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Budget Analysis

Health Department
Mardan, Peshawar &
Swabi Districts

From 2011-12 to 2013-14

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Abbreviations/Acronyms

EDO Executive District Officer
CGPA Center for Governance and Public Accountability
GHS General Hospital Services
EPI Extended Program for Immunization
DSM District Support Manager
FY Financial Year
KPK Khyber Pakhtunkhwa
PKR Pakistani Rupee
BHU Basic Health Unit
RHC Rural Health Center
PPHI People Primary Healthcare Initiative
TA Travelling Allowance
TB Tuberculoses
NWFP North West Frontier Province
PH Primary Health
HCV Hepatitis C Virus
HBS Hepatitis B
HIV Human Immunodeficiency Virus
A&E Accidents and Emergency
DO District Officer
DHO District Health Officer

1. Introduction

1.1: Background of the Current Study: Health Sector Strategy

Comprehensive development strategy (CDS) 2010-17 is the latest policy/strategy document developed by the Government of Khyber Pakhtunkhwa which reflects vision and strategic direction of the policy makers. This strategy envisaged a vision of 'attaining a secure, just and prosperous society through socioeconomic and human resource development, creation of equal opportunities, good governance and optimal utilization of resources in a sustainable manner'. [1] Within the framework of the CDS, a strategy for the Health Sector was developed with consultation of relevant stakeholders from the health profession and local community. Though political government changed in the meantime but priorities may be more or less the same as the document comprehensively analyzed the outcomes and key challenges faced to achieve those outcomes. Budget 2013-14 was also part of that continuation, though presented by the new government. Priority areas for the health sector were selected which were later formulated into the five health outcomes shown in the box 1.1 below[2];

Box 1.1

Outcome 1: Enhancing coverage and access to essential health services, especially for the poor and vulnerable,

Outcome 2: A measurable reduction in morbidity and mortality due to common diseases especially among vulnerable segments of the population,

Outcome 3: Improved human resource management,

Outcome 4: Improved governance and accountability,

Outcome 5: Improved regulation and quality assurance.

[1] Comprehensive Development Strategy 2010-17, Government of Khyber Pakhtunkhwa, April, 2010

[2] Khyber Pakhtunkhwa Health Sector Strategy 2010-17, April 2010

1.2: Objectives of the Study

Current study is an attempt to analytically look into the three year budget allocation to the health sector of the three districts and analyze it in the context of the outcome indicators of the overall health strategy. This study is aimed at analyzing the budget making process, prioritization, budget allocations, utilization and gauging people participation in the entire process. Specific objectives of the study are to:

1. Review the budget making process, its effectiveness and suggest improvements in the health sector budgeting at district Peshawar, Mardan and Swabi.

2. Demystify budget books through sector and year wise trend analysis enabling the citizen to interpret, understand and advocate for equitable and accountable allocation of health budget and its utilization in Peshawar, Mardan and Swabi districts.

3. Identify areas of improvement in the budget making, utilization and relevant procedures and departments involved and present recommendation to the selected district and provincial authorities. This will also help as a feedback to those policy makers who have devised the overall health sector strategy.

1.3: Data Collection & Methodology

In order to get information and analyze them for findings, CGPA formed a team of budget analysts, comprising of a budget analysis consultant, program officer accountability and program officer RTI. The study used primary as well as secondary data for the analysis. Primary data source and method was Key Informants Interviews mainly with the Health Department Officials. Frequent visits were made to the health officials in all three districts and feedbacks were received from doctors and population who use government health facilities. While secondary data sources were budget rules 2003, budget books for education and health for Peshawar, Mardan and Swabi districts.

The team followed a plan containing detail of major activities, their timeline, responsibility and expected deliverables. The plan itself presented a logically sequenced methodology encompassing activities including access to the source books/budget books, tabulation of key information, historical trend analysis, and sector and sub sector analysis.

To get the source/budget books, the Budget Analysis team approached office of the Executive District Officer Health, Deputy District Health Officer and Finance and Planning Department at district level. A formal information request was submitted to these officials for provision of budget books from

financial years 2011-12 to 2013-14. Once the budget books were received, the team extracted historical data for each year from for the health sectors of the respective districts. The data comprised of allocated and revised budget for 2011-2012, 2012-13 and budget allocation for 2013-14. Figures extracted were put into tables. The tables were further presented through charts and graphs, making the analysis understandable and presentable. Linear charts were used to portray trends (of increase or decrease), pie charts were used to depict shares of different sectors or sub sectors while bars were used to presents volumes in respective financial years.

