What is Gender Budgeting: An illustration though the analysis of two Health-related schemes in Karnataka (ThayiBhagya and Vajpayee ArogyashreeYojna)

JyotsnaJha and Varun Sharma

Centre for Budget and Policy Studies (CBPS, Bangalore)

(Prepared as part of the work for Task Force on Gender Budgeting constituted by the Department of Women and Child Development, Karnataka)

Work in progress and not to be used for any other purpose without prior permission

October 2014

Acknowledgements

1. The Department of Women and Child Development for financial support

2. ShreekanthMahinderan and DivyaKrishnaswamy for support in data processing

Contents

1.0 Gender Budgeting: A brief Background

The concept of gender budgets and the practise of gender budgeting worldwide have their genesis in women's budget documents initiated during mid-1980s in Australia. It was largely a state-lead initiative in Australia and it took different forms and trajectories in different countries depending upon who started the process and where it was located. The concept has since then evolved and unfolded differently in different countries and in different contexts even within the same countries. While the State initiated the practise in some countries, in others, women's groups took the lead. With greater advocacy at both national and international levels, a large number of countries have adopted the process formally. India is also one of those countries where the practice is now adopted officially by the Government of India and a few state governments. While the term Gender Budgeting (GB) is now used much more frequently and by a far more variety of people, it does not necessary connote the same meaning or process.

Commonwealth Secretariat has been one of the major international agencies that promoted the idea and supported it with research, manuals and capacity building exercises. The Secretariat's work focused on working with governments and used budgets and expenditures as major tools for gender budgeting. Later, UN agencies and other international NGOs also promoted the aspects of people's, especially women's participation in budgeting and monitoring. These are correlated and interdependent and a broad notion of gender budgeting encompasses both.

1.1 Gender Budgeting in Karnataka

In India also, the practise at the level of the government started with Women Component Plans (WCP) in the 1990s when the Government of India asked particular ministries to allocate specific share on women. While it brought the importance of backing specific interventions for women with adequate financial allocations, it suffered from obvious limitations. One, it was limited only to those ministries and departments where women could be specifically separated as beneficiaries. Gender based challenges are not limited to these departments alone and that remained unaddressed. Even the departments with WCPs did not pay much attention to the issue of gender based challenges and therefore the WCP was not really effective in ensuring gender responsive planning, budgeting and monitoring. The practice was formally discontinued in 2009-10. The Government of India started presenting a separate 'Gender Budget' statement (Statement 20, Expenditure Budget, Volume 1) as part of the Union Budget since 2005-06, and the same practice is now followed by some state governments, including Karnataka. The schemes with 100 per cent funds meant for women and girls are reported in Part A of the GB statement while those with at least 30 per cent funds are classified under Statement B. While the initiative is a welcome step, the exercise is fraught with limitations: inappropriate and somewhat illogical classification of schemes for Parts A and B, lack of assumptions and explanations for the classification, and the lack of reporting of actual expenditure against these allocations in the subsequent fiscal years (CBGA 2012). These limitations make the practise of gender budgeting in India a toothless exercise.

Karnataka adopted the process of gender budgeting on a regular basis since 2007-08. It follows the same process of issuing Part A and B statements. Although the number of departments reporting schemes in GB statements has increased from 23 in 2007-08 to 29 in 2013-14, and the amounts allocated has swelled from 16000 crores to nearly 121000 crores in 2013-14, the reviews have identified a number of limitations in the classification and thereby raising doubts regarding the correctness of the scheme being fit to be included in GB statements. While some limitations are similar to those faced at the Union Budget level, some are specific to Karnataka. Lack of sex-segregated data, limited capacities in terms of what gender budgeting is, and limited technical staff adversely influence the practise. One specific feature in Karnataka is the presence of Karnataka MahilaAbhivrudhiYojane (KMAY), which was introduced as a scheme in 1995. It is similar to Women's Component Plan in nature but has not been discontinued even after the introduction of gender budget statements. Both KMAY and gender budgets are reported; they are often overlapping but not necessarily the same for all the departments. As per KMAY, one third of total resources in individual beneficiary oriented schemes are to be earmarked for women, and the departments are to report the financial and physical targets. The Women and Child Development (WCD) department has a KMAY cell to monitor the scheme. Simultaneous presence of gender budget and KMAY confuses the departments. (CBGA 2012)

In addition to the government/s, civil society organisations have also been active in carrying out gender budgeting practices in many countries / areas. An early review of gender budgeting practices in different countries refers to Centre for Budget and Policy Study's work in partnership with Karnataka Women's Information and Resource Centre (KWIRC) on 'Building budgets from below' as an important example where the focus was on enhancing the budget related capacities of elected women politicians at local levels and developing a dream budget (Budlender, undated). Civil Society organisations have lately been active in many Indian states.

Taking note of the limitations and challenges pertaining to gender budget exercise, the Government of Karnataka has set up a Task Force constituting of academics working in this area to review the practise, identify the gaps, provide examples of analyses to show the alternative ways of analysing information and furnish recommendations for reform. Each member took the responsibility of analysing two schemes with support of their respective organisations. This is a report by JyotsnaJha, Director, Centre for Budget and Policy Studies (CBPS), who is a member of the Task Force, and her colleagues on the two schemes related with health issues.

1.2 What is Gender Budgeting?

The notion of gender budgeting evolved from the need for ensuring adequate money for funding initiatives that promote women's positioning and impacts gender equality in diverse areas. Broadly speaking, it refers to exercises that can answer one or more of these questions: (i) whether there is enough funds for initiatives that are designed to benefit women, (ii) whether the design and funding of these initiatives are gender responsive in the sense that it can be expected to positively change women's status and positioning, (iii) whether the fund flow and utilisation of such a scheme/schemes ensures its timely and intended utilisation, (v) whether gender responsive monitoring mechanisms and processes are present and active, (vi) whether revenue generation policies and exercises are gender

responsive and inclusive of women's voice, and (vii) whether there is space for women's voice in money-budget-expenditure related issues.

Depending on particular contexts, it is important that a gender budgeting exercise gives importance to and include analyses of other forms of inequality that exist. For instance, in Indian context, age and social groups are other markers of inequality and when seen alongside gender, these can give far deeper insights and pointers for policy/budget/delivery reform.

1.3Tools for Carrying out Gender Budgeting exercise

The nature and form of gender budgeting exercise needs to be ultimately decided in a particular context. In most cases, gender budget initiatives have been confined to microeconomic and expenditure aspects of the budgets leaving revenue and larger macroeconomic issues out. As a result, there is not much work on tools related to macroeconomic analyses. In general, the tools used for general expenditure and accountability analyses have been modified and used for gendered analyses, and hence they are the tools for gender budgeting as well. These include:

1.3.1 Public Expenditure Reviews

Public Expenditure Reviews with their analyses budgets and expenditure across different heads, activities and purposes help in delineating gender focus especially if gender disaggregated data for physical indicators is also available and made use of.

1.3.2 Benefit Incidence Analysis

Benefit incidence analysis is a standard tool for public expenditure analysis that describes the distributional consequences of public spending. Although BIA has primarilybeen used for income / consumption groups, the tool can be used for other categorization of the population as well (e.g. Age groups, gender, geographical area, social classes etc.). This tool is dependent on data availability for expenditure and disaggregated data for utilization; the disaggregation has to be for the specific area of interest – income/expenditure levels, sex, location, social group, etc.)

