and Junior Assistants (clerks responsible for the accounts of the state budget) in the PHCs. In some cases, the Junior Assistants lacked basic skills and had not received any training. It was also observed that there was the contractual appointed clerk at the PHC for managing only the NRHM accounts. Some medical officers of the PHC, the head of the facility and the disbursing officers were unable to demonstrate any financial understanding of the working of the budget and accounts.

In all PHCs under study, it was noted that the budget documents (expenditure related) were mostly maintained as loose sheets and badly organized.

BDO Level

Whether it is Health or any other department in the Panchayat Samiti, the BDO functions as a Drawing and Disbursing Officer (DDO)[46] and is the Administrative head of the Panchayat Samiti (PS). This basically means that the BDO draws the funds from the Treasury/banks and distributes the same to the agencies executing the related activities of the Department on behalf of the ZP. Apart from this, the BDO has the responsibility of compiling the accounts (all the revenue receipts and expenditure) and reporting to the designated offices, the Accounts and Finance Office (CAFO) at the district headquarters (ZP) as guided by the Maharashtra ZP and PS Act 1962.

Thus, the BDO's role first involves getting information from the DHO (District Health Office/Department) regarding allocations to PHCs, obtaining release of funds from the taluka banks into which the government treasury allocations are made, and finally disbursing to PHCs against bills claims.

- **Receiving Allocation Grant Letter from DHO**

The allocations made by the DHO's office, that is information on how much is to be disbursed to which PHC is conveyed through the grant distribution letter (Table 4.1 illustrates the cash flow for the salary under various sub heads). As observed from the secondary documents, the format of the grant letter sent from the DHO differs slightly in both the districts. In District A, the cash flow includes only the allocation of that particular month, whereas in District B these details include allocations not only for that particular month but also the cumulative allocation from all the previous months and the total. The latter gives information to the BDO about the allocated grant at her/his disposal.

The Table below illustrates the various sub heads (schemes) under major head 2211- Family Welfare wherein salaries come out of the plan budget. There are other sub heads at the PHC that include salaries from the non plan budget.(Refer to Box 3.1: Budget Heads at PHCs in

[46]In District 'A', the document, Administrative *and Financial Powers: Order Book 1996* was referred. The document listed new DDO and their financial role and power assigned and the caution to be taken while executing the role of DDO.

the chapter three) for the list of subheads at the PHC level. The table also illustrates Plan and Non plan classification, which is no longer valid because a number of existing schemes and continuing expenditure continue to be under the Plan.

Table 4.1: Cash Flow Allocation for Salary

	Allocation of the Grant for Salary for the month of August Paid in June 2011 (Rs. In Thousand)						
	Name of the PHC in Block	**District Family welfare (2211 0051)**	**Reproductive & child health (2211 05410**	**Expanded Program of immunization(221 1 0621)**	**Leprosy Control Unit (2210 E007)**	**Rural Family Welfare Centre(22110149)**	**Total**
1	2	3	4	5		7	8
opening balance		0	0	1110	105	10315	11530
Received Grants		300	150	1200	200	10000	11850
Total Available Grants		300	150	2310	305	20315	23380
1	**P HC A**	0	0	0	0	100	100
2	**PHC B**	0	0	0	80	130	210
3	**PHC C**	0	0	60	0	80	140
4	**PHC D**	0	0	50	0	120	170

Note: Similar cash flow is prepared for line items like **travel, Miscellaneous** under different budget sub heads.

- **Receiving Bills (Salary and Non salary Pay Bill) from PHCs**

The BDO functions as the Drawing and Disbursing Officer for withdrawing funds at the PHC level. In order to withdraw funds for expenditure incurred by them, all PHCs come to the BDO office with bills claiming expenditure. At the BDO office, the bills are checked, verified and finally the BDO's authorisation for withdrawal is given. Earlier, the process followed was such that the PHC bills were submitted to the taluka Treasury directly by the MO and funds were withdrawn. This system was closed down, and under the current system, the PHCs submit bills to the BDO first, who verifies and then draws the cheques, which are handed to PHCs. It is in this sense that the BDO first draws and then disburses funds. Verifying the documents submitted by PHCs is known as 'passing' the bill which is done by the Accounts Section at the BDO office. The verification includes cross checking the bills, ensuring that amounts match, the totals total vertically and horizontally in the Table and so on. These officers take note of the details in Register no. 12. After the passing is done by the Accounts Officer, the BDO authorises/sanctions the expenditure by signing on the bills. Following the BDO's sanction, the cheques are prepared by the accountant for disbursement to PHCs. The Accounts staff of the PS, who are under the administrative control of the CAFO manage the accounts efficiently.

- **Drawing and Distributing Funds**

While information for allocation to PHCs is received by the BDO from the DHO; the actual transfer of funds happens through CAFO. The online mechanism of fund distribution is limited up to the ZP level, thus transfer of funds from CAFO to BDO occurs through the District Central Cooperative Bank to the taluka banks which have the business of the government treasury. The BDO further withdraws funds from the banks and transfers the same to the PHCs.

Three out of four Panchayat Samitis reported that they do not have the information about the budget estimate as the line office of each department in the taluka send its budget demands for its development work and salaries budget to the respective departments and accordingly, it is included in the general budget. The views of many respondents were summarised and this is what they conveyed, "*How much has been allocated to a taluka is known by the DHO. Since they have a budget, they know what is the staffing position, salary requirements and other requirements of expenses. Our office or I don't know what the budget for the taluka is or what will be the grant which will be received. The BDO office remits as directed by the DHO* "

According to a respondent at the BDO office,

"*The role of PS (BDO) is related to finance distributing and accounting. They do not receive budget estimates proposals from PHCs, besides; the budget in principle is not their work. The respective line office of each department manages the budget on its own, for example, each department like construction, animal husbandry, etc. send its budget demands for their development work and salaries budget to their respective departments and accordingly it is included in the general budget. Thus, PHCs send their budget directly to DHO office.*"

- **Managing 'minus' grants or withdrawal on 'guarantee'**

One issue is how the BDO level manages minus grants (referred in the section on PHC level above). It was explained by the most of the Accountant from the CAFO and BDO office, that the BDO office receives remittances for 14 different departments from ZP. The BDO office receives all the funds in the same cash book, so an adjustment is possible if some savings are found in some of them. The difference is then adjusted in consultation with the CAFO. As one respondent mentioned, "*If health is in minus, they may have funds from education which can be used...If one PHC was provided 5 lakhs and their spending was 5.5 lakhs, even if they took out Rs.10000-Rs.20000 from one department, if 5 departments' savings are used, the difference can be filled.*"

Thus the BDO who has no role in budget formulation, has a significant role in finance management at the taluka level.

- **Record Keeping**

The two most important records reported by all the respondents at the PS and the ZP are Register of Receipts (Register no. 13) and Register of Expenditure (Register no. 14), which show account transactions in detail with the abstract at month end and progressive balance of the funds with PS. Maintaining these two registers are also guided by the Rules[47]. The Rules also direct the BDO's office to prepare a monthly account of the statement of receipts and revenue expenditure and send it to the CAFO, ZP. At the end of the financial year, the

[47] Zilla Parishad and Panchayat Samitis' Account code 1968

BDO prepares the annual account[48] with the details of the receipts and expenditure and submits it to the ZP, which forms the part of the ZP annual account statement document. The PS records the transaction for accounting purposes used for reporting at the taluka level.

DHO- CAFO Level

When it comes to the disbursement processes, the DHO or other Heads of Departments (HOD) at the ZP function closely with the ZP's Finance Department Head- Chief Accounts and Finance Officer (CAFO). The Officer is a designated Drawing and Disbursing Officer (DDO) at the ZP for withdrawal of the State Grant. The DHO using the unique 10 digit code checks grant allocation for health in the CAFO's account on the online system- BEAMS available up to ZP (Table 4.2 On line Budget distribution on BEAMS to the ZP in District A). The ZP receives the budget grants/allocation for the health budget head (2210 and 2211 are the revenue account health budget head) from almost four state departments (R,S,T,O[49]) which are referred to as `Grants-in-Aid' (GIA). Under decentralisation, these GIA are provided as Establishment, Purposive and State plan Grants under Sections 183, 182 and 187, respectively, of the Maharashtra Zilla Parishad and Panchayat Samiti Act, 1961 for carrying out various health activities.

Table 4.2: On line Budget Distribution on BEAMS to the ZP in District A

Grant No	Scheme-Object	Object Description	NP/P	July				
				Gran	Bill	Exp	Carry'd -ve Bal	Balanc
R-01	22110541 -31	GRANT IN AID	P	0	0	0	0	0
R-01	22110541 -36	GRANT IN AID-SALARY	P	0	1	150000	-340000.000	-490000
R-01	22110051 -31	GRANT IN AID	P	0	0	0	0	0
R-01	22110051 -36	GRANT IN AID-SALARY	P	0	3	875000	0	-875000
R-01	22100389 -36	GRANT IN AID-SALARY	NP	0	2	3200000	-5100000.000	-8300000
R-01	22100531 -36	GRANT IN AID-SALARY	P	0	1	400000	-1600000.000	-2000000
S-01	22104606 -31	GRANT IN AID	NP	586000	1	586000	0	0
S-01	22104606 -36	GRANT IN AID-SALARY	NP	3939000	2	8000000	0	-4061000
R-01	22110149 -31	GRANT IN AID	P	0	0	0	0	0
R-01	22110149 -36	GRANT IN AID-SALARY	P	0	1	10000000	19583000.000	-29583000
R-01	22104992 -36	GRANT IN AID-SALARY	NP	0	1	1600000	-6700000.000	-8300000
R-01	22105041 -31	GRANT IN AID	NP	0	0	0	0	0
R-01	22105041 -36	GRANT IN AID-SALARY	NP	0	1	16500000	60000000.000	-76500000
O-44	2210E061 -31	GRANT IN AID	P	7500000	0	0	0	7500000
O-44	2210D935 -31	GRANT IN AID	P	200000	0	0	0	200000
O-44	22109851 -31	GRANT IN AID	P	850000	0	0	0	850000
T-05	22104938 -31	GRANT IN AID	P	0	0	0	0	0
T-05	22104876 -31	GRANT IN AID	P	1.3E+07	0	0	0	12750000
T-05	2210D982 -31	GRANT IN AID	P	250000	0	0	0	250000
R-01	22110621 -31	GRANT IN AID	NP	0	0	0	0	0
R-01	22110621 -36	GRANT IN AID-SALARY	NP	0	1	1200000	-2184000.000	-3384000
O-44	22109822 -31	GRANT IN AID	P	1770000	0	0	0	1770000
R-01	2210E007 -31	GRANT IN AID	NP	8000	0	0	0	8000
R-01	2210E007 -36	GRANT IN AID-SALARY	NP	100000	1	150000	0	-50000
T-05	22104858 -31	GRANT IN AID	P	962000	0	0	0	962000
T-05	22102935 -31	GRANT IN AID	P	0	0	0	0	0
O-44	2210D953 -31	GRANT IN AID	P	200000	0	0	0	200000
T-05	22104885 -31	GRANT IN AID	P	0	0	0	0	0
T-05	22104831 -31	GRANT IN AID	P	0	0	0	0	0
O-44	2210D944 -31	GRANT IN AID	P	420000	0	0	0	420000

Note: Grants allocated by the various state departments are shown in the first column. The next two columns respectively mention the scheme/object head for which grant is allotted and whether the grant received is in the form of Salary (GRANT IN AID- Salary) or GRANT

[48] As per the Maharashtra Zilla Parishads and Panchayat Samitis Account Code (MZP&PS) and Bombay Village Panchayat 1958 (Budget & Accounts) Section 60.

[49] 'R' stands for Public Health Department, 'S' Medical Education and Research , 'T'- Tribal Development Department and 'O'- Planning Department.

IN AID for non-salary line items.[50] The fourth column mentions Plan and non-Plan classification of schemes. Following these, various details for the grant as applicable to the month are mentioned.

Source: Screen print from Budget Estimate, Allocation and Monitoring Systems (BEAMS) website; www.beams.intranet.maharashtra.gov.in.

On further enquiry it was observed that there are various designated grant distribution and Controlling Officers at the district, regional, DHS and state levels from whom these funds are sent to the ZP. Table 4.2 shows that for the budget sub heads 22105041, 22100389, 22104992, and 2210E007, the allocations were uploaded by the Dy. Director regional health circle based on the instructions received from the Jt. Director, BAA. For the remaining budget heads, schemes objects grants were uploaded by another designated controlling officer. For example, grants under 2211 major head were reported to be uploaded by the Additional Director- Family Welfare and not the Dy. Director Regional Health Circle. Similarly, the designated Controlling Officers of the Planning and Tribal Department upload their allocations. There exists a hierarchical chain through which funds flows to the ZP operated by different designated Controlling Officers at different levels of governance. From the BEAMS it was not simple for the researcher to go online and map all Controlling Officers involved in fund devolution, their geographical location of state and district and to identify schemes under which funds were devolved to the agencies/spending units.

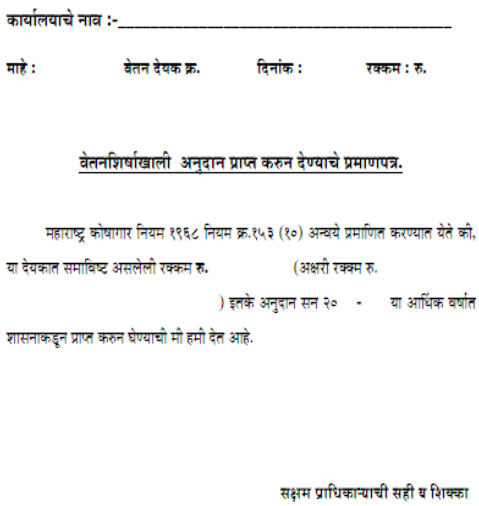
While mapping the budget head grant that reaches the PHCs, 'Public health Primary Health Centre (PHC) 22105041', it was noted that the budget allocation shown was in minus (negative) and zero for the salary component. As far as disbursement of allotted grants seen on the BEAMS, it was reported that the funds may not be evenly distributed throughout the year or in a particular month; grants may not be disbursed at all. Such cases are known as those with 'minus' grants. This can also be seen in Table 4.2 where Salary Grant in Aid is shown in the negative in some of the cases. The ZP has not received the health budget allocated (local sector) on the BDS till August for the Financial Year 2011-12.

A respondent in District A reported delays in arrival of funds from Health Department Secretariat / Mantralaya,

"*There have been no grants released so far. The grants of first four months April to July had already been taken on guarantee with help of hamipatra (guarantee) and recently the DHO office had to do the same for the month of August.While, salaries have been taken care of with withdrawal on guarantee, no bill has been put for non-salary component in first five months of the year. The annual budget for the non-salary component of the health department in the district's was about 70 – 80 lakhs.*"

[50]Includes Telephone, electricity and water charges; Domestic travel expenses; office expenses; Rent, Rate & Taxes; computer expense; petrol, oil, lubricants; motor vehicle.

Specimen Copy of the Guarantee



कार्यालयाचे नाव :-_____

माहे : वेतन देयक क्र. दिनांक : रक्कम : रु.

वेतनशिर्षाखाली अनुदान प्राप्त करुन देण्याचे प्रमाणपत्र.

महाराष्ट्र कोषागार नियम १९६८ नियम क्र.१५३ (१०) अन्वये प्रमाणित करण्यात येते की,

या देयकात समाविष्ट असलेली रक्कम रु. (अक्षरी रक्कम रु.

) इलके अनुदान सन २० - या आर्थिक वर्षात

शासनाकडुन प्राप्त करुन घेण्याची मी हमी देत आहे.

सक्षम प्राधिकाऱ्याची सही व शिक्का

In the case of Minus GIA, the withdrawal is done from treasury based on a 'guarantee' from CEO on a letter. Such withdrawal, referred to as '*hamipatra*' in Marathi, is made on the basis of a rule of Maharashtra Treasury Rule (MTR) under Rule no.153 (10). The underlying implication of this provision is that funds can be withdrawn by backing on 'awaited grants' or 'guarantee'. The *hamipatra* thus states that the grant is 'awaited' and withdrawal should be allowed. This is signed by the CEO and passed in the Treasury from where the money is withdrawn by the CAFO.

When asked whether the *hamipatra* is sufficient to support all demands of funds, a DHO level respondent explained that only the amount for salaries component can be withdrawn on this basis as the rule allows withdrawal on guarantee only for salaries. As for non-salary bills, the respondent mentioned that "*Till the time the grants do not come on the Budget Distribution System (BDS), we do not withdraw any money. We do not have the allocation and authorisation thus cannot prepare the bill. One does not know from the zero allocation how much grant is sanctioned/approved for the particular year or period*".

To our surprise, nether district seems to have information about the total authorised health budget allocation to their ZP. No information on time and magnitude of the transfer is reported to be the practice and the major lacunae. It was observed that a supplement document was tabled at the time of budget approval in the Legislature (budget session in month of March April) along with the mandatory budget documents. This secondary budget is titled 'Budget Estimates part 3- supplementary to 'A' Annexure', which gives details of the budget authorided for the ZP (Table 4.3). The document shows the details of Plan and non-Plan wise classification of schemes wise grants-in-aid allocated to the ZP. This document includes all the GIA that flow from the various administrative departments of the state, but not details on expenditure of previous years incurred by these ZPs. This shows the normal practice of allocations is decided upon by the state unit and intimated to district and project (ZP) units as well as the Treasury, which allocates funds accordingly. The project units at the district accordingly obtain releases of funds from the Treasury based on submission of bills and subject to budgetary discipline inherent in the Treasury system.

Table 4.3: Budget Estimate furnished under the Grants-in-aid for the Schemes Primary Health Centre (22105041)

Plan & Non Plan			Demand No. R-1 Major Head 2210- Medical and Public Health					
2011-12			Subhead –(02)(08) Primary Health Centre (saproyjan –					
code-**2210**								**5041**
(Rs. In Thousand)								
			36 Grants-in-aid(Salary)			36 Grants-in-aid(non-salary)		
Sr. No	Dist. Code	District allocation	Zilla Parishad (196)	Panchayat Samiti (197)	Gram Panchayat (197)	Zilla Paraisha d (196)	Panchaya t Samiti (197)	Gram Panchayat (197)
	Thane	274035	267114			6922		
	Raigard	162579	157619			4960		
	Dist A	193696	185438			8262		
	Dist B	215467	209174			6293		
	District C							
	District D							
	Total	5877301	3512511			10600		

Source: Budget Estimates part 3- supplementary to 'A' Annexure, 2011-12, Govt. of Maharashtra.

- **Allocating Funds to PHCs**

Based on the availability of funds, the DHO has to execute the role of allotment of grants to PHCs. The DHO devises allocations for PHCs. Accordingly, these allocations are informed to the BDOs through allocation letter-cash flow as mentioned above. However, the actual transfer or distribution of funds to the BDO happens through CAFO. BEAMS is available up to the district level, thus transfer of funds from CAFO to the BDO happens through the Treasury or banks that have the business of the Government Treasury. The budget demands received from PHCs in the formulation stage play an important role in determining the allocations; however, as mentioned previously in the chapter on budget formulation, the budget estimates and monthly salary demands are not sent by all PHCs of the district. In the absence of demands from PHCs, cash flow allocations to all the PHCs irrespective of whether they have received demands from these facilities is done based on estimation by the DHO.

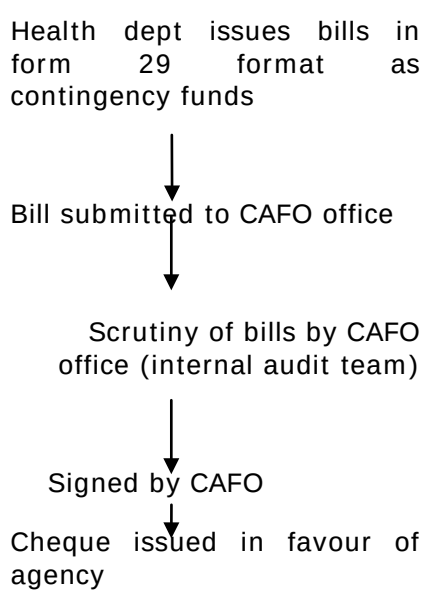
In the case of payment of salary, the government generally does not default. When asked why allocations were being made to the PHCs that did not send budget demands, a respondent in District A said, "*We have to do it, we can't help! Then they complain saying there are no salaries and it all comes in newspapers*".

In both districts, it was observed that the DHO followed the practice of devising allocations for PHCs over time. The scope or discretionary power of allocation of the budget lies with the DHO. The allocation was made generally less than the demanded amount compelling the PHCs to get in touch with the DHO to fill the deficit allocations. To quote a respondent, "*Say for example, somebody has demanded Rs. 2.5 lakhs, we give them about Rs. 2.25 lakhs or so. Basically we send Rs. 20000-Rs.25000 less*." However, despite the cut in demand, the overall allocations are done.

- **Withdrawing Funds from CAFO**

Once the budget and account section of the DHO is sure of the grant online allocation, further processes, such as drafting a bill slip in a format defined in the Maharashtra Treasury Rule are undertaken (Annexure 4.1 Specimen copy of Draft Pay bill prepared by the DHO to be submitted to treasury). The following is the practice explained below.

Flow chart of the process followed at the CAFO



Scrutiny of draft slip, proposal and other set of documents are drafted by the Jr. & Sr. Accounts Assistant with respect to the budget head by the CAFO office. The CAFO signs the documents and the CEO countersigns. The Jr. Accounts Assistant in the CAFO office separates office copy and final copy and makes an entry in the token register for submission to the Treasury (token register is meant to get an idea for the number of bills submitted to treasury and for validation). The bill is then submitted to the Treasury by the CAFO office, and the Treasury gives a token to acknowledge the receipt of the bill. The Treasury issues a cheque on the return of the token (eight days are required for issuing cheque on submission of bill). Cheque numbers are registered in
The Register in the Accounts Department of the CAFO, and cheques are deposited in the District Fund operated in the District central cooperative banks. Depending on the nature of the bill submitted by the DHO, the cheques are issued to the DHO or if the grant is about the PHCs grant salary and non salary, they are transferred to the taluka branches or sub treasury for disbursement at the block level to the BDO.

Overall, in PHC line one can see that multiplicity of institutions creates several complications. Authorities like CAFO and BDO who have no role in budget formulation, have a strong hold over funds. They as Drawing and Disbursement Officers (DDO) are held responsible for maintaining expenditure related information for accounting and reporting purposes. This, among other things, also leads to taking away controlling power from the DHO to some extent (this will become more clear as we see findings from the Hospitals Line). More than anything else, PHCs not having information on allocations made to them is a cause of concern. There is irregularity of information flow from the BDO to PHC level on the one hand, while on the other, there is irregularity in sending budget demands from PHCs to the DHO. This leads to stagnant budgets year after year and demands from the lower level remain unaccounted for.

At levels of frontline units, Drawing and Disbursement Officers (DDO) are required for withdrawing funds. In case of hospitals, the facility heads are designated DDOs; similarly, the ZP's Chief Accounts and Finance Officer (CAFO) is also designated as DDO by the Finance and Health Department. The findings relating to processes in each line are mentioned below:

HOSPITALS LINE

At the level of frontline services in the hospitals line, the distribution of funds happens through the online system BEAMS (Budget Estimate, Allocation and Monitoring Systems). The head of the facility in these cases - the Medical Superintendent (MS) at the Rural, Cottage or Sub-District Hospital as well as the Civil Surgeon (CS) at the District Hospital - are designated as Drawing and Disbursing Officers (DDO) for their own facilities. This is so, except in the case of some RHs which do not have such power, in which case, the CS of the district functions as the DDO. All these facilities receive grants from the Dy. Director at the Regional level.

The steps involved at the level of frontline units are thus similar to those at the PHC level: receiving grant allocation, preparing pay and salary bills, submission of bills. Apart from these, the Hospitals Line follows strong control over expenditure from the Dy. Director's office upon the frontline units. Some of the findings relating to this aspect have also been brought out.

- **Receiving Grant Allocation**

Rural Hospitals, Sub-District Hospitals as well as District Hospitals reported that the budget allotment to their facility happens through an online system known as BDS (budget distribution system) or BEAMS since 2007. Earlier, there was the system of receiving a letter (hard copy of authorisation of the allotted grants) from the Dy. Director Health Circle; in some cases, the Civil Surgeon also sent allotment grants letters informing Drawing and Disbursing Officers. Now, with the BEAMS, the monthly budget allotted grants can be seen. The hard copy of the grant allotment is received later after the grants on BEAMS are uploaded. Expressing his opinion, one respondent from the facility level mentioned, "*This on-line mechanism is more reliable and we keep the printout of each month for our record in the facility*".

The details of grant allocation or cash flow are uploaded on BEAMS on the fourth or the fifth of every month by the Dy. Director Health Circle. The facility head (the MS or the Asst. Superintendent on behalf of MS) looks at the online allotment and the grants under each budget head applicable to their facility.

