Assessment of bottlenecks in public financial management for health financing in Jammu & Kashmir
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ACS</td>
<td>Additional Chief Secretary</td>
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<tr>
<td>AE</td>
<td>actual budget</td>
</tr>
<tr>
<td>AG</td>
<td>accountant general</td>
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<tr>
<td>AHI</td>
<td>Access Health International</td>
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<td>AHS</td>
<td>Annual Health Survey</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>AO</td>
<td>accounts officer</td>
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<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<td>BEAMS</td>
<td>budget estimation allocation and monitoring system</td>
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<tr>
<td>BCO</td>
<td>budget controlling officer</td>
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<td>BE</td>
<td>budget estimate</td>
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<tr>
<td>BEM</td>
<td>budget estimation and monitoring</td>
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<tr>
<td>BAM</td>
<td>block accounts manager</td>
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<tr>
<td>BHAP</td>
<td>block health action plan</td>
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<tr>
<td>BMO</td>
<td>block medical officer</td>
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<tr>
<td>BMEO</td>
<td>block monitoring and evaluation officer</td>
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<td>block program manager</td>
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<td>BPMU</td>
<td>block program management unit</td>
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<tr>
<td>CAO</td>
<td>chief accounts officer</td>
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<td>CAG</td>
<td>Comptroller and Auditor General</td>
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<td>CAPEX</td>
<td>capital expenditure</td>
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<tr>
<td>CDAC</td>
<td>Centre for Development of Advanced Computing</td>
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<td>CHC</td>
<td>community health centre</td>
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<td>CPIS</td>
<td>centralized personnel information system</td>
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<td>CMO</td>
<td>chief medical officer</td>
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<td>CPSMS</td>
<td>central plan schemes monitoring system</td>
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<td>CRM</td>
<td>common review mission</td>
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<td>CS</td>
<td>central sector</td>
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<td>central sponsored schemes</td>
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<td>district account manager</td>
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<td>DDO</td>
<td>drawing and disbursement officer</td>
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<td>DGAT</td>
<td>Director General - Accounts and Treasuries</td>
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<tr>
<td>DH</td>
<td>district hospital</td>
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<td>DHAP</td>
<td>district health action plan</td>
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<td>DHME</td>
<td>department of health and medical education</td>
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<td>JKPaySys</td>
<td>Jammu and Kashmir payment system</td>
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<td>JKMSCL</td>
<td>Jammu and Kashmir Medical Supplies Corporation Limited</td>
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<tr>
<td>JNNURM</td>
<td>Jawaharlal Nehru National Urban Renewal Mission</td>
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<tr>
<td>KII</td>
<td>key informant interview</td>
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<tr>
<td>MDM</td>
<td>Mid Day Meal Scheme</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MIS</td>
<td>management information system</td>
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<td>MFP</td>
<td>Mission flexible pool</td>
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<td>MGNREGS</td>
<td>Mahatma Gandhi National Rural Employment Guarantee Scheme</td>
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<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MTEF</td>
<td>Mid-term expenditure framework</td>
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<td>NAM</td>
<td>National AYUSH Mission</td>
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<td>NCD</td>
<td>Noncommunicable disease</td>
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<td>NDCP</td>
<td>National Disease Control Program</td>
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<td>NFHS</td>
<td>National Family Health Survey</td>
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<td>NFAMS</td>
<td>National finance and accounts management system</td>
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<td>NHPM</td>
<td>National Health Mission</td>
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<td>NMHP</td>
<td>National Mental Health Program</td>
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<td>NoC</td>
<td>no objection certificate</td>
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<td>National Rural Health Mission</td>
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<td>National Rural Drinking Water Programme</td>
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<td>NUHM</td>
<td>National Urban Health Mission</td>
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<td>NVBDCP</td>
<td>National Vector Borne Disease Control Programme</td>
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<td>OOPE</td>
<td>out-of-pocket expenditure</td>
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<td>PAO</td>
<td>pay and accounts office</td>
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<td>public finance management</td>
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<td>PFMS</td>
<td>public financial management system</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>PIP</td>
<td>program implementation plan</td>
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<td>Pradhan Mantri Jan Arogya Yojana</td>
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<td>In-depth interviews</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>PROOF</td>
<td>photographic record of onsite facility</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>DHS</td>
<td>district health society</td>
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<td>DHS J</td>
<td>director health services, Jammu</td>
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<td>DHS K</td>
<td>director health services, Kashmir</td>
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<td>DLHS</td>
<td>district level household survey</td>
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<td>DMEO</td>
<td>district monitoring and evaluation officer</td>
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<td>DoF</td>
<td>directorate of medical education</td>
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<td>DVDMS</td>
<td>drug vaccine distribution management system</td>
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<td>ELA</td>
<td>expected level of achievement</td>
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<td>FA</td>
<td>financial advisor</td>
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<td>financial management information system</td>
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<td>fiscal responsibility and budget management</td>
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<td>GeM</td>
<td>government e-marketplace</td>
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<td>GFR</td>
<td>government finance rules</td>
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<td>GMC</td>
<td>government medical college</td>
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<tr>
<td>Gol</td>
<td>Government of India</td>
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<tr>
<td>HDF</td>
<td>hospital development fund</td>
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<tr>
<td>HoD</td>
<td>head of department</td>
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<td>HOD</td>
<td>head of department</td>
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<td>HR</td>
<td>human resources</td>
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<td>HSCs</td>
<td>health sub centres</td>
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<td>ICMR</td>
<td>Indian Council for Medical Research</td>
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<td>ICDS</td>
<td>integrated child development scheme</td>
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<td>PMGSY</td>
<td>Pradhan Mantri Gramin Sadak Yojana</td>
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<td>RBSK</td>
<td>Rashtriya Bal Suraksha Karyakram</td>
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<td>RCH</td>
<td>reproductive and child health</td>
</tr>
<tr>
<td>RE</td>
<td>resource envelope</td>
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<td>RE</td>
<td>revised estimate</td>
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<td>RKS</td>
<td>Rogi Kalyan Samiti</td>
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<td>RMNCH</td>
<td>reproductive maternal new-born and child health</td>
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<td>RNTCP</td>
<td>Revised National Tuberculosis Program</td>
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<td>RoP</td>
<td>record of proceedings</td>
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<td>SAP</td>
<td>state action plan</td>
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<tr>
<td>SAM</td>
<td>state accounts manager</td>
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<tr>
<td>SC</td>
<td>sub centre</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SDH</td>
<td>sub district hospital</td>
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<td>SFM</td>
<td>state finance manager</td>
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<tr>
<td>SHA</td>
<td>state health agency</td>
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<tr>
<td>SHS</td>
<td>state health society</td>
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<td>SNA</td>
<td>single nodal agency</td>
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<td>SPM</td>
<td>state program manager</td>
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<td>SPMU</td>
<td>state program management unit</td>
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<td>SRS</td>
<td>sample registration survey</td>
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<td>SSA</td>
<td>Sarva Sikshya Abhiyan</td>
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<td>TDS</td>
<td>tax deduction of sources</td>
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<td>TMIDH</td>
<td>the technology mission for integrated development of horticulture</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>U5MR</td>
<td>under 5 mortality rate</td>
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<td>UIP</td>
<td>Universal Immunization Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UT</td>
<td>Union Territory</td>
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<tr>
<td>VHSNC</td>
<td>village health sanitation and nutrition committee</td>
</tr>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
'Accounts' or 'Actuals' of a year: The amounts of receipts and disbursements for the financial year as finally recorded in the Comptroller & Auditor General's (CAG) books (as audited by CAG).

Activity: A scheme undertaken in pursuance of the programme framed for implementing a function like 'Construction of primary schools (boys)' under 'Primary Education' and 'Establishment of testing labs' under 'Prevention of Food Adulteration.'

Administrative approval: The formal acceptance thereof by the competent authority for incurring expenditure on a work initiated by or connected with the requirements of the Department. In the case of works executed by the Public Works Department, it is an order to that department to execute a certain specified work at a stated sum to meet the administrative needs of the department requisitioning the work. Note- Administrative Approval is not an authorization to take up execution of work unless there is a special provision of funds for that work and technical sanction stands accorded to its detailed estimates of quantities and costs.

Annual financial statement (or budget): The statement of estimated receipts and expenditure of the Government of Union territory of Jammu and Kashmir as per its policy in respect of a financial year and caused to be laid by the Lieutenant Governor before the Legislative Assembly in terms of Section 41 of the Jammu and Kashmir Reorganisation Act.

Appropriation: the amount authorized by the Legislative Assembly for expenditure under a specific unit of appropriation or part of that amount placed at the disposal of a Disbursing Officer by controlling authority, out of funds placed at its disposal.

Audit: An independent examination of financial information of any entity, whether profit-oriented or not, irrespective of its size or legal form, when such an examination is conducted with a view to express an opinion thereon.

Budget calendar: The calendar fixed by the Government for the preparation of the budget and its completion up to the stage of the passing of Appropriation Bills.

Budget estimates: The detailed estimates of receipts and expenditure for the Budget year.

A budget year or financial year: The year commencing on April 1st and ending on March 31st.

Budget controlling officer: Financial advisor/chief accounts officer/accounts officer who, with the approval of the head of the department, submits estimates to the government and is responsible for budgeting and controlling the incurring of expenditure and/or the collection of revenues by the authorities subordinate to the department.

Cash basis: The basis of what is expected to be received in cash & also paid in cash during a budget year.

Capital expenditure (CAPEX): Activities which are undertaken as a result of the implementation of pre-conceived plans. Such expenditures are either developmental in nature or such that help in undertaking a developmental programme.

Codal formalities: All rules and regulations are required to be followed completely in a particular activity. Fulfilment of formalities like administrative approval to be accorded by a competent authority, technical sanction, fund availability, free from all encumbrances, and No Objection Certificates (NOC) from the regulatory authority, if required.
**Demands for grants:** The estimates of expenditure from the Consolidated Fund included in the Budget Statements and required to be voted by the Legislative Assembly are broken into the Demands for Grants in terms of J&K Legislative Assembly Business Rules. Normally a separate Demand is required to be presented for each Department or the major services under the control of a department. Each such Demand includes the total provisions required for a service, i.e., provisions on account of revenue expenditure, capital expenditure, grants to autonomous bodies, local bodies etc. and also loans and advances relating to that service. Estimates of expenditure included in the Demands for Grants are for gross amounts. The receipts and recoveries taken in the reduction of expenditure are shown by way of below-the-line entries. The estimate of expenditure in the Demands for Grants for those amounts for which the vote of the legislative assembly is required is shown separately and is called 'voted' expenditure. The estimates for 'charged' expenditure under any head which are not subject to vote of the Legislative Assembly are also indicated in the Demands for Grants but in italics. When there is no estimate for expenditure under any head requiring a vote of the legislative assembly, then it is not called a Demand. It is called ' Appropriation' and is included as such in the list of Demands.

**Drawing and disbursing officer:** An officer who is authorized to operate upon a treasury to the extent of the funds placed at his disposal. A list of such authorities is fixed from time to time by the concerned Administrative Department in consultation with its Director Finance/Financial Advisor and Chief Accounts Officer in respect of the heads of accounts related to that Department.

**Disbursing officer:** A Head of Office and also any other Gazetted Officer so designated by a Department of the Union territory of Jammu and Kashmir, a Head of Department or an Administrator, to make specific payments on behalf of the Government of Jammu and Kashmir. The term shall also include a Head of Department or an Administrator where he/she himself/herself discharges such function.

**General financial rules (GFRs):** A compilation of rules and orders of the Government of India to be followed by all while dealing with matters involving public finances. These rules and orders are treated as executive instructions to be observed by all Departments and Organisations under the Government and specified Bodies except otherwise provided for in these Rules.

**Legislative Assembly:** The Legislative Assembly of Jammu and Kashmir as defined in the Jammu and Kashmir Reorganisation Act, 2019.

**Public Works Department:** It includes Roads and Buildings, Irrigation and Flood control, Public Health Engineering, Power Development and any other branches of the Public Works Department, inclusive of engineering and construction wings of Forest, Rural Development and other Departments.

**Rate contract:** An agreement between the supplier and purchaser to supply items for a fixed unit price for a specified period of time, i.e., till the validity of the rate contract. The actual supply of the items occurs when the purchaser requires the items and consequently issues a separate purchase order for the number of items required. Rate contracts are generally employed by government ministries and departments since they require items in bulk. Therefore, rate contracts are regulated under several rules to streamline the process and maintain accountability and uniformity.

**Re-appropriation:** The transfer of savings from one unit of appropriation to meet additional expenditure under another unit within the same grant ordered by a competent authority.

**Recurring expenditure:** Expenditure which involves a liability beyond the financial year in which it is originally sanctioned.

**Revenue expenditure:** Expenditure which has to be incurred for the running of administration, maintenance of assets already created or meeting of pensionary and debt obligations of the Government. In other words, such expenditure does not result in the creation of assets extension in the existing level of development in different spheres of activity.

**Revised estimates:** The estimates of the probable receipts or expenditures of a financial year under the various major and minor heads and their primary units of appropriation, framed in the course of that year on the basis of the actual transactions recorded till then and in the light of any fact(s) which may be known as regards the remainder of the year. A revised estimate is in no way a provision for expenditure, and an entry in it carries with it no authority for expenditure of any kind. Revised Estimates are neither 'budget' nor appropriations of money, nor do they supersede the budget estimates as the basis for the regulation of expenditure. The inclusion of increased expenditure in the revised estimates does not supersede the necessity for applying for an additional appropriation, nor the revised estimates are the proper channel for such applications. Similarly, the revised estimates do not prevent the necessity for the formal surrender of sums unlikely to be spent.
**Supplementary demands for grants:** The statement of supplementary demands laid before the Legislative Assembly in terms of Section 44 of the Jammu and Kashmir Reorganisation Act, 2019, shows an estimated amount of further expenditure necessary in respect of a financial year over and above the expenditure authorized in the Annual Financial Statement for that year.

**Revenue receipts:** Receipts accrue to the Government as a result of its functioning recurringly. These are different compared to the capital receipts which arise from the sale of assets, recovery of loans and advances etc.

- **Tax revenue:** which accrues as a result of the implementation of Acts passed by the Legislative Assembly and other statutory orders issued by the Government from time to time and those.
- **Non-tax revenue:** accrued from various Government Functions other than tax revenue.
- **Grants-in-aid/contributions** represent a transfer of resources from the Centre to the Union territory of Jammu and Kashmir based on the awards of the Finance Commissions or for developmental purposes.

**Technical sanction:** The sanction of the competent authority to the technical specifications, calculations of quantities of items of work and material, and a properly detailed estimate of the cost of work. As its name indicates, it amounts to no more than a guarantee that the proposals are structurally sound and that the cost estimates are calculated and based on adequate data and the reasonability of rates.

**Tender:** An invitation to bid for a project or accept a formal offer such as a takeover bid. Tendering usually refers to the process whereby governments and financial institutions invite bids for large projects that must be submitted within a finite deadline.

**Works:** Whether original or of maintenance nature, works will be either 'works-in-progress', 'procurements' or 'new works. The works-in-progress are continuing works which have been taken up earlier and for which provision of funds in the budget becomes the first charge. New works, on the other hand, are those which have to be taken up for the first time. These could be, Major or Minor Works.

- **Major work** means work other than minor work.
- **Minor work** means an original work or a work of repair, or improvement, the estimated cost of which exclusive of departmental charges do not exceed the ceiling fixed in the Public Works Department in consultation with the Finance Department. The Public Works Department includes all the departments responsible for executing works under rules.
Jammu and Kashmir ranked sixth among all UTs in the NITI Aayog’s fourth round (2019–2020) health index (overall performance) and second in the incremental performance category. The UT (and the erstwhile state) is historically considered good performing, with most health indicators being better than the national averages. The Infant Mortality Rate (IMR) and Under Five Mortality Rate (U5MR) in the UT has come down to 20 and 21 compared to 30 and 35 at National Level, respectively. The J&K has achieved the replacement Fertility level, as the Total Fertility Rate has reached 1.4, the second-lowest amongst the states. As per National Family Health Survey, the other Maternal and Child Health indicators have also shown significant improvement and are much better than the national average.

The average out-of-pocket medical expenditure per hospitalisation case (excluding childbirth) in Urban areas is Rs. 14,644 (Rs. 4,402 national average). The same in rural areas is Rs. 4,707 (Rs. 4,078 national average). The average expenditure per childbirth (excluding abortion cases) in urban areas is Rs. 3,435 (Rs. 1,874 national average). The same in rural areas is Rs. 3,344 (Rs. 1,305 national average). For a system predominantly serviced by the Government health centres that are expected to be providing health services at free or subsidised rates, the OOP expenditures are pretty high. The survey also indicates low health insurance coverage (public/private) for the people of J&K.

According to the latest National Health Accounts report, the Government health expenditure in FY 2017–18 is 1.6% of its GSDP. The Government health expenditure is 54%, and the out-of-pocket expenditure (OOPE) is 43% of the total health expenditure in J&K. The health and health financing indicators of J&K are better compared to the national indicators.