1.3.3 Public Expenditure Tracking Surveys (PETS)

PETS seek to answer two main questions. The first question "Do public funds and material resources end up where they were supposed to?" is referred to as the diagnostic part of a PETS. It consists in identifying the actual flows of public funds in a programme or a sector and establishes to what extent public funds and other resources reach the service providers. A discrepancy between the amount of funds disbursed from the government and the amount of funds received by the service provider is referred to as leakage. Timeliness of funds received could also be an aspect of inquiry. The second question "Why are funds diverted?" is referred to as the analytic part of a PETS, where the aim is to explain why leakage is observed. A gender-aware public expenditure tracking survey would need to go beyond the questions asked by PETS to ask who (males/females) within the service unit benefit. It could also check whether resources for items that are especially targeted to one sex reach the units, for example money for building toilets for women and girls. A gender-aware PETS

needs to make sure that both women and men are interviewed and that collected data are presented and analysed in a sex-disaggregated manner (Fatou Lo and NisreenAlami, 2011)

1.3.4 Citizen/community based interventions

A set of tools using citizens or community groups for either monitoring the services or rating the services have evolved in the area of accountability. These include Citizen Report Cards, Community Scorecards, citizen based management committees, and so on. These use a variety of quantitative / qualitative / participatory instruments for management and appraisals of programmes are quiet successful in collecting demand side data or information pertaining to delivery. While civil society groups are using Citizen Report Cards and Community Scorecards much more than the government bodies, citizen based management is now common in a number of government run programmes. When gender is an important marker in such analyses both in terms of participation and analyses, these exercises become gender aware. And when these include aspects of budgeting and expenditure, these do come under the fold of gender budget exercises.

1.3.5 Participatory Planning at all levels

Participatory planning and budgeting at all levels ensuring participation of both males and females, and taking concerns of all including women and girls is also a kind of gender budgeting exercise. For instance, capacity building of elected members at all levels including local and state governments on aspects of gender responsive planning, budgeting and monitoring can ensure effective gender monitoring and provide critical inputs.

1.3.6 Gender analysis of tax and other revenue generating policies

Gender analysis is one of the first steps for gender budgeting. Gender analysis of tax and other revenue means to study the gender segregated impact on male and female of all ages would give pointers for steps that are required in macroeconomic sphere.

It is important that all these tools can be used for the purpose of gender budgeting but they may not be used all at one time or every year for every sector. What is important is to understand that gender equality concerns are integrated in all reviews, analyses, tracking and evaluations, and the findings must be fed to the planning and budgeting exercises of respective governments. The following two sections are illustrations of the kinds of analyses that is possible for different schemes using the available data and the pointers that one can have for additional data generation as well as for state plans and budgets.

2.0ThayiBhaghya: Comprehensive Health Programme for Maternal Care

ThayiBhagya is a category 'A' scheme as per the Gender Budget document of Karnataka. Any scheme entirely meant for women / girls alone goes to category 'A'. But the questions pertaining to their use across different socio-economic sections, the ease of use, the adequacy of funds available, etc. are the aspects that need to be understood. In order to make various programmes for mother and child caremore effective, the state government has integrated them under one programme naming it "ThayiBhagya". The Programme has four schemes: JananiSurakshaYojana (JSY), PrasootiAraike, Madilu and ThayiBhagya; important to note that ThayiBhgya is both a scheme – a subset, and the name of the comprehensive programme. The objectives of this programme are:

- Reducing maternal and infant mortality rate.
- Providing health care to all pregnant women, to make health care accessible to pregnant women living in tribal, mountainous and inaccessible regions.
- Encouraging pregnant women for regular ante natal check-up.
- Encouraging deliveries in the hospitals.
- Funding caesarean section whenever required.
- Participation of private institutions in health care.
- Encouraging small family norms.

JananiSurakshaYojana (JSY) is a hundred per cent centrally sponsored scheme for safe motherhood under National Rural Health Mission (NRHM). It was implemented with the objective of reducing Maternal Mortality Rate (MMR) and Neo Natal Mortality Rate (NNMR) by promoting institutional deliveries among poor pregnant women. It was launched in 2005 by modifying National Maternal Benefit Scheme (NMBS). JSY is a conditional cash transfer scheme for institutional care for pregnant women. All pregnant women belonging to the below poverty line (BPL) and certain other defined category households[1], and (i) of the age of 19 years or above, and (ii) up to two live births are eligible. Incentives are built in for grass root workers such as ASHA, Anganwadi Workers or any other link worker for assisting pregnant woman in accessing maternal health care (NRHM GoI; 2005).

PrasootiAraike was initiated to provide incentives to BPL women who belong to SC/ST category during prenatal and postnatal period. Rs.1500/- is given in cash and Rs.500/- in kind to compensate wage loss. Madilu scheme is started by the government to provide post natal care for the mother and the child. The objective of this scheme is to encourage poor pregnant women to deliver in health centres and hospitals in order to considerably reduce maternal and infant mortality in the state. The beneficiaries must belong to below poverty line families, and deliver in government hospitals. The benefit is limited to two live deliveries.

Note 1: The benefits would be extended to all women from BPL families of 10 low performing states namely 8 EAG states (Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Rajasthan, Bihar, Jharkhand and Orissa) and the states of Assam and J&K even after the third live birth if the mother, of her own accord chooses to undergo sterilization in the health facility where she delivered,immediately after the delivery. Satisfaction of the Medical officer through a process, about the number of living children of the expectant mother would be a pre-condition to availing the benefit of this scheme.
Note 2: The benefits would also be available to such pregnant women falling in the above category even though not registered under JSY previously during pregnancy period but needing institutional care for delivery including management of complications like obstructed labour, PPH, eclampsia, PP sepsis etc.
Note 3: State will devise necessary mechanisms for adequate certification from the Medical officer of the health institution from where woman has taken treatment. This would be essential for disbursement of benefit.

ThayiBhagya provides totally free service for the pregnant women belonging to BPL families, in registered private hospitals. The rationale for working out this strategy was that though there are very large numbers of government health care institutions in the state, they often face shortage of specialist doctors, especially the gynecologists, anesthetists and paediatricians. These posts remain mostly vacant in Taluk hospitals and Community Health Centres. The assumption is that by entering into partnership with private hospitals, it was assumed that women can be provided with better access to specialised services necessary for institutional deliveries. A pregnant woman belonging to BPL family can avail delivery services free of cost in the registered private hospital near her house. She is not required to pay any charges right from the point of admission to discharge. The benefit is limited to the first two live deliveries. The beneficiaries are identified through the ANC cards issued to them. The scheme has been introduced in the six "C" category districts of Gulbarga, Bidar, Raichur, Koppal, Bijapur and Bagalkot and the backward district Chamarajanagar. The hospitals having requisite facilities will be registered under the programme with the approval of District Health Society. The Hospitals will then sign an MOU with the Department. Government Hospitals can also participate in this scheme. The eligibility for participation in the scheme is:

- The hospital should have minimum 10 inpatient beds.
- Should have proper functional Operation Theatre and Delivery room
- 24 hrs. availability of gynecologists, anesthetists and pediatricians
- Should have link with Blood banks
- The DHO has to identify such hospitals and invite them for partnership. Interested hospitals can sign the MOU.

Such registered hospitals are paid Rs. 3.00 lakhs per 100 deliveries, which includes normal delivery, complicated deliveries, caesarean, forceps deliveries etc. These hospitals are paid 10% i.e., Rs.30,000in advance on participation in the scheme. This is to encourage more and more private hospitals to participate in the programme. The Government Hospitals are also paid an additional Rs. 1.50 lakhs for every 100 deliveries, out of which 50% goes to the Health Care Committee and the remaining is shared among the Hospital doctors, nurses and staff as per Yeshaswini guidelines.

2.1 ThayiBhagya: Budget and Expenditure Analysis

The expenditure and budget for ThayiBhagya, as reflected in the Government of Karnataka state document covers three of the four schemes: PrasootiAraike, Madilu and ThayiBhagya. JSY, as fully centrally sponsored part of the NRHM, did not get reflected in the state budget in any form till 2013-14. In 2013-14, this gets reflected as NRHM transfers from the centre but it is not possible to separate it from the total just by using the state budget document. We will first analyse the ThayiBhagya allocations valid for three schemes and then at a later stage discuss JSY allocations.

