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Abstract

This paper critically examines the Conditionalities Framework under India's National Health Mission (NHM), which marked an important step in performance-based financing for the health sector. Drawing on incentive disbursement data for the period 2019–20 to 2024–25, the analysis finds that the framework has generated only limited effective incentives for states to improve health sector performance. While the Framework has helped signal the Central government's health priorities and encouraged adoption of system-level reforms in states, its capacity to drive substantive improvements in state-level health outcomes remains constrained. The paper highlights several conceptual and design challenges that weaken the incentive effect of the framework. These include the reliance on relative performance assessment within state groups, which creates a zero-sum incentive structure and dilutes rewards; the inclusion of performance indicators that are not fully within the control of the incentivised state-level NHM apparatus; and the dependence on self-reported performance data, which raises concerns about data credibility and scope for gaming. Strengthening the framework will require revisiting the choice of performance conditionalities, performance assessment cycles, and the mechanisms for performance verification. Surveys like the National Family Health Surveys (NFHS) could be leveraged to reinforce third-party performance validation.

Keywords: Performance Based Financing, Conditionalities Framework, National Health Mission, Health Financing, India

Introduction

In India, recent years have witnessed significant discussions and policy nudges on adoption of performance-based fund disbursements within the health financing landscape. The inefficiencies associated with input-based line-item budgeting in health has been globally recognized for long, prompting efforts to introduce result-oriented budgeting frameworks. These are commonly referred to as Results Based Financing (RBF). The approach involves incentivising both demand and supply side stakeholders in health by setting up payment mechanisms linked to actual health services (results) rather than inputs or line-item expenditures. RBF is positioned as a strategic approach to advancing Universal Health Coverage (UHC) by enhancing achievements from health budgets.

One of the most widely implemented forms of RBF schemes in LMICs has been Performance-Based Financing (PBF) (Witter *et.al.* 2021). PBF entails providing incentives to health care providers to augment health services by linking provider payments to the attainment of pre-agreed service delivery and quality targets. It is based on the principal agent framework, aiming to incentivise effort at the facility-level (Witter *et.al.* 2021). In a typical PBF framework, the financing agency (often referred to as the 'purchaser') enters into a contract with health facilities, outlining payment rates for providers, the pre-agreed quantity and quality indicators of performance, the mechanism for performance evaluation and penalties, if targets were unmet. Health facilities are granted considerable autonomy to achieve the performance benchmarks. The benchmarks include a combination of service volume, quality assessments, essential drug availability, and occasionally patient satisfaction or equity measures. Some of the most notable examples of PBF implementation has been in Rwanda, Cameroon, Burundi, Nigeria, Democratic Republic of Congo and Argentina.

Evidence on the impact of PBF on health outcomes has been mixed, with results often being found to be contingent on the specific framework adopted, the soundness of performance targets and the local context and system dynamics in which it was implemented. While PBF initiatives have shown success in several countries, they have been discontinued in others, including Benin, Chad, and Sierra Leone. Typically, a blend of institutional arrangements, governmental factors and capacity requirements have been identified as prerequisites for its successful implementation.

In India, over the last two decades, there has been an enhanced focus on outputs generated from budgetary allocations on schemes of the central government. The introduction of 'outcome budgeting' in 2005, the establishment of 'Performance monitoring and Evaluation system' in 2009, and the 'Output-outcome monitoring framework' in 2017-18 bear testimony to this fact. Additionally, performance-linked payments to staff and financial rewards to service delivery units for achieving certain standards of service have been incorporated in selected central schemes. In the context of health, the two flagship schemes, National Health Mission (NHM) and Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) have embedded elements of performance-linked payments. Under NHM, these include payments to frontline health workers 'ASHAs' (Accredited Social Health Activists) on the basis of the actual volume of services

delivered, and rewarding health facilities through programs like Kayakalp and LaQshya for achieving quality standards. Under AB-PMJAY, providers are reimbursed through case-based payments, thereby creating direct incentives for the delivery of specified service packages.

