Availability and Accessibility of Health Protection Policies in Jammu and Kashmir: An Analysis of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

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ABSTRACT:

Social Health Protection (SHP) is a human right to health, and India's Pradhan Mantri Jan Arogya Yojana (PM-JAY) is one of the world's largest informal sector-based SHP Policy (SHPP). Unlike other Indian states/UTs, PM-JAY was made "Completely Universal" in Jammu and Kashmir (J&K) in December–2020. This paper examines the availability and accessibility outcomes of this SHPP, based on a Mixed–Methods study of 300 Households and 30 Secondary-Stakeholders from Kashmir, J&K. The paper argues that PM-JAY has significantly increased the availability of healthcare services across districts – hospitals, doctors, medicine, equipment and diagnostic-testing facilities. Provided treatment with respect and dignity and changed the utilization pattern towards specialized healthcare. While the private sector has contributed, the availability and reliance are more on public hospitals. All socio-economic, geographical and gender diversities have accessed PM-JAY, with higher proportion of vulnerable groups among benefitted, and no signs of access inequality. Notwithstanding, some scattered issues continue to persist. The paper contends that PM-JAY as a universal SHPP has demonstrated wider coverage and inclusivity in J&K. However, for large-scale and sustained availability and equitable access, strengthening registration system, deeper awareness generation and CSO engagement, quality control, and expansion of empaneled hospitals, public transport and ambulance service in far-flung Rural and Tribal areas needs to be prioritized.

Keywords: *Social Health Protection, Availability, Accessibility, Jammu and Kashmir.*

INTRODUCTION

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Social Health Protection (SHP) is grounded in the human right to health and social security and SDG 3.8 (ILO, 2020; World Bank, 2021). It aims to achieve universal access for all by alleviating Out-of-Pocket Health Expenditure (OOPHE) and indirect health costs – losing savings, selling assets, and borrowing money (ILO, 2022). Globallaround 400 million people lack access to essential health services, with a majority from low income and fragile countries (World Bank, 2015). Informal and unorganized workers, especially women, face a higher risk of falling into poverty due to unforeseen expenses (GIZ, 2020). This makes universal SHP coverage critical (Cotlear, Nagpal, Smith, Tandon, & Cortez, 2015). Most of the developing and fragile countries lack universal SHP, however, several of them have some form of Social Health Protection Policies (SHPPs) in place. The evidence suggests that they have achieved better health protection, increased labor productivity, and broken the cycle of ill health and poverty (Adlung, 2014; ILO, 2020), however, at the same time there are still many policy and research gaps to be addressed.

In India, SHP coverage was mostly formal sector-based until 2008 when Rashtriya Swasthya Bima Yojana (RSBY) was launched and extended as National SHPP to cover the unprotected informal population (Forgia & Nagpal, 2012; GIZ, 2020). Although the policy was large in reach, its financial coverage was only Rs. 30,000 per household (HH), limited to 5 HH members, and excluded some marginal groups (Gopichandran, 2019). Hence, RSBY was replaced by Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018, with a target of 100 million poor families and an annual coverage of Rs. 500,000 to the entire insured family. It covers 1,393 procedures for secondary and tertiary treatment, with 3 days of pre and 15 days post-hospitalization expenses. This made PM-JAY one of the largest SHPPs in the world (Gopichandran, 2019). The initial evidence of PM-JAY (in Section 2.2) in a diversely populated country suggests mixed outcomes leaving a lot of scope of further research.

In Jammu & Kashmir (J&K) after RSBY, PM-JAY was also extended, but in December 2020 a landmark decision from the Prime Minister made it ‘Completely Universal’ – ‘universal coverage irrespective of economic background (rich or poor) and geographies.’ With this J&K became the first state/UT in India with such a SHPP. How has this “Completely Universal” SHP done in the politically fragile UT of J&K remains an unanswered question. This paper contributes to addressing these research gaps by examining the availability and accessibility outcomes and challenges of PM-

JAY in J&K. Availability of PM-JAY across geographies and diverse groups, and healthcare facilities within PM-JAY empaneled hospitals. Accessibility to different healthcare facilities to diverse social, occupational and gender groups, especially poor and vulnerable.

This paper is extracted from a larger study which used a Mixed–Methods Approach in data collection – based on Multi-Stakeholder Analysis, with a sample of 300 households and 30 other stakeholders from 5 villages and 2 Municipal Corporations of 2 districts (Srinagar & Kupwara) of J&K. Districts were selected purposively to get a holistic understanding of the region with Srinagar being the capital city and predominantly Urban, and Kupwara being a borderline area and predominantly rural and tribal. The HHs were selected through simple random sampling using the Census (2011) and village level data, and secondary stakeholders were selected using purposive sampling at various levels of administration. This paper is mostly based on results from HH survey. To get a holistic understanding of availability and non-availability, access and access-difficulties, 50% of the respondents were PM-JAY benefitted HHs and 50% non-benefitted HHs with equal proportions from Tribal, Rural and Urban Communities.