A perusal of the state government budget and expenditure on this scheme as depicted in the following Table shows that the allocations for the programme have increased both in nominal and real terms between 2011-12 and 2013-14, the increase being much lower in real terms. The relative importance of the programme as indicated by its relative share in the department’s budget is decreasing. The programme is an initiative of the Department of Health and Family Welfare (DoHFW) in the Government of Karnataka. While the expenditure

/ budget allocation for DoHFW as percentage of total Government of Karnataka budget has been increasing, as its relative share increased from 3.45 per cent of the total expenditure in 2011-12 to 4.31 of the total budget in 2013-14, the relative share of ThayiBhagya in the total DoHFW has declined from 2.77 to 1.26 in the same period (Table 2.1). This is indeed not an encouraging sign as the percentage of institutional births is still less than desirable in the state. As per latest figures, nearly 27 per cent of deliveries still take place outside health institutions and without much professional help (based on data provided by Human Development Division for 2012-13)

Table 2.1: Details of ThayiBhagya (Nominal and Real - Rs in Lakhs) (2011-2014)

	Nominal			Real		
Expenditure Head	2011-2012	2012-2013 RE	2013-14 BE	2011-2012	2012-2013 RE	2013-14 BE
Other Expenses	2201.86	8382.43	4900	1,367.61	4,873.51	2,848.84
Special Component Plan	4542.77	2000	2000	2,821.60	1,162.79	1,162.79
Tribal Sub Plan	1455.37	817.57	600	903.96	475.33	348.84
Deduct - SCP Pooled Upfront	0	0	-900	0.00	0.00	-523.26
ThayiBhagya (Total)	8,200.00	11,200.00	6,600.00	5,093.17	6,511.63	3,837.21
Health & Family Welfare (Total)	2,95,820.32	3,74,368.07	5,23,739.84	1,83,739.33	2,17,655.85	3,04,499.91
Total Expenditure / Budget (Government of Karnataka)	85,75,616.0	104,02,310.0	121,61,087.0	53,26,469.6	60,47,854.6	70,70,399.4
ThayiBhagya (as % of Health & Family Welfare)	2.77	2.99	1.26			
Health & Family Welfare (as % of Total Expenditure)	**3.45**	**3.60**	**4.31**			

Note: BE – Budget Estimates RE – Revised Estimates;
Real values are calculated by using the values GSDP deflator (1.61), (1.72) and (1.72) for the year 2011-2012, 2012-2013 and 2013-2014 respectively.
The base year for the GSDP deflator is 2004-2005
The Total Expenditure for Health and Family Welfare was derived from summing up the expenditures under Major Heads 2210 and 2211 in the Budget document of the Government of Karnataka.
Source: Budget Document (2013-2014), Government of Karnataka

The budget document does not allow any other meaningful analysis for the programme. The distribution across three expenditure heads does not tell us much except for the distribution of allocation for tribal areas. In subsequent sections we attempt using other sources available in public domain for carrying out further analysis.

2.2 ThayiBhagya: User Analysis

There is hardly any information available on users for ThayiBhagya in public domain. The web search lead to location of one data-source that provided the number of beneficiaries for all four schemes in the state, as presented in the following Table. Table 2.2 shows that over 9 lakh women have used the schemes every year, the number being the highest for JSY. Almost half of the beneficiaries have been targeted using JSY, while Madilu and PrasootiAakhie are the next important sources. JSY is the oldest of these programmes and its coverage has increased over time (Table 2.3). PrasootiAraike, Madilu and ThayiBhagya, all these programmes have become operational in the field after 2007-08.

Table 2.2: Number of beneficiaries in Safe Motherhood Schemes in Karnataka.

Number of Beneficiaries	2009-10 (Actual)	2010-11 (Actual)	2011-12 (Target)
JananiSurakshaYojna (JSY)	4,73,145	4,45,997	4,00,000
ThayiBhagya	28,186	39,262	32,000
Madilu	2,47,372	2,87,075	3,60,000
PrasootiAakhie	2,36,277	1,78,041	3,60,000

Source: Results-Framework Document for Government of Karnataka (Department of Health and Family Welfare) (2011-2012) http://www.performance.gov.in/sites/all/document/files/states/Karnataka/Health_Family_Welfare.pdf

Table 2.3: Total number of JSY beneficiaries in Karnataka (2005-10)

Year	Total number of beneficiaries under JSY
2005-06	50,542
2006-07	2,33,147
2007-08	2,83,000
2008-09	4,00,349
2009-10	4,75,193

Source: http://pib.nic.in/newsite/PrintRelease.aspx?relid=67669,

2.3 ThayiBhagya: Benefit incidence analysis (BIA)

BIA is an effective tool to examine the differential impact of public expenditure by juxtaposing the costs of the services against the distribution of users across different classes or groups. BIA estimates the value of benefits typically measured as the unit cost of providing the service. The identification of users of the service is usually based on data from large household surveys, which tend to collect information on the utilization of service based of different demographic and socioeconomic characteristics of individuals and households. Depending upon the objective of a particular exercise, the users are distributed across classes / groups, e.g. male and female, rural and urban, poorest and richest, young and old. Some of the questions that can be asked are (this is only indicative; the questions are determined by the nature of particular analysis):

- Are the benefits of public spending equitably distributed by gender? Does this spending mitigate or exacerbate gender inequities?
- Are gender benefit gaps different for poor and non-poor? Rural and urban? Between social group?
- How can allocations of public expenditure be changed to improve gender equity?

In order to carry out BIA for any particular scheme or intervention, one needs data for both the unit cost and distributional characteristics of beneficiaries pertaining to the same period. ThayiBhagya poses a challenge because of the limited information available on users. We used District Level Health Survey (DLHS-III) unit level data for Karnataka state for the year 2007-08 for (i) estimating the number of beneficiaries/ users for JSY (as that was the only operational programme in that year out of all four schemes listed under ThayiBhagya), and (ii) user population categorized in five lowest to highest wealth (asset ownership) quintiles. For the total number of beneficiaries under JSY in Karnataka in 2007-08, the source of Press information bureau, Government of India has been used. Using these data, we have attempted to analyse the distribution of recipients under JSY /other scheme users over

wealth (asset ownership) quintile in an earlier study.[2] We will be reproducing that section here from that study, as this is relevant here as well.

Table 2.4 shows that 283 thousand were benefited under JSY in Karnataka. Considering that 64 percent of these hold BPL card [eligibility for getting benefit under JSY or other state scheme]. Total number of estimated beneficiaries with BPL cards is 179, 988. Table 5 shows that distribution of total number of beneficiaries under JSY [with and without BPL cards] by wealth class.

Table 2.4: Distribution of total number of JSY beneficiaries by wealth/asset ownership categories in 2007

Wealth / Asset ownership Quintile	**Total number of estimated beneficiaries with BPL card**	**Total number of beneficiaries irrespective of BPL card**
Lowest	17,815	27,932
Low	59,279	84,409
Middle	56,515	77,656
High	37,165	68,755
Highest	9,214	24,248
Total	1,79,988	2,83,000

Source: District level household and health facility survey [DLHS] Round-3, Karnataka 2007-08

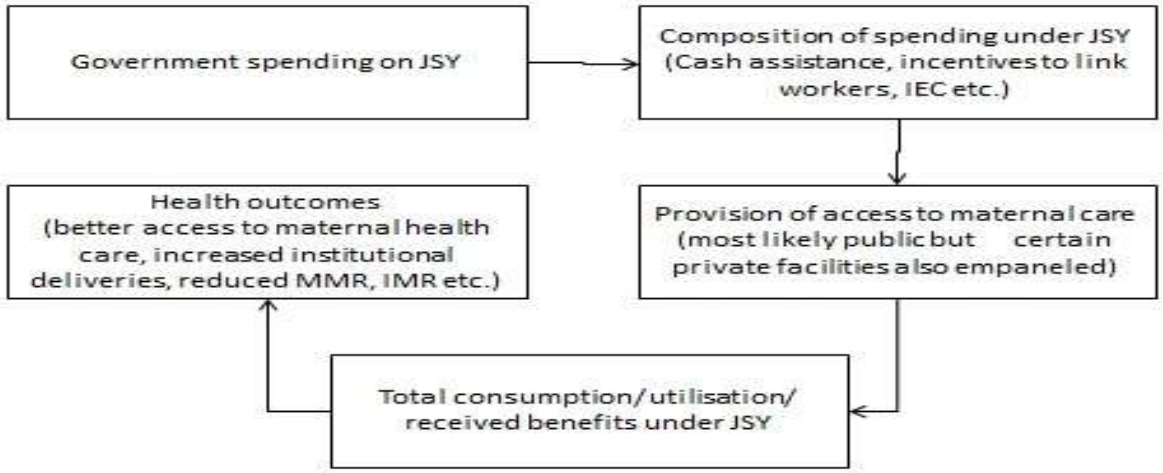
JSY is meant to benefit pregnant women from deprived socio-economic categories. To know whether spending is strong or weak we have considered the chain of spending on JSY. The first link is between government spending on JSY and the composition of spending. As JSY is a demand side intervention, if the proportion of spending on incentives on institutional deliveries/ home deliveries/ C-sections is higher than other components, this link will be considered strong and will have a strong impact on health outcomesamong the population at large[3].The second link is translation of allocated fund into effective provisioning of services and is dependent upon the efficiency of the sector[4]. Efficiency is based on the capacity of a health facility and if expenditure is made to enhance the capacity of existing health facilities, effective provisioning could result.The third link establishes how the total provisioning of effective services is affected by public spending[5]. The final link is between the provisioning of health services (both private and public) and health outcomes at the individual level (Figure 1).

