सत्यमेव जयते

Government of Jammu and Kashmir

HEALTH FINANCING PROGRESS MATRIX

SUB-NATIONAL ASSESSMENT

Jammu and Kashmir, India

2024

World Health Organization

India

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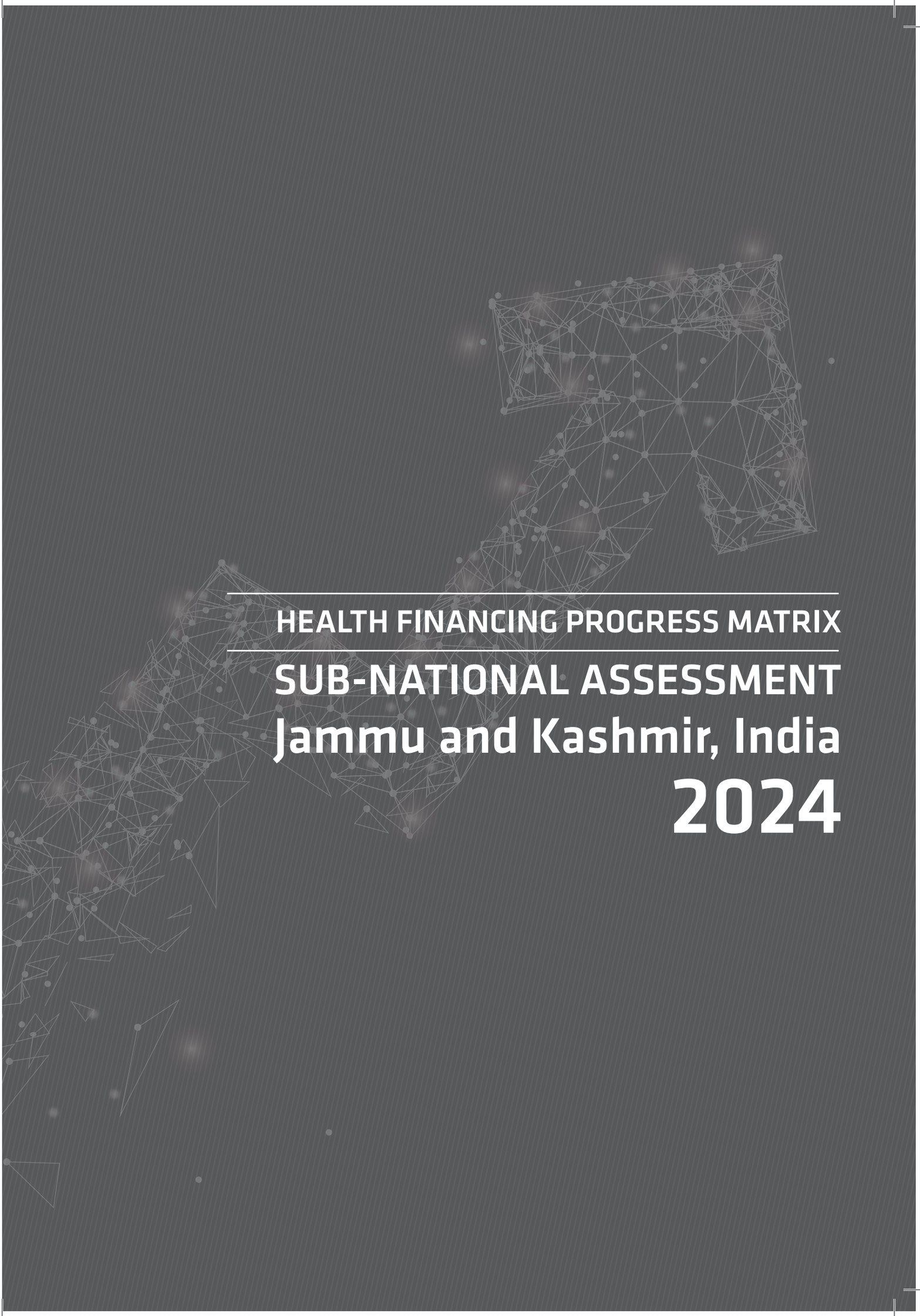

HEALTH FINANCING PROGRESS MATRIX

SUB-NATIONAL ASSESSMENT
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Abbreviations

ABDM	Ayushman Bharat Digital Mission
ABHIM	Ayushman Bharat Health Infrastructure Mission
AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
AFMS	armed forces medical service
ASHA	accredited social health activist
BE	budget estimates
BEAMS	budget estimation allocation and monitoring mechanism
CAG	Comptroller Auditor General
CBG	case based groups
CEO	chief executive officer
CGHS	central government health scheme
CHC	community health centre
CMO	chief medical officer
CPEA	cross programme efficiency analysis
CRM	common review missions
DOHFW	Department of Health and Family Welfare
DRGs	diagnosis related group
ESIC	Employee State Insurance Corporation
ESIS	Employee State Insurance Scheme
FFS	fee for service
GDP	gross domestic product
GeM	government e-marketplace
GGE	general government expenditure
GHE	government health expenditure
GoI	Government of India
GSDP	gross state domestic product
GSHIS	government sponsored health insurance schemes
GST	goods and service tax
HBP	health benefit package
HTA	health technology assessment
HWCs	health and wellness centre
ICD	International Classification of Diseases
ICHI	International Classification of Health Interventions
IPHS	indian public health standards
IRDAI	Insurance Regulatory and Development Authority of India
IRHS	indian railway health service
ISA	implementation support agency
J&K	Jammu and Kashmir
JKEMS	Jammu and Kashmir emergency medical services
JKMSCL	Jammu and Kashmir Medical Supplies Corporation Limited
MoHFW	Ministry of Health and Family Welfare
NABH	National Accreditation Board of Hospitals

NAFU	National Anti-Fraud Unit
NCDC	National Centre for Disease Control
NHA	National Health Authority
NHM	National Health Mission
NQAS	National Quality Assurance Standards
OOPE	out-of-pocket expenditure
OPD	outpatient department
PFM	public financial management
PHC	primary health centres
PPMs	provider payment mechanisms
RKS	Rogi Kalyan Samiti
RSBY	Rashtriya Swasthya Bima Yojana
SDG	sustainable development goal
SECC	socio economic caste census
SHA	state health agency
SHS	state health society
SNA	single nodal account
THE	total health expenditure
TPA	third part administrator
UHC	universal health coverage
UT	union territory
WHO	World Health Organization

About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's (or a subnational unit thereof) health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for UHC" into nineteen desirable attributes, which form the basis of the assessment. By identifying areas of strength and weakness in the current health financing system, together with priority policy directions, HFPM assessments complement monitoring of key quantitative indicators on service coverage and financial protection, now enshrined in the Sustainable Development Goals agenda.

HFPM assessments can be implemented within a short time period and provide close-to-real time information for policy-makers. Findings support the development of health financing strategies, technical alignment across government and external technical assistance agencies, and provide the basis for monitoring progress over time. The HFPM is the first instrument which allows the systematic tracking of the development and implementation of health financing policies which matter for UHC.

In summary, HFPM country assessments consists of two stages:

- **Stage 1:** A mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- **Stage 2:** A detailed assessment of thirty-three areas of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Further details about the HFPM are available here:
https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/healthfinancing-progress-matrix

About this report

This Health Financing Progress Matrix (HFPM) high-level report provides a concise summary of the key strengths and weaknesses of the health financing system in Jammu and Kashmir, based on the response and rating for each assessment question. This is the first report, globally, which assesses a subnational health system using the HFPM, and as such is of interest to many other countries, particularly on how decision-making authorities is shared between different levels of government.

State-specific health financing policy does not exist in J&K, as it is a union territory (UT). This means that the governance of the UT is overseen by officials deputed by the Union Government, with majority of public financing also coming from the Union. This in contrast to states, which tend to have considerably more autonomy vis-à-vis governance and revenue-raising capacity. The Government of India has a National Health Policy 2017 where health financing policy is detailed. While the ministry of finance at the state and central level is responsible for tax collection and budget formulation, the MOHFW at the Central or Union level and the Department of Health and family welfare at the state/UT level participate in determining the detailed budgets and resource envelopes for respective ministry and department. The detailed budget for medical and health services of the department is decided at the state/UT level in consultation with the directorates and departments.

Using the structure of the seven assessment areas and the desirable attributes of health financing systems, the report identifies key areas of health financing policy in Jammu and Kashmir which need to be addressed to drive progress towards UHC. Looking both at the current situation, and what needs to happen in the future, helps to identify the priority areas for further analytical work, technical support, and implementation.

Also included in this report is the latest information on how J&K is performing on key service coverage indicators as defined by NITI Aayog, together with key health expenditure indicators. For subnational comparison alternative sources had to be used given that these are typically only validated and reported at the national level.

Methodology and timeline

The Health Financing Progress Matrix (HFPM) for Jammu and Kashmir was undertaken based on a request from the Government of Jammu and Kashmir to the WHO Country Office for India to support the union territory (UT) in exploring ways of strengthening its health system. To that end, WHO India commissioned this assessment to an independent institution who have previous experience in health financing in India.

The assessment was undertaken based on the most recent version of the Health Financing Progress Matrix. Completion of the assessment was based primarily on a desk review of relevant studies, report and documents. However, consultations were also undertaken by the implementing partner though this had to be done remotely owing to the COVID-19 pandemic and change in leadership within Jammu and Kashmir.

Further details are listed in the table below

October 2021	Final version of stage 1 assessment shared by implementing partner
January 2022	Final version of HFPM for Jammu and Kashmir shared by implementing partner
February 2022	Validation meeting with Jammu and Kashmir leadership
January 2024	Review by WHO

Jammu and Kashmir UHC performance

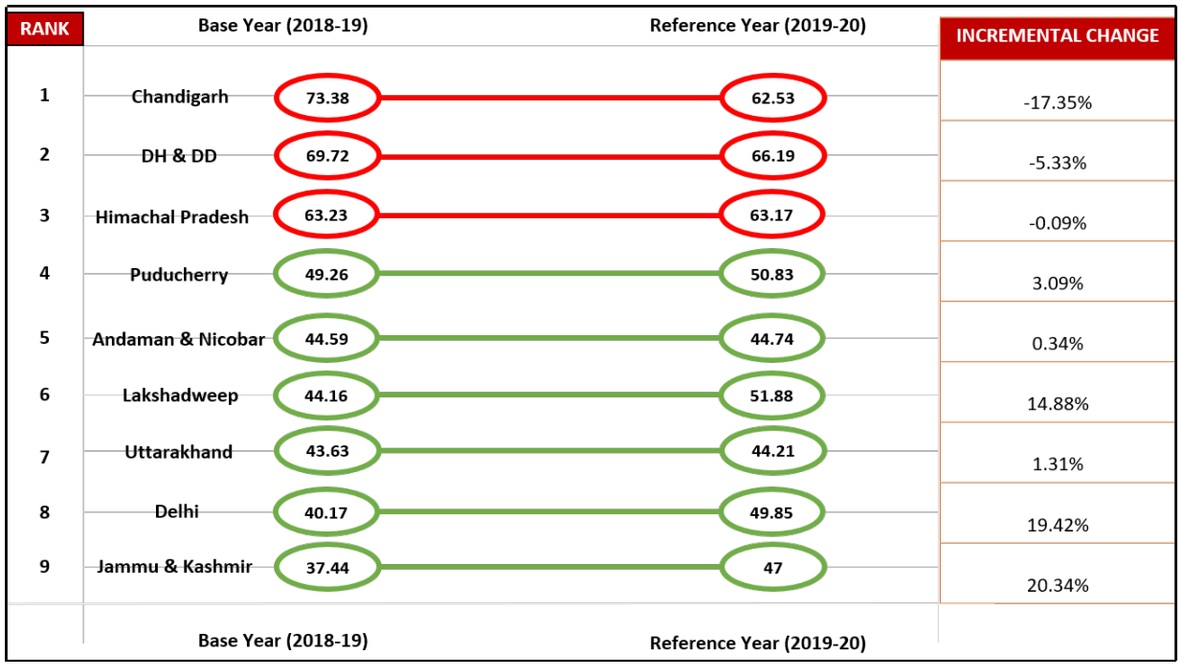
Jammu and Kashmir UHC performance

SDG Indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access[1].

Given that the UHC Service Coverage Index is usually computed at the country or national level, an estimate is not available specifically for Jammu and Kashmir. An alternative is the Health Index produced in an annual report by NITI Aayog (a central government think tank), together with the Ministry of Health and Family Welfare and the World Bank[2]. This report is an annual ranking of all states and union territories (UTs) on overall levels of performance and change over time, based on a composite index score (Fig. 1), covering domains such as Health Outcomes, Governance and Information and Key Inputs and Processes. Details of the indicators used are provided in **Annex 1**.

To assess the current and incremental performance of Jammu and Kashmir along these indicators, the comparators were limited to the union territories (which are centrally administered) as they have similar systems of governance and financing for government programmes (Fig. 1). It is, however, important to bear in mind that Jammu and Kashmir's status was changed from a state to a union territory in the year 2019 though for the purpose of this assessment, it has been addressed and referred to as a UT even if some data pre-dates the change in its governance status. The incremental performance is measured between the *base year* of 2018-2019 and *reference year* of 2019-2020, the most recent estimate available. Moreover, **Annex 2** also provides an overview of the rankings for other groups of states and UTs, that is, large and small, to provide a relative sense of where various subnational entities stand vis-à-vis their overall composite score on this index.

Fig. 1. Union territories and hilly states (overall performance) – Composite index score and rank, base and reference years (2018-2019 and 2019-2020)



Source: *Compiled by Authors from Health States Progressive India Round IV, 2019-2020*
Note: *Lines depict changes in Composite Index Score rank from Base Year (2018-2019) to Reference Year (2019-2020). Green lines indicate improvement, red lines denote deterioration while yellow lines indicate no change in the position. The Composite Index Score is presented in the circle. UT of Ladakh not included due to non-availability of data.*

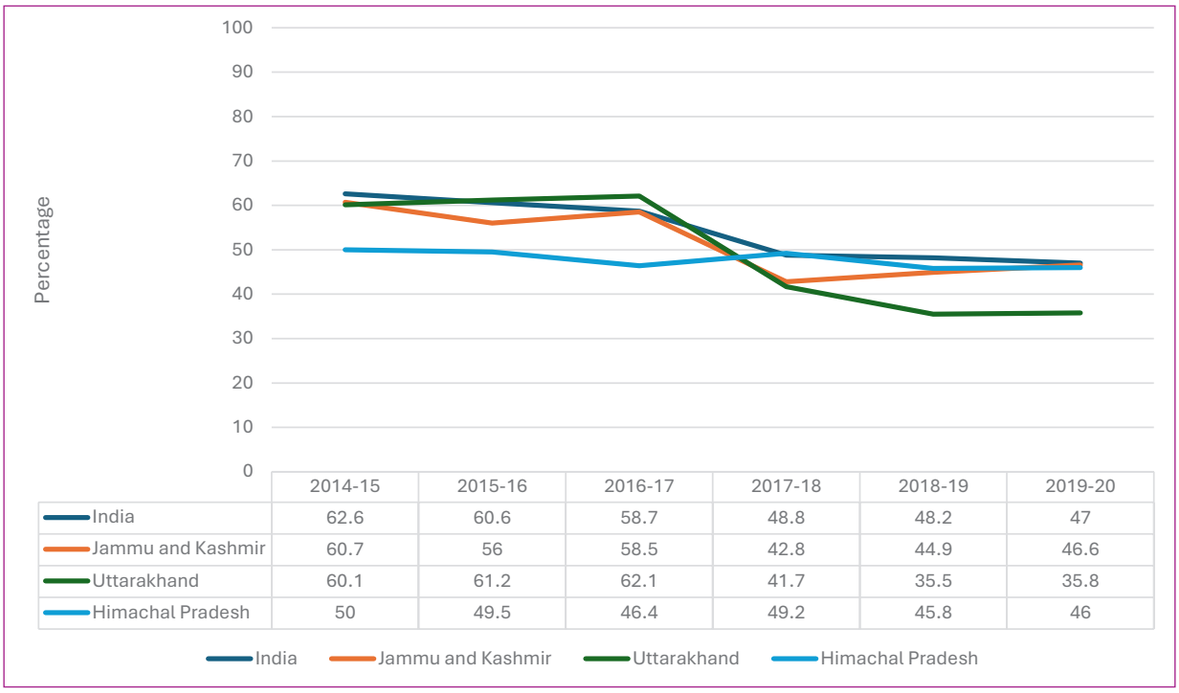
While Fig. 1. indicates a low score for Jammu and Kashmir compared to other UTs, a closer look at the incremental improvement between the base year and reference year suggests that much has been done in way of improving key indicators of health system performance as defined by this Index. Though no systematic assessment regarding the reason for such improvement is available, a study conducted by WHO India, in 2022, showed an increasing a budget envelope for the health department in Jammu and Kashmir between 2016 and 2020, though utilization remained low[3].