BACKGROUND

Availability and Accessibility – Global Overview

Availability

Availability is the first concern when it comes to SHP. The availability of SHP varies widely across countries and regions influenced by economic, political, and social factors. The key aspect of availability which has received considerable attention in SHP literature is – *Coverage*. Globally, significant disparities exist in the availability of SHP. High-income countries have comprehensive systems in place, often characterized by Universal Health Coverage (WHO, 2023). In low and middle-income countries, there is widespread agreement and interest that Universal SHPPs (USHPPs), mostly bottom-up non-contributory tax-financed policies, are important for achieving health protection goals as they guarantee everyone access to essential healthcare services and are relatively better than targeted approaches because of being administratively less expensive and free from local political challenges (Shriwise & Stuckler, 2015; Cotlear et al., 2015). Largely these policies are argued to have led to increased health coverage of the poor and vulnerable thereby protecting them from hazardous health financing

(Adlung & Jutting, 2006). However, these countries often face challenges in providing adequate SHP due to limited financial resources, insufficient healthcare infrastructure, and large informal sectors (World Bank, 2021). There is a growing concern that the commitment to USHP coverage is low and diminishing (ILO, 2014). The UHC index rose only by 3 points between 2015 and 2021, with no discernible change since 2019 (WHO, 2023).

There are also *gaps in promised vs actual legal coverage* of UHC. In some countries all people should by law have free access to health-care services – but they do not have such, because formal legal coverage remains low such as in many countries of Africa and Asia (ILO, 2011: 2018). Many UHC policies have focused on financial entitlements of population groups without a matched emphasis on the *equitable availability* and quality of healthcare supply, thereby undermining their effectiveness (OECD, 2019).

The literature also highlights *Infrastructural and Human Resource Availability*. The availability of a sufficient and skilled workforce as well as the necessary physical facilities, tools and supplies distributed geographically to cater to the entire population, are prerequisites for the effective delivery of SHP services (Penn, Mueller, Morgan, Fujisawa, Kallas, Beinassis, Barrenho, Vardugo, Constanza, Ramos, Kendir, Lafortune, Balestat, Canaud, Levy, Berchet, Thomson, Garcia, Haywood & Min, 2022; ILO, 2018). However, an estimated 30–36% of the world's population has no access to the services of adequate medical professionals, and low-income countries have the highest levels of such deficits (ILO, 2011). Countries such as Afghanistan, Djibouti, Pakistan, Somalia, Sudan, and Yemen have health workforce densities below the worldwide median of 49 per 10,000 people. Consequently, they face the greatest healthcare workforce related issues concerning UHC. There are also issues of malpractices in ensuring free care to the insured (WHO, 2010).

Some SHP frameworks face inadequacy of availability or *exclusion of some key* health issues including HIV/AIDS and mental health (Adlung 2014; ILO, 2020). Reports also suggest a *widespread lack of awareness* of rights and other practical difficulties (ILO, 2011; 2018).

Accessibility

After availability the next agenda in SHP implementation is ensuring access to all the needy which mostly includes the poor and vulnerable. The WHO (2017) believes that all people irrespective of income, age, race, ethnicity, gender, disability, and location should receive the needed

promotive, preventive, curative, rehabilitative or palliative health service and protection. It is based on the principle of "leaving no one behind." When we look at the evidence on accessibility across the developing world, there is a universal agreement that SHPPs are contributing to removing socio-economic and other inequalities of access (ILO, 2021). However, studies also argue that design, financing, coverage, effectiveness, and/or geographical service imbalance, have failed several SHPPs in removing health inequalities for women, unemployed, informal workers, and rural populations (Cotlear, et al 2015; Adlung, 2014). The report of International Labour Organization argues that about 1.3 billion people worldwide, especially in the developing world, lack access to effective and affordable quality health care (ILO, 2008). Another report of International Labour Organization argues that high population coverage does not necessarily translate into equitable access, *gaps in coverage* disproportionately affect women and men with unstable or irregular incomes, and migrant workers and their families (ILO, 2018). The OECD report argues that not all health sector policies that are considered Universal are necessarily equitable or pro-poor to the fullest extent (OECD, 2019). The *rigid targeting systems* have left the near-poor exposed, thereby highlighting the need for a fully Universal system.

An inequitable access within relatively poor households, due to *geographical isolation* – living in rural and more scattered areas where public, NGOs, and private for-profit health services are sparse (Hsiao & Shaw, 2007). A report from World Health Organization, found that in Ghana also found that many people irrespective of socioeconomic status, living remotely did not have easy access to health facilities (WHO, 2010). While reflecting on premium payment based SHPPs, found that, there are persistent problems of social exclusion — communities' poorest members are not able to participate due to lack of *resources to pay the premium* (Jutting, 2002). Health user-fee exemption SHPPs have failed to help the poor to prevent or manage the risk of ill-health due to *limited government health* budget (Yates, 2006).

Availability and Accessibility – Overview of India and J&K

Availability

In India public SHP beyond formal sector has remained narrow, however, over the last two decades there has been a resurgence in the publicly funded SHP (Garg & Sharma, 2023). There is considerable evidence that the availability of SHPPs in India has *contributed to scaling-up health insurance* coverage for bottom-of-the-pyramid (ILO, 2014; Taneja & Taneja, 2016;

Mishra & Manda, 2018), and led to extended coverage, *benefit package* and *hospital networking* (Sarwal & Kumar, 2020).