While large-scale, stand-alone PBF programs like those seen in some LMICs have not been implemented in India, core PBF principles are currently applied to a portion of NHM allocation to states through NHM's Conditionalities Framework. This framework closely approximates PBF approaches in the international context, and links a significant portion of Central funding to states' achievement to measurable health outcomes and operational benchmarks. Currently, the Conditionalities Framework, links approximately 20% of state-level NHM Flexi-pool allocations to predefined performance indicators. creating financial incentives for improving health outcomes and system performance.[4] Since its initiation in 2013-14, the framework has evolved through gradual policy experimentation and programmatic adaptations through extensive revisions to target performance indicators. The proportion of NHM allocation linked to performance has also increased from 10 per cent in 2013-14 to 20 per cent in 2018-19.

With nearly a decade of implementation and evolution of the Conditionalities Framework, a critical assessment of the integration of PBF principles within health financing through this framework in India is due. This paper seeks to review the NHM's Conditionalities Framework and undertake a critical assessment of its performance and associated challenges. Section I of the paper reflects on international PBF models and provides an overview of experiences with performance-based financing in health. Section II details the key design and operational features of the NHM's Conditionalities Framework in India. Section III analyses the effectiveness of NHM's Conditionalities Framework in terms of incentivising performance of states. Section IV discusses the key conceptual and design issues associated with the framework, and Section V provides a summary and suggestions on the way forward.

I. International Models and Experiences with Performance Based Financing in Health

A. Implementation Features

PBF schemes have been largely supported through donor funding in LMICs, and are executed in parallel with other health schemes. In most countries, these have been started as donor-supported pilots in selected districts or facilities, and then scaled up regionally or nationally as positive impacts emerged. In some countries, PBF implementation has either remained partial/regional or stopped after implementing it for a few years. Implementation of PBF across types of health facilities has also varied across countries. Some have rolled out PBF across all facilities, while others have targeted only at primary health care facilities.

[4] Although other forms of performance linked payments have been incorporated in some of the central health schemes, NHM's Conditionalities Framework is closest to the international PBF models.

Typically, PBF schemes have focussed on a selective set of health services which lie in the interest domain of donors. These include maternal, newborn, and child health (MNCH) services, including antenatal care, skilled birth attendance, immunizations, postnatal care, and family planning. In some contexts, PBF schemes have also targeted tuberculosis, HIV services, and primary care for non-communicable diseases. In essence, the focus derives from the health sector priorities in the countries where it has been implemented.

Financially, PBF contracts have typically channeled a significant portion of health facility operating budgets through performance-linked payments. For example, district hospital facilities in Rwanda have received roughly a third of their funding through PBF (Fritsche et al. 2014), while in Burundi, the share reached up to 80% for small health centers (Renaud 2013). Payments were made on a periodic basis, contingent upon external verification through audits, site visits, and beneficiary feedback.[5]

Table 1 summarizes key features of PBF frameworks implemented across different countries. Among these, the framework that aligns with a decentralized setup like India is Argentina's flagship Plan Nacer (launched in 2004) and its expanded successor, Programa SUMAR (introduced in 2012). Under this model, 40% of transfers to provinces are performance-based, linked to the achievement of specified indicators. Unlike India, however, provincial governments in Argentina remunerate healthcare providers on a fee-for-service (FFS) basis for services included in the benefits package. This design creates incentives at multiple levels: provincial governments are motivated to improve coverage and performance on indicators, while providers are directly incentivized by provincial authorities through FFS payments tied to service delivery volumes. The target levels for the performance indicators are fixed via a process of negotiation between the provincial governments and central government.

[5] However, as a proportion of the health budget of countries, PBF schemes account for a relatively small portion. Even in the widely cited successful case of Argentina, the PBF scheme Programa Sumar accounted for less than 1% of the average annual provincial health budgets (Sabignoso *et.al.* 2020).