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending and defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income". Large is defined using two thresholds first greater than 10% of the household budget and secondly greater than 25% of the household budget. As for SDG 3.8.1, decentralized data for India was not available vis-à-vis catastrophic health expenditure thus out-pocket-expenditure (OOPE) as a share of total health expenditure was used as a proxy. Though it is usually recommended that OOPE as a share of current health expenditure be used, owing to the muti-year attribution issue inherent in capital expenditure, this could not teased out at the sub-national level for this assessment. Though data for current health expenditure at a sub-national level is available with the health accounts country team at the Ministry, it is not shared publicly and thus, was not used for this assessment.

The data based on OOPE was sourced from the various rounds of National Health Accounts conducted in the country, which also provide state and UT level insight on key financing

indicators for select geographic regions. A detailed table of indicators for these states and territories (including Jammu and Kashmir) is provided in **Annex 3**.

Fig. 2. Out-of-pocket expenditure as percentage of total health expenditure



	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
India	62.6	60.6	58.7	48.8	48.2	47
Jammu and Kashmir	60.7	56	58.5	42.8	44.9	46.6
Uttarakhand	60.1	61.2	62.1	41.7	35.5	35.8
Himachal Pradesh	50	49.5	46.4	49.2	45.8	46

Source: *National Health Accounts for India*

Fig. 2. provides OOPE figures for Jammu and Kashmir over these rounds of the National Health Accounts and juxtaposes it against the national figures for OOPE available[4]. Jammu and Kashmir have been compared with other 'hilly states' which form a special category of states in relation to the support they receive from the Union/Central Govt. for co-financed health schemes. In the case of National Health Mission and AB-PMJAY this proportion is 90:10 (Center: State) compared to 60:40 for other states. As health accounts do not provide estimates for union territories, the comparison was undertaken within the aforementioned category.

Jammu and Kashmir HFPM summary

Jammu and Kashmir HFPM summary

Summary of findings and recommendations	
Assessment area	**Summary findings and recommendations**
Policy process and governance	Regarding the health financing and policy landscape in Jammu and Kashmir, the policy framework is largely based on the national health policy. There is no UT level health financing policy or more broadly policy statement on health and UHC at the UT level. It is important moving forward: 1. A comprehensive health financing evidence generation drive is undertaken to inform the UTs UHC agenda and pathway 2. A review of evidence of gaps and overlaps highlighted in this assessment regarding revenue raising, populations covered and health financing functions to guide policy dialogue on harmonization or integration of pools across the schemes to improve systems efficiency and equity.
Revenue raising	Increased investments by the Union and UT Government has resulted in downward trend in OOPE as proportion of THE. Nevertheless, there is room for greater improvement in the way revenues are raised for health in J&K. Some potential ways are. **1. Ensure increased execution of the budget** by addressing PFM bottlenecks including capacity for PFM as well as ensuring the timely disbursement of funds to ensure service availability and coverage. **2. Institute a medium-term expenditure framework.** This instrument is critical for multiyear planning and enables the sector and government have a clear view of what is planned and mobilized for health. **3.** The need for **health resource tracking to** monitor the impact of recent reforms to provide evidence on how resources are being used. **4. Policy dialogue for improving the reliance on health taxes** for addressing health risky behaviors. There is room to increase taxation on harmful products like tobacco as the current levels fall short of global standards (75% WHO, 80% IMF). Evidence-based dialogue on these policy tools can improve the uptake of this policy instrument. Sustainability of initiatives such as PMJAY needs to be contextualized in light of the stagnant health budget. It is recommended that financial and strategic planning for stable, predictable, and sustainable revenue mobilization needs to be taken up. In addition, adequate and timely utilization of the existing health budget also needs urgent attention.

Summary of findings and recommendations	
Assessment area	**Summary findings and recommendations**
Pooling revenues	Broadly the tax-based pool is fragmented across health and central ministries, with negligible flexibility to use the budget funds across the schemes. The convergence of AB PMJAY and SEHAT with existing schemes provides significant promise of addressing the challenge around re-distributive capacity and harmonizing benefits. the issue is to ensure integration across the pools and/or harmonization of purchasing functions across at the very least to minimize inequities in access. This convergence must aim to: 1. Minimize potential resistance because of changes in the benefit coverage provided to the specific populations 2. Expand equitable coverage benefits to the population. 3. Provide basis for evidence-based dialogue on the impact of further feasibility of reforms for UHC.
Purchasing health services	Purchasing arrangements in J&K are scheme specific and fragmented, with only ABPMJAY SEHAT using scheme information to inform decision-making. This may result in potential for conflicting incentives at delivery level and result in selective service provision. Moreover, quality of care is not incentivized by and large. Public hospitals have limited autonomy vis-à-vis resource reallocation and thus have limited decision-making space. Recommendations for improving purchasing arrangements include: 1. **Harmonization of purchasing arrangements** across schemes and across service functions (primary care versus secondary and tertiary care) with a bid to increase efficiency in service delivery and improving complementarity of PPMs for quality of care. 2. NHA is commencing a **pilot on diagnosis related groups** that will demonstrate the feasibility and early effectiveness of implementing PPMs for health insurance. The Government in J&K should be an early adopter of the reforms and should commence adaptation of the systems accordingly to this end. 3. **Introduce a policy analysis unit** within SHA or local university to conduct analytical studies for health financing in J&K based on locally available data to inform provider payment reform for UHC in J&K with a **system-wide, rather than scheme-basis** perspective. 4. The UT may establish an **autonomous strategic purchasing office** that can work to optimize payment mechanisms within ABPMJAY and beyond by putting in appropriate incentives for ensuring efficiency, equity and quality of care.
Benefits and conditions of access	At a systemic level J&K has some progress in this domain specifically relating to co-payments as a rationing mechanism. However, improvement is required vis-à-vis benefit design reforms.

Summary of findings and recommendations	
Assessment area	**Summary findings and recommendations**
Benefits and conditions of access	The presence of Regional HTA centres in Shillong in the Northeast to inform benefit design processes also offers opportunities **for institutionalization of HTA** in the benefit design process. J&K should leverage this and build capacity within the SHA to conduct such assessment to inform benefit package design and ensure cost–effectiveness of services being offered under PMJAY SEHAT. Such assessments should also factor in economic evaluation, budget impact analysis with a view to promoting equity and financial protection and improve overall system efficiency. Within the general budget revenue channelled through the DOHFW, it is important that the government **institutionalizes costing for health services based** on a medium-term horizon that enables the UT to project future costs based on UHC targets and allocate resources as required. The institutionalization of cost-surveillance for PMJAY SEHAT will also be crucial to inform benefit design and pricing of packages. There is also a need to **strengthen the alignment of purchasing systems** to the benefit package to ensure that the services guaranteed in the benefit packages across schemes are realized at the point of use. The J&K public sector facilities provide a range of services according to IPHS standards. However, there remains an issue of OOPE in public hospitals. The employment-based schemes also provide similar services without any such evidence of OOPE. The lack of evidence of OOPE in AB PMJAY and SEHAT needs research, in addition to regular monitoring and evaluation as well as assessment of knowledge of entitlements among beneficiaries should be carried out in all schemes.

Summary of findings and recommendations	
Assessment area	**Summary findings and recommendations**
Public financial management	Based on a parallel study commissioned by WHO India Office, it was found that PFM challenges in J&K arise largely due to misalignment between planning and spending needs, budget under execution due to delays, capacity problems largely at the lower levels that result in poor planning and budget execution. There are also challenges in budget structure which need to be addressed to improve alignment to health financing reforms. The following actions are recommended: 1. There is need to f**inalize the analysis of public financial management systems** to identify barriers to be addressed across the PFM cycle. In addition to the rectification of fund flow bottlenecks, the UT needs to identify underlying issues to reduce under spending. 2. There is need to **strengthen the relations** between Department of Health and Medicine and Department of Finance. Institutionalization of dialogue between the two departments will increase the effectiveness of the planning and the budget execution and monitoring phases. This dialogue should also include evidence-based advocacy for **budget structure review and reform** to ensure alignment of the same with purchasing functions. 3. The union territory of Jammu and Kashmir needs to **develop significant capacity** for planning and financial management to ensure strengthening of budget formulation and execution. 4. There is need to **develop medium term strategic plans** for UHC with clear goals and targets, aligned to the UTs broader UHC vision.
Public health functions and programmes	As most broader policy issues reside with the national Govt. J&K should aim to achieve greater levels of implementation efficiency within this framework. However, experiences from COVID-19 have shown how even at a subnational level, Governments can reorient processes (for example, PFM) to respond to emerging needs and these experiences should help inform the UT's broader health financing strategy and approach

Stage 1

Assessment

Stage 1:

Health coverage schemes in Jammu and Kashmir

Health coverage schemes in Jammu and Kashmir comprise a wide array of central and UT level initiatives covering a diverse range of services and/or population groups. A brief overview of each vis-a-vis its main objective and intent, is specified below:

1. **General budget revenue**: The public provision system, administered by the Department of Health. It comprises financing for the entire range of services from preventive to specialized curative as well as vertical disease programs. This also includes the National Health Mission (NHM), launched in 2005 to focus on health system strengthening and focusing on enhancement of primary care provision. It is financed by revenue from the Union level government (90%) of funding which is disbursed as part of the general tax revenue through the Public Financial Management System (PFMS) and a co-financing component of 10% from the Government of Jammu and Kashmir which is disbursed through the UT Treasury.

2. **PM-JAY SEHAT**: The UT adapted version of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY launched in 2018), a health coverage scheme for families identified under deprivation criteria as per the socio economic caste census survey (SECC), 2011, covering over 1500 inpatient procedures on a family floater basis (covering all members in the household) up to INR 500 000 (approximately USD 6000). The national scheme aims to cover the bottom 40% of the population through co-financing with states and UTs though Jammu and Kashmir have universalized this scheme for its citizen and pays for families not covered under the SECC database. The scheme is managed and governed by the state health agency of Jammu and Kashmir, under the Department of Health

3. **Employee State Insurance Scheme:** The ESIS, launched in 1952 is a social security scheme for formal sector workers below a specified income threshold (INR 21 000 or approximately USD 2600 as of 2023-2024). As part of social security benefits, the scheme covers medical expenditures for the enrolled employee and his/her family for the entire range of services. The scheme is financed by employer and employee contributions as well as state government contributions and is managed and governed by the Employee State Insurance Company (ESIC) under the Ministry of Labour, Government of India.

4. **Central Government Health Scheme:** Central Government Health Scheme (CGHS) gives health care facilities to registered employees and pensioners (as well as their spouse and children) of the Central Government of India. The enrolled members are provided reimbursement and cashless facilities under this scheme, including services taken from the private sector. There is no established financial cap on the total amount of services that can be availed. CGHS is managed and governed by the Ministry of Health, Government of India.

5. **Armed Forces Medical Services:** This scheme was launched in 1947 to provide all

medical services to armed forces personnel and pensioners as well as their families and dependants. The scheme is governed and managed by the Department of Defence, Government of India.

6. **Indian Railway Health Service**: Coves all current and former railway employees and their families. It also covers licensed porters under the scheme and is managed and governed by the Ministry of Railways, Government of India.

7. **Private insurance:** Private insurance currently has a limited role in the overall health financing landscape of Jammu and Kashmir. Nevertheless, it still covers about 150 000 individuals in the UT and is regulated by the Insurance Regulatory Development Authority of India (IRDAI). Participation in private insurance schemes is entirely voluntary.

UT-specific health financing policy does not exist in J&K. The Government of India has a National Health Policy 2017 where which expresses some policy imperatives related to health financing policy. While the ministry of finance at the state and central level is responsible for tax collection and budget formulation, the MOHFW at the central level and the Department of health and family welfare at the state or UT level participate in determining the detailed budgets and resource envelopes for respective ministry and department. The detailed budget for medical and health services of the department is decided at the state and UT level in consultation with the directorates and departments.

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
YEAR OF ESTABLISHMENT When was the scheme launched?	In 1948 on recommendation of the Bhore committee[5], a national health system was setup based on the United Kingdom publicly funded model. This was further bolstered by the National Health Mission (NHM) launched in 2005, which witnessed enhanced Government investment for health systems strengthening, especially for primary care.	PMJAY was originally launched for a specified poor population in December 2018. The scheme was rechristened as PMJAY SEHAT and universalized? in December 2020[8].	ESIS was established in 1952. It started its operations in three districts of J&K in 1989[6].	CGHS was launched in 1954[7].
FOCUS OF THE SCHEME What kind of coverage is this: Universal public access, targeted, disease programmes, etc.	This includes public health care facilities that all citizens are entitled to use, that is, Universal public access	This is insurance coverage for specified inpatient and day care procedures that covers all permanent residents in J&K.	This is a social health insurance scheme for employees and their dependents working in factories and establishments employing 10 or more persons whose wage is less than INR 21 000 per month.	This is an employment-based contributory scheme for the employees and pensioners of the central government, certain autonomous, semi-autonomous government organizations, members of parliament, state governors, accredited journalists and their dependents.
TARGET POPULATION Are all citizens covered, or a specific subgroup for example, under 5s, salaried workers?	1.34 million (projected numbers according to 2011 census data)[9] population of the UT for the year 2021.	Around 2.05 million families are eligible for coverage under PMJAY-SEHAT. This is a scheme that has expanded the population coverage beyond PMJAY's eligibility criteria. This includes 1.46 million families to be covered by the UT under PMJAY-SEHAT (those not part of SECC databased and funded entirely by Jammu and Kashmir Government) and 0.6 million families covered in PMJAY (co-financed by J&K and the Central Government) as per the RSBY/ SECC data[10].	As of March 2020, the scheme covers 121 980 employees, 133 440 family units, and 517 747 beneficiaries[11]	As of October 2021, there were 4592 cardholders in the cities of Jammu and Srinagar. The total number of beneficiaries was 12 450

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
POPULATION COVERED Actual numbers relative to target population	In the year 2020-2021, the public system provided 17 million OP consultations and 0.76 million hospitalizations. In terms of the coverage, about 91.2% of the total population (95.9% among rural and 77.9% of urban population) who needed hospitalization (excluding childbirth) received it from government/public hospitals. Most of these hospitalizations (95%) were provided free of cost to the patients[12].	As of November 2021, 5.78 million individual Ayushman cards have been generated. Although this amounts to 43% of coverage in terms of distribution of cards, the scheme envisages providing Ayushman cards to all its citizens. The Ayushman cards serve to validate eligible beneficiaries for availing services and created when listed SECC beneficiaries utilize services under the scheme the first time.	As of March 2020, the scheme covers 121 980 employees, 133 440 family units, and 517 747 beneficiaries.	As of October 2021, there were 4592 cardholders in the cities of Jammu and Srinagar. The total number of beneficiaries was 12 450.
BASIS FOR COVERAGE For example, Mandatory, automatic, voluntary	Automatic	Although the scheme coverage is automatic for all citizens, the issuance of Ayushman cards is Voluntary.	Mandatory	Mandatory
BENEFIT ENTITLEMENTS Is a list of services or level of care defined? Do users have to make co-payments?	A fixed set of primary, secondary, and tertiary entitlements can be availed at different levels of public health facilities, from primary to specialized care. Under Jammu and Kashmir Emergency Medical Services (JKEMS), free ambulance services are provided for all kinds of medical emergencies, including for the transportation of pregnant women.	The health services covered under the programme include hospitalization expenses, day care surgeries, follow-up care, pre and post-hospitalization expense benefits and maternal, newborn child/children services. A positive list of 1592 secondary and tertiary care services including medical and surgical procedures as included in health benefit package 2.0. Out of these, 21 procedures are reserved for government hospitals only.	The insured persons are protected during contingencies such as sickness, maternity, death or disablement due to employment injury or occupational disease. Free medical care is provided to the Insured Persons and their family through a network of ESI Dispensaries and Hospitals.	The scheme provides for OPD Treatment with specialist consultation and issue of medicines at the scheme owned wellness centres and polyclinics. Inpatient treatment can be availed at public and private empanelled hospitals. Diagnostic investigations can be availed at empanelled diagnostic centres.

