



Deconstructing the DMHP: Part III

Mapping the Fiscal Process

AUTHORS

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Introduction

Since its inception in 1996, the District Mental Health Programme (DMHP) has been integral to the delivery of basic mental health services at a community level in India¹. To date, the DMHP covers 692 districts and has established itself as a key component of the National Mental Health Programme (NMHP)². From a budgetary perspective, mental health funding accounts for 1.3 percent of the government's outlay toward health³. The DMHP, under the aegis of the NMHP, is an essential segment of the government's budgetary provisions towards mental health. However, owing to the decentralised nature of the programme and joint financial responsibility of both the Centre and State in granting funds to the DMHP, it becomes necessary to trace the fiscal allocations towards DMHP and map the budgetary process to determine the extent to which the programme contributes to mental health funding provisions.

This issue brief is part three in a five-part series on the DMHP. The purpose of the brief is to map the process of DMHP funds allocation and disbursement, deconstruct the funding structure for the various components and highlight trends in financing of the DMHP.

Process of allocating and disbursing funds for the DMHP

The NMHP, the umbrella programme for the DMHP, is financed through the National Health Mission (NHM). The NHM is the principal financial vehicle through which the Central Government directs its health expenditure. The NMHP falls under the 'Flexible Pool for Non-Communicable Diseases, Injury and Trauma', the fourth financial component of the NHM⁴. The NCD Flexipool accounted for 3 percent of the NHM allocations to various health components for the FY 2019-20, a 25 percent increase from the previous year, FY 2018-19⁵.

Previously, under the XII FYP, allocations to the NMHP were made through the National Rural Health Mission (NRHM), which has now been subsumed as a sub-mission under the NHM along with the National Urban Health Mission (NUHM)⁶. The Financial Management Group (FMG) is the fiscal authority responsible for the financial management of all NHM programmes. Its functions include planning, budgeting, accounting, reporting, management of internal controls such as internal and external audits, procurement, disbursement of funds and monitoring of the performance of the programme⁷. The FMG was appointed under the NHM (previously NHRM) Finance Division of the Ministry of Health and Family Welfare (MoHFW). To improve financial management capabilities, states and districts have been notified to set up FMGs at both levels to enable them to effectively manage funds they receive from the government⁸.

Approval for funding under the NHM is based on State Project Implementation Plans (PIPs). At the district, the Programme Officer is responsible for drafting the District Health Action Plan for the DMHP in the upcoming year and presenting it to the District Health Society. All planned activities for the DMHP from the various districts are consolidated along with other health expenditures by the State Government in the NHM PIP and are submitted to the MoHFW. Revisions, if necessary, are sent back to the states to address the recommended changes and return it to the ministry. Once the revised PIPs have been examined and approved, the final approved budgets called the Record of Proceeding (ROPs) are released. On approval of the RoPs, funds are split between the central and state governments. For most states, funds are shared in a 60:40 ratio between the centre and state, with the exception of Himalayan and North-eastern states where the ratio is 90:10. Funds are then disbursed in instalments to the states to distribute for approved DMHP activities. This process is illustrated in *Figure 1*.