This particular methodology was adopted to ensure alignment to the very purpose of the study to make it easily understandable and usable for citizens. The analyses made are in simple and understandable manner, making it easy for the citizen to interpret the complex budgetary terms and their utility. To this end all figures given in the budget books have been plotted over tables, charts and graphs followed by commentary explaining the change happened from one fiscal year to another. Also the analyses have been framed in shape of key findings enabling the reader to grasp key indicators conveniently.

1.4: Scope of the study

This study is restricted to the health budgets of the three districts from the fiscal year 2011-12 onwards. The main sector covered under this study is health sector with sub heads including General Hospital Services, Administration, Basic Health Units, Drug Control, Mother and Child Health Care, other diseases prevention in the three districts and related administrative and operational heads. The analysis uses information from the budgets books, interviews with health officials and inputs from the civil society. Two main cut off points have been used for the analysis i.e. the estimates made prior to the budget allocation, the actual expenditure in shape of revised estimates. The study analyzed estimated and revised budgets for fiscal years, 2011-12, and 2012-13 and 2013-14 for district Mardan, Swabi and Peshawar. The study do not cover budgets allocated or spent in the non government sectors like Civil Society, NGOs and other direct spending in the sector. The study also excluded the development budget from the analysis as it only focus on the current budget.

2. A brief Profile of Population of Mardan, Peshawar & Swabi Districts

According to the 1998 census, the combined population of these three districts is equal to 4.5 million out of a total population of 17.7 million of the Khyber Pakhtunkhwa province, which mean a quarter of the population of the province lives in these three districts. The projected average population density of these three districts is much higher at around 5160 persons per square kilometer as compared to the overall projected population density of the province at around 361 persons per square kilo meter. It is to be noted that population density has increased sharply in these three districts as compared to 3173 person/square kilo meter during 1998 census thus putting pressure on existing health facilities in these districts. The projected population of these three districts for 2013, based on the annual average growth rate of the previous two censuses, is hovering around 7.3 million out of a total of 27 million for the province, around 27.12 % of the total population of the province. It should also be noted that these three districts also received a bulk of population as Internally Displaced Persons (IDPs) due to War on Terror in Malakand Division & FATA thus the actual population will be much higher. Newspaper reports suggest that a part of these IDPs are now being permanently settled in these districts as they have no sources of livelihood left in their home districts to earn a decent living.

Some of the characteristics of the population of the three districts under study and of Khyber Pakhtunkhwa are given below in table 1.1. Projected figures are also given based on the annual average growth rate of population from census in 1981 to census in 1998. The data also shows that majority of the population lives in the rural areas thus putting pressure on the government to provide health facilities at their door-steps. Though literacy rate has been improved in 2011-12 as compared to 1998, but still half of the population is illiterate and any public health awareness campaign will be difficult to reach to all the segments of population, especially the poor and vulnerable. Special measures would be needed to educate the illiterate population through public awareness campaign. Similarly, female literacy ratio is very low as compared to male literacy ratio which will inhabit government efforts to reach the mother and child related health issues.

Provision of health facilities to rural areas (through BHUs, RHC etc) is a major task for the government if it wants to control migration from villages to the cities. Health facilities in major cities are already under tremendous pressure as lack of quality health facilities at the district level cause shifting of burden on major cities.

Table 1.1: Population and Literacy Indicators-A comparison

	Peshawar	Mardan	Swabi	Khyber Pakhtunkwa
Population				
1998 Census (in numbers)	2,026,851	1,460,100	1,026,804	17,744,000
Urban (in %)	48.5%	17.5%	17.5%	16.9%
Rural (in %)	51.5%	79.8%	82.5%	83.1%
Growth Rate[1]	3.6%	3.0%	2.96%	2.8%
2013 (Projected)	3,435,266	2,278,103	1,590,433	26,928,708
Area (in Sq Km)	1,257	1,632	1,543	74,521
Literacy Ratio 10 year + (1998)[2]	41.70%	36.5%	36%	35.41%
Male	55.97%	53.5%	54%	51.39%
Female	25.85	18.4%	18%	18.82%
Literacy Ratio 10 year + (2011)[3]	54.0%	48.0%	52%	50.0%
Male	68.0%	65.0%	68%	68.0%
Female	38.0%	31.0%	36%	33%

1. Annual Average Growth Rate from based on 1981 & 1998 census
2. Based on 1998 census
3. Based on PSLM 2010-11

3. Current Status of Health Facilities & Needs

This section provides basic information of health service delivery and their current situation in the three districts under study.