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
			Additionally, the scheme also contracts private sector hospitals for super specialty care. The scheme also offers treatment under the alternative systems of medicines including Ayurveda and Homeopathy.	The services can be availed through a cashless facility or reimbursement of expenses in case of emergency as well as for the purchase of the specified hearing aids, artificial limbs, appliances, etc. The scheme also provides for alternate system of medicine
CONDITIONS OF ACCESS **Are there any conditions to be met to access services? (Referral, procedures, products, etc.)**	No conditions. Patients can visit any government health-care facility without a referral mechanism to avail consultation, hospitalization, surgical inputs, specified diagnosis services and medicines.	The benefits are available only from the empanelled hospitals. The benefits are restricted to specified packages for which the provider may include certain medicines, procedures, or products. Certain covered procedures are restricted to the public sector; the beneficiaries must visit public hospitals to avail benefits of this coverage. However, certain states allow a referral from public to private sector if the procedure in question is not available at a government facility. No referrals are required under this scheme from a primary or specialist level and patients can access hospital care without any barriers	Beneficiaries can avail services from the network of dispensaries and hospitals of the ESIC. The services can also be availed from empanelled hospitals if any. To avail services from the empanelled hospitals referral from the ESI Hospital or dispensary is mandatory, except in case of emergency[11].	Beneficiaries in all CGHS cities can avail OPD consultation from specialists in any government hospital directly without the need for any referral. Beneficiaries below the age of 75 years in all CGHS cities can seek OPD consultation from specialists in any of the CGHS empanelled hospitals after being referred by the Medical Officer or CMO In-charge of the Wellness Centre. The referral is valid for one month and for three OPD consultations. The beneficiary is required to report back to the concerned Wellness Centre and the Medical Officer or CMO In-charge will endorse the investigations and issue medicines as per guidelines.

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
				Beneficiaries of age 75 years and above can directly avail the OPD facilities at the empanelled hospitals without any referral from the Medical Officer of CGHS for listed investigations and procedures. There is a cap on charges for hospitalization in empanelled hospitals.
STRUCTURE AND DESIGN OF COPAYMENT Is there a copayment? If yes, how much and do exemptions exist?	The charge of an OPD ticket is INR 10. The access to essential drugs and specified list of diagnostics are free of cost in the government hospitals, under the free drugs and diagnostics initiative.	There are no user fees, and the treatment is free of cost to the beneficiaries till the limit of INR 500 000 per beneficiary family. However, evidence in other states indicated that there could be instances wherein the beneficiaries may need to pay out of pocket payment for certain inputs to treatment, depending on procedures and providers.	There are no user fees, and the treatment is free of cost to the beneficiaries at the point of service.	There are no user fees or co-payment.
REVENUE SOURCES Where does the money come from? Budget allocations/ transfer, prepaid contributions?	Public health systems are funded through the government budget.	The PMJAY SEHAT is an amalgamation of two initiatives in J&K viz. a) PMJAY and b) SEHAT, though they are in effect the same scheme. PMJAY is a centrally sponsored scheme with a cost-sharing arrangement between central (90%) and the UT government (10%). The SEHAT scheme, which covers the rest of the population, is fully funded through the UT budget.	The scheme is funded through ear-marked prepaid contributions from employees and employers. Contribution rates w.e.f. 01.07.2019 are as follows: employee share is 0.75% of the wages and that of employer's share is 3.25% of the wages in every wage period. Based on collections, ESIC allocates INR 2600 per beneficiary family (split even for administration and other expenses), of which 1/8th has to be contributed by the state governments	The scheme is funded through tax-funded general revenue of the Department of Health under the Ministry of Health and Family Welfare of the Government of India. Beneficiaries pay a nominal contribution in the form of deductions ranging from INR 250 to INR 1000 every month, depending upon the salary of the employees. Pensioners/ family pensioners availing

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
				CGHS facilities contribute equivalent to their subscription at the time of their retirement or at the time of the death of government servant, either on yearly basis or one-time (ten years) contribution for whole life validity
POOLING ARRANGEMENTS Is the health budget allocated to regional authorities? Is there a single or multiple insurance fund?	The UT government's funds for health care services and medical education are pooled at the treasury level to fund general health services Under the National Health Mission, in J&K, the central and UT funds are pooled in a 90:10 ratio. These allocations are initially released to the UT treasury followed by transfer to the State Health Society (SHS), District Health Societies, and different levels of facilities through single nodal accounts (SNAs). The Government of India, under the universal immunization programme, procures and supplies all vaccines along with diluents. Procurement of drugs, machinery equipment, etc. are being done by the UT's central purchasing committee (J&K Medical Supplies Corporation Limited) on an institutional basis and then issued to institutions [13,14,15,16]	Funds are released by the Ministry of Health and Family Welfare to the National health authority under three categories. 1) Direct head office grant 2) Grant-in-aid for administrative expense 3) Grant in aid for implementation purposes. The NHA coordinates with the state level state health agency (SHA) for financial and administrative purposes. At the UT level, the funds are pooled by SHA in two separate accounts meant for health claims payment and administrative expenses, respectively. Both SHA and NHA transfer their shares to these escrow accounts. The pooled funds for premiums are then released to the insurance company, as per the agreements. Bajaj Allianz General Insurance Company Limited acts as an insurer for PMJAY SEHAT[17]	The funds of the scheme are managed in a single pool managed centrally by the Ministry of Labour and Employment, Government of India. The funds are allocated to the state and UTs as per the beneficiary base, and not on the basis of need.	The funds of the scheme are managed in a single pool centrally by the Ministry of Health and Family Welfare, Government of India. The funds are allocated as per the needs, that is, historic and current utilization trends, irrespective of state-specific collection of funds. The prepaid contribution of the beneficiary gets subsumed into general revenues.

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
PURCHASING and PROVIDER PAYMENT How are funds used to purchase service under this scheme?	The scheme utilizes line-item budgets for UT-owned facilities. The fulltime government employees are paid salaries. The part-time government employees are engaged on a fixed remuneration. The National Health Mission hires contractual employees who are paid a lump sum fixed amount. The grassroot level volunteers (Accredited Social Health Activist – ASHA) are paid performance-based incentives under the mission, in addition to a fixed monthly compensation of INR 2000. Dentists and doctors of alternative medicines are also paid performance-based incentives up to INR 15 000, in addition to a fixed payment of INR 35 000 per month[18,19]	The providers are paid a pre-defined package rate depending on the procedure under the health benefits package. The payments earmarked for each package are subject to a mandatory pre-authorization. The Third-Party Administrator MD India Health care Service (TPA) Pvt. Ltd. does the pre-authorization and claims processing. Claim settlements are done through a private insurance entity. The insurer is paid by the state health agency through a competitive tendering process	There is a line-item budget for own hospitals and salaries for physicians and staff in dispensaries and hospitals. There are package rates to private empanelled hospitals and diagnostic centres, in case of tertiary/specialty treatment and diagnosis. The goods and services are purchased centrally with uniform specifications. Large equipment is procured through Government e-Marketplace (GeM) portal[20]	There is centralized purchasing and procurement of services for facilities under CGHS. In case of treatment in an emergency situation from the empanelled hospital, the claim is to be submitted to the concerned department by serving employees and to the medical officer in charge of the CGHS wellness Centre (where the CGHS card is registered) by the beneficiary within 3 months of discharge from the hospital.
SERVICE DELIVERY and CONTRACTING Which providers are services purchased from? Are contracts/service agreements agreement used?	Services are delivered through public facilities. This includes a) 22 district hospitals; b) 7 Trauma Hospitals; c) 77 Community Health Centres; d) 610 primary health centres; e) 2602 Subcentres and f) 226 MAC (Mobile aid centres)[21]	Public, Private for-profit, and Private non-profit facilities, which are empanelled through contracts, provide services under this scheme. As of September 2021, 239 hospitals (125 public, 68 GOI, and 46 private facilities) are empanelled under the scheme.	Services are delivered through ESIC owned facilities. This includes an ESIC hospital, 8 ESIC dispensaries, one clinic for homeopathy and one for Ayurvedic treatment, though portability exists across states. The three empanelled hospitals and two laboratories, concentrated in Jammu, are engaged through contracts.	Services are delivered through CGHS owned wellness centres, public health care facilities and empanelled private hospitals and laboratories. The scheme uses line-item budgets and salaries for their own facilities and staff, respectively. The two empanelled hospitals and laboratories, concentrated in Jammu, are engaged through contract and agreement.

Assessment areas	General budget revenue	PM-JAY SEHAT	Employee State Insurance Scheme	Central Government Health Scheme
GOVERNANCE OF HEALTH FINANCING Describe the management and governance arrangements	The Department of health medical education at the UT level, in collaboration with the Ministry of Health and Family Welfare of the government of India, provides primary care across the UT through National Health Mission. The secondary and tertiary care hospitalization and outpatient services are provided through UT government-owned and run facilities managed by the Directorate of Health Services, Kashmir. The Department works broadly under guidelines issued by the central Ministry, especially in case of NHM, though it determines its own priorities vis-a-vis strategic investment and operational planning.	The scheme is managed by the National Health Authority (NHA) under the Ministry of Health and Family Welfare at the central level, in financial and organizational partnership with states and UTs. At the UT level, the scheme is governed by the state health agency under the department of health and medical education. While NHA at the national level formulates policies and program details, the states and UTs have flexibilities in fixing rates, deciding on operation modalities, selecting the insurance company, and on the use of revenue generated by public hospitals. states and UTs can also reserve certain health benefits packages under the scheme for public hospitals.	The scheme is run by the Employee State Insurance Corporation, an autonomous body under the Ministry of Labour and Employment, Government of India. At the subnational level, it is managed by state ESI departments which can belong to different ministries (health or labour) depending on the state's or UT's prerogative. While majority of the funding and oversight is by ESIC and its subnational departments, the UT government is also expected to supplement funding to ensure access and effective service delivery for ESI beneficiaries.	The scheme is run by CGHS under the Ministry of Health and Family Welfare. There is no involvement of subnational governments directly. However, CGHS sets up zonal committees to ensure adequate oversight over catchment areas.

Assessment areas	Armed Forces Medical Service	Indian Railway Health Service	Private insurance
YEAR OF ESTABLISHMENT When was the scheme launched?	AFMS was launched in 1947[22].	IRMS was launched in 1853[23].	Private health insurance was launched in 1986 in India.
FOCUS OF THE SCHEME What kind of coverage is this: Universal public access, targeted, disease programmes, etc.	This scheme provides comprehensive health care to personnel belonging to Armed Forces, their families, and dependents.	This scheme provides services to current and former railway employees and their dependents. It also covers other categories of staff such as vendors and licensed porters. Contractors and their staff can avail of treatment from the railway medical facilities, though are required to pay out-of-pocket for care.	These are voluntary and commercial health insurance schemes providing coverage against hospitalization expenses to individuals and their families who opt for it. The coverage is limited to the sum insured for which the premium has been paid for.
TARGET POPULATION Are all citizens covered, or a specific subgroup for example, under 5s, salaried workers?	As of 2021, India has an estimated 5.12 million armed force personnel amounting to around 25 million dependent clientele. Being classified information, the number of defence personnel in J&K is not available[22].	As of March 2020, Indian Railways has 1 253 592 employees. The Indian Railways Health Services (IRHS) catered to an estimated 67 million beneficiaries. Specific numbers of beneficiaries who belong to the UT of Jammu and Kashmir could not be ascertained.	Any individual can join a private insurance scheme, either solitarily or as a group.
POPULATION COVERED Actual numbers relative to target population	As of 2021, India has an estimated 5.12 million armed force personnel amounting to around 25 million dependent clientele. Being classified information, the number of defence personnel in J&K is not available.	As of March 2020, Indian Railways has 1 253 592 employees. The Indian Railways Health Services (IRHS) catered to an estimated 67 million beneficiaries. Specific numbers of beneficiaries who belong to the UT of Jammu and Kashmir could not be ascertained.	According to the estimate of the IRDAI in 2019-2020, around 142 000 individuals in J&K avail private health insurance. This amounts to 0.93% of the total population. According to an estimate, less than 0.1% of the rural and 1.4% of the urban population in J&K avail private insurance
BASIS FOR COVERAGE For example, Mandatory, automatic, voluntary	Automatic	Automatic	Voluntary

Assessment areas	Armed Forces Medical Service	Indian Railway Health Service	Private insurance
BENEFIT ENTITLEMENTS Is a list of services or level of care defined? Do users have to make co-payments?	Beneficiaries under this scheme are provided with preventive and curative primary, secondary as well as tertiary care services including dental care through hospitals under this scheme. Telemedicine and mobile medical treatment facilities are also provided to the personnel in the field through medical aid posts, advanced dressing stations and forward surgical centres. The scheme also provides maternal and child health care as per Ministry of Health and Family Welfare guidelines, relief and rehabilitation services like artificial limbs to defence personnel and their dependents.	Beneficiaries under the scheme are provided promotive and curative- primary, secondary and tertiary care extending to occupational and industrial health. This includes a pre-placement examination of candidates, periodic medical examination of employees, certification of injuries, etc. under the Workmen's Compensation Act, invalidation of unfit employees through Medical Boards, provision of in-house medical certification for sickness or fitness, education and awareness campaigns for employees and family's dental treatment. The scheme also oversees the implementation of the National Health Programmes and Food Standard and Safety Act over Railways, monitors the quality of water and sanitation at railway stations and colonies.	Private health insurance generally provides coverage for expenses arising out of specified hospitalization and day-care procedures. This includes the cost of consultation, diagnostic procedures, medicines and consumables, surgical procedures, etc. It also covers pre-and post-hospitalization expenses and domiciliary care. The negative list in terms of a list of exclusions is specified in the policy document.
CONDITIONS OF ACCESS Are there any conditions to be met to access services? (referral, procedures, products, etc.)	Beneficiaries can avail services from the countrywide network of peripheral hospitals/field units, zonal hospitals, command hospitals of AFMS. A reference from field/ zonal hospital is required for availing specialty and super specialty services. The patients are referred to the command hospitals as per the availability of specialty services available at that particular hospital.	Beneficiaries can avail services free of cost from railway polyclinics and hospitals. Receiving services from empanelled hospitals requires a referral from the railway hospital. The referral by an authorised medical officer to any government/recognized hospital covers investigations and treatment in that particular facility. In cases where additional investigations are required but not available at that specific hospital, another referral routed through the authorised medical officer is required.	Beneficiaries can avail of services from any registered and eligible health facilities. This may involve cashless hospitalization, from facilities that are empanelled by the insurer, with a prior pre-authorization or reimbursement of expenses with a prior intimation. There may be limits for room charges, depending on the coverage bought. Certain items may not be covered, and the insured may need to pay for such expenses.
STRUCTURE and DESIGN OF COPAYMENT Is there a co-payment? If yes, how much and do exemptions exist?	There are no user fees, and the treatment is free of cost to the beneficiaries.	There are no user fees, and the treatment is provided free of cost to the beneficiaries. The beneficiaries can avail the treatment from the empanelled hospital on referral by the railway's medical officer. The expenditure borne by the beneficiary is reimbursed by the Ministry of Railways.	The scheme generally does not have a co-payment. However, the insured need to pay for the expenses on services and inputs that are not covered or excluded. This could vary across different insurance provide