The Government of Jammu & Kashmir has recently rolled out “Social, Endeavour for Health and Telemedicine (SEHAT)”, a universal health insurance scheme aligned with Pradhan Mantri Jan Arogya Yojana (PMJAY). The scheme ensures that all citizens access secondary and tertiary inpatient services. The new Health Care Investment Policy (HCIP, 2019) aims to improve the private sector presence in the UT to serve the people better.

Nevertheless, the Government realises that there is still a lot to be done to mobilise resources to improve the health and wellbeing of its citizens. To enhance value for its money, the Government requested the WHO Country Office in India to provide technical support to assess its public financial management system. Therefore, ACCESS Health International was commissioned to undertake a dip-stick study completed in a short span of 3 months. In this report, we present the findings from this study, discuss the issues as understood through interactions with the Finance and Health Department Officials, and provide some short-, medium- and long-term recommendations that could help the Union Territory in its journey toward achieving UHC.
The study followed a Quantitative-Qualitative design and included collecting primary and secondary information from the UTs Health Directorate, State Health Society, and other health financing entities. Secondary data was collected to understand the expenditure trends and utilisation patterns to know the absorptive capacity of the UT of Jammu & Kashmir. The study also looked at the policies adopted by the Health and Finance sectors to provide good healthcare services to achieve universal health coverage (UHC).

The key components of this assessment include (i) review of literature, (ii) financial resource tracking, (iii) data analysis for understanding resource utilisation and (iv) bottleneck analysis (through stakeholder interviews) for identifying systemic bottlenecks leading to inefficiencies in resource utilisation, macro-level reasons thereof, and suggestions for enhancing the public financial management system. The assessment was conducted using a bottleneck assessment tool jointly developed by the study team and WHO Country Office for India.
Bottlenecks and recommendations

Bottleneck 01 - Planning and execution challenges
The Union Territory of Jammu & Kashmir does not have a comprehensive policy document that clearly outlines the priorities of the health sector and the strategies to provide requisite services to the people. 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 allocations increased from Rs. 3037 Cr. in 2016–2017 to Rs. 4448 Cr in 2019–2020, equalling 46.5%. The incremental budget allocation to the health sector is evident from the abovementioned figures. However, the actual expenditure remained stagnant, approximately around Rs. 1800 Cr between 2016–2020. About 92% of the actual expenditure is on paying staff salaries, and all other expenses add up to the remaining 8%. These numbers indicate scope for improvement in the planning and execution of the health budget.

Recommendation - Identifying the priorities of the health sector and articulating them in a legally approved policy is a critical move towards an efficient PFM system
Articulate the health systems priorities and identify the short-, medium- & long-term goals based on the population’s needs. After that, build upon the system’s strengths and develop a comprehensive strategy that addresses the priorities. The strategy should integrate the national policies and programs reflected in the health sector’s existing national strategy and program documents.

A Medium-Term Expenditure Framework (MTEF) analysis is recommended to ensure better financial planning in the health sector. MTEF is an internationally tested and recognised standard planning tool that describes the Government’s spending plan over 3–5 years. It aims to ensure that budget reflects priorities and puts forward the Government’s commitments toward achieving Universal Health Coverage. MTEF provides stability and certainty within the budget process. A carefully prepared MTEF ensures allocation of resources to priority services, more efficient planning and management, a framework for assessing policy proposals, more transparency and a clear demonstration of how fiscal targets will be met.

Bottleneck 02 - Fund absorption capacity
The analysis of audited financial data for four years between 2016–2020 shows that the utilization of funds (Actual Expenditure as a percentage of the Budget Estimates) has declined from 63% in 2016–2017 to 42% in FY 2019–2020. Some reasons for low utilisation were reported, including delays in administrative approvals, delays in fund disbursements, the long turn-around time for clearing bills, limited knowledge of the DDOs to undertake activities and works, and hesitation in decision making, challenges in monitoring fund utilization. Moreover, vacant medical and paramedical staff positions, procurement and infrastructure-related challenges add to the overall problem of fund absorption.

Recommendation - Improve absorptive capacity and fund utilisation
It is vital to understand the underlying fund absorption challenges. Therefore, a detailed study is essential to understand the low absorptive capacity in the health sector. It is also crucial to undertake studies to understand the demand for health services in UT, the stock-outs, and their frequencies experienced by health facilities, infrastructure needs, etc. These are essential for better planning and resource allocation.
It is also crucial to better monitor fund utilization. The DDOs have to play a more proactive role in performing their duties. All the new DDOs should be given a detailed orientation to their duties and the General Financial Rules (GFR). The incumbent DDOs should be provided with refresher training periodically.
Procurement of diagnostics involves multiple complexities due to the increasing number of medical equipment, differences in specifications, quality control, tendering processes and provision of after-sales services of the equipment procured. Both JKMSCL and the CMCMOs are not well equipped to understand the complexities of diagnostic equipment procurements.

Conduct an assessment of the functional efficiency of procurement and supply chain management. The assessment would include procurement and supply chain audit, demand forecasting from facilities, and tendering and quality management processes.

Encourage better use of software like the BEAMS to better monitor fund utilization. Conduct a more comprehensive monitoring review involving the Department of Finance, the Department of Planning, and the Health Department to ask the right questions and propose workable solutions for better fund utilization. The technology could be used for real-time monitoring.

Assess the pool of resources available at the District/Block level through different sources. Using the assessment results, orient and sensitize the DDOs for monitoring and optimising funds. This will help empower the DDOs for better decision-making, resulting in improved fund utilisation.

**Bottleneck 03 - Procurement Challenges**

In the FY 2019–2020, the expenditure booked under the object heads "Drugs & instruments" and "Machinery & Equipment" clubbed together was 2.1% of the total expenditure. Since the service delivery in J&K is predominantly by the public sector, high out-of-pocket expenditures in the public sector can be directly linked to the low expenditure on the essential input factors.

Procurement of diagnostics involves multiple complexities due to the increasing number of medical equipment, differences in specifications, quality control, tendering processes and provision of after-sales services of the equipment procured. Both JKMSCL and the CMCMOs are not well equipped to understand the complexities of diagnostic equipment procurements.

**Recommendation - Strengthen the Procurement Ecosystem**

Conduct an assessment of the functional efficiency of procurement and supply chain management. The assessment would include procurement and supply chain audit, demand forecasting from facilities, and tendering and quality management processes.

The UT should improve the ecosystem capacity to undertake diagnostic procurement through JKMSCL. The UT can learn best practices from other procurement corporations like KMSCL of Kerala, which procures a range of equipment, from a simple weighing machine to high-end equipment like MRI Scanners, Linear Accelerators, etc.

In the meantime, diagnostic services can be outsourced to the private sector through a transparent contracting mechanism so that service delivery is not hampered in public facilities.

**Bottleneck 04 - Human Resource Capacity**

The problem of human resources is threefold and has a cascading effect on the health system. The issues that are closely related are (i) the vacant positions at all levels of the health system, including accounting staff, (ii) the overburdened existing accounts staff and (iii) the need for creating new cadres of professionals essential in the system. This contributes to the cascading effect on service delivery and fund utilisation.

**Recommendation - Building financial management capacity**

Training of Trainers (TOT) on improving capacity on financial and accounting processes and guidelines for project implementation

For finance personnel: There is a need for capacity at every level due to the evolution of the financial systems. The financial management guidelines are being revised from time to time. Further, the accounts managers are stuck to their routine activities. They are not aware of differential financing, time management, etc. Hence a financial management module needs to be developed, and training needs to be imparted to all the finance personnel working in the health department. Training on SNA also has to be imparted to the Financial Management and Accounting staff.

For DDOs: As most of the DDOs working under the health department are doctors, they are unaware of the financial management systems. Hence, they require training concerning the financial management guidelines, GFR, and operation of monitoring software (PFMS and BEAMS).

Introducing the cadre of facility-level accountants through NHM funds would be another short-term solution. This cadre is in place and functional in other Indian states such as Assam. This will considerably reduce the burden of work on the Block Accounts Managers.

**Bottleneck 05 - Infrastructure maintenance**

The Rural Health Statistics (RHS) 2019 suggests that the Union Territory of Jammu & Kashmir has a surplus of the health centre and hospital buildings compared to the requirement calculated per the Indian Public Health Standards. However, about 65% of the rural health centres function through rented buildings. This directly impacts service delivery, generating awareness through branding and other linked activities. While most health centres have basic facilities such as regular water and electricity supply, the same is still a challenge in about 30% of the rural health centres (RHS 2019). The existing Government-owned buildings are also old and require major repair works.
**Recommendation - Strengthen the capacity to plan and execute capital investments in new and existing infrastructure**

Capital expenditures are more complicated in terms of execution than recurrent expenditures. The execution needs different departments to collaborate, and the completion takes multiple years. It is equally important to have well-defined and transparent project selection norms for infrastructure projects in the health sector. Therefore, the UT should devise special provisions for streamlining infrastructure projects within a dedicated monitoring and accountability framework. Also, gradually shift from rent to own buildings and focus on better maintaining existing infrastructure. Establishing an in-house engineering wing in the health department to reduce dependency on technical approval processes for infrastructure projects is a welcome move by the Government.

The recent Health Care Investment Policy (HCIP) of Jammu & Kashmir, which focuses on creating a robust private sector in the UT, is also a good move toward building health infrastructure.

**Bottleneck 06 - Hesitation in decision making**

During the interviews, some officials pointed out a significant problem in the system, which pertains to the hesitation of officials from the health department as they do not understand the General Financial Rules (GFR) very well. The Financial Advisors are also hesitant to give resolute advice due to their limited understanding of the health sector.

**Recommendation - Sector-specific addendum to the current General Financial Rules**

There is a need to develop a health sector-specific addendum to the GFR that clarifies the rules better in the health sector and gives financial advisors and health care officials more confidence to take firm decisions.

**Overall recommendation - Adopting a health systems approach**

The Department of health is unique in many ways, and the finance dept needs to understand them better. Our consultative workshop’s first interaction with health and finance department officials demonstrated this finding. It made it evident that many problems can be solved just by understanding the two systems better and finding practical solutions to real-life situations. Therefore, taking a health systems approach where the interplay between different health system pillars becomes the base for understanding and solving the problems will better benefit the system and the people of Jammu & Kashmir.

Capacity building of the existing human resources is the need of the hour and is an essential, feasible short-term solution. Build the capacity of the existing human resources at different levels for assessing the health system’s preparedness for service delivery, estimating the population need or demand, meticulous physical and financial planning, accounting and financial management, procurement and supply chain management, data analytics, monitoring and evaluation.
Delivering quality health services to the community is the key function that any health system needs to perform. It can be achieved if the public resources are used efficiently, effectively, and equitably. However, poor quality of service delivery due to weak planning and expenditure systems and lack of a reliable mechanism for tracking and monitoring the resources has been observed across many countries. Indeed, it is often unclear to the health system personnel whether the utilization of the public resources is consistent with the resources allocated and is reaching the intended beneficiaries. The prime reason behind this is a weak correlation between public spending and outcomes and the unavailability of adequate information regarding resource flow, resource utilization, and quality of services delivered, resulting in an inability to effectively plan resource deployment. Over the years, many tools and techniques have been developed for strengthening the relationship of accountability in service delivery by improving the quality of information related to the expenditure of public resources.

The Government of India’s 11th Five Year Plan identified and documented the need to enhance the quality of public expenditure and support the monitoring of funds under the Centrally Sponsored Schemes (CSS). To fulfill these needs, the government established a web-based software known as Public Financial Management System (PFMS), which provides a comprehensive Decision Support System (DSS) and Management Information System to ensure informed planning, budgeting, and effective monitoring of the CSS. The UT of Jammu & Kashmir monitors the UT budget through Budget Estimation, Allocation and Management System (BEAMS), Jammu & Kashmir Payment System (JK PaySys) and Treasury Net. The Government of India and Jammu & Kashmir have made significant efforts to achieve Millennium Development Goals (MDG). They now are focusing on achieving the Sustainable Development Goal targets. In the last 14 years (2005 to 2019), the Union Government has invested about Rs. 3684 crores in Jammu & Kashmir through National Health Mission (NHM) to financially support these efforts. The Government of Jammu & Kashmir has invested about Rs. 20 838 crores in the UT Health budget. The utilization of the UT health budget is about 42% during FY 2018–2019. Similarly, the UT achieved 69% of fund utilization against the funds released under NHM in FY 2018–2019. To further improve fund utilization, the UT needs to improve its budget planning and implementation.

1.1 Overview of public financial management and health financing systems

The PFM system ensures that government resources are used effectively, efficiently, and transparently. The health financing system has a similar mandate, with a specific focus on the health sector and a further mandate to meet universal health coverage (UHC) goals. Even though the PFM and health financing system have different roles, some key components of their respective policy tools can work in the same direction toward more predictable financing, more effective and efficient use of funds, and greater transparency and sustainability.

1.2 The public financial management

Public financial management (PFM) is the set of rules and institutions governing all processes related to public funds. It provides sectors with a platform for managing resources from all sources and across different levels of the Government. Public finance processes are typically structured around the annual budget cycle to ensure that public expenditure is well planned, executed, and monitored. A standard budget cycle includes three stages: budget formulation, execution, and monitoring. The three PFM outcomes are fiscal discipline (spend what you can afford), allocative efficiency (spend on the ‘right’ things), and operational efficiency (provision of public services at a reasonable quality and cost). The budget reflects the government’s policy priorities, and the execution process should have high credibility and control. The
These functions are needed to address health financing and budgeting challenges. When the PFM system and health financing system are working in harmony, they can reinforce one another's objectives and make the following results possible:

- **Funds are directed to health sector priorities.** Funds can be pooled, allocated and disbursed across populations, geographic areas, and time to respond to health needs and ensure equity and financial protection for target populations.

- **Pooling risk** to protect individuals from financial risk associated with their health care needs and ensure equity;

- **Strategic purchasing** of health services on behalf of a population to ensure equity, efficiency, quality and value for money;

- **Benefit design and rationing policies**, including measures such as patient cost-sharing (through user fees or co-payments), service exclusions and waiting lists.¹⁰

- **Health sector policies and priorities are reflected in the budget.** Health budget allocations are predictable, sufficient, and stable enough to meet health sector objectives and commitments.

- **Funds are directed to health sector priorities.** Funds can be pooled, allocated and disbursed across populations, geographic areas, and time to respond to health needs and ensure equity and financial protection for target populations.

- **Funds are used effectively and efficiently to deliver high-value services.** Funds are directed to priority

Adopted from Allen, Hemming and Potter (2013); Cangiano, Curristine and Lazare (2013); ACCA (2011); PEFA Secretariat (2016); Simson, Sharma and Aziz (2011); World Bank (2004)

### 1.3 The health financing system

The health financing system is the set of policies and supporting arrangements that govern the resources and economic incentives of the health system. The health financing system has the following functions that support UHC goals:

- **Raising revenue** efficiently and equitably from stable sources;

- **Pooling risk** to protect individuals from financial risk associated with their health care needs and ensure equity;

- **Strategic purchasing** of health services on behalf of a population to ensure equity, efficiency, quality and value for money;

- **Stewardship**, including governance of health financing agencies and regulation of markets; and

- **Benefit design and rationing policies**, including measures such as patient cost-sharing (through user fees or co-payments), service exclusions and waiting lists.¹⁰

These functions are needed to address health financing and budgeting challenges.

### 1.4 Areas of mutual reinforcement

When the PFM system and health financing system are working in harmony, they can reinforce one another's objectives and make the following results possible:

- Health sector policies and priorities are reflected in the budget. Health budget allocations are predictable, sufficient, and stable enough to meet health sector objectives and commitments.

- Funds are directed to health sector priorities. Funds can be pooled, allocated and disbursed across populations, geographic areas, and time to respond to health needs and ensure equity and financial protection for target populations.

- Funds are used effectively and efficiently to deliver high-value services. Funds are directed to priority
The health sector is critical to a country’s efforts to achieve its broader development objectives, which are also the mandate of the ministry of finance. However, at the policy development level or during the implementation phase, PFM and health financing reforms can misalign and go in different (sometimes contradictory) directions. There can also be misunderstandings between health and finance authorities. Finance authorities sometimes have the impression that the health sector does not understand how PFM rules work and how those rules can help the public sector function more effectively. The lack of measurable, immediate results from public spending on health can reinforce perceptions that the sector is ineffective and inefficient. In addition, health spending often deviates from budget targets in the absence of effective planning and clear demand assessment, and by the very nature of health being unpredictable, the volume, type, and geographic distribution of needs are difficult to predict. This is sometimes attributed to low absorptive capacity and inefficiency. Still, the underspending often reflects difficulties in budgeting and disbursing funds according to national PFM rules and a lack of flexibility to reallocate funds to areas with higher-than-anticipated needs. This situation can lead to the vicious cycle of low budget allocations, the mismatch between budgets and priorities, and underspending. In many cases, the misalignment occurs and persists because the PFM and health financing system are designed and operated in parallel. (See Fig. 2)

In general, a strong PFM that provides predictability in the resource envelope releases funds in a timely and flexible manner and supports effective financial accountability and transparency is critical for implementing health financing reforms. General improvements in the PFM should, therefore, typically improve alignment between the PFM and health financing system.