All the three tier of governments i,e; Federal, Provincial and District Governments provides health service in one or the other form. Federal government is mainly responsible for formulating the overall health policy for the country and some tertiary and vertical programs which are implemented throughout the country. Federal government also provides financial support to communicable disease prevention and its control. Prevention & control of Hepatitis, Malaria, and Diarrhea etc are some of the examples. At the provincial level also, Health strategy and policy are designed and implemented such as the latest Comprehensive Strategy 2010-17 for the health sector in the overall framework of Comprehensive Development Strategy. Besides provision of policy guidelines, provinces also help in implementing the federal level policy and programs of prevention and control of communicable diseases. Provinces has also full control of tertiary health care hospitals and overseas and monitor

primary and secondary level health care by the districts. The district level main responsibility is to provide primary and secondary level health care facilities. It also implements the provincial and federal level programs. So when it comes to implementation the overall health care initiatives of the federal and provincial governments, it is the district governments which implement these programs thus the focus of this study is on the district level.

3.1: Health Facilities

According to the white paper on the budget of 2013-14, there are 12,568 beds in the hospital throughout the province. Similarly in terms of human resource, Health department is the second largest employer in the province with total number of 52,842 employees including more than 13,000 LHWs.

The overall situation of the health facilities is very grim in the province as for a population of around 27 million people there are only 12,568 beds available in the hospitals for a ratio of 1 bed for 2143 persons. Similarly there is only one hospital (any type of) per 16705 persons in the province. The situation is more severe in the districts under study as these are most populated districts of the province. The number of persons per hospital in Swabi, Mardan & Peshawar is 23737, 25887, and 31516 respectively. As more than 83% (around 22 million) of the population of the province lives in the rural areas, there are only 784 BHUs to cater for their health needs. Even these available BHUs are often far away from the patient's home and the facilities don't attain the minimum satisfactory level of the populations. For example in rural areas of Swabi District, only 7% mothers deliver their children in a government provided health facility (Govt hospital/RHC/BHU etc)[3] while the bulk of mothers deliver their children at home. The same ratio is 14% and 20% for Mardan and Peshawar District. In another example, based on the PSLM survey of 2007-08, 43% of the people in rural areas did not visit a government facility for diarrhea treatment because there was no government facility or it was too far away. A further 15% said that a doctor was never available upon the visit while another 13% said that if the staff was available they were not courteous at all.

[3] Based on the statistics provided in the Pakistan Social & Living Standard Measurement Survey 2010-11

Table 1.2 provides district-wise health facilities in three districts under study with the overall situation in Khyber Pakhtunkhwa province.

Table 1.2: District-wise Health Facilities in Mardan, Swabi & Peshawar

	Mardan	Swabi	Peshawar	KP
BHUs	50	40	48	784
Dispensaries	18	13	37	421
Hospitals	6	5	12	48
Other Hospitals	-	-	-	121
MCH Centre	3	3	4	66
RHCs	6	4	3	86
SHCs	3	0	0	26
TB/Leprosy Clinic	2	2	5	60

Source: http://www.healthkp.gov.pk/

3.2: Health Needs: A situation analysis of the health sector

The overall situation of health care provision is very poor in the province. To have a glimpse of the situation, two tables are presented here to show the status of health care facilities in the districts under study. Table 1.3 below shows the percentage distribution of population fallen sick or injured and their effort to seek consultation for the health care. Around 7.82% of the population reported an illness during the previous two weeks in the entire province and almost 94 % of these fallen sick sought for health consultation. This shows people do give top priority to their health status and if provided with affordable and quality care, they can be treated for their illness. However due to poor coverage and quality of the government health facilities, only a small portion of the sick population go to government run health facilities.

Table 1.4 reports the details of the health consultation sought by type of facility. Only around 30% of those who fallen sick or injured visit a government run health facility while the remaining prefer to go other facilities. A bulk of these people goes to either a private health facility or to a chemist for the treatment of their illness. There may be two major reasons for this: One is the quality of the health facility provided by the government and the other is the distance of health facility from people who are either sick or injured. A quarter of sick or injured population visit the chemist which is alarming as

most of the chemist are not trained for the job and it is illegal to give medicine over the counter. Studies suggest that it may cause serious health issues. This was also noticed by our field supervisor in their visits to the respective districts. For example, one field supervisor spent some time with an untrained chemist in close vicinity of the DHQ hospital Swabi and the sick/injured often visit for treatment despite the fact that a DHQ hospital was just around the corner. This shows the dissatisfaction of the persons on the government health facility provided near his home. The need is to gain confidence of the population which is only possible through quality health care provision. A medical officer at a BHU in District Swabi told our field reporter that due to shortage of medicine in the facility, poor people do not visit the facility as they can afford to buy medicine from the market.