[2]JyotsnaJha, DivyaKrishnaswamy and Varun Sharma (2014), Public Expenditure on Children in Karnataka: 2001-02 TO 2013-14, Centre for Budget and Policy Studies, Bangalore and UNICEF, Hyderabad

[3] A break-up of the JSY confirms this: approximately 60 percent of the total fund is approved for incentivizing deliveries and around 40 percent to incentivize ASHA/ other link workers.

[4] DLHS (2007-08) data shows that 28 per cent of the total women surveyed (ever married) provided responses about their place of last delivery; there was not much difference as per the place of delivery (public, private and home).

[5] Data from DLHS-3 shows that public provisioning overall is not crowding out the private sector or home based deliveries.



(Adapted from Demery, L. (2000), "Benefit incidence: a practitioner's guide)

Figure 1: Public Spending on JSY and Health Outcomes: Link Chain

Expenditure incidence analysis here focuses mainly on the first of these links addressing the question, 'to what extent do governments spend on services which improve the lives of the poor?' When combined with the 'tracking' of spending at the facilities, this analysis can also help assess the second link. Hence, the starting point is the utilization of services by households/ individuals i.e. institutional deliveries primarily in public health facilities in the case of JSY. By combining this information with information about the cost of providing the service under JSY scheme, the incidence of the benefit of government spending on JSY can be estimated across household groups. In Karnataka 27 percent of the total respondents between the ages of 19 to 49 years provided responses in the DLHS, 2007-08 survey when asked about the place where they last delivered their child. The following trends were seen amongst this group. Only 12 per cent (855 women) of these received financial assistance under JSY or any state scheme. Out of these:

- 44 per cent had delivered in a public health facility and 29 per cent had delivered in a private health facility. 26 per cent received financial benefits when the delivery took place at home.
- 83 per cent of total beneficiaries were located in a rural location while 17 per cent were in an urban location. Hence it seems that the scheme has been targeted properly to rural inhabitants.
- Only 31 per cent of all women belonged to SC or ST category; this is especially interesting as the scheme was meant for women from BPL families.
- When all women who had received cash assistance under JSY were grouped under five wealth index quintiles[6] ranging from poorest to richest, it was seen that only 10per cent of all who received financial assistance belonged to poorest category. The proportion of those belonging to the middle and rich categories is significantly high (at 27 per cent and 26 per cent respectively).

[6] While these are being referred to as wealth quintiles it is important to note that these quintiles have been made within the BPL income category.

We considered only the responses of women who hold BPL cards as only women from economically weaker sections are entitled to avail benefits under JSY. There were 1,140,000[7] total live births estimated in Karnataka during 2007 (total number of deliveries irrespective of BPL). Devadasan, N., et al (2008), estimated that there were a total of 305,558[8]estimated deliveries among BPL families. Hence, we see that among all women who delivered in 2007, 27 percentwomen were from an economically deprived category. From the NRHM PIP documents we see that during 2007-08 Rs2,900 lakh was approved for JSY. Per beneficiary expenditure was estimated by dividing the total expenditure/ approved fund by estimated number of prospective beneficiaries under JSY (i.e. 305,558). Per beneficiary allocation under JSY comes to Rs 949.

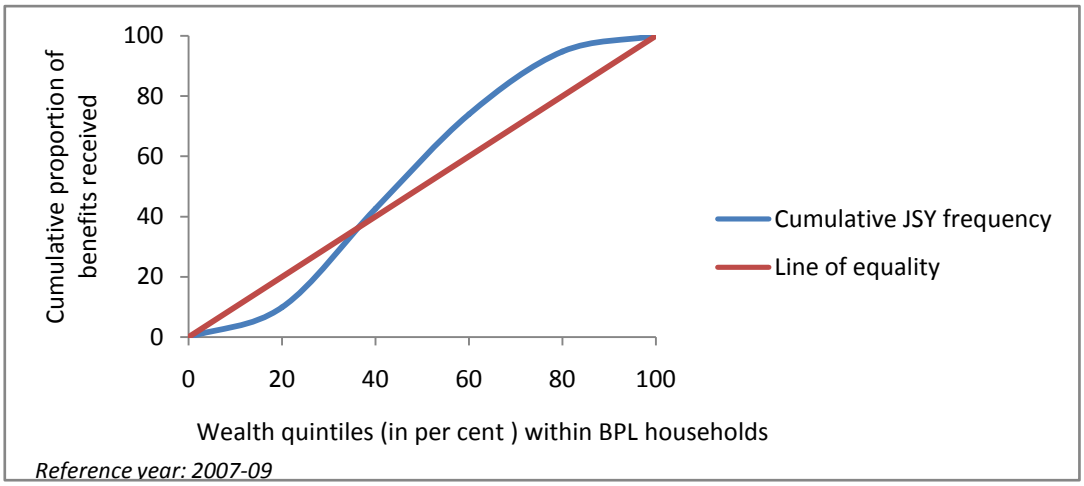


Figure 2: Concentration curve showing distribution of JananiSurakshaYojana (JSY) benefits (percent) by wealth (asset ownership) quintiles

As per DLHS (2007-08) 4,211 women held BPL cards and 14 per cent received benefits under JSY or any other state scheme. An economic categorization of beneficiaries shows that amongst the poor, benefits are not reaching those with lowest ownership of assets; merely 10 per cent of those availed benefits belong to the lowest wealth quintile.An economic categorization from the lowest to highest asset ownership within the BPL category when plotted on a concentration curve (Figure 2) shows that the JSY line is initially below the line of equality and later becomes concave showing the distribution becomes more pro-poor, as the coverage goes up.

The neutrality in the benefit incidence is represented by the diagonal line. It captures the perfect equality in the distribution of benefits. If the benefit concentration curve lies above the 45-degree line, the benefits from the public provisioning of the service are said to be pro-poor (Milanovic 1995; Sahn and Younger 1999, 2000; Demery 2000; Davoodi, Tiongson, and Asawanuchit 2003). Such a concentration curve is concave rather than convex. As interpreted by Davoodi, Tiongson, and Asawanuchit (2003), an implication of the concavity for quintiles is that Q1 exceeds Q5 and that Q1 is larger than 20 per cent—that is, the

[7] For more details refer Johnston, R. (2012, October 12). India Abortions and Live Births by State and Territory, 1971-2011. [http://www.johnstonsarchive.net/policy/abortion/india/ab-indias.html]

[8] Estimates were based on data using fertility rates from SRS data (Sample Registration System for more details [read Devadasan, N., Elias, M. A., John, D., Grahacharya, S., &Ralte, L. (2008). A Conditional Cash Assistance Programme for Promoting Institutional Deliveries among the Poor in India: Process Evaluation Results. Studies in Health Services Organisation & Policy, 24, 257-273.].

benefits of public spending disproportionately go to the bottom quintile in absolute terms and relative to their share in the population. Similarly, the benefits are said to be pro-rich if Q1 is less than Q5 or when the concentration curve for the benefits lies below the 45-degree line.