Table 1- Key Features of PBF Frameworks Adopted in International Settings

Country	Evolution & Roll-out	Key Design / Institutional Characteristics	Financing Features	Service Coverage / Focus
Rwanda	Pilots in early 2000s → national scale-up in 2006.	National PBF program; central government acts as purchaser; community PBF added later; independent verification agency.	Funds flow directly to facility bank accounts; facility directors have spending autonomy.	Covers facilities at all levels; wide service package (general and community health).
Burundi	Pilots in 2006 → national roll-out in 2010.	Mandatory for public, voluntary for private; two-step payment: monthly output-based + quarterly quality score; autonomy for facilities.	Facility budgets significantly funded by PBF: **30–35% for hospitals**, **80–85% for health centers**; funds paid directly; staff incentives included.	The broad package includes technical quality and patient satisfaction measures.
Zimbabwe	Launched 2011; initial 18 rural districts → expanded to all 60 rural districts.	Implemented with World Bank support; designed to revitalize the system and expand access to MNCH services.	Donor-supported; facility-level payments linked to performance.	Targets rural districts; maternal, newborn and child health (MNCH).
Cameroon	Regional/partial coverage; not national.	Targeted primary health care facilities; smaller-scale system compared to Rwanda/Burundi.	Mixed financing (details limited); donor-supported.	Mainly primary health care (PHC).
Benin	Started 2012 → **halted in 2017**.	Targeted PHC facilities; partial/regional coverage only.	**Donor funded** with limited domestic government financing.	PHC-level PBF; discontinued due to sustainability issues and lack of national ownership
Nigeria	Pilot from late 2012 to mid-2018 in Adamawa, Nasarawa, Ondo states.	Included both PBF and Decentralized Financing Facility (DFF) for comparison; DFF allowed autonomy without performance linkage.	World Bank–funded pilot; facility autonomy supported.	Selected states; maternal/primary care focus typical of PBF pilots.
DRC (Congo)	Launched 2016 under Health Ministry; part of Health System Strengthening Project.	Contracts with facilities; quarterly payments tied to service volume.	World Bank–financed; performance-based funding flows to facilities.	Prioritized services especially RMNCH (reproductive, maternal, newborn, child health).
Argentina	Plan Nacer (2004) → SUMAR	Federal structure; central–provincial	60% capitation (linked to	Uninsured populations;

	(2012 expansion).	negotiated targets; payments based on enrollment + results; provinces pay providers via fee-for-service (FFS).	enrollment); 40% results-based; FFS covers incremental cost while salaries are funded by provinces.	pregnant women; children <6; indicators include ANC, skilled birth attendance, immunization.
Cambodia	Pilots in early 2000s → national H-EQIP roll-out during 2012–2016.	Ministry contracts semi-autonomous fund managers; uses balanced scorecards; formal nationwide PBF integration.	Incentives tied to quantity & quality; integrated with Health Equity Funds (HEF) to protect poor and enhance utilization.	Skilled deliveries, facility quality, and service quantity; equity-linked through HEF.
Afghanistan	Large-scale PBF through contracting-out under Sehatmandi Project; paused after 2021 due to loss of donor funding.	NGO-based service delivery; performance-linked contracts.	Heavily donor-financed; collapsed after withdrawal of international funding and political change.	Nationwide essential services prior to 2021.
Uganda	Pilot began in 2003; **not scaled**.	Small scale; insufficient impact on outcomes.	No major domestic resources mobilized.	Pilot-level PHC services only.
Egypt	PBF pilots in PHC; **halted after mixed results**.	PHC-level; partial implementation.	Discontinued due to performance and evaluation concerns.	PHC services in selected regions.
Sierra Leone	Initiated PBF; **paused** during Ebola crisis.	Payment delays + donor shifts disrupted implementation.	Donor-dependent; stopped after funding instability.	PHC and MNCH-focused before interruption.
Burkina Faso	PBF initiated but later **discontinued**.	Operational and sustainability challenges.	Insufficient financing + operational difficulties.	Limited pilot; not scaled.
Chad	PBF initiated but **ceased**.	Weak ownership and system limitations.	Sustainability and governance issues.	Limited coverage before termination.

B. *Evidence on Impact of PBF Models*

PBF models have differential features and implementing mechanisms across countries, reflecting local contexts and health system design (Renmans *et.al.* 2017). Possibly due to this, evidence on the impact of PBF models have been mixed. While several studies document positive impacts on selected health outcomes in particular contexts (Basinga *et al*. 2011; Gertler *et al.* 2014), others report limited or no effects (Gage & Bauhoff 2021). Similarly, findings are varied for broader health system indicators. Some evaluations report improvements in health worker motivation (Shen *et. al* 2017 for Zambia, Bhatnagar & George 2016 for Nigeria). and in quality of care (Bonfrer *et al.* 2014 for Burundi, De Walque *et al.* 2017 for Cameroon, Shapira *et al.* 2023 for DRC), whereas other studies find no significant effects on these dimensions across different implementation settings (Mutasa *et al.* 2021; Lamba *et al.* 2025).