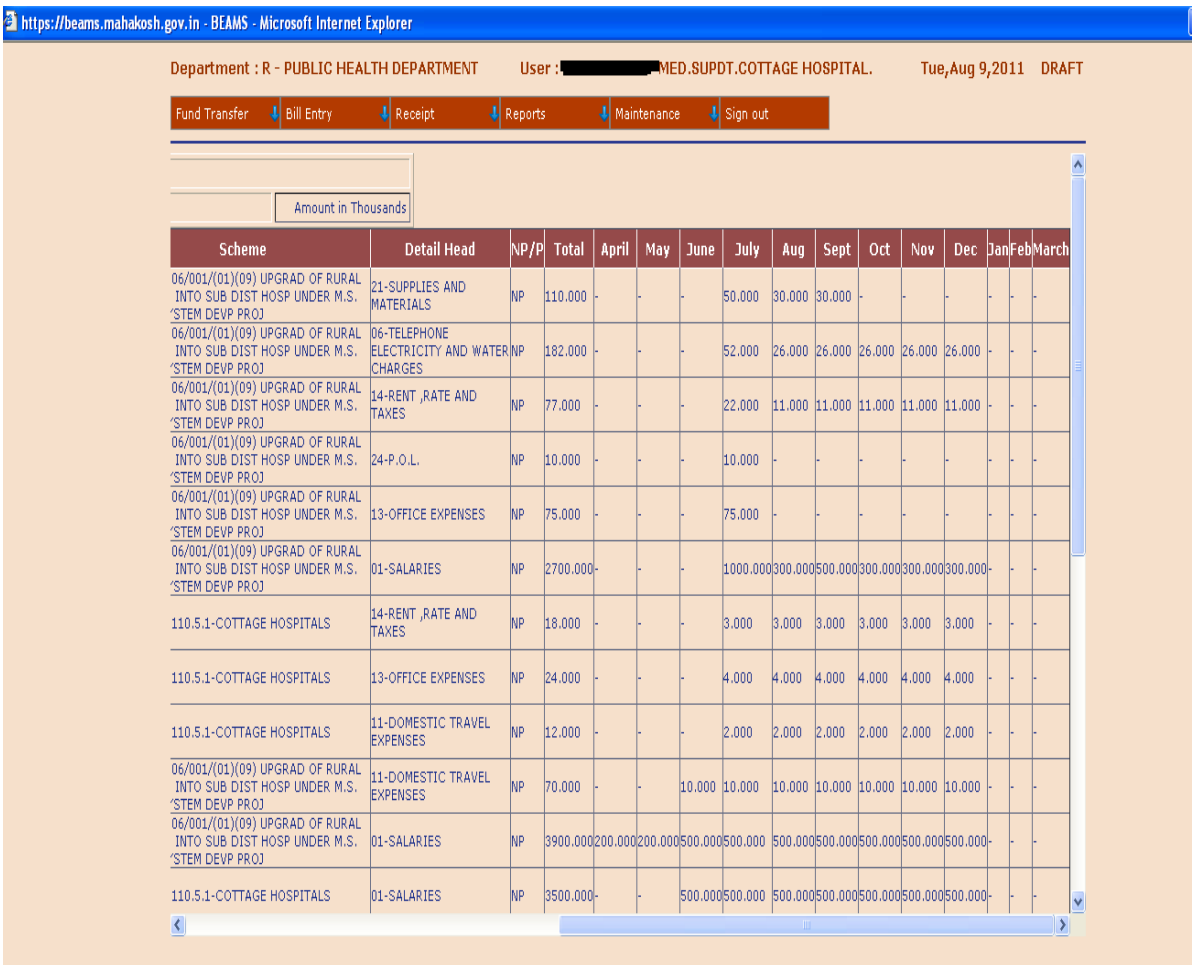
Missing Information on Annual Grants: Problem of operating BEAMS

According to some of the respondents at the hospitals, the grants allotted to the facility for the entire year or the grants to be disbursed in the months to come are not displayed on the BEAMS. After repeated probing, these respondents revealed that the information was available only for a month. Going by this, the facilities have no information about the grant allocation in the future to plan their expenditure accordingly. This also meant that they did not have any idea of the amount of their annual allocation compared to their budget estimates/demands. On the contrary, a respondent of the Sub district hospital in District A, who was able to see the monthly cash flow till December, was not sure if the grants shown were meant for the full year or only up to December. The respondent explained,

"*In general this (grant) is not for the full year, but we assume that this is the full year's grant. As of today, this is shown as the annual grant, so we assume that this is for the full year and we spend, this increases till March with some additions. But as of today, what we see, we need to treat it as for the full year.*"

In yet another case, on asking the respondent whether he was aware of how much grant had been allotted to the facility, the reply was rather vague - "They actually divide the total amount by 12 and post on the website; assume that they want to give you Rs.1 lakh, and then they will precede with Rs. 8,000." Some respondents were of the opinion that budgets are not very transparent and that there is no surety as to by how much allocation will be increased.

Whether grants are uploaded for the entire year or not, what is evident from the responses is that individuals at the facility level are not aware of it. One is led to make assumptions as to what an allocated amount represents, which makes the entire process unclear. Some of the respondents said that budget grant allocation information was not easily available to the individuals at the RH level. In a rather interesting reverse flow of interaction, the MS began to ask the interviewer questions about the documents collected from the state level relating to the district. Looking at the DPC documents and the allocation for health, the MS responded shockingly – "*We never knew that this is the budget for the district. We haven't seen such a district DPC document before.*" Respondents at the Dy. Director's level said that the facilities do not look at the detailed options on BEAMS, but see only the monthly details. One respondent noted that when one goes to 'show details', one can view the entire grant. The problem of operating BDS is significant at all levels and is mentioned in detail at the Dy. Director's level.


https://beams.mahakosh.gov.in - BEAMS - Microsoft Internet Explorer

Department : R - PUBLIC HEALTH DEPARTMENT User : [redacted]MED.SUPDT.COTTAGE HOSPITAL. Tue,Aug 9,2011 DRAFT

Fund Transfer | Bill Entry | Receipt | Reports | Maintenance | Sign out

Amount in Thousands

Scheme	Detail Head	NP/P	Total	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	21-SUPPLIES AND MATERIALS	NP	110.000	-	-	-	50.000	30.000	30.000	-	-	-	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	06-TELEPHONE ELECTRICITY AND WATER CHARGES	NP	182.000	-	-	-	52.000	26.000	26.000	26.000	26.000	26.000	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	14-RENT ,RATE AND TAXES	NP	77.000	-	-	-	22.000	11.000	11.000	11.000	11.000	11.000	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	24-P.O.L.	NP	10.000	-	-	-	10.000	-	-	-	-	-	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	13-OFFICE EXPENSES	NP	75.000	-	-	-	75.000	-	-	-	-	-	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	01-SALARIES	NP	2700.000	-	-	-	1000.000	300.000	500.000	300.000	300.000	300.000	-	-	-
110.5.1-COTTAGE HOSPITALS	14-RENT ,RATE AND TAXES	NP	18.000	-	-	-	3.000	3.000	3.000	3.000	3.000	3.000	-	-	-
110.5.1-COTTAGE HOSPITALS	13-OFFICE EXPENSES	NP	24.000	-	-	-	4.000	4.000	4.000	4.000	4.000	4.000	-	-	-
110.5.1-COTTAGE HOSPITALS	11-DOMESTIC TRAVEL EXPENSES	NP	12.000	-	-	-	2.000	2.000	2.000	2.000	2.000	2.000	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	11-DOMESTIC TRAVEL EXPENSES	NP	70.000	-	-	10.000	10.000	10.000	10.000	10.000	10.000	10.000	-	-	-
06/001/(01)(09) UPGRAD OF RURAL INTO SUB DIST HOSP UNDER M.S. STEM DEVP PROJ	01-SALARIES	NP	3900.000	200.000	200.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	-	-	-
110.5.1-COTTAGE HOSPITALS	01-SALARIES	NP	3500.000	-	-	500.000	500.000	500.000	500.000	500.000	500.000	500.000	-	-	-

Source: Screen print from Budget Estimate, Allocation and Monitoring Systems (BEAMS) website; www.beams.intranet.maharashtra.gov.in.

- **Preparing Bills, Submission, Authorisation and Grant Withdrawals from the Treasury**

For submitting the monthly salary bills, various supporting documents are required. The attachment involves lists of Government Resolutions (GR) about the sanctioned and regular post of each individual and lists of non permanent posts, a print out from SEVAARTH web site[51](government portal having the statistical information on staffing position of permanent, temporary, vacant post, etc. assigned to DDO). The Salary Pay bill is prepared in the format prescribed by the rule of MTR. The facilities fill the details on BEAMS for generating the authorisation slip which is also attached. MS is the signatory of the documents as DDO, the entire bunch is then submitted in the Treasury. In case the document submitted to the Treasury is incomplete, the Treasury Office puts the remark/note on the document and returns it to the DDO.

For the funds received from the Treasury, employee salary is directly deposited into the employee's account, while non salary line items amount is given as a cheque to the agency or the amount is withdrawn for further usage. It was reported that after the online BEAMS notification of grant allotment or the cash flow, it takes one or two days for the salary to be drawn into the employees' account at the facility level.

If the salary pay bill is more than the allotment in the BEAMS cash flow, the withdrawal from the treasury is permitted or accepted by putting a minus sign. Even if there is no grant allotment in a particular month, the salaries can be withdrawn based on guarantee.

The online grant allotment represents the maximum limit of expenditure allowed line item wise for a particular facility. If the pay bill is higher than that under the cash flow, BEAMS does not accept the figure to generate the authorisation slip, approved authorisation for treasury withdrawal. As mentioned by the respondent, "*Even if say the pay bill is of Rs. 5700 and the on-line allocated grant is Rs. 5000, we have to submit the bill of Rs. 5000 only*". Thus, the amount of the bill cannot exceed the allotment. And the difference amount is in the form of pending bills. As mentioned in the formulation chapter, the demand of grants was based on the huge accumulation of the pending pay bill of two to three years (refer to Table 3.5 in Chapter 3). For example, one hospital had demanded Rs. 1 lakh for POL for the year against which Rs.30,000 to Rs.35,000 was received; Rs. 12,000 to Rs. 14,000 was allocated for the year and the additional amount provided was meant for settling pending bills. Such pending bills are generally settled at the end of the year. The decision regarding provisioning of additional amount lies with the Dy. Director and the facility has to send evidence of extra bills as well as follow up constantly with the Dy. Director for allotting funds on the BEAMS.

The respondents of the RHs and Sub district hospitals in both the districts shared that there had been regular instructions about grants to be spent in the same month as the one in which they were allocated in the BEAMS, with no scope of postponing the expenditure to next month. The grants are pulled back and are not authorised to incur expenditure in the following month. If expenditures are higher than what is shown on BEAMS, the treasury will not accept them. Elaborating the point, he mentioned that earlier, treasury people used to pass bills without much more details because the whole facility's bills used to be collectively balanced in March, but now the Treasury does not have permission to do so.

[51] https://sevaarth.mahakosh.gov.in/

The study observed thatall sample hospitals (except Sub district and District hospitals) were aware of selected usage of online BEAMS and used only what was functionally required such as bill entry, generating the authorisation slip and looking at the cash flow for that month considered useful for by them for treasury withdrawal. The BEAMS has the added features apart from see the monthly cash flow such as change cash flow forward, surrender of the excess grant, filling monthly expenditure statement (MES), MIS to generate the report etc., which was not used by all the Rural, Sub district hospitals. It is not clear whether the respondent was aware of the option of seeing the grants for the next month. It seems that even if they can see allotments for the future, they are not aware till which month the allotted grant is applicable and how to change the cash flow–pull backward or push forward**.** This shows lack of knowledge of the online system.

- **Grants lapsed by Controlling Officer: Mechanism of Controlling Expenditure**

Complaining about lapsed grants or pulled by the Dy. Director's office, a respondent said that before BEAMS, the practice followed was that at year end (i.e., in March) they used to receive funds in order to clear the bill related to TA, say Rs. 1 to Rs. 1.5 lakhs or so. Now, with BEAMS, the funds are given on a monthly basis; if it is not spent in that specified period it is withdrawn and in the next month, funds are not allotted. This respondent said, "*It is like whatever is serviced on your plate, if you eat less they will reduce the quantity next time even if you want more*". Recalling an incident where the facility's grants were pulled, a respondent mentioned that the Dy. Director's office called once on the first day of the month asking for a voucher, without which they said that they would pull back the grants. This was not possible for the facility as the process generally begins on the fourth or fifth of the month. The grants lapsed and they could not do anything. The facility had submitted revised estimates later but was not sure when it would be received. Another respondent mentioned, "*They will ask you whether you utilised that amount (provided in previous month) or not, if yes then they will give you the next amount; if not, then we are not sure that they will provide it or not the following month, since the previous amount is pending*."

The rush of expenditure usually happens during the last quarter, especially in the last month of the financial year. Some respondents reported that there still exists the practice of receiving the budget allocation at the last moment (i.e., 31 March) in the closing month of the financial year to rush to incur expenditure, which otherwise would lead to lapse or surrender. To illustrate, based on the revised estimate (secondary document) prepared by one district hospital, the allocation was made for 2010-11 under the budget head 2211 0603 for the scheme, 'School Health Check-up Treatment and Operation of Students in First to Fourth Standard' for the line item Grants-in aid for non-salary purposes, Rs. 2.50 lakhs was allotted on 31st March 2011. Since the expenditure was not incurred on that date, the grant allocation lapsed.

The study observed that service delivery units/hospitals lack the flexibility to know the information of fund flows and budget, which is essential to understand their financial entitlements and also to safeguard against funds being pulled back by higher levels of officials. In practice, the controlling mechanism is implemented to curb the unevenness of expenditure but still the rush of expenditure remains a problem and can be said due to weak information flow on the cash flow to the hospitals.

The problem is more acute at the hospital level because the Hospital Line renders day-to-day healthcare to the people, and all the hospitals in the district rely too heavily on information and the grant transfers from higher-level authorities. These transfers are uncertain and restricted in ways that make their effective use difficult.

- **Budget Related Information /Documents available at the RH Level**

The accounts maintained at the facility include Register no. 14, which has information about the grants received and expenditure. Thus, the two files include one for receiving grants and the other for expenditure of the bill and payments. In the received grant file, printouts of allocated grants month wise and authorisation slips from the BDS are filed. Another register maintained is the cash book. It was observed that the expenditure statement is provided by the RH to the CS every month, and the CS sends it further to the Dy. Director.

Statement of Expenditure (SOE) All the sample hospitals reported that they prepare the monthly statement of expenditure (SOE), which includes the monthly and progressive expenditure schemes wise for all the subheads applicable to that facility and report to the respective Controlling Officers. To illustrate, the grant allotment received from the Dy. Director regional office is reported to him and Family Welfare Program Schemes (scheme related to the major head 2211) are reported to the Controlling Office of the Family Bureau office. Reports are in hard copy and are hand-delivered.

Reappropriation Statement or Variance Statement: All the hospitals under the study reported that they prepare the annual reappropriation (viniyojan lekha in Marathi) or variance statement (Table 4.4). It includes information of the Budget/grant allocated on the BEAMS and expenditure scheme wise for all the subheads applicable to that facility, which is mandatory to report to the respective Controlling Officers.

The respondent said that the grant allotted is authorised by the Controlling Officer through the BEAMS, "*Now there is no provision of making any change or shifting the grant from one line item to another under the scheme*". He mentioned that the Treasury people used to pass bills without much detail, because the whole facility's bills used to be collectively balanced in March, the end of the fiscal year. Now, however, the Treasury does not have permission to do so and does not accept the pay bill with the BEAMS authorisation slip.

Table 4.5 is the statement of one sub head (scheme) 'Upgradation of Primary Health Centres into Rural Hospitals' under the budget head 221000413 for the RH.

Table 4.5: RH Statement of Estimate and Actual Expenditure for Financial Year (FY) 2011-12

Scheme ; Upgradation of Primary Health Centres into Rural Hospitals, 221000413 (Rs. In Thousands)					
Line items	Approved grant 2010-11	Final received grant 2010-11	Actual expenditure 2010-11	Reason for difference	Estimated for year 2011-12 by estimating officer
1	2	3	4	5	6
Salary	5220	5220	6721	Excess due to 6 pay commission	6858
TA	68	58	54	(-) surrender	110
Office expenses	78	66	66	(-) surrender	200
POL	16	11	11		40
Rents, rates & taxes	22	22	22		250
electricity and water charges	10	10	10		200
motor vehicles					35

Source: statement collected by RH; column 6 added from the budget demand

Deputy (DY.) Director Health Service, Regional Level

Dy. Directors of the eight regional health circles receive grants online (BEAMS) from the Jt. Director BAA and distribute them further to the Hospitals Line and additionally to the ZP of the District under the region. The Dy. Director functions as a budget grant allocating, authorising and Sub controlling Officer[52]at the regional level. Grant uploading online on BEAMS in the form of cash flow (monthly or a period) authorises the DDOs of the facilities at various levels to incur expenditure by allowing them to withdraw funds from the Treasury. There are around 22 budget sub heads operated by the Dy. Director. Of these, about 10-12 sub heads known as the "state sector" heads are directly under the controlling and monitoring authority of the Dy. Director. The remaining sub heads are 'grants-in- aid' to the ZP known as the 'local sector'. The Dy. Director office for this local sector grant only allocates the budget grant online on BEAMS and authorises the CAFO to withdraw without any controlling of grants or monitoring expenditure.

Methods of Controlling Grants and Redistribution

It was observed that the methods adapted by both the regional offices to ensure that there were no unspent grants at the facility level were starkly different. In one case, grants unspent during a month were carried forward to the next month, whereas in the other, the grants were pulled back by the regional office. The detailed findings of both are mentioned below with the illustration given by the respondents.

[52] Chief Controlling officer is Jt. Direct, BAA. Sub controlling Officer at the regional level responsible for the departmental matter at the regional circle for eg. budget related to hospitals, ZP grants, Plan Grants to the District Planning Council .

Carrying Forward Grants

A respondent mentioned that a Controlling Officer (Dy. Director) has the authority to change the cash flow. According to the respondent, it was possible to carry forward grants to the following month, if a particular facility had a balance of unspent amount from the previous month. The respondent explained that if one facility had unspent amount under some line item for a particular month that can be carried forward to the next month. In such a case, the expenditure in the next month is then treated as cumulative of the unspent amounts from the previous month. This cumulative amount is thus available for authorisation. Giving an example of this, the respondent said, "*Say in one RH, the monthly cash flow for line item OE is Rs. 5000. If in April, there is an unspent amount of Rs. 4000, then the cumulative balance of Rs. 9000 will be shown in May. If in case, this again remains unspent entirely, it can be carried forward and the balance shown in June will be Rs. 14000.*"

As for spending the allotted grant, the respondent mentioned that, "*We expect that they (facilities) incur/book expenses in that month or at least in the next two to three months. By December, we expect them to spent at least 60 percent of the grants. If they are unable to book the expenses, leading to accumulation of funds, then we ask them to surrender grants.*"

Withdrawal/Pulling Back of Grants

Another respondent (Dy. Director) of another Health Circle mentioned that as per the cash flow on the BEAMS, the expenditure should occur from month to month. In order to pattern incurring expenditure as per the cash allocation and to avoid the situation of unevenness of expenditure during the year that spikes during the last quarter of the financial year and to control the unspent amounts (surrender of savings) as controlling of expenditure, the DDOs of the facilities are instructed to adhere strictly to the cash flow. Explaining the reason for withdrawal or pulling grants, the respondent mentioned, *"We have to tell them that if you don't spend, we will take back the grant and give it to someone else who requires it. Because this (not spending) means that you do not require it!*" The respondent also claims that as a matter of experience, funds for the rest of the year are received based on the initial expenses up to four months and they provide repeated reminders to the facilities asking them to spend all the grants availed.

Reallocation and Reappropriation of Grants

As the regional head, the Dy. Director health services has been delegated with the power to reallocate grants in accordance with the rules prescribed in the 'Manual and Financial Powers, 1978' and MBM under the Rule 155'. The Dy. Director is authorised to reallocate from one facility to another under the same line item/object head. For example, if one rural hospital has underspent grants for diet and another requires more, then the Dy. Director can reallocate these excess funds to another RH that needs more diet funds. The facility with underspending is asked to surrender grants or the grants are pulled back by the Dy. Director. The same is allocated in turn to the other facility. Such reallocation is formally communicated to the DHS, the Jt. Director, BAA.

Reallocation of grants from one object head/line item to a different line item under the same sub head can be done with permission from the DHS (Jt. Director, BAA).Giving an example of this, a respondent at the Dy. Director level said, "*Last year, we had a balance of around Rs. 4-5 lakhs in the line item Office Expense (OE) line items. Approval was sought from the BAA by sending a proposal and we got clearance*". The respondent explained the procedure in detail. Based on the excess balance 'saving' showed online, a print out of the same is taken

attached with a note for reappropriation (in Marathi Punorathan Prasthav) and submitted to the BAA. The note mentions the amount that remains unspent, the line item to which it belongs, the reason why it remained unspent, and the line item to which it is to be reappropriated. This is illustrated in the respondent's words, "*We have 4-5 lakhs unspent amount as balance since OE which was distributed on cash flow was sufficient for RHs. Now we have the balance, so we want to reallocate this to other line items like electric bill payment or phone bill payment. We see to it that they (facilities) don't lapse the cash flow*."

Equal Grant Distribution for certain Line Items all Rural Hospitals

Secondary documents showed that for line items on T.A and POL, equal grants as cash flow was prepared for all the RHs. A respondent mentioned that in one case, when grants received are less than the requirement, the Dy. Director's office distributes cash flow equally to the facilities and keeps some bills pending. The respondent in another circle held that every time the grants are received, it is the Dy. Director who determines whether the distribution should be made on an equal basis or based on the criteria like demand received, earlier expenditure, etc.

Specifically, with respect to distribution of TA grants, a respondent mentioned that it was equal in all the facilities in the circle, and the reason given was, "*For each RH there is a meeting to be incurred by the Medical Superintendent and the Asst. Superintendent has to travel to report, so they have to incur Travel expenses. Thus I have given the cash flow of Rs. 5000 to each*". Respondents from both the circle offices held that if one facility is provided more funds than the other, then the rest feel bad, thus they have to do equal distribution.

The practice of equal distribution of grants is also being followed for certain line items (TA) by the Controlling Officer. The process of budget allocations and decisions on spending is almost entirely top-down, and the hospitals depend exclusively on the Controlling Officer. Reallocation, reappropriation of the funds to the line items that have a demand shows that the Regional Administration-Controlling Officer has discretionary powers over the allocation/resources actually received by hospitals.

Expenditure Monitoring

The Dy. Director's office functions as a monitoring authority for the expenditure incurred by the DDOs to which they distribute funds. The Controlling Officer executes the mechanism to update information regarding the progress of the expenditure incurred by the disbursing officer and seeks a monthly statement of expenditure (SOE). Each disbursing officer thus provides a statement of expenditure (SOE) for the month and progressive expenditure. Statements of expenditure (SOE) are sought in the prescribed format statement in 'Form no. 9' according to Maharashtra Budget Manual Rule 155 (i). After receiving the SOE from all the DDOs, the Controlling Officer prepares the consolidated statement in the register of expenditure known as 'Form 10'. This is then used by the Controlling Officer to monitor the expenditure against the budget allocations and to reconcile with the Accountant General's office (external oversight agency) for accounting purposes. The Controlling Officer calls mandatory monthly meetings every month which discusses the expenditure statements of each district and facility, as well as reasons for any variances. This meeting is held on a specific date every month and is attended by the Administrative Officers of all the districts, the CS as well as the DHO.

Most of the respondents in the Hospital Line and the Controlling Officers (Dy. Director Health) reported that there is an institutionalised process according to the provisions of the Maharashtra Budget Manual (MBM) in the matter watching the progress of expenditure that

every disbursing officer forwards the Statement of Expenditure (SOE) to the immediate superior Controlling Officer.

Another way of monitoring as mentioned by the respondent is to monitor the number of Pay bills submitted by the DDO online BEAMS for authorisation. Giving an example of this, a respondent from the region mentioned 'Last year in the case of one district it so happened that the expenditure on the system was shown very large compared to grants given. When we scrutinised, it turned out that one bill was mistakenly generated 25 times on BEAMS'. In such situations, one needs to go to the Directorate of Accounts and Treasuries to correct this. Thus, the Controlling Officer holds the key role in grant disbursement and controlling expenditure.

Receiving Grants from Jt. Director, BAA and Grant Distribution to DDOs

The Dy. Director first receives grants online and the hard copy of the letter comes later from the Jt. Director, BAA. Both the circle offices under study mentioned that the cash flow is first received for two months, April-May and then for seven months, June to December. The Dy. Director regional circle office prepares the cash flow for hospitals based on annual and revised budget estimates received from the different facilities. Initially, draft cash flow is prepared in an excel file which gives an idea about the demand placed by the facilities. This helps the Dy. Director to decide on distributing the budget grant to different facilities. In case of distributing grants to the ZP, the Dy. Director receives instructions in the form of a hard copy from the Jt. Director, BAA stating the amount to be distributed (Annexure: 4.2 Budget grant allocation received from BAA to be distributed to the ZP as GIA) . Since the Dy. Directors do not receive health budget estimates from DHOs, they are unaware of the demands made at the time of budget formulation.

It was reported that there was uncertainty whether the budget grant allotted would be in line with the proposed estimates. A respondent said, "*The cash flow received is sometimes more and sometimes less*". However, expressing certainty over receiving funds, another respondent mentioned, "*It is not that the government payments will be stopped. We are sure that the payment will be made, if not today then the next time*". In case of lower grants allotted, the demands are raised during the four, eight and eleven monthly revised budgets.

Distribution of Revised Grants at the closing month of the Financial Year

The grants of the revised budget, eleven monthly take place at the end of the financial year, grants are generally received by the office on the last day of the year, that is, 31st March. Respondents in both the regional offices, Dy. Director Level, reported that even if grants are received one or two days (closing month of the financial year) before 31st March, the staff at the office, sits up until late in night to ensure that all funds are distributed. This clearly reported that the practice of receiving the budget allocation/grants at the last moment still exist pushing hard to incur expenditure ultimately lead to lapse or surrender by the DDO's at the district level.

Expressing anguish, the respondents shared the difficulties of opening the BEAMS online on the last days of the financial year as tere was too much of traffic on the website resulting in slow functioning or outage. Thus, at the level of the facilities, they were unable to open BEAMS to take a copy of the authorisation slip in order to withdraw funds from the Treasury. Further, the withdrawal needs to be made before the Treasury closes for the day. Funds not withdrawn get lapsed. In the respondent's words, "*If there is an internet problem, even when we put grants, it is not possible for them (facilities) to get grants. Everything goes in vain*." Despite grants being allocated, the facilities lose the allocations. Referring to a case

where grants lapsed on 31st March, the respondent mentioned that the facility from one taluka reached the Treasury at 7:45 p.m. and the Treasury refused to take the bill saying that there would be no change in the 8 p.m. shut down. They requested several times but the Treasury did not listen and thus the facility's grants lapsed. Such a phenomenon is called 'underutilisation' of funds on the facilities' part at the time of reappropriation.