However, the same SHP model, especially the initial phase of PM-JAY, has come under a lot of criticism as well. Ghosh & Qadeer (2019) argue that the policy is in crisis due to *little public spending* which ultimately limits the services claimed. Also, the policy is following an *inefficient model* of India's healthcare system by focusing on secondary and tertiary healthcare and ignoring the primary healthcare system wherein most cases are treated. Further, it is based on a *faulty universal approach* incorporating only one segment of the population through an illogical insurance model. In a review report on Pradhan Mantri Jan Arogya Yojana, highlights that more than 70% of their study respondents reported a *lack of necessary facilities in their home state* as the primary reason for seeking treatment outside their state (Vitsupakorn, Bharali, Yamey, Wenhui & Kumar, 2021).

In the case of J&K, there is lack of comprehensive research in case of earlier SHPPs and PM-JAY. Whatever evidence available is mainly from grey literature (newspapers), which report that PM-JAY has covered all sections of society and protected them from financial risk and catastrophic health expenditure (Ahanger, 2020). A report in The Greater Kashmir, highlights that with increased availability, PM-JAY has treated 60,594 patients, in 218 empaneled hospitals, under 123986 claims with an expenditure of Rs. 60.12 crores (J&K households spend 44% from their own pockets on health, 2022).

Accessibility

In Indian SHPPs are argued to have enabled people to access the lifesaving care they need when sick without financial hardship. However, despite laudable progress over the past decades, right to health is not yet a reality for all in India (ILO, 2022b). Mishra & Manda (2018) found lower hospitalization rates of poor, SC, ST and disabled HHs, and higher morbidity rate among females, and argue that this unequal nature of healthcare system has limited the accessibility, affordability, and effectiveness of health insurance schemes. A continued intra-district and rural-urban disparities was found due to the uneven distribution of empaneled hospitals (Nandi, Schneider & Dixit, 2017). In case of PM-JAY, reports that policy does not reach a large segment of desired beneficiaries due to overly strict eligibility requirements and low enrolment (Vitsupakorn et al., 2021). In the article titled 'India's Aadhaar scheme and the promise of inclusive social protection', highlights that while

the Aadhaar based system of registration offers the benefits of technology to India's SHP system, yet there are questions about uneven geographic enrolment mirroring inequality and under-provision with the least served populations, regions and states being also the least enrolled. In the case of J&K there is no comprehensive evidence on the accessibility of PM-JAY (Bhatia & Bhabha, 2017).

Overall, this existing literature on availability and accessibility of SHP across developing countries, India, and J&K suggests some progressive outcomes but at the same time highlight several contextual, design, implementation as well as research gaps. The rest of this paper uses field evidence to highlight the contributions and challenges of PM-JAY as a Universal SHP Model in politically fragile region of J&K and its larger implications.

AVAILABILITY OUTCOMES OF PM-JAY IN J&K

PM-JAY is provisionally a USHPP in J&K available to all segments of the population irrespective of caste, income, occupation, gender, and geographical location. The policy provides free health service for secondary and tertiary treatments through various empaneled private and public hospitals. This section examines the availability outcomes and challenges of the policy using different parameters.

Geographical Availability

Having a legally mandated USHHP is one thing, but its actual availability across all geographies especially in the politically and geographically fragile region of J&K is a different and difficult task. The study purposefully targeted the Urban, Rural and Tribal areas within two districts of Srinagar and Kupwara, to examine whether all geographies are covered with equality in coverage.

The study which consisted of randomly selected 50% beneficiary and 50% non-beneficiary HHs found that the majority of these HHs have Ayushman Cards commonly known as Golden Cards. The non-beneficiary HHs have not availed the policy benefit because they did not have any such illness in the family or preferred not using PM-JAY services. Hence, becoming a non-beneficiary has no association with non-availability of the PM-JAY or political and/or administrative meddling. These findings reconfirm the fact that the availability of SHPPs has contributed to scaling-up health insurance

coverage, as reported by Taneja & Taneja (2016) and Mishra & Manda (2018) at the country level. Also corroborate with the wider global evidence that USHPPs guarantee everyone access to essential healthcare services and are free from local political challenges (Shriwise & Stuckler, 2015; Cotlear et al., 2015).

Further, not having a healthcare service available within a district, especially in far-flung districts such as Kupwara, can create several access blockages thereby non-utilization or healthcare migration. In inconsistent findings of one of the mentioned reports, found that lack of necessary facilities in the home state/district is the primary reason for seeking treatment outside their state, the study found that PM-JAY has been able to make healthcare services available within districts, as 80% of beneficiary HHs have availed treatment within their respective districts (Vitsupakorn et al., 2021). These results are consistent across social, occupational and gender groups. However, out of those who have not received treatment within the district, Tribal HHs constitute 24%, Rural 20% and Urban only 12%, (Table, 1). These reports of outside district treatment are mainly from Kupwara, which had only two public empaneled hospitals unit 2021, and one private hospital was empaneled after 2021. Moreover, some Tribal and Rural families have received treatment in Srinagar, because they had migrated there for work or were referred for treatment. While the expansion of empaneled hospitals in Kupwara has minimized the need of going for treatment outside the district, there is a need of more empaneled hospitals considering scattered nature of population. Broadly, these findings suggest that within-district availability of empaneled hospitals has significantly reduced the geographical hindrance to PM-JAY benefit.