### 1.5 Need for alignment between the PFM and health financing system

The health sector is critical to a country’s efforts to achieve its broader development objectives, which are also the mandate of the ministry of finance. However, at the policy development level or during the implementation phase, PFM and health financing reforms can misalign and go in different (sometimes contradictory) directions. There can also be misunderstandings between health and finance authorities. Finance authorities sometimes have the impression that the health sector does not understand how PFM rules work and how those rules can help the public sector function more effectively. The lack of measurable, immediate results from public spending on health can reinforce perceptions that the sector is ineffective and inefficient. In addition, health spending often deviates from budget targets in the absence of effective planning and clear demand assessment, and by the very nature of health being unpredictable, the volume, type, and geographic distribution of needs are difficult to predict. This is sometimes attributed to low absorptive capacity and inefficiency. Still, the underspending often reflects difficulties in budgeting and disbursing funds according to national PFM rules and a lack of flexibility to reallocate funds to areas with higher-than-anticipated needs. This situation can lead to the vicious cycle of low budget allocations, the mismatch between budgets and priorities, and underspending. In many cases, the misalignment occurs and persists because the PFM and health financing system are designed and operated in parallel. (See Fig. 2)
Scope for strengthening PFM

1.6 Global
The execution of health budgets in developing countries has received considerable attention in recent years\(^1\)\(^2\)\(^3\), \(^4\)\(^5\)\(^6\)\(^7\)\(^8\)\(^9\)\(^10\) (Barroy H. et al., 2016; Cashin C. et al., 2017; Welham B. et al., 2017). Empirical evidence of poor budget execution in the health sector has also been highlighted. Studies in Nepal and Ghana have shown how delays in the transfer of funds in the health sector lead to underutilisation of health budgets and affect service delivery\(^11\)\(^12\)\(^13\)\(^14\)\(^15\)\(^16\) (Hart, 2017; Blanchet et al., 2012; Schieber et al., 2012). The factors that lead to delays in the transfer of funds have been less explored. Country-specific studies in local contexts are required for an understanding of the issue (Welham B. et al., 2017)\(^15\). In 2017, Cashin et al. also reported that Planning and budgeting are often delinked processes\(^16\). In 2016, the overseas development institute evidenced that the budget timetables that need to be aligned with the parallel programmatic annual work plans are often prone to slippage\(^17\).

1.7 At the national level in India
In India, preliminary studies on selected schemes (i.e., MGNREGA, PMGSY, IAY, NRDWP, RKVY, TMIDH, BRGF, NRHM, SSA, MDM, ICDS, JNNURM, NLCPR, NEC, PMRP) initiated by the Union Government have also pointed out problems of budget execution\(^18\)\(^19\)\(^20\)\(^21\)\(^22\)\(^23\)\(^24\)\(^25\)\(^26\)\(^27\)\(^28\)\(^29\)\(^30\) (Gupta et al., 2011; Gayithri, 2012; Choudhury et al., 2013; Barker et al., 2014; Bhanumurthy et al., 2014). These studies have argued that the nature of involvement of different tiers of Government and administration and the institutional features associated with them have lowered the effectiveness of funds allocated to many of these schemes. The poor capacity for decentralised planning and implementation at the lower units under NHM has resulted in poor budget formulation and execution of the program\(^31\). Moreover, institutional gaps like the staff vacancies at implementation units and weak planning across different components of budgets have been argued to lower the effectiveness of resource allocation to different activities (line items).

1.8 At the sub-national level in Jammu & Kashmir

1. The sector-wise expenditure reveals 36.08% of expenditure on General Services, 27.61% on Social Services and 31.37% on economic services. Social services, education, sports, art and culture, medical and public health, water supply, and sanitation are the main spenders. They together cost about 80% of social services. In the case of general services, the main expenditure is on pensions, administrative services, interest payments and servicing of debt. They comprise about 97% of total expenditure.

2. A comparative picture of revenue expenditure and services is given in Table 1. The table also shows the revenue expenditure changes from two standpoints, 2006–2007 and 2016–2017. Within revenue expenditure, for J&K, the share of general services declined significantly (6%). This decline was shifted to an increase in social services (marginally, 2%) and economic services, which increased by 4%. The annualised growth rate across all the categories was between 9% and 12%. Looking at the share of services in total expenditure we find that share of general services is highest, though declining. J&K gives equal weightage to both social and economic services.

3. The degradation of infrastructure created due to the absence of adequate maintenance grants is another area of concern and needs to be addressed by providing adequate funds in the capital/revenue expenditure, whichever is applicable on a fixed basis.

4. The report highlights that “Salaries” constitute 85% of the revenue expenditure of the Health and Family Welfare, Water and Sanitation, and Housing and Urban Development (HUD). Operation and Maintenance (O &M) is less than 1% of the Health and Family Welfare WS, Sanitation& HUD. Medical and public health and family welfare constitute around 20.6% of social sector expenditure in 2016–17.
Table 1: Per capita revenue expenditure
(Rs. in crore, at current prices)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Revenue expenditure (in Rs.)</td>
<td>9618.7</td>
<td>29620</td>
</tr>
<tr>
<td>a. General services (% to total)</td>
<td>4217.6 (44%)</td>
<td>11242 (38%)</td>
</tr>
<tr>
<td>b. Social services (% to total)</td>
<td>2610.8 (27%)</td>
<td>8604 (29%)</td>
</tr>
<tr>
<td>c. Economic (% to total)</td>
<td>2790.3 (29%)</td>
<td>9775 (33%)</td>
</tr>
<tr>
<td>d. Grant-in-aid contributions</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The 12th Common Review Mission (CRM), which evaluated the implementation of NHM in 19 States, reports several PFM challenges. For J&K, the same report flagged the following challenges:

1. Delays in fund transfer from State Treasury to SHS by 36 to 215 days in the year FY 2017–2018 and for the year FY 2018–2019, delay was 62 to 78 days.
2. The untied funds for the current financial year have not yet been released by the SHS.
3. The submission of the Statutory Audit Report by the State for FY 2017–2018 is pending.
4. The Audit of Rogi Kalyan Samithi (RKS) covered only untied funds and not the user charges collected by the facilities.
5. The provisions of Tax Deducted at Source (TDS) are not being properly complied with within most of the facilities.
6. In most facilities, expenditure filing (payments to vendors) is not done through PFMS.
7. In most of the facilities, only cashbooks are being maintained, and no ledgers are being maintained at CHC/SDH, PHC, or SC levels.
8. There are long-standing vacancies for Block Accounts Manager.

During the interviews, it was informed to the team that the delays in fund transfer from UT treasury to SHS had come down to 15–30 days. Further, PFMS is now being used for expenditure filing by all the institutions.

1.9 Union Territory health system - Jammu & Kashmir

Jammu & Kashmir is a Union Territory of India (a state until 31 December 2019), located in the northern part of the Indian subcontinent, centred on the plains around Jammu to the south and the Vale of Kashmir to the north with 12.5 million residents (2011 Census). It covers an area of 222,236 square kilometres. Himachal Pradesh and Punjab border the UT to the south and Ladakh to the east. The UT has 23 District Hospitals, 84 Community Health Centres, 637 Primary Health Centres and 2967 Sub Centres.

General services include (1) Organs of State, (2) Fiscal services, (3) Interest payments and servicing of debts, (4) Administrative services (5) Pension and (6) Miscellaneous General services.
### Table 2: Profile - Jammu & Kashmir, Union Territory

<table>
<thead>
<tr>
<th>Indicators</th>
<th>India</th>
<th>J&amp;K</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate (1000 Live births)</td>
<td>22</td>
<td>15</td>
<td>SRS 2019</td>
</tr>
<tr>
<td>IMR (1000 live births)</td>
<td>30</td>
<td>20</td>
<td>SRS 2019</td>
</tr>
<tr>
<td>U5MR (1000 live births)</td>
<td>35</td>
<td>21</td>
<td>SRS 2019</td>
</tr>
<tr>
<td>Crude death rate</td>
<td>6</td>
<td>4.6</td>
<td>SRS 2019</td>
</tr>
<tr>
<td>Total fertility rate (children per woman)</td>
<td>2.0</td>
<td>1.4</td>
<td>NFHS 5</td>
</tr>
<tr>
<td>Death rate-tuberculosis</td>
<td>33</td>
<td>18</td>
<td>Disease burden, ICMR 2017</td>
</tr>
</tbody>
</table>

**Health delivery system**

<table>
<thead>
<tr>
<th>Health sub-centres (HSCs)</th>
<th>155 404</th>
<th>2470</th>
<th>RHS 2019–20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health centres</td>
<td>24 918</td>
<td>923</td>
<td></td>
</tr>
<tr>
<td>Community health centres</td>
<td>5183</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>District hospital (DH)</td>
<td>810</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

**Delivery system performance**

<table>
<thead>
<tr>
<th>Institutional births (%)</th>
<th>88.6</th>
<th>92.4</th>
<th>NFHS-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional births in a public facility (%)</td>
<td>61.9</td>
<td>86.8</td>
<td></td>
</tr>
<tr>
<td>Home delivery conducted by skilled health personnel (out of total deliveries) (%)</td>
<td>3.2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Births delivered by caesarean section (%)</td>
<td>21.5</td>
<td>41.7</td>
<td></td>
</tr>
<tr>
<td>Births in a public health facility delivered by caesarean section (%)</td>
<td>14.3</td>
<td>42.7</td>
<td></td>
</tr>
<tr>
<td>Average OPE per delivery in a public health facility</td>
<td>2916</td>
<td>5145</td>
<td></td>
</tr>
</tbody>
</table>
2 Methodology

2.1 Objective of study

1) Review of publicly funded health financing schemes in J&K.
2) Review and describe the Budgeting formulation and negotiation process in J&K.
3) Describe the fund's flow process and review budget execution & accountability processes in J&K.
4) Identify any key strengths, weaknesses or bottlenecks in the PFM system (at the UT level) and the reasons for why they exist vis-à-vis the ability of the system to effectively deliver needed services at the field level.
5) Examine the congruence of the PFM system in J&K with current and prospective health financing reforms for UHC.
6) Based on the findings, recommendations are the potential pathways toward better outcomes for UHC.

2.2 Study design

The study adopted a qualitative approach, including primary and secondary information collected from the UT health directorate, UT Health Society and other health financing entities in two stages. In the first stage, historical financial data was collected and analysed to understand the expenditure trends and utilization patterns to know the absorptive capacity of the UT of Jammu & Kashmir. The study also looked at the policies adopted by the Health and Finance Sector to provide good healthcare services to achieve universal health coverage (UHC).

In the second stage, primary information was collected based on the assessment tool for analysing public financial management (PFM) bottlenecks customised to suit the PFM system at the sub-national level, i.e., the Union Territory of Jammu & Kashmir. This assessment tool aimed to identify key weaknesses, misalignments, and root causes in how revenues are allocated and implemented in health, from top to frontline providers. The tool was structured according to the key functions in managing public finance or the public funds to and within the health sector.

The assessment involved evaluation of the budget processes (both through the treasury route and society/off-budget route of financing the health sector). The process included planning, allocation, disbursement, monitoring and assessing the budget’s impact. The key components of this assessment included:

1) Review of literature: All the important financial policies, guidelines, documents etc., were reviewed to understand the health financing landscape, budget structure and its cycle, the decision-making process, and the end-to-end fund flow mechanism.
2) Resource tracking: seeks to identify the sources of funds from origin to executing agency and the allocation of funds to specific schemes/programs and sub-programs, i.e., fund flow mechanism.
3) Resource utilization: Analysis of the resource use involves understanding the utilisation pattern and assessing delays and shortfalls in the execution of approved budgets for health services, which
Key informant interviews were conducted with technical officials from the Ministry of Health (planning, finance, procurement, monitoring and human resource departments); and Ministry of Finance (revenue, expenditure, accounting, treasure etc. departments); and the health insurance agency to identify bottlenecks and challenges as well as their causes. In addition, select DPs working in the UT be interviewed.

4) **Bottleneck analysis**: Identification of bottlenecks and inefficiencies in resource utilisation, macro-level reasons thereof, and suggestions for enhancing the public financial management system.

**Fig.4: Key stakeholders for PFMS Bottleneck assessment**
Primary data collection

Table 3: Tools developed and administered in the study

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Name of the tool</th>
<th>Administered to officials from Interviews conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Providers</td>
<td>Providers/ Drawing and Disbursement Officers (DDO)</td>
</tr>
<tr>
<td>2</td>
<td>DoHME officials</td>
<td>Department of health &amp; medical education (DoMHE)</td>
</tr>
<tr>
<td>3</td>
<td>DOF officials</td>
<td>Department of finance (DOF) officials</td>
</tr>
<tr>
<td>4</td>
<td>Policymaker</td>
<td>UT leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
</tr>
</tbody>
</table>

|      |                  | 25 | 05 | 04 | 01 | 35 |

*Note: One district and one block in Kashmir and Jammu divisions, respectively, were selected for drawing and disbursing officers (DDOs), district accounts managers (DAM) and block accounts manager (BAM) interviews conducted at the district and block levels.

In-person consultations

Two in-person consultations were conducted in Srinagar. Each consultation was attended by officials from the Department of Health and Medical Education (DoHME), Department of Finance (DoF) and Department of Planning. Both the consultations were chaired by the Mission Director, National Health Mission, Jammu and Kashmir.

The first consultation was conducted in October 2021 to customise the PFM bottleneck analysis tool developed for this study. The questions from the tools were checked for feasibility and their usefulness. The tool was thus finalised after the consultation and was piloted in Srinagar. The second consultation was conducted in April 2022 to validate the findings of the study.

The list of Government officials who attended the consultations is given in the annexure for reference.
3 Study findings and observations

The findings section of this report has two broad sub-sections, (i) Government Health Financing Schemes in J&K and (ii) The Supportive Environment. The first sub-section explains the major government health financing schemes in Jammu & Kashmir following the PFM cycle approach. Each step of the PFM cycle, viz; budget formulation, budget execution and budget monitoring under every healthcare financing scheme, is first described, followed by narrating the main findings and observations from the secondary information and key informant interviews, including actual quotes from the interviews. Thereafter the specific recommendations are presented for appropriate action. Subsequently, the second sub-section describes the three major supportive functions: procurement, infrastructure and human resources. Under each supportive function are highlighted the key findings from the qualitative and quantitative data analysis followed by the specific recommendations for appropriate action.

3.1 Government health financing scheme in J&K

Health financing resource flows in the public sector mainly consist of central and UT government budget sources and facility-level resources through user fees for certain earmarked services. The primary source of fund flow for the health sector is the UT budget, which mainly finances the service delivery at all tiers of public health institutions. The two main departments that incur the majority of expenditure under the treasury route are the department of medical & public health and the department of family welfare, and expenditure is incurred by the budget heads 2210, 2211, 4210, 4211, 6210 and 6211. There are other ministries and departments, such as the Social Welfare Department, Tribal etc. fund various smaller health programs, but they are not routed through the health department. The second major source of resource flow is through central sector schemes (CS) and centrally sponsored schemes (CSS). The central sector schemes are fully funded by the central government, whereas the centrally sponsored schemes are funded partially by both the Central and State/UT Governments. National Health Mission includes rural and urban missions, National Ayush Mission, the Tertiary Care program, and Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PMJAY), which are the major centrally sponsored schemes in the health sector. Though the funds collected for facilities make up a minor share, they also serve as a source of funds for operational expenses in public facilities.

Fig.6: Key sources of the key health financing pathways in Jammu & Kashmir
Treasury budget - Budget allocations through the treasury budget of Union Territory form a significant part of UT health spending. The treasury budget consists of pooled resources of the UT and grants or loans for centrally sponsored programs from the central government. The treasury route of spending includes funds allocated to public facilities, UT-level health insurance programs, local self-government allocation, and other individual UT-level initiatives.

National Health Mission/National AYUSH Mission - Both programs are Centrally sponsored schemes with 90:10 funding from the centre and UT. Based on the approval of the PIP submitted by the UT government, funds are transferred to the UT treasury and later to UT/District health societies.

AB-PMJAY-SEHAT scheme - This forms the third main health financing scheme implemented in the State. AB-PMJAY covers around 6.2 lakh families in UT. But the UT has extended the coverage of the scheme beyond the target beneficiary of the scheme and covers the rest of the population (14.56 Lakh families) through the UT scheme called the PM-JAY SEHAT scheme.

Facility-level user fees - Public facilities collect nominal user fees from patients. The administrative oversight for user fees collected is under Rogi Kalyan Samitis, which utilizes the income generated for operational expenses of the facilities.

This report will primarily focus on Jammu & Kashmir’s treasury and the NHM budget.