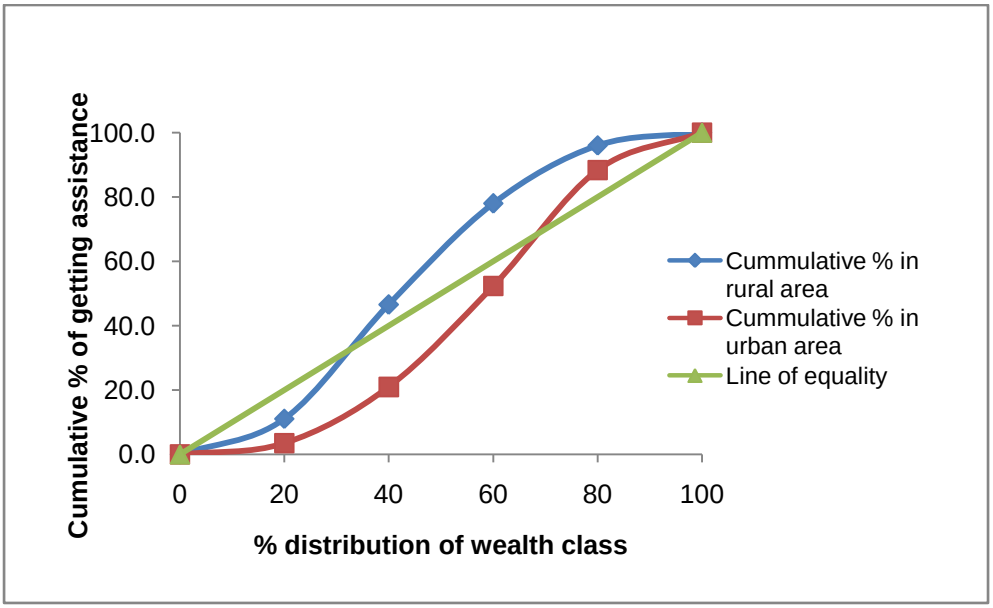


Figure 3: Concentration curve showing distribution of JananiSurakshaYojana (JSY) benefits (per cent) for rural and urban areas by wealth (asset ownership) quintiles (2007-08)

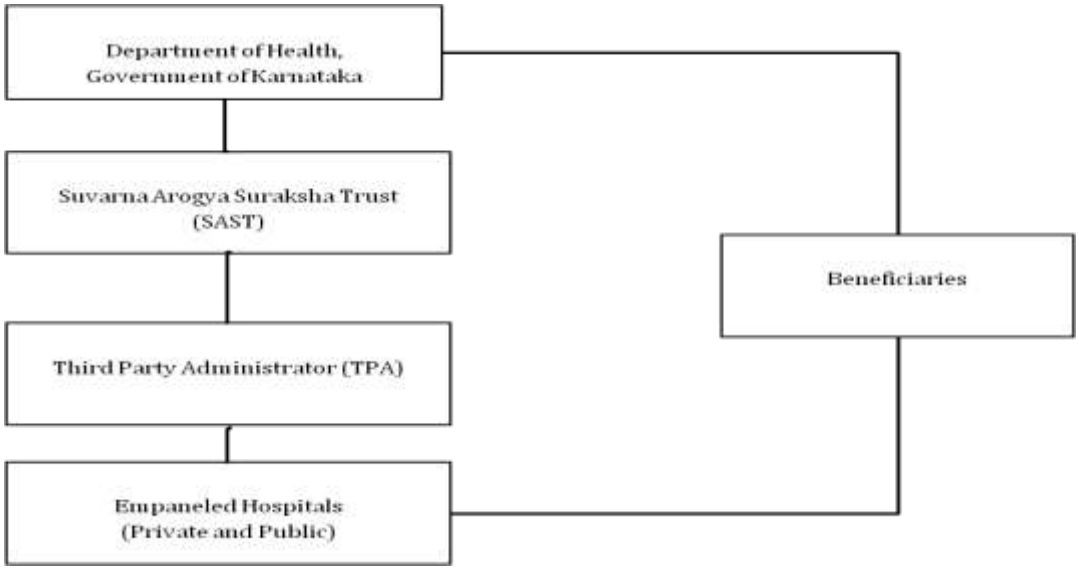
The concept of "dominance" is also important when interpreting one or more concentration curves. If one concentration curve lies everywhere above another concentration curve (except possibly at the extremes), that concentration curve is said to dominate the other concentration curve. If one concentration curve dominates another, the ranking of the two curves in terms of their respective degrees of inequality is unambiguous. If, on the other hand, the two curves cross (as often occurs), their respective degrees of inequality are ambiguous. The two curves are not intersecting in Figure 3 showing two concentration curves for rural and urban areas. The distribution is relatively more pro-poor in urban as compared to rural areas.

3. Vajpayee Arogyashree Scheme (VAS): Health Insurance Scheme for Tertiary Care for Poor Households

Inspired by Rajiv Arogyashree scheme of Andhra Pradesh, GoK launched Vajpayee Arogyashree Scheme (VAS)[9] in 2009-10 to provide coverage for treatment of serious and life threatening ailments for the vulnerable segment of society (primarily BPL HHs). The government decided to extend the benefit of the scheme to the BPL families of the State on phased manner. Accordingly, it was first started in Gulbarga Division covering 14.39 lakhs BPL families in February 2010, and then extended to Belgaum Division in the month of August 2010 covering 16.91 lakhs BPL families. Subsequently, it was extended to Bangalore & Mysore Division in the month of June 2012 thus, covering the entire state.

The scheme was launched with an objective to provide improved access of quality tertiary medical care for treatment of identified diseases involving hospitalization, surgery and therapies through an identified network of health care providers to BPL HHs. Tertiary healthcare is defined as specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions. It provides a cover of Rs. 150,000 per household per year with a buffer of Rs. 50,000. The Government of Karnataka established SuvarnaArogyaSuraksha Trust (SAST) and registered it as a separate body under the aegis of Health and Family Welfare Department in order to implement SuvarnaArogyaSuraksha Scheme (now Vajpayee Arogyashree scheme). The Trust started functioning in April 2009. The following chart shows the institutional framework of VAS.

Figure 1: VAS institutional framework



Source: La Forgia, Gerard, and SomilNagpal, World Bank(2012)

[99] The scheme was earlier known as SuvarnaArogyaSuraksha Scheme.

The following Table summarises the highlights of the scheme.

Table 1: Vajpayee Arogyashree Scheme (VAS): Main Features

Launch year	2009
Geographical area	Seven districts of Gulbarga Division (Bellary, Bidar, Gulbarga, Koppal, Raichur, Yadagiri), Karnataka State and proposed state wide rollout by 2012
Target/eligible population	Below poverty line households in the Gulbarga Division and in the database of food, civil supplies and consumer affairs
Number of beneficiaries	1.5 million BPL households (7.5 individuals)
Unit of enrolment	Household
Benefits package	402 predefined packages and 50 follow-up packages. Scheme covers only tertiary care (high end and low frequency illnesses)
Maximum insurance coverage	Rs. 1,50,000 per household per year and a buffer of Rs. 50,000
Hospital empanelment criteria	At least 50 beds, well equipped operation theatre; post-operative rooms with ventilator; round-the-clock lab and radiology support; trained paramedics; availability of specialists
Number of empanelled hospitals (government and private)	94 (86 private and 8 public health facilities)
Sources of funds	100 per cent from state government
Total expenditure (millions Rs.) in 2009–10	Nil for financial year 2009-10 as claims commenced in 2010-11, value of claims (10.11.2010) Rs. 21,90,77,400
Premium price in 2009–10	Not Applicable
Provider payment mechanism	Predefined package rates
Information Technology (IT) tools used	Software of TPA and Comprehensive Management information system (MIS)
Number of hospitalizations a year	3738 hospitalization (15.11.2010)
Utilization rate	0.30 (hospitalized to enrolled ratio)
Most common procedures	Cardiovascular surgeries (72 per cent by amount)
Governing agency and legal status	SuvarnaArogyaSuraksha Trust (autonomous trust)
Executing agency/ intermediaries used	TPA contracted for three year and yearly performance evaluation
Number of full-time staff, including contract personnel, in the implementing agency	<10
Administrative costs as per cent of total spending	10% assumed of total spending (Rs. 2,19,07,740)
Cost-containment measures	Package rates, prior authorization, physical verification by arogyamithras

Source: World Bank, 2012

3.1 VAS: Budget and Expenditure Analysis

VAS is an entirely state government funded scheme. The allocations have increased both in nominal and real terms between 2011-12 and 1013-14.However, the relative importance has declined marginally in terms of the proportion of the departmental budget/expenditure devoted to this scheme. This is despite the fact, as pointed out earlier, that the relative share of DoHFW has increased in the total Government of Karnataka budget. As in the case of ThayiBhagya, the budget documents do not tell us much beyond this.