Problem of Operating BEAMS

BEAMS, online computerised system developed by the Finance Department, Government of Maharashtra, is used to distribute the budget and to authorise expenditure, monitor the expenditure against the predetermined targets by providing the expenditure data to the Government. The system enables the Controlling Officers to modify the grant allocation provided to the facilities. Having seen the operation functionalities in the above section some of the problems reported by the respondents as follows:

Referring to an instance of the facilities' inability to operate BEAMS, one respondent shared that even when it comes to surrendering the grants through BEAMS, facilities do not do so and instead ask the Dy. Director's office to withdraw grants. Explaining the extent of inability of some of the staff in operating BEAMS, the respondent mentioned "*They can't take out BEAMS of the salary which they receive. They go to the cyber cafe' to take the authorisation slip and also give them the password*".

When asked whether any sort of training was provided on how to use BEAMS, a respondent said, "*No training has been provided to anyone. Government has only provided computers*." Referring to the only orientation/training provided on BDS, the respondent explained that it was held for one day with about 2000 people from all the districts of the circle together in a huge hall. Some details were explained that could not be understood by the participants. According to the respondent, about 80 percent of hte people attending this training had no knowledge of the budget distribution system or the computer.

A remarkable example of individual effort to learn BEAMS was the case of one respondent who learnt from others, trial and error and developed a very good grip over the system. In her own words, "*I had once sat up till 2 am and learnt BDS from someone. My colleague was also present but he still doesn't understand anything*." The Dy. Director's office includes different tables/desks different budget heads: this respondent operates other heads which are not on her desk since not everybody can operate BDS.

Though BEAMS system has significantly improved in terms of timeliness of authorisation of the budget grants and monitoring, some operational problems exist, such as slow operation-efficiency in using the BEAMS, at the district level and below, frontline services provider staff not competent to handle the system due to lack of training, lack of ability to use the features to change the cash flow thus the amount /budget get lapsed.

To conclude, the Dy. Director plays crucial and a larger role authorised by the various budget rules, the Officer is the immediate Controlling Officer at the regional level for the DDOs located at the district. As seen in the previous chapter for the hospital he/she receives the budget demands from the estimating officers or the DDOs of the facilities, prepares cash flow for hospitals based on annual and revised budget estimates received from different facilities and uploads them on the BEAMS. At the regional level the Dy. Director, as Controlling Officer is authorised to reallocate, redistribute/ reappropriate grants from one facility to another for selected line items under the same subhead line item/object head subject to certain rules and conditions, watch the expenditure through SOE received by

him/her in periodic meetings monitor through periodic progress reports etc., probe excess expenditure and anticipate savings. The role of internal auditor is discussed in the next chapter on oversight. The regional office, Dy. Director, holds a substantial amount of disaggregated information both administrative and financial proceedings - records, unpublished/official documents reported to for their internal usage. None of the Dy. Directors shared the budget estimate or actual expenditure with the researcher and some of the DDOs reported that the officer in terms of sharing the information is less transparent to subordinate DDOs.

The Dy. Director keeps specific formats for recording the receipts/expenditures and in order to partially rectify this intrinsic reduction in transparency, it is suggested that the Controlling Officers produce and publish as much information as possible about the budget estimates received, allocation and redistribution to DDOs/hospitals.

Jt. Director, Budget, Accounts and Administration

This office is often referred to as the Controller's Office, but according to the respondent, "*It is better not to use that term.*" Explaining this, the respondent mentioned that controlling means who controls the grant distribution or has the overall supervisory job regarding expenditure. Giving an example of frontline services, whatever funds this office receives it distributes to the eight circles or regional heads, while the basis for distribution to RH, SDH or DH is judged by the circle office. Therefore in that sense, those offices become the controlling offices. Similarly, the Bureau Chiefs -Joint Director or Additional Directors of malaria, filaria and water borne diseases; TB BCG leprosy program; Dy. Director of Public Health laboratories, Dy. Director transport, Dy. Director for publicity and IEC, etc. also have their Controlling Officers.

The office of Jt. Director monitors the progress of the expenditure online and anticipates saving (surrender of non utilised funds) or puts the collective demand for obtaining supplementary grants/excess. Apart from this, the office has a significant role to play in the reappropriation of grants, which basically includes approving the redistribution of allotted grants and ensuring accounts booked by the treasuries by Controlling Officers are in line with the accounting practices.

The key steps involved in the distribution process as performed by this office are receiving grants from the Secretariat, Public Health or Finance Department, distributing grants further to the Dy. Directors and other officers and redistribution. The office has the important role in oversight (see chapter Oversight - Internal and External Audit).

Receiving and Distributing Budget Funds

The Jt. Director, BAA receives budget grants for all the sections falling under DHS and further releases funds online to various controlling officers and DDOs[53]. As mentioned before, all the grants relating to budget head 2210, are sent to this Controlling Officer for further distribution. According to one of the respondents, the plan grants (details on Plan health budget in next chapter) were previously distributed by the Planning Cell in DHS, but now this section distributed the non-plan grants only. It was reported that since this year 2011-12 that distribution of Plan budget of 2210 (major head for head) is also routed from this section.

[53]Drawing and Disbursing Officers are placed in different areas and make drawals from the respective treasuries for disbursement within their jurisdiction. There are more than one Drawing and Disbursing officers under the control of a Controlling Officer.

From the Jt. Director BAA, the budget funds are further disbursed to the eight Dy. Directors at regional health circles level and to the various Bureau Chiefs -Joint Director or additional directors–of malaria, filarial and water borne diseases; TB BCG leprosy programme; Dy. Director of public health laboratories, Dy. Director transport, Dy. Director for publicity and IEC, etc. at DHS level. Along with online distribution of funds, this office also issues a hard copy of distribution.

Delayed in receiving the Budget Grant at ZP

Referring to findings from district level, the respondent from the Jt. Director office was informed that the DHO was facing problem of not receiving grants (for salary and non salary line items), and the salaries were being withdrawn on guarantee basis. Explaining the reason for this, the respondent said that this year a new GR was issued by the Finance Department (FD), Secretariat (dated May 6, 2011) according to which in order to incur expenditure on objects of grant in aid salary and grant in aid non salary (respectively numbered 31 and 36 in the budget), the ZP needs to take the FD's approval. Backed by the FD's Government Resolution, another circular was issued by the Directorate of Accounts and Treasuries (DAT) for all the treasuries and sub treasuries stating that before accepting the pay bills of any kind from the ZP, they must check whether they have a letter of authorisation from the FD Secretariat. The respondent said, "*The DAT's boss eventually is the FD. So they have to follow the FD's GR"*. Thus, the pay bills remained pending at the ZP level in that financial year.

Till 2008, the practice of releasing the 'Grants in Aid' to the ZP was through 'Ways and Means Advances'[54]. The system of releasing the advance, and the Rural Development Department was held responsible for budget accounting of the GIA and recovery of the excess grants. With this excess recovery there were issues of none surrendering of the unutilised grants by the ZP. Thus, with the implementation of BDS (later rename as BEAMS) the GIA are now transferred by the respective administrative departments to the ZPs. With the change in the operational system the one of the respondent at the secretariat health Department giving a remark on the move, said, "*This is more of a 'control or regulatory mechanism' on part of FD and may be to keep a check and push them to surrender*" .

Delay in receiving the Supplementary (revised) Grants

Respondents reported significant delays in receiving supplementary grants (revised estimate demands); supplementary demand grants of the four monthly budget the, approval/authorisation of which takes place in the monsoon session (mid July to mid August), are often not received until October.

Expressing the core problem, a respondent said, "*The main aspect is that the purpose of supplementary must be served. If the grants are released late and remain un-spent up to December, then the FD will again object to that*." Supplemental four monthly budget demand should be received by mid September at the latest, assuming that the finalising/publishing the document, sent to all the departments takes about a month.

The funds are routed from top to bottom, there are some authorities that allot funds, some that distribute them below and the end users draw funds for usage for during health service provisioning. Delays in receiving grants (supplementary- revised budget grant) from the Secretariat, Finance or Public Health Department have been reported by respondents.

[54]ZP are granted temporary Ways and Means Advances very month to meet expenditure on transferred staff, schemes and works under section 100 of the Maharashtra ZP & PS Act 1961

The respondent was talking about a particular supplement for diet which was approved/ authorized by the legislature, but for which receiving the supplementary grant was pending. When asked what they did in the case of non-receipt of grants, the respondent said that their office informed the Public Health Department, Secretariat about grants not being released. That department further requests FD to release the same or if FD has already released and grants are piling at their level then consider the request. On probing further on delay occurring at each level, it was understood that once grants are received by this section, passing on to the Dy. Direct and further to the facility who demanded it takes two days at the most. The main delay occurs in receiving grants from secretariat, Finance department or at the Public health department.

Budget related information /documents available

The health budget demands of the ZP are received directly by the Joint (Jt.) Director where the consolidation of the data subhead /scheme wise is done. The budget related information records are kept in the following format: Proposed grants (demand proposed by the ZP), sanctioned grants - authorized, disbursed grants, distributed grants in the form of cash flow to deputy directors. As one respondent said, "One can still get the records of 10 years back". The expenditure for districts lies with the deputy directors.

Apart from the disaggregated health data of ZP, most of the information is at the consolidated stage form, including the budget demand and the expenditure received from the Dy. director and from the bureau chiefs[55] are the controlling officers of their respective program. It is observed that none of the above information (disaggregated district wise) is available in the public domain.

When asked whether any record of disbursed funds against actual expenditure is available, the respondent said, "It is not possible to get the entire state level information like who has spent how much and when, etc. So for the purpose of our information, we take out the expenditure related information from BEAMS for all the districts." These details are available on the BEAMS (under MIS option) which include object wise, District wise, DDO wise expenditure. The staff at this office thus takes a print of the BEAMS on monthly basis and maintains a file of the same. When asked whether this is maintained only for internal purpose for office record.

The study observed that often the controlling officers, Jt. Director, BAA and also Dy. Director, claim that expenditure figures are unaudited and express reluctance to share the same. However, the Maharashtra Budget Manual clearly states that the ultimate responsibility for keeping the expenditure data within a grant lies with the departmental controlling officer and not with the Accountant General. It is very clear from the Manual that the controlling officers should have the final budget expenditure data. Such avoidable health budget information constraints can be addressed by the regional level authorities by making information accessible to the public so that the citizens can request actual expenditure related information formally from the controlling officers.

[55]Joint Director or Additional Directors of malaria, filaria and water borne diseases; TB BCG leprosy programs; Dy. Director of Public Health Laboratories, Dy. Director Transport, Dy. Director for Publicity and IEC, etc.

Secretariat, Public Health Department (PHD) and Finance Department

Allocations Devised by PHD

After FD allocates funds online to the PHD, the latter further allocates funds to all the four directorates including DHS. Generally, FD releases funds by the first or second week of June, and PHD funds are released in another week's time. Allocations made by FD are for both plan and non-plan budget.

The PHD distributes funds to the Jt. Director, BAA based on the allocations devised by it. This distribution is made for both plan and non-plan funds. One may recollect that at the time of budget formulation, the Jt. Director, BAA received demands only for the non-plan budget. The budget cell in the PHD provides a cash flow budget in which they include month wise grants that are approved by the finance department.

While the FD has control over the funds distributed to each administrative department, the PHD does the same for funds distributed at the Directorate level. The PHD holds regular meetings to review plan and non-plan budgets as well as activities. Officers from the Directorate level like the Jt. Director, BAA and those from the planning cell visit the PHD for this purpose.

Expenditure Wing in the Finance Department

For budget distribution, the expenditure cell/wings of the FD are assigned to the various administrative departments (around 33-34) under the administrative control of Secretary (Expenditure). The expenditure wing /cell no. 13 deals with health budget disbursement. While the distribution of funds are online on BEAMS, it gives allocation and authorisation of the budget grant allotted for the expenditure of the administrative departments in the Secretariat.

To conclude, the process of budget allocations and decisions on spending is almost entirely top-down: districts depend exclusively on the higher level of the authorities, and have little influence over budget allocations. The entire process of budget distribution is closely linked with the controlling mechanism, each officer who passes on grants to the level below or subordinate level of governance becomes the controlling authority primarily responsible to keep track of the expenditure through the grants distributed by her/him, authorised to reallocate grants. The distributive systems of allocation operating between the state and local level (districts) follow the PRI and transfer grants deciding the spending priorities of PRIs and also the priorities of the states towards that district. Another is the parallel network of the Health Line department (CS and other health officials such as TB, malaria, blindness control etc.) that functions in the districts. Thus, several parallel structures/systems that operates above and below them brings complex issues of allocation, discretion and governance. Districts have different budgets for funds coming from different sources. There is no institution or process in any state that compiles information that can be treated as the annual budget for a district. At the district level, State budget allocations to the district are harder to access as there are no district-level consolidated budget documents.

CHAPTER 5

PLAN BUDGET

This chapter focuses on the actual process of planning and budgeting at the district and state levels, how funds flow to the districts and encounter during the study around tracking budget.

The planning mechanism in India follows a three tier system, with planning done at the Centre, State and District levels. In order to make the planning process more participative at the grassroots level, it is essential that people understand aspects such as types of plans and the bodies responsible for preparation and implementation.

Since the country follows a Plan based model of economy, the expenditure of the Government is divided into Plan and Non-Plan. As the name suggests, Plan expenditure is directly related to expenditure on schemes and programs envisaged in the Five Year Plans and which is operationalised through the State Annual Plan. Non-Plan expenditure is the expenditure incurred on recurrent expenses such as salaries and non salaries line items as well as on operation and maintenance of existing assets (Second Administrative Reform Commission, 14 Report, and Government of India). Thus, the Plan in this context includes grants which are received from the central government and the resources available with the state. In the federal system, many financial resources are transferred from the union government every year to every state, such as share of states in the central tax, allocation in the form of grants and loans for new and targeted interventions for socio-economic development. This close association between the Centres's planning Commission and the state deals with the formation of the Annual Plan Budget, the negotiation between the union government and the state government. The plan outlay (total financial resources deployed for budget and Expenditure) devised by the state level departments are approved by the Union and Planning Commission, after which it is put forth as approved/finalized Plan outlay (Annexure No. 5.1 Approval letter from the Government of India (GOI)).

Annual Plan outlays are segregated as sector wise and sub sector allocations. The sectoral allocation which involves various statutory bodies, such as Maharashtra Electricity Board or the Road Corporation, deals with outlays meant for power, transportation and economic services, which are not budgeted in the state administrative departments. Sectoral outlay for the 'social and community services' are to promote social development[56].Another group is Economic Services Sectors, which includes Irrigation & Flood Control, Power Development, Industry & Mineral, Transport, Communication, Science, Technology and Environment, Agriculture and Allied Services, Rural Development, Special Area Program/Services which are of social relevance[57]. Yet another group is General Services that includes the outlay for General Services such as Legislative Assembly, Public Service Commission, District Administration, etc[58].

[56]Includes Education, Sports, Art and Culture; Health and Family Welfare ; Water Supply and Sanitation, Housing and Urban Development, Welfare of SC, ST and OBC ; Labour and labour Welfare; Social Welfare and Nutrition and Secretariat of Social Services Administrative Departments.
[57] State Finance Study of Budgets, Reserve Bank of India, www.rbi.org.in. mention/includes Rural Development in the social sector.
[58]Treasury and Accounts, Police, Jail, Supply and Consumption, Stationery and Printing, Fire Control and Protection and other administrative services.

Table 5.1: Annual Plan Outlay, Maharashtra				
Plan Type	Outlay 2010-11		Outlay 2011-12	
	Rs. Crore	%	Rs. Crore	%
1.General State Plan	26769.3	70.6	29254.0	70.5
General District Plan	3905.24	10.3	4319.5	10.4
Total General Plan	**30,674.5**	**80.9**	**33573.5**	**80.9**
3. SCSP (State Plan)	3217.10	8.48	3431	8.27
SCP (District Plan)	650.01	1.71	802	2.93
Total SCP Plan	**3,867.11**	**10.2**	**4233.0**	**10.2**
4. TSP (State plan	2,306.9	6.08	1700	4.10
TSP (District Plan)	1067.41	2.82	1993	4.80
Total TSP & OTSP Plan	**3,374.36**	**8.90**	**3693.5**	**8.9**
Total Plan Budget	37,916.0	100	41,500.0	100.0
Source: Approval letter from GOI (Annexure 5.1); Annual Plan 2011-12.				

Once the total plan outlay for the entire state is decided, the share of Tribal sub plan[59] (TSP and OTSP-henceforth mentioned as TSP) and Scheduled Caste Sub Plan (SCSP) are earmarked. In 2011-12, the total plan was worth Rs. 41,500 crores, of which the funds allocated for SCSP and TSP were Rs. 4233 crores and Rs. 3693.5 crores respectively, the percentage shares of which come to 10.2 percent and 8.9 percent (Table 5.1). The Department of Social Justice for the SCP and the Department of Tribal Development for TSP are assigned the role and responsibility of planning and executing schemes, and also monitoring the implementation if executed by different implementing agencies/departments. The remaining outlay is used for preparing the 'General State Plan' and the 'District Plan'.

General State Plan and District Plan

All the three types of plans, General, SCSP and TSP have outlays devised specifically for districts and states, known as District Plan and State Plan, respectively. At the state level, the decision as to how much funds should be distributed amongst the District Plan and the State Plan is taken by the Planning Sub-committee of the Cabinet (PSC), which includes state level ministers of departments like Finance, Planning, ST Development and Social Justice. While the PSC makes all the final decisions in the matter of Planning in the state, the Planning Department has general control over all items relating to state level planning and is subordinate to the PSC. For formation and execution of schemes, the Planning Department issues guidelines to the concerned authorities in the state and districts from time to time. These guidelines may range from generic details like sources of funds and better mechanisms for demanding funds to very specific guidelines such as focus area, suggested increase in budget demand and the distribution of grants. Apart from planning and coordinating with various administrative departments, the Planning Department devises some plan schemes. An example of this is the scheme for bridging regional imbalance. Apart

[59] Tribes comprise marginalised sections of Indian society. According to the constitutional obligatory for social and economic development of groups,thetribal development program was designed a special tribal sub plan. Districts where tribes live in large numbers are declared as tribal areas. Similarly, for weaker sections, there is a Special Component Plan (SCP) for Scheduled Castes (SCs).

from the regular schemes, the Planning Department may also come up with new schemes from time to time, such as the thirteen recent schemes that address issues of health, education and income that were devised for implementation in 125 backward talukas of the state. In 2011-12 as shown in Table 5.1, the State Plan allocation is about 82 percent of the total plan, while the District Plan comprises the remaining 18 percent. This level of allocation to the district has increased compared to the past.

At the state level, there are various administrative departments such as the Education Department, Public Health and Family Welfare Department, Medical Education and Research Department, Rural Development and Agriculture. Further, like any other administrative department, the Public Health and Family Welfare Department has various Plan components in the budget, to cover new schemes or upgrade or expand existing schemes as well as for new infrastructure or replacement of infrastructure which are referred to as 'State Health Plan Schemes'. The Public Health Plan outlay for 2010-11 was Rs. 719.5 crores (Annexure No. 5.1. Approval letter from the Government of India and the sector wise outlay), which was subsequently increased to Rs. 792 crores in 2011-12; this comprised Rs. 657.83 crores for budgeted expenses and a balance of Rs. 134 crores to meet the supplementary budget.

As a process of democratic decentralisation, the government had adopted the policy of balanced development on the basis of district as a unit of planning for formulation of annual plans. This was to ensure balanced development with benefit to all parts of the State. For this purpose, in Maharashtra, the District Planning and Development Council (DPDC[60]) was established consistent with the Constitution. The DPC is responsible for preparing the plan, consolidating the draft plans of the Zilla Parishad, Urban local government, with the expectation of addressing local level issues for effective delivery of services in the districts. For 2010-11, the total outlay for the District Plan was fixed at Rs. 3750 crore, which was later increased by the Government of India (GOI) to Rs. 3905.24.

In order to understand the DPC grants, the representatives from the Planning Department, Secretariat, the District Planning Officer and the District Collector were contacted. Government resolutions and circulars were referred to. The following section presents the findings on allocation (envelop/ceiling) criteria to DPC based on a predetermined formula, the process of preparing and finalising the District Plan Outlay and the Collector's delegated powers.

Ceiling of the General District Plan Grant

The allocation to individual districts by the District Planning Committee (DPC) is based on a predetermined formula known as Paranjape formula, which assigns weights to various factors, including the district's total population, rural population, geographical area and Human Development Index (HDI). All the four aspects are assigned respective weights of 30 percent, 20 percent, 30 percent and 20 percent. The formula used based on the Government resolution is illustrated in Box 5.1.

Once the ceiling of the General District Plan is formulated by the Planning Department, the District DPCs are informed. The exercise of budget separation indicates the allocation of the funds that will be available to the DPC to help it plan its activities.

[60] In Maharashtra, DPDC is constituted in every district as per Planning Dept. G.R. dated 1/10/1974. As per the 74th Amendment of the Constitution (243-Z/D) DPDCs were replaced by District Planning Councils (DPCs) which are constituted as per G.R. Dated 15/3/1999. The district collector is the Secretary and ex-officio member of the DPC.

Box 5.1: General District Plan Allocation Formula - An example of Parbhani District

The allocation to individual districts done through the District Planning Committee (DPC) is based on a predetermined formula known as the Paranjape formula, which assigns weights to each of the four indicators: a district's total population (30%), rural population (20%), geographical area (30%) and Human Development Index (20%). For 2010-11, the total outlay for District Plan was fixed at Rs. 3750 crore (later the approved outlay was Rs. 3905.24 as seen in Table 5.1.). The pattern of distribution for all the districts in the State is illustrated by the example of Parbhani District given below:

A] Total population of the District: According to the total population norm, 30 percent of the total outlay needs to be distributed across all 35 districts. Hence, 30 percent of Rs. 3750 crore, Rs. 1125 crore, will be distributed based on the total population of Maharashtra State, which is 7,84,19,695. The population of Parbhani district is 13,40,042, which accounts for 1.7 percent of the state population. Thus, the allocation for the district based on total population norm is 1.7 percent of Rs. 1125 crore, which is Rs. 19.22 crore.

B] Total rural population of the District: Of the total outlay, 20 percent (Rs. 750 crore, or 20% of Rs. 3750 crore) needs to be distributed across all districts according to the total rural population norm. The total rural population of Maharashtra State is 4,21,97,281, whereas that of Parbhani district is 9,06,668. This comes to 2.1 percent of the state's total rural population. Therefore, the allocation to Parbhani district based on the rural population norm is 2.1 percent of Rs. 750 crore or Rs. 16.11 crore.

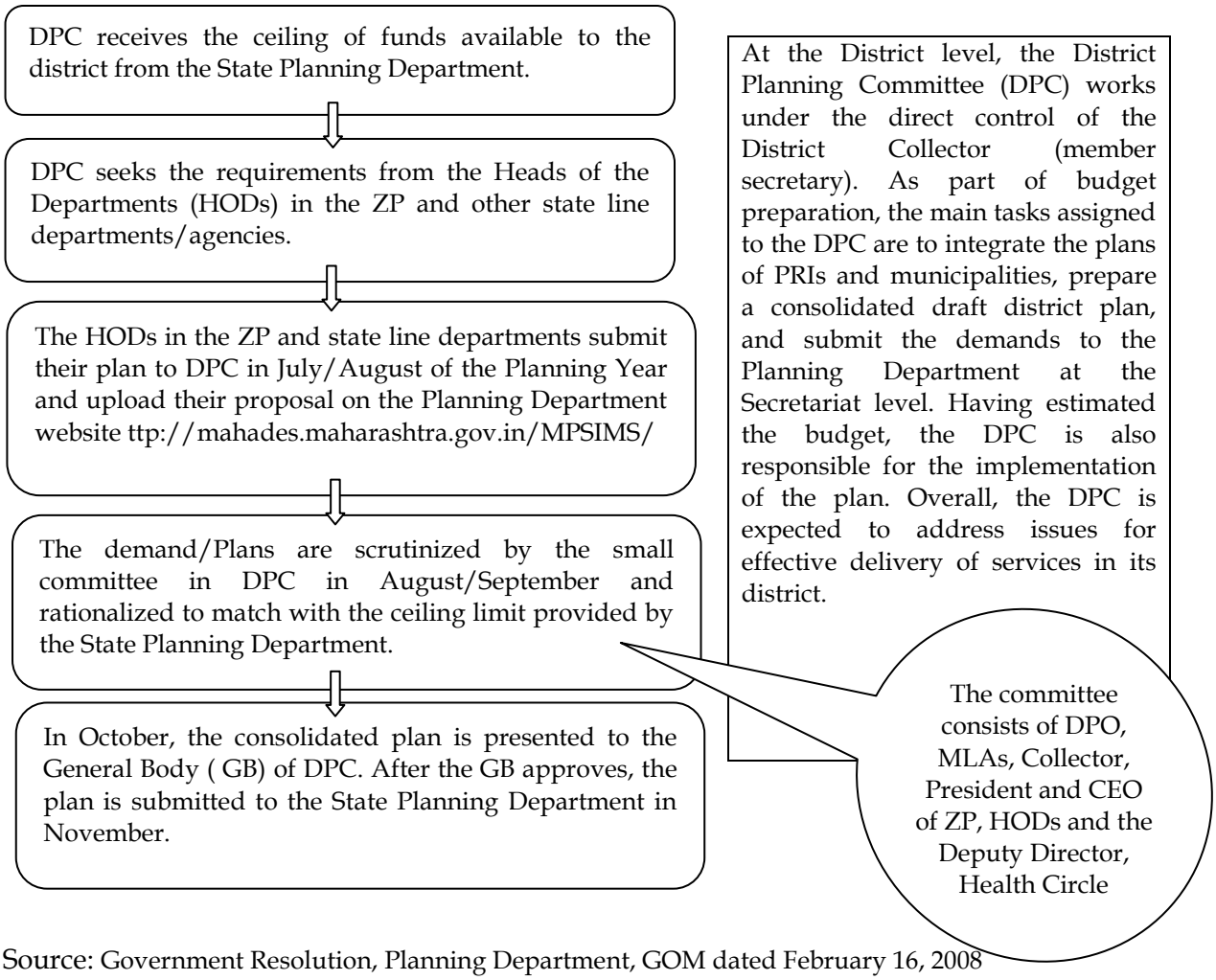
C] Total Area of the District: Nearly 30 percent or Rs. 1125 crore of the total outlay needs to be distributed based on the geographical area of the district. The total area (sq. km.) of Maharashtra State is 3,07,713, of which Parbhani District occupies 6,214,sq.km. that is, 2 percent of the state's area. The allocation for the district is thus Rs. 22.72 crore, which is 2 percent of Rs. 1125 crore.