3.1.1 Treasury budget

3.1.1.1 Budget formulation

The budget formulation is executed in a bottom-up manner. The Drawing and Disbursement Officers (DDOs) (E.g., CMOs) are responsible for preparing and executing the budget. The DDOs use the Budget Estimation Allocation Monitoring System (BEAMS) portal to prepare the Budget (see section 3.2.4.1 below). The DDO requires the Treasury and Accountant General (AG) codes to log in to the BEAMS portal. The revenue budget (recurrent budget) is fixed first, followed by the capital budget (CAPEX). The salaries of officials serving at different designations are mostly predetermined and proposed with only a fixed percentage increment over the previous year. At the same time, budgeting for other establishment cost, such as office expenses, travel expenses etc., is based upon actual requirements and the previous year’s performance. The DDOs use the Centralised Personnel Information System (CPIS) portal to collect information for employees under them and estimates the funds required for the salary head.

3.1.1.1.1 Budget formulation process

Fig.7: The process of budget formulation
**Demand for Grants** is the form in which estimates of expenditure from the Consolidated Fund, included in the annual financial statement and required to be voted upon in the Lok Sabha, are submitted in pursuance of Article 113 of the Constitution.

### Estimating revenue (recurrent) budget

The DDO logs into the BEAMS portal & enters the Budget Estimate (BE) & Revised Estimate (RE) for each object head (e.g., Form B2 of Budget Circular). Multiple DDOs prepare the budget under one department. The combined budget is sent to the HOD, who is also the Budget Controlling Officer (BCO). The DDO submits the estimates to the BCO, who evaluates the proposed estimates against the previous year's performance & applies cuts wherever required.

The BCO then consolidates the estimates provided by the DDOs and forwards them to the concerned administrative department, which consolidates the estimates received from all the BCOs. The compiled estimates are then forwarded to the Finance Dept. At this level, the "Detail Demands for Grants" are consolidated.

After submitting estimates by the health department, the demand is scrutinised at every level of the budget division in the Finance Department. It includes Asst. Accounts Officer, Accounts Officer, Joint Director-Budget, Director General Budget and finally by the Finance Commissioner who approves the figures. The Joint Director-Budget evaluates the estimates received from each administrative department and prepares budget notes. Then the notes are uploaded to BEAMS by the Dept. Section Officers.

The budget discussion is attended by officials from the health and finance department in the presence of the Finance Commissioner. During the discussions, the budget note extract is taken from the BEAMS portal, and the decision (accept/reject/alter) is communicated to the department. Past performance is considered while finalising the figures, and necessary cuts are exercised wherever required. Increased figures are accepted if expenditure targets are met or the demand is backed by proper justification.
Estimating capital budget

The DDOs are not allowed to enter the estimates for the CAPEX part in the BEAMs portal directly as the Finance Department cannot scrutinise it, and necessary revisions cannot be made. The DDOs are provided with form B12 and asked to submit the information on the proposed works. The B12 form consists of a separate column for Sl. No., Name of the Work, District, Location, Budget estimate, margin cost, revised cost, whether administrative approval/technical sanction accorded, cumulative expenditure, previous March expenditure, approved CAPEX budget for the current year, expenditure up to September and next year proposal. The Finance Department reviews the B12 form, and upon their approval, only the details of the works are entered in the BEAMS portal. The permission for entry of CAPEX is given only to the HOD level. If a "Work" requires more than one year for completion, the annual budget is provided based on the yearly absorption against the total project cost. Previously lumpsum provision was provided under CAPEX to the administrative department, and they used to allocate the budget for different works among their respective DDOs.

Budget negotiation

The negotiations are done during the Budget discussion. Future Plans are discussed as per the demand, previous utilisation considered, and justification is sought for under-utilisation. If satisfactory justifications are given, then the proposed figures are retained; otherwise, revisions are made.

Budgeting timelines

The Budget circular was issued in August. The Proposals from DDOs are received by 30th September. The discussion with respective administrative departments begins on 10th October and continues till 25th October. The major discussion is done on the CAPEX part, and the revenue expenditure part is generally fixed. The compilation of demands is done till 30th November. Meetings with the Business and political class on policy decisions go till the first week of December. The compiled proposals are required to be submitted to Union Government by 15th December. After the finance department approves, the budget is submitted to the Government of India for placing the same before the parliament.
3.1.1.1.2 Findings

- The basis of making "Revenue budgets" is incremental rather than need-based. It was reported by the DDOs that they add 10% to the previous year's budget and send it to the higher level. A health official quoted, "percentage increase has done over the previous year, not need-based" another official quoted, "...Most items in non-plan budget are from past experiences. It increases uniformly..." and "...planning is sometimes on presumptions also as it is not possible to see in all districts whether it is required there or not".

- Since salaries are a non-negotiable expense, it was observed that the focus of the officials while preparing the budget is on estimating the salary component. Whereas the requirement of the catchment population is not explicitly considered as a basis for preparing the budget estimates.

- The ground-level teams do not appear to be equipped with the appropriate know-how to assess the health need of the people, and therefore, they do not use it for financial planning. This makes it difficult for the higher-ups to defend the demands and therefore suffer slashes or cuts or even rejection. Therefore, lead to revisions or rejection of the estimated budget. One of the finance officials from the DoHME mentioned, "We do not have the capacity to utilise the fund actually", "either they don't have the expert hand in the field who would be utilizing that in accordance with the guidelines or in accordance with the rules".

- Though the capital budget is prepared with a bottom-up approach, the final allocation is not as per the need articulated by the institution due to its historical record of underspending and, sometimes, due to the cash crunch. One of the officials from the planning department stated, "There may be multiple proposals. Principal takes the final call for selecting the proposal as there is ceiling by the finance department. Budgeting is done on the basis of priority".

- The opportunity of revising the capital budget while preparing Revised Estimates (RE) is not used optimally. This is mainly because of the significant turn-around time in administrative approvals (from health and finance departments) to revise the capital budgets for slow-moving projects and to reallocate funds to fast-moving projects. An Official from the Planning Department stated that "Pace of works differ. Reappropriation at (the time of preparing) RE (revised estimates) is not properly utilised as it is delayed. Reallocation within the same head to be allowed, it should not be given to the finance department".

- The Budget Estimates (BE) for salary head are prepared as per sanctioned HR strength; however, at the time of preparing RE, only the occupied positions are considered. Hence the budget is revised to adjust for the vacant positions. An official from the DoHME quoted, "Suppose a particular department has a sanctioned strength of 100 employees, they will propose for 100 employees for a full year. At the time of RE, we have to see what is the actual employees in position and the actual filled position. This can be about 60. This is why at the time of RE, the budget for salary head was slashed, and only three months' salary against the vacant position was provided. At BE level, we propose for 12 months for vacant positions also".

- In the context of revising the budget under heads other than "Salary" at the RE stage, a health official stated, "the budget at RE gets reduced because of the pace of expenditure; at times, the pace of expenditure may not be good. To ensure austerity measures and proper fiscal marksmanship, the department cut down on certain things they feel are not required".

- At the end of the financial year, all the unspent balances lapse. An official quoted an example "suppose the department may have asked the budget for electricity as a lumpsum amount of Rs. 300 Cr, but expenditure is out of bills submitted by the electricity department. Only that amount is booked and cleared, and the rest amount lapsed on 31 March".

- The use of technology in budget preparation has made the entire process transparent and accessible in real-time. However, the preparation of the capital/CAPEX budget is still paper-based. An official of the Finance Department quoted, "Capex budget is done manually and not through BEAMS as it cannot be scrutinised and necessary cuts cannot be imposed (for budget finalisation)".

3.1.1.1.3 Recommendations

- Develop a comprehensive vision for the health sector and create a plan with realistic targets to enhance the availability of human resources, infrastructure, drugs, and consumables.
The plan could include health sector-specific immediate, short-, mid- and long-term targets with a financial commitment to implement the plan successfully. An essential tool which could be adopted for sound financial planning is the Mid-Term Expenditure Framework (MTEF).

To enhance the utilization of allocated budgets, the provision of Revised Estimates should be viewed as an opportunity to reallocate funds to line items where more money is required rather than deducting the budgets.

The administrative and technical approvals could be expedited by setting up a fast-track mechanism for the timely reallocation of funds.

The capacity of the DDOs and their team members who prepare the budgets must be built to make need-based plans for their catchment area.

Develop and integrate the CAPEX budget preparation application with the main system.

3.1.1.2 Budget execution

When the final budget figures are available, the same are released by the Finance department to the respective Administrative Department through BEAMS. The administrative department releases the same to the Head of Departments (HOD), who then release it to their respective DDOs. Usually, 50% of the budget amount is released in April, 25% by October/November and the final 25% in the last quarter. Though this is the ideal scenario, it may not necessarily be followed in reality.

*OECD defines MTEF as “Medium Term Expenditure Framework (MTEF) is a tool for linking the budgetary process to broad fiscal policy goals beyond the annual budgetary cycle. MTEFs allow authorities to establish multi-year budget estimates or ceilings and/or detailed expenditure plans, which could typically have a span of three to five years. Such framework supports governments in making good macroeconomic projections, setting spending limits -taking into account indebtedness and future income-, and in general, understanding the consequences of fiscal decisions. A well designed MTEF would result in credible and predictable annual budgets, provide relatively accurate medium-term macroeconomic projections, allow understanding the source and size of fiscal challenges, the multi-year impact of new income and expenditure policy proposals before being adopted and provide early warnings about the sustainability of ongoing policies.

Fig. 9: Fund flow for UT budget

DHS - Director, Health Services; MD - Mission Director; GMC - Government Medical College; FA/CAO - Financial Advisor/Chief Accounts Officer; EMO - Block Medical Officer; CMO - Chief Medical Officer; M3 - Medical Superintendent
3.1.1.2.1 Budget execution processes

The Government uses three software applications to make the budget execution process seamless. The applications are JKPaySys, TreasuryNet and BEAMS.

- **Submission:** When a "Work" is executed, the Sr. Assistant logs in to the JKPaySys portal and prepares the bill, which is then verified and submitted by the Drawing and Disbursement Officer (DDO) to the Treasury.

- **Verification:** All the bills are checked online. Figures, photographs, and formalities are checked. A printed hard copy of the same is also submitted to the Treasury. A unique code is printed on the bill, which the Treasury is required to feed into the software TreasuryNet so that the bill gets reflected there. If there is any objection bill can be returned to the DDO both manually and online. If it is correct, the budget gets booked.

- **Consolidation:** The Treasury consolidates all the bills received during the day and creates demand. All demands are submitted to Director General – Accounts and Treasuries (DGAT) by 5 pm daily, where they are compiled.

- **Confirmation:** The resource division confirms the availability of funds against the total demand. The DGAT, Resource Division and Finance Secretary meet the following day and prioritise the expenditure based on fund availability.

- **Disbursement:** The payments are then disbursed directly to the party through TreasuryNet. As soon as the budget is booked, the balance gets reduced for that amount simultaneously in all the portals.

*Fig.10: Budget execution process*

*JK Payment System (PayManager) provides the common and integrated platform for DDO's to prepare the all types of bills for booking of expenditure*

*TreasuryNet is the web-based system which caters to the online transactions in treasuries as well as generates compiled accounts. It also provides various reports & queries to support decision making in financial matters*
3.1.1.2 Findings

- The analysis of audited financial data for four years between 2016–2020 shows that the utilization of funds (Actual Expenditure as a percentage of the Budget Estimates) has declined from 63% in 2016–17 to 42% in FY 2019–2020. This indicates the need to strengthen the health department's fund absorption capacity.

- Instances of disbursement of funds close to the end of the financial year impact the utilisation due to time constraints to follow administrative procedure and codal formalities for booking of expenditures. To substantiate this point, we quote the following:
  - One of the DDOs stated that delayed fund release makes it very difficult for the accounting staff to complete the formalities for procurement. Therefore, money remains unutilised; it lapses and then is returned to the Treasury at the end of the financial year. "We receive some fund tranche very late. And with some terms this much you can spend by this time there are many conditions on spending these funds. And late funds receiving and late funds dispersal down the line shows resistance in spending that fund at the last moment".
  - A Finance Department official stated, "The timely release of the budget is there. (The) lapse of funds is on (the) part of DDO(s). 50% fund release in April, 25% by October/November next 25% in the last quarter. The stated problem might just be a sporadic event that too for the remaining 25% and not a regular practice, as there is rarely any paucity of funds". However, this was not substantiated by BEAMS.

- Scope for strengthening the capacity of DDOs to understand financial management principles and processes.
  - During the interviews, the DDOs mentioned that the ceiling on expenditure applied by the Finance department at the end of the third quarter of the financial year limits from fully utilising the funds received in the fourth quarter. However, the official from the finance department stated, "the DDOs are misunderstanding ceiling as a restriction. He further explained, “In order to ensure quarter-wise uniform expenditure, finance dept. has come up with this reform not to push expenditure to March and not follow the codal formalities. Expenditure may be incurred against the rules”. A senior Finance Department official mentioned, “We find the expenditure rush at the end of the year, i.e. November, December. That is why we have come up with the expenditure monitoring, 30%, 30%, 30% and 10% or 15% in the last month of March”.
  - The DDOs are generally medical doctors who are not trained in accounting and using the three financial management-related software applications. The clerks appointed to assist the DDOs are also not trained in accountancy and the use of the three software applications. Therefore, the task of preparing bills and approving them for submission is shifted to the District or Block Accounts Manager hired to handle the accounts under the National Health Mission.

A longer turn-around time for clearing bills after submission of the same to the Treasury was reported. An official from the finance department said, "The mismatch of daily receipt and expenditure results in the delay of transfer of funds. Expenditure is daily, but the receipt is not".

3.1.1.2 Recommendations

- Train the designated officers with the requisite skills to handle financial management-related software applications to execute their responsibilities smoothly.

- Newly appointed DDOs should be oriented to the financial management, General Financial Rules (GFR) and requisite software applications. Also, periodic refresher training should be organised to refresh and update their acquired knowledge.

- The timely release of the quarterly tranches is essential for the optimal utilisation of allocated funds. Ensuring the same will enhance the absorptive capacity of the health department.

*Codal formalities imply the fulfilment of formalities to be accorded by the competent authority.
3.1.1.3 Budget monitoring
At each administrative level, the BEAMS software application provides an interface that empowers the DDOs/HODs to monitor the expenditures in real-time. Moreover, the system has inbuilt checks and balances at each level to flag deviations. The system does not allow over-expenditure under any budget head, minimising human error.

3.1.1.3.1 Budget monitoring process
Through BEAMS, expenditure progress can be monitored monthly under all the heads of accounts, i.e., from the detailed heads to the major heads. This ensures better fund utilisation and liquidity management. The BEAMS system also monitors the anticipated excess/ surrender position to enable decisions regarding fund withdrawal or reallocation to different heads of accounts. The system also enables the generation of various statements, which are vital from the management's perspective and facilitates building a constructive management information system which could be explored for effective performance appraisal and valuable for implementation of zero-based Budgeting and performance-based Budgeting system.

The BEAMS application is integrated with the Treasury Net and the JK Pay-Sys application, an efficient and effective Integrated Financial Management System in the Union territory of Jammu & Kashmir for better public delivery and governance system. In addition, the department has deployed a periodic review system to monitor the financial position and has set mechanisms to take requisite action to address the highlighted issues.

3.1.1.3.2 Findings
• The emphasis of budget monitoring is more on preventing over-spending under different heads. However, a similar emphasis is not given to under-spending, limiting the optimal utilization of resources.
• The accounting staff carries out monitoring. However, the finding of the monitoring exercise is not utilized by DDOs for improving the absorption capacity of the respective health institutions.
• Incentives for effective financial monitoring are not embedded in the system. Good performers are seldom awarded.

3.1.1.3.3 Recommendation
• To develop monitoring indicators that the DDOs could use periodically to identify financial management bottlenecks linking them to practical action points for better utilization of funds. Therefore, creating a periodic monitoring feedback loop.
• Encourage developing an environment for effective financial management by providing appropriate financial incentives to the accounting staff. Better financial performance could be linked to monetary incentives to accounting staff.
• Provide adequate and periodic training and capacity building to empower the staff to undertake procurement activity and effectively apply internal control measures while verifying the day-to-day financial transactions.