Assessment areas	Armed Forces Medical Service	Indian Railway Health Service	Private insurance
		However, the contractors must pay for the services according to the rates set by the Ministry of Railways. Employees of the contractors can avail of the services free of cost provided the contractor pays for the food, medicines, and dressings.	
REVENUE SOURCES **Where does the money come from? Budget allocations/transfers, prepaid contributions?**	The scheme is funded through tax-funded general revenue of the Ministry of Defence. Being classified information, the exact amount of funding for J&K is not available.	The IRHS is funded through tax-funded general revenue by the Ministry of Railways. The Ministry of Railways spends about 2.1% of its budget (All India 2014) on health care.	Private health insurance schemes are funded by pre-paid contributions of the insured individuals.
POOLING ARRANGEMENTS **Is the health budget allocated to regional authorities? Is there a single or multiple insurance fund?**	The funds of the scheme are managed in a single pool centrally by Ministry of Defence, Government of India. The funds are then allocated to Directorate General Medical Service of Army, Navy and Air force as per the needs.	The funds of the scheme are managed in a single pool centrally by the Ministry of Railways, Government of India. The funds are then allocated to each of the zonal railways as per their needs.	The pre-paid contributions are pooled by individual insurance companies with an element of risk pooling across population groups and areas within these individual funds.
PURCHASING and PROVIDER PAYMENT **How are funds used to purchase service under this scheme?**	There is a defined budget for field units, hospitals and salaries for physicians and staff. Goods and services are purchased centrally followed by allocation to the medical services of the Army, Navy and Air force.	The Ministry of Railways allocates the budget to each of the zonal railways from where the chief medical director of the zonal railways further allocates it to each of the divisions.	The private insurance firms purchase services from the providers on behalf of the insured beneficiaries. The providers are paid on the fee-for-service basis.
SERVICE DELIVERY and CONTRACTING **Which providers are services purchased from? Are contracts/service agreements agreement used?**	Services are provided free of cost through a countrywide network of medical facilities of the Armed forces. There is a total of 11 Army Hospitals in J&K which cater to the needs of army personnel in the UT. Only allopathic care is being provided. Services of an alternate medicinal system like Homeopathy, Ayurveda, Unani are not provided.	Services are delivered through a nationwide network of 128 railway hospitals and other empanelled private hospitals. The empanelled private hospitals require referrals from the railway hospitals except for 3 empanelled hospitals and 1 pathology lab in J&K.	The services are provided by registered private, public, and not-for-profit health care providers, who meet specified eligibility requirements and are in a contractual relation with the private insurer
GOVERNANCE OF HEALTH FINANCING **Describe the management and governance arrangements**	Ministry of Defence governs the scheme through the Directorate General Medical Service, headed by the Director General of Armed force Medical Services.	The scheme is run by the Ministry of Railways.	The Insurance Regulatory and Development Authority (IRDAI), under the insurance division of the ministry of finance, is a regulatory body that regulates private insurance providers.

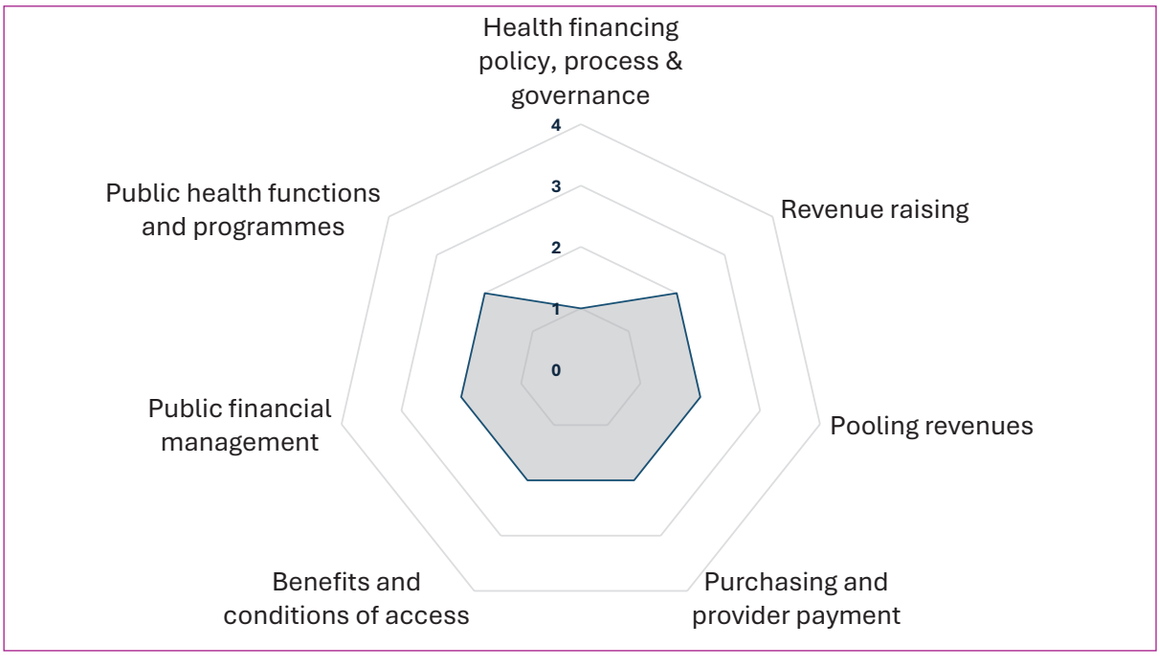
Stage 2

Assessment

Stage 2:

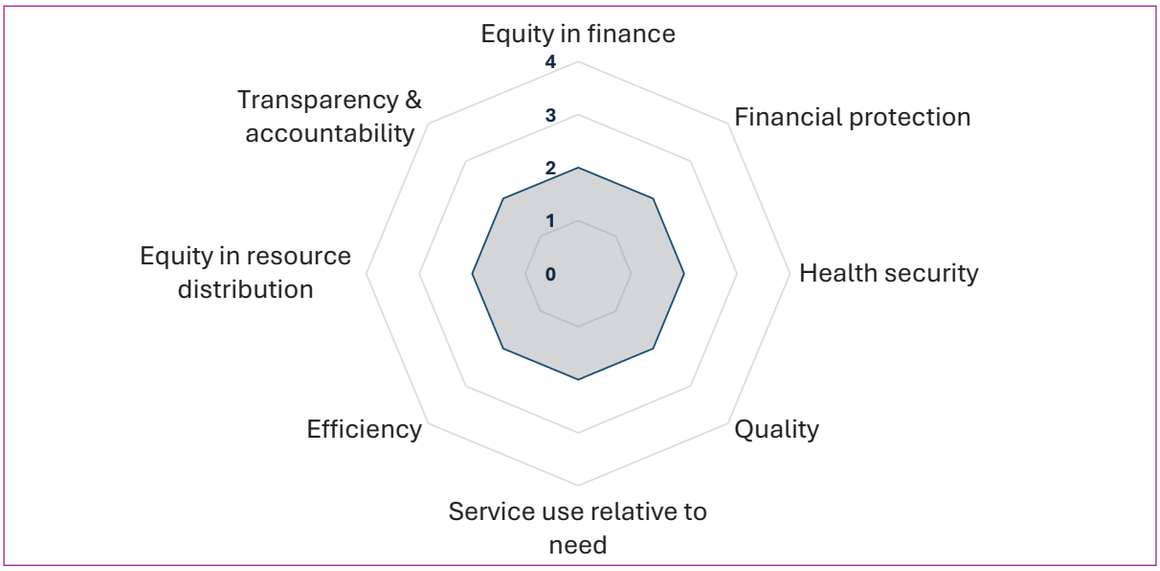
Summary of ratings by assessment area

Fig. 3. Average rating by assessment area (spider diagram)



Source: *Based on HFPM data collection template v2.0, Jammu and Kashmir 2022*

Fig. 4. Average rating by goals and objectives (spider diagram)



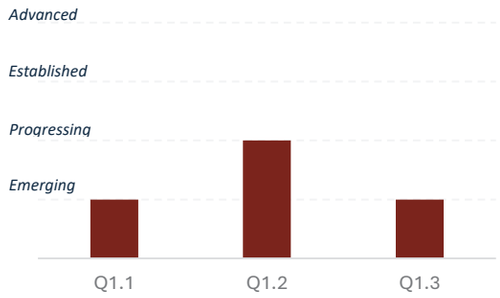
Source: *Based on HFPM data collection template v2.0, Jammu and Kashmir 2022*

Assessment rating by individual question

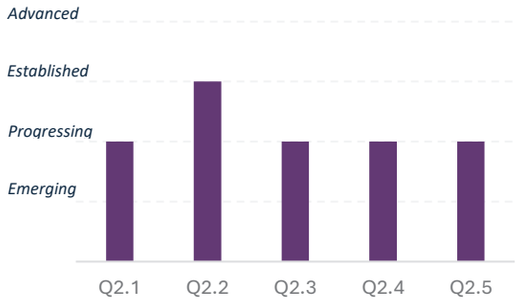
Assessment rating by individual question

Fig. 5. Assessment rating by individual question

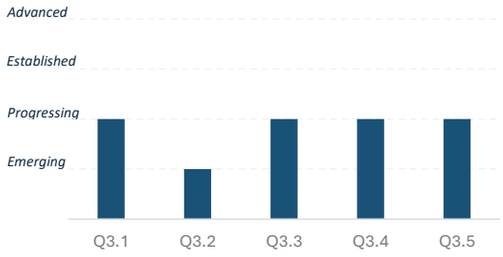
1. Health financing policy, process and governance



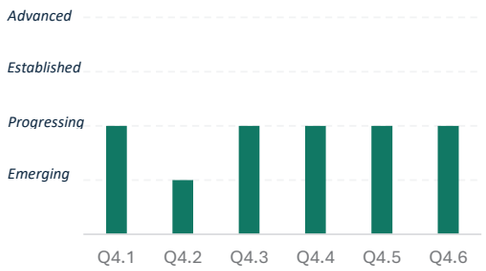
2. Revenue raising



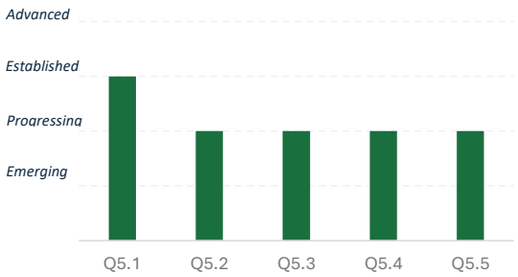
3. Pooling revenues



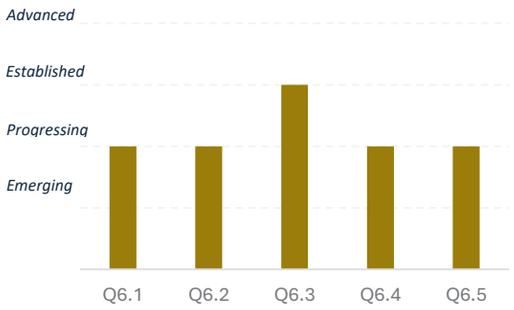
4. Purchasing and provider payment



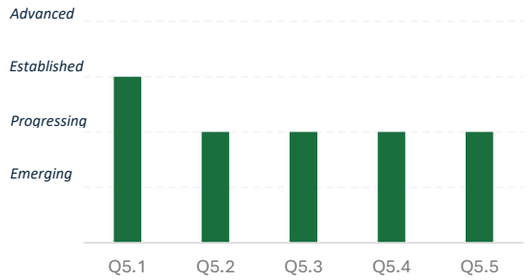
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes



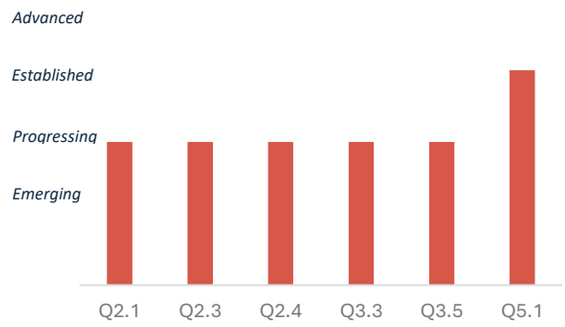
See Annex 3 for question details

Assessment rating by UHC goals

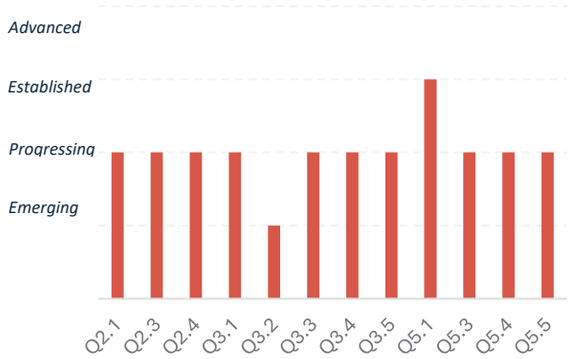
Assessment rating by UHC goals

Fig. 6. Assessment rating by intermediate objective and final coverage goals

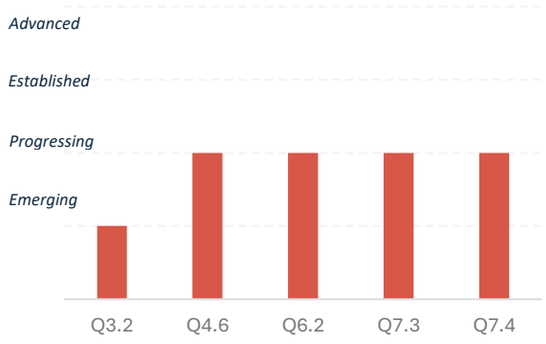
Equity in finance



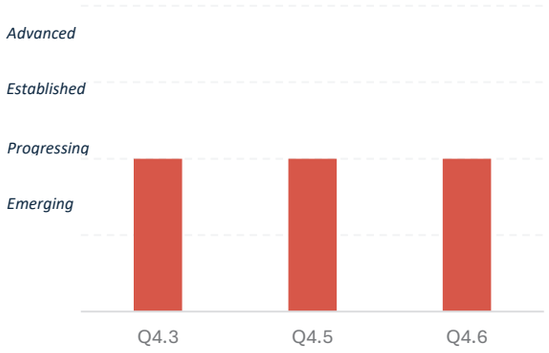
Financial protection



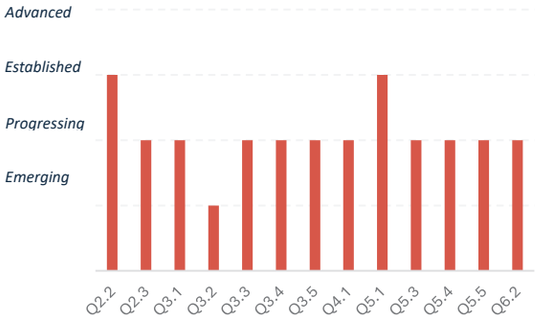
Health security



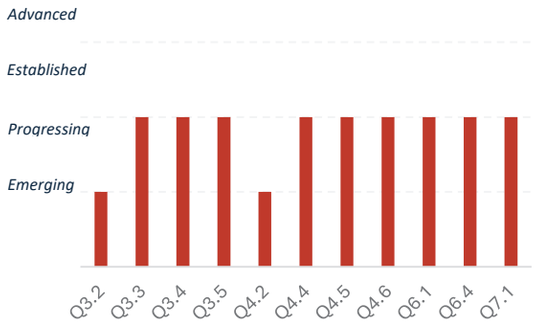
Quality



Service use relative to need



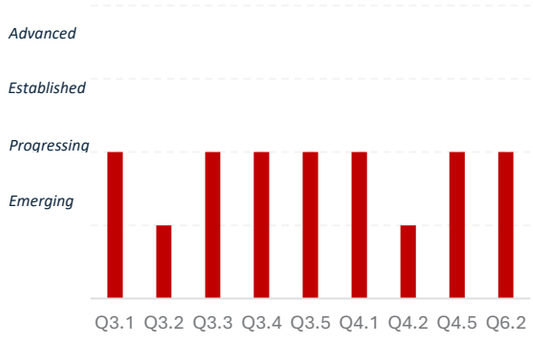
Efficiency



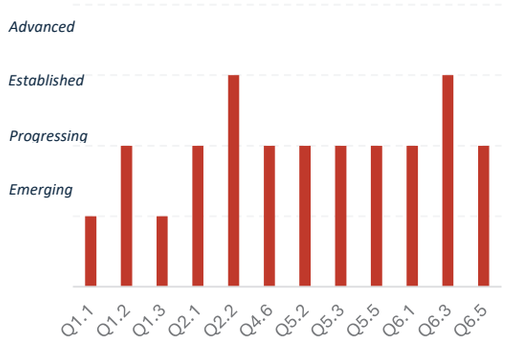
Assessment rating by intermediate objective