There are also concerns on equity implications of PBF models. PBF encourages providers to prioritize populations that are the easiest to cater to, presumably excluding marginalized communities (Paul *et. al*. 2025, Lannes *et. al*. 2015). Also, there is some evidence that facilities which are better performers ex-ante would end up receiving higher share of incentives. For instance, in Zimbabwe, it was found that facilities with more staff, higher consultation volumes and with less remote and more wealthy target populations earned significantly higher bonuses (Kovacs *et. al.* 2022). This "Matthew Effect" has the potential to exacerbate inequities between facilities/provinces, leading to diverging trajectories in performance (Paul *et. al*. 2025).

Cost effectiveness of PBF models *vis-à-vis* other forms of facility financing like Direct Facility Financing (DFF) has also been questioned. Findings from an RCT experiment in Nigeria showed that for most indicators (excluding institutional deliveries), the impact of PBF was comparable to DFF, even though the PBF disbursed twice the amount of funding as DFF (Khanna *et.al.* 2021). Similarly, demand side initiatives such as Conditional Cash Transfers (CCT) have been found to yield similar effects on maternal and child health care indicators as PBF initiatives (De Walque et al. 2022). Cost concerns on PBF models emerge on account of the administrative costs associated with rigorous verification and monitoring processes for performance assessment. Illustrating these cost concerns, a study focusing on the PBF implementation in Benin found that for every USD paid to the providers, about 0.50 USD were used for the verification of performance (Antony *et. al.* 2017).

At the conceptual level, PBF assumes that inadequate incentives lie at the core of poor health service delivery in LMICs (Paul *et al.* 2025). In many LMICs, however, the binding constraints are shortages in resources, capacity, and health systems. Emphasizing financial incentives can therefore, misidentify the problem, as weak performance often reflects factors beyond providers' control. Evidence from several countries shows that DFF models that enhance funding and provider autonomy achieve outcomes comparable to PBF (World Bank Report). These issues have prompted a gradual rethinking in recent years of PBF as a panacea for healthcare access challenges in LMICs.

II. Stepping Towards Performance Based Financing in Health- The NHM Conditionalities Framework

The NHM's Conditionalities Framework resembles the key feature of international PBF programs, tying payments to verified results on pre-agreed targets. Under the Conditionalities framework, payments are tied to the achievement of specific "*conditionalities*" at the state-level. While some of the conditionalities reflect achievement in specific health indicators, others target strengthening health systems and bringing about systemic changes at the state-level. The evolution of the framework and the conditionalities imposed have been discussed in the next section.

A. Distinguishing Features of the NHM Conditionalities Framework from International PBF Models

The Conditionalities Framework of NHM has adapted only selective elements of PBF models in other countries, and departs from those models in several ways. First, unlike typical PBF settings where incentives are provided at the level of health facilities, the central government in India provides incentives to state governments through the Conditionalities Framework to improve performance in specific health outputs, outcomes and bring about systemic changes. This implies that the incentivisation in the framework is envisaged at the level of the state governments, and not at the level of health facilities (provider). The framework does not include any designated mechanism to transfer the incentives earned by state governments to health facilities. Second, the incentives earned by state governments on their achievements can be utilized for only certain activities approved by the central government.[6] This is unlike the PBF feature of provider autonomy and flexibility in use of funds in health facilities. Third, unlike most international PBF models where payments are contingent on external verification of performance, third-party validation of performance achievements is not a standard practice in the NHM's Conditionalities Framework, with the exception of a few special cases.[7] Although verification and monitoring of the data reported on performance exist, these are typically integrated within health departments or NHM frameworks rather than being assigned to fully independent third-party bodies (except a few audits and surveys). Fourth, the conceptualization of the purchaser-provider split in the NHM framework is different from that envisaged in international models of PBF. Since PBF is recognized as a part of strategic purchasing of healthcare services, its implementation in most countries is concomitant with institutional changes that involve a separation of purchasing and provider functions. This feature of purchaser-provider split forms a core element of implementation in international PBF approaches. In India however, public health facilities are both operated and financed by government entities, and therefore, the purchaser-provider split is largely absent. However, as the Conditionalities Framework constitutes an agreement between the Central and State governments, the Central government may be perceived as the purchaser, and state governments as providers.