While the prevalence of diseases may be around 7% in the overall population, its prevalence is almost double below the age of five years. In Khyber Pakhtunkhwa 12.04 percent of the children under age 5 were reported sick or injured as compared to 7% for the overall population. Similarly around 66 percent of the mothers deliver their children at home while only 14 visit a government health facility. In Swabi District, 73% of the deliveries occur at home while only 7% visit a government health facility. In Mardan, the ratio of home delivery is 68% while that at government facility is 14%. Similarly, in Peshawar the ratio of home delivery is 56% while at government facility is 20%. There is a lack of skilled birth attendant at government health care facilities and there is a special need for training community midwife under the maternal and neonatal child health programmes. New mother and child health care units need to develop.

Table 1.3: %age distribution of Population fallen sick or injured during last two weeks of the interview and by health consultation sought

Region	Sick or Injured			Health Consultation		
	Male	Female	Total	Male	Female	Total
Swabi	**7.01**	**9.65**	**8.35**	**97.35**	**94.79**	**95.85**
Urban	5.51	6.54	6.04	100.00	100.00	100.00
Rural	7.35	10.36	8.87	96.91	94.05	95.21
Mardan	**5.51**	**8.60**	**7.05**	**99.25**	**94.75**	**96.52**
Urban	5.27	9.57	7.41	100.00	95.92	97.38
Rural	5.58	8.34	6.95	99.06	94.40	96.27
Peshawar	**6.22**	**7.83**	**7.00**	**97.20**	**95.70**	**96.39**
Urban	5.37	7.18	6.23	97.17	96.91	97.03
Rural	7.19	8.54	7.85	97.23	94.61	95.83
Khyber Pakhtunkhwa	**6.82**	**8.84**	**7.82**	**94.88**	**94.42**	**94.62**
Urban	5.80	8.04	6.90	97.04	96.87	96.94
Rural	7.03	9.00	8.01	94.51	93.98	94.21

Source: PSLM Survey 2010-11

Table 1.4: Percent distribution of health consultation in past two weeks by type of health provider Consulted

	Private Disp/Hospital	Public Disp/Hospital	RHC/BHU	Hakeem	Homeopath	Chemist	Other
Swabi	**37.87**	**23.19**	**10.11**	**0.85**	**0.98**	**24.47**	**2.53**
Urban	53.36	27.24	1.80	0.00	1.40	14.92	1.28
Rural	35.38	22.54	11.45	0.99	0.92	26.00	2.73
Mardan	**41.22**	**30.51**	**5.80**	**0.90**	**0.34**	**20.93**	**0.31**
Urban	42.98	46.46	0.00	0.95	0.00	9.62	0.00
Rural	40.71	25.90	7.47	0.88	0.44	24.20	0.40
Peshawar	**41.55**	**34.75**	**6.28**	**0.58**	**0.00**	**16.20**	0.64
Urban	46.04	35.33	2.83	0.00	0.00	15.28	0.52
Rural	37.58	34.23	9.32	1.10	0.00	17.02	0.75
Khyber Pakhtunkhwa	**49.92**	**26.44**	**7.40**	**0.97**	**0.37**	**14.29**	0.62
Urban	50.10	34.05	1.85	0.72	0.43	12.54	0.32
Rural	49.89	25.07	8.40	1.02	0.35	14.61	0.67

In Khyber Pakhtunkhwa as in other parts of the country, quality of health services is often poor, resulting in waste of both government and household resources and having little impact on health outcomes, particularly women and children. Khyber Pakhtunkwa government in their 2010 health sector situation analysis did a comprehensive need assessment in the health sector with consultation of doctors and health sector professionals, which are given in Box 1.2;