D] Human Development Index (HDI): Twenty percent of the total outlay needs to be distributed across all 35 districts based on the HDI norm, which is Rs. 750 crore. The allocations for HDI have been calculated by subtracting the HDI from 1 and then multiplying it with the total population of state/district. The HDI for Parbhani is 0.43 and the total population of the district is 906668. Based on this, the allocation to the district is Rs. 19.18 crore.

The **total outlay** received by Parbhani based on the aforementioned four parameters is thus Rs. 77.24 crore, which is an addition of all the four types of allocations (Rs. 19.22 crore + Rs. 16.11 crore + Rs. 22.72 crore + Rs. 19.18 crore).

Once the General District Plan is formulated by the Planning Department, it is informed to the District DPCs. Thus, a top- down approach is followed in the District Plans.

Figure 5.1: DPC Planning Process



Source: Government Resolution, Planning Department, GOM dated February 16, 2008

The DPC Budget Planning Process

The DPC deals directly with the Planning Department. At the time of budget formulation, the Planning Department issues a letter providing instructions regarding the budget estimation to all DPDCs. The estimates of all the districts are submitted to the Planning Department. Similarly, the distribution of grants is also made directly to the District Collector who is the Drawing and Disbursing Officer of the DPDC. As a respondent from the Planning Department mentioned, usually the process of budget formulation for the District plan starts around July at their level.

First, the PSC's decision for allocation of funds among State Plan and District Plan is communicated to the Planning Department. The allocation criteria for distributing funds to DPCs are fixed (as mentioned in Box 5.1). The Planning Department thus communicates the allocations of each district to the DPCs and asks them to prepare a plan. The District Planning Officer (DPO) calls for the proposals submitted by the implementing agencies, such as health or educationOn receiving estimates from the Heads of Departments (HODs) of implementing agencies, the DPC scrutinizes their proposals according to the guidelines issued[61]by the Planning Department and submits the final draft to the Collector for

[61]Such as districts are instructed about allocating proportions in two groups, two-thirds of the outlay is to be kept for the core group and the rest for the non core group. The core group includes three sectors, namely, agriculture and allied activities, rural development, social and community services

approval. The Collector then holds a meeting of all the implementing agencies and prepares the District Plan. This is sent to the DPC for further discussion and the plan is approved within the limits of allotted funds. After the approval of the Annual Plan by the Collector and Small Group Committee, it is submitted to the Government. The Planning Department meets all district collector and looks at the finalised plan, based on which, it is determined if any additional outlay is required. This is generally done in December-January every year.

At present, the District Collector's function is Member Secretary and he has been delegated powers in administrative and financial matters[62]. The Collector is the Controlling Officer for distribution as well as re-appropriation of funds (with prior approval of the DPC) for the DPC schemes for that particular district. Earlier, the process for administrative sanction was time consuming and lengthy, which included the need for approvals from the respective state administrative departments. However, this has been reformed and the Collector has been vested with delegated powers for administrative sanction of the budget to avoid delays in approvals and fund disbursals to the district. If an infrastructure project is to be completed in two years and if there is need for an increase in the already sanctioned amount, the Collector is authorised to give an increase upto 30 percent of the sanctioned amount. For requisitions above this amount, administrative sanctions have to be taken from the Planning Department and the Secretariat. In case some funds are left unspent and funds are needed by some other department, the Collector can reappropriate such funds. He/she has to notify the Planning Department about the revised plan. Like the SCSP, the TSP is also attached to the DPC.

The Collector as the Controlling officer, receives the grants from the Planning, Social Justice for the Special Component Plan Grant and in case the District has tribal population grants, they are received from the Tribal Development Department and distributed to implementing agencies, such as Civil Surgeon for Hospital Line, ZP for PHC Line or any other HOD. The Collector receives grants online (BEAMS) and each implementing officer checks the grant allocation in the Collector's account on the online systems, BEAMS and there is follow up with the Collector or DPC office.

One of the sources through which funds flow in the district to the frontline provider is through its own health line department through various disbursing agencies (Controlling Officer) operating at the state level (as was the case office of Joint Director ,BAA) and the regional level (Deputy Director, regional health circle). In the above section, through the District Plan, grants from the Planning/Tribal/Social Justice Department are made available to the district health officials, that is, the Civil Surgeon and the DHO.

State Health Plan Budget: Planning Cell, DHS

For coordinating procedures relating to 'State Health Plan Schemes', a unit called 'Planning Cell' operates at the DHS level. Instructions regarding preparation of the plan budget, demands for Annual and Five Year Plans are sent from this cell to all the program officers. The planning cell receives demands in the already laid proforma/format (detailing the nature of the scheme with service/performance related information such targets and achievements, financial and physical progress of the works commensurate with the preceding plan period[63], and nature of the grant received/used for the existing scheme –

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and economic services , while the non-core group includes six sectors such as transport, irrigation and flood control, industry and mining and general services.

[62] Government Resolution (GR) dated February 16, 2008, GOM.

[63]Of previous annual plan and the progressive status in the Five Year Plan.

either central financed or state contributed) and alsoseeks the suggestion and opinion as to which schemes the Program Officers want to continue or discontinue; or if they want to bring in any change. After receiving the demands, the planning cell compiles the demands scheme wise, vets all proposals of plan demand and prioritises the demand for removing the regional backlog[64], that is, regional development and the related one of substantive poverty in the state. The hard copy of the demand proposals are sent to the Public Health Department, Secretariat. All the administrative departments including the Public Health Department submit their demand/proposal, filled online on web base software application to the Planning Department, Secretariat. Thus the final approval is done in the PSC.

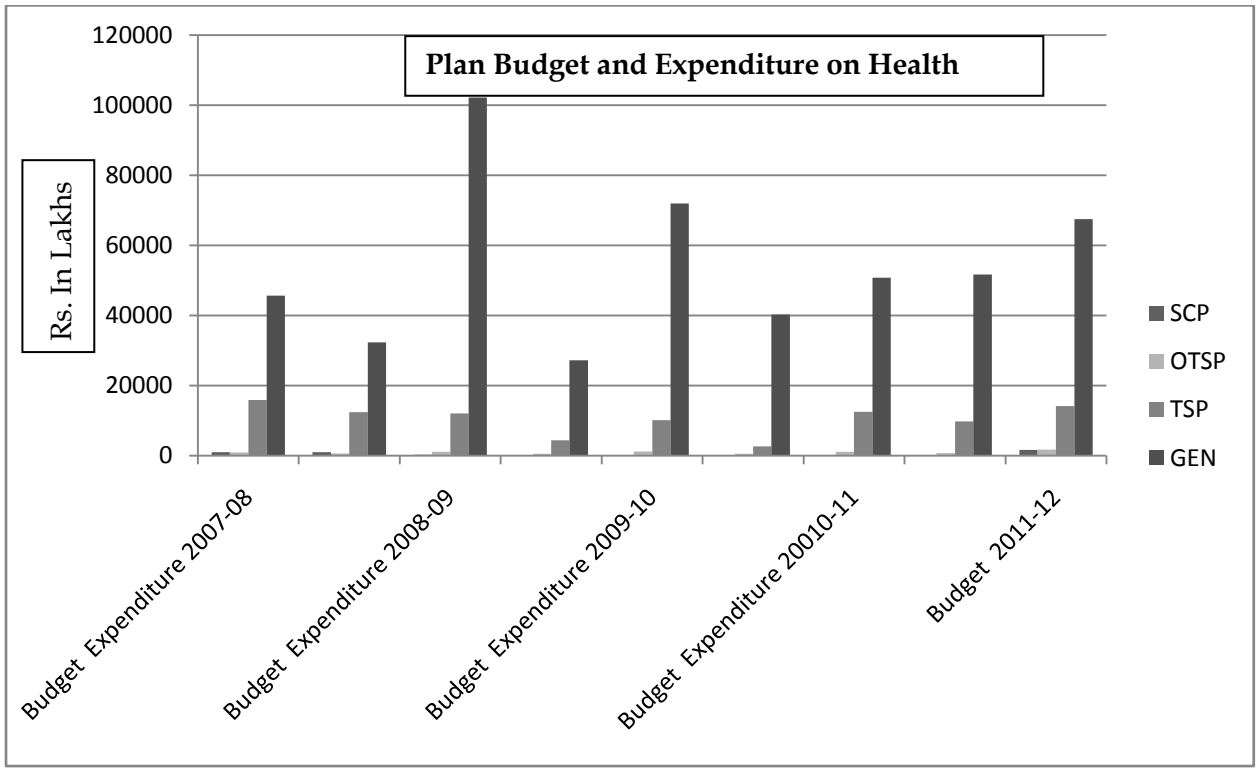
At the time of budget distribution, the Finance Department makes online distribution of funds to the Public Health Department. From here the distribution is made to the directorate level. For both plan and non-plan budget of DHS, the online fund transfer is made to the Joint Director, BAA. While demands for non-plan and also the plan budget grants, Grants-in-aid that are given to the ZP, are received by the Joint Director, BAA and thus they distribute directly; for the State Plan Budget, the planning unit plays the role of devising allocations. Thus, depending upon demand, fund availability and previous expenditure, the planning cell allocates the plan budget and sends it to the Joint Director, BAA. The latter does the distribution of funds as per the guidance of the planning cell.

The planning cell holds monthly meetings to review the progress of expenditure. The Joint Director, Planning Cell, holds a meeting. All the program officers and the eight divisional CEOs attend with reports of monthly and progressive expenditure.

[64] The state has been aware of the problems of uneven regional developmentand the related one of substantive poverty in the state for several years now. It hadtaken the unique step of estimating the 'development backlog' of the relatively lessdeveloped regions and the investments required to erase the backlog (NIPFP)

Figure 5.2: Plan Budget and Expenditure on Health

	Budget Expenditure 2007-08		Budget Expenditure 2008-09		Budget Expenditure 2009-10		Budget Expenditure 20010-11		Budget 2011-12
SCP	1040	1040	271	0	90	0	0	0	1600
OTSP	882	594	1109	581	1155	558	1108	763	1694
TSP	15893	12388	12030	4360	10116	2622	12486	9815	14198
GEN	45662	32335	102236	27178	72001	40251	50739	51664	67526



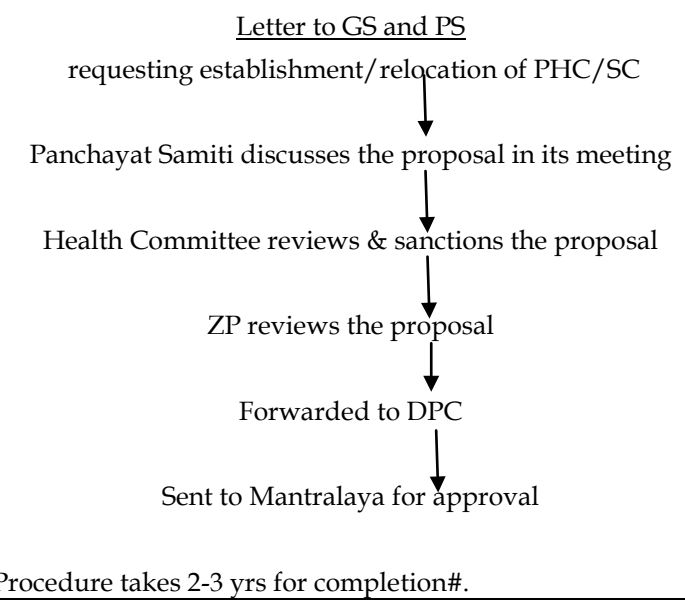
Note: Budget and expenditure related to PHC and Hospital Line, major heads 2210 and 4210 coordinated by the Deputy Director, Planning Cell, DHS.

Case of proposing a new PHC

The ZP DHO office has separate sections/desk officers, referred to as the 'Planning Cell', who deal after the formulation and coordinating process of Plan Budgets (District/local sector – DPC, TSP and OTSP). The Plan budget both in the General DPC and TSP, as also observed in Table 5.2 in the local scheme, contain schemes related to the component of new construction, renovation, maintenance, and so on.

The findings from the tracking exercise are presented below:

Figure 5.3: Flow of proposal for Establishment/Relocation of PHC/SC



Procedure takes 2-3 yrs for completion#.

A respondent reported the cumbersome procedures involved - that work needs to be sanctioned and approved from authorities outside the Department of Health, such as the state Public Works Department, issues such as land access need to be negotiated, and competent authorities need to provide a certificate of approval. All this requires coordination between multiple administrative authorities, which leads to delays in getting approval and to start work.

In District B, it was observed that in one taluka, the Taluka Health officer (THO) office took the initiative with the support of the local representative to go through all the processes at his level, such as preparing the note and submitting it to the local Gram Panchyat (GP) and Panchayat Samiti (PS) for discussion and received the approval of the general body, and a declaration in the form of an offer letter stating willingness to offer the land for the proposed construction of the new PHC submitted to the Collector stating that the land ownership right would stay with the district authority. The Collector refers the same to the Chief Executive Officer, ZP along with the information substantiated normative population norms, number of villages, distance from villages, etc. in the format specified by the planning cell of the DHO office.

The process is taken ahead by the planning cell, DHO. As reported in Districts A and B the general practice is that after receiving the proposal from the THO, for technical sanctioning[65]follow up is done with the engineer of the Public Works Department, ZP. After receiving the technical approval, the DHO proposes the demand in the subject committee (Health Committee), ZP for consideration. The proposal is tabled in the ZP governing body (final decision making body at the ZP) for final approval/authorisation of the ZP. Once it is approved, the approved proposals are sent to the DPC (District Collector is ex officio) to consider in the general plan budget of the DPC. The DHO corresponds with the Joint Director Planning Cell at the Directorate of Health Services (DHS) which is done by the CAO (Chief Administrative Officer of the DHO) during their monthly meeting with the DHS (Joint Director, PHC) for approval. (Figure 5. 3)

Now the situation is that the district-level unit prepared the necessary proposal and sent the proposal with the necessary paperwork required to get the project approved through two ways, one through the DPC and another to get consideration in the state plan. It is at the higher level, that is at the planning and finance department level, where it will be decided whether the proposal will be considered as approved in the District Plan or State Plan. This will be reflected in the District Plan budget document or in the State Plan document of the Health or Tribal or Planning Department.

[65]Includes parameters such as feasibility in a particular geographic area, estimation of the cost for construction and installation of the equipment.

As observed from various documents collected in District A, Table 5.2 highlights some of the schemes reflected in different components of the plan. For example, for the scheme for 'Construction of Primary Health Centres', the district as a unit receives the budget grant from the General District Plan- 2210 4751 and TSP plan-2210 4876. Similarly, there are other schemes; however, the subhead numbers are different for the same schemes thereby making it difficult to identify schemes from which funds are remitted to the agencies/spending units. In District A , while tracking plan budgets on the 'Construction of Primary Health Centres', it was unclear whether the proposal for the new PHCs had stalled at the level of technical sanction or at the administrative proposal or at the level of the District Collector or at the administrative department (health or tribal department). The basic issue here is the lack of integrated and user-friendly data.

Table 5.2: Multiple Schemes under the common Sub head for Plan Schemes at the District Level

TSP plan		**General District Plan**		
2210 4876	**2210 2934**	**2210 0558**	**2210 4751**	**2210 4769**
1. Establishment of Sub Centres	1. Increase in Medicine grants to Sub Centres	Increase in Medicine grants to Sub Centres		
2. Construction of Sub Centres	2. Providing Special Health Facilities in Sensitive Tribal Area			
3. Establishment and Maintenance of Primary Health Centres	3. Increase in Medicine Grants to Primary Health Centres	Increase in Medicine Grants to Primary Health Centres		
4. Construction of Primary Health Centres	4. Establishment of Primary Health Centres	Establishment of Primary Health Centres	Construction of Primary Health Centres	Strengthening of Primary Health Centres
5. Establishment/ Maintenance/ Construction of Health Institutions	5. Shifting of Primary Health Centres from Community Health Centres			
	6. Diet facilities to Primary Health Centres	Medical Examination of Ashram School going Children		

Sources : Various documents collected during the field work in District A ; Accounting structure follows at the district level are the 8 digits account system of which initial 4 digit is major for head (2210 for revenue account and 4210 capital account) which remain common across all the sectors of the government and remaining 4 digit is subhead /scheme name.

Hospital Line at the District Level

Like DHO or other Heads of Departments (HODs) at the ZP, the CS or HOD of the state line department sends budget demands to the DPC and receives allocations from the Collector. It was observed that the CS office plays an important role in preparing the proposal as a wish list[66]and sends it to the District Planning Committee (DPC) to consider it in the core group category of the District Plan budget (local sector). It was reported that the process starts with a letter by the DPC to the Civil Surgeon requesting budgetary proposals for purchase of materials and supplies (one of the scheme in core group). The Pharmacist then formulates the proposal (this includes demand for thehis own hospital, that is, the District hospital and also for the Rural hospitals in the districts) and sends it to the CS for his remarks. The CS finalises the proposal and forwards it to the DPC, which reviews the proposal and sanctions it. The sanctioned amount is sent to the Collector, who in turn communicates the sanctioned amount to the CS. The grants are released every three months through uploaded cash flow on BEAMS, which is later withdrawn from the treasury.

As observed in Districts A and B, the Plan grant for the purchase of medicines under the sub head scheme, 'Increase in Medicine grants to community health centres' is demanded from district funds (DPC) by the Civil Surgeon's office. Most respondents reported that short supply of medicines at the state level is met by using the DPC plan fund for medicines. The CS demand for medicines includes demand both for own institution (District Hospital) and also for all Rural Hospitals in the district. As reported in both the districts, the demand for the scheme, 'Increase in Medicine Grants to community health centres' is guided by the financial allocation norms. For the Rural Hospital, the revised allocation norms is Rs. 6 lakhs for the RHs in the tribal area and Rs. 4 lakhs for those in the non tribal area per year against the old allocation norm of Rs. 2 lakhs per RH. After the District Collector and the higher authority (Deputy Director, Health Circle) give administrative and technical sanctioning for the schemes, the Civil Surgeon coordinates the local purchase. In this context, a respondent reported that out of the total outlay approved in the DPC for the scheme, the district CS is authorised only 25 percent for local purchase; 25 percent lies with the Deputy Director, regional level for the purchase of laboratory and surgical equipment and 50 percent lies with the DHS for the centralised procurement system.

In a rather interesting reverse flow of interaction, the Medical Superintendent of RH asked the interviewer about the documents collected from the state level relating to the district. Looking at the DPC documents and the allocation for health, the MS responded shockingly,–

"We never knew that this is the budget for the district or under the DPC. We have not seen such a district DPC document before. We collect the medicine from the CS office; we don't know that some procurement are possible at the district level under this plan health budget. We don't even know whether it is procured by the CS or the Deputy Director. They just call us, 'Come and collect the medicines'; we just place our demand and receive the medicines- who does what we never come to know."

Thus, one can see even with the decentralised scheme of medicine that local purchase is the stop gap arrangement for small quantities of medicines.

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[66] Some of them are Grants-in-aid to Rural Hospital for line items like supply of medicines (Increase in Medicine grants to community health centres), Diet facilities in health centres, Upgradation of 30 Bed-Rural Hospital into 100 Bed Sub-District Hospital, Providing additional Facilities/Purchase of Additional Equipment in Hospistal Construction/Establishment of hospitals, etc.

One Rural Hospital has undergone the construction of boundary walls, postmortem room and a road inside the hospital. As reported in this case, the administrative approval was received in 2010-11, but the work was executed in the current year (2011-12) for which the outlay budget was Rs.26 lakhs. It was later noticed by the researcher that the activity was undertaken under the DPC fund, under the scheme head, 'Major Work-district administration' under the sub head 4059 1525. This was different from the usual subhead of health budget/expenditure head[1]. Thus, the DPC outlay and budget was re appropriated for the said construction (with necessary approval taken from the DPC and informed to the Planning Department) under the recent reform of delegation of power (both administrative and financial power) to the District Collector.

In both the PHC and hospital lines, the Plan budget grant flows to the district through various channels, DPC and health line department. The process seems complicated, because the information about expenditure data is scattered at many levels, the DHO, CS, DPC and tribal office. The DPC has information in terms of the outlay and expenditure for the General District Plan, but, it was observed that information about outlays related district plan of TSP and the SCP budget of district plan are with the respective agencies. Adding to the complexity, the State health plan schemes data are scattered in the various line offices operating at the regional and district levels. No single document contains all the basic information for budget analysis (Planning Commission, GOI).

The current system lacks comprehensive information on the plan budget processes at the district level, as observed in the plan expenditure data; some form of complied monthly physical and financial pprogress reports, monthly expenditure statements, activity-wise physical progress as well as financial progress are evaluated by the Deputy Director, Health Circle. The Deputy Director collects all health plan expenditure from the district and reports to the Planning Cell, DHS. A respondent reported, "it is the administrative role to collect from the district ZP and other health agencies and compile and report to the DHS.'

The State Government started publishing the district budget with only the District Plan (DPC) Component (Box. 5.2.). The Hon. Governor of the State directed 1 the State Government to include non-plan developmental expenditure while working out the above details of region-wise allocation and expenditure for all sectors.

Box 5.2: District General Plan Budget Document of District B

The Planning Department, Secretariat has published a separate document, since 2009-10, known as 'Civil Budget Estimates Past II, O- Planning Department: District Plan'. This document is prepared separately for each district with information (Budget estimate and expenditure data) pertaining to all schemes/matters relating to General District Plan. This informatory booklet is presented in the Legislative Assembly along with other mandated Budget documents.

Items	Act Exp 2009-10	BE 2010-11	RE 2010-11	BE 2011-12
(61) District Plan—[redacted]				
(61) (01) Grants for plan schemes under Section 187 of the Maharashtra Zilla Parishads and Panchayat Samitis Act, 1961. (2210 9822)	36,52			
31, Grant-in-aid (Non-Salary) ...		81,00	81,00	82,56
(61) (03) Grant-in-aid to Rural Hospial for Supply of Medicines (2210 9842)	28,00			
31 Grant-in-aid (Non-Salary) ...		20,00	40,00	28,00
(61) (04) Construction of Sub-Centres (2210 9851)				
31 Grant-in-aid (Non-Salary) ...	25,00	35,00	35,00	40,00
(61) (05) Repairs and Maintenance of Primary Health Centres/Subcentres (2210 9869)				
31 Grant-in-aid (Non-Salary) ...	20,00	..	..	..
(61) (06) Construction of Primary Health Centres (2210 9878)				
31 Grant-in-aid (Non-Salary) ...	2,00,00	..	..	..
(61) (07) Strengthening of Primary Health Centres (2210 9887)				
31 Grant-in-aid (Non-Salary) ...	2,50	..	..	..
(61) (08) Children Health Check-up Programme at Ashram School (2210 9896)				
31 Grant-in-aid (Non-Salary) ...		1,00	1,00	..
Total—2210 ...	..	1,37,00	5,36,00	4,40,56
	3,96,00			

In a rather interesting reverse flow of interaction, the Medical Superintendent of RH asked the interviewer about the documents collected from the state level relating to the district. Looking at the DPC documents and the allocation for health, the MS responded shockingly,–

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The State Government started publishing the district budget with only the District Plan (DPC) Component (Box. 5.2.). The Hon. Governor of the State directed[68]the State Government to include non-plan developmental expenditure while working out the above details of region-wise allocation and expenditure for all sectors.

[67] Health head usually is 4210 for capital expenditure or 2210 for revenue account for recurring expenditure. Initial 4 digitsare major for health which remains common across all the sectors of the government and the remaining 4 digitsare subhead /scheme name.

[68]Directives by the Governor of Maharashtra under Rule 7 of the Development Boards for Vidarbha, Marathwada and the Rest of Maharashtra Order, 2011, for regionwise distribution of outlays in the Annual Plan of FY 2012-13, http://rajbhavan.maharashtra.gov.in/ dated August 25, 2012.

CHAPTER 6

OVERSIGHT - INTERNAL AND EXTERNAL AUDIT

Internal oversight involves management control systems for ensuring compliance with rules and regulations, reliability of financial data and reports and for facilitating efficient government operations. Effective control over expenditure against the budgetary authorisation/provisions remains the key element in the internal control system in the administrative departments. The oversight system helps planning, implementing, supervising and monitoring an organisation's activities. The controls ensure that the entire operation at each level of administrative operation follows some basic standards in guarding against misuse and inefficient use of resources, countering fraud and error, checking maintenance of satisfactory accounting records, safeguarding government assets and determining whether budgetary objectives set out in the government policies are being achieved.

Departmental Oversight and Control of Expenditure

Each administrative department is responsible for oversight and control of expenditure against the sanctioned grants and appropriations placed at their disposal. Heads of Departments and Controlling Officers, and Disbursing Officers subordinate to them exercise this control. As observed in the case of the Finance and Health Department, they have a built-in control in the form of inspections, periodic meetings or monitoring through periodic progress reports.

The Finance Department, which manages the finances through its technical wing known as 'Directorate of Accounts and Treasury' (DAT), controls and monitors all the receipts and payments/disbursements of the government. The DAT has treasuries at the district and sub district levels, institutions from which field-level officers physically 'draw' funds allotted to them by the government. All treasuries report to the Directorate and also simultaneously to the external oversight agency, the Accountant General (AG) (Chart 6.1). The District Collector has assigned the responsibility[69]for general administration and functioning of the treasuries under his/her jurisdiction and reports to the Secretary, Finance Department. The District Collector does the routine inspections of the treasury. If irregularities of any kind are brought to the Collector by the AG or identified during the inspection, the Collector personally conducts investigations which are reported to the AG and Secretary, Finance Department. Line offices of the DAT at the regional level periodically review and inspect all the district and sub district treasuries. As observed/reported, there is the built-in internal oversight/control system for the monitoring /control of expenditure.

The Maharashtra Budget Manual (MBM) guides the control and monitoring of the progress of expenditure to ensure that financial operations and its reporting adhere to the laws and regulations in order to minimize the risk of errors and irregularities. The control and monitoring is done by reporting mechanism of obtaining Statements of Expenditure (SOE) from all the DDOs /Controlling Officers[70] in the format prescribed in the MBM. The

[69]Guided as per the Maharashtra Treasury Rule Book, 1968.