3.1.2 National Health Mission budget
3.1.2.1 Budgeting formulation
3.1.2.1.1 Budgeting formulation process
The process of planning starts with Block Health Action Plan (BHAP). The block personnel conducts gap analyses for their facility, and then BHAPs are prepared accordingly. BHAPs are then compiled at the district to prepare the District Health Action Plans (DHAP), which are then submitted to the UT office. At the UT office, the DHAPs are analysed by different program management units, director planning, SFM, SAM and SPM. DHAPs are scrutinised to check what gaps have been highlighted. A meeting with the district officials is done to discuss the plans submitted by individual districts. As resources are limited, certain activities are shortlisted after a discussion that can be done in the proposed year. No discussion is done for routine activities. The SPIP is then prepared and discussed with the different program management units. The executive committee meeting is done under the chairmanship of ACS held. If ACS desires, a meeting with Chief Secretary is also held. Then SPIP is then submitted to the Government of India, and approvals are accorded. Planning is a continuous process. UNICEF has done a gap analysis for 2022-23 with the help of DPMU and BPMU up to the PHC level. The districts and the blocks were asked to incorporate the gaps identified through this analysis in the respective health action plans. The gap analysis was limited to planning and not to financial management. UNICEF has developed a mobile application for gap analysis highlighting the respective institutions’ gaps. The gap analysis report, developed as a mobile app, was used for the PIP formulation process at the block and district levels. This was mentioned by Mission Director, NHM, during the consultative meeting.
Re-appropriation of funds under NHM

The implementing unit is allowed to re-appropriate the approved amount within different activities of the same flexible pool. However, it is subject to final approval from the UT Health Society. The re-appropriation process generally takes 3–4 days. In unplanned expenditure, the liability amount is recouped upon satisfactory justification provided to the district.

3.1.2.1.2 Findings

- **A mismatch between health priorities and funds mobilized and allocated:** Earlier, NCD was not a major concern in the valley; however, now it has become a priority. Many vertical programs or schemes are operating under the NCD program. Among NCDs, Cardio-vascular diseases (CVD) have been the leading cause of death worldwide, and ischemic heart disease (IHD) and stroke are the major contributors to CVD. Similarly, accidents and injuries contribute to disability-adjusted life years (DALYs) as the younger generation is more prone to accidental injuries. With the increasing complexities of modern life and stress, mental health too has emerged as a big challenge. However, the allocation is not as per population need. The Planning and resource allocation should be on the basis of the disease burden. However, in reality, as narrated by a Health official, “...Manpower requirement for NCD clinics was received for 45 CHC in the first phase. Extra 20 clinics were proposed but were approved without any manpower. Hence HR rationalisation was carried out. As a result, the program is not implemented to the fullest as NCD clinics cannot run without HR”.

- **NHM planning is format based.** The exact format is used at all levels. One of the NHM officials said, “It is confusing for the lower-level units and loses its relevance as activities are limited at that level”. One of the NHM officials quoted," You know that the PIP format is quite lengthy. We fill these formats easily at the UT level as we have a dedicated planning unit at the UT headquarters. However, at the district level, only three people do this exercise, i.e., District Program Manager (DPM), District Accounts Manager (DAM), and District Monitoring and Evaluation Officer (DMEO). It would be very beneficial if the ministry could provide shorter formats for the district and block level based on their actual need. For example, not every District hospital has a Medical College; however, formats for same is communicated to all the districts”.

- **The decline in funds mobilized for NHM:** The overall NHM Resource Envelope for J&K has shown a decline over the three years from Rs. 814.09 Cr. in 2018–19 to Rs. 738.79 Cr. in 2020–2021. The main reason for the decline, as quoted by an official, was that the J&K resource envelope reduced considerably at the time of reorganisation. The resource envelope came down from Rs. 808.81 Cr in FY 2019–2020 to Rs. 738.79 Cr in FY 2020–2021. An NHM official said, “…our RE was reduced drastically at the time of reorganization. For example, Ladakh received RE of about 100 Cr. If we go by the population distribution criteria, the RE of Ladakh should have been 10–12 crore. As a result, our RE got reduced” The matter, reportedly, was taken up with the Government of India.

- **Planning time is short:** As per the Operational Guideline for Financial Management under NRHM (2012) issued by MoHFW, the Districts must submit the DHAPs to the SHS by 31st October, and the SHS has to further submit the PIP to MoHFW by 31st December. Therefore, to give enough time to the Districts and Blocks to properly prepare their action plans, the formats have to be shared in August. An NHM official reported that the DHAP and BHAP formats were received in December, which impacts the planning and budget preparation. The official said, “Time is short, not enough for budget preparation.”
3.1.2.1.3 Recommendations

- Strengthen the capacity of managers to undertake need-based planning. Equip the team with the necessary knowledge and skills for the same.
- Develop smaller formats for District and Block Health Action Plans (DHAPs & BHAPs) customised to local needs considering the requisite activities. Similarly, Record of Proceedings (RoP) preparation can be done with different formats for dissemination to lower levels. For example, the state of Assam has customized the District and Block level RoP to include only the relevant activities and exclude all the other activities for which no amount has been demanded by or budgeted for the respective institution.
- Timely dissemination of DHAP and BHAP formats to lower levels. It is helpful for the managers to receive the formats by August as this will allow more time for planning.

3.1.2.2 Budget execution

Since the introduction of the Single Nodal Agency (SNA) concept, physical transfer of funds is not executed under NHM. All the health institutions have been instructed to open zero-balance bank accounts. The UT health society provides quarterly/monthly limits against the budget approved for each district. The districts provide similar limits to the block-level institutions against which the expenditures are incurred.

Fig.12: Fund flow under National Health Mission

3.1.2.2.1 Budget execution processes

The UT Treasury has to transfer the central funds and the matching share of J&K-UT to the SHS account within 15 days of receipt from the Government of India.

As soon as a vendor submits the bills, the concerned Accounts Manager submits the same on file to the DDO. After due approval from the DDO, the details are entered into the PFMS portal to process the vendor’s payment. After approval in the PFMS portal, the print payment advice is generated and submitted to the concerned bank for payment release.

3.1.2.2.2 Findings

  - NRHM-RCH Flexible Pool (FP): Regarding the quantum of funds allocated to different FPs under NHM, the NRHM-RCH FP is the major pool (95% of total approvals excluding IM in FY 2020–2021). During the three years from 2018–2019 to 2020–2021, the approvals have seen an increase of 61% (from Rs. 666 Cr. in F.Y. 2018–2019 to Rs. 1073 Cr. in FY 2020–2021). However, the percentage utilization against the approvals during the same period has come down from 67% to 58% (Rs. 447 Cr. in F.Y. 2018–2019 and Rs. 621 Cr. in FY 2020–2021).
  - NUHM flexible pool: There has been consistent improvement in the utilization of NUHM funds. The utilization has increased from 67% in FY 2018–2019 to 71% in FY 2020–2021.
  - NDCP and NCD flexible pools: These FPs have comparatively small allocations (together about 3–4% of total approval). Fund utilization under both the communicable and non-communicable disease FPs was modest. Under NDCP, more than 50% of unspent balances were reported
During the three years. Also, the utilization against approvals under NCDs has gone down from 49% in FY 2018–2019 to 7% in FY 2020–2021.

- **District level performance:**
  - All the districts have consistently reported utilization for activities under NRHM-RCH Flexible pool; however, the reporting for other programmes/activities has been inconsistent and not in the prescribed format.
  - Under NRHM-RCH flexible pool, 7 out of the 20 districts in Jammu & Kashmir have reported an average utilization of more than 90% during the three years. District Kishtwar has reported less than 80% utilization. All other districts have an average utilization between 80–90%.
  - It was reported by an NHM Finance Personnel that there are delays in the transfer of funds from the UT Treasury to the SHS account. A senior official of the health department informed that "From the point, the Ministry of Health releases the money and till the time the UT health society gets the fund in their SNA, it takes almost one month and three weeks (7–8 weeks)".
  - However, the Finance department clarified that placing the demand and follow-up with the Finance Department is the recipient department's responsibility. Timely placement of requisition of funds by the department can avoid any subsequent delays. An official from the Finance department quoted, "When the funds are received from the GoI, it is transferred to the society account only after the dept. places the demand. Department is not aware of when the fund is received from the government’s finance dept and does not know for which department the funds have been received. They wait for the respective department to raise the demand. The department needs to follow up with the finance dept. On-demand, funds get transferred within a week unless there are certain issues the respective department fails to explain".
  - The introduction of the Single Nodal Agency (SNA) for the Central Sponsored Schemes such as NHM, NAM etc., has brought the concept of virtual money with the opening of zero balance accounts for all the health institutions up to the lowest level. SNA has been implemented up to the sub-block level institutions, i.e., PHC, HSC, and VHSNC. However, these institutions neither have the infrastructure nor the staff to make the financial transaction using SNA. Currently, the responsibility of making the financial transactions for all these institutions is on the respective Block Accounts Manager and handling the same for the Block CHC.
  - **Issues with PFMS portal:**
    - While the portal performs smoothly at the beginning of the month, it becomes very slow toward the end of the month.
    - Print Payment Advice (PPA) issued from the portal does not reflect the Bank Server immediately in some cases. It takes up to 2 days resulting in delayed payments.
    - Since the introduction of SNA, some features, such as importing beneficiary data from an external source (e.g., RCH portal), have been unavailable. The entries must be made manually, which may result in duplication of payment. However, the same may get resolved after complete migration to the SNA system.

3.1.2.3 **Recommendation**

- Timely requisition of funds by concerned departments is essential for the timely release of funds. Also, follow-up is equally important for appropriate action. The Health Department could strengthen its communication with the Finance department to avoid delays in fund release under centrally sponsored schemes.
- For smooth implementation of SNA, new positions for PHC-level accountants need to be created to take care of the facility-level financial transactions. Similar positions have been created in other states under NHM.
- The concurrent auditors (NHM) have observed deviations in the financial transactions concerning compliance with GFR and taxation provisions. In this context, it is recommended to have training for the finance personnel.
- Capacity building of non-accounting staff at PHC/SC level on accounting and financial management basics.

3.1.2.3.1 **Budget monitoring**

**Budget monitoring process**

NHM funds are being monitored through Financial Monitoring Reports (FMR), which contain both physical and financial achievements. The FMRs are being reported monthly by the Block Program Management Units (BPMU) to the District Program Management Units (DPMU).

The DPMU consolidates the block FMRs and submits the same to the respective divisional program unit, who consolidate and forward the same to the UT Health Society. The FMRs are analysed at each level to
monitor the respective units’ program and component-wise fund utilisation.

Monitoring initiative by NHM finance personnel

The State Accounts Manager and District Accounts Managers have created WhatsApp groups to monitor the progress of utilisation of the respective implementing units. The higher-level institutions post the activity wise financial progress of their respective lower-level institutions in the WhatsApp group on monthly basis and seek explanation against activities for which poor utilization has been reported. The lower-level institutions post their fund requirements in the group, which is then timely processed by the respective higher-level unit.

3.1.2.3.2 Findings

- Preparation and submission of Financial Monitoring Reports are typically delayed by 2–10 days either due to delay in reporting from the lower institutions or to assigning other activities by the BMO given vacant establishment staff positions.
- The monitoring activities such as a supervisory visit to subordinate units suffer as much of the time is devoted to budget execution.

3.1.2.3.3 Recommendation

- The BEAMS application has the potential to be integrated with the PFMS application to obtain information on each Centrally Sponsored Scheme and its corresponding Union territory Share to be adopted for distribution through BEAMS.
- To conduct a detailed analysis of the current work profile to understand the scope for streamlining the roles and responsibilities of the DAM and BAMs.

3.1.3 Ayushman Bharat - PMJAY and PMJAY - SEHAT

3.1.3.1 Budget formation

Ayushman Bharat - PMJAY and PMJAY-SEHAT schemes are currently being implemented in J&K on the insurance mode through Bajaj Allianz General Insurance Company. The packages for both AB-PMJAY and AB-PMJAY SEHAT are the same. Every guideline applicable to AB - PMJAY applies to AB - PMJAY SEHAT.

The State Health Agency gets the quote from the prospective insurance companies, advises the modalities of the premium and sends the proposal to the administrative department, i.e., the health and medical education department. The DHME then forwards the proposal to the finance department. The finance department releases the funds through the treasury.

3.1.3.2 Budget execution

The AB-PMJAY scheme covers 5.97 lakh families, whereas 14.8 lakh families are covered under the AB-PMJAY SEHAT scheme. 1.10 crore population is covered in terms of individuals. The Premium amount is the same for both the schemes, i.e., Rs. 849.

Approximately 150 public (CHC and above) and 60 private hospitals are empanelled under both schemes. The public hospitals received 64% of the total claims (more than Rs. 200 cr). As per the claims statistics, the utilisation in the tertiary care hospitals is 45% and in other hospitals (CHCs and DH) is 55%. The public sector primarily provides tertiary care services in the absence of good tertiary care in private hospitals in J&K. However, minor secondary care procedures, such as appendicectomy, are only done in private hospitals.

The DoHME has issued guidelines for the utilisation of claim amounts by the respective health institutions. 50% of the amount is to be utilised for drugs, consumables and plants, 25% is utilised as an untied amount for hospital development activities like purchase of equipment, strengthening of lab etc., 20% is given as the incentives to the staff, including doctors, Arogya Mitras, and the remaining 5% is transferred to SHA every month as revolving fund. The SHA is currently devising a mechanism to deduct 5% of the claim amount at the time of receipt of the payment from the insurance company.

3.1.3.3 Budget monitoring

The SHA has issued explicit guidelines for utilisation. However, there is no mechanism to monitor the utilisation of the claim amount. One of the officials stated, “the understanding depends from person to person; some are doing it pretty well, some are utilizing the money very well, some have strengthened their hospital in a very good
way, but some are, you know, very laggy and they are not utilizing the money, and they are keeping it with this fear that there might be audit objection. Like we have an example, district hospital Pulwama utilized this money very efficiently similarly we have one example here GMC Srinagar, they have utilized this money properly, so there are good examples”.

3.1.3.4 Findings

• **Finalisation of insurance company:** The J&K Health Department’s contract with the Insurance Company was for three years. It was informed during the interview that the total pay-out released to the insurance company was Rs. 174 crores. However, the claims released by the insurance company amounted to more than Rs. 300 crores which the Insurance Company bore. Therefore, the insurance company made an early exit. After that, a new tender was floated, and the applicant company quoted a premium of Rs. 2299, which is almost three times higher than the previous premium (Rs. 849 per household). Given this, the administrative and finance departments advised retendering after redefining and restructuring some of the packages to avoid duplication of services. The tenders have been re-floated, and the premium is expected to come down this time.

• **Duplication:** PMJAY execution is universal, leading to duplicity in service delivery and payments. For example, the Janani Sishu Suraksha Karyakram (JSSK) provides hospitals with financial assistance for caesarean sections and normal deliveries; the same is also provided under the PMJAY scheme. Therefore, the hospitals receive financial assistance from both schemes, leading to duplication of payments.

• **Weak supply:** Procurement is primarily done in real-time based on the patient inflow. This system is not prudent as it is not economising the resources nor solving the availability of drugs and consumables. One of the officials stated, “right now, the implants, for example, the orthopaedic implants, the cardiac implants or any implants they (hospitals) have to buy from external sources, they have to buy it from the market. So, the government can also supply those implants in a very efficient manner, a very effective manner. You know, right now, I am giving you an example of a double chamber pacemaker; the pacemaker implant for the double chamber is available at 1.20 lakh from the market, but the actual cost is below 1 lakh, so the hospital has to cross-subsidize this package with the other package. So, if the government is supplying it, we can reduce the cost (to) an excellent level. If the implant is available at (Rs) 90,000, the hospital will save (Rs) 30,000”.

• **Procurement from claim money:** If an institution plans to make any expenditure on the purchase of emergency drugs or medical equipment out of the claim money, it has to first approach the Government approved stores. The local tendering option can be exercised if the same is unavailable there. However, it requires many administrative approvals, creating confusion among the health institutions.

• **Delays in claim reimbursement:** In J&K, the entire population is covered either through PMJAY or through PMJAY-SEHAT leading to the inclusion of those sections of the society with high health-seeking behaviour. Hence, utilisation is relatively higher compared to the other states/UTs. The insurance company has suffered from higher service utilisation leading to delayed payments and high rejection rates. The rejection rate was almost 50%, considered the highest in India at one stage. However, it has come down to below 10% now.

3.1.3.5 Recommendations

• An assessment of the claims is essential to understand the utilisation patterns. The results will provide insights for tweaking the scheme so that the insurance company can continue providing services at reasonable premium rates without incurring heavy losses.

• To carry out duplication mapping exercise and act accordingly to avoid double payments from different schemes/programmes.

• Strengthening and streamlining the procurement of drugs and consumables under PMJAY through demand forecasting using annual claims data for each facility/district can help in reducing the cost and improve the efficiency of procurement.

• Timely payments are essential for the retention of empanelled hospitals. Ensuring the same should be given priority. A robust monitoring mechanism and swift processes are critical for implementing the scheme.

• To strengthen health facility officials’ capacity to manage insurance claims per the guidelines and develop plans for improvement of service delivery utilising funds received from claims reimbursements.

• Explore avenues for using claim amounts to initiate new services that can help enhance service delivery, such as Dialysis units or Diagnostic laboratories.
3.2 Supporting environment

3.2.1 Procurement of medical supplies (drugs, equipment, etc.) and furniture

Procurement system

Government institutions under the DoMHE are mandated to procure medical goods and supplies through the JKMSCL. Those goods or supplies unavailable with the JKMSCL can be procured from the Government of India’s Government e-Marketplace, i.e., the GeM portal. This portal provided a user-friendly platform for Government Officers to procure common user goods and services. JKMSCL issues a NOC (No Objection Certificate) to the health institution to procure medical goods and supplies that are unavailable with the JKMSCL. If the requisite item is unavailable with any of the two agencies, then procurement from the local market is allowed. However, in such a case, the procuring institution is responsible for ensuring the quality of purchased medical goods or supplies.