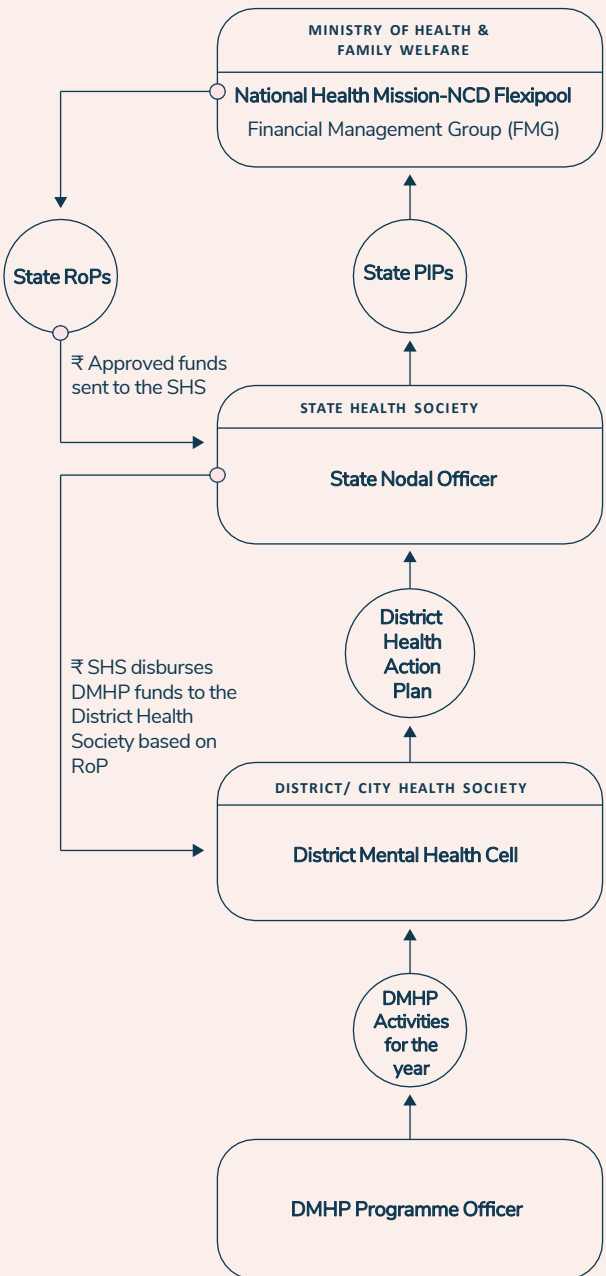
Every year State PIPs are submitted to the MoHFW by February and approved RoPs are issued in April. To ensure sufficient time is allotted to consolidate all state health programmes and activities in the PIP in January, the DMHP plan should be shared with the State Government by December of the previous year. Once funds are approved, they are directed to the State Health Society (SHS) where they are earmarked for approved activities. The State Nodal Officer for the NMHP releases grants to the District/ City Health Societies for each of the respective DMHP districts designated for the year under the state plan.

While it is clear that central funds for the DMHP are allocated through the NHM, it is difficult to ascertain how states finance the DMHP. This could be attributed to the flexibility assigned to the states under the NHM to plan and decide the use of budgets for financing health programmes⁴. States historically, though, have received criticism on their budget allocations towards the DMHP which have generally been low⁹.

The funding to the DMHP by the Central Government has been limited to five years from the date of initiation of the DMHP in a particular district. Following this period of five years, States are required to take over and sustain the programme¹⁰. Government reports indicate that while this has been stipulated in the guidelines, in reality, states have been hesitant to completely finance the programme. In certain states, where the Centre is no longer providing financial support, the funds are insufficient to meet expenditures for the programme¹¹.

Figure 1: Process flow for DMHP fund allocation and distribution for the implementation of district-level activities under the NMHP

(Image Credit: IMHO; Data Source: 12th Plan Guidelines for the DMHP)