[70]Drawing and Disbursing Officers are placed in different areas and make withdrawals from the respective treasuries for disbursement within their jurisdiction. There are more than one Drawing and

Controlling Officer consolidates the figures supplied by his/her subordinate offices and sends a consolidated statement to his/her Head of Department by the 15th of the same month. The Head of Department will consolidate the figures for the Department as a whole, and add to them the figures of book adjustments carried out by the Accountant General. He/she then prepares a statement in the same form in duplicate and sends one copy to the administrative Secretariat concerned and the other to the Finance Department by the end of the same month. Theoretically, the manual prescribes the system for monitoring the progress of expenditure. While this practice is followed in the DHS by sending a hard copy of the Statement, there is the absence of the use of modern computerized technology.

DHS Internal Audit

Under the Directorate of Health Services (DHS), the internal audit cell in BAA headed by the Jt. Director and assisted by the Assistant Director, BAA , is also entrusted with the internal audit and assessment of health grants (Grants-in-aid) given to the ZPs. This officer is also the controlling officer who distributes grants to the DDOs, conducts internal audits of their line offices just as the Dy. Director; Regional Health Circle conducts audits of SDH, RH. Similarly the Jt. Director malaria, filaria undertakes the audit of DMO.

A respondent mentioned that the staffs allocated for the internal audit functions was inadequate and therefore conducting the internal audits of about 700 DDOs proved difficult. As an interim arrangement, there was some division and delegation of work. The internal audit cell carries out internal audit for all the offices of the Program Bureau in charge, eight Deputy Directors, regional circle, civil hospitals and mental hospitals.

Account and audit is a joint responsibility, as it is the prevalent practice in India. Internal audit is set up as part of the Accounts Section. As there is no segregation of duties for internal audit and disbursement and accounting functions, there is potential conflict of interests that might hamper the effective functioning of the internal audit. Thus as oversight, the internal audit is vested with the Controller of Accounts, who is also responsible for accounting and disbursement functions.

The Secretary of the Department, as part of the management, is responsible for the internal audit and internal inspection in the department to ensure both accuracy in accounts and efficiency in operation. The Public Health Department had constituted a team comprising the Assistant Director, BAA, Chief Administrative Office of DHS and a Pharmacist for conducting inspection on a regular basis through the year. A respondent stated that the oversight mechanism was set up in the context of misappropriation/irregularity that happened under the line item, 'Material and Supplies'- an excessive purchase/expenditure incurred than that proposed in 2008-09. The team is assigned to inspect store verification once a year, actual and balance available and purchase of stores and stocks at the regional office of the Deputy Director level, one district in the jurisdiction of the Deputy Director, one SDH, RH, and one PHC level of that district.

Thus there are various mechanisms to control and monitor the expenditure. The responsibility for monitoring the progress of expenditure against a grant rests with the executive, who is ultimately responsible for keeping the expenditure within that Grant. As reported by the Second Administration Reforms Commission, "Internal controls can be regarded as one of the foundations of good governance and the first line of defense against improprieties. They also provide the public with 'reasonable assurances' that if

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Disbursing officers under a Controlling Officer. The Head of the Department exercises control over his Controlling Officers.

improprieties do occur, they will be made transparent and appropriately addressed" (ARC 14th Report).

External Audit

The external oversight is conducted through legislature committees such as Estimate Committees, Public Accounts Committee (PAC), Panchayati Raj Institutions (PRI) Committee in order to exercise control over the executive to ensure that funds approved have been utilised with due regard to economy and efficiency, for the purpose intended, to reduce bureaucratic corruption and abuse of power. To facilitate the legislative oversight on public expenditure and revenue, the Comptroller and Auditor General (CAG) or Accountant General (AG) of the State discharges all the duties and performs the dual role of compiling the accounts of the state government and conducting the audit of the state accounts and placing them in the legislature. Thus, the legislature oversight conducts the ex post scrutiny on the basis of audit findings after budget implementation. The Constitution of India has provided that the Comptroller and Auditor General of India (CAG) is a high independent statutory authority. The Constitution prescribes exhaustive safeguards for the independent functioning of the CAG. The range of audit performed by the CAG includes regularity (financial) audit, regularity (compliance with law and rules) audit and performance audit. The Audit reports raise many important issues about weak budgetary controls, inappropriate accounting, deficiencies in revenue collection, wastage of public resources, poor returns on investments, diversion of funds, system deficiencies and numerous instances of poor management of public resources. The audit findings assist the legislature in exercising control over the executive to ensure that funds approved have been utilised efficiently.

This external oversight agency, through its report, has exposed a number of misappropriations and system deficiencies. However, one can see in a number of instances, that the CAG, when it raises serious concerns, usually makes remarks like "response awaited from the department" implying the executive's inherent tendency to evade or subvert external control.

Audit of Local Government

For the local government, urban local bodies and PRIs, assessing, supervising the accounts and audit are done by a recently institutionalised agency, 'Directorate for Local Fund Accounts Audits (DLFAA)'. The Maharashtra ordinance[71]amended the Bombay Local Fund Audit Act, 1930 giving new status to DLFAA as a separate directorate to conduct the statutory audit of PRIs, certify the Annual Accounts prepared by the Zilla Parishad, and prepare an annual audit review report on the financial working of PRIs for placing it before the State Legislature for oversight. The Legislative Committee, the Panchayati Raj Committee (PRC) call witnesses/administrator to answers questions on matters related to the department's activities and report to the State Legislature. The External audit of accounts of all the administrative departments of the Government of Maharashtra (GOM) till the point of release of funds through BDS to the PRIs (ZP) are conducted by the Accountant General, whereas the external audit of accounts of the PRIs are conducted by the DLFAA.

The oversight is done through democratic set processes, for instance, Legislative committees call witnesses on matters related to the Department's activities and report to the Legislature. However, there is a significant time lag in the scrutiny of the audit report, as observed for

[71]Maharashtra Ordinance No. V of 2011

2011-12; the committee has tabled its scrutiny report (available on the website[72]) of 2005-06 audit report in the legislature.

At the ZP (1st tier of PRIs) as reported in most of the cases, the financial management responsibilities rest with the Chief Accounts and Finance Officer ,

(CAFO), head of the Finance Department which functions under the overall control of the Chief Executive Officer (CEO) of the Zilla Parishad. The CAFO's responsibilities as enumerated in the Legislature Act and rules[73] include

(a) Drawing and Disbursing Officer

(b) Accounting Officer

(c) Primary Auditor

(d) Financial Advisor.

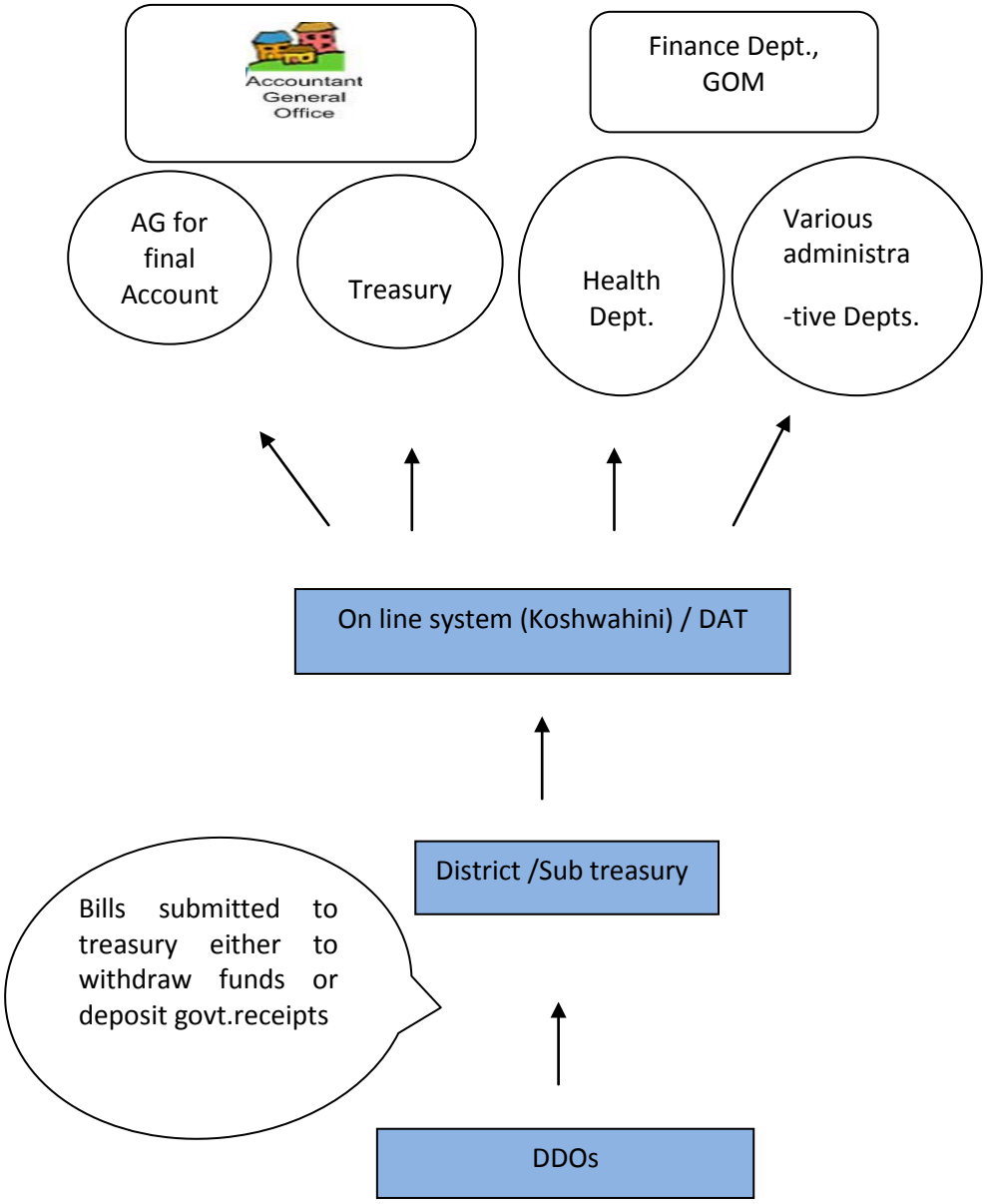
To fulfill these critical financial responsibilities, the CAFO office has different sections/units such as Budget Unit, Compilation Unit, Accounts and Audit, Payroll scrutiny, processing pensions of ex-employees of the ZP etc. The Accounts Section in the CAFO office seeks account statements of revenue and expenditure and the variation of the expenditure from the final modified grants from the taluka. The BDO, compiles them, verifies its accounts with treasury register books and reconciles with the AG office every month to ensure proper accounting of the funds, which also help the ZP office to come up with the Annual accounts. The mandated Annual account statement[74] is prepared and placed before the subject committee, Finance Committee of ZP for oversight. The audit section scrutinizes all the bills received from the various departments including the Health Department of the ZP. It also conducts the internal audit, preliminary checking of all the transactions relating to receipts or expenditure likely to be challenged on the application of a primary audit by the DLFAA.

[72]http://mls.org.in/Vidhanmandal_Samitya.aspx#

[73]Maharashtra Zilla Parishad and Panchyat Samiti Act ,1961 and Zilla Parishad and Panchyat Samiti Accounts Code 1968.

[74]As per the ZP & PS Act, 1961.Para 136 (1).

Figure 6.1: Internal and External Control System through Treasury



Note: When the DDO submits authorised bills to the treasury, money is given to the Drawing and Disbursing Officers for implementation of the scheme and vouchers (passed bills) are passed on to the Pr. Accountant General Office along with initial accounts by the Treasury Offices for compilation of Accounts. Similarly, Government Receipts are also collected in the Treasury and the accounts of receipts are passed on to the Pr. Accountant General Office for compilation of Accounts. The AG's office performs voucher-level computerisation to compile the monthly accounts received from all treasuries and submits a consolidated account to the state government.

Given the above context and broad observations, the research findings are as follows:

Internal and External Audit at PHCs, THO and BDO

Most respondents at PHC and DHO reported that there is internal oversight (audit) by the CAFO, and the external audits are done by district staff of DLFAA and by the Accountant General (AG).

Internal regular audit is done by the CAFO, Head of the Accounts and Finance Department in the ZP, once in a year. Apart from regular audit, there is also special oversight where the CAFO sends an investigation team for checking the specific activities with the intended purpose. Most of the PHCs and the THO office reported that the investigation team or what is known as the "audit team" was from the CAFO's office. The team visits the Panchayat Samiti (PS) office and is accompanied by the accountant from the PS. The team comprises usually three to four people headed by one person and it carries the audit either at the CAFO's office or at the BDO's office or at times, visits the PHCs/THO. The members of the team divide the work amongst themselves - one looks at the cash book, another looks at salary bills, equipment, medicines, accounts, musters, service book and so on. As was reported in one instance, the special team was appointed by the CAFO to visit the taluka place (PS) to cross check the pay revision (Sixth Pay) calculation done by the PHC clerk, check the service books[75]of all the staff along with the salary bill vouchers. In another instance, it was reported in one taluka in District A that the internal oversight/investigation teams visited the Taluka Panchayat Samiti (PS) office to compile accounts statements as there was no proper reporting and there was delay in the submission of the statement to the ZP and also to investigate the reason for such delay and non-reporting.

Many respondents at the PHCs reported that most of the audit observations or issues/remarks raised are about the errors in calculating salary increment payment, incorrect accounting and incomplete accounting in the cash book, errors in calculating leave and privilege leave and its records. The issues are resolved by following the instructions of the internal auditor, making the necessary changes, updating the records and documenting the remedial action taken in the watch register[76]and settling the compliance in the form of responding to the objections raised by the internal audit. In one such case, compliance was settled by recovering the excess amount paid to one of the PHC staff. The error observed by the internal auditor related to an excess salary increment of Rs. 170/- per month paid for almost 10-11 years; thus the compliance was settled with the recovery amount of Rs. 17,000/-.

It was observed that there are rules that guide the CAFO in its responsibility for the internal audit and periodic checking of account records. It was difficult for the researcher to get internal audit tour details, the number and the nature of the audit. The audit report on local government[77]on a number of occasions had raised concern about the weak or inefficient functioning of the internal audit system in PRIs (local bodies).

[75]Employee details regarding the date of joining till his/her retirement, his/her increment, posting, transfers, leaves taken, leave without pay, leaves encashed, etc.

[76]Register to maintain a record of issues raised by the auditor and the action taken to clear the objection.

[77]Fourth and Fifth Report of the Comptroller and Auditor General of India on Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs) in Maharashtra.

External Audit

External audit for all the PHCs are done by the regional and district staff of the Directorate for Local Fund Accounts Audits (DLFAA), generally in the month of September and October. The Accountant General (AG) conducts the test audit held once in a five year period. Audits are mostly on accounting and the financial transactions in the PHC, THO and BDO.

In one Taluka in District B, the DLFAA auditor had made some audit observations on PHCs in the form of a Half Margin Memo. A summary report of their observations made during a visit, (explained in Box 6.1) addressed to the institution headwas received by the Taluka Medical office to respond as compliance. The audit and compliance settlement was for the period 2004-05 to 2007-08. It was reported that the memo was read department wise in the CEO's office, ZP wherein the Chief Administrative Office (CAO) facilitated this meeting to seek the responses from the subordinate officers of the respective departments.

It was observed that the auditor, either DLFAA or AG, follows the procedures for settling the objections. The auditor gives time to the agency to respond to audit (objection) findings, after which issues and concerns are taken in the form of audit Para in their report. The following box (Box 6.1) provides a brief on this process about the audit objection as reflected as 'Para' in audit report.

Most respondents reported that objections raised by the external auditors are settled or compliance is made by making necessary corrections in the record as instructed and recoveries if excess payments are made for miscalculation of the payment.

Box 6.1: Audit Process : Field Day Observations to Para in the Audit Report
In the audit report, generally, we read that the auditor had to raise the issues/concerns/observations in the form of Para on under assessment of tax, irregularities and misuse of expenditure, whether expenditure incurred was in conformity with the laws, rules and regulations, etc. How this irregularity para is arrived at is not known to the general public. The attempt here is to brief about the process/stages of the audit which are ultimately reflected in the audit report.
In the case of any audit (finance, performance) by the external agency, during its visit to the facility or agency/office, they check records, as most of them reported that both the internal auditors examine/scrutinize the same records as those for external auditors. On identifying the issues and concerns, the auditor team issues a half margin memo, which includes a summary of the informatory visit and an examination of files/records to the agency, expecting the head of that unit to comment satisfactorily on the half margin memo. If it is found convincing, then there is no further probe.
During the visit to the unit, the auditor collects records and documents for further scrutiny at their head office for preparing the draft inspection report. The issues identified in the inspection report are forwarded to the respective department heads for clarification, for example, if the concerns/observations are related to the PHC, the report are sent to the DHO and CEO of the ZP . If the case is of similar nature across departments, the finance accounts records are cross validated. Thus, the Registry of Financial Accounts (RFA) is prepared by the auditors, with the expectation that the Head of the Department will respond, and if the reply is found convincing the statement of finding (SOF) closes the accounts file. If not found convincing, the draft Para is proposed and communicated to the Department before inclusion in the CAG report.

As was observed in both Districts A and B, the ZP publishes the Administrative Report, as mandated under the Maharashtra ZP and PS ACT[78]. Along with other departmental information, it includes a section on audit notes with the replies thereto reported separately for the ZP and PS. The scant information provided in this administrative report makes it impossible to correlate the objection raised, response to the objection by the official and the action taken in terms of remedial measures.

Hospital Line

Internal and external audit and inspection are undertaken by different agencies. Most of the respondents (sample rural hospital, district and sub district hospital) reported that they undergo the statutory account audit by the Accountant General (AG). Medical store or equipment statutory physical verification is done by the Store Verification unit of the DAT, Finance Department. Stores Verification involves the reconciliation of the actual available stores and stocks balances of hospitals with their Assets/book balances, verification of the actual stock with the description of the Stock taken to the register, verification of the

[78]Section 142 which states that every Zilla Parishad shall publish the administration report in such form and in such manner as the State Government may prescribe and the report shall be laid before each House of the State Legislature as soon as it is published. It should also include in its administration report the audit notes with the replies thereto, as also the report of the Panchayat Samiti received by it.

quantum of various stocks/items used, whether it was in excess of the requirement, and whether the losses/shortages shown are correct and reasonable. Purchase procedure of stocks and stores as also the necessity to purchase them is verified.

As reported by the respondents, the internal audit and inspection is a routine exercise done once a year throughout the department line offices. The internal audit involves scrutiny of cash book, salary and other payment bills, equipment, medicines, attendance musters and service book of individual employees, registers[79]detailing the receipts deposited in the treasury and expenditure (withdrawal) from the treasury with treasury voucher number of bills.

As was observed in District A, the internal audit and inspection of the RH are done by the District Civil Surgeon's office. The audit team comprises the team headed by the Chief Administrative Officer (CAO), accountants and the pharmacist from the Civil Surgeon's office and usually four persons visit each RH for internal investigation and audit. The Civil Surgeon is supported by the administrative unit headed by the Chief Administrative Officer (CAO) placed in the CS office and shares the responsibilities of the CS on issues of administrative functioning such as ensuring that the rural and sub district Hospitals record accounts in compliance with governments rules and procedures and report reliable financial data.

The CAO submits the investigation report to the CS and also shares the same report in the monthly meeting held with the CAO at the Deputy Director's office. In District B, internal audit and inspection of the RH in the district was reported to be usually conducted by the Deputy Director, Health Circle Regional Office (by the Grant Controlling Officer) and not by the District Civil Surgeon (CS) office, as the CS was placed in the teaching hospital and did not have a separate office or full time officials. Another District Civil Surgeon's office had full staff support with the Chief Administrative Officer (CAO), Administrative Officer (AO) and a few accountants to conduct internal audit and investigations. Thus, the oversight was taken care by the Deputy Director's office.

Once the expenditure is incurred or funds are withdrawn by DDOs through treasury, the expenditures are booked with the AG's account with the treasury voucher numbers of the bills, as treasuries submit their data to the AG. The monthly or quarterly Statement of Expenditure (SOE) with the details on treasury voucher number bills are acquired by the internal auditor (CS office in District A and Dy. Director Health circle in District B are assigned with the responsibilities to reconciliation the account with the AG). Reconciliation verifies the expenditure mentioned in the treasury and the DDOs are booked under proper budget account heads to rectify errors in booking expenditure and receipts. The reconciliation is done on the web based application developed in the office of the Accountant General (AG) for facilitating an online system[80]. This helps the controlling office to keep track of allocated grants and the actual expenditure incurred by the DDOs under their control.

[79]Registers required as per Maharashtra Treasury Rules, Maharashtra Contingent Expenditure Rules, Budget Manual, Maharashtra Civil Services Rules, Medical dept etc. are to be maintained.

[80]Reconciliation of the receipts and expenditure with the AG is done on a web based http://agmaha.cag.gov.in.The DDOs or Controlling Officers with the designated 10 digit entry of voucher level details , as the acknowledgement of entry with the AG he/she take the Reconciliation Acknowledgement Printout .

Dy. Director, Regional Health Circle Office

The regional health circle office, as discussed earlier, holds the responsibilities of fund distribution and controlling the expenditure to the DDOs of the Civil (district) and rural hospitals, prepares the reappropriation accounts- original grants and final modified grants expenditure statement of all major head of accounts, and compiles and submits the consolidated expenditure statement (SOE) to the higher authorities for accounting purposes. Apart from this, the Dy. Director attends human resources related enquires/complaints as instructed by the higher authorities, conducts internal audit and inspections and physical verification of stock and stores. The Dy. Director, health circle office functions as subordinate officer of the Jt. Director, BAA. Internal controls take the form of inspections, periodic meetings or monitoring through periodic progress reports.

It was observed in both the regional circle offices that the Dy. Director's office has assigned responsibilities to the administrative officer, CAO, (Annexure 6.1) to support the Dy. Director in executing the administrative functions. The CAO, on behalf of the Dy. Director, convenes the meeting on a fixed date every month to take stock of the activities from all subordinate CAOs and Administrative Officers (AOs) operating in the DHO, sub district and rural hospitals and other public health line officials (such as district malaria, leprosy, TB etc) of the Public Health Department at the district level. The meeting discusses the issues related to budget expenditure, reporting for both non plan and plan expenditure, takes stock of the status of the reconciliation[81] with the AG at different levels, takes stock of existing human resources in different offices and plans activities for the improvement of the performance of health indicators.

The Dy. Director's office at the regional level plays an important role, apart from the responsibilities of fund distribution and controlling the expenditure to the DDOs, it compiles the health indicators and submits them to the concerned higher authorities, Bureau Chief (program), Jt. Director and DHS, obtains inspection and internal audit report conducted by the subordinate CAO and Administrative Officers (AO) at the Hospital Line and PHC Line. The Dy. Director also updates himself/herself by taking stock of observations/audit raised by external oversight agencies and responses submitted.

Jt. Director, Budget, Accounts and Administration (BAA)

The BAA wing of DHS is responsible for accounting and internal audit and is headed by a Jt. Director who functions under the DHS. The Joint Director is supported by an Asst. Director, Budget, Accounts and Audit. The Jt. Director and Asst. Director are both non-medical persons with a background in finance and accounts and highly experienced staff deputed from the Finance Department. This wing also functions closely with the Finance Department at the Secretariat level. The BAA wing has a unit with a small team specifically assigned for internal audit and the assessment of the health grant given to the ZP to ensure that financial operations and its reporting adhere to the laws and regulations, codes and manuals to minimise the risk of errors and irregularities. Another important function of the BAA is to coordinate with the various offices of the Department and expedite the settlement of audit Paras contained in the Inspection Reports issued by the Accountant General.

[81]Reconciliation with the AG is done to check that the expenditure mentioned in the Treasury and the DDOs are booked under proper budget account heads to rectify errors in booking expenditure and receipts.

It was observed that there were delays in the internal audit of the district civil hospital and other offices. A respondent from the BAA reported that since mid 2009 efforts have been made to set the target (number of institutions) and ensure that the turn comes back in one and a half to two years or so. It was reported that audits for district civil hospitals for 2004-05 had been completed, and in 2011-12, three district hospitals have been selected for the audit for the financial year 2008-09. While the importance of internal audit is well recognised, the respondent reported that considerable delays occur due to insufficient human resources.

The unit also conducts the assessment of health Grants-in-aid given to the ZPs. This assessment is to ascertain whether any amount has remained unspent with the ZPs or whether the grants have been diverted for other purposes. The review of the internal control mechanism in the health department was conducted by the AG in the Audit Report (Civil) for the year ended March 31, 2005. It was reported that the Jt. Director was not able to exercise proper budgetary controls for releasing grants-in-aid to Zilla Parishads. The 2010 report raises the concern of inefficient discharge of functions, "*introduction of distribution of cash grants does not dispense with the system of assessment of grants*" given by the different departments to the ZPs.

To conclude, the internal audits are in the form of inspections, periodic meetings or monitoring through periodic progress reports. Most of the reports are prepared and submitted to their respective authorities. However, access to the hitherto privileged documents such as report of inspection or proceedings was not made available to the researcher. The Second Administrative Commission Report (ARC in its 14th report) stated that in India, internal audits are conducted in a routine manner and have not been updated over several decades and do not assess the risk at the aggregate level. Internal audits are mostly related to observing that the accounting procedures are in compliance with the law.

The importance of oversight in budgetary processes cannot be overstated as a tool to determine if budgetary objectives are being achieved or to guard against misuse and inefficient use of resources or to counter fraud and error or to monitor maintenance of satisfactory accounting records or in safeguarding government assets. However, the study found a weak legislative oversight, which is made further ineffective by the significant time lag in the scrutiny of the audit report, thus defeating the purpose of the democratic process of legislative oversight. With regard to the internal audit, the scant information that is generated about action taken by the department vis-v-vis budget decisions is not made available to the public. Unavailability of audit information makes it difficult for common people to be informed about the amount of money forgone because of irregularities or misappropriation.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

The conclusions that can be drawn from this large and varied body of text are as follows:

Starting from the first point of contact in health care service provision, at the PHC level, the process of formulating and demanding budgetary estimates isnot very structured and systematic in practice and also not directed/guided by defined guidelines. It was also noticed that the budget estimates are not sent to the higher authority in time leading to delay in the entire chain of events. Overall, this might result in a substantial disconnect between the need, the demand and receipt of resources which may lead to inadequate and/or inefficient fund allocation management.