Box 1.2

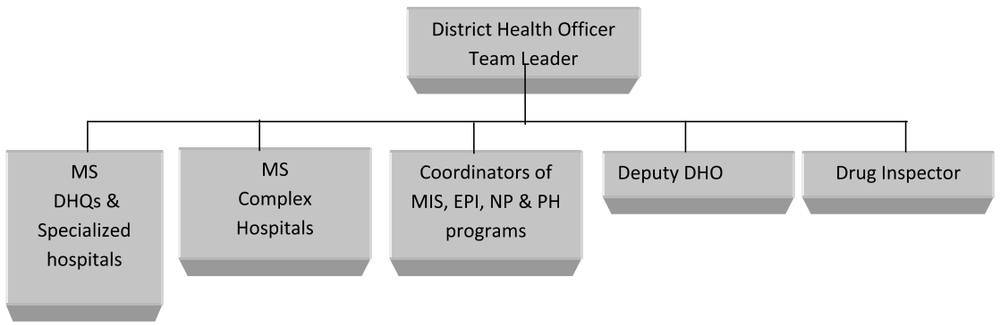
1. Mother and child related health care provision is one of the primary health facility needed to be provided to the citizens especially to the poor and most vulnerable. Parents need to be convinced to visit government health facilities.
2. The provision of rehabilitation services to the conflict areas and militancy related casualties is needed as these three districts were heavily targeted by such incidents. These three districts received a large number of Internally Displaced Persons (IDPs) and the burden on the existing facilities is tremendous.
3. Enhancement of the capacity of Accident and Emergency Departments in these three districts to provide the much needed care at the earliest to save the lives of those who need quick emergency help.
4. Launch of rigorous vaccination campaigns for diseases like polio, HCV/HBS/HIV etc aided by strong campaign on media is much needed. Provision of security to the Anti-polio workers should be strengthened as their teams are on the target from the militants. The workers involved in such campaigns are also deprived of their salaries due to lower budget allocations.
5. Establishment of Drug control units
6. Alertness of ambulances on 24/7 basis and quick first aid.
7. Cheap /affordable health camps/units in far flung areas of District

4. Structure of District Health Department

Normally, health care delivery network in a district is headed by District Health Officer in each district, being the team leader. The DHO is assisted by Deputy DHO, the Medical Superintendents of DHQ hospital and Medical Complex, Coordinators of MIS, EPI, NP and PH programmes.

Organogram

The organizational structure of district health department is given below.



5. Analysis of health budgets of Peshawar, Mardan & Swabi

Districts of Peshawar, Mardan & Swabi of the Peshawar valley comprise of more than 25 per cent of the total population of Khyber Pakhtunkhwa province. Following the purpose of this study, the research team has collected, plotted and presented the budget information in a simple and concise manner, making it convenient for citizens to comprehend and advocate for more equitable and accountable budgeting and thus utilization. To this end, the information collected from source books and key informants have been plotted in the form of tables, charts, graphs. For explanation of complex terms, interpretation has been added to each of the table, chart or table. All the figures and facts presented here are taken from the budget books and hence represent actual data as found in the books. Each section carry analysis on at least three perspectives, overall allocation with percentage against the total, allocation and spending in the main heads, allocation and spending in the sub heads. Variances and trends in the respective tables, and charts are presented likewise.

5.1: Total District Health Budget Allocations

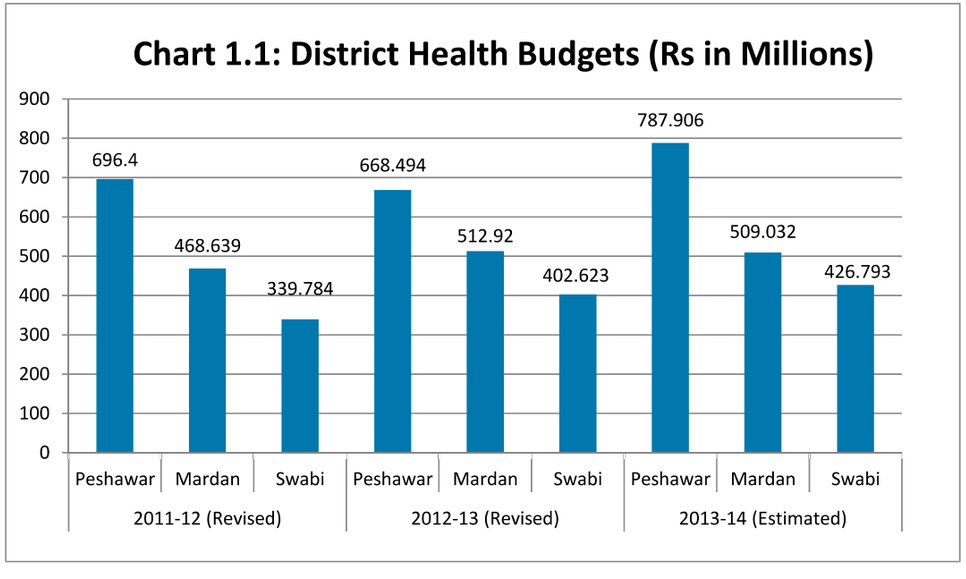
The overall health budget for three districts under study is shown in Table 1.5 below. Successive district health budgets show an increase from the previous financial years, on average. The revised budgets are much higher than the one which were estimated at the time of budgets. In our discussions with budget making officials in the districts, we were told that in fact the actual budget is the revised one as the values in the estimated budgets are arbitrary. Almost all the revised budgets are higher than the one planned at the start of the financial years. This shows poor planning at the start of the budget making as the difference between the estimated and revised budgets is as high as 66% for the year 2011-12 for Mardan District.