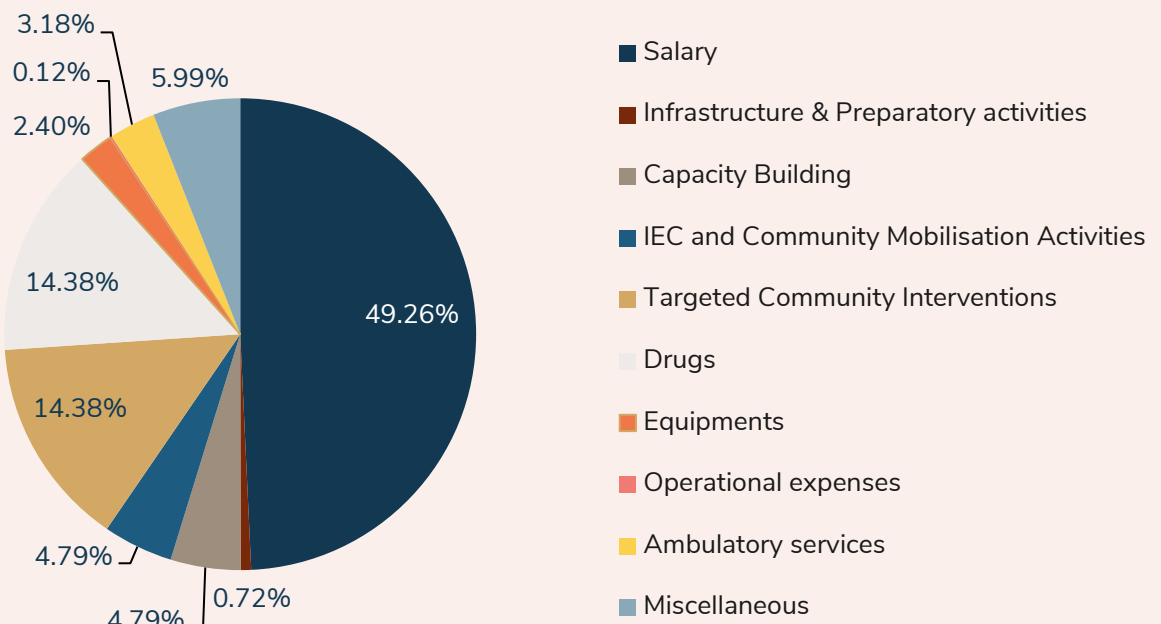
Budget allocations for DMHP Components

Guidelines prescribed by the XII FYP provide an estimate for the cost of initiating the DMHP in a district for a period of five years. The DMHP programme earmarks funds for 10 components:

1. Salaries for human resources
2. Infrastructure development and other preparatory activity costs
3. Capacity building expenses
4. Information, Education and Communication (IEC) and community mobilization activities
5. Targeted outreach activities
6. Psychotropic Drugs
7. Equipment
8. Operational expenses
9. Ambulatory services
10. Miscellaneous expenses that include travel and contingency costs

The largest expense category is towards salaries of DMHP staff which amounts to INR 20,555,496, approximately 50 percent of the total expenditure. Targeted community interventions at schools, colleges, workplaces that include imparting counselling training to teachers and provision of psychotropic medication are the next highest expense, both estimates are at INR 6,000,000 each. The estimated expenditure for the training of healthcare professionals and for conducting awareness generation and community mobilisation activities is INR 2,000,000 each. Expenses for travel and contingencies are around INR 2,500,000, The remaining expenses are towards ambulatory services (INR 1,326,168), equipment (INR 1,000,000), one-time infrastructure and planning costs (INR 300,000) and operational expenses (INR 50,000)⁷. Figure 2 depicts the proportion of funding estimates for each component of the DMHP.

Figure 2: Proportion of funding estimates for each component of the DMHP for the initial five years
(Image credit: IMHO; Data source: 12th Plan Guidelines for the DMHP)





In 2008, prior to the release of the XII FYP guidelines, the Indian Council for Marketing Research (ICMR), a consulting agency, carried out an evaluation study of the 20 DMHP districts that implemented the programme during the IX and X FYP¹⁰. The researchers collected information on yearly receipts on utilisation to determine actual expenditures for the different components of the programme. The findings reveal different utilisation trends across the districts. For salaries, six districts had exceeded allocations while in certain other states the salary outlays were under-utilised as medical professionals employed in government hospitals were contracted on to the DMHP, receiving their funds from non-DMHP sources or not utilized at all due to non-availability of staff. Low salary remunerations and the poor salary structure have been a concern for several states and have affected their ability to recruit and retain qualified mental health professionals to the DMHP¹¹. Similar utilization trends of over-utilisation in certain districts and under-utilization in others were observed for drug provision and equipment, including vehicles. On the other hand, for the capacity building and IEC related components, all districts in the study reported below par utilization¹⁰. This could be attributed to the absence of a standardized set of activities for training and IEC and the poor volition on the part of few districts to conduct training sessions for general healthcare workers¹⁰.