Ambiguity about the roles and responsibilities related to the budget has resulted in the non-availability of budget related data/information at the PHC, Taluka and DHO levels.PHC wise or taluka wise disaggregated information is not available with the District level authorities (DHO).

When it comes to the distribution of grants, the grant distribution authority (Controlling Officer) tends to control the expenditure by approving lesser amounts against the budget that has been demanded, or by releasing lesser grants against those approved, in turn allowing scope for reappropriation by the Controlling Officer.The process of budget allocations and decisions on spending hasan entirely top-down approach. For example, the study observed that at the service delivery unit, hospitals lack the flexibility to know the information of fund flows and budget which is essential to understand their financial entitlements and also to safeguard against funds being pulled back by higher levels of officials.In practice, the controlling mechanisms are implemented to curb the unevenness of expenditure, yetthe rush of expenditure remains a problem due to weak informationon the cash flow to the hospitals.

The account and audit is the responsibility of the Jt. Director, BAA who heads the Internal Audit Cell of the Directorate of Health Servicesas it is the prevalent practice in India. Internal audit is part of the accounts section in the government setup. As there is no segregation of duties and responsibilities of the Jt. Director, BAA and Asst. Director, BAA, there is potential of conflict of interest that might hamper the effective functioning of the Internal Audit. The oversight of internal audit is vested with the Controller of Accounts, who is also responsible for accounting and disbursement functions in the case of DHS, Internal Audits.

The processor oversight is at each level of the administrative operations to determine whether budgetary objectives are being achieved. It acts as a safeguard against misuse and inefficient use of resources, countering fraud and error, checking maintenance of satisfactory accounting records and safeguarding government assets. However, significant time lag in the scrutiny of audit report, which is the prime objective of democratic processes of legislative oversight, is defeated. The internal audit with scant information to the public about actions taken by the department makes it difficult for common people to abstract information about the amount of money forgone owing to irregularities and lack of sight or misappropriation.

One of the many challenges faced by individuals and researchers while trying to analyse a government's budget is securing necessary information such as the budget document, policy documents and information on plans and programs. In the absence of comprehensive, timely and accessible information about spending and outcomes, real accountability and learning are practically impossible. This is a major gap that must be addressed.

Recommendations

Information about health inputs and outcomes are necessary for formulating policies and monitoring activities, whether they are related to budgetary/fund allocation, human resources or infrastructure. An optimal use of Information Technology and an enhanced level of computerization should be used for recording the budget demands sent by the frontline healthcare service providers to the respective higher authority. This would place a great amount of information in the hands of the department and also reduce subjectivism in the transfer of funds. It would reduce the discretionary power in the hands of the Controlling Officers, track the flow of funds and disseminate information ensuring transparency in all transactions, which will contribute to improvements in budget transparency.

Budget transparency and accountability work is constrained by the paucity of information and formal and informal opportunities to engage in the budget process. In both these systems (and others), there are also a variety of semi-autonomous structures at the local level, or even at the level of the institution, such as the hospital. It is especially critical that information about the roles and responsibilities at each level, from the Directorate to the sub-centre level, should be made transparent when systems operate according to such complex divisions of labour. This sound management practice is important for public transparency.

In recent times, there has been considerable improvement in budget transparency. The budgetary allocations alongwith statistical information of health (and other) funds whichare decentralized are made available in the public domain as part of the budget document. Change is meaningful but slow, and there is fear of possible backsliding. The Directives by the Governor of Maharashtra in this regard, guided the state government to include district wise disaggregated non-plan expenditure. The Department should follow the directives and continuepublishing such information more often, disseminate it widely and make it available on the website for public use. A robust financial information system needs to be created in the Department. In line with the recommendations of the Second Administrative Reforms Commission, the Department should make accessible to the public real time data on budget and expenditure at all levels. This would also be honoring the spirit of the Right to Information which mandates that government organisations should attempt to provide maximum information through voluntary disclosures[82].

The current system lacks comprehensive information on the health budget and expenditure, particularly at the regional anddistrict levels. This needs to be remedied at the earliest. At the regional level, the Deputy Director, Health Circle is assigned administrative role and collects, compiles monthly expenditure statements, physical and financial progress reports of the Health Department. Substantiating the fact that the Deputy Director is the Controlling Officer, he/she receives the budget demand from the all the hospitals in the district, distributes grants and reconciles with the AG. District level data are made available with the Deputy Director, Health at the regional level. In addition to the above, the Dy. Director is also a member of the DPC, and he/she also collects the statement of expenditure and

[82]Recommendation 5.3.5 ,14 Report of the Administrative Reform Commission.

physical and financial progress statement from the Collectors and the ZP. This demand can be put forward to the DHS, Health Department and the Dy. Director, Health Circle to provide such disaggregated data in the Performance Budget.

The Performance Budget, of the Public Health Department gives an overview of the healthcare system of Maharashtra with information provided in the volume. However, at present, the Public Health and Medical Education Departments' performance budget has shrunk to a considerably small volume. The number of pages which used to have most of the important information related to the performance indicators of the facilities, expenditure and financial requirement do not appear in the present version. The current performance budget document has limited information, disaggregated allocation, role and responsibilities. Even if one wants to access backdated information, this rich resource is not available on the Public Health Department website.

At the district level, given the fact that that there are multiple grant distribution authorities (Controlling Officers) through whom funds flow to the frontline providers, the Civil Surgeon does not have the budget and expenditure details of all these hospitals under his/her jurisdiction. Information pertaining to the budget and expenditure must be sought by the Civil Surgeon from all the hospitals within the district to monitor the process of budget allocations and decisions on spending, which has hitherto remained exclusively with the respective Controlling Officers. This should be followed by enhancing citizens' access to budgetary information at the district level. Such transparency will bring in demands for accountability about budget related decisions taken by the Controlling Officers at the district level.

It is the government's responsibility to build the capacities of government institutions in the basics of budget-making, especially of frontline institutions of service delivery like, primary health centre and hospitals. At the level of PHC, they lack the requisite skill to prepare the budget demand and maintain records. Substantial understaffing was noticed in the clerical and accountslevel, which hampers various activities including implementation, planning and reporting. The state government, needs to address implementation bottlenecks and staff training.

The Maharashtra Budget Manual, which is supposed to provide the last word on all budget related matters and is the main source of instructions for regulating the budgetary and accounting procedure, remains a backdated document. The Manual's latest version happens to be from 1994, since then changes have taken place in the budgetary processes and procedures, which were implemented through the mechanism of instructions and guidelines through various GRs and circulars. These are not formally documented till date and the information flow regarding budgetary processes remains highly centralized. The Maharashtra Budget Manual has remained static around financial management and has not evolved to include linked issues related to accountability, gender sensitivity, transparency and participation, or addressing social exclusion. These remain issues that need to be addressed.

The Right to Information Act (RTI) law enacted by the Parliament of India in 2005 allows the citizens of India to access records of the Central and State Governments. The Act also recommends that every public authority computerize their records andproactively publish certain categories for wide dissemination.These two enactments are remarkable landmarks to break the state's monopoly over official oversight and legitimizes citizen-inclusion into exclusive affairs of the state. The window of opportunity these acts provide needs to be utilised well, so that budget processes are further democratised in the state.

The importance of interface of citizen with the auditor is well noticed and so is the participation of civil society in terms of informing the auditors about the quality of public services. In the given situation, the role of civil society groups can start by developing an effective interface with the CAG/Accountant General/DLFA when local audits take place. This element is critical, because it is at the local level that service delivery becomes the key fulcrum of budget work. Therefore, how adequate the budget is to meet the service delivery needs of the people and how effectively the resources are used become key questions to be answered. The Mahatma Gandhi National Rural Guarantee Act, 2005 (MGNREGA) presents an opportunity to do this wherein the CAG's formal audit includes a community-led social audit.

Further Areas of Research / The Way Forward

This study has tried to shed light on the complexity of the budgetary process of the State Government. The study has unfolded various intricacies involved in the budgetary process at different levels hierarchically, from the frontline service providers to the ministry level. The key issue of lack in transparency within all the administrative levels comes forth as a major finding of this research effort. However, apart from understanding the budgetary process, there is scope for considerable research especially in the area of fund allocations or fund transfers. It has been noticed all over the world, that the transfer systems are often based not on the demand for services, but on the supply of infrastructure, thus leading to inefficiency. When the supply of infrastructure is distributed inequitably, this supply-driven allocation also increases inequality. For example, suppose that the wealthy areas of the state have a surplus of high end hospitals, which are expensive to run, funds may be allocated to keep them functional, even if they are not occupied. On the other hand, there may be a high demand for primary care services in poorer areas where there are no health services. If funds are allocated where there is an oversupply of health care facilities, rather than where there is an unmet demand for health care services, the allocation is both inefficient and inequitable. In order to meet the goals of efficiency and equity, the government needs to allocate scarce public resources to areas that have a demand for them. This calls for studying demand and planning allocations in line with analysis of service provision for the benefit of the people/target population.

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Annexure 1.1: Interview Guidelines

Institutional Structures
What is the nature of this institution/agency/facility? Please describe role, association, contribution to the health care services and resources for health services providers. (Note: These would include Planning and Budgeting, Distribution of the public spending, Information flow, oversight, monitoring) [Note: The agencies would include, autonomous body like District Planning Council, Tribal office, local fund audit office][1]
To carry out your role and responsibilities as specified, what is the administrative hierarchy? What is the composition? Which line department/office are you part of? [1]
What is the extent of your association with the healthcare services and resources for health services providers (list out name of agencies associated)? Is this association guided by certain Act, administrative guidelines? What are the mechanisms/ process of coordination?[1]
Administrative Processes and Information Flow
What information regarding health care services / resources for health services providers/oversight do you have? What is the nature of this information? (Note: These would include multiple channels of fund/budget/expenditure and information flow, oversight/ service and performance indicators.)
Do you do any analysis/compilation of the data (service/financial, as applicable)? If yes, what is the nature of that exercise? Is the exercise guided by any Act/guidelines?[1]
Administrative Processes governing Allocations, Expenditure
Do you have any role in **process of preparation and finalising** with respect to expenditure/allocation/ budget proposal? If YES , how is the finalisation done? (stages and steps) If NO, who plays the role? [Note: These would also include, various act, rules, guideline involved with respect to allocation, oversight] *Probe 1. Does any Act determine the amount that has to be proposed?* *Probe 2. Which are the stages of the process that you are involved in (Planning /execution /post budget or other)?* *Probe 3: How is the need assessment done ?*[1]
Do you have any role in process of **plan vetting**, if YES , please elaborate; if NO, who plays the role *Probe 1: If there is any discrepancy what do you do?*[1]
Do you have any role in the **process of plan approval**, if YES, please elaborate; if NO, who plays the role? How is the approval done (stages and steps) ?[1]

Note: These would include, autonomous body like District Planning council, ZP, demanding contingency fund. *Probe 1.Does any Act, guidelines or precedence determine the amount that has to be approved?* *Probe 2.Which are the stages of the process that you are involved in?* *Probe 3. How are you informed about any change in rule/regulation?* *Probe 4; What if the proposed amount is not sanctioned/ partially sanctioned or proposal/scheme are dropped? How is the gap between demand and sanction filled?*
Distribution of Public Spending
Once the plan/allocation/budget reaches the district level, is there any scope of redistribution of resources? Do the regional and district administrations have discretionary power over the allocation/resources actually received by lower levels? Which are the relevant rules that guide these procedures (Acts, laws) ? Or are there any administrative practices being followed over time? And what are the rules /approval norms that are to be followed under such circumstances? *Probe 1. Revisions in budgets take place, process?* *Probe 2. is there any specific ceiling for proposing the requisite amount? in case of deficit in funds, are additional grants sanctioned (What is the process for obtaining additional grants?)* *Probe 3: What in case of emergency?*
What is your role in the process of Disbursement of Funds? *Probe 1.To whom do you disburse to and from where do you get the money?* (Schemes major head no.). *Probe 2: If NO, who plays the role? What is the process? How much time does it takes to process a certain proposal* (to give or to receive, and what are the problem in delay)? [Note: Drawing and Disbursement powers. BEAMS, Treasury route, Koshwahini. Mode of transfers, Online accounting and monitoring practices. Submission Guidelines and Conditions for Release along with timelines. Need to understand timelines for proposal approved and released/received amount.][1]
Accounting Practices, Transparency and Oversight Mechanisms
What are the administrative and financial proceedings (records, published or unpublished/official document for internal use) maintained in your offices? Are there any specific formats for recording the receipts/expenditures? Do the proceedings formats follow certain rules? From whom do you receive and to whom do you send the data? What type of Online accounting and monitoring practices?[1]
Do you have any role of internal monitoring /oversight, If YES, Please elaborate [Note: Type of the records and the procedural compliance] If NO, name the official/ hierarchy/agencies? What is the nature of oversight (financial /performance)? How often is this process done? Which agency is entrusted upon with the internal audits? Which is the agency entrusted for external audits? What is the process of

audit/oversight? How is the audit remark resolved? Probe: unutilised fund, probable reasons for unutilisation, timeliness of the process.
Are procedural documents open to the public?[1] Are annual reports published? Is there any mandate to publish reports?
Whether the existing set of rules have any provision for guaranteeing an element of public participation in the decision making? Is there a participatory process at local level for citizens to give inputs into the planning or budget process? [1]

Annexure 1.1a: Interview Guidelines

मुलाखत मार्गदर्शिका

संस्थेची संरचना:

१. ह्या संस्थेचे/विभागाचे स्वरूप काय आहे? आरोग्य सेवांमध्ये व त्या सेवा पुराविण्यासाठी लागणाऱ्या संसाधनांमध्ये आपला सहभाग कशाप्रकारे आहे?
(टिप: ह्यामध्ये नियोजन, अंदाजपत्रक तयार करणे सार्वजनिक खर्चासाठी पैशांचे वितरण माहितीचा पुरवठा व देखरेख या विषयी माहिती अपेक्षित आहे.)
(टिप: जिल्हा नियोजन मंडळ, आदिवासी विभाग व local fund audit आदि संस्थांचा सहभाग अपेक्षित आहे.)[१]

२. तुमच्या संस्थेमधील प्रशासकिय पदश्रेणीचे वर्णन करु शकता का?
तुम्ही कोणत्या विभागाचे घटक आहात? तुमच्या संस्थेची/विभागाची संरचना कशी आहे?[२]

३. आरोग्यसेवा पुरवठादारांशी व आरोग्य सेवा पुरविण्यासाठी लागणाऱ्या संसाधनांशी तुमच्या संस्थेचा कशाप्रकारे संबंध आहे? कोणकोणत्या विभागाशी/संस्थांशी या संदर्भात तुमचा संपर्क/संबंध येतो? हा कार्यभाग कोणत्या कायदा/प्रशासकिय नियमावर्लीनुसार पार पाडला जातो का? त्याची कार्यपद्धती काय आहे? एकमेकांशी समन्वय साधण्याची पद्धत कशी असते?[३]

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[१] आरोग्यसेवा पुरेवठादरांशी असणारा प्रशाकिय यंत्रणेशी संबंध उदा. जिल्हा परिषद व जिल्हा आरोग्य अधिकारी यांच्यातील संबंध जिल्हा पातळीवरील यंत्रणा व गावातील आरोग्य केंद्रे.

[२] आरोग्य सेवांच्या व्यवस्थापनासाठी आरोग्य विभागात वरेच प्रशासकिय स्तर आहेत. जसे जिल्हा शल्य चिकित्सक ग्रामिण रुग्णालय व जिल्हा रुग्णालयाचा कारभार पाहतो व जिल्हा आरोग्य अधिकारी सर्व प्रा. आ. केंद्रांचा

[३] समन्वय साधण्याच्या प्रक्रिया/पद्धती जसे जिल्हा आरोग्य अधिकाऱ्याचे कार्यालय व Accountant General यांच्यात विनियोजनासाठी समन्वय साधला जातो.

प्रशासकिय कार्यपद्धती व माहिती पुरवठाः

१. आरोग्य सेवा पुरविणारी यंत्रणा/आरोग्य सेवांची संसाधने यावरील नियंत्रणासंदर्भात कोणती माहिती आपणाकडे उपलब्ध आहे?
ह्या माहितीचे स्वरुप काय आहे?
(*टिपः निधीचे विविध स्त्रोत/अंदाजपत्रके/खर्चाचा तपशील/माहितीचा पुरवठा/सेवा निर्देषांक यांचा समावेश ह्यामध्ये असेल.*)

२. सेवा निर्देषांक/आर्थिक माहितीचे संकलन अथवा विश्लेषण आपल्या कार्यालयात आहे का? असल्यास संकलन/विश्लेषणाची पद्धत काय? यासाठी कोणत्या नियमावली, मार्गदर्शक तत्वे किंवा कायद्यातील तरतूदी आहेत काय?[४]

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[४] CAA कार्यालयातील सर्व जिल्हयांच्या अंदाजपत्रकांचे व खर्चाच्या तपशलांचे संकलन केले जाते. तसेच, महाराष्ट्र जिल्हा परिषद व पंचायत समिती कायदा १९६१ अन्वये कलम १८३, १८२ व १८७ नुसार जिल्हा परिषेदेस निधी उपलब्ध होतो.

निधी वितरण व खर्चासंबंधीत प्रशासकिय कार्यपद्धती:

१. खर्चाचा तपशील/निधी वाटप/अंदाजपत्रकाचा प्रस्ताव तयार करण्यासाठी व त्यास अंतिम स्वरुप देण्यासाठी आपला सहभाग असतो का? जर असेल तर अंतिम स्वरुप देण्याची पद्धत कशी असते? जर नाही, तर मग ही जबाबदारी कोण पार पाडते? (*टिप: निधी वाटप व नियंत्रणासाठी विविध कायदे, तरतूदींचा समावेश अपेक्षित आहे*)

उपप्रश्न:

- प्रस्तावित रक्कमेसाठी काही विशिष्ट कायद्याची तरतूद/मार्गदर्शक तत्व आहे काय?
- अंदाजपत्रक तयार करण्यासाठी कोणकोणत्या टप्प्यांवर आपला सहभाग असतो? (*नियोजन/अंमलबजावणी/इतर*)
- प्रस्ताव तयार करताना जनतेच्या गरजांचे मूल्यमापन केले जाते का? त्याची प्रक्रिया काय आहे?[५]

२. खर्चाबाबतीत व अंदाजपत्रकांच्या मूल्यमापनात आपला काही सहभाग असतो का? जर हो, प्रक्रियेचे सविस्तर वर्णन करावे. जर नाही, इतर कोणाचा सहभाग यात असतो?

उपप्रश्न - प्रस्ताव काही शंका/चूक आढळून आल्यास आपण काय करता?[६]

३. खर्चाबाबतीत व अंदाजपत्रक/प्रस्ताव मान्यता देण्याच्या प्रक्रियेत आपल्या संस्थेचा सहभाग असतो का जर हो, प्रक्रियेचे सविस्तर वर्णन करावे जर नाही मान्यता प्रक्रियेत कोणकोणत्या संस्था/कार्यालयांचा सहभाग असतो (*टिप: जिल्हा नियोजन कार्यालय जिल्हा परिषद यांसारख्या संस्थांचा समावेश अपेक्षित आहे*)

उपप्रश्न
- मान्यता देण्यासाठी काही विशिष्ट कायदा आहे का?
- त्या प्रक्रियेतील कोणत्या टप्प्यांवर आपला सहभाग असतो?
- एखाद्या नियमावलीत काही बदल केल्यास ते आपणास कसे कळविण्यात येते?
- प्रस्तावित रक्कम नामंजूर होण्याची शक्यत आहेत काय?
- एखादा प्रस्ताव योजना वगळण्याची शक्यता असते का? तसे झाल्यास प्रस्तावित रक्कम व मंजूर रक्कम यामधील मेळ कसा घातला जातो?

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५. अंदाजपत्रक तयार करताना जनतेच्या गरजांचा विचार केला जातो की, मागील वर्षीच्या अंदाजपकातील आकडे थोडे फुगवून नवीन अंदाजपवक तयार केले जाते हे समजून घेण्याचा प्रयत्न आहे

६. जसे जिल्हा स्तरावर उपसंचालक कोणत्याही योजनेचे तांत्रिक मूल्यमापन करुन, सरकारी नियमावलीमध्ये खर्च बसतोय कि नाही हे पडताळूनच जिल्हा नियोजन कार्यालयात मान्यतेसाठी पाठविण्यात येते

७. जिल्हा परिषद जनरल बॉडीची प्रशासकीय मान्यतेची प्रक्रिया त्या विभागाच्या सचिवांची व जिल्हा नियोजन मंडळाची प्रशासकिय मान्यतेची प्रक्रिया जाणून घ्यायचा प्रयत्न आहे तसचे १६ फेब्रुवारी २००८ रोजीचा कलेक्टरना दिलेले नवीन अधिकराबाबतचा समजून घेणे

सार्वजनिक निधीचे वितरण:

१. मंजूर निधी जिल्हा पातळीवर पोचल्यानंतर त्याचा पुर्नवाटप होउ शकतो का? गाव पातळीवर किती प्रमाणात निधी वितरित करायचे विशेष अधिकार क्षेत्रिय व जिल्हा प्रशासनांना असतात का? निधी वितरण करण्यासाठी कोणत्या कायदेशीर बाबी लक्षात घ्याव्या लागतात ह्यामध्ये काही प्रशासकिय प्रक्रियांचा समावेश असतो का?

उपप्रश्न
- अंदाजपत्रकामध्ये सुधारणा होतात का? त्याची प्रक्रिया काय?
- प्रस्तावित रक्कमेसाठी सुनिश्चित मर्यादा आहे का?
- मंजूर निधी कमी पडल्यास अतिरिक्त निधी मंजूर केला जातो का? त्याची प्रक्रिया काय आहे?
- नैसर्गिक आपत्ती किंवा निकडीच्या प्रसंगी निधी कसा उपलब्ध करुन दिला जातो?

२. निधी वितरणात आपला सहभाग कशाप्रकारे असतो?

उपप्रश्न
- तुम्ही कोणाला/कोणत्या कार्यालयास निधी वितरित करता? तूम्हाला निधी कोठून येतो? (योजना निहाय मुख्य शिर्ष)
- तुमचा सहभाग नसल्यास निधी वितरणाची जबाबदारी कोणाची असते? निधी वितरणाची प्रक्रिया काय?
- एखादा प्रस्ताव तयार होऊन त्यास मंजूरी मिळून, निधी उपलब्ध होण्यास किती कालावधी लागतो? *(टिप: BEAMS निधी काढणे व वितरित करण्याचे अधिकार कोशागरात,कोशवाहिनी इलेक्ट्रॉनिक नियंत्रण व देखरेख इ ची माहिती मिळणे अपेक्षित)*[५]

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[५] सार्वजनिक निधी वितरणाची प्रक्रिया सविस्तरपणे जाणून घेणे

लेखी जमा खर्चाचा हिशेब, पारदर्शकता व पर्यवेक्षण प्रक्रिया:

१ प्रशासकिय व आर्थिक कामकाजाचे कोणते दस्ताऐवज आपल्या कार्यालयात कशाप्रकारे ठेवले जातात? जमा/खर्च दर्शविणारी कागदपत्र विशिष्ट पद्धतीत/स्वरुपात ठेवली जातात का? ह्या कामकाजाचे स्वरुप काही नियमावलीच्या आधारे अधोरेखित केले आहे का? आपल्याकडील विविध माहिती आपणास कोणाकडून येते व ती आपण कोणाला पाठवता? ऑनलाईन जमाखर्चाचा लेखाजोखा व देखरेखीसाठी कोणत्या पद्धती आहेत?[९]

२ संस्थात कार्यालयातील पर्यवेक्षण व देखरेखीसंबंधी आपला सहभाग असतो काय?
जर हो, कपया आपल्या सहभागाबद्दल सविस्तर माहिती द्या *(टिप: पर्यवेक्षण व देखरेखीसाठी उपयुक्त कागदपत्रांचे वर्णन करा)*
जर नाही मग या कामासाठी इतर कोणत्या संस्था जबाबदार आहेत? पर्यवेक्षणाचे स्वरुप काय? त्याची कार्यपद्धती कोणती संस्था करते? बाहय हिशेबतपासणीसाठी कोणत्या संस्था काम करतात? हिशेबतपासणीची कार्यपद्धती कशी आहे? हिशेबतपासणीमध्ये हिशेबात काही त्रुटी सापडल्यास त्याचे निवारण कसे केले जाते?
उपप्रश्न - न वापरलेल्या निधीसंबंधी अधिक माहिती देणे
- हिशेबतपासणी दरवर्षी वेळच्या वेळी का होत नाही?

३ कामकाजाचे दस्तऐवज सार्वजनिक असतात का?[१०] वार्षिक अहवाल छापले जातात का? हे अहवाल छापण्यास बंधनकारक आहे का?