[6] As per activities approved in the Record of Proceedings (RoP) of NHM (Source- RoP 2024-2026).

[7] The inclusion of NITI Health Performance Index in the list of criteria prescribed by the Conditionalities Framework from 2017-18 until 2023-24 was an exception.

B. Incentive Pool under NHM Conditionalities Framework

Between 2013-14 to 2017-18, 10 per cent of the total allocation under NHM at the National-level was earmarked for the incentive pool under the Conditionalities Framework. In 2018-19, this incentive pool was enhanced by increasing the proportion of NHM allocation earmarked -from 10 to 20 per cent. Notably, in 2016-17 and 2017-18, relatively better performing states received majority of funds from the incentive pool (NHSRC 2019). Keeping this in view, since 2018-19, the previous single national incentive pool was divided into five separate pools in proportion to the NHM funds allocated to different groups of states: EAG, Non EAG, North East, Hilly States and UTs (NHSRC 2019). This was expected to ensure better inclusion and funding of weaker states from the incentive pool.

At the beginning of each year, the allocation on the incentive pool along with the conditionalities and weights attached to various incentives and penalties is communicated to states through the NHM's Record of Proceedings (RoP) for each state. At the end of the year, based on the scores attained by the state on these pre-specified criteria and the total budget available, the state's net reward/penalty is calculated. The attained scores (along with the available pool) therefore, determine how much of the incentive component allotted in the beginning is finally disbursed to the state[8]. Funds left in the pool after distribution of the incentive/penalty to all states within that pool, if any, are then distributed amongst them as per the NHM budget allocation/distribution formula.[9] This implies that not all of the incentive pool budgeted for a specific category of states may actually get distributed based on performance.

C. Performance Criteria Included Under the NHM Conditionalities Framework

The performance criteria included under the Conditionalities Framework have largely focused on areas where the Central government would like to incentivize increased effort and reform by states. Broadly, these can be categorized into five sets (Table 2). The first set includes conditionalities and incentives on implementation of various programs that have been operating under NHM at different points of time. In the early years (2013-14, 2014-15 and 2015-16), it included conditionalities for rolling out and minimizing gaps in implementation of RBSK, JSSY and NUHM. In more recent years, with the initiation of Ayushman Bharat, conditionalities on implementation of Health and Wellness centres (AB-HWCs/AAMs) have been included. Additionally, in recent years with the increased emphasis of the central government on viral hepatitis control, curbing the rising burden of non-communicable diseases, mental health and elimination

[8] One should note that (since 2019-20) the incentive pool allocated in states' NHM Records of Proceedings (RoPs) carries the description "GoI Support for Incentive Pool based on last year's performance assuming no incentive/reduction on account of performance". Therefore, the incentive pool mentioned in the RoP is the amount allocated to the state if it scores zero on the sum of all indicators. A positive score entitles a state to earn an incentive over and above this amount to the extent of this designated amount, and vice versa in case of a negative score.

[9] This may happen if the net score of all states in a pool (category) is negative, i.e. there's a net penalty in that group.

of Tuberculosis, performance conditionalities associated with these programs have been included. Also, following the COVID-19 pandemic and revision of Indian Public Health standards (IPHS) in 2022, conditionalities on functionality and capacity of public health laboratories and implementation of IPHS norms were incorporated within the framework.

The second set of performance criteria incorporated in the conditionalities relates to several aspects of governance in state health systems (Table 2). These include conditionalities for overseeing quality of health facilities, measuring performance and competency of service delivery personnel, setting up data platforms for improved transparency/monitoring, and processes for posting of health personnel at the state-level. For improving quality of public health facilities, targets on LaQshya, and rating of PHCs and district hospitals (based on inputs and service delivery) have been incorporated. On data platforms and reporting, a major emphasis has been laid on setting up and uploading information in digital platforms like Human Resource Information System (HRIS) and Health Management Information System (HMIS). Also, to support the free drugs and diagnostic initiative of Government of India, conditionalities have been incorporated on implementation of the IT portal on Drug and Vaccine Distribution Management System (DVDMS) to ensure timely procurement and distribution of drugs and diagnostics related items. Similarly, following the COVID pandemic, there has been a renewed emphasis on disease surveillance and in that context, conditionalities on reporting of diseases on the Integrated Health Information Platform (IHIP