While the XII FYP guidelines provide direction on allocations, states have been provided certain flexibility in how they choose to allocate and utilize funds. In 2018-19, the Assam Government released operational guidelines for the implementation of NMHP in the state. Rather than component-wise distributions, funds are allocated based for each activity under the DMHP in addition to expenses related to drugs, equipment and ambulatory services. For instance, the detailed budget estimates for outreach activities at schools, colleges, workplaces and jails are broken down further under the guidelines¹².

Previous financial outlays towards the DMHP

As highlighted in part one of the DMHP series, the programme was launched in 1996 with an initial budgetary provision of INR 270 million. By the IX FYP, the programme covered 27 districts. In the subsequent X FYP, the DMHP expanded to 94 districts and received an allocation of INR 1.9 billion. This rising trend in budgetary allocations continued into the XI FYP, with the DMHP extending to 123 districts with an outlay of INR 100 billion¹³. The guidelines issued by the MoHFW for the implementation of District-level activities under the NHMP under the XII FYP pre-approved an outlay of INR 126.5 billion toward the DMHP⁷. Across all periods, however, it was unanimously observed that central funds actually allocated were substantially reduced due to sub-par utilization of funds¹⁴.

Trends in DMHP expenditure/ budget allocations

Since the XII FYP plan, there has been little to no evidence on the financial performance of the DMHP across the states. Estimating DMHP budgets and expenditure is a challenge. Budgets released by the MoHFW every year, titled 'Demand for Grants' provide an estimate of funds for all NMHP activities. However, the NHMP does not delineate the proportion of funds that are allocated to the multiple activities under the overarching tertiary programme¹⁵.

The Guidelines for Implementation of District level activities under the XII FYP present a list of activities planned at a district level for the NMHP. Among the several activities, DMHP was granted the largest proportion of funds at INR 126.5 billion, around 80 percent of the INR 157.7 billion approved for NMHP district-level activities⁷.