The overall revised budget for the Peshawar District is actually showing a decline from Rs 696.4 million in 2011-12 to Rs 668.5 million in 2012-13. However, the current year estimated budget shows an increase of 18% to Rs 787.9 million from the previous year revised budget of Rs 668.5 million. For the Mardan District, budget estimates for the current financial year show a decline of around 1% as the allocation are Rs 509 million in 2013-14 as against Rs 512.9 million in 2012-13. However, the amount in 2012-13 is much higher, at around 10%, than the revised estimates of Rs 468.6 million in 2011-12. For the Swabi District, the budget allocation shows an overall rising trend for the last three years.

Looking at the health budgets of the three districts, the per capita health expenditure of the district is around Rs 240 which is very low. The per capita spending of the district on health in 2013-14 for Peshawar, Mardan & Swabi are Rs 229, Rs 223 and Rs 268 respectively. This shows a steady rise from the per capita expenditure of the districts on health in the year 2011-12. The first and foremost problem of the health sector is lower budget allocation in the budgets despite the fact that in Comprehensive Development Strategy, health sector was the priority sector for the provincial government.

Table 1.5: District-wise Allocation of Budget for the Health Sector (Rs in Millions)

Districts	2011-12		2012-13		2013-14
	Estimated	Revised	Estimated	Revised	Estimated
Peshawar	560.9	696.4	656.3	668.5	787.9
Mardan	281.9	468.6	431.4	512.9	509.0
Swabi	233.4	339.8	338.8	402.6	426.8



5.2: Allocations to Different Heads in Health Sector

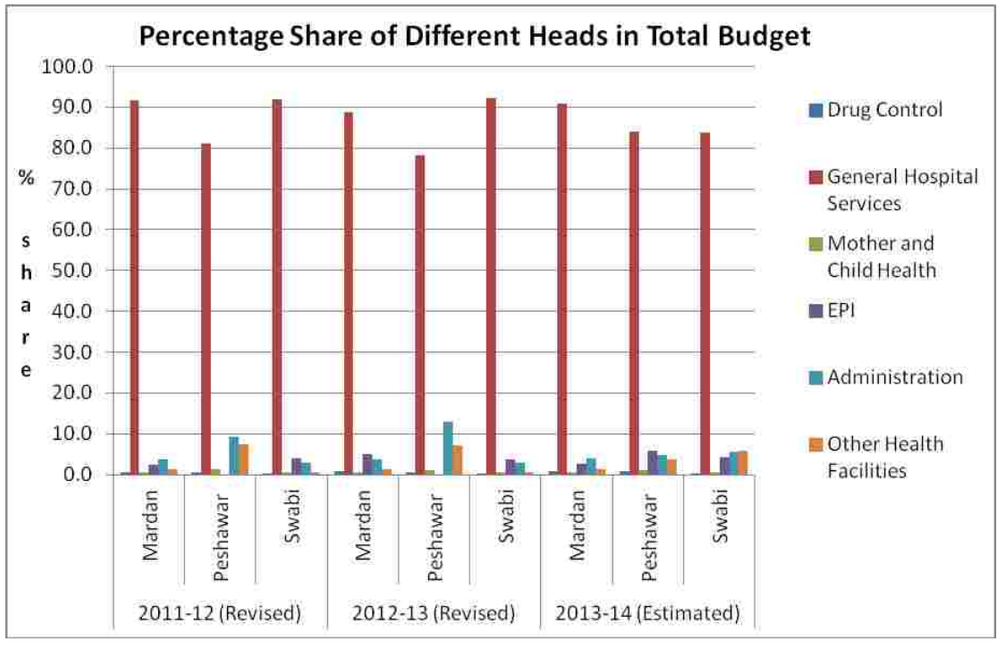
Table 1.6 reports the break-up of the total health budget in different heads for the three years. It clearly indicates that the major chunk of district health budgets goes to the General Hospital Services for all the three districts. The trend is quite stable over the span of three years. On average, 87% of the district health budget goes to the General Hospital Services and only a meager 13% is left for other heads. For the district of Mardan and Swabi the average percentage share of general health services in the total district budget touches around 90% while for the district of Peshawar it is around 81%. Drug Control and Mother & Child Health Care, for example, receive only a meager amount of funds in the district budgets over the span of three years across the districts. The lower priority given to these sub-heads depicts that the provincial government is not following its own comprehensive development strategy devised for the health sector. This necessitate that our budget planning should be in accordance with our own strategies set for the sector to achieve the desired objectives. Table 1.7 reports the percentage share of different heads in the total district health budget while for an easy comprehension of the percentage share; column chart is also given below.