Fig. 6 (continued). Assessment rating by intermediate objective and final coverage goals

Equity in resource distribution



Transparency and accountability



Summary of findings by questions under HFPM

Summary of findings by questions under HFPM

Policy process and governance		
Q 1.1	**Is there an up-to-date health financing policy statement guided by goals and based on evidence?**	**Status**
Key areas of strength and weakness in J&K	Due to its recent conversion to a union territory, policy formulation for J&K is largely framed by the Union-level framework. J&K does not have any specific financing-related diagnosis/assessment or a health financing strategy and has set allocation goals as defined in the National Health Policy, 2017 (health spending to 2.5% GDP and 8% of GGE by 2025)[24]. Locally generated and contextualized evidence base is weak and while some indication of macro-level funding patterns is available through the National Health Accounts, state-level accounts are not generated.	**EMERGING**
Way forward	Given that it is a union territory and therefore under the purview of the central government and given its special status, it may be prudent for the UT to explore the possibility of an enabling policy framework developed together with the Union-level government.	
Q 1.2	**Are health financing agencies held accountable through appropriate governance arrangements and processes?**	**Status**
Key areas of strength and weakness in J&K	**The general budget revenue/treasury (state/UT and Union):** Primary care is provided in J&K through the National Health Mission (NHM), which is co-funded by central and UT govt. Secondary and tertiary care hospitalization and outpatient services are provided through UT government-owned and run facilities managed by the Directorate of Health Services, Kashmir. Accountability mechanisms thereunder are defined within the NHM framework as well as the broader Govt. rules and processes. **PMJAY-SEHAT:** The scheme is managed by the National Health Authority (NHA) under the Prime Minister's Office, with corresponding State Health Agencies (SHAs) accountable to their own subnational Governments. NHA was made autonomous in 2019 to make the purchasing entity autonomous of the MOHFW. This was in a bid to make it more agile as a purchaser[25].	**PROGRESSING**

Policy process and governance		
Key areas of strength and weakness in J&K	The NHA is governed by a Governing Board chaired by the Union Minister for Health and Family Welfare, Government of India; and is headed by a full-time Chief Executive Officer (CEO) supported by Additional. CEO, Deputy CEO and Executive Directors. The CEO of the NHA functions as the Member Secretary of the Governing Board. The scheme is co-managed in financial and organizational partnership with the UT. SHA is headed by a CEO. SHA can hire additional staff or engaged Implementation Support (ISA) to perform required tasks for implementation of the scheme. CEO, SHA is appointed by the state government and is ex-officio member secretary of the Governing Council of the SHA. The SHA has fully operational autonomy and has considerable flexibility vis-à-vis claims rate, utilization, reserving procedures for public hospitals and general operational processes. **Employee State Insurance Scheme:** The scheme is run by the employee state insurance corporation, an autonomous body under the Ministry of Labour and Employment, Government of India. At the subnational level, it is managed by the regional office of the state or UT. Though accountability channels are well defined, in practice there is considerable scope for improvement. **Central Government Health Scheme:** The scheme is run by the Directorate General of Health Services CGHS under the Ministry of Health and Family Welfare, with defined accountability channels, though information is limited. **Indian Railway Health Service:** The scheme is run by the Ministry of Railways. Information on accountability channels and processes are limited **Armed Forces Medical Service:** Ministry of Defence governs the scheme through the Directorate General Medical Service, headed by the Director General of Armed force Medical Services. **Private insurance:** The Insurance Regulatory and Development Authority (IRDAI), under the insurance division of the Ministry of Finance, is a regulatory body that regulates private insurance providers.	**PROGRESSING**

Policy process and governance		
Way forward	In general, there exists a great deal of fragmentation of the health financing landscape with many schemes having their own governance and accountability mechanisms. In most cases, the degree to which such accountability processes are effective is unknown. Duplication and coordination across disparate schemes are a prevailing issue. Exploring means of removing duplication establishing synergies across departments should be an important are that the J&K should look to pursue.	
Q 1.3	**Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?**	**Status**
Key areas of strength and weakness in J&K	National Health Accounts (NHA) estimates of India are regularly produced every year since 2013-2014 (In addition to earlier two rounds of 2004-2005 and 2008-2009 published in 2019). The reports on these NHA are publicly available[4]. While the NHA estimates of India provide information on macro-level health financing indicators (including public, private including household expenditure) for the UT (at the time of the latest publication, J&K was still a state), the UT is yet to produce UT-specific health account estimates. Therefore, while NHA data is widely used to track expenditure patterns, no data is available on financial protection and subnational breakdown of health expenditure. Similarly, no document routinely tracks health benefits and provides estimates through benefit incidence analysis.	**EMERGING**
Way forward	While research on financial protection in terms of catastrophic expenditure and impoverishment are available from other states through a cross-sectional analysis, no such study could be located for Jammu and Kashmir. It is important that the UT generate required evidence such as health accounts and a systemic performance valuation of its health system to help inform the key policy steps moving forward.	

Revenue raising		
Q 2.1	**Does your country's strategy for domestic resource mobilization reflect international experience and evidence?**	**Status**
Key areas of strength and weakness in J&K	The level of health spending in Jammu and Kashmir is low with total health expenditure (THE) of the UT estimated as 2.9% of GSDP in 2017-2018, down from 4.1% in the previous year. The government health expenditure (GHE) as % of GSDP remains constant stands at 1.6%.	**PROGRESSING**

Revenue raising		
Key areas of strength and weakness in J&K	Domestic resource mobilization was initially dominated by out-of-pocket spending which accounts for 58% of THE in 2016-2017 but has since declined to 43% of THE in 2017-2018[4], with an increase of GHE as a proportion of THE from 39% in 2016-2017 to 54% in 2017-2018, with further increase in Govt. share anticipated due to PMJAY SEHAT and Health and Wellness Centers providing primary care. This reliance on domestic resources bodes well for sustainability in the UT and will likely enhance levels of financial protection.	**PROGRESSING**
Way forward	While there is no policy document guiding the systematic mobilization of financing, recent years have witnessed a progressively greater reliance on public spending. This is well aligned with best practice for health financing for UHC and the UT, through various initiatives is moving in the right direction.	
Q 2.2	**How predictable is public funding for health in your country over a number of years?**	**Status**
Key areas of strength and weakness in J&K	Health spending in India is co-financed by national and subnational units. In the case of union territories like Jammu and Kashmir (which are administered by the Federal/Union government), the Union government provides 90% of financing and the UT providing 10% of the co-financing for the scheme/program (PMJAY and NHM), beyond its own general budget revenue. Prior to the COVID-19 pandemic the spending in health by the Union Govt. had stagnated to 1.2% approximately of GDP which is one of the lowest in the SEARO region of WHO, while in J&K, Government Health Expenditure has largely been 1.1-1.7% of Gross State Domestic product. Thus, while absolute levels of financing are low, Government budget has predictability based on a historical pattern of an approximate 10% year on year increase in the health sector, including a potential revision during the mid-year (known as Revised Estimates), though this is also predictable in its frequency. This is despite the absence of Medium-Term Expenditure Framework (MTEF), which is not used in any of the states in India, though more recently, the National Health Mission has adopted two-year budget planning cycles which are still in a nascent stage.	**ESTABLISHED**
Way forward	While predictability of funding does exist, forward budgeting is confined to a single year for government revenues though NHM has moved to two-year budget planning cycles.	**ESTABLISHED**

Revenue raising		
Way forward	However, budget formulation needs to inform by a detailed needs assessment exercise rather than legacy administrative processes and historical trends. To that end, J&K should consider adopting a Medium-Term Expenditure Plan based on its current and anticipated priorities.	**ESTABLISHED**
Q 2.3	**How stable is the flow of public funds to health providers?**	**Status**
Key areas of strength and weakness in J&K	Underspending of UT and NHM budget is a persistent problem[26]. The delay in fund release is a major reason for lower budget execution. Reasons for delay in fund release relate to weak capacity of relevant staff to submit statutory expenditure statements and in understanding compliance issues and budget rules and regulations. Moreover, a major chunk of funds is released in the last two quarters leading to little available time for effective utilization which is compounded by delays witnessed in approval of revised operational plans for health sector program[3].	**PROGRESSING**
Way forward	Capacity building of sector staff in financial management and processes is essential. Additionally, the root cause of fund delays and disbursements should be identified with greater dialogue between various department to optimize the timing related to release of funds.	
Q 2.4	**To what extent are the different revenue sources raised in a progressive way?**	**Status**
Key areas of strength and weakness in J&K	According to National Health Accounts 2021, 54% of THE comes in the form of GHE, and OOPE is comprised of 43% of THE in 2017-2018. While this is an improvement on earlier trends, OOPE funding remains dominant thereby leading to a regressive health financing system and potential inequities in financial access to care. Moreover, schemes such as ESIS have an upper wage limit for inclusion thereby limiting cross-subsidization from high income to lower income bands, thus making the revenue raising regressive. That said, overall taxation system in India is (at the Union level) is progressive in nature. Even Goods and Services Tax (GST) which is a consumption tax has been stratified to ensure that a lower rate is applicable on goods and services consumed by poor and vulnerable[27]. Therefore, while revenue pooling from the public side can be considered progressive, its relatively smaller share vis-à-vis OOPE implies that overall, revenue sources for health sector are regressive in nature.	**PROGRESSING**

Revenue raising		
Way forward	While strategies to reduce OOPE need to be explored, it is also important to remove the regressive elements within current schemes such as ESIS. This will help spread risks across all formal sector employees as well as support better cross subsidization. At a macro level, targeted revenue raising tools such as wealth tax, sin tax, etc. should be explored as potential tools for raising additional revenues	**PROGRESSING**
Q 2.5	**To what extent does government use taxes and subsidies as instruments to affect health behaviours?**	**Status**
Key areas of strength and weakness in J&K	According to the Global Adult Tobacco Survey (2016-2017), an estimated 20.8 percent of adults smoke tobacco and 4.3 percent use smokeless tobacco in J&K[28].The UT imposed 40% taxes (value-added tax) on tobacco products since 2013-2014, which has been reduced to 28% (goods and services tax) since 2017-2018 which is below the WHO recommendation of 75%[29]. To promote the establishment of private hospitals in J&K, the UT has introduced the Health Care Investment Policy-2019. As per the policy, the UT will promote and encourage the private parties and entrepreneurs by providing incentives in the form of a 30% subsidy on capital investment for setting up multispecialty hospitals, super specialty hospitals, medical colleges, nursing colleges and paramedical colleges[30].	**PROGRESSING**
Way Forward	The UT should consider raising taxes on demerit goods such as tobacco while also ensuring that any subsidies provided to private hospitals tie on with the UHC objectives and aspirations of the state by integrating them into the public financing system via PMJAY SEHAT and making additional subsidies contingent on such collaboration and engagement.	

Pooling revenues		
Q 3.1	**Does your country's strategy for pooling revenues reflect international experience and evidence?**	**Status**
Key areas of strength and weakness in J&K	The pooling strategy for J&K shows a nascent attempt to adopt global best practice. There is a persistence of fragmentation of the health financing landscape including the pool managed by DOHFW, including NHM, PMJAY SEHAT the universal insurance scheme for inpatient services and the numerous government subsidized schemes affiliated to different ministries. There are no strategic documents. However, the UT through AB PMJAY and SEHAT scheme envisages pooling government revenues to cover different segments of the poor and non-poor population. In addition, the formal sector employees and their families are covered through centrally sponsored and managed schemes, either through payroll taxes and employer contribution or as employment benefits (ESIS, CGHS, Railways, etc.). The government has commenced policy dialogue with regard to converging existing schemes gradually under AB PMJAY and SEHAT. Such an attempt to converge existing schemes for ensuring equitable expansion of coverage may be faced with resistance from those who are already part of schemes that provide higher and broader coverage.	**PROGRESSING**
Way Forward	The roll out of PMJAY and SEHAT indicated a move towards universalization. However, in the early stage of its implementation, the UT must ensure strategies in regarding compensatory measures to sustain the scheme and expand to cover more sources and beneficiaries and avoid duplication of efforts. There is need to expedite discussions on the convergence agenda with all government schemes to ensure increased subsidization across risk profiles and improve administrative efficiency.	
Q 3.2	**To what extent is the capacity of the health system to re-distribute prepaid funds limited?**	**Status**
Key areas of strength and weakness in J&K	The tax-based funding of UT and central government pool as well as PMJAY SEHAT provide the greatest scope for redistribution given their universal coverage of populations for primary health care services and inpatient services, respectively. The GSHIS PMJAY is also financed from tax-based revenues. The other smaller pools are of employment-based schemes of different central ministries.	**EMERGING**

Pooling revenues		
Key areas of strength and weakness in J&K	These pools are restricted to specific population that is, respective employees and their families and thus have less scope for redistribution particularly across socio economic status. Private voluntary insurance schemes are negligible in size and are accessible only to those who can afford to pay the premium.	**EMERGING**
Way forward	There is little scope for redistribution of funds across schemes and they work in siloes. It is recommended that in time, the UT progress towards a unified pool to ensure better risk pooling and cross-subsidization to enhance efficiency and equity within its health financing system (even if only at the backend information level).	
Q 3.3	**What measures are in place to address problems arising from multiple fragmented pools?**	**Status**
Key areas of strength and weakness in J&K	The tax-based pool is fragmented across the health department and central ministries. While the MOHFW and UT Health Department pool is the largest, there is limited coordination at present between MOHFW/ UT Health Department and other Ministries (such as Defence, Railway, Labour, etc). These pools cater to overlapping populations. For example, members of the employment-based schemes are also entitled to use free services from UT-run hospitals. There are ongoing policy discussions largely at national level (that directly affect union territories like Jammu and Kashmir) to converge many of the sector-specific schemes under PMJAY[31]. This will increase redistribution and efficiency. Thus far these involve ESIC and CGHS schemes. The Central Government Health Scheme has been onboarded on the National Health Authority's (NHA) IT platforms. To ensure cashless, paperless and efficiency delivery of health care services and reduce fragmented funding flows. The onboarding of CGHS on NHA's IT platform would reduce the compliance cost by eliminating the need of any paper related procedure. Further, this will also help to optimize the technical and human resources.	**PROGRESSING**
Way forward	As the national conversation around scheme integration evolves, J&K should start charting out the necessary roadmap within its individual context on how such an integration/convergence could be actioned at an operational level	