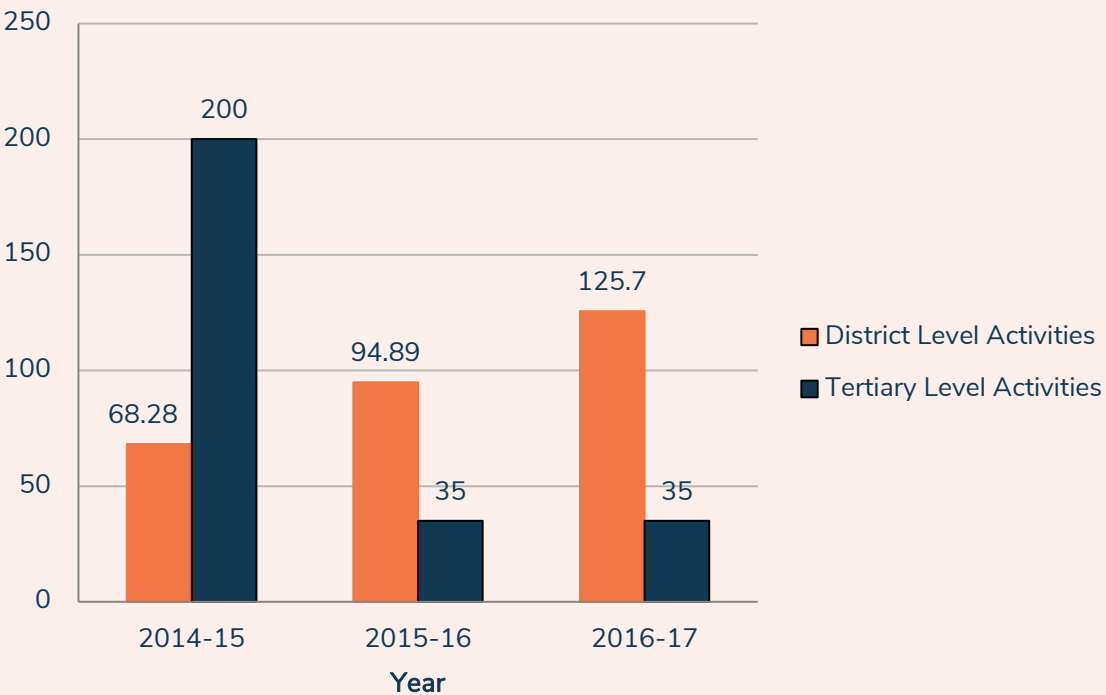


In 2017, a parliamentary question was posed to determine allocation towards mental health. In response, it was indicated that over a three-year period from 2014, INR 28.89 billion was allocated towards NMHP district-level activities. As indicated in *Figure 3*, funds for district-level activities rose, while for NMHP tertiary activities, funding seemed to drop¹⁶.

In the following year, in response to a question in the Rajya Sabha, the MoHFW provided funding information on NMHP district level activities across

a three-year period for all States and Union Territories. In general funding towards district-level activities, more than doubled between 2015-16 to 2016-17. In 2015-16, sixteen states/ union territories did not receive any funds for NMHP district-level activities. From 2015-16 to 2017-18, funds declined significantly, by nearly half. A detailed breakdown of funds by state/ union territory can be found in *Figure 4*¹⁷.

Figure 3: Details of funds allocated from 2014-2017 under NMHP (in INR Crores)
(Image Credit: IMHO; Data source: Rajya Sabha Unstarred Question No. 4447, April 2017)





It is important to remember that the DMHP is only one part of the NMHP district-level activity portfolio and it is difficult to ascertain the proportion of funding allocated towards the DMHP specifically.

However, using the XII FYP guidelines as a yardstick, it can be assumed that the DMHP comprises a majority of the funds appropriated towards the NMHP district-level activities⁷.

Figure 4: NMHP District-level activities funds approved for States and UTs for 3 years [in lakhs] (1/2)

(Image credit: IMHO; Data source: Rajya Sabha Unstarred Question No. 87, December 2018)