Fig.13: Procurement system

Procurement process

Jammu and Kashmir Medical Supplies Corporation Limited (JKMSCL) issued a letter in October/November to all the revenue institutions to finalise their annual demand (primarily for drugs) for the subsequent year. Annual demand is prepared by the BMO/CMO, then consolidated at the HOD level, which sees the availability of funds and then places an order with JKMSCL. Thus, sometimes the demands from the BMO/CMO are curtailed. The requirements from the HODs come by the end of December. The annual requisition from the implementing agencies is done through Drug Vaccine Distribution Management System (DVDMS), developed by CDAC. DVDMS is used to monitor the supply chain from the point of the requirement to the ultimate delivery.

*Budget for procurement: Some of the Objects of Expenditure under Other Costs are stock backed like Materials and Supplies, Tools and Plants, Machinery & Equipment, Clothing and Bedding, Furniture and Fixture, Uniforms, POL, Rent/Rates & Taxes, Drugs & Instruments and the like. Estimates under these heads have to be adopted carefully because the user Departments have a tendency to overestimate their requirements. Every such budget estimate, therefore, be backed by sufficient data and information. Every proposal for adoption of these estimates should justify the estimated requirement with reference to the stocks already held, details of the assessment for the year, basis taken for judicious assessment, estimated cost of the assessment made indicating the source of the rates adopted for the purpose. Inventory created in the process of these purchases has necessarily to be kept within reasonable limits as otherwise, there will be blockade of capital, a serious financial irregularity calling for the required administrative action. At the same time, these requirements should also not be underestimated particularly in case of consumables like drugs provided to the needy through hospitals and dispensaries or class room aids needed by the educational institutions. Such under estimates eventually bring disrepute to the Government, which is not a good situation. Ref – Budget Manual, Govt. of Jammu & Kashmir
The rate contract entered for drugs and equipment is generally valid for two years. These rates must be available on the website www.JKMSCLbusiness.com and www.JKtenders.com. JKMSCL cannot issue the drugs without Quality Check (QC). There is a technical evaluation/demonstration stage where experts throughout the UT are called for a demo. They interact with the suppliers, see the machinery, and the same is sorted out there in any query. Many suppliers get disqualified as per the expert's opinion. The high quality of the product is ensured. QC sometimes takes longer, 2–3 months in some cases. A stringent policy about QC is in place.

Procurement mechanism (contracting and quality check)

The financial data from the Treasury and the NHM shows a declining trend in fund utilisation under the budget heads for procurement.

- The expenditure on procurement as per the UT budget shows a steep decline under the budget head of drugs and instruments. The expenditure in absolute figures has reduced from Rs. 81 Crore (91% utilization) in 2016–2017 to Rs. 17 Crore (15% utilization) in 2019–2020.
- The UT officials have informed that the utilisation has improved drastically in the last two years in response to the COVID-19 pandemic. The JKMSCL Position of Funds statement for the FY 2021–2022 (as of 28.04.2022) reported payments of Rs. 514.69 Cr made under the head “Drug” against the total funds received of Rs. 687.91 Cr, which equates to 75% fund utilization. Similarly, under the head “Machinery & Equipment”, payment of Rs. 560.03 Cr was reported against the total funds received by Rs. 818.54 Cr during the FY 2021–2022, equating to 68% fund utilization. The abovementioned unaudited expenditure statements were shared with the study team to verify the improvement in utilisation. Given the flexibility and relaxations for prioritising procurement in a pandemic situation, it would be important to understand what impact the relaxation in procurement rules had in improving the utilization and what can be done to maintain or further improve fund utilization.
A downward utilisation trend is also noted under the object head "Machinery and Equipment" dedicated to procurement. Except for the year 2018–2019, the expenditure exceeded the allocation. The utilisation reduced from 100% in 2016–2017 to 83% in 2019–2020. However, the expenditure gap is small compared to the expenditure on the procurement of drugs and instruments.

Under NHM, a similar trend is observed. The approvals under the budget head for procurement have increased consistently during the three-year period (2018–2021). However, fund utilisation was low (55%) and had shown a steep decline in FY 2020–2021 to 37%.

Accumulation of unspent funds has subsequently increased amounting to Rs. 104 cores.
For annual tendering, ideally, the tendering should be finalised by February and supply contracts issued by the end of March so that the supplies begin at the start of the new FY, i.e., April. The official from the JKMSCL stated that “there are procedural delays due to complications. Delays also are from the supplier’s part. Normally 70–80% of drugs are procured in time”.

The JKMSCL official and a few health officials raised concerns regarding the reduction in demand for generic medicines in public hospitals. The perception is that the reduction in demand is because of the diminishing belief in medicines disbursed through public facilities among patients. Many medicines given under the JKMSCL stay with the institution without being consumed, and later the officials are held responsible for the expired medicine in the government medical stores. Similarly, it was also reported that government medical officers do not prescribe generic drugs. A provider-level interview stated that “…the use of medicine supplied by the Government has reduced because neither the doctor prescribes it nor patient takes it.”

The DDOs in interviews complained of delays in receiving NOCs from the JKMSCL, resulting in delays in local procurement. However, while conversing with the JKMSCL official, it was highlighted that “JKMSCL does not deal with individual DDOs (BMO/CMO); we only deal with the respective HOD directly. The procurement requirement comes through the HOD only. Hence the HOD is only entitled to ask the NOC (No objection certificate for procuring from any source other than JKMSCL), and when asked officially, the same is issued along with the corresponding money being refunded. The BMOs/CMOs are not aware of the standard operating process and therefore end up asking for NOC directly from the JKMSCL, which is rejected. The BMOs/CMOs should therefore be informed about the SOP so that they route their demand for NOC through the HOD. Sometimes drugs are available but are not lifted by the concerned DDO even after repeated reminders. Also, some DDOs demand small quantities of medicines that JKMSCL cannot fulfil as it is a mass procurement agency, and therefore small quantities are expected to be procured locally”.

Limited local procurement capacity: Due to limited knowledge of the various financial management aspects, the DDOs are hesitant to decide on financial matters, especially with respect to procurement activities. They are afraid of being penalised given non-adherence to formalities. One of the finance officials from the DoHME stated, “Most DDOs are non-technical for finance; they are not in the better position to make the right choices”. He also mentioned that “the DDOs are sceptical when it comes to procurement due to vigilance case.”

Despite anecdotal evidence of drug availability at the facility level, a recent sample audit by NIPI indicates approximately 60% availability of drugs at Health and Wellness Centres (HWC).

As per NSSO average medical expenditure on drugs per hospitalisation is Rs. 2739 (58%), and on diagnostic tests is Rs. 985 (20%). (TE - Rs. 4720). This also indicates towards low availability of medicines and diagnostics in government hospitals.

In response to the study’s preliminary findings, a senior health official had indicated that prima facie might appear as a procurement problem. However, it is rooted in not having a robust supply chain management and indenting system.

3.2.1.2 Recommendations

- Conduct an assessment of the functional efficiency of procurement and supply chain management. The assessment would include procurement and supply chain audit, demand forecasting from
facilities, and tendering and quality management processes.

- The different institutional arrangements can also be considered for strengthening JKMSCL through cross-learning from States such as Kerala (KMSCL) or Rajasthan (RMSCL). Both these medical supplies corporations have set up systems for procurement of diagnostic equipment, including defining specifications of diagnostic equipment, rate contracts, installation support, annual maintenance contracts, biomedical maintenance training support to public institutions and operating tertiary care equipment through the PPP model. Institutional cross-learning and technical support can be availed from these medical services corporations can be used to set up an Equipment Procurement Cell for the UT.

- Performance monitoring for JKMSCL to expedite NOC approval has to be created and implemented for seamless procurement. Automating the NOC application and approval process could be implemented to expedite approvals and enhance systemic transparency.

- Procurement of diagnostics involves multiple complexities due to the increasing number of medical equipment, differences in specifications, quality control, tendering processes and provision of after-sales services of the equipment procured. Both JKMSCL and the CMOs are not well equipped to understand the complexities of diagnostic equipment procurements. Hence the strategy should first focus on improving the ecosystem capacity to undertake diagnostic procurement through JKMSCL, and the UT can learn the best practices from other procurement corporations like KMSCL of Kerala, which procures a range of equipment starting from a simple weighing machine to high-end equipment like MRI Scanners, Linear Accelerators, etc.

- In the meantime, diagnostic services can be outsourced to the private sector through a transparent contracting mechanism so that service delivery is not hampered in public facilities.

### 3.2.2 Infrastructure

#### 3.2.2.1 Quantitative and qualitative findings

- The Rural Health Statistics (RHS) 2019 suggests that the Union Territory of Jammu & Kashmir has a surplus of the health centre and hospital buildings compared to the requirement calculated per the Indian Public Health Standards.

- About 65% of the rural health centres are functioning through rented buildings. This directly impacts service delivery, generating awareness through branding and other linked activities.

- While most health centres have basic facilities such as regular water and electricity supply, the same is still a challenge in about 30% of the rural health centres (RHS 2019).

#### Table 4: Building position of health facilities as on 31.03.2022

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Required</th>
<th>Total functioning</th>
<th>Functioning in</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Govt. building</td>
<td>Rented building</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number</td>
<td>% of Total functioning</td>
<td>Number</td>
</tr>
<tr>
<td>Rural area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub centre</td>
<td>2042</td>
<td>2470</td>
<td>872</td>
<td>35%</td>
<td>1598</td>
</tr>
<tr>
<td>Primary health centre</td>
<td>333</td>
<td>923</td>
<td>714</td>
<td>77%</td>
<td>209</td>
</tr>
<tr>
<td>Community health centre</td>
<td>83</td>
<td>77</td>
<td>77</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Urban area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary health centre</td>
<td>80</td>
<td>49</td>
<td>22</td>
<td>45%</td>
<td>27</td>
</tr>
</tbody>
</table>

- The health budgets, including the Treasury and the NHM, show a moderate to low utilization of funds under the infrastructure heads. The NHM budget analysis highlights increasing unspent balances under the infrastructure heads in the last three years.
Multiple officials pointed out that “(staff) quarters are required in health centres in the far-flung areas, even CMO office/quarters are in dilapidated condition”.

The District Gap Analysis report published by UNICEF in 2022 highlights that the functionality and maintenance of the health facilities in J&K need to be improved.

A DDO pointed out that “the existing health centres in Government-owned buildings are in dilapidated condition and demand maintenance and upkeep”.

Commenting on the issue of the requirement of maintenance and repairs of the government-owned building, one of the officials stated, “the DDOs are ignorant of funds available from different sources that can be used for undertaking minor repair and maintenance works. Rather than depending solely on the treasury funds, they can propose such activities under NHM”.

Approvals for infrastructure and works face considerable delays across levels. One of the officials from the planning division stated, “sometimes administrative approval is awaited, or some technical sanction regarding some activities is awaited”. He also emphasized that “even though sometimes there is the good pace of expenditure, but somewhere there is some fault regarding some codal formalities resulting in delayed payment by treasury” Another official stated that “there is no engineering division in the directorate, the in-house executive agency is required”. There is heavy dependency on the UT-level engineering department officials as there is no in-house capacity.
3.2.2.2 Recommendations

- Draw attention to improving the condition of government-owned health centre buildings. Train DDOs to undertake minor repair and maintenance work for the upkeep of the health centres. The funds available in the Hospital Development Fund can be effectively utilised for the maintenance and upkeep of health centres by the DDO’s.

- Health infrastructure planning and development is done by the Public Works Department, and this involves inter-departmental administrative approvals leading to delays in Capex budget utilisation. Hence, it is recommended to develop an annual infrastructure plan at the CMO level, considering the availability of funds from different sources and the quality standards for public hospitals.

- An important recommendation during the consultative meeting was to establish an in-house engineering wing in the health department to reduce dependency on technical approval processes for infrastructure projects. The UT Government is reported to have initiated working on similar lines.

- Put a prospective mechanism for ascertaining budget reappropriation needs at the RE stage and ascertain the scope for optimizing approvals process flow.

3.2.3 Human resources

The health sector is human resource-intensive. Therefore, the availability and capacity of its human resources impact the health sector’s performance. This is true for all human resources, including the medical, paramedical, accounting, and financial management staff.

3.2.3.1 Quantitative and qualitative findings

- The staff position concerning the medical and paramedical workforce in J&K seems adequate in number as per the RHS 2019–20. However, many positions remain vacant across all medical and paramedical staff categories. Discussion with key stakeholders also suggests scope for strengthening the human resource availability in the Jammu Division, primarily in rural areas.

### Table 5: Status of human resources for health in J&K (RHS 2019)

<table>
<thead>
<tr>
<th>Category</th>
<th>Jammu &amp; Kashmir (Rural)</th>
<th>Required</th>
<th>Sanctioned</th>
<th>In position</th>
<th>Vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists (surgeons, OB&amp;GY, physicians &amp; paediatricians)</td>
<td></td>
<td>308</td>
<td>321</td>
<td>230</td>
<td>91</td>
</tr>
<tr>
<td>General duty medical officers (GDMOs) - allopathic (CHC)</td>
<td></td>
<td>154</td>
<td>729</td>
<td>571</td>
<td>158</td>
</tr>
<tr>
<td>Doctor (PHC)</td>
<td></td>
<td>923</td>
<td>1477</td>
<td>940</td>
<td>537</td>
</tr>
<tr>
<td>AYUSH specialist</td>
<td></td>
<td>77</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>General duty medical officers (GDMOs) - AYUSH</td>
<td></td>
<td>-</td>
<td>23</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td>AYUSH doctors</td>
<td></td>
<td>-</td>
<td>489</td>
<td>569</td>
<td>-</td>
</tr>
<tr>
<td>Nursing staff</td>
<td></td>
<td>1462</td>
<td>1815</td>
<td>1385</td>
<td>430</td>
</tr>
<tr>
<td>Health worker (female) / ANM</td>
<td></td>
<td>3393</td>
<td>5000</td>
<td>4511</td>
<td>489</td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td>1000</td>
<td>1289</td>
<td>1058</td>
<td>231</td>
</tr>
<tr>
<td>Laboratory technician</td>
<td></td>
<td>1000</td>
<td>1004</td>
<td>882</td>
<td>122</td>
</tr>
</tbody>
</table>

- The financial data analysis also indicates expenditure gaps increasing over the years, indicating limited utilisation and stagnation due to recruitment challenges. The fund utilisation under the NHM has not been more than 75% in the last three years.
• The interviews repeatedly highlighted that there is a shortage of accounting staff in the health department. One of the officials stated, "after NHM coming in, picture infrastructure has improved a lot, but we don't have ample human resources to maintain that infrastructure". Another official reported, "there is a shortage of staff with a finance background; new posts need to be created for Accounts Officers".

• The DDOs and their supporting clerk are neither trained in accountancy nor are well acquainted with the software applications used for regular accountancy work at different levels within the health department. An interview stated that "non-finance people are managing the DDO roles and they don't have finance and accounting background, so they face issue in working on that position. DDOs should be made aware of their powers. They should be given the training to understand the procurement processes".

• Moreover, with the increasing digitisation of office work, the senior staff faces challenges using the software applications. It is therefore shifting the burden to the contractual staff hired under NHM. During the interview, one of the DDOs at the district level stated that "Computer knowledge people (are) required, older staff (are) not much proficient".

• To increase the complexity further, it was informed that the UT had not conducted any training programs with respect to financial management, GFR guidelines, FMIS such as PFMS portal, BEAMS etc., and computer operation for the past several years (especially of the finance and accounts staff) and some have never been trained but have been given responsibility. One of the officials stated, "need of capacity at every level due to evolvement of the financial systems. The accounts managers are stuck to routine activities. They do not know about differential financing, time management".

• Long delays in salaries (only of NHM Staff) have also impacted the morale of the staff. One of the block level officials pointed out, "there are delays of up to 2 months in salary disbursement due to unavailability of funds".

• The introduction of the Single Nodal Agency (SNA) for the Central Sponsored Schemes such as NHM has brought the concept of virtual money with the opening of zero balance accounts for all the health institutions up to the lowest level. SNA is implemented at the lowest facility level (PHC and HSC).
However, these institutions neither have the infrastructure nor the staff to make the financial transaction using SNA. The burden of making the financial transactions for all these institutions will now come to the respective Block Accounts Manager, who is also responsible for making the transaction at the Block CHC.