Nature of healthcare Availability (Public or Private)

Unlike the World Bank (2021) findings, that USHPPs are caught in difficulties of limited financial resources and insufficient healthcare infrastructure, empanelment of several public and private hospitals within both the sample districts indicates that there is widespread availability of PM-JAY service and choice in J&K. On utilization, the study found that 66% of beneficiary HHs have availed treatment from public, 33% from private, and 3% from both public and private empaneled hospitals. The results are consistent across social, occupational and gender groups (Table, 1). The majority of beneficiary HHs accessing public hospitals, indicates more availability and reliance on government compared to private healthcare system. Interactions

with the respondents within both the districts also indicated more trust in public compared to private empaneled hospitals.

Availability within Empaneled Hospitals:

Timely availability of beds

Often hospitals in developing countries are overcrowded and getting a bed for hospitalization on time remains a challenge. The study examined this issue and found that 99% of beneficiary HHs did not experience any difficulty in getting a bed on time. The results are consistent when examined across social, occupational, and gender groups (Table, 1). These findings suggest an ease in getting hospitalized whenever needed, and equitability of access irrespective of social, economic, gender background. These are also indicative of a well-functioning healthcare system that prioritizes prompt and efficient care delivery, as reported in the studies of Penn et al (2022) and ILO (2018) as well.

Availability of doctors, paramedical staff, and drug stores

The existence of an empaneled hospital has no value without having the availability of doctors for all the related illnesses, paramedical staff, and 24x7 PM-JAY drug stores, as provisioned in PM-JAY guidelines. The evidence shows that 98% of beneficiary HHs found doctors and paramedical staff available, and PM-JAY affiliated drug stores open 24x7. These findings are consistent across various social, occupational and gender groups (Table, 1). This ease of availability of doctors and paramedical staff for PM-JAY patients indicates a high level of commitment on the part of empaneled hospitals to ensure continued support and care to patients. The availability of 24x7 PM-JAY related drug stores in an empaneled hospitals indicates ease of access to essential and emergency medicines for patients under treatment. Looking from a bigger perspective these findings confirm that bottom-up non-contributory tax-financed universal policies are better than targeted approaches because of being administratively efficient and less expensive (Shriwise & Stuckler, 2015).

Availability of equipment, diagnostic tests, and referral facilities

Regarding the *equipments* (implants, lens, surgical equipment etc.), provided in the empaneled hospitals, 95% of the beneficiary HHs reported ease of availability. This finding is consistent across various social, occupational

and gender groups. A few beneficiary HHs reported that all equipments needed for the treatment were not available in the PM-JAY affiliated drug stores and to get those, they were facilitated by the hospital administration. However, 5% of the beneficiary HHs reported that the quality of equipment was not good (Table, 1). During the interviews all these HHs reported that the quality of lens implants in cataract surgery was not good.

Similarly, about *diagnostic tests*, 97% of beneficiary HHs reported that the facility was either available within the hospital or the hospital administration helped them in availing it from outside. This finding is consistent across various social, occupational and gender groups. However, 3% of the beneficiary HHs reported difficulties in getting all the diagnostic tests done (Table, 1) in private hospitals and highlighted the need of improvement in availability and quality. These issues of low-quality equipment and difficulties in getting diagnostic tests done, though reported by a small proportion of HHs, indicate what refers to as **malpractices** in ensuring free and quality care to the insured (WHO, 2010).

Emergency or normal *referral* is an important aspect of the healthcare in PM-JAY and the data highlights that 98% of PM-JAY beneficiary HHs were not referred from their original hospital. The results are consistent across social, occupational and gender groups. Only 2% of beneficiary HHs reported being referred from one hospital to another (Table, 1). The reason being that the specific treatment was not available in the first empaneled hospital which led to their referral to a district hospital or Srinagar city. The quality of referral was reported to be satisfactory and timely.

Availability of low-cost Treatment

To examine the experience of beneficiaries with the cost of availed PM-JAY treatment, expensiveness, and unnecessary procedures, Table–1 highlights that 97% of beneficiary HHs believed that treatment could not have been done with simpler procedures and lesser expenses. These findings are consistent across various social, occupational, and gender groups (Table, 1). These findings suggest a greater level of confidence among beneficiary HHs in the appropriateness and cost-effectiveness of the treatment they received under the PM-JAY.