Pooling revenues		
Q 3.4	**Are multiple revenue sources and funding streams organized in a complementary manner in support of a common set of benefits?**	**Status**
Key areas of strength and weakness in J&K	The tax-funded pool does not have any complementarity with other pools. This pool is used for providing primary and preventive health care services as well as secondary and tertiary care hospitalization to all citizens. The tax-funded employment-based schemes organize their provisions separately without any complementarity with publicly funded facilities. The AB PMJAY and SEHAT have the potential of addressing this issue of fragmented pools through convergence efforts. Efforts have been undertaken at a national level to identify and remove duplication of fund flows in NHM and AB PMJAY SEHAT. By and large though the benefits across the schemes are similar. More recently, the National Health Authority has initiated efforts towards defragmenting functionalities across PMJAY, CGHS and ESIS by ensuring a common IT infrastructure which has resulted in a convergence across these schemes vis-a-vis empanelled providers and greater access for all beneficiaries, including under AB-PMJAY SEHAT. While entitlements still differ, it is anticipated that further streamlining will be undertaken across financing function and characteristics in the time ahead {REF}, especially in view of the Ayushman Bharat Digital Mission which will establish unique identifiers for beneficiary health records and provide a unified repository of health care facilities and professionals in the country[31,32].	**PROGRESSING**
Way forward	The UT should systematically assess Cross Programmatic Efficiency to identify and weed out redundancies in funding and service delivery across various operational schemes However, notable progress has been made in defragmentation of health coverage schemes such as AB-PMJAY SEHAT, CGHS, ESIS and these efforts should be further built on to remove functional and design overlaps.	
Q 3.5	**What is the role and scale of voluntary health insurance in financing health care?**	**Status**
Key areas of strength and weakness in J&K	The share of voluntary health insurance (prepayment) in total financing is small estimated at 3% of THE, covering around 1% of the population. Private voluntary insurance traditionally remains inaccessible to the poor and is not linked through any institutional or organizational means to government funded health system.	**PROGRESSING**

Pooling revenues		
Way Forward	As this is a minor share of the pooling mechanism, no immediate recommendations are felt necessary. However, growth of this sector should be monitored in the time ahead (through active Government stewardship and if necessary, intervention), to ensure that it does not impact systemic equity	**PROGRESSING**

Purchasing and provider payment		
Q 4.1	**To what extent is the payment of providers driven by information on the health needs of the population they serve?**	**Status**
Key areas of strength and weakness in J&K	The payment mechanism in the public sector is based on the government budget, which is line item based, thereby limiting the scope for a flexible, needs based budget. However, some flexibility in budget preparation under the National Health Mission exists. During the preparation of the project implementation plan and the health action plan, districts do send facility and service-related requirements to the UT, which may reflect population needs, though a large proportion of allocation is still input driven. It is the prerogative of the UT Health Department and State Health Mission to prepare a detailed budget. At the UT level, while the Finance Department determines the total resource envelope for the health department, the National Health Mission at the MOHFW determines the resource envelope for the State Health Mission. Such resource allocation depends on past expenditure trends and structures around inputs without equity consideration. The GSHIS like AB PMJAY and SEHAT offers targeted interventions for the hospitalization need of the population. As the payment in AB PMJAY and SEHAT is based on the disease-related groups and thus, reflects the exhibited hospitalization demand of the people. The package is largely informed by the HBP developed by the National Health Authority which in turn determines the package based on claims data on utilization as well as through consultative process with stakeholders including subnational entities. It is adapted at the state and UT level to ensure that it is responsive to local epidemiological needs including Burden of Disease.	**PROGRESSING**

Purchasing and provider payment		
Key areas of strength and weakness in J&K	Regarding other schemes such as ESIS and CGHS, use of information to inform provider payments in largely limited and is based on a combination of payment mechanisms (capitation, fee-for-service, global budget) which are not informed by evidence vis-a-vis population needs and utilization patterns.	**PROGRESSING**
Way forward	Apart from some degree of planning under PMJAY SEHAT, payment to providers in the Govt. system as well as in other insurance schemes (ESIS and CGHS) is primarily driven by historical trends and levels of input. As this is not conducive to optimal technical and allocative efficiency, it is imperative that J&K initiate recording of health specific epidemiological as well as outcomes data to better ensure value for money. This would require strengthening of its data collection systems as a first step and gradually moving to needs based planning and outcomes-based payments within the sector.	
Q 4.2	**Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?**	**Status**
Key areas of strength and weakness in J&K	Public providers under the UT Health Department and employment-based schemes of Central Ministries are paid through a line-item based budget. Some schemes in the public sector use different payment mechanisms. For example, certain grassroots level workers like the Accredited Social Health Activists (ASHAs) under the National Health Mission are paid incentives against specific services and the doctors who serve in far-flung areas are also incentivized[33]. The AB-PMJAY and SEHAT use some form of case-based groups (CBG) system for purchasing hospitalization services from private and public providers. The providers are paid a fixed amount per defined diagnosis and discharge. The providers from remote and underdeveloped districts (aspirational districts) receive additional 10% incentives in addition to the standard package rates[34]. The provider payment in the private sector is fee-for-service, for the beneficiaries of employment-based schemes, voluntary health insurance schemes, or patients who make OOPE payments. The payment rate level differs between the public and private sectors. Public health providers receive salaries and allowances, and rates are based on the grades they belong to. These rates are set by the Pay Commission. Certain public providers are contractual and paid a lump-sum monthly remuneration.	**EMERGING**

Purchasing and provider payment		
Key areas of strength and weakness in J&K	The providers in the public hospitals empanelled under AB PMJAY and SEHAT are paid using case-based payments with predefined tariffs that differ by state. In addition, adjustments are made for the type of hospital and the remoteness of the hospital. The rates are the same between public and private providers for those empanelled with PMJAY. In the CGHS scheme, the government uses fee-for-service payments based on a predetermined tariff for inputs. Claims were initially paper based but the government has since moved to the electronic format using PMJAY's IT system. Thus, at the primary care level and for the those not covered by health insurance schemes, line-item budgets prevail. These provide conflicting incentives for the public providers who are also providing services for PMJAY and CGHS as the incentives to the provider, due to its FFS payment may result in preference for such low volume of services and do not incentivize quality service provision while, in PMJAY, the payment mechanism increase service volume but not improvements in quality of care. Similarly, the FFS payments in CGHS and other schemes increase service volume but not improvements in quality of care. There has been no deliberate attempt to harmonize payment mechanisms.	**EMERGING**
Way forward	As is clear from above, the public primary care level is primarily financed by line-item budgets with public and private hospitals under PMJAY being paid through case-based group (and private receiving FFS through OOPE). Moreover, CGHS is paid through FFS and often consists of a similar network of providers. Thus, different incentives exist at different levels creating potential issues with patient selection and deviations in quality of care. It is important for J&K to explore ways of standardizing rates and mechanisms for provider payments across hospitals to ensure that equity and quality is not compromised as a function of the scheme to which the individual belongs.	
Q 4.3	**Do purchasing arrangements promote quality of care?**	**Status**
Key areas of strength and weakness in J&K	In the public sector, the line item-based payment involves a fixed amount of salary to the full-time and contractual providers, regardless of quality or coordination of care. The performance-based incentives of the grassroots level workers are linked to the magnitude of work.	**PROGRESSING**

Purchasing and provider payment		
Key areas of strength and weakness in J&K	Therefore, it generally does not promote quality of care. Similarly, the providers in private sector facilities do not receive any incentives for improved quality of care or coordination across specialties and different levels of care. Therefore, the level of payments, the payment method and purchasing are not regarded to be promoting quality of care. There has been improvement in a limited area, but there has been no systemic impact on the quality of care. The recent quality improvement initiatives in public and private hospitals viz. National Quality Assurance Standards (NQAS), National Accreditation Board for Hospitals and Health care Providers (NABH), and schemes like LaQshya and Kayakalp under the National Health Mission provide facility-level incentives. Very few district hospitals and CHCs have received NQAS certification. While most of the health facilities have participated in the Kayakalp programme, some have received awards as well. Fewer hospitals and health care providers have received the NABH accreditation as it remains a voluntary in nature[35]. The processes under AB PMJAY and SEHAT promote quality of care. It has set a strict protocol and guidelines to empanel hospitals. Private facilities need to meet certain infrastructure and human resource requirements for empanelment. It has provisions of regular quality audits and Quality Certification. AB PMJAY and SEHAT also incentivize the facility for improved quality (NABH accredited facilities are paid 10% more). No accreditation or designated process is followed for quality improvement in employment-based schemes, which involves line-item budgeting for provider payments.	**PROGRESSING**
Way forward	There are marginal efforts towards improving quality but given that most certifications and accreditations are voluntary in nature, adoption has been slow. Moreover, even where quality is incentivized (PMJAY), the focus remains on input rather than outputs or outcomes. To strengthen quality of care at a systemic level, it is proposed that J&K look to institutionalize quality improvement efforts at a local level. The state and district quality cells established by the Govt. of India should be operationalized and strengthened to provide QI and QA support not only to public but also private hospitals.	

Purchasing and provider payment		
	Additionally, barriers to QI and QA adoption should be explored and accordingly strategies should be explored to instill a 'culture of quality' in J&K	**PROGRESSING**
Q 4.4	**Do provider payment methods and complementary administrative mechanisms address potential over- or underprovision of services?**	**Status**
Key areas of strength and weakness in J&K	Input-based line-item budgeting, which remains the preferred method in the public system and employment-based schemes in J&K, does not promote efficiency in resource allocation. In AB PMJAY and SEHAT, the payment is for health benefits packages that are based on some form of CBG, which has the potential to improve efficiency, evidence on which is yet to be researched. The efficiency of provision may get affected because the CBG payments are not based on or case mix analysis, and thus affects incentives of the providers. There could be over-provision of procedures whose rates are perceived to be higher than costs, and under provision of procedures which are deemed commercially inviable. The AB PMJAY and SEHAT also have a provision for incentives to public providers, in addition to their fixed salaries. A National Anti-Fraud Unit (NAFU) has been set up by NHA to regularly monitor and analyse utilization and beneficiary data to identify suspect claims, e-cards and entities which may be indulging in malpractices/abuse/fraud. NAFU also undertakes medical audits and field investigations to validate the suspicion of the flagged entities. Such administrative mechanisms can address the potential over-or under provision of services under AB PMJAY and SEHAT[36]. In the private sector, payment is based on fee-for-services, which inherently does not provide for any mechanism to control over- or under provision of services.	**PROGERSSING**
Way forward	Largely, provider payment mechanisms are unable to influence over or underutilization efforts in the system. Notwithstanding PMJAY and SEHAT, where in the NAFU unit is present (which any case focuses on fraudulent activity rather than volume of need), there is no systemic analysis of the scale of under or over provision either in the public or employment insurance schemes. However, assessing under or over provision in these two systems will first require a fundamental reimagining of payment mechanisms as line-item budgets (pubic, ESIS) and FFS (CGHS), do not provide the right sent of incentives for rationalizing service volumes.	

Purchasing and provider payment		
Q 4.5	**Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?**	**Status**
Key areas of strength and weakness in J&K	The line-item budgeting in the public system and employment-based schemes does not provide for capturing of patient encounter data that can be used for decision-making. The AB PMJAY and SEHAT and private insurance schemes have enabled digitalised capturing of patient characteristics, diagnostics, and services for retrospective claims payment. The data has a potential for research to use for broader purchasing decisions at the scheme level, but no such studies are known for J&K.	**PROGRESSING**
Way forward	J&K should strengthen the quality of its data as well as the nature of data it sources. Coding systems such as ICD-11 & ICHI should be introduced into the system at large to ensure standardized terminologies that can help guide design of payment systems. J&K could also consider extending incentives to facilities for the quality of information and data they share (financial or non-financial) as well as provide the facilitating ecosystem for adopting better information systems and data tools.	
Q 4.6	**To what extent do providers have financial autonomy and are held accountable?**	**Status**
Key areas of strength and weakness in J&K	Providers in the public sector and employment-based schemes neither have financial and managerial autonomy nor any discretionary funds for purchasing decisions. In the National Health Mission, under the Rogi Kalyan Samitis (RKS), the public hospitals are provided with flexible funding for spending on local needs through local decision-making[37]. Similarly, public hospitals have flexibility in spending the funds they receive in the form of claims reimbursement under AB PMJAY and SEHAT. There is limited flexibility in these two provisions as they are to be executed within the guidelines provided by the UT and central governments. The private providers remain autonomous when they provide OOP care. However, in case of hospitalization, they remain partially accountable when serving under private, employment-based, or government-sponsored health insurance schemes.	**PROGRESSING**
Way forward	While some level of autonomy does exist in the public sector through use of RKS funds, there still exist certain specific guidelines on how these are to be used. Moreover, while line-item budgeting is highly restrictive, there exists no systemic assessment or idea of how PMJAY SEHAT funds are utilized by hospitals, thereby raising issues of accountability.	**PROGRESSING**

Purchasing and provider payment		
Way forward	J&K should look to systematically assess how greater autonomy can be provided under current budgeting rules (increased virement, programme-based budgets, etc.) while also ensuring better financial monitoring of flexible funds. Moreover, private sector should be incentivized to share information on how funds from purchaser are utilized as this will also serve as a key input to design of better provider payment mechanisms such as DRGs	**PROGRESSING**

Benefits and conditions of access		
Q 5.1	**Is there a set of explicitly defined benefits for the entire population?**	**Status**
Key areas of strength and weakness in J&K	The entire population can avail of a fixed set of primary, secondary and tertiary services from different levels of public health facilities. These services involve provisions through the National Health Mission including maternal, neonatal, child and adolescent health care, inputs for family planning, child malnutritional interventions, treatment and prevention of certain communicable diseases and noncommunicable diseases. Although NHM is not a targeted programme, it is a strategic intervention to improve access for specific populations including women, adolescents, poor and rural population. The public system hospitals and clinics also provide treatment of the common condition (such as eye, dental, skincare, etc.) and support services include laboratory, imaging and pharmacy. Public facilities at the district level and above provide hospitalization for secondary and tertiary care. No explicit positive or negative list is available for this. All employment-based schemes provide all kinds of services implicitly described in general terms like preventive, primary, secondary, and tertiary care without listing the specific services in the form of a defined explicit list. GSHIS like AB PMJAY and SEHAT has an explicit list of secondary and tertiary care hospitalization listed as HBP 2.2. It does not cover outpatient treatment and thus provides limited benefits[38]. The Central Government Health Scheme includes all services that are provided at empanelled facilities and does not define any package. In the existing Railway medical system all medical services like OPD,	**ESTABLISHED**

Benefits and conditions of access		
Key areas of strength and weakness in J&K	diagnosing, medicines, surgeries, in-patient care, major treatment/surgeries carried out in referral private/CGHS hospitals and follow-up checking are part of employees' welfare scheme offered to employees and their dependents. It is a part of service condition.	**ESTABLISHED**
Way forward	J&K should continue to expand its service profile as it is doing through its new Health and Wellness Centres and Indian Public Health Standards guidelines[39]. However, the J&K should also ensure service availability as per these guidelines and put in place necessary infrastructure and human resources for the same.	
Q 5.2	**Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?**	**Status**
Key areas of strength and weakness in J&K	**Public system:** The set of benefits under the public system and the NHM is guided by Indian Public Health Standards (IPHS), established by the central government in 2012. These were developed in a consultative manner. While the standards are made by the Government of India, the UT is responsible for monitoring the implementation of the standards in peripheral institutions. The Comptroller Auditor General (CAG) report of 2017 indicated that none of the Subcentres/ Primary Health Centres/Community Health Centres had been upgraded to the level of Indian Public Health Standards (IPHS) in Jammu and Kashmir[40]. **AB PMJAY and SEHAT:** The health benefits package under AB PMJAY and SEHAT have been designed and revised by the NHA with the help of in-house experts and representatives from private sectors from various states and UTs. The revised list in the form of HBP 2.2 has 1669 procedures with an increase in rates of certain existing procedures, the addition of new procedures, realignment of multimodal, cross-specialty, add-on and follow-up procedures, and the introduction of the more nuanced package for unspecified procedures. Subnational entities have the flexibility to review and revise the HBP to improve coverage. In some cases, the addition of new technologies and interventions is informed by HTA but not always. The HTA process is very much in the nascent phase. There is a regional HTA centre that is yet to be utilized by the UT in influencing policy decisions for benefit design. The states and UTs have flexibility in keeping or revising their rates, deciding about the provider payment mechanisms, and deciding the use of revenues generated by the public hospitals empanelled under the scheme.	**PROGRESSING**