Table 1.6: Head-wise Allocation of Budget for the Health Sector in Districts (Rs in Millions)

Head-Wise Allocations	2011-12 (Revised)			2012-13 (Revised)			2013-14 (Estimated)		
	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi
Drug Control	3.1	4.5	0.8	3.5	4.4	0.5	4.1	5.3	0.6
General Hospital Services	429.2	565.2	303.8	454.8	529.3	372.8	462.6	661.1	357.6
Mother and Child Health	1.9	9.1	1.8	2.3	6.8	2.0	2.6	8.1	2.3
EPI	10.8	0.0	12.8	26.5	0.0	15.2	13.4	45.9	17.8
Administration	17.9	65.2	10.0	19.4	88.5	12.0	19.9	38.1	23.7
Other Health Facilities	5.7	52.3	1.6	6.5	48.6	2.0	6.3	29.4	24.8
Total	**468.6**	**696.4**	**330.8**	**512.9**	**677.6**	**404.7**	**509.0**	**787.9**	**426.8**

Table 1.7: Head-wise percentage Allocation of Budget for the Health Sector in Districts

Head Wise Allocations in %	2011-12 (Revised)			2012-13 (Revised)			2013-14 (Estimated)		
	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi
Drug Control	0.7	0.6	0.2	0.7	0.6	0.1	0.8	0.7	0.1
General Hospital Services	91.6	81.2	91.8	88.7	78.1	92.1	90.9	83.9	83.8
Mother and Child Health	0.4	1.3	0.5	0.4	1.0	0.5	0.5	1.0	0.5
EPI	2.3	0.0	3.9	5.2	0.0	3.8	2.6	5.8	4.2
Administration	3.8	9.4	3.0	3.8	13.1	3.0	3.9	4.8	5.6
Other Health Facilities	1.2	7.5	0.5	1.3	7.2	0.5	1.2	3.7	5.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