3.2.3.2 Recommendations

- Conduct a detailed analysis of the current work profile to understand the scope for streamlining the roles and responsibilities of the DAM and BAMs.
- To reduce the work burden of BAMs, it is recommended to introduce a new position for facility-level accountants. Many states in India have this position under NHM, which could be funded through NHM in J&K. It may not be necessary to have an accountant at all the PHCs. Phase-wise expansion according to the need is advisable.
- The guidelines prescribed for the various financial aspects in the existing GFR are generic. GFR should be the guiding document; however, there should be a separate department-wise manual that caters to the requirement of the respective department.
- Empower the DDOs with requisite knowledge and skills in accounting, financial management and GFR for effective decision-making at their level.
- The UT is facing issues filling the vacant positions for the medical, para-medical and administrative categories working under the health department. It is therefore imminent to adopt a rational deployment approach in the placement and transfers of human resources,
- **Building financial management capacity**: Training of Trainers (TOT) on improving capacity on financial and accounting processes and guidelines for project implementation.
  - **For finance personnel**: There is a need for capacity at every level due to the evolvement of the financial systems. The financial management guidelines are being revised from time to time. Further, the accounts managers are stuck to their routine activities. They are not aware of differential financing, time management etc. Hence a financial management module needs to be developed, and training must be imparted to all the finance personnel working in the health department. Training on SNA also has to be imparted to the Financial Management and Accounting staff.
  - **For DDOs**: As most of the DDOs working under the health department are doctors, they are unaware of the financial management systems. Hence, they require training with respect to the financial management guidelines, GFR and operation of monitoring software (PFMS and BEAMS).
- **Procurement cycle**: The absence of a proper procurement planning process has hindered the optimal utilisation of the procurement budget by the DDOs, especially for the equipment budget. Although funds are being released timely as per the ceilings prescribed by the finance department, i.e. 75% of the budget is being released before the end of Q3. However, the delay in the procurement planning results in major procurements being pushed to Q4 and subsequent lapse of money due to a shortage of time for fulfilment of the codal formalities and release of funds for procurement. Hence, the DDOs require training to plan for the annual procurement cycle to avoid lapse of funds budget for procurement.
- **Government e-Marketplace**: GFR has made it mandatory to carry out all the procurement activities through the GeM portal only. However, most DDOs and dealing assistants are unaware of all the features available in GeM. E.g., filter for a local supplier, choose desired specifications etc. Hence, comprehensive training on the GeM portal is required for all the officials involved in procurement activities under the health department.

3.2.4 Software and technology

3.2.4.1 Budget estimation allocation monitoring system

The Government of Jammu & Kashmir introduced Budget Estimation Allocation Monitoring System (BEAMS) to make a paperless system with the objective of distributing the budget and to authorize expenditure. This system would therefore be used as a tool for easy coordination between different Officials/ users through a web-based platform. It would also considerably reduce administrative delays and make the budget-related information available on a real-time basis which is, in fact, a revolutionary step in technological advancement. This system permits the withdrawal/surrender of budget grants. The system provides a limited facility to modify cash flows. Management Information System (MIS) within the reporting System gives various reports on budget authorizations, cash flows, fund transfer transactions and authorization slip generation. The BEAMS application has a wide scope compared to the manual budgeting process, which lacks
transparency and is construed with difficulties due to time delay in authorizations, ineffective monitoring and budget control mechanism. The new system offers greater flexibility of inputs and, in return, the process for greater emphasis on outputs and performance. The BEAMS application enables one to view budget allocation instantly without any time delay, just at the click of a button. The flow of information is very reliable, accurate and fast, enabling better monitoring, control and a sustainable decision support system for better planning and expenditure audit. The BEAMS has inbuilt tools enabling internal budget control and external interface.

There are various levels of Budget Estimation and Data exchange. The information flows from one level to another in a bidirectional manner. The Budget formulation involves from the actual base unit of expenditure incurring authority to the highest level, which authorizes the expenditure that is Legislature of the Union territory of Jammu & Kashmir.

![Fig. 22: Information flow in BEAMS](image)

**Comprehensive use of BEAMS**

In the BEAMS system, there is a separate provision for preparing budget estimates in the prescribed formats, allocating funds to different departments after proper approval, and monitoring expenditure on a real-time basis directly from the treasury system. Through this system, expenditure progress can be monitored monthly under all the heads of accounts, from the detailed head to the major head of account department-wise, to ensure better fund utilization management and liquidity management. The BEAMS system is also used to monitor the anticipated excess/ surrender position so that the decision to withdraw funds or re-allocate under a different head of account is taken.

The system also enables the generation of various statements, which are vital from the management's perspective and facilitates building a constructive Management Information System which could be explored for effective performance appraisal and valuable for implementation of zero-based Budgeting and performance-based Budgeting system. The BEAMS application is integrated with the Treasury Net and the JK Pay-Sys application, an efficient and effective Integrated Financial Management System in the Union territory of Jammu and Kashmir for better public delivery and governance system. The BEAMS application has the potential to be integrated with the Public Financial Management System (PFMS) application to obtain information on each Centrally Sponsored Scheme and its corresponding Union territory Share to be adopted for distribution through BEAMS.

**Findings**

- The performance monitoring system of BEAMS is not adequately used by the DDOs for periodic monitoring and understanding of the issues in the low utilisation of specific budget heads.
- BEAMS is used for planning revenue (recurrent) budget only and not for planning CAPEX budget. The CAPEX figures are entered in BEAMS after the finalization of the budget.

**Recommendation**

- Provide training to the DDOs on the performance monitoring aspect of BEAMS so that they can analyse and improve upon the current utilisation status of their respective institution.
- Explore the possibility of planning the CAPEX budget through BEAMS to expedite the approval process and enable real-time monitoring.

3.2.4.2 **EMPOWERMENT**

Empowerment is an initiative launched by the Government of J&K to bring transparency in the execution of
3.2.4.3 Photographic reporting of on-site facilities

It is a mobile application to monitor the progress of all the works allocated to different DDOs of different departments. It gives a pictorial view of the work along with its geographical coordinates, i.e., latitude and longitude and user comments on work progress. The CPIS number of the concerned employee authorised by the DDO to take a photograph is used for logging in to the PROOF application to ensure the authenticity of the photographs.

3.2.4.4 MeraVetan App

Employees of UT of the Jammu and Kashmir government were fully dependent upon DDOs for knowing their salary details, and a lot of paper was wasted on printing salary slips by DDOs. With the introduction of the MeraVetan App, the dependency on DDOs is now negligible, and a lot of paper usage is saved in the process. Once the app is installed on the mobile employees using credentials, one can view the salary details by selecting a particular month and year. Employees can see his total deductions, total allowances, net and gross amount of salary, along with other details.

3.2.4.5 GeM Portal

Government e-Market Place or GeM (more popularly known) is a Government of India's e-platform for government buyers and private sellers. GeM ensures that items are supplied at rates below the open market. Earlier procurement was being carried out through an open tendering and rate contract system. However, GFR is now mandated to make all the procurements through the GeM portal. If something is unavailable in GeM, then procurement can be done through other modes upon receiving a non-availability Certificate from the portal. Following are the major concerns with respect to procurement through the GeM portal:

- The central procurement agency will lose its importance if it has to procure only through GeM. GeM is most suitable as an alternative for health facility level procurement.

- GeM does not have the facility of a rate contract which would be valid for a particular period. If a rate contract is entered, the purchase can be made throughout the year based on actual requirements. In the case of GeM, the bidding process would take 2–3 months and is a one-time purchase. The institution has to go through all the processes in GeM multiple times if the same equipment is purchased more than once during the year.

- The quality offered by GeM is sometimes not good. One of the officers stated, "there is a full proof mechanism for procurement of equipment by JKMSCL. First tendering will be sone, then technical bids will be received; there is a technical evaluation/demonstration stage where experts throughout the UT are called for demo. They interact with the supplier, see the machinery, and in case of any query, the same is sorted. Many suppliers get disqualified as per the expert's opinion. JKMSCL has no role in finalizing the supplier. The high quality of the product is ensured. There is no option for sampling/demonstration/ expert opinion is GeM".

- Most of the drugs are not available on GeM. Hence procurement is done through the old procedure of rate-contract.

- One of the DDOs said, "Procurement through GeM is costlier than local, supply also delayed 20 to 30 days."
Recommendations: potential pathways towards better UHC outcomes

- Assess the pool of resources available at the District/Block level through different sources. Using the results of the assessment, orient and sensitize the DDOs for the monitoring and optimal utilisation of funds. This will help empower the DDOs for better decision making resulting in improved fund utilisation.
- Instances of good practices for monitoring through informal channels are highly appreciated. However, it is important to learn from such instances and institutionalize accountability and monitoring feedback routes. Using available easy-to-use technology for operationalising such monitoring and feedback routes could be explored.
- Financial Management capacity is pivotal for any sector to progress efficiently. Therefore, enhancing the capacity for financial management at all health system levels is essential. An in-house team of trainers should be created at the UT level for conducting training for recruits and periodic refresher training for the existing staff.
- Develop comprehensive UHC policy to help align financial management systems with catering to the service delivery needs.
### Annexure 1: List of interviews conducted

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name</th>
<th>Designation</th>
<th>Organization</th>
<th>Administrative level</th>
<th>Tool used</th>
<th>Date of interview</th>
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<tr>
<td>1</td>
<td>Shri Shafaat Yehya</td>
<td>Joint Director, Budget</td>
<td>Budget Division, DoF</td>
<td>UT HQ</td>
<td>DoF</td>
<td>12.11.2021</td>
</tr>
<tr>
<td>2</td>
<td>Shri Sabir Ahmed</td>
<td>Asst. Account Officer</td>
<td>Budget Division, DoF</td>
<td>UT HQ</td>
<td>DoF</td>
<td>24.11.2021</td>
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<td>3</td>
<td>Shri Ravinder Rana</td>
<td>Assistant Director Planning</td>
<td>Government Medical College, Jammu</td>
<td>Divisional HQ</td>
<td>Provider</td>
<td>17.11.2021</td>
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<td>4</td>
<td>Shri Mubarak Ahmad</td>
<td>S.O. Planning</td>
<td>District Planning Cell, Budgam</td>
<td>District</td>
<td>Provider</td>
<td>13.11.2021</td>
</tr>
<tr>
<td><strong>Department of Health &amp; Medical Education</strong></td>
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<td><strong>Kashmir division</strong></td>
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<td>5</td>
<td>Dr Mohal Lal</td>
<td>Mission Director</td>
<td>National AYUSH Mission</td>
<td>UT HQ</td>
<td>DoHME</td>
<td>18.11.2021</td>
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<tr>
<td>6</td>
<td>Shri Aakeb Rather</td>
<td>State Account Manager</td>
<td>National AYUSH Mission</td>
<td>UT HQ</td>
<td>DoHME</td>
<td>18.11.2021</td>
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<tr>
<td>7</td>
<td>Shri Umar Khan</td>
<td>Financial Advisor/Chief Accounts Officer</td>
<td>JKMSCL</td>
<td>UT HQ</td>
<td>DoHME</td>
<td>22.11.2021</td>
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<tr>
<td>8</td>
<td>Shri Feroze Ahmed Mir</td>
<td>Financial Advisor/Chief Accounts Officer</td>
<td>DHS, Kashmir Division</td>
<td>Divisional HQ</td>
<td>DoHME</td>
<td>23.11.2021</td>
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<tr>
<td>9</td>
<td>Prof Dr Samia Rashid</td>
<td>Principal</td>
<td>Government Medical College, Srinagar</td>
<td>Divisional HQ</td>
<td>Provider</td>
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<td>10</td>
<td>Smt. Sabreena Kadir</td>
<td>Chief Accounts Officer</td>
<td>Government Medical College, Srinagar</td>
<td>Divisional HQ</td>
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</tr>
<tr>
<td>11</td>
<td>Dr Tajamul Hussain</td>
<td>Chief Medical Officer</td>
<td>CMO office, Budgam</td>
<td>District</td>
<td>Provider</td>
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<tr>
<td>12</td>
<td>Shri Bashir Ahmad</td>
<td>Sr Assistant</td>
<td>CMO office, Budgam</td>
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<td>13</td>
<td>Shri Nisar Nabi Wani</td>
<td>District Program Manager (NHM)</td>
<td>CMO office, Budgam</td>
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<td>Provider</td>
<td>13.11.2021</td>
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<tr>
<td>14</td>
<td>Shri Inayatullah Zaffar</td>
<td>District Accounts Manager (NHM)</td>
<td>CMO office, Budgam</td>
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<tr>
<td>15</td>
<td>Dr Mohammad Ayoub Fateh Khan</td>
<td>Medical Superintendent</td>
<td>District Hospital, Budgam</td>
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<td>Provider</td>
<td>13.11.2021</td>
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<tr>
<td>16</td>
<td>Smt. Asmat Jan</td>
<td>Accounts Manager (NHM)</td>
<td>District Hospital, Budgam</td>
<td>District</td>
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<td>13.11.2021</td>
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<tr>
<td>17</td>
<td>Dr Arshid Qadri</td>
<td>Block Medical Officer</td>
<td>Khansahib CHC, Budgam</td>
<td>Block</td>
<td>Provider</td>
<td>13.11.2021</td>
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<tr>
<td>18</td>
<td>Shri Mohammad Shafi</td>
<td>Block Monitoring &amp; Evaluation Officer (NHM)</td>
<td>Khansahib CHC, Budgam</td>
<td>Block</td>
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<td>13.11.2021</td>
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<tr>
<td>19</td>
<td>Shri Muqeeem Fazli</td>
<td>Block Account Manager (NHM)</td>
<td>Khansahib CHC, Budgam</td>
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</tr>
<tr>
<td>20</td>
<td>Shri Mushtaq Ahmad</td>
<td>Block Monitoring &amp; Evaluation Officer (NHM)</td>
<td>Zadibal CHC, Srinagar</td>
<td>Block</td>
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</tr>
<tr>
<td>21</td>
<td>Shri Tariq Ahmad Khan</td>
<td>Block Account Manager (NHM)</td>
<td>Zadibal CHC, Srinagar</td>
<td>Block</td>
<td>Provider</td>
<td>12.11.2021</td>
</tr>
</tbody>
</table>
One district and one block in Kashmir and Jammu division were selected in consultation with higher authority.
Instructions for the Interviewer

The following is to be read verbatim to the respondent prior to the interview. If the subject then agrees to participate, you must sign on the line marked “Witness to Consent Procedures” at the end of this form. Also, mark the date on the appropriate line.

Purpose

You are invited to take part in the Public Finance Assessment (PFM) study, which aims to support the Department of Health & Medical Education, Jammu & Kashmir, in enhancing the effectiveness of public financing of the health sector. The main objective of the assignment is to identify the key issues and bottlenecks in how revenues are allocated and implemented in health, from top to frontline providers. The study will identify issues and challenges in budget formulation and execution that hinder the effective planning and use of budgeted resources in the health sector. Lessons learned from the study will inform the UT Government of Jammu & Kashmir about the recommendations to strengthen the public financial management system for better health outcomes.

Procedures

The interview will take about 1 to 1.5 hours of your time. With your permission, we will make a record of the interview. You do not have to answer any questions you feel uncomfortable with, and you are free to stop the interview anytime.

Risks/discomforts

We do not think being part of this project will create any risk for you. If you feel uncomfortable, do not want to answer a specific question, or decide you no longer want to participate, just let us know, and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The interview transcript will only be accessible to members of the project team, and they will not be allowed to share it with anyone else. The transcripts and all records will be kept confidentially.

VOLUNTARY PARTICIPATION

You do not have to agree to participate in this project, and you may change your mind anytime. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked)

PERMISSION TO PROCEED

Is it okay to proceed with the interview?

Voluntary participation

Witness to Consent Procedures (to be signed by interviewer after subject has verbally consented)

Date

Section A: General information

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<table>
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<tr>
<td>1</td>
<td>Interviewer</td>
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<tr>
<td>2</td>
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<td>3</td>
<td>Department</td>
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<td>Start time (hh: mm)</td>
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<td>End time (hh: mm)</td>
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</table>
Section B

To be administered with drawing and disbursement officer (medical college /district hospital /community health centre/primary health centre) /CMHO /district program manager /district accounts manager /block program manager /block accounts manager

1. Can you tell me about your role with the DoHME? Are you aware of the process of different aspects of the budget cycle (formulation, execution, monitoring) apart from your routine work? Are you involved in the budget cycle? If yes, what is your role in the budget cycle?

2. What do you think about the budget amount allocated to your health institution? Is the allocated annual budget to your institution enough to cover the cost relating to the volume of service output required? (Probe for whether they think the amount is enough, less or greater than their needs and the reasons?)

3. Is the annual budget calendar followed and given enough time for each health institution to participate in the process meaningfully?

4. Do you find the budget circulars sufficiently comprehensive and clear to correctly complete your contributions to the overall process and the health institution's budget? If not, do you get the needed support from the Dept. of Finance to help resolve issues?

5. What information do you receive regarding results, output targets, ceilings, and funding sources on which to base your planning? If not, how do you establish plans and budgets for your health institution? (Probe: Is past performance used to adjust targets for the current year?)

6. Do you receive any feedback from the DoHME against your budget proposals? If yes, whether the feedback is structured and documented.