Benefits and conditions of access		
Key areas of strength and weakness in J&K	Lastly, the states and UTs are empowered to reserve certain health benefits packages for public hospitals. These are decided in consultation with various stakeholders. Accordingly, J&K have 1592 packages, of which 21 are reserved for public hospitals. No analysis has been conducted to understand the impact of these decisions	**PROGRESSING**
Way forward	In the time ahead, J&K should make use of Health Technology Assessment and other economic evaluations to inform its service delivery interventions. Building local capacity to conduct this will be a key first step as well as clear idea of how such assessment as well as building an understanding of the concepts and need for such evaluations.	
Q 5.3	**To what extent are population entitlements and conditions of access defined explicitly and in easy to understand terms?**	**Status**
Key areas of strength and weakness in J&K	The GoI has introduced the India Public Health Standards which are a set of uniform standards envisaged to improve the quality of health care delivery in the country. and for reviewing the functionality of health facilities including the Subcentres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Subdistrict and District Hospitals. The guidelines detail the services that should be provided at each level of the health system and the inputs required including human resources, equipment, etc. It also includes entitlements for patients. However, the guidelines are intended for policy-makers and for providers. The availability of similar information for the public is lacking. The entitlements, benefits and services provided under AB PMJAY and SEHAT are explicitly mentioned in the scheme document, and on the central PMJAY and UT-level websites of the scheme. The issuance of AB PMJAY golden card to all potential beneficiaries can be termed as proxy of awareness of the scheme and its benefits. However, the actual knowledge of entitlements and benefits to the beneficiaries is unmapped. With CGHS and ESIS, benefits are defined vaguely vis-a-vis levels of care and thus the question on beneficiary entitlement awareness may not be relevant beyond that relating to the broader contours of service provision.	**PROGRESSING**

Benefits and conditions of access		
Way forward	At public facilities, greater effort needs to be put in to provide population with an idea of where broader areas of service are available. In the case of PMJAY SEHAT, while entitlements awareness is unmapped, Govt. communication clearly specifies the inpatient nature of the scheme, though specific entitlements (especially for high burden diseases) need to be more clearly communicated	**PROGRESSING**
Q 5.4	**Are user charges designed to ensure financial obligations clear and have functioning protection mechanisms for patients?**	**Status**
Key areas of strength and weakness in J&K	A clear national policy exists for no user fees to be charged at a primary level (Health and Wellness Centres)[41]. However, this is still levied at primary facilities in J&K. User fees at higher secondary and tertiary facilities do exist and these are clearly defined as per official guidelines[42]. However, patients end up making OOP payments while availing of hospitalization at public hospitals[43]. This creates avenues for financial hardships. No such instances are found in employment-based schemes which also do not have any 'formal' co-payments. GSHIS PMJAY does not have any co-payment; however, there is no UT-specific evidence that patients need not pay anything while availing of AB PMJAY and SEHAT benefits.	**PROGRESSING**
Way forward	Given the long-term cost–effectiveness of ensuring a strong primary care system, the UT should ensure that no user fees are levied at this level. A gap analysis on what these funds are spent on (cleaners, consumables, etc.) and should be factored into the regular budgetary outflow to primary care facilities.	
Q 5.5	**Are defined benefits aligned with available revenues, available health services and purchasing mechanisms?**	**Status**
Key areas of strength and weakness in J&K	The benefit package offered through public health facilities is paid for through the general budget and is supposed to be free for all citizens. The GoI has initiated a policy removing user charges for primary health care following the roll out of the AB HWCs programme, however, in J&K, public sector hospitals charge INR 10 for an OPD ticket. The administrative oversight for user fees collected is under Rogi Kalyan Samitis, which utilizes the income generated for operational expenses of the facilities. Access to essential drugs and a specified list of diagnostics are free of cost in the government hospitals, under the free drugs and diagnostics initiative.	**PROGRESSING**

Benefits and conditions of access		
Key areas of strength and weakness in J&K	For various reasons, sometimes patients have to purchase medicines and diagnostic services from the private sector resulting in OOP while availing public sector facilities. A study conducted on the bottlenecks in the PFM system in J&K has found that this largely due to delays in procurement related to delays in release of funds and receipt of drugs from suppliers[3]. Additionally, because of the comparatively poor quality of services in the public sector, the private sector accounts for the bulk of service delivery implying a misalignment in the available revenue and other resources versus the promised benefit package. Programme implementation plans are used to determine the activities and priorities funded in the National Health mission. Investments in HRH and Infrastructure are costed based on unit costs available at the Union level and planning is conducted within pre-defined allocations to the UT government from the Central level. Line-item budgets are used to reimburse public providers for services provided which by itself does not incentivize providers to improve the quality and the volume of services. The government has introduced performance linked payments to spur increased service delivery for the enhanced primary care package within the Health and Wellness Centres. This is a new reform in the system and there is no evidence at this point of the effect of this on the volume and quality of services provided. Furthermore, the government provides some of the funds to facilities as untied grants that are used to invest in infrastructure improvements at the facility level. These are all incentives provided at the provider level. In addition to these, the GOI also provides a 10% conditional grant as an incentive to the states and UTs that have performed well on various aspects assessed annually by NITI Aayog. The use of these funds is at the discretion of the subnational government. In employment-based schemes, there are no user fees, and all services are provided free of cost to the beneficiaries at their facilities. All services are included in the package and hospitalization expenses incurred at empanelled hospitals, most of which involve pre-decided rates, are reimbursed. Case based payments are used to reimburse providers in the networks affiliated with these schemes especially CGHS and ESIC where private providers are contracted for secondary and tertiary services. the CGHS has a list of packages with differentiated rates for accredited and non-accredited facilities. These are updated annually.	**PROGRESSING**

Benefits and conditions of access		
Key areas of strength and weakness in J&K	The ESIC uses CGHS rates to reimburse the network of private providers. For the facilities owned by the schemes, line-budget items are used. Primary care services are provided through, ESI dispensaries where capitation payments are used to reimburse providers with contracts also being entered into with private GPs or Insurance Medical Practitioners (IMPs). An assessment of the ESIC scheme highlights challenges with the purchasing system including limited tracking of essential data and process elements to help inform development of efficient payment systems; contractual incentives and systems for performance and quality are lacking, with an overriding focus on cost containment; the obligations of the state and UT regarding guarantee of services to beneficiaries by providing funding and ensuring service availability should be strengthened and patient feedback mechanisms should be strengthened. In the AB PMJAY and SEHAT scheme HBP design is informed by a costing process that is subject to the budget constraint provided that this refers to the services included in the HBP 2.2 defined at the national level. The costing for those added at the level of the union territory is not clear. Even though there is yet to be any quantitative evidence of balance billing some studies have indicated that there is some occurrence of these in some states in both public and private sector generally. There is no UT-specific evidence to corroborate this. The benefits defined are aligned to the available health services, however in the case of Jammu and Kashmir, given the paucity of private health services for tertiary care, arrangements have been made by the government to send patients requiring this care to the nearby UT of Chandigarh to provide care at the expense of PMJAY SEHAT.	**PROGRESSING**
Way forward	Use of cost and activity data for ensuring service delivery volumes is fairly limited in J&K. In the future, J&K should ensure that service profiles are well aligned with budgeting and purchasing mechanisms. This can be done through a better understanding of current costs and activities within the public and private sector as well as identifying and systematically resolving PFM issues which may be impeding transfer and utilization of current levels of funding. Also refer to the CAG in terms of the next level up, that is, Established.	

Public financial management		
Q 6.1	**Is there any up to date assessment of key public financial management bottlenecks in health?**	**Status**
Key areas of strength and weakness in J&K	A detailed assessment of the UT-level health financing and public financial management system has not been done in the recent past by any external agency. The 12th Common Review Missions (CRM) conducted in 2018 by the Government of India narrowly focused on assessing bottlenecks in the financial management of the National Health Mission (NHM). This review pointed out delays in fund transfer from the state treasury to state health societies (J&K was a state at the time of the review). It also pointed to avenues of improvement in financial human resources and documentation of financial transactions at the peripheral levels[44].	**PROGRESSING**
Way forward	While J&K has conducted a PFM bottleneck assessment together with WHO, this requires a more periodic assessment on part of the UT machinery to track progress made. It is recommended that the time ahead, building on this current research, J&K should conduct regular reviews of the problem areas identified under the PFM assessment and improve upon the issues identified.	
Q 6.2	**Do health budget formulation and implementation support align with sector priorities and flexible resource use?**	**Status**
Key areas of strength and weakness in J&K	The health budget at INR 1800 crores and the share of the health budget in the total UT budget at around 4% are stagnant for many years[45]. In 2017-18, it had the lowest proportion among all Indian states and UTs. The resource envelope of the NHM has also reduced during 2018-2021. The low prioritization of health could be because of low absorptive capacity as well as competing priorities of the UT government. The formulation of the budget is aligned to the priorities of the government (Union and UT). The budget for NHM is informed by the development of the Programme Implementation Plan and funds are allocated accordingly. Funds are provided by the Union level (90% total budget) and the UT level (10% of the total budget) for the centrally sponsored schemes that fund central priorities for health including CGHS, the Ayushman Bharat Programmes (HWCs, PMJAY, ABDM, ABHIM) and others as well as the central sector schemes and the broader NHM. The rest of the funds are from the UT level aligned with its priorities.	**PROGRESSING**

Public financial management		
Key areas of strength and weakness in J&K	The challenges that exist include the amounts budgeted for the priorities and the inputs required to ensure effective coverage. This results in misalignment of funds budgeted for and the funds needed for service delivery. This is due to inadequate capacity for planning especially at the lower levels which results in misalignment with the budget allocated and the amounts utilized at the end of the financial year. It also stems from the lack of multiyear planning aligned to the NHP 2017 or to the UHC objectives and goals of the UT. Currently, the departments continue to prepare the budgets based on historical allocations adding a fixed percentage (10% as informed by several officials during interviews) every year. Year on year Budget Estimate (BE) or allocation to the health sector testify the 10% logic. The budget execution is plagued with underutilization of funds for capital expenditure and recurrent revenue. Recent assessment highlights the utilization has consistently declined from 63% in 2016-17 to 52% in 2019-2020. This is largely due to delays in disbursement of funds despite having systems in place related largely to having many approval processes in place. The report also highlights the fact that there is room for improved dialogue between the Department of Treasury and the Department of Health to strengthen the budget formulation and execution phases. The budget structure is following the administrative classification with funds allocated to administrative units under the Department of Health and Family Welfare and is not aligned to sector targets. In addition, line-item budgets are used for both the Union level expenditure and the UT expenditure. The Union level budget has an output indicator framework drawn up for every financial year with targets for the Department of Health and Family Welfare that the states and UTs report on. However, this is only for the Centrally funded priorities. It is not clear whether a similar framework exists for the UT level priorities in J&K.	**PROGRESSING**
Way forward	While there are mechanisms for addressing this misalignment including the provision by the PFM rules for 10% virement under routine circumstances with provision for a higher proportion under emergencies and the development of revised estimates in the middle of the year informed by estimates of	**PROGRESSING**

Public financial management		
Way forward	government revenue available, there is nevertheless a need to support capacity building for planning to ensure budget formulation aligns to needs and health sector priorities. The implementation of a Medium-Term Expenditure Framework could also strengthen this alignment in addition to a medium-term plan for UHC. Additionally, more strategic dialogue between Department of Health and Finance would also help improve the planning process, the starting point of which can be adoption of an objective output indicator framework specifically for J&K.	**PROGRESSING**
Q 6.3	**Are processes in place for health authorities to engage in overall budget planning and multiyear budgeting?**	**Status**
Key areas of strength and weakness in J&K	There are systems and processes in place for annual budget planning. No multiyear budgeting system exist in the UT of J&K, though recently efforts have been initiated to ensure two-year budget cycles under NHM. For annual budgeting, there is a consultative process of budget formulation in which the department of finance hold consultations with different departments, including health. Similarly, the State Health Mission involves a consultative process of developing a UT implementation plan and budget for the NHM involving stakeholders, experts, and professional associations. The chronic underspending of the budget affects the negotiation power of the health department. Mid-year reallocation, that is, revised budget process also involves consultations with line ministries.	**ESTABLISHED**
Way forward	J&K, as most places in India, has a structured approach vis-à-vis involvement of the health authorities in overall budget planning. However, multiyear budgeting is still in limited use in the country, which will be an important next step to reduce variability in yearly allocations and to ensure that adequate resources can be allocated to health sector for its broader strategic plan over a longer time frame.	

Q 6.4	Are there measures to address problems arising from both under and over budget spending in health?	Status
Key areas of strength and weakness in J&K	The budget execution is plagued with underutilization of funds for capital expenditure and recurrent revenue. Recent assessment highlights the utilization has consistently declined from 63% in 2016-17 to 52% in 2019-2020. This is largely due to delays in disbursement of funds despite having systems in place related largely to having many approval processes in place. There are measures in place to address underspending through regular review meetings and checks including official approvals with different levels of responsibility spelt out by the PFM rules. The Department of Health and Family welfare has the flexibility for reallocation across spending areas of 10%. This approval is delegated to the Additional Chief Secretary (Health). Any reallocation above this requires approval from the Department of Finance**.** The Government of Jammu and Kashmir introduced Budget Estimation Allocation Monitoring System (BEAMS) to make a paperless system with the objective to distribute the budget and to authorize expenditure. Complete transparency in terms of real-time funds position exists at all levels through the BEAMS (Budget Estimation Allocation and Monitoring System). Through this system expenditure progress can be monitored on monthly basis under all the head of accounts from detailed head to the major head of account department-wise for ensuring better fund utilization management and liquidity management[46]. However, overspending is not legally possible in the system because of the provisions of the Government Financial Rules. Similarly, there is no provision for allowing any kind of overspending in the NHM system as well. There is a monitoring process in place where flags regarding underspending can be raised and discussed. Despite the processes and systems in place, as indicated earlier, there is significant underspending within the health sector due to disbursement challenges. Furthermore, there are challenges of under budgeting which in turn affect service delivery.	**PROGRESSING**

Way forward	Using the PFM assessment being undertaken, J&K should look to minimize current levels of underspending and reasons for delays in disbursements. Performance indicators should be established for fund disbursement turn-around-times to ensure that there are no inordinate delays in availability at the implementation level. Additionally, effective execution would also require better budget planning to ensure alignment of sector needs and priorities with the available resource envelope. Suggestion for the same have been provided in Q6.2 above.	**PROGRESSING**
Q 6.5	**Is expenditure reporting in health comprehensive, timely and publicly available?**	**Status**
Key areas of strength and weakness in J&K	Health expenditure reporting is only limited to the public sector. This involves the use of computerized PFMS. The reporting is timely in the treasury system and experiences some delays in the NHM system. However, while other states make their treasury budgets publicly available, in J&K expenditure reporting in the treasury system is available in PDF formats only and requires an approval of a formal request being put to the government. However, the same in the NHM context is not made public, though was available on the official NHM website till a few years ago.	**PROGRESSING**
Way forward	As a first step, it would be important that the Government of J&K ensure public availability of expenditure data. This will help augment efforts by academia and researchers to support UT efforts in understanding the issues pertaining to public health financing and program implementation. It would also be useful for the UT to consider setting up and research and analysis unit that can explore emerging areas of enquiry vis-a-vis public health financing.	