४ निर्णय प्रक्रियेत लोकसहभाग हमी देणारी काही नियम अथवा कायदे आहेत का? स्थानिक पातळीवर, अंदाजपत्रक तयार करताना किंवा नियोजन करताना नागरिकांचा समावेश असतो का? त्यासाठी काही विशिष्ट कार्यपद्धती आहे का?[११]

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[९] जसे, ग्रामीण विकास विभागाकडून जिल्हा परिषदेला दिलेला निधी ग्रामीण विकास विभागाच्या अर्थसंकल्पात खर्च म्हणून नमूद केला जातो व जिल्हा परिषद आपल्या अंदाजपत्रकात जमा म्हणून दर्शविते अशाप्रकारे विविध संस्थांमार्फत ठेवण्यात येणारे लेखा संबंधित दस्ताऐवज

[१०] पंचायत राज संस्थामधील सर्व कागदपत्रे माफक शुल्क भरुन जनतेसाठी खुले करण्यात येतात तसेच अर्थसंकल्पातील पारदर्शकतेसाठी अनेक मार्गदर्शक तत्वे केंद्र सरकारने दिली आहेत

[११] राष्टीय स्तरावरील योजना व अर्थसंकल्प हयावर सबळ परिणाम व्हावा यासाठी अर्थसंकल्पाविषयी पारदर्शक माहिती व स्थानिक लोकांचा सहभाग महत्वाचा असतो

प्रमुख अधिकारी:

राज्य स्तरावर-

१ सचिव कार्यालय (कक्ष अधिकारी): सार्वजनिक आरोग्य विभाग मंत्रालय, ग्रामीण विकास विभाग, मंत्रालय
२ कक्ष अधिकारी: नियोजन विभाग, आरोग्य संचलनालय
३ संहसंचालक: इस्पितळ अर्थसंकल्प व प्रशासकिय नियोजन विभाग
४ लेखाधिकारी: Audits & Accounts Office, सार्वजनिक आरोग्य विभाग
५ जिल्हा राज्य चिकित्सक
६ वरिष्ठ लेखाधिकरी: Accountant General Office, (मुंबई/नागपूर)

क्षेत्रिय जिल्हा स्तरावर -

७ जिल्हा नियोजन अधिकरी
८ उपसंचालक, आरोग्य सेवा (अमरावती व सोलापूर)
९ लेखा अधिकारी: जिल्हा परिषद जिल्हा रुग्णालय आरोग्य संचलनालय
१० जिल्हा आरोग्य अधिकारी
११ Chief Accounting & Finance Officer, जिल्हा परिषद
१२ Chief Executive Officer, जिल्हा परिषद
१३ ब्यूरो चीफ: मलेरिया/क्षयरोग
१४ प्रोग्राम मॅनेजर, राष्ट्रिय ग्रामीण आरोग्य अभियान (अमरावती व सोलापूर)
१५ Pharmacist : जिल्हा रुग्णालय/ग्रामीण रुग्णालय/आरोग्य विभाग जिल्हा परिषद

तालुका स्तरावर -

१६ तालुका वैद्यकिय अधिकारी : प्राथमिक आरोग्य केंद्र
१७ वैद्यकिय अधिकारी : प्राथमिक आरोग्य केंद्र
१८ Local Fund Audit District Staff (Amravati & Solapur)
१९ लेखा अधिकारी : ग्रामीण रुग्णालय

Annexure 1.1b: Key Respondents Identified

Taluka Level

1. Taluka Medical Officer (TMO) : PHC *(compilation of budget proposals across all PHCs in the district).*
2. Medical Officer (MO): PHC *(formulation of budget proposals).*
3. Accounts Officer: RH *(formulation of budget proposals).*

District/ Regional Level

1. District Planning Officer *(formulation, scrutiny, approval and execution of plan budget proposals from ZP, Civil Hospital).*
2. Deputy Director Health Services, Regional Office.
3. Accounts officer: Zilla Parishad /Civil Hospital/Directorate of Health Services *(formulation/ compilation, scrutiny, finalisation of budget/expenditure proposals and oversight).*
4. District Health Officer *(compilation and execution of budget/expenditure proposals from all PHCs across districts).*
5. Chief Accounting and Finance Officer, ZP *(scrutiny and finalisation of budget/expenditure proposals, drawing and disbursement authority).*
6. Chief Executive Officer, ZP *(approval and finalisation authority for budget/expenditure proposals).*
7. Bureau Chief: Malaria program/TB program *(compilation of budget/expenditure proposals across district).*
8. Pharmacist: Civil Hospital/RH/Health Department, Zilla Parishad *(formulation of medicine budget proposals).*

State Level

9. Secretariat Office (Desk Officer): Public Health Department, Mantralaya/Rural Development Department, Mantralaya *(scrutiny of plan and non plan budget/expenditure proposals for all districts, submission for final approval).*
10. Desk Officer: Planning Department, Directorate of Health Services *(scrutiny of plan budget/ expenditure proposals for all districts).*
11. Joint Director: Hospitals/Budget and Administration/Planning Department/Malaria and TB Program *(scrutiny and approval of budget proposals).*

12. Account Officer: Audit and Accounts office, public health *(compilation and scrutiny of non plan budget proposals, and distribution of budgets for all districts).*

Civil Surgeon (compilation, approval and execution of budge/expenditure proposals for civil hospital and rural hospital).

Annexure 1.2: Accounts and Coding of Classification

Classification	Sectoral Classification	Major Heads
Consolidated Fund Revenue receipts	1-Tax revenue 2-Non-tax revenue 3-Grant in aid, contribution	0024-0045 0046-1600 1601-1606
Consolidated Fund Revenue Expenditure	1-General services 2-Social services 3-Economic services 4-Grant in aid, contribution	2011-2079 2202-2252 2401-3475 3601-3606
Consolidated Fund Capital receipts	1-Miscelleneous capital Receipts	4000
Consolidated Fund Capital expenditure	1-Capital A/C of General Services 2-Capital A/C of Social Services 3-Capital A/c of Economic Services 4-Grants in Aid & contribution 5-Public Debts 6-Loans & Advances 7-Interstate settlements 8-Transfers to Emergency Funds	4046-4075 4202-4250 4401-5475 6000 6001-6004 6075-7615 810 7999
Contingency Fund		8000
Public Account	1-Small Savings, PPF etc. 2-Deposits and Advances 3-Suspense and Miscellaneous 4-Remittance 5-Cash Balance	8001-8235 8336-8554 8656-8680 8781-8797 8999

Annexure 3.1: Circular instructing the Submission of Estimate

Time line for submission of Annual budget estimate and four monthly estimates for FY 2011-12					
Sr. No.	**Offices**	**Period**	**Sr. No.**	**Offices**	**Period**
1	Asst. Director, Health care (Blind) Mumbai	16.8.2010 to 17.8.2010			
2	Asst. Director, Health care (Medical) Mumbai		32	Yavatmal District Zilla Parishad	13.9.2010 to 14.9.2010
3	Asst. Director, Health care (नि. वि. मू) Mumbai		33	Dy. Director Health care, Latur Circle	
4	Add. Director , Health Care (Mental), Mumbai	18.8.2010	34	Latur District Zilla Parishad	
5	Director , National Rural Health Mission Abhiyan		35	Nanded District Zilla Parishad	15.9.2010 to 16.9.2010
6	Director , Health Services (DHS)		36	Beed District Zilla Parishad	
7	Dy. Director, Health care, Thane circle	20.8.2010 to 21.8.2010	37	Osmanabad District Zilla Parishad	
8	Thane District Zilla Parishad		38	Addl. Director , Health Care (Family Welfare), Pune	17.9.2010 to 18.9.2010
9	Raigard District Zilla Parishad		39-40	Asst. Director, Health care (M. Elep & VBD) Pune 1 & 2	
10	Ratnagiri District Zilla Parishad	23.8.2010 to 24.8.2010	41	Dy. Director, Health care (goitre) Mumbai	
11	Sindhudurgh District Zilla Parishad		42	Dy. Director , Health care, Nagpur circle	20.9.2010 to 21.9.2010
12	Dy. Director, Health care (Blood infection)		43	Nagpur District Zilla Parishad	
13	Dy. Director, Health care (TB & leprosy) Mumbai		44	Bandara District Zilla Parishad	
14	Dy. Director, Health care , Nasik circle	25.8.2010 to 26.8.2010	45	Gondia District Zilla Parishad	22.9.2010 to 23.9.2010
15	Nasik District Zilla Parishad		46	Wardha District Zilla Parishad	
16	Dhule District Zilla Parishad		47	Gadchiroli District Zilla Parishad	
17	Nandurbar District Zilla Parishad	27.8.2010	48	Chandrapur District Zilla Parishad	24.9.2010
18	Jalgoan District Zilla Parishad	30.8.2010 to 31.8.2010	49	Dean, Govt. Medical College and Hospital, Nagpur	27.9.2010 to 28.9.2010
19	Ahmednagar District Zilla Parishad		50	Asst. Director,Health care (leprosy) Pune	
20	Dy. Director ,Health care , Aurangabad regional circle	1.9.2010 to	51	Asst. Director, Health care (	

		2.9.2010		Transport/Vehicle) Pune	
21	Aurangabad District Zilla Parishad		52	Asst. Director,Health care (आ. मा. जि.आ) Pune	29.9.2010 to 30.9.2010
22	Jalna District Zilla Parishad		53	Asst. Director,Health care (IEC) Pune	
23	Parbhani District Zilla Parishad	3.9.2010 to 4.9.2010	54	Asst. Director,Health care (Laboratory) Pune	
24	Hingoli District Zilla Parishad		55	Dy. Director, Health care, Pune circle	1.10.2010
25	Aurangabad District Zilla Parishad		56	Pune Zilla Parishad	3.10.2010 to 4.10.2010
26	Dean, Govt. Medical College and Hospital, Aurangabad	6.9.2010 to 7.9.2010	57	Solapur Zilla Parishad	
27	Dy. Director, Health care , Akola circle		58	Dean, Govt. Medical College and Hospital, Solapur	
28	Akola District Zilla Parishad		59	Dy. Director, health care, Kolapur Circle	5.10.2010 to 6.10.2010
29	Washim District Zilla Parishad	8.9.2010 to 9.9.2010	60	Kolapur Zilla Parishad	
30	Buldhana District Zilla Parishad		61	Sangli Zilla Parisahad	
31	Amravati District Zilla Parishad		62	Satara Zilla Parishad	7.10.2010 to 8.10.2010
			63	Dean, Govt. Medical College and Hospital, Sangli	

Annexure 3.2a: Civil Budget Estimate (White Book) Part II

PUBLIC HEALTH DEPARTMENT—DEMAND No. R-1
2210, MEDICAL AND PUBLIC HEALTH

(Rs. in thousands)

2210, MEDICAL AND PUBLIC HEALTH 06-Public Health 001-Direction and Administration		Actuals, 2009-2010 योजनेतर Non-Plan	Actuals, 2009-2010 योजनांतर्गत Plan	Actuals, 2009-2010 एकूण Total	Budget Estimates, 2010-2011 योजनेतर Non-Plan	Budget Estimates, 2010-2011 योजनांतर्गत Plan	Budget Estimates, 2010-2011 एकूण Total
(02) (05) Mobile Health Service by Launch (Local Sector) (2210 501 2)							
01 Salary		..	..	..	..	..	..
13 Office Expenses		..	..	..	..	..	..
21 Supplies and Materials		..	..	..	..	..	..
31 Grant-in-aid (Non-Salary)		6,42	..	6,42	4,65	..	4,65
36 Grant-in-aid (Salary)		38,23	..	38,23	55,60	..	55,60
51 Motor Vehicles		..	..	..	..	..	..
52 Machinery and Equipment		..	..	..	..	..	..
Total—(02) (05)	..	44,65	..	44,65	60,25	..	60,25
(02) (06) Student's Medical check-up in Ashram School (Local Sector) (2210 502 1)							
21 Supplies and Materials		..	..	..	..	..	..
31 Grant-in-aid		24,57	..	24,57	27,85	..	27,85
Total—(02) (06)	..	24,57	..	24,57	27,85	..	27,85
(02) (07) Vaccination (Local Sector) (2210 503 2)							
01 Salary		..	..	..	..	..	..
03 Overtime Allowances		..	..	..	..	..	..
06 Telephone, Electricity and Water Charges		..	..	..	..	..	..
11 Domestic travel Expenses		..	..	..	..	..	..
13 Office Expenses		..	..	..	..	..	..
31 Grant-in-aid (Non-Salary)		6,03	..	6,03	9,63	..	9,63
36 Grant-in-aid (Salary)		5,22,70	..	5,22,70	9,08,16	..	9,08,16
Total—(02) (07)	..	5,28,73	..	5,28,73	9,17,79	..	9,17,79
(02) (08) Primary Health Centres (Local Sector) (2210 504 1)							
01 Salary		..	..	..	..	..	..
02 Wages		..	..	..	..	..	..
03 Overtime Allowances		..	..	..	..	..	..
06 Telephone, Electricity and Water Charges		..	..	..	..	..	..
11 Domestic travel Expenses		..	..	..	..	..	..
13 Office Expenses		..	..	..	..	..	..
14 Rent, Rates and Taxes		..	..	..	..	..	..
17 Computer Expenses		..	..	..	..	..	..
19 Diet Charges		..	..	..	..	..	..
21 Supplies and Materials		..	..	..	..	..	..
24 Petrol, Oil, Lubricants		..	..	..	..	..	..
27 Supplies and Materials		..	..	..	..	..	..
31 Grant-in-aid (Non-Salary)		29,33,73	..	29,33,73	29,73,01	..	29,73,01
36 Grant-in-aid (Salary)		440,02,32	..	440,02,32	461,36,28	..	461,36,28
51 Motor Vehicles		..	..	..	..	..	..
Total—(02) (08)	..	469,36,05	..	469,36,05	491,09,29	..	491,09,29
Total—(02) Proposive Grants to Zilla Parishads under Section 182 of the Maharashtra Zilla Parishads and Panchayat Samiti's Act 1961. (Local Sector)	..	500,99,41	..	500,99,41	528,39,83	..	528,39,83
Total—001-Direction and Administration Charged	..	34,88	..	34,88	35,76	..	35,76
Total—001-Direction and Administration Voted	..	994,50,82	..	994,50,82	1096,63,30	..	1096,63,30

सार्वजनिक आरोग्य विभाग—मागणी क्रमांक आर-१
२२१०, वैद्यकीय सेवा व सार्वजनिक आरोग्य

(रुपये हजारात)

सुधारित अंदाज, २०१०-२०११ Revised Estimates, 2010-2011 योजनेतर Non-Plan	सुधारित अंदाज, २०१०-२०११ योजनांतर्गत Plan	सुधारित अंदाज, २०१०-२०११ एकूण Total	अर्थसंकल्पीय अंदाज, २०११-२०१२ Budget Estimates, 2011-2012 योजनेतर Non-Plan	अर्थसंकल्पीय अंदाज, २०११-२०१२ योजनांतर्गत Plan	अर्थसंकल्पीय अंदाज, २०११-२०१२ एकूण Total	२२१०, वैद्यकीय सेवा व सार्वजनिक आरोग्य ०६-सार्वजनिक आरोग्य ००१, संचालन व प्रशासन
						(०२) (०५) सचेहता आरोग्य सेवा पुरविणे (स्थानिक क्षेत्र) (२२१० ५०१ २)
..	..	..	..	..	..	०१ वेतन
..	..	..	..	..	..	१३ कार्यालयीन खर्च
..	..	..	..	..	..	२१ पुरवठा व सामग्री
4,65	..	4,65	4,65	..	4,65	३१ सहायक अनुदान (वेतनेतर)
67,71	..	67,71	68,72	..	61,72	३६ सहायक अनुदान (वेतन)
..	..	..	..	..	..	५१ मोटार वाहने
..	..	..	..	..	..	५२ यंत्रसामग्री व साधनसामग्री
72,36	..	72,36	66,37	..	66,37	एकूण-(०२) (०५)
						(०२) (०६) आश्रमशाळेतील विद्यार्थ्यांची वैद्यकीय तपासणी (स्थानिक क्षेत्र) (२२१० ५०२ १)
..	..	..	..	..	..	२१ पुरवठा व सामग्री
27,00	..	27,00	14,79	..	14,79	३१ सहायक अनुदान
27,00	..	27,00	14,79	..	14,79	एकूण-(०२) (०६)
						(०२) (०७) लसटोचणी (स्थानिक क्षेत्र) (२२१० ५०३ २)
..	..	..	..	..	..	०१ वेतन
..	..	..	..	..	..	०३ अतिकालिक भत्ता
..	..	..	..	..	..	०६ दूरध्वनी, वीज व पाणी शुल्क
..	..	..	..	..	..	११ देशांतर्गत प्रवास खर्च
..	..	..	..	..	..	१३ कार्यालयीन खर्च
9,63	..	9,63	9,63	..	9,63	३१ सहायक अनुदान (वेतनेतर)
5,22,70	..	5,22,70	9,66,77	..	9,66,77	३६ सहायक अनुदान (वेतन)
5,32,33	..	5,32,33	9,76,40	..	9,76,40	एकूण-(०२) (०७)
						(०२) (०८) प्राथमिक आरोग्य केंद्रे (स्थानिक क्षेत्र) (२२१० ५०४ १)
..	..	..	..	..	..	०१ वेतन
15,00	..	15,00	..	..	..	०२ मजुरी
..	..	..	..	..	..	०३ अतिकालिक भत्ता
..	..	..	..	..	..	०६ दूरध्वनी, वीज व पाणी शुल्क
..	..	..	..	..	..	११ देशांतर्गत प्रवास खर्च
..	..	..	..	..	..	१३ कार्यालयीन खर्च
..	..	..	..	..	..	१४ भाडे, पट्टी व कर
..	..	..	..	..	..	१७ संगणक खर्च
..	..	..	..	..	..	१९ आहार खर्च
..	..	..	..	..	..	२१ पुरवठा व सामग्री
..	..	..	..	..	..	२४ पेट्रोल, तेल व वंगण
..	..	..	..	..	..	२७ लहान बांधकामे
29,73,01	..	29,73,01	29,73,01	..	29,73,01	३१ सहायक अनुदान (वेतनेतर)
534,00,00	..	534,00,00	558,00,00	..	558,00,00	३६ सहायक अनुदान (वेतन)
..	..	..	..	..	..	५१ मोटार वाहने
563,88,01	..	563,88,01	587,73,01	..	587,73,01	एकूण-(०२) (०८)
603,00,06	..	603,00,06	625,76,72	..	625,76,72	एकूण-(०२) महाराष्ट्र जिल्हा परिषद व पंचायत समिती अधिनियम, १९६१ याच्या कलम १८२ अन्वये जिल्हा परिषदांना अनुदान (स्थानिक क्षेत्रातील योजना)
35,76	..	35,76	35,76	..	35,76	भारित } एकूण—००१-संचालन व प्रशासन
1194,01,63	..	1194,01,63	1251,70,43	..	1251,70,43	दायित्व }

Annexure 3.2b: Budget estimate (authorized) for Zilla Parishad scheme for Primary Health Centre (PHC) under budget head 2210 5041- 8- public health for the Year 2011-12. Figure in Rs.in thousands

sr.no	Dist. ZP	salaries	wages	Overtime allowance	Phone,electric &water	domestic travel expenses	office expenses	rents,rates & taxes	computer	परिरक्षण	POL	Motor Vehicles	supplies and materials	Diet	Total
1	Thane	267114	2123.77	722.60	768.97	1101.80	228.93	0.00	0.00	17.02	1773.33	185.49	0.00	0.00	274036
2	Raigad	157619	997.90	257.69	513.04	1781.55	216.60	25.83	0.00	0.00	1056.60	110.36	0.00	0.00	162579
3	Ratnagiri	147912	2087.96	58.70	1445.19	2935.00	534.17	0.00	0.00	196.65	1651.82	196.65	0.00	0.00	157018
4	Pune	211359	3177.43	154.38	3151.60	1563.77	1899.53	56.35	0.00	0.00	4578.60	381.55	0.00	56.35	226379
5	Solapur	209175	0.00	1174.00	587.00	2054.50	880.50	117.40	0.00	70.44	1174.00	234.80	0.00	0.00	215468
6	Satara	224065	7736.66	88.05	293.50	2465.40	469.60	146.75	0.00	0.00	446.12	170.23	0.00	0.00	235881
7	Nashik	352903	338.11	1291.40	1451.06	2641.50	982.64	5.87	0.00	0.00	2297.52	378.62	0.00	587.00	362877
8	Dhule	140136	0.00	58.70	704.40	1584.90	410.90	0.00	58.70	0.00	587.00	176.10	0.00	0.00	143717
9	Nandurbar	334628	316.98	314.05	0.00	1199.83	314.05	176.10	117.40	0.00	1361.84	372.75	0.00	587.00	339388
10	Jalgaon	297275	176.10	293.50	58.70	2348.00	451.99	0.00	0.00	0.00	1310.18	1127.04	0.00	17.61	303058
11	A'nagar	248887	67.51	0.00	563.52	1232.70	1174.00	0.00	0.00	0.00	1467.50	528.30	0.00	234.80	254155
12	Kolhapur	188894	1300.79	381.55	293.50	2935.00	633.96	0.00	0.00	293.50	1242.68	322.85	0.00	0.00	196298
13	Sangali	135267	1174.00	381.55	939.20	1761.00	0.00	0.00	0.00	0.00	381.55	176.10	0.00	0.00	140080
14	Sindhudurg	117192	0.00	293.50	880.50	2054.50	587.00	0.00	0.00	234.80	1226.83	587.00	0.00	0.00	123056
15	Aurangabad	144418	1415.84	14.68	352.20	1761.00	763.10	29.35	0.00	5.87	880.50	176.10	0.00	0.00	149817
16	Jalna	122790	1183.39	938.03	428.51	1467.50	500.12	0.00	0.00	0.00	369.22	117.40	0.00	0.00	127794
17	Parbhani	82437	587.00	35.22	234.80	587.00	381.55	29.35	0.00	0.00	909.85	90.99	0.00	0.00	85293
18	Hingoli	59610	322.85	64.57	64.57	410.90	176.10	0.00	0.00	0.00	722.01	64.57	0.00	0.00	61436
19	Latur	139282	528.30	1303.14	587.00	1761.00	704.40	0.00	0.00	81.01	1080.08	135.01	0.00	0.00	145462
20	Nanded	203060	939.20	469.60	704.40	5870.00	939.20	146.75	0.00	0.00	1761.00	234.80	0.00	0.00	214125
21	Beed	121231	485.45	117.40	528.30	1467.50	275.89	29.35	0.00	176.10	1085.95	146.75	0.00	0.00	125544
22	Osmanabad	149068	805.95	498.95	493.08	880.50	369.81	587.00	0.00	0.00	986.16	308.18	0.00	0.00	153998
23	Akola	72980	0.00	52.83	70.44	563.52	140.88	0.00	0.00	0.00	259.45	42.26	0.00	0.00	74109
24	Washim	55982	0.00	0.00	0.00	410.90	381.55	0.00	0.00	0.00	328.72	205.45	0.00	0.00	57309
25	Buldhana	203855	1489.81	161.43	351.03	880.50	528.30	123.27	0.00	41.09	1266.75	161.43	0.00	0.00	208859
26	Amravati	185430	1373.58	316.98	558.82	2935.00	629.26	70.44	0.00	0.00	1807.96	510.69	0.00	58.70	193691
27	Yawatmal	207160	234.80	17.61	293.50	1174.00	381.55	0.00	0.00	176.10	645.70	146.75	0.00	0.00	210230
28	Nagpur	69758	293.50	352.20	587.00	1174.00	587.00	58.70	0.00	146.75	880.50	176.10	0.00	0.00	74014
29	Bhandara	118883	1467.50	0.00	498.95	997.90	528.30	41.09	0.00	193.71	587.00	111.53	0.00	17.61	123327
30	Gondiya	134048	3612.40	264.15	1174.00	1526.20	997.90	88.05	0.00	88.05	997.90	146.75	0.00	322.85	143266
31	Wardha	96312	0.00	129.14	293.50	880.50	58.70	117.40	0.00	0.00	293.50	79.25	0.00	0.00	98164
32	Gadchiroli	234417	352.20	176.10	410.90	2054.50	727.29	58.70	0.00	23.48	528.30	205.45	0.00	293.50	239247
33	Chandrapu	146853	932.74	163.19	1090.06	1386.49	680.92	23.48	0.00	0.00	1532.07	181.97	0.00	293.50	153137
	DHS	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	104482.5	0.00	104482
	Total	5580000	35521.72	10544.87	20371.25	55848.35	18535.70	1931.23	176.10	1744.56	37478.19	8189.24	104482.5	2468.92	5896277

Annexure 4.1: Specimen Copy of Draft Pay bill prepared by the DHO to be submitted to the Treasury

		विनर्शत		Allotement For the year 2011 - 2012	1174000
		Government of Maharastra		Expenditure including this bills	586000
		From MTR 44 (See Rill 391)		Balance	588000
		(GRAND IN - AID BILL)			
Hea of Account		Consolidated Fund Voated Expenditure	Name of Treasury Amravati		Chief Account & Finanace Officer
Admdndstrative		२२१० वैद्यकिय व सार्वजनिक आरोग्य			Zilla Parishad,Amravati
Demand No.		१०१ - ५(१) आयुर्वेद दवाखाने	No.		
Sector/Subsector		२२१०४६०६			For use in Treasury
Major Head			Date		
Minor Head				Pay Rs. ----------	
Sub Head				---------- ---------- ---------- only	
Object of Expdt.					
Below Rs :- 586001/-	Detailed Of Head		Amount	Cheque Drawn	Cheque delivered
	GIA/Contribution/Subsidies (full details of claim)		Plan / Non-Plan	Date	
	माहे जुलै ११ देय ऑगस्ट ११ प्रवास सादिल व इतर				
	देयक		0 / 586000		For use in Audit Officer
				Admitted Rs. / Objected Rs. / Reasons For Objection / Auditor	Section Officer / Account Officer
	Total		0 / 586000		
	In Words :-FIVE LAKH EIGHTY SIX THOUSAND ONLY -				
Certifed that ;-					
1) The Grantee has executed the Requisite bond has been exempted from execting a bond in					
2) I have no reason to believe that grantee instititon is involved in corrupt.					
		Countersigned			
Dated	18-07-2011				
		Chief Executive Officer	**Chief Account & Finanace Officer**		

Note: Pay bill prepared under the under the sub head (scheme) - Ayuverdic dispensaries (budget head 2210 4606) for the miscellaneous expenditure for the month of July paid August of Rs. 5.86 Lakhs under the non plan.

Annexure 4.2: Budget Grant Information received from BAA to be distributed to the ZP as GIA

For tracking the flow of budget distribution the sub head (2210-4965 Mofussil hospitals and 2210-5041 Primary Health Center) that reaches to the frontline services provider, PHC. For the year 2010-11, the table A shows the grant was received was allocated for the six months in the form of grant allocation which was uploaded on the Online system of BDS by the controlling office, Dy. Director health .