Table 3.1: Budget and Expenditure Details of Vajpayee ArogyashreeYojna(Nominal and Real- Rs in Lakhs) (2011-2014)

	Nominal			Real		
Expenditure Head	2011-2012	2012-2013 RE	2013-14 BE	2011-2012	2012-2013 RE	2013-14 BE
Other Expenses	700.00	2,784.00	2,300.00	434.78	1,618.60	1,337.21
Special Development Plan	900.00	1,700.00	2,000.00	559.01	988.37	1,162.79
Special Component Plan	1,680.00	1,040.00	2,700.00	1,043.48	604.65	1,569.77
Tribal Sub Plan	720.00	476.00	800.00	447.20	276.74	465.12
Deduct - SCP Pooled Upfront	0.00	0.00	-1,000.00	0.00	0.00	-581.40
Vajpayee Arogyashree	4,000.00	6,000.00	6,800.00	2,484.47	3,488.37	3,953.49
Health & Family Welfare	2,95,820.32	3,74,368.07	5,23,739.84	1,83,739.33	2,17,655.85	3,04,499.91
Total Expenditure/Budget, Government of Karnataka	85,75,616.0	104,02,310.0	121,61,087.0	53,26,469.6	60,47,854.6	70,70,399.4
Vajpayee Arogyashree (as % of Health & Family Welfare)	1.35	1.60	1.30			
Health & Family Welfare (% of Total Expenditure)	3.45	3.60	4.31			

Note: BE – Budget Estimates RE – Revised Estimates;
Real values are calculated by using the values GSDP deflator (1.61), (1.72) and (1.72) for the year 2011-2012, 2012-2013 and 2013-2014 respectively.
The base year for the GSDP deflator is 2004-2005.
The Total Expenditure for Health and Family Welfare was derived from summing up the expenditures under Major Heads 2210 and 2211 in the Government of Karnataka Budget document.
Source: Gender Budget (2013-2014), Government of Karnataka (As presented to the Legislature in July 2013)

3.2 VAS: Utilisation Patterns

Detailed information regarding VAS beneficiaries is available in public domain. The information is gender segregated allowing gender analysis possible. Details of beneficiaries contain information related to the identification of beneficiary [BPL card number], demographic characteristics [age, name, gender, caste, taluk/ village and district], details of disease [preauthorisation number, final diagnosis, disease, disease main category and disease sub-category], source of treatment [name of hospital], treatment [plan for treatment, package code, surgery code, date of admission and date of discharge] and expenditure [preauthorised amount approved, hospital claim amount, gross amount approved by the trust, tax deducted at source and net amount paid to hospital].[10]

[10]Data regarding the beneficiaries' details was obtained from the SuvarnaArogyaSuraksha Trust (SAST) webpage. The data is available for all years for which VAS is operational. However, the data is available in PDF format and we needed data in data sheets for the ease of analysis. The SAST on WCD's request made the data in this format available to us. This made the analysis much easier and less tedious.

Vajpayee Arogyashree is categorised as “category B” scheme as per the Gender budget document of Government of Karnataka. As mentioned earlier, category B presents women specific budget provisions wherein at least 30% of provision is meant for women. Given that females represent nearly half of the total population, their representation in the utilisation of such a scheme should also be nearly fifty per cent. This does not appear to be the case. Table 3.2 presenting data for the three consecutive years starting 2010-11 shows that the proportion of male among total VAS beneficiaries is higher than their female counterpart in all three years. Males’ representation varies between 57 to 60 per cent while females represent only about 40 to 42 per cent of the total. It can also be noticed that the proportion of female has been marginally declining from 42.2 per cent in 2010-11 to 41.7 per cent in 2011-12 to 40.6 per cent in 2012-13. This is indeed not a good sign.

Table 3.2: Sex-wise Distribution of VAS Beneficiaries (2010-13)

	2010-11		**2011-12**		**2012-13**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Female	1,728	42.2	3,157	41.7	5,213	40.6	10,098	41.2
Male	2,367	57.8	4,407	58.3	7,621	59.4	14,395	58.8
Total	4,095	100.0	7,564	100.0	12,834	100.0	24,493	100.0

Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html
http://www.sast.gov.in/home/Details/Claims_10-11.pdf,http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

The age-wise distribution of VAS beneficiaries reveals that children (0-18 year olds) and older people (above 50 years) outnumber other age groups. Males outnumber females in every age category except in the age-group of 20-30 years. However, even for the reproductively active age group of 15-45 years, males constitute about 52-55 per cent of all VAS beneficiaries every year (Table 3.4).

Table 3.3: Age-wise Distribution of VAS Beneficiaries (2010-2013)

	Female		Male		Total	
Age wise Categories	Number	% distribution by sex for this age group	Number	% distribution by sex for this age group	Number	% distribution by age group
Less than or Equal to 19 yrs	2,553	45.61	3,045	54.39	5,598	22.86
20 - 30 yrs	1,682	51.30	1,597	48.70	3,279	13.39
31 - 40 yrs	2,003	47.43	2,220	52.57	4,223	17.24
41 - 50 yrs	1,937	38.85	3,049	61.15	4,986	20.36
More than or Equal to 51 yrs	1,923	30.01	4,484	69.99	6,407	26.16
Total	10,098	41.23	14,395	58.77	24,493	100.00

Note:
1. Percentages given under Female and Male heads are row percentages.
Source:
SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html
http://www.sast.gov.in/home/Details/Claims_10-11.pdf,
http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

Table 3.4: Number and Percentage of VAS Beneficiaries in the age category 15-45 years (2010-13)

Year	Female		Male		Total	
	No	%	No	%	No	%
2010-2011	939	47.74	1028	52.26	1967	17.48
2011-2012	1697	47.60	1868	52.40	3565	31.67
2012-2013	2626	45.88	3098	54.12	5724	50.85
Total	5262	46.75	5994	53.25	11256	100.00

Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html
http://www.sast.gov.in/home/Details/Claims_10-11.pdf,
http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

Caste-wise distribution of beneficiaries also suggest that males outnumber females among all social groups, the difference being the highest for the minorities, and lowest for the 'others'. While the age-wise distribution between males and females remains largely the same over the years with minor variations, the year to year variations are much more notable for male-female distribution for different social groups (Table 3.5). However, in general, what remains true is that less females in all groups barring those in their 20s, and those from 'others' category have received benefits under the VAS. An overwhelming majority of both male and female patients have gone to private hospitals indicating no notable gender difference (Table 3.6). This, however, raises another issue about why public hospitals are not being favoured and whether the quality of service delivery can be improved by using the money used in such schemes that are vehicles of transfer of public resources to private, profit-making facilities.