A long-standing issue in SHPP discourse – lack of public awareness about their rights (ILO, 2011; 2018) continues to remain as one of the bottlenecks in PM-JAY implementation in J&K as well. The study found widespread

lack of awareness. among HHs about 3 days pre-hospitalization and 15 days post-hospitalization cost being part of PM-JAY. Consequently, patients have incurred Out of Pocket Expenditure (OOPE) on medicines and tests before and after treatment which were not counted in the insurance cover by the hospitals. The engagement of Civil Society Organizations (CSOs) in SHPPs usually plays an important role in awareness generation and mobilization, however, in consistent with the results of one of the mentioned reports, highlight that NGOs are sparse in geographically isolated locations, no engagement of CSOs was found in case of PM-JAY in the sample Districts (Hsiao et al., 2007).

Overall, these findings on availability within empaneled hospitals reinstate the results of Penn et al (2022) and ILO (2018), that the availability of a sufficient and skilled workforce, necessary physical facilities, tools, and supplies, distributed geographically to cater to the entire population, are prerequisites for the effective delivery of SHPP. However, at the same time they also highlight a few bottlenecks in facilities especially in case of private hospitals.

Changing Nature of Professional Healthcare Utilization

Dependence on unskilled and in-adequately trained staff for healthcare is one of the key concerns to USHP in developing countries (Penn et al., 2022; ILO, 2018), and addressing such challenge is one of the key agendas of PM-JAY. The study examined the healthcare utilization pattern changes due to the availability of PM-JAY and found that 89% of the beneficiary HHs were using professional healthcare services before the PM-JAY, and 11% have started using such services more often with the availability of PM-JAY. Before the enactment of PM-JAY they were mostly relying on the mercy of local medical shops or not adequately trained or relevant health care professionals. This includes Tribal and Rural (12% each) compared to Urban (10%), and Informal sector workers (13%) compared to Formal sector (6%), and Women (12%) compared to Men (11%), indicating that the culture of non-professional service usage was relatively more prevalent among vulnerable informal sector people before PM-JAY implementation (Table 1).

Table 1: Availability of PM-JAY Services

	Overall	Social groups			Occupational Sectors		Gender groups	
		Tribal	Rural	Urban	Formal	Informal	Male	Female
Where have you availed the PM-JAY service?								
Within District	80	74	74	88	75	80	73	87
Outside District	18	24	20	12	19	18	23	12
Both	1	2	2	0	3	1	2	0
Type of hospital visited for PM-JAY treatment.								
Public	66	66	50	84	64	68	68	65
Private	31	32	46	16	31	32	30	33
Both	3	2	4	0	6	1	2	2
Availability of beds when hospitalized.								
Easily available	99	98	98	100	100	98	98	100
Waited for bed	1	2	2	0	0	2	2	0
24X7 availability of doctors, paramedical staff and drug stores in the empaneled hospitals.								
Doctors	98	100	98	96	97	98	97	100
Paramedics	100	100	100	100	100	100	100	100
Drug Store	99	100	100	98	97	100	99	100
Availability of equipment, and diagnostic testing in the empaneled hospitals.								
Equipment	95	100	100	86	97	95	98	92
Diagnostic Testing	97	98	96	96	94	95	97	98
Instances of referral from one empaneled hospital to the other.								
Yes	2	2	2	2	6	1	2	2
Treatment could have been done with simpler procedures and lesser expenses?								
No	97	96	98	96	100	96	99	93
Availing healthcare from professional (doctors/specialists) after PM-JAY?								
Same as Before	89	88	88	90	94	87	89	88
More often than before	11	12	12	10	6	13	11	12

ACCESSIBILITY OUTCOMES AND CHALLENGES

Making PM-JAY "Completely Universal" in J&K is one of the key inbuilt policy design features for increasing accessibility to all without any socio-economic filters. This section uses different indicators to examine whether this universal nature of the policy and other related factors have eliminated accessibility barriers to PM-JAY.

Access to Registration of PM-JAY

The Golden Card is key for obtaining treatment under PM-JAY, hence in the entire policy process it holds a significant position. The study examined the registration and usage related access and access inequalities across sample and found that mass registration has taken place and there are no signs of inequality of access. All beneficiary and non-beneficiary HHs have one or more members registered under PM-JAY. While this is a good sign, interactions with sample HHs and Registration Centre Representatives (RCR), revealed several issues in the registration process, mainly related to the Aadhaar Based System which had also expressed skepticism at the beginning of the policy, considering complex spatial and social features of India states (Bhatia & Bhabha, 2017). The issues found include difficulty with the fingerprints of older people, delay in the preparation of cards which in some cases has taken up to 3 months, loopholes in the baseline data which leads to data mismatch, difficulty in adding new members, and name correction possible only after rejection of an existing card. Further, while RCR representatives mentioned that there is a fixed fee of Rs. 30 per application, all beneficiaries reported paying between Rs. 200 to Rs. 300 for getting a Golden Card.

The study did not find any cases of rejection of the Golden Card for the treatment from any group, which highlights the role of Golden Cards in ensuring a smooth and consistent implementation of healthcare protection through PM-JAY. The majority 98% of beneficiary HHs reported no incidence of non-acceptance, whilst 2% reported rejection due to data mismatch which was resolved after some days. This trend is consistent across social groups, occupational sectors, and gender categories (Table, 2).