		Distributed grant for 2 month (April to may) 2010-11 (Rs. In Thousand)						**Distributed grant for 4 month (June to Sept) 2010-11 (Rs. In Thousand)**									
subhead		**Eight Dy. Dir Health Circle**						**Eight Dy. Dir Health Circle**									
		A	**B**	**C**	**D**	**E**	**F**	**G**	**E**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**E**
2210-4965 Mofussil hospitals	35-Salary	3250	764	826	2233	1088	2560	4682	6736	6502	1528	1656	4468	2176	5122	9372	13480
	31-nonsalary	106	65	86	65	61	154	163	288	221	132	178	148	133	312	350	610
	Total	3356	829	912	2298	1149	2714	4845	7024	6723	1660	1834	4616	2309	5434	9722	14090
2210-5041 Primary Health Center	35-Salary	102902	63826	154374	77344	61760	85344	100243	123114	205806	127656	308753	154688	123526	170691	200495	246235
	31-non salary	2981	1942	4212	3280	1719	2478	2345	3000	5989	3897	8464	6594	3480	4983	4726	6045
	Total	105883	65768	158586	80624	63479	87822	102588	126114	211795	131553	317217	161282	127006	175674	205221	252280

Annexure 5.1: Approval letter from the Government of India and Sector wise Outlay

M-13048/15/(MR)2009-SP-W
Government of India
Planning Commission
(State Plans Division)

Yojana Bhawan, Sansad Marg,
New Delhi-110 001
Dated: 6th January, 2011

To

The Chief Secretary,
Government of Maharashtra,
Mumbai.

Subject: Approval of Annual Plan 2010-11 of Maharashtra– reg.

Sir,

I am directed to refer to D. O. letter No. Vaniyo-2010/CR-76/Desk-1411 dated 27th December, 2010 from Government of Maharashtra seeking approval of sectoral Plan Outlay for Annual Plan 2010-11 amounting to Rs. 37,916.00 crore for the State.

2. The Scheme of Financing of the agreed Annual Plan 2010-11 is given at Annexure-I.

3. The statement showing distribution of the approved Annual Plan 2010-11 among different sectors, is given at Annexure-II.

4. I am directed to invite your attention to the procedure for sending adjustment proposal and revision of outlays and to request you to send the adjustment proposal and proposal for revision of outlays fully supported by Revised Scheme of Financing for the Annual Plan (2010-11), if any, together with appropriate justifications, immediately.

5. Statements showing actual expenditure incurred and the corresponding actual Scheme of Financing of the Annual Plan 2010-11 should be sent to the Planning Commission before 30th September, 2011.

6. The plan programmes need to be monitored closely with a view to achieve the financial and physical targets.

Kindly acknowledge the receipt of the letter.

Yours faithfully,

Encls: As above

(T.K.Pandey)
Joint Secretary (State Plans)

ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
1	Agriculture & Allied Activities	1	Crop Husbandry	State	680.19	20.44	17.34	0.00	717.97	0.00
				District	94.08	80.51	16.36	7.67	198.62	4.88
				Total	**774.27**	**100.95**	**33.70**	**7.67**	**916.59**	**4.88**
		2	Horticulture	State	172.95	0.00	1.90	0.00	174.85	0.00
				District	8.28	0.00	1.36	0.00	9.64	0.94
				Total	**181.23**	**0.00**	**3.26**	**0.00**	**184.49**	**0.94**
		3	Soil & Water Conservation	State	437.70	0.00	9.02	0.00	446.72	410.73
				District	148.59	5.91	16.83	3.37	174.70	166.74
				Total	**586.29**	**5.91**	**25.85**	**3.37**	**621.42**	**577.47**
		4	Animal Husbandry	State	63.98	0.00	0.00	0.00	63.98	1.97
				District	64.94	11.46	6.28	1.25	83.93	14.48
				Total	**128.92**	**11.46**	**6.28**	**1.25**	**147.91**	**16.45**
		5	Dairy Development	State	1.35	0.00	0.05	0.00	1.40	0.55
				District	7.17	0.00	0.00	0.00	7.17	0.01
				Total	**8.52**	**0.00**	**0.05**	**0.00**	**8.57**	**0.56**
		6	Fisheries	State	76.85	0.00	0.00	0.00	76.85	36.90
				District	22.05	0.33	0.71	0.09	23.18	15.46
				Total	**98.90**	**0.33**	**0.71**	**0.09**	**100.03**	**52.36**
		7	Forest & Wildlife	State	87.87	0.00	0.00	0.00	87.87	20.29
				District	59.11	0.00	12.31	2.00	73.42	32.03
				Total	**146.98**	**0.00**	**12.31**	**2.00**	**161.30**	**52.32**
		8	Social Forestry	State	4.00	0.00	0.00	0.00	4.00	0.00
				District	2.21	0.00	0.00	0.00	2.21	0.60
				Total	**6.21**	**0.00**	**0.00**	**0.00**	**6.21**	**0.60**
		9	Food Storage, Warehousing & Marketting	State	219.87	0.00	0.00	0.00	219.87	79.92
				Total	**219.87**	**0.00**	**0.00**	**0.00**	**219.87**	**79.92**
		10	Agricultural Education & Research	State	42.00	0.00	0.50	0.00	42.50	0.00
				Total	**42.00**	**0.00**	**0.50**	**0.00**	**42.50**	**0.00**
		11	Co-operation	State	0.98	0.00	0.10	0.00	1.08	0.00
				District	27.48	1.44	2.24	0.15	31.31	0.04
				Total	**28.46**	**1.44**	**2.34**	**0.15**	**32.39**	**0.04**

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
			All Sub-Sector	State	1,787.74	20.44	28.91	0.00	1,837.09	550.36
				District	433.91	99.65	56.09	14.53	604.18	235.16
				Total	**2,221.65**	**120.09**	**85.00**	**14.53**	**2,441.27**	**785.52**
2	Rural Development	1	Integrated Rural Development	State	188.31	217.86	0.00	0.00	406.17	0.00
				District	74.66	0.00	0.00	0.00	74.66	2.50
				Total	**262.97**	**217.86**	**0.00**	**0.00**	**480.83**	**2.50**
		2	Drought Prone Area Programme	State	0.00	0.00	0.00	0.00	0.00	0.00
				District	26.86	0.00	9.40	0.00	36.26	0.00
				Total	**26.86**	**0.00**	**9.40**	**0.00**	**36.26**	**0.00**
		3	Rural Employment	State	4.00	0.00	0.00	0.00	4.00	0.00
				District	46.93	15.45	49.59	9.45	121.42	0.85
				Total	**50.93**	**15.45**	**49.59**	**9.45**	**125.42**	**0.85**
		4	EGS	State	0.00	83.91	73.22	0.00	157.13	0.00
				Total	**0.00**	**83.91**	**73.22**	**0.00**	**157.13**	**0.00**
		5	Land Reforms	State	64.10	0.00	0.00	0.00	64.10	0.00
				Total	**64.10**	**0.00**	**0.00**	**0.00**	**64.10**	**0.00**
		6	Community Development	State	135.00	0.00	0.00	0.00	135.00	0.00
				District	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**135.00**	**0.00**	**0.00**	**0.00**	**135.00**	**0.00**
		7	Employment Guarantee	State	221.99	0.00	0.00	0.00	221.99	0.00
				District	139.46	0.00	0.00	0.00	139.46	0.33
				Total	**361.45**	**0.00**	**0.00**	**0.00**	**361.45**	**0.33**
			All Sub-Sector	State	613.40	301.77	73.22	0.00	988.39	0.00
				District	287.91	15.45	58.99	9.45	371.80	3.68
				Total	**901.31**	**317.22**	**132.21**	**9.45**	**1,360.18**	**3.68**
3	Special Area Development	1	Development of Hilly Area	State	75.97	0.00	0.00	0.00	75.97	75.97
				Total	**75.97**	**0.00**	**0.00**	**0.00**	**75.97**	**75.97**
		2	Development of Western Ghats	State	61.72	0.00	0.00	0.00	61.72	0.00
				Total	**61.72**	**0.00**	**0.00**	**0.00**	**61.72**	**0.00**
		3	Removal of Regional Disparities	State	153.22	0.00	0.00	0.00	153.22	100.00

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
				Total	**153.22**	**0.00**	**0.00**	**0.00**	**153.22**	**100.00**
			All Sub-Sector	State	290.91	0.00	0.00	0.00	290.91	175.97
				Total	**290.91**	**0.00**	**0.00**	**0.00**	**290.91**	**175.97**
4	**Irrigation & Flood Control**	**1**	**Major & Medium Irrigation**	State	6,985.32	0.00	20.00	0.00	7,005.32	5,111.98
				Total	**6,985.32**	**0.00**	**20.00**	**0.00**	**7,005.32**	**5,111.98**
		2	**Minor Irrigation (State Sector)**	State	809.72	0.00	80.00	0.00	889.72	844.45
				District	0.00	0.00	8.06	0.16	8.22	3.36
				Total	**809.72**	**0.00**	**88.06**	**0.16**	**897.94**	**847.81**
		3	**Minor Irrigation (Local Sector)**	State	12.96	0.00	0.00	0.00	12.96	1.00
				District	261.68	0.00	37.94	4.71	304.33	25.97
				Total	**274.64**	**0.00**	**37.94**	**4.71**	**317.29**	**26.97**
		4	**Command Area Development**	State	43.45	0.00	0.00	0.00	43.45	21.15
				District	0.00	0.00	0.10	0.00	0.10	0.10
				Total	**43.45**	**0.00**	**0.10**	**0.00**	**43.55**	**21.25**
		5	**Flood Control**	State	10.01	0.00	0.00	0.00	10.01	9.16
				District	5.84	0.00	0.00	0.00	5.84	5.69
				Total	**15.85**	**0.00**	**0.00**	**0.00**	**15.85**	**14.85**
			All Sub-Sector	State	7,861.46	0.00	100.00	0.00	7,961.46	5,987.74
				District	267.52	0.00	46.10	4.87	318.49	35.12
				Total	**8,128.98**	**0.00**	**146.10**	**4.87**	**8,279.95**	**6,022.86**
5	**Energy**	**1**	**Energy Development**	State	2,073.43	0.00	24.31	0.00	2,097.74	1,955.00
				District	0.00	25.58	22.77	5.46	53.81	0.85
				Total	**2,073.43**	**25.58**	**47.08**	**5.46**	**2,151.55**	**1,955.85**
		2	**Hydel Energy Development**	State	450.09	0.00	0.00	0.00	450.09	350.75
				Total	**450.09**	**0.00**	**0.00**	**0.00**	**450.09**	**350.75**
		3	**Non-Conventional Energy Development**	State	111.14	0.00	7.00	0.00	118.14	0.00
				District	16.92	0.00	3.92	0.30	21.14	2.37
				Total	**128.06**	**0.00**	**10.92**	**0.30**	**139.28**	**2.37**
			All Sub-Sector	State	2,634.66	0.00	31.31	0.00	2,665.97	2,305.75
				District	16.92	25.58	26.69	5.76	74.95	3.22
				Total	**2,651.58**	**25.58**	**58.00**	**5.76**	**2,740.92**	**2,308.97**

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
6	Industry & Minerals	1	Village & Small Scale Industries	State	52.56	0.00	0.50	0.00	53.06	9.16
				District	22.49	7.77	0.34	0.34	30.94	2.68
				Total	**75.05**	**7.77**	**0.84**	**0.34**	**84.00**	**11.84**
		2	Medium & Large Scale Industries	State	113.94	25.00	0.00	0.00	138.94	71.30
				District	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**113.94**	**25.00**	**0.00**	**0.00**	**138.94**	**71.30**
			All Sub-Sector	State	166.50	25.00	0.50	0.00	192.00	80.46
				District	22.49	7.77	0.34	0.34	30.94	2.68
				Total	**188.99**	**32.77**	**0.84**	**0.34**	**222.94**	**83.14**
7	Transport	1	Ports, Light Houses & Shipping	State	18.20	0.00	0.00	0.00	18.20	0.00
				District	34.14	0.00	0.00	0.00	34.14	0.00
				Total	**52.34**	**0.00**	**0.00**	**0.00**	**52.34**	**0.00**
		2	Roads & Bridges	State	2,600.26	0.00	17.29	0.00	2,617.55	1,896.00
				District	725.63	14.24	82.62	18.62	841.11	592.20
				Total	**3,325.89**	**14.24**	**99.91**	**18.62**	**3,458.66**	**2,488.20**
		3	Road Transport	State	114.84	0.00	0.00	0.00	114.84	6.00
				Total	**114.84**	**0.00**	**0.00**	**0.00**	**114.84**	**6.00**
		4	Inland Water Transport	State	0.00	0.00	0.00	0.00	0.00	0.00
				District	1.20	0.00	0.00	0.00	1.20	0.10
				Total	**1.20**	**0.00**	**0.00**	**0.00**	**1.20**	**0.10**
		5	Urban Rail & Metro Transport	State	480.38	0.00	0.00	0.00	480.38	0.00
				Total	**480.38**	**0.00**	**0.00**	**0.00**	**480.38**	**0.00**
		6	Air Transport	State	105.49	10.00	0.00	0.00	115.49	0.00
				Total	**105.49**	**10.00**	**0.00**	**0.00**	**115.49**	**0.00**
			All Sub-Sector	State	3,319.17	10.00	17.29	0.00	3,346.46	1,902.00
				District	760.97	14.24	82.62	18.62	876.45	592.30
				Total	**4,080.14**	**24.24**	**99.91**	**18.62**	**4,222.91**	**2,494.30**
8	Science, Technology & Environment	1	Research & Development	State	7.50	0.00	0.00	0.00	7.50	0.00
				Total	**7.50**	**0.00**	**0.00**	**0.00**	**7.50**	**0.00**

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
		2	Ecology & Environment	State	10.20	0.00	0.00	0.00	10.20	0.00
				Total	**10.20**	**0.00**	**0.00**	**0.00**	**10.20**	**0.00**
		3	Remote Sensing Applications	State	5.00	0.00	0.00	0.00	5.00	0.00
				Total	**5.00**	**0.00**	**0.00**	**0.00**	**5.00**	**0.00**
			All Sub-Sector	State	22.70	0.00	0.00	0.00	22.70	0.00
				Total	**22.70**	**0.00**	**0.00**	**0.00**	**22.70**	**0.00**
9	General Economic Services	1	Survey & Statistics	State	39.14	0.00	0.00	0.00	39.14	0.00
				Total	**39.14**	**0.00**	**0.00**	**0.00**	**39.14**	**0.00**
		2	Development of Pilgrim Centers	State	227.26	0.00	0.00	0.00	227.26	0.00
				Total	**227.26**	**0.00**	**0.00**	**0.00**	**227.26**	**0.00**
		3	Tourism Devlopment	State	133.25	0.00	0.00	0.00	133.25	0.00
				District	143.29	0.00	6.54	0.20	150.03	5.13
				Total	**276.54**	**0.00**	**6.54**	**0.20**	**283.28**	**5.13**
		4	Government Training Programme	State	0.75	0.00	0.00	0.00	0.75	0.00
				Total	**0.75**	**0.00**	**0.00**	**0.00**	**0.75**	**0.00**
		5	Development of Reg. Rural Banks	State	10.00	0.00	0.00	0.00	10.00	10.00
				Total	**10.00**	**0.00**	**0.00**	**0.00**	**10.00**	**10.00**
			All Sub-Sector	State	410.40	0.00	0.00	0.00	410.40	10.00
				District	143.29	0.00	6.54	0.20	150.03	5.13
				Total	**553.69**	**0.00**	**6.54**	**0.20**	**560.43**	**15.13**
10	Social & Community Services	1	General Education	State	1,161.77	93.81	104.49	0.00	1,360.07	0.00
				District	39.36	14.76	0.67	0.72	55.51	4.51
				Total	**1,201.13**	**108.57**	**105.16**	**0.72**	**1,415.58**	**4.51**
		2	Technical Education	State	75.29	0.00	4.84	0.00	80.13	29.48
				District	155.93	3.93	34.81	3.12	197.79	85.87
				Total	**231.22**	**3.93**	**39.65**	**3.12**	**277.92**	**115.35**

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
		3	Art & Culture	State	67.16	0.00	5.50	0.00	72.66	0.00
				District	6.91	0.00	0.00	0.00	6.91	2.67
				Total	**74.07**	**0.00**	**5.50**	**0.00**	**79.57**	**2.67**
		4	Sports & Youth Welfare	State	96.72	0.00	5.05	0.00	101.77	0.00
				District	27.74	9.36	4.40	1.66	43.16	0.51
				Total	**124.46**	**9.36**	**9.45**	**1.66**	**144.93**	**0.51**
		5	Medical Education	State	184.94	30.00	0.10	0.00	215.04	116.76
				District	7.84	0.00	0.00	0.00	7.84	5.16
				Total	**192.78**	**30.00**	**0.10**	**0.00**	**222.88**	**121.92**
		6	Public Health	State	567.71	37.03	36.13	0.00	640.87	143.50
				District	151.82	0.00	100.18	10.37	262.37	28.76
				Total	719.53	**37.03**	**136.31**	**10.37**	**903.24**	**172.26**
		7	Water Supply & Sanitation	State	311.04	60.00	6.00	0.00	377.04	1.84
				District	394.83	21.08	28.09	5.46	449.46	4.09
				Total	**705.87**	**81.08**	**34.09**	**5.46**	**826.50**	**5.92**
		8	Public Housing	State	1,391.23	568.37	93.63	0.00	2,053.23	0.00
				District	497.30	67.12	88.80	25.01	678.22	5.38
				Total	**1,888.53**	**635.49**	**182.43**	**25.01**	**2,731.46**	**5.38**
		9	Urban Development	State	2,536.55	21.00	5.00	0.00	2,562.55	0.00
				District	**206.67**	0.00	0.56	0.00	207.24	**6.55**
				Total	**2,743.23**	**21.00**	**5.56**	**0.00**	**2,769.79**	**6.55**
		10	Information & Publicity	State	2.88	0.00	0.10	0.00	2.98	0.00
				District	3.31	1.92	0.52	0.07	5.82	0.06
				Total	**6.19**	**1.92**	**0.62**	**0.07**	**8.80**	**0.06**
		11	Welfare of Backward Classes	State	384.36	1,084.19	0.00	0.00	1,468.55	165.25
				District	40.65	364.02	284.55	124.34	813.56	38.52
				Total	**425.01**	**1,448.21**	**284.55**	**124.34**	**2,282.11**	**203.77**
		12	Labour & Labour Welfare	State	19.41	0.00	0.00	0.00	19.41	2.78
				District	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**19.41**	**0.00**	**0.00**	**0.00**	**19.41**	**2.78**

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
		13	Welfare of Weaker Section	State	353.91	681.79	44.50	0.00	1,080.20	6.00
				District	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**353.91**	**681.79**	**44.50**	**0.00**	**1,080.20**	**6.00**
		14	Nutrition	State	546.13	33.94	23.68	0.00	603.75	0.00
				District	2.51	0.15	12.75	0.48	15.89	0.20
				Total	**548.64**	**34.09**	**36.43**	**0.48**	**619.64**	**0.20**
		15	Employment & Self Employment	State	2.94	0.00	20.00	0.00	22.94	0.00
				Total	**2.94**	**0.00**	**20.00**	**0.00**	**22.94**	**0.00**
		16	Welfare of Women & Children	State	97.27	0.50	59.00	0.00	156.77	5.10
				District	146.84	4.85	2.73	1.20	155.62	1.07
				Total	**244.11**	**5.35**	**61.73**	**1.20**	**312.39**	**6.17**
		17	Higher Education	State	33.68	0.00	0.00	0.00	33.68	4.50
				District	15.80	0.00	0.00	0.00	15.80	0.33
				Total	**49.48**	**0.00**	**0.00**	**0.00**	**49.48**	**4.83**
		18	Welfare of Minorities	State	234.28	0.00	0.00	0.00	234.28	10.30
				Total	**234.28**	**0.00**	**0.00**	**0.00**	**234.28**	**10.30**
		19	Local Area Development	State	534.32	39.51	34.48	0.00	608.31	534.17
				Total	**534.32**	**39.51**	**34.48**	**0.00**	**608.31**	**534.17**
		20	Social Security & Insurance	State	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
		21	Higher Education (Arts)	State	10.71	0.00	0.00	0.00	10.71	5.95
				Total	**10.71**	**0.00**	**0.00**	**0.00**	**10.71**	**5.95**
		22	Vocational Education	State	25.61	0.00	0.00	0.00	25.61	24.10
				District	19.51	0.13	5.40	0.27	25.31	0.03
				Total	**45.12**	**0.13**	**5.40**	**0.27**	**50.92**	**24.13**
		23	Professional Education	State	165.11	0.00	0.00	0.00	165.11	118.67
				Total	**165.11**	**0.00**	**0.00**	**0.00**	**165.11**	**118.67**
		24	Public Libraries	State	1.00	0.00	0.00	0.00	1.00	0.40
				District	13.63	0.00	0.11	0.00	13.74	1.49
				Total	14.63	0.00	0.11	0.00	14.74	1.89

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ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
		25	Welfare of Tribal	State	0.00	0.00	1,261.15	0.00	1,261.15	104.90
				Total	**0.00**	**0.00**	**1,261.15**	**0.00**	**1,261.15**	**104.90**
		26	Education of Tribal	State	0.00	0.00	351.95	0.00	351.95	125.45
				Total	**0.00**	**0.00**	**351.95**	**0.00**	**351.95**	**125.45**
		27	Education of Backward Classes	State	0.00	209.75	0.00	0.00	209.75	66.00
				Total	**0.00**	**209.75**	**0.00**	**0.00**	**209.75**	**66.00**
			All Sub-Sector	State	8,804.02	2,859.89	2,055.60	0.00	13,719.51	1,465.15
				District	1,730.65	487.32	563.57	172.70	2,954.24	185.19
				Total	**10,534.67**	**3,347.21**	**2,619.17**	**172.70**	**16,673.75**	**1,650.33**
11	General Services	1	Public Offices & Infrastructure Facilities	State	380.70	0.00	0.00	0.00	380.70	211.00
				District	194.01	0.00	0.00	0.00	194.01	7.42
				Total	**574.71**	**0.00**	**0.00**	**0.00**	**574.71**	**218.42**
		2	Staff Training Programme	State	6.50	0.00	0.00	0.00	6.50	0.00
				Total	**6.50**	**0.00**	**0.00**	**0.00**	**6.50**	**0.00**
		3	Staff Housing	State	84.01	0.00	0.00	0.00	84.01	84.01
				District	47.57	0.00	0.00	0.00	47.57	38.30
				Total	**131.58**	**0.00**	**0.00**	**0.00**	**131.58**	**122.31**
		4	e-Governance	State	24.82	0.00	0.00	0.00	24.82	0.00
				Total	**24.82**	**0.00**	**0.00**	**0.00**	**24.82**	**0.00**
		5	Stationery & Printing	State	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
		6	Administration	State	12.80	0.00	0.00	0.00	12.80	1.92
				District	0.00	0.00	0.00	0.00	0.00	0.00
				Total	**12.80**	**0.00**	**0.00**	**0.00**	**12.80**	**1.92**
		7	General Admistration	State	83.28	0.00	0.00	0.00	83.28	83.28
				Total	**83.28**	**0.00**	**0.00**	**0.00**	**83.28**	**83.28**
		8	Law & Order Administration	State	199.05	0.00	0.00	0.00	199.05	76.32
				Total	**199.05**	**0.00**	**0.00**	**0.00**	**199.05**	**76.32**
		9	Prison and Correctional Services	State	12.92	0.00	0.00	0.00	12.92	7.84
				Total	**12.92**	**0.00**	**0.00**	**0.00**	**12.92**	**7.84**
		10	Disaster Management	State	53.25	0.00	0.12	0.00	53.37	0.00
				Total	**53.25**	**0.00**	**0.12**	**0.00**	**53.37**	**0.00**

ANNEXURE-II

ANNUAL PLAN 2010-11,MAHARASHTRA -APPROVED OUTLAY

(Rs. in crore)

Sr. No.	Sector	Sr. No.	Sub-Sector	Scheme Level	Approved Outlays for Annual Plan 2010-11					
					Total Outlay					Of which capital
					General	SCSP	TSP	OTSP	Total	
			All Sub-Sector	State	857.33	0.00	0.12	0.00	857.45	464.38
				District	241.58	0.00	0.00	0.00	241.58	45.71
				Total	**1,098.91**	**0.00**	**0.12**	**0.00**	**1,099.03**	**510.09**
12	Other Programmes	1	Other Programmes	State	1.00	0.00	0.00	0.00	1.00	0.00
				Total	**1.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**
			All Sub-Sector	State	1.00	0.00	0.00	0.00	1.00	0.00
				Total	**1.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**
	All Sector		All Sub-Sector	State	26,769.29	3,217.10	2,306.95	0.00	32,293.34	12,941.81
				District	3,905.24	650.01	840.94	226.47	5,622.66	1,108.19
				Total	**30,674.53**	**3,867.11**	**3,147.89**	**226.47**	**37,916.00**	**14,050.00**

Annexure 5.2: Sectoral Plan Outlay, Maharashtra 2011-12

Sectorwise position of the plan outlay for the year 2011-2012 is as follows :—

(Rs. crore)

Sector	Annual Plan 2011-2012 (Allocated)
1. Agriculture and Allied Services	2826.74
2. Rural Development	1144.07
3. Special Areas Programmes	185.48
4. Irrigation & Flood Control.	7577.29
5. Power.	2996.36
6. Industries and Mineral	302.35
7. Transport	4625.49
8. Science,Technology and Environment.	28.50
9. General Economic Services.	738.88
10. Social and Community Services.	19296.62
11. General Services.	1409.87
12. Other Programmes.	368.35
Grand Total	41500.00

Note: Screen Shot from Financial Statement, 2011-12, GOM.

Annexure 6.1: Responsibilities and Rules assigned to the CAO- Chief Administrative Officer

Responsibilities and Rule assigned to the CAO-Chief Administrative Officer

1. Departmental enquires / complaints

2. Supply medicines to rural hospitals and other health care institutions

3. Issue administrative approval for the minor civil and electrical work

4. Send proposal for administrative approval of major civil and electrical work to DHS and Government

5. Send monthly expenditure of plan scheme reports

6. Submit quarterly expenditure statement under plan schemes

7. Attend staff meeting / divisional meeting of civil surgeon, DHO etc and DPC meeting

8. Compile all the health indicators and submit to concerned burea Chief and Jt. Director and DHS.

Account Related

1. Release of quarterly grants to ZP and others

2. Reappropriation of accounts – original grants and final modified grants

3. Monthly expenditure statement of all major head of accounts.

Audit

1. Compliance of audit para of subordinate office

2. Inspection and physical verification of stock and stores.

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.