Table 3.5: Caste-wise Distribution of VAS Beneficiaries (2010-2013)

	Female		Male		Total	
Caste wise categories	Number	%	Number	%	Number	%
Minority	1,012	38.29	1,631	61.71	2,643	10.79
Others	7,784	49.27	8,014	50.73	15,798	64.50
Scheduled Caste	837	42.79	1,119	57.21	1,956	7.99
Scheduled Tribe	465	44.16	588	55.84	1,053	4.30
Total	10,098	41.23	14,395	58.77	24,493	100.00

Note:Percentages given under Female and Male heads are row percentages. Percentages under total are column percentages.
Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html
http://www.sast.gov.in/home/Details/Claims_10-11.pdf,
http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

Table 3.6: Distribution of VAS beneficiaries by type of health care facility

	2010-11				**2011-12**				**2012-13**			
	Female		**Male**		**Female**		**Male**		**Female**		**Male**	
Government	129	(7.5)	125	(5.3)	278	(8.8)	261	(5.9)	383	(7.3)	424	(5.6)
Private	1,599	(92.5)	2,242	(94.7)	2,879	(91.2)	4,146	(94.1)	4,830	(92.7)	7,197	(94.4)
Total	1,728	(100.0)	2,367	(100.0)	3,157	(100.0)	4,407	(100.0)	5,213	(100.0)	7,621	(100.0)

Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html,
http://www.sast.gov.in/home/Details/Claims_10-11.pdf, http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

Table 3.7: Distribution of VAS beneficiaries by diseases for which they sought treatment

	2010-11				2011-12				2012-13			
	Female		Male		Female		Male		Female		Male	
Burns	49	(2.8)	29	(1.2)	123	(3.9)	89	(2.0)	150	(2.9)	120	(1.6)
Cancer Treatment	312	(18.1)	227	(9.6)	702	(22.2)	623	(14.1)	1,739	(33.4)	1,567	(20.6)
Cardio Vascular Diseases	1,010	(58.4)	1,318	(55.7)	1,812	(57.4)	2,643	(60.0)	2,400	(46.0)	3,829	(50.2)
Neonatal	37	(2.1)	59	(2.5)	55	(1.7)	53	(1.2)	42	(0.8)	65	(0.9)
Neurological Diseases	212	(12.3)	328	(13.9)	285	(9.0)	523	(11.9)	571	(11.0)	992	(13.0)
Polytrauma	0	(0.0)	7	(0.3)	1	(0.0)	3	(0.1)	3	(0.1)	4	(0.1)
Renal Diseases	108	(6.3)	399	(16.9)	179	(5.7)	473	(10.7)	308	(5.9)	1,044	(13.7)
Total	1,728	(100.0)	2,367	(100.0)	3,157	(100.0)	4,407	(100.0)	5,213	(100.0)	7,621	(100.0)

Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html
http://www.sast.gov.in/home/Details/Claims_10-11.pdf,
http://www.sast.gov.in/home/Details/Claims_11-12.pdf,
http://www.sast.gov.in/home/Details/Claims_12-13.pdf

Table 3.8: Distribution of Medically Certified Deaths Eight Leading Cause Groups for males, females and total (2011)

Cause of Death	Male	Female	Total
Diseases of the circulatory System	30.25	29.49	29.97
Injury, Poisoning and Certain other consequences of external causes	11.29	11.05	11.20
Certain infectious and parasitic diseases	10.80	10.49	10.68
Certain conditions originating in the perinatal period	9.03	9.87	9.33
Diseases of the respiratory system	8.22	7.34	7.90
Diseases of the digestive system	8.24	3.60	6.55
Endocrine, Nutritional and metabolic diseases	5.86	7.24	6.36
Neoplasm (cancer)	5.56	7.19	6.15
Other groups	10.77	13.74	11.85
Total	100.00	100.00	100.00

Source: Report on Medical Certification of Cause of Death 2011, Directorate of Economics and Statistics, Government of Karnataka, 2013

It is also important to see whether there is any difference between males and females and if that is in line with the known incidence of diseases. However, it is not so easy to locate reliable disease incidence data and there can be regional variations. Nevertheless, we have attempted an analysis using the data on causes of death for medically certified deaths published by the Government of Karnataka. A perusal of VAS beneficiary data suggests that highest number of people, both males and females, have sought treatment for cardio-vascular diseases or diseases of the circulatory system in all three years. This is followed by neurological diseases and cancer treatment (Table 3.7). Such diseases have been cited as the reason for death for 29.5 per cent of females and 30.2 per cent of males among those whose deaths have been medically certified in 2001 in Karnataka (Table 3.8). This implies that there is not much gender difference in the incidence of such diseases. However, The number of males claiming treatment for such diseases using VAS is much higher than females claiming treatment for similar diseases (Table 3.7). Whether this difference is an indicator of any gender discrimination or not, is an issue of further investigation. This difference is not necessarily visible everywhere. Cancer has been a cause of death for a greater proportion of women (7.19%) than males (5.16%) and the number of females has also been higher among the VAS claimants during all three years.

VAS utilisation is much higher in Gulbarga and Belgaum divisions as compared to Bangalore and Mysore divisions. But this could be due to the fact that the scheme has been extended to Bangalore and Mysore only this year and therefore it is yet to pick up momentum there.

Table 3.9: Distribution of beneficiaries by district and administration division (2012-2013)

District and Administration division	2012-2013					
	Female		Male		Total	
	No	%	No	%	No	%
Bangalore Division	**283**	**40.60**	**414**	**59.40**	**697**	**5.43**
Bangalore Urban and Rural	47	42.73	63	57.27	110	0.86
Chikkaballapur	13	36.11	23	63.89	36	0.28
Chitradurga	43	43.00	57	57.00	100	0.78
Davanagere	47	35.88	84	64.12	131	1.02
Kolar	17	41.46	24	58.54	41	0.32
Ramanagara	14	40.00	21	60.00	35	0.27
Shimoga	71	47.33	79	52.67	150	1.17
Tumkur	31	32.98	63	67.02	94	0.73
Belgaum Division	**2,394**	**40.76**	**3,479**	**59.24**	**5,873**	**45.76**
Bagalkot	352	42.98	467	57.02	819	6.38
Belgaum	626	42.21	857	57.79	1,483	11.56
Bijapur	323	39.49	495	60.51	818	6.37
Dharwad	243	40.37	359	59.63	602	4.69
Gadag	184	38.25	297	61.75	481	3.75
Haveri	301	38.34	484	61.66	785	6.12
Uttara Kannada	365	41.24	520	58.76	885	6.90
Gulbarga Division	**2,220**	**40.51**	**3,260**	**59.49**	**5,480**	**42.70**
Bellary	401	39.05	626	60.95	1,027	8.00
Bidar	285	38.78	450	61.22	735	5.73
Gulbarga	576	41.95	797	58.05	1,373	10.70
Koppal	363	42.21	497	57.79	860	6.70
Raichur	357	41.51	503	58.49	860	6.70
Yadgir	238	38.08	387	61.92	625	4.87
Mysore Division	**316**	**40.31**	**468**	**59.69**	**784**	**6.11**
Chamarajanagar	37	37.37	62	62.63	99	0.77
Chikamagalur	21	35.59	38	64.41	59	0.46
Dakshina Kannada	32	41.03	46	58.97	78	0.61
Hassan	38	33.33	76	66.67	114	0.89
Kodagu	15	35.71	27	64.29	42	0.33
Mandya	43	35.25	79	64.75	122	0.95
Mysore	112	47.26	125	52.74	237	1.85
Udupi	18	54.55	15	45.45	33	0.26
Total	**5,213**	**40.62**	**7,621**	**59.38**	**12,834**	**100.00**

Note: Percentages given under Female and Male heads are row percentages. It should be interpreted as percentage of female (or) male beneficiaries to total beneficiaries in a district/administrative division.
Percentages given under Total head are column percentages. It should be interpreted as percentage of beneficiaries in a particular district/administrative division to total beneficiaries

Source: SuvarnaArogyaSuraksha Trust, http://www.sast.gov.in/home/Home.html

http://www.sast.gov.in/home/Details/Claims_10-11.pdf, http://www.sast.gov.in/home/Details/Claims_11-12.pdf, http://www.sast.gov.in/home/Details/Claims_12-13.pdf

3.3 VAS: Benefit Incidence Analysis

Using budget and beneficiary data, we have attempted benefit incidence analysis (BIA) across sex and age groups for one year, i.e., 2012-13. Table 13 shows the claim by the hospital, gross amount approved by the trust and the net amount paid by the trust to the hospital by age categories. The payment to females is only about 40 per cent of the total payments. Therefore, though the categorization of the scheme under group 'B' is justified, it needs further investigation to see why female claims are lower than those for males.