Access of Treatment Across Socio-economic and Gender Groups

Looking at the accessibility across socio-economic and gender groups, the study highlights an extensive coverage of the policy across all these diversities, thereby, removal of gap between promised and actual legal SHP coverage and access, which according to the ILO (2011: 2018) has been a

concern in SHPP implementation in many African and Asian countries. In fact, the findings show a better coverage for poor and vulnerable within these socio-economic and gender groups, which is opposite to what Mishra & Manda (2018) found in RSBY that unequal nature of healthcare system has limited the SHP accessibility of poor and disadvantaged. When we look at the level of education, the sample represents all the possible groups among both beneficiaries and non-beneficiaries – Illiterate, Primary Pass, Middle Pass, Matriculate, Graduates and Above. However, within beneficiaries the proportion of illiterate and lower educated HHs is higher compared higher educated – Illiterate comprising 47%, Primary Pass 11%, Middle Pass 17%, High School pass 12%, 12th pass 7%, and Graduate and Above 11% (Table 2). The concentration of these illiterates and less educated HHs is higher among the poorer social groups – STs and Rural, which indicates that the policy has covered more educationally disadvantaged and marginal HHs in Kashmir.

Similarly, the status of ration cards shows a larger concentration of HHs from poorer economic backgrounds – Below Poverty Line (BPL), Antyodaya Anna Yojana (AAY) and Priority Households (PHH) among beneficiaries. In overall sample their proportion in beneficiaries compared to non-beneficiaries is – APL 25% compared to 34%, BPL 37% compared to 35%, AAY 15% compared to 14%, and PHH 22% compared to 17%. Except for a few outliers this trend is consistent across districts, social, occupational and gender groups (Table, 2).

The occupational and landholding status of a HHs plays a crucial role in understanding the economic status and thereby access to healthcare. When examined the study found 79% within the informal sector compared to 21% from the formal sector having received PM-JAY treatment. Breaking the informal sector further down, the most disadvantaged workers have higher participation rates such as Daily Wage Laborers 50%, Shopkeepers/Artisans 13%, Farmers 9%, Self-Employed 6%, and Drivers 1%. In the formal sector 15% constitute Government and 6% Private Employees (Table, 4.7). Similarly, the landholding variable shows that the policy has covered HHs from all different landholding backgrounds, however, the majority is from Landless (26%), and Marginal Holders 73% (Table, 2).

Overall, these findings highlight that PM-JAY in J&K has shown a significant commitment to the Core Principle of USHP - “Leaving No One Behind” (WHO 2017) and its Fundamental Objective – removing the socio-economic and other inequalities of access to healthcare (ILO, 2021).

Table 2: Access to PM-JAY

	Overall		Srinagar						Kupwara					
			Beneficiary			Non-Beneficiary			Beneficiary			Non-Beneficiary		
	Beneficiary	Non-beneficiary	Tribal	Rural	Urban	Tribal	Rural	Urban	Tribal	Rural	Urban	Tribal	Rural	Urban
Golden Card considered for free treatment (Beneficiary HHs)?														
Yes	98	--	--	--	--	--	--	--	--	--	--	--	--	--
Educational level across different groups.														
Illiterate	47	41	64	48	40	64	28	12	48	52	32	36	48	58
Primary level	11	7	16	4	12	8	0	4	16	8	8	0	12	21
Middle	17	18	12	24	4	12	24	16	16	20	32	28	20	8
10th	12	13	8	8	12	8	12	32	12	16	12	8	12	8
12th	7	9	0	8	20	0	16	12	4	0	8	8	0	0
Graduation & above	11	15	0	8	12	8	20	24	4	4	8	20	8	5
Occupation of household head														
Daily wage laborer	29	75	80	44	16	84	24	4	52	56	52	64	52	64
Shop keeper/ artisan			12	4	48	0	8	36	2	4	4	4	16	0
Farmer			0	24	4	4	28	4	4	4	20	4	0	4
Self-employed			4	4	4	0	0	8	12	8	4	8	16	8
Driver			0	0	0	0	0	0	8	8	0	4	4	0
Government Job	21	25	4	12	18	8	28	28	24	20	12	12	8	12
Private Job			0	15	14	4	12	20	0	0	8	4	4	12
Landholding ownership														
No land	26	20	12	20	64	12	8	48	4	36	20	16	24	12
Marginal (< 1 hectare)	73	78	88	76	36	88	92	44	96	64	80	84	76	87
Small (1 to 2 hectare)	1	2	0	4	0	0	0	8	0	0	0	0	0	0
Ration Card holding.														
APL	25	34	8	16	48	28	36	48	24	28	24	16	56	17

BPL	37	35	36	44	0	40	44	4	48	32	64	48	28	50
AAY	15	14	24	16	0	20	8	0	24	28	0	32	12	12
PHH	22	17	32	24	52	12	12	48	4	12	12	4	4	21
Distance to closest empaneled hospital (Beneficiaries & Non-Beneficiary).														
0 to 5 Kms	19		--	--	--	--	--	--	--	--	--	--	--	--
6 to 10 Kms	18		--	--	--	--	--	--	--	--	--	--	--	--
11 to15 Kms	15		--	--	--	--	--	--	--	--	--	--	--	--
16 to 20 Kms	16		--	--	--	--	--	--	--	--	--	--	--	--
21 to 25 Kms	14		--	--	--	--	--	--	--	--	--	--	--	--
Above 25 Kms	18		--	--	--	--	--	--	--	--	--	--	--	--