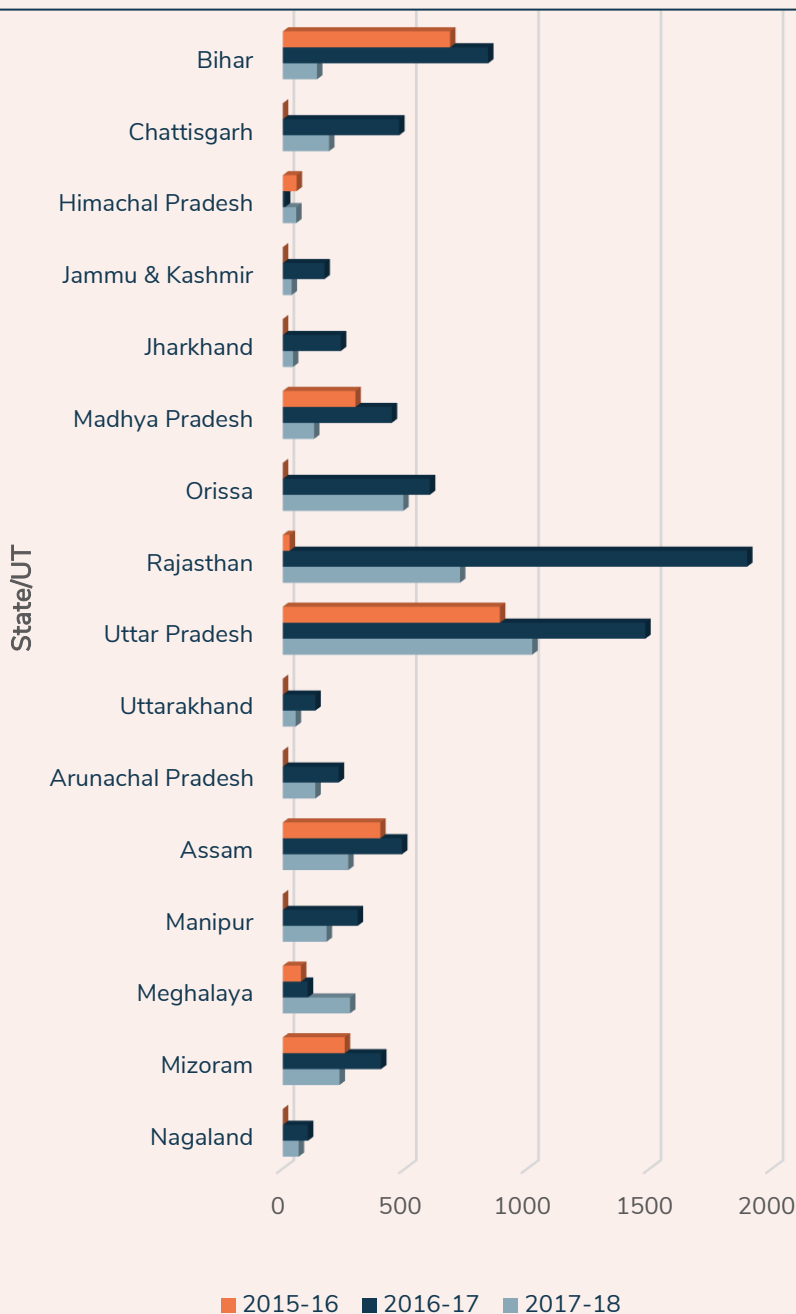
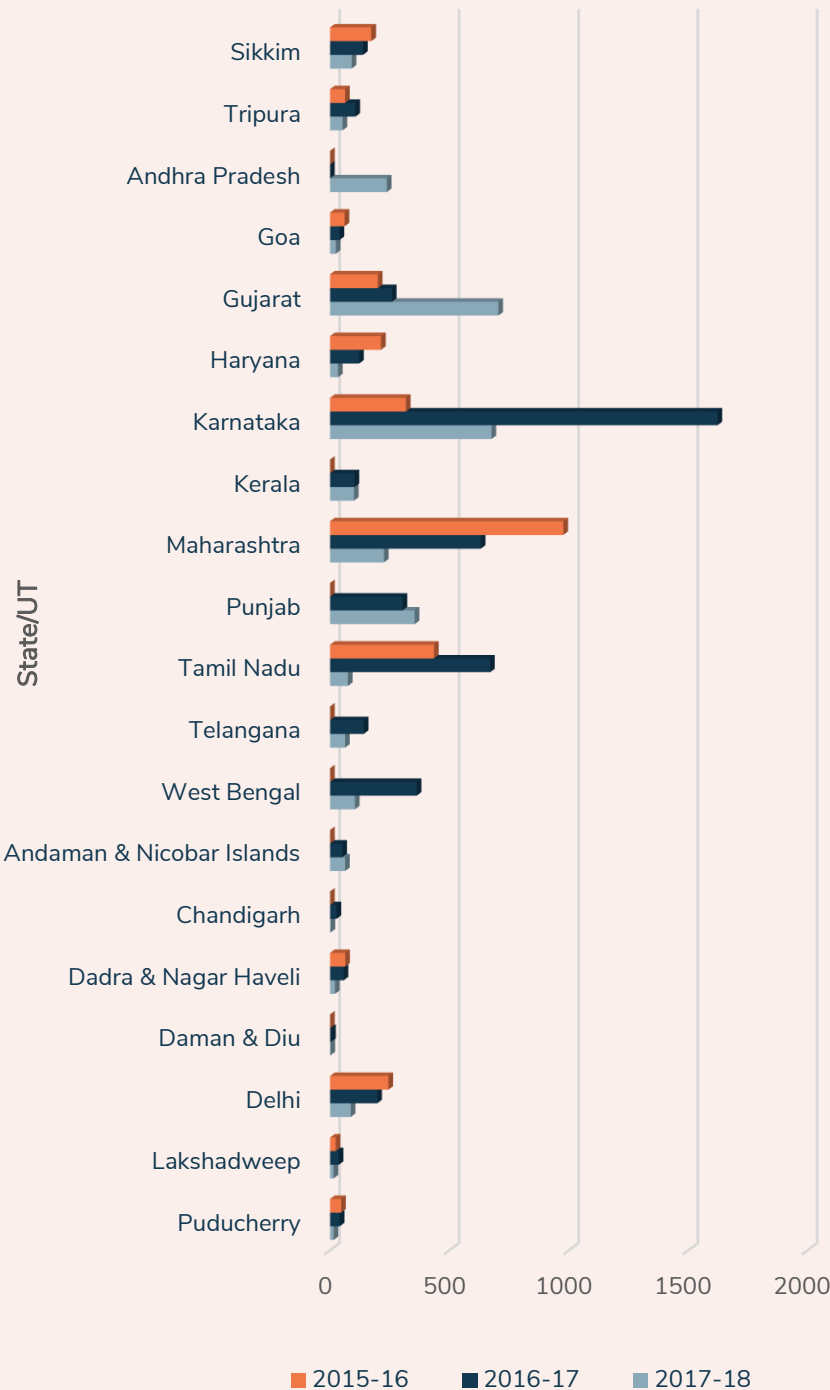