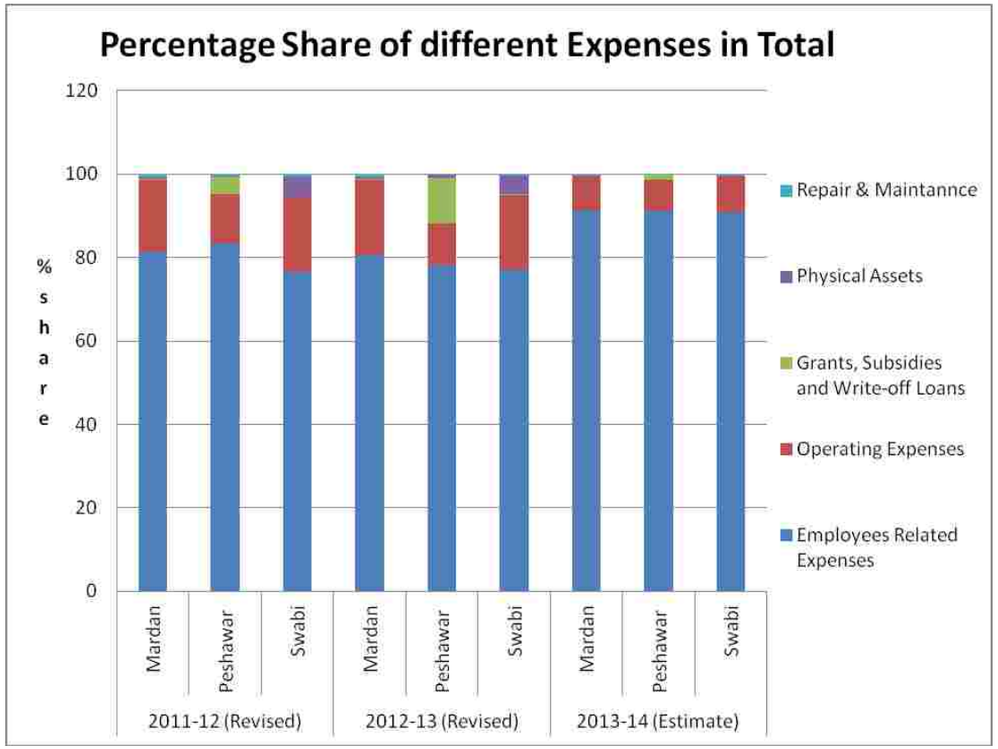


5.3: Expenses wise break-up of the District Health Budgets

Table 1.8 is showing the expenses-wise break-up of the total health expenses. The data clearly shows that a major chunk of the expenses goes to the employee's related expenses. The mere comparison of 2011-12 with the year 2013-14 brings home the fact that percentage share of Salary has increased and it has gained more than 10 percentage point (82 to 92) over the 3 years. Whereas the budgets of other heads have been compromised; e.g. operating expenses decreased from 17% in 2011-12 to 8% in 2013-14. The high share of salaries is understandable as health sector is the second largest employer in the province according to the latest budget documents. This magnifies the focus of our policies and plans in the social sector. While not being critical of the salary expenditure, the focus is to underline the need for a considerable increase in the overall outlay of health budget which is too small right now. The expenditure variations in other heads validate this point. The budget of assets, repair & maintenance and grants is almost frozen over the last 3 years. Again, given the rate of inflation, one could easily conclude that the budget allocations in assets, repair and maintenance and grants have actually deceases over the last 3 years. This is an alarming situation. Failure to allocate more money in repair and maintenance heads may have changed our health facilities into ruins. However the need is to accompany these expenses with expenses in other sectors to support the large presence of human resource base. It was observed during field interviews that hospitals with lack of equipments in working conditions and lack of free drugs may compel the health service seeker to opt out from the public health service delivery. Unless and until this strong employee base is not supported through good machinery and free medicines, the outcome indicators set for the health sector are not achievable. Low expenses on Repairs and Maintenance may cause the machinery become obsolete. Our discussions with technicians of the laboratories suggest that most of the valuable machinery is damaged and its repairing cost may swell if not done at the earliest.

Table 1.8: Expenses-wise break-up of the District Health Budget (Rs in Millions)

Expenses	2011-12 (Revised)			2012-13 (Revised)			2013-14 (Estimate)		
	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi	Mardan	Peshawar	Swabi
Employees Related Expenses	381.11	579.77	259.75	414.25	522.59	310.34	465.50	717.27	387.30
Operating Expenses	81.16	82.74	60.96	91.96	66.52	72.10	41.64	59.75	38.22
Grants, Subsidies and Write-off Loans	1.30	29.06	0.70	0.50	74.00	1.10	0.00	10.00	0.00
Physical Assets	1.72	2.83	16.26	2.95	3.87	17.29	0.01	0.02	0.02
Repair & Maintenance	3.35	2.02	2.12	3.27	1.52	1.77	1.89	0.87	1.26
Total	**468.64**	**696.40**	**339.78**	**512.92**	**668.49**	**402.59**	**509.03**	**787.91**	**426.79**



6. Findings And Recommendations

- The basic finding is the very low level of overall allocation to the health sector in the three most populated districts of Khyber Pakhtunkhwa. The need is to raise the overall budget so that the outcome sets in the comprehensive development strategy be achieved. Our province is still below on the MDGs in the health sector and only a greater allocation can achieve those objectives by 2015.
- Overall the district budgets on health show an increase over three year period but that is just enough to cater for inflation and not enough for growth in population.
- It was noted that while making the budget, previous year budget was increased/decreased evenly. No exercise is done to determine the actual needs of health facility. This is evident from the fact the revised budgets are always significantly different from the one planned at the start of the year.
- There is no mechanism and practice of involving community stakeholders in budget making. Interviews done with EDO show that the basic budget document are being prepared by assistants in the respective health facility and even the doctors and high-ups do not involve themselves in the budget making exercise.
- It is also noticed that the Posts of Doctors are lying vacant while every year Finance Department allocate budget for these vacant post
- The first reaction our budget analysis team faced from district government officials was non cooperative, saying that budget is a secret document and cannot be shared with everyone.
- In all the three districts under study, almost 90% of the district health budget goes to the General Hospital Services thus leaving not much money for EPI, Mother and Child Care, Drug Control and other health facilities.
- On the expenses side, the major chunk (almost 90%) goes to the salaries of the employees. We recommend these expenses should be complemented with expenses on Repair and Maintenance to improve efficiency of the doctors.
- The allocation of health budget for Peshawar has been inconsistent. Though it gained an average increase of 10% between 2011-12 and 2013-14, it does not match with the increasing population and its needs in the district.

- Lack of medicine at BHUs and other government hospital at the village level is a major concern and the doctors in-charge were complaining as patients only visit government health facility if free medicines are available.

- To increase the OPD in District Head Quarter hospitals and other government facilities, specialists in respective fields are needed. It was noticed during our field visit that most of the sanctioned post of the specialist doctors are vacant.

- Lower budget allocation to the Mother and Child Care centers restrict the government health facility to offer only a week special activity in a whole month. The budget should be increased as most of the patients are children and their mothers.
- While on the Anti-polio campaign, no doctors are available in the BHUs thus causing this particular health facility to be virtually closed during those days.