Treatment with Respect and Dignity

The access to healthcare facilities with dignity is an important element of human wellbeing, thereby a target of PM-JAY as well. The study examined the perception of respondents about whether they felt being treated with the utmost dignity, respect, and care in the empaneled hospitals and found that 97% of patients in beneficiary HHs have felt such. This finding is consistent across various social, occupational, and gender groups. Conversely, 3% of PM-JAY sample patients reported that the treatment was not dignifying (Figure, 1). While these findings broadly suggest that PM-JAY has imbibed the Golden Rules of SHP implementation in J&K – delivered with respect for the dignity and worth of patients (Development Pathways, 2019), they also highlight marginal but concerning issues of inequality in treatment and care.

Physical Access to Empaneled Hospitals – Proximity, Roads, and Transport

Proximity to Empaneled Hospitals

Being a difficult topography, the location of a HHs can create proximity challenges in access to PM-JAY, especially in far-off districts such as Kupwara and groups such as Tribal and Rural. The study examined the proximity to empaneled hospitals and associated challenges and found that in an overall sample 19% of the sample HHs have an empaneled hospital within 0 to 5 Kms from their residence, 18% within 6 to 10 Kms, 15% 11 to 15 Kms, 16% 16 to 20 Kms, 14% 21 to 25 Kms, and 18% within Above 25 Kms (Table, 2). However, when segregated across social groups a notable difference emerges. As shown in Figure, 2 only 2% of Tribal and 14% of Rural sample HHs

have an empaneled hospital within 0 to 5 Kms compared to 40% urban HHs. On the other extreme 36% Tribal and 12% Rural compared to 6% Urban HHs have the closest empaneled hospital more than 25 Kms away from home. These findings indicate that while in the overall sample a considerable number of HHs have PM-JAY healthcare facilities available nearby to their residence, there is a notable disparity between Tribal and Rural areas compared to Urban. The availability of empaneled hospitals in and around district headquarters has reduced barriers to access as mentioned in Section – 3.1. However, within districts there are physical limitations (distance) which create difficulties in access mainly for Tribal and Rural HHs and also in developing countries (Cotlear et al., 2015; Adlung, 2014; Hsiao et al., 2007). Such physical limitations of access are also found in India (Nandi et al., 2017).

Road connectivity and transport access to empaneled hospitals:

Often there is the availability of a healthcare infrastructure but a lack of roads to the facility makes it difficult for people, especially from far-off regions, to access the treatment. While examining the road connectivity the study found that in overall sample and across all the social, occupational and gender groups 100% HHs have road connectivity to the empaneled hospitals (Table, 3). These findings suggest that access to empaneled hospitals via roadways is nearly universal.

Having the road connectivity establishes that people can reach to hospitals, whiles, access to transport determines whether people they will reach on time or not, especially in case of a medical emergency. The majority (92%) of sample respondents have reported having transportation access to reach to the empaneled hospitals, and these results are consistent across social, occupational, and geographical groups (Table, 3). However, 8% of the sample respondents reported lacking such access, particularly among certain marginalized demographic groups (Table, 2). Ensuring equitable access to transportation for these HHs is crucial for reducing disparity in healthcare utilization.

When we look deeper into transportation access, it is surprising to note that there is a widespread lack of public transportation and/or ambulance service mainly across rural and tribal communities and people are heavily reliant on privately hired transportation, which at the time of an emergency is very costly, considering that PM-JAY does not cover the travel cost to

empaneled hospitals. The majority (71%) of sample HHs have reported using rented Sumo, 3% ambulance, and 4% conventional modes of horse riding or walking in case of a medical emergency. These results are consistent across social, occupational and gender groups (Table, 3). When segregated across social groups, the relatively advantageous groups have more access to their own transport compared to the disadvantaged such as 36% Urban, compared to 24% Rural and 6% Tribal HHs, and within occupational groups, 31% formal compared to 19% informal sector workers have reported using their own vehicle in case of medical emergency. Even the horse riding is mostly reported from few Tribal HHs (Table, 3). Overall, these findings indicate a huge disparity in the access to transport and a deficit of public transport, especially the availability of ambulance service in tribal and rural areas.