Figure 4: NMHP District-level activities funds approved for States and UTs for 3 years [in lakhs] (2/2)

(Image credit: IMHO; Data source: Rajya Sabha Unstarred Question No. 87, December 2018)





Accountability and audit mechanisms

The Grant-in-aid distributed to the NMHP is contingent upon conditions under the General Financial Rules, 2005. Financial accounts under the grantee institutions (the DMHP, in this case) are subject to inspections by the MoHFW, the sanctioning authority and audits by the Comptroller and Auditor General of India. Performance audits have been conducted in the past on mental health services that have included the DMHP in certain states such as West Bengal (2014) and Kerala (2010)^{18,19}. Internal controls are also established for audits by the office of the Chief Controller of the Accounts of the MoHFW, when a request has been issued⁶.

Conclusion

The DMHP, in its various iterations, has faced a number of implementation challenges compounded by funding-related bottlenecks. The Mental Health Policy Group (MHPG), designated by the MoHFW to draft the DMHP guidelines for the XII FYP, highlighted inconsistent fund flow, underutilisation, difficulties in accessing funds due to administrative delays and poor coordination between disbursement authorities at a state level as some challenges²⁰. To address funding inefficiencies, the MHPG recommended establishing a clear programme management apparatus to ensure the 'efficient, timely and full implementation of the DMHP'²⁰. It is difficult to ascertain if these recommendations have been implemented by the relevant authority as there is no evidence of their adoption.

The DMHP has been requisite to scaling up mental health service delivery in the country by enhancing access to services at a community level²¹. With this in mind, it is important to consider where the DMHP is positioned among the government's mental health financing priorities. While the thrust of the National Mental Health Policy and the Mental Healthcare Act, 2017 has been towards integrating mental health services with general healthcare, it should be noted that a staggering amount of financial resources from the MoHFW are directed towards the maintenance of mental health institutions while less than 10 percent is allocated towards the DMHP, according to data from 2017-18²². Part four of the DMHP series aims to critically assess some of these strategic and implementation misalignments and further unpack the funding challenges highlighted in this brief.



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