Public health functions and programmes		
Q 7.1	**Are specific health programmes aligned with or integrated into overall health financing strategies and policies?**	**Status**
Key areas of strength and weakness in J&K	UT-specific health financing policy does not exist in J&K. The Government of India has a National Health Policy 2017 where health financing policy is detailed. While the ministry of finance at the UT and central level is responsible for tax collection and budget formulation, the MOHFW at the central level and the Department of health and family welfare at the UT level participate in determining the detailed budgets and resource envelopes for respective ministry and department. The detailed budget for medical and health services of the department is decided at the UT level in consultation with the directorates and departments. For the public health programmes, the budget is decided through a bottom-up approach under the National Health Mission and is approved by the central health mission at the MOHFW level. The budget of various employment-based schemes is decided by respective ministries. The budget of AB PMJAY and SEHAT scheme is decided by the NHA under MOHFW. There are no separate disease specific programmes apart from programmatically focused verticals under the ambit of NHM. There exists some overlap for some conditions and diseases between NHM and schemes especially PMJAY, but this is a considered arrangement that the government put in place to ensure full coverage of services. Purchasing arrangement are not well aligned with PFM systems and with health priorities although some measures have been put in place as detailed in Section 4 of this review.	**PROGRESSING**
Way forward	Most health programmes reflect national health financing plans and policies. However, integrated service delivery does not exist and is purely aspirational, with little cross linkage and overlap across these various programmes.	
Q 7.2	**Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?**	**Status**
Key areas of strength and weakness in J&K	Under the National Health Mission, the funding and functions of most national health programmes are coordinated from the centre and UT, although they are implemented individually at the district and subdistrict levels. While there is a coordination of National health programmes and delivery of primary care at the level of PHCs, the delivery of secondary and tertiary care at the public hospitals is in isolation of the national health programmes.	**PROGRESSING**

Public health functions and programmes		
Key areas of strength and weakness in J&K	The referral between the Ayushman Bharat health and wellness centres offering primary care and the AB PMJAY and SEHAT scheme that offers coverage for secondary and tertiary care is not established. The capacity of health financing governance institutions at the UT level could be limited as there is attrition of staff at the secretariat level. The technical, managerial, and information and communication technology related capacity of the directorate and district level staff is unknown.	**PROGRESSING**
Way forward	There is little formal and effective integration cross health programmes. J&K should, within its governance mandate, work towards establishing linkages across these various programmes through the use of information technology. This is feasible given the universal biometric system (AADHAR), though the central Government's endorsement of this would be an important prerequisite.	
Q 7.3	**Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?**	**Status**
Key areas of strength and weakness in J&K	The IHR implementation in India is led by and coordinated at the National Centre for Disease Control (NCDC). There are no UT-level initiatives for J&K[47].	**PROGRESSING**
Way forward	N/A	
Q 7.4	**Are public financial management systems in place to enable a timely response to public health emergencies?**	**Status**
Key areas of strength and weakness in J&K	Most public health emergencies are funded and managed from the central government level. From the experience with COVID-19, these included[48]: - Relaxing rules regarding public procurements to secure essential medical supplies and equipment. - Authorizing and facilitating line ministries to use savings and charge emergency spending for COVID-19 expenditure - Execution of relief measures directly to beneficiaries through public financial management system In addition, the UT government took the following initiatives locally during the ongoing COVID-19 Pandemic.	**PROGRESSING**

Public health functions and programmes		
Key areas of strength and weakness in J&K	• In the budget 2021-2022, the J&K government allocated INR 228 Crores for oxygen generation plans in all medical colleges. In addition, the budget also provided INR 40 crores as ex-gratia relief for COVID-19 warriors. • The UT also launched a 'Special Assistance Scheme for COVID-19 mortalities (SASCM – Sakshm) that provides for financial assistance and pensions to the families affected by COVID-19. The financial allocation for this initiative could not be ascertained[49]. • With a formal government order, procedures to entertain bills pertaining to procurement of goods and services were relaxed during the COVID-19 pandemic and lockdown period. • A special cell for hand holding the families of COVID-19-19 victims and facilitating the extension of benefits under different government schemes and special assistance was created	**PROGRESSING**
Way forward	J&K should take the relevant learnings and experiences from the COVID-19 response to see which rules and practices can be absorbed and adapted into the Government machinery in the interest of better and more effective public financial management.	

Annexures

Annexure 1

Indicators by domain and subdomain

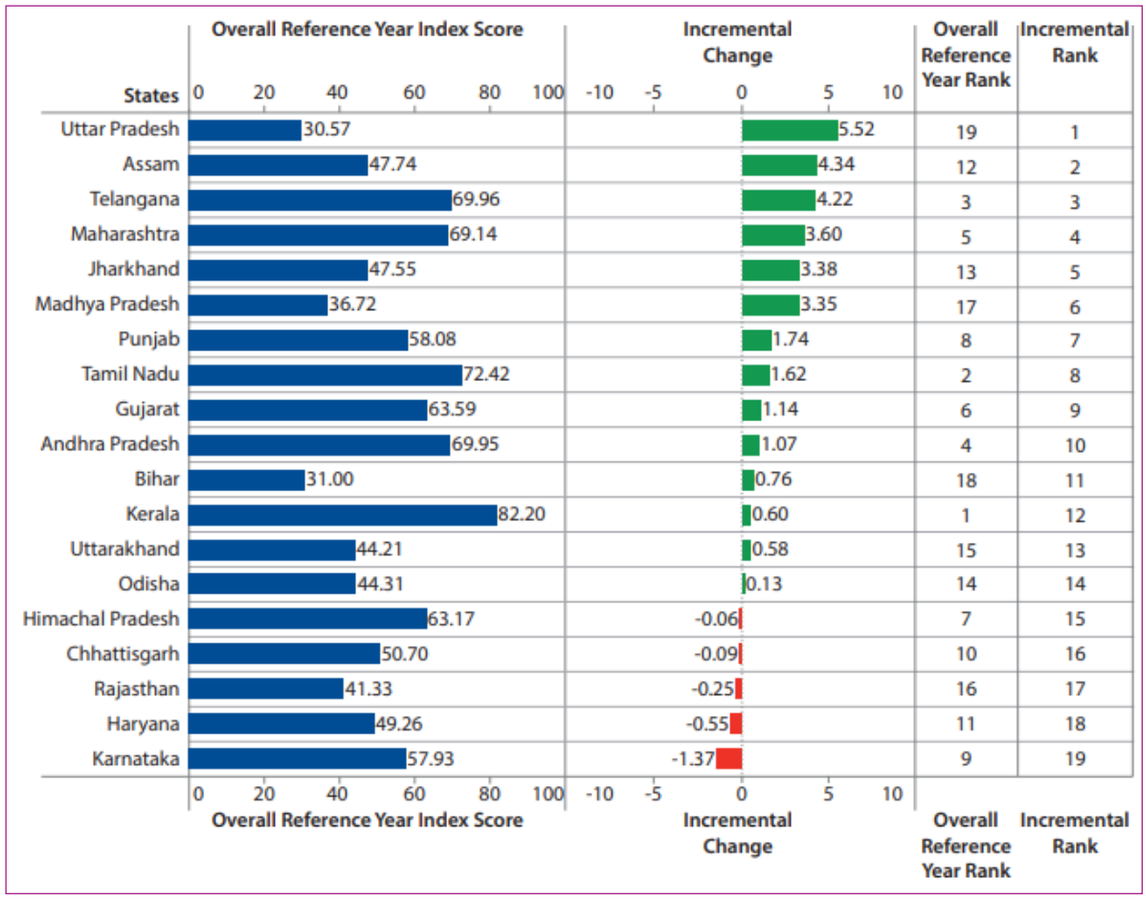
Domain 1: Health outcomes subdomain 1.1 key outcomes	
1.1.1	Neonatal mortality rate (NMR)
1.1.2	Under five mortality rate (U5MR)
1.1.3	Sex ratio at birth (SRB)
1.1.4	Maternal mortality ratio (MMR)
Domain 1: Health outcomes subdomain 1.2 intermediate outcomes	
1.2.1	Modern contraceptive prevalence rate (MCPR)
1.2.2	Full immunization coverage (percent)
1.2.3	a. Proportion of antenatal care (ANC) registered within first trimester against total registrations
	b. Proportion of pregnant women who received 4 or more ANCs
1.2.4	Proportion of institutional deliveries
1.2.5	Total case notification of TB (percent)
1.2.6	TB treatment success rate
1.2.7	Proportion of people living with HIV (PLHIV) on antiretroviral therapy (ART)
Domain 2: Governance and information subdomain 2.1 health monitoring and data integrity	
2.1.1	Institutional deliveries – percentage deviation of reported HMIS data from SRS
Domain 2: Governance and information subdomain 2.2 governance	
2.2.1	Average occupancy of an officer (in months) combined for following three posts at state level for last three years. (Principal secretary/secretary where PS not applicable; mission director (NHM); director (Health Services)/ DGHS where DHS not applicable)
2.2.2	Average occupancy of a full-time CMO (in months) in last three years for all districts
2.2.3	Number of days for transfer of central NHM fund from state treasury to implementation agency (department/society) based on the largest tranche of the last financial year+
Domain 3: Key inputs and processes subdomain 3.1 health systems/service delivery	
3.1.1	Proportion of shortfall of health care providers (regular + contractual) against required number of health care providers in public health facilities
3.1.2	Proportion of total staff (regular + contractual) covered under a functional IT enabled integrated human resources management information system (HRMIS)
3.1.3	a. Proportion of specified type of facilities functioning as first referral units (FRUs)
	b. Proportion of public health facilities with Kayakalp score of >70% against total number of public health facilities
3.1.4	Proportion of functional health and wellness centres
3.1.5	Proportion of district hospitals with functional cardiac care units (CCUs)

3.1.6	a. Level of registration of births (percent)
	b. Level of registration of deaths (percent)
3.1.7	Completeness of IDSP reporting of P and L Form (percent)
3.1.8	a. Proportion of public health facilities with accreditation certificates by a standard quality assurance programme (NQAS/NABH)
	b. Proportion of district hospitals and CHCs certified under LaQshya (separately for labour room and maternity OT)
3.1.9	Proportion of state government health expenditure to total state expenditure

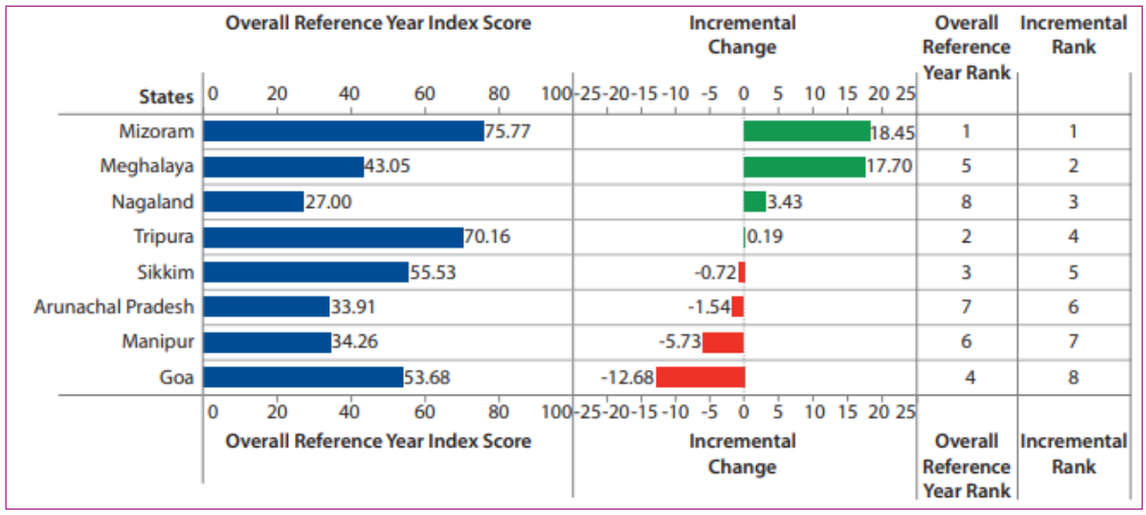
Annexure 2

Ranking of large and small states (Reference year 2019-2020)

Large states



Small states



Key health financing indicators for select states – NHA estimates 2017-2018

S. No	State	Total Health Expenditure (THE)			Government Health Expenditure (GHE)				Out of Pocket Expenditure (OOPE)					Population	GSDP	GGE
		In crores	% of GSDP	Per Capita in Rs.	% of THE	% of GSDP	% of GGE	Per Capita in Rs.	In crores	In crores	% of THE	% of GSDP	% of GGE	Per Capita in Rs.	in Crores		
1	Assam	8,366	2.9	2461	56.6	1.6	7.5	1392	4,733	3,002	35.9	1	4.8	883	3.4	288691	63174
2	Andhra Pradesh	24,068	3	4628	29.8	0.9	5.3	1381	7,182	16,130	67	2	12	3102	5.2	793186	134704
3	Bihar	16,388	3.4	1389	40	1.4	5	556	6,561	9,535	58.2	2	7.2	808	11.8	484740	131531
4	Chhattisgarh	8,572	3	3061	49.5	1.5	6.4	1516	4,244	3,322	38.8	1.2	5	1186	2.8	284194	66231
5	Gujarat	23,681	1.8	3534	42.5	0.8	7	1502	10,064	10,390	43.9	0.8	7.2	1551	6.7	1328068	144373
6	Haryana	12,121	1.9	4329	33	0.6	4.6	1428	3,997	6,108	50.4	0.9	7	2181	2.8	649592	86795
7	Jammu and Kashmir	4,042	2.9	3109	54	1.6	4.3	1679	2,183	1,731	42.8	1.3	3.4	1332	1.3	137427	51269
8	Jharkhand	10,085	3.7	2726	29.4	1.1	4.7	801	2,963	6,853	68	2.5	10.9	1852	3.7	276243	62903
9	Karnataka	29,465	2.2	4533	32.6	0.7	5.5	1476	9,594	10,068	34.2	0.7	5.8	1549	6.5	1357579	173149
10	Kerala	32,424	4.6	9264	24.5	1.1	7.3	2272	7,951	22,271	68.7	3.2	20.5	6363	3.5	701577	108697
11	Madhya Pradesh	19,619	2.7	2422	40.5	1.1	4.9	980	7,941	11,049	56.3	1.5	6.9	1364	8.1	724729	161159
12	Maharashtra	63,350	2.6	5236	25.9	0.7	6.1	1356	16,406	31,092	49.1	1.3	11.6	2570	12.1	2411600	268413
13	Odisha	13,771	3.2	3130	38.6	1.2	5.7	1207	5,312	7,698	55.9	1.8	8.3	1750	4.4	434769	92946
14	Punjab	12,692	2.7	4231	25.7	0.7	5	1086	3,258	8,805	69.4	1.8	13.6	2935	3	478636	64817
15	Rajasthan	25,888	3.1	3406	40.2	1.2	6.3	1369	10,407	12,831	49.6	1.5	7.7	1688	7.6	835170	166465
16	Tamil Nadu	29,664	2	3955	41	0.8	6.5	1621	12,155	13,627	45.9	0.9	7.2	1817	7.5	1461841	188077
17	Uttar Pradesh	73,171	5	3296	24.3	1.2	5.8	801	17,773	53,127	72.6	3.6	17.4	2393	22.2	1460443	305311
18	Uttarakhand	3,259	1.5	2963	54.9	0.8	5.1	1625	1,788	1,361	41.7	0.6	3.9	1237	1.1	222836	34997
19	West Bengal[20]	42,820	4.3	4460	24.4	1	6.5	1088	10,442	29,902	69.8	3	18.6	3115	9.6	999585	160445
20	Telangana	15,789	2.1	4267	39.8	0.8	5.7	1698	6,281	7,844	49.7	1	7.2	2120	3.7	753127	109267
21	Himachal Pradesh	4,579	3.3	6541	48.6	1.6	7.2	3177	2224	2254	49.2	1.6	7.3	3220	0.7	138351	30809

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Figures

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This report provides a comprehensive evaluation of Jammu and Kashmir's health financing system, identifying areas of strength and weakness and benchmarking it against current best practices in health financing design and processes. The study is based on a policy level review and will help guide necessary reforms to enhance health financing performance in Jammu and Kashmir.

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