Table 3: Accessibility to Different PM-JAY Services

	Overall	Social groups			Occupational Sectors		Gender groups	
		Tribal	Rural	Urban	Formal	Informal	Male	Female
Road connectivity to empanelled hospitals (Beneficiaries & Non-Beneficiaries HHs).								
Yes	100	100	100	100	100	100	100	100
Transport availability to reach to the empanelled hospital (Beneficiaries & Non-Beneficiaries HHs)?								
Yes	92	94	82	98	86	93	91	92
No	8	6	18	2	14	7	9	8
Transport used during medical emergency (Beneficiaries & Non-Beneficiaries HHs).								
Ambulance	3	4	4	2	3	4	2	5
Own Vehicle	22	6	24	36	31	19	16	32
Rented Sumo/ car	71	88	72	52	67	72	81	55
Horse Riding/ Walking	4	2	0	0	0	5	1	8

CONCLUSION AND POLICY IMPLICATIONS

Unlike several SHPPs in the Developing World and especially in Politically Fragile Regions, as highlighted in Section–2, PM-JAY demonstrates progressive outcomes in J&K as far as the key SHP parameters of availability and accessibility are concerned. While corroborating with some and refuting some empirical literature on availability and accessibility

of SHHPs, as highlighted in Section–3 and Section–4, the paper mainly attributes this progress to PM-JAY's design feature of being a "Completely Universal" SHPP in J&K. A role model for the rest of Indian states/UTs, where same policy, because of not being Completely Universal, is criticized for being a faulty universal approach incorporating only one segment of the population as well as for other developing countries, especially Politically Fragile Regions (Ghosh & Qadeer, 2019).

Availability

The paper concludes that SHPP availability has exponentially increased in J&K with the Universalization of PM-JAY since December 2020, as the policy has covered all geographical areas. The availability of empaneled (public and private) hospitals within the districts has removed several blockages to healthcare service availability, and with the increasing number of empaneled hospitals in districts the healthcare migration of people outside the district for treatment is decreasing. Interestingly, the reliance and preference towards government-funded healthcare system is more than private healthcare even in PM-JAY.

Regarding the availability of healthcare facilities within empaneled hospitals, the paper concludes that, in consistent with PM-JAY guidelines, there is generally timely and equitable availability of hospital beds, which is indicative of a well-functioning healthcare system that prioritizes prompt and efficient care delivery. There is 24x7 availability of doctors, paramedical staff, PM-JAY affiliated drug stores, equipment, and diagnostic testing facilities in most of the empaneled hospitals, ensuring continuous care for patients during hospitalization.

The paper also demonstrates a high level of confidence among beneficiary HHs in the appropriateness of the treatment under PM-JAY, as the majority believed that treatment could not have been done with simpler procedures and lesser expenses. For several poor and vulnerable HHs, PM-JAY has altered the treatment culture towards professional care, who were mostly relying on the mercy of local medical shops or not adequately trained or relevant health care professionals. It can be fairly contended that PM-JAY in J&K, has led to an increased health coverage of the poor and vulnerable thereby protected them from hazardous health financing (Adlung & Jutting, 2006).

Notwithstanding, like results of some earlier studies as highlighted in Section – 2, there are few small but concerning issues of non-availability

and poor-quality of equipment and diagnostic-testing facilities in private empaneled hospitals. Further, while basic awareness about the PM-JAY is there, comprehensive awareness about pre and post hospitalization coverage is almost non-existent, and engagement of CSOs invisible. These findings suggest room for improvement in availability – increasing the number of empaneled hospitals, strict monitoring on the part of the PM-JAY administration, comprehensive public awareness generation, and engagement of CSOs in implementation.

Accessibility

The paper concludes that PM-JAY has demonstrates a huge expansion in the registration process with both beneficiary and non-beneficiary HHs having Golden Cards, thereby no access inequality at the hospital gate with all Card holders allowed for treatment. Further, the policy has delivered on the core principle of SDGs and USHPP – "Leaving No One behind" (WHO, 2017), by reaching to all the socio-economic, geographical, and gender groups, highlighting the policy's commitment to give access to all diversities within J&K. Notably, the higher proportion of illiterate and lower-educated compared to higher educated, BPL, AAY and PHH compared to APL ration card holders, informal sector workers compared to formal sector, and landless and marginal holders compared to small holders among beneficiaries, suggest the policy's effectiveness in reaching to the poorest of the poor and vulnerable groups, thereby overcoming the concerns of disadvantaged exclusion from SHPPs in India (Mishra & Manda, 2018). Furthermore, the treatment with respect and dignity, which is usually one of the concerns in healthcare delivery, and a golden rule in the delivery of SHP has been addressed in PM-JAY in the case of J&K(Development Pathways, 2019).

Notwithstanding, there are some accessibility related bottlenecks in the policy process. The registration process is caught up with delay in preparation of Golden Cards, excessive charges, difficulty in fingerprints of the elderly, and issues with name changes and adding new members which need to be addressed. The access to empaneled hospitals via roadways is nearly universal, regardless of social, occupational, or gender factors, however, there is an issue of distance especially for Tribal and Rural communities, which highlight the need for widened distribution of empaneled healthcare infrastructure in far-flung areas, especially districts like – Kupwara, so that all people can have equal ease of access. Also, the heavy reliance on expensive privately hired transportation in the case of a medical emergency is a big concern

in Rural and Tribal areas. Equality of access to affordable transportation is crucial to reducing physical disparity in healthcare utilization. This demand strengthening of public transport system and making widespread availability of an ambulance service mainly in geographically distant areas. A fixed amount of transportation amount to and from the empaneled hospital can be added to PM-JAY insurance coverage to relieve people from such financial cost.

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