7. When do you receive final confirmation of the expenditure budgets for the year?

8. What is the health institution's budget execution rate? What challenges does the health institution face in executing its budget? (Probe for specific areas under which challenges occur. Probe regarding flexibility in reallocation across priorities when needed, e.g., in a pandemic)

9. How are payments transferred to and received by the health institution? What are the administrative requirements to request and receive funds?

10. What are the major technical and operational issues you have faced with respect to the following information systems?
    a. PFMS / DBT (NHM).
    b. BEAMS.
    c. Treasurynet.
    d. JKPaySys.

11. Are payments to the health institution made on time and in full? (Probe: Are there delays in receipt of funds under NHM?)
    a. How does this impact the functioning of the lower levels?
    b. What is the impact of such delays on fund disbursement to the lower levels? (NHM)

12. Does the health institution hold cash? What are the policies related to cash management? Does the health institution maintain any bank account? Does the health institution have the authority to access and use the funds in these accounts?

13. Does the health institution carry out the procurement of drugs and equipment by itself? If so, what is the procurement process? How is non-medical procurement handled at the health institution? Does the health institution have the authority to enter into contracts with public and private suppliers?

14. How are the Salary and other HR payments handled in the health institution?

15. How much authority and flexibility does the health institution have to reallocate budget expenditures during the year? Are overruns incurred by the health institution compensated? If yes, how?

16. What is your role with respect to budget monitoring at the health institution? What data and information do you use for budget monitoring?

17. Which data are you able to automate from the available monitoring systems? What type of analysis is carried out by you?

18. What is the reporting mechanism? (Probe, what is the reporting cycle? How long does it take for budget
19. Are expenditures typically below budgeted target levels? If yes, describe the magnitude of underspending and the causes. If the expenditure is above the budgeted target levels, what are the areas of overspending?

20. Enlist the training you have received to date for financial management and implementation of PFMS software. What are your capacity-building needs?

21. How does the health institution manage the receipt from insurance schemes? Are they deposited with the treasury, or does the health institution utilize the same by itself?

22. What is your understanding of the recently implemented “Single Nodal Agency” function for PFMS payment under NHM? How do you think it will impact your autonomy towards budget execution under NHM? (Probe for suggestions for the improvement of the challenges identified).

Thank you for your time.

*Applicable only for DH / MCH / SDH*
The following is to be read verbatim to the respondent before the interview. If the subject agrees to participate, you must sign on the line marked "Witness to Consent Procedures" at the end of this form. Also, mark the date on the appropriate line.

**Purpose**

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**Procedures**

The interview will take about 1 to 1.5 hours of your time. With your permission, we will make a record of the interview. You do not have to answer any questions you feel uncomfortable with, and you are free to stop the interview anytime.

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**Voluntary participation**

You do not have to agree to participate in this project, and you may change your mind anytime. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked).

**Permission to proceed**

Is it okay to proceed with the interview?

**Voluntary participation**

Witness to Consent Procedures (to be signed by interviewer after the subject has verbally consented)

---

**Date**

**Section A: General Information**

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<thead>
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<th>8 Episode</th>
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<tr>
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<td>14</td>
<td>End time (hh: mm)</td>
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</table>
Section B

Question 1-12 for discussion with Director (Health Services / AYUSH / Medical Education) / Director Finance (DoHME) / State Program Manager (NHM)

23. Can you tell me about your role with the DoHME? How are you involved in the budget cycle?
24. How is the Budget Estimate for DoHME prepared? (Probe, on what basis is there a formula? Are there any targets? Allocation to Hospitals, dispensaries, PHCs, SCs, etc.)
25. In your opinion, is the allocation for the annual budget (BE) enough for the DoHME?
26. What share of public revenue for health is raised at the sub-national level? What share of this stays at that level?
27. What was the quantum of unutilized funds in the last few years?
   a. What are the areas of underutilization? (Probe: List top five areas, e.g., HR, Procurement, Infrastructure, etc.)
   b. What are the reasons for underutilization? (Probe: List the top five problems, e.g., non-availability of doctors, postings and transfers, defaulting contractors, etc.; revenue and capital budget execution)
28. Are you aware of any delays in the budget process in the disbursement of funds from the DoF to the DoHME?
   a. If yes, what reasons do you think caused these delays? (Ask for evidence)
   b. What mechanisms are in place to ensure that there are no delays?
29. Are you aware of any delays in the budget process in the disbursement of funds from the DoHME to the Hospitals / Health Centres?
   a. If yes, what reasons do you think caused these delays? (Ask for evidence)
   b. If not, what mechanisms are in place to ensure no delays?
30. How flexible can the budget-making process accommodate new ideas or start new initiatives? How do you take new ideas or initiatives forward? (Probe how resource requirement is estimated for new proposals?)
31. What is the budget monitoring and control mechanism? What is your role in this mechanism?
32. Is there an integrated financial management system for tracking the spending of the health department?
33. Are staff who perform finance tasks within the DoHME at subnational levels of government properly trained as accountants and economists?
34. What are the key capacity-building challenges of personnel who perform finance tasks at different levels of budget execution and monitoring systems?

Question 13-15 only for discussion with Procurement Manager / Nodal Officer

35. Who is responsible for pharmaceutical procurement? For other health care commodities? How are responsibilities split across levels of the system?
36. Are district health officers or public health facilities responsible for independently procuring pharmaceutical products?
37. What are the key issues and challenges in the procurement process?

Question 16-24 only for discussion with the state finance manager /state accounts manager (NHM)

38. What are the key programs/areas where there is low utilization of NHM funds? (Probe for programs and reasons for each program)
39. Whether the UT able to fulfil all the conditionalities with respect to the release of funds from the Government of India? (Probe if the full amount of central allocation is received or not?)
40. What is the impact of underspending / overspending over the next year’s budget allocation? If the budget is underspent, is the same carried forward to the next year?
41. What is your opinion about the adequacy of the finance/accounts staff and their knowledge of financial
Thank you for your time.

42. What is the status of implementing the single nodal account (SNA) in UT? What are the key bottlenecks you are facing in implementing SNA?

43. What are the key challenges in implementing the PFMS system/software in the UT?

Question 23-24 (Common for all)

44. What are the key challenges in the budget process? (Probe in budget making, execution and monitoring)

45. Do you have any recommendations for improving the budget process?
The following is to be read verbatim to the respondent before the interview. If the subject agrees to participate, you must sign on the line marked “Witness to Consent Procedures” at the end of this form. Also, mark the date on the appropriate line.

**Purpose**

You are invited to participate in the Public Finance Assessment (PFM) study, which aims to support the Department of Health & Medical Education, Jammu & Kashmir, in enhancing the effectiveness of public financing of the health sector. The assignment's main objective is to identify the key issues and bottlenecks in how revenues are allocated and implemented in health, from top to frontline providers. The study will identify issues and challenges in budget formulation and execution that hinder the effective planning and use of budgeted resources in the health sector. Lessons learned from the study will inform the UT Government of Jammu & Kashmir about the recommendations to strengthen the public financial management system for better health outcomes.

**Procedures**

The interview will take about 1 to 1.5 hours of your time. With your permission, we will make a record of the interview. You do not have to answer any questions you feel uncomfortable with, and you are free to stop the interview anytime.

**Risks/discomforts**

We do not think being part of this project will create any risk for you. If you feel uncomfortable, do not want to answer a specific question, or decide you no longer want to participate, just let us know, and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The interview transcript will only be accessible to members of the project team, and they will not be allowed to share it with anyone else. The transcripts and all records will be kept confidentially.

**Voluntary participation**

You do not have to agree to participate in this project, and you may change your mind anytime. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked).

---

**Annexure 4: PFM assessment tool for Department of Finance**

**Public financial system assessment**

**Qualitative interviews - department of finance**

**Key informants**

**Instructions for the interviewer**

---

**Date**

I. **General information**

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<table>
<thead>
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<tbody>
<tr>
<td>15</td>
<td>Interviewer</td>
</tr>
<tr>
<td>16</td>
<td>Name of respondent</td>
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<tr>
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</tr>
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<tr>
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<td>Start time (hh: mm)</td>
</tr>
<tr>
<td>21</td>
<td>End time (hh: mm)</td>
</tr>
</tbody>
</table>
Section B
To be administered with AGCA / Joint Director (Budget) / Chief Accounts Officer

46. Can you tell me about your role with the DoF?
47. How are you involved in the budget process for the DoHME?
48. On what basis is the Budget Estimate (BE) for the health sector decided for the annual budgeting process? (Probe: What is the major source of revenue/fund flow for the health sector in Jammu & Kashmir (tax / non-tax / CSS / DP etc.?)
49. Is there legislation that mandates targets or ceilings for the health sector?
50. What is the negotiation process between the DoF and DoHME? (Probe: Who is involved? When does the budget process start? How long does it take? What happens during the negotiation process?)
51. Is there institutionalized coordination between the programme planning and the budgeting process? (Probe: At Which level? Is there a process to review health service/programme prioritization?)
52. How many officials/administrative layers at different levels are involved in the budget cycle?
53. Are you aware of any delays in the disbursement of funds from DoF to DoHME?
   a. If yes, what reasons do you think caused these delays?
   b. What mechanisms are in place to ensure that there are no delays?
54. What are the norms for monitoring budget execution of the health budget? (Probe: What data and information are used for budget monitoring?)
55. Is there a need to link different finance software solutions used in the UT?
56. What are the key challenges across these public finance management systems?
57. What is the status of implementing the single nodal account (SNA) in UT? What are the key bottlenecks you are facing in implementing SNA?
58. Has an in-depth diagnosis/assessment of health-sector-specific PFM bottlenecks been recently conducted, e.g., within the last 3–5 years?
59. What are the key capacity-building challenges of personnel who perform finance tasks at different levels of budget execution and monitoring systems?
60. Do you have any recommendations for how to improve the budget process? (Specifically, to address delays in funds and/or leakages of funds)

Thank you for your time.
The following is to be read verbatim to the respondent before the interview. If the subject agrees to participate, you must sign on the line marked “Witness to Consent Procedures” at the end of this form. Also, mark the date on the appropriate line.

**Purpose**
You are invited to participate in the Public Finance Assessment (PFM) study, which aims to support the Department of Health & Medical Education, Jammu & Kashmir, in enhancing the effectiveness of public financing of the health sector. The assignment's main objective is to identify the key issues and bottlenecks in how revenues are allocated and implemented in health, from top to frontline providers. The study will identify issues and challenges in budget formulation and execution that hinder the effective planning and use of budgeted resources in the health sector. Lessons learned from the study will inform the UT Government of Jammu & Kashmir about the recommendations to strengthen the public financial management system for better health outcomes.

**Procedures**
The interview will take about 1 to 1.5 hours of your time. With your permission, we will make a record of the interview. You do not have to answer any questions you feel uncomfortable with, and you are free to stop the interview anytime.

**Risks/discomforts**
We do not think part of this project will create any risk for you. If you feel uncomfortable, do not want to answer a specific question, or decide you no longer want to participate, just let us know, and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The interview transcript will only be accessible to project team members, and they will not be allowed to share it with anyone else. The transcripts and all records will be kept confidentially.

**Voluntary participation**
You do not have to agree to participate in this project, and you may change your mind anytime. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked).

**Permission to proceed**
Is it okay to proceed with the interview?

**Voluntary participation**
Witness to Consent Procedures (to be signed by interviewer after the subject has verbally consented)

---

### Instructions for the interviewer

The following is to be read verbatim to the respondent before the interview. If the subject agrees to participate, you must sign on the line marked “Witness to Consent Procedures” at the end of this form. Also, mark the date on the appropriate line.

### Purpose
You are invited to participate in the Public Finance Assessment (PFM) study, which aims to support the Department of Health & Medical Education, Jammu & Kashmir, in enhancing the effectiveness of public financing of the health sector. The assignment's main objective is to identify the key issues and bottlenecks in how revenues are allocated and implemented in health, from top to frontline providers. The study will identify issues and challenges in budget formulation and execution that hinder the effective planning and use of budgeted resources in the health sector. Lessons learned from the study will inform the UT Government of Jammu & Kashmir about the recommendations to strengthen the public financial management system for better health outcomes.

### Procedures
The interview will take about 1 to 1.5 hours of your time. With your permission, we will make a record of the interview. You do not have to answer any questions you feel uncomfortable with, and you are free to stop the interview anytime.

### Risks/discomforts
We do not think part of this project will create any risk for you. If you feel uncomfortable, do not want to answer a specific question, or decide you no longer want to participate, just let us know, and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The interview transcript will only be accessible to project team members, and they will not be allowed to share it with anyone else. The transcripts and all records will be kept confidentially.

### Voluntary participation
You do not have to agree to participate in this project, and you may change your mind anytime. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked).

### Permission to proceed
Is it okay to proceed with the interview?

### Voluntary participation
Witness to Consent Procedures (to be signed by interviewer after the subject has verbally consented)

---

### Date

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<tr>
<td>23 Name of respondent</td>
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<td>24 Department</td>
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<td>25 Designation</td>
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<td>26 Date of interview</td>
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<tr>
<td>27 Start time (hh: mm)</td>
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<td>28 End time (hh: mm)</td>
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Section B
To be administered with Additional Chief Secretary (Finance / Health), Mission Director (NHM), Chief Executive Officer (SHA)

1. Does the UT have a comprehensive and up-to-date Universal Health Coverage policy/plan covering at least the coming three years? What are the main health sector objectives, targets, key public programmes, and priorities the UT is working towards?

2. How sufficient and stable has been the allocation to the health sector to meet stated health sector policy /strategy objectives? Are fiscal projections of actual resources in line with policy priorities and future needs?

3. Is the health sector plan and/or UHC plan fully cost, and corresponding funding sources for all the areas, programs, priorities, facilities, and services for each year have been identified? (Probe for MTEF assessment)

4. What are the key bottlenecks in the utilization of health sector budgets, both UT programs and centrally sponsored schemes /programs? (Probe: what are the key challenges faced in providing facility-based services? Human Resources, Infrastructure, Drugs & Consumables, Equipment & Instruments, Poor Demand, Procurement process)

5. What is your perspective on the integration of existing mechanisms to monitor budget execution? (Probe for BEAMS, PFMS, Treasury Net)

6. What is your opinion about the advantages and disadvantages of implementing a single nodal account (SNA) in UT?

7. Any other suggestions?

Thank you for your time.

Annexure 6 - Object head-wise trend lines

Fig. 23 : Trend for BE/RE/AE under salary head

<table>
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Fig. 24: Trend for BE/RE/AE under works head

![Graph showing trend for BE/RE/AE under works head]

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<thead>
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Fig. 25: Trend for BE/RE/AE under grant in Aid head

![Graph showing trend for BE/RE/AE under grant in Aid head]

<table>
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<td>2019-20</td>
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<td>365</td>
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Fig. 26: Trend for BE/RE/AE under drugs and instruments head

![Graph showing trend for BE/RE/AE under drugs and instruments head]

<table>
<thead>
<tr>
<th>Year</th>
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<td>2019-20</td>
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Fig. 27: Trend for BE/RE/AE under stipend and scholarship head

Fig. 28: Trend for BE/RE/AE under machinery and equipment head

Fig. 29: Trend for BE/RE/AE under electricity charges head
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<th>Data sources</th>
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| Policy and strategy                   | • J&K Reorganization Act 2019  
• 15th finance commission report  
• Fiscal responsibility and budget management Act (FRBM Act), 2003 (National) and 2006 (for J&K)  
• Health policy/ SDG progress report |
| Revenue for the health sector          | • Economic survey  
• State finances: Reserve Bank of India  
• Annual financial statement  
• NHM PIP  
• SHA annual report |
| Budget formulation                    | • Budget manual  
• Budget circular  
• Budget speech  
• Detailed demand for grants  
• State program implementation plan, NHM  
• District health action plan, NHM  
• State record of proceedings (RoP), NHM  
• District program implementation Plan, NHM |
| Budget execution and payment          | • Budget manual  
• Jammu & Kashmir financial code-Vol-I, 2006  
• E-procurement system, Govt. of J&K  
• Operational guidelines for financial management - NRHM, 2012 |
| Budget monitoring                     | • Budget allocation expenditure management system (BEAMS)  
• National finance and accounts management system (NFAMS)  
• Outcome budget  
• Performance budget |
| Accountability mechanism              | • Performance audit report by CAG  
• Statutory audit (audit observations & action taken report)  
• Concurrent audit (audit observations & action taken report) |
| Financial management information systems | • Budget allocation expenditure management system (BEAMS)  
• Public financial management system (PFMS) portal  
• National finance and accounts management system (NFAMS) |
References


9. Detailed Demand for Grants, Department of Health & Medical Education, Jammu & Kashmir. Available at : https://jakfinance.nic.in/budgetnew.html


NHM Administrative Approval FY 2021-22 Jammu & Kashmir; Available at: https://nhm.gov.in/index4.php?lang=1&level=0&linkid=48&lid=61
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Public financial management system is a key component of ensuring efficiency and effectiveness within the health financing architecture. Given Jammu & Kashmir’s stated policy objective of transitioning to UHC, a review and strengthening of its PFM system, to better align with UHC and health financing goals, is essential.