Table3.10: Distribution of VAS claims by age categories and gender of beneficiary (2012-13)

	Distribution of total amount claimed by hospital		**Distribution of gross amount approved by SAST**		**Distribution of net amount paid by SAST to the hospital**	
Age group	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
19 years and below	761.8	850.2	694.5	768.2	625.4	692.1
21 to 30 years	715.1	689.8	654.2	620.2	589.9	559.3
31 to 40 years	756.1	910.4	586.5	828.8	528.9	747.1
41 to 50 years	495.4	1007.5	445.6	891.9	402.1	805.2
51 and above	425.4	1031.3	376.7	941.0	340.1	849.0
Total	3153.8	4489.1	2757.6	4050.1	2486.5	3652.8
Female Male Ratio	41.26	68.74	40.51	59.49	40.50	59.50

Source: Utilisation data SAST

Note: All figures are in lakhs and figures in brackets are percentage

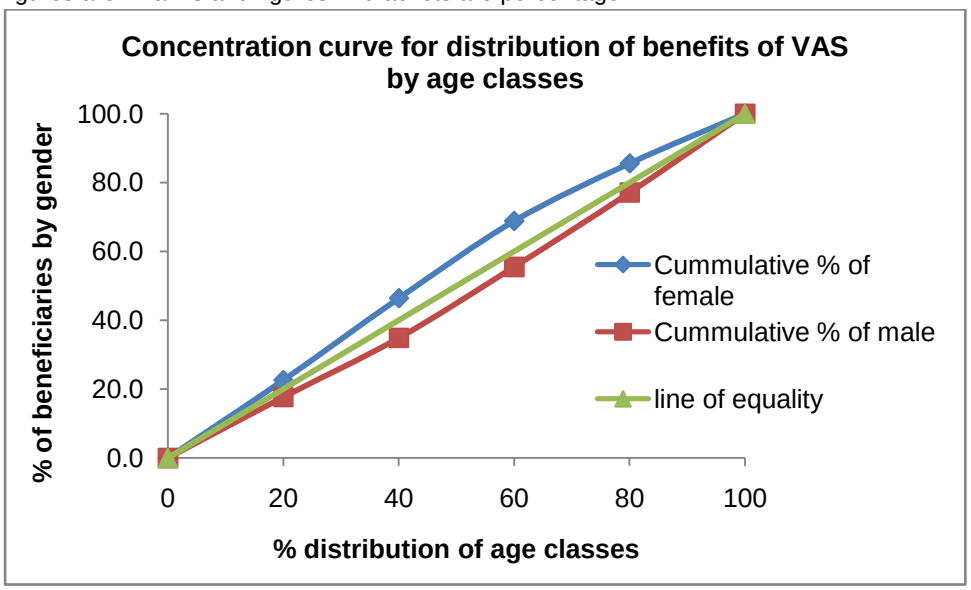


Figure 4: Concentration curve showing distribution of VAS beneficiaries (per cent) for age quintiles (2012-13)

The concentration curve shows that the distribution of public spending on VAS is pro-young in case of female. The concentration curve for females lies above the line of equality. In case of males, it lies below the line of equality which shows that the fifth quintile exceeds the first quintile, i.e., the payments for the fifth quintile is larger than 20 per cent. This means that the benefits of public spending disproportionately go to the highest quintile of age group in absolute terms and relative to their share in the population. In this case, it means that the distribution is pro-elder for males. Whether lower representation of women coupled with lower representation of older age women is a result of any neglect or not is an area of further investigation.

4. Discussion Points / Suggestions

4.1. ThayiBhagya

Need for better information on financial allocations / expenditure as well as data on beneficiaries segregated by gender / social group / economic group / age to support planning, allocation and monitoring is huge, especially in schemes such as ThayiBhagya. Lack of data limits the analyses on many counts:

-lack of information on beneficiary makes it impossible to carry out any analysis related to their distribution. Which section of the society is using these more? Why so? Which districts and regions are making greater use of? These questions remain unanswered. Also, it is not clear why have multiple schemes of similar nature and why not collapse them into one; funding (centre – state) could be one reason but three are state funded schemes.

- it is not clear what is the basis for allocations under safe motherhood (ThayiBhagya) programme and how is it distributed across districts and locations (rural/urban) except when it is clearly targeted to one region. Do the districts with lower than state average figures in institutional birth get a larger share? All beneficiaries are women, hence the classification as group 'A' is justified.

- it is not clear how much money is actually used for transfers. Do the allocations include administrative costs? What is the ratio? Redefinition and renaming of expenditure heads based in the budget documents would help in improving the analysis.

- in order to strengthen linkages between institutional birth and women's/children health, more and better information could be generated by supporting researches into impact on maternal / infant mortality rates. These could serve as advocacy tools for greater allocation for such programmes.

4.2. VAS

VAS data availability is much better. Incidentally, we attempted to access Yeshashwini, another health insurance scheme for similar data and realized that no gender-segregated data is available for the period 2003-1012. About 40 per cent of the expenditure has gone for females and therefore, classification under category 'B' is also justified. However, some issues relating to the budget document remains similar and other kind of issues emerge from the analysis of beneficiary data:

- Females cover only about 40 per cent of the beneficiaries. An inquiry into why the proportion is not close to half is needed. Is there any reason why the proportion of older women as compared to older men is small? Once the cause is known, the question regarding the possibility of incentivising their participation could be debated.

- Both ThayBhagya (shceme) and VAS divert public funds to private providers in a significant manner. Most private health institutions are located in urban areas / district headquarters. Is it gender friendly or does it go against enhanced women's participation for better health care (due to transport, safety and distance-related issues) Could there be a case for weighing an option of strengthening public health institutions in remote locations to enhance women's participation in VAS kind of schemes?

4.3. Gender Budget Documents and Processes

Gender budget process and documents can be strengthened through a variety of measures:

- Gender budget documents could make a simple beginning by incorporating some of the analyses on use / effectiveness / reach of the programme using research studies. Also, physical targets using RFD document, etc. could be added to give a better picture.

- Merging KMAY ang Gender Budget exercises as one is critical to get rid of unnecessary confusion and duplicity of work.

- A gender budget monitoring report could be brought annually by the WCD, GoK using some of the studies and monitoring reports. This can be used as advocacy tool for greater allocation, better allocation, change of definitions and headings in the budget document, recategorisation of schemes in different groups – A and B, gender-segregated data, and so on. While the WCD can commission selected studies, it can also make use of studies / reports through other sources. At a later stage, each department could be asked to contribute, or it could be by rotation – some this year, some next and so on.

- Development of a manual and training of different departments in preparing gender budgets and undertaking gender monitoring. Orientation of different tools that can be used for gender budgeting would help in better gender monitoring.

References:

Budlender, Debbie. (not dated). *Review of gender budget initiatives*. Community Agency for Social Enquiry.

Budlender, Debbie, & Hewitt, Guy. (August 2002). *Gender Budgets Make More Cents: Country Studies and Good Practice*. London.

CBGA. (2012). *Recognising Gender Biases, Rethinking Budgets: Review of Gender responsive Budgeting in the Union and Select States*. New Delhi: Centre for Budget and Governance Accountability.

el, Pooja Parvati et. (2012). Recongnising Gender Biases, Rethinking Budgets. New Delhi: CBGA (Centre for Budget and Governance Accountability).

GoK. (2011). *Report on Medical Certification of Cause of Death* Bangalore.

GoK. (2011-12). *Karnataka State Budget*.

GoK. (2012-13). *Karnataka State Budget*.

GoK. (2013-14a). *Gender Budget*.

GoK. (2013-14b). *Karnataka State Budget*.

Jha, Jyotsna, Krishnaswamy, Divya, & Sharma, Varum. (2014). Public Expenditure on Children in Karnataka. Bangalore: Centre for Budget and Policy Studies (CBPS).

Karnataka, Government of. (2013). *Gender Budget 2013 2014 (As presented in July 2013)*. (2). Bangalore, Karnataka

Lo, Fatou Aminata, & Alami, Nisreen. (October 2011). *Budgeting to End Gender Inequalities in the Education Sector*. New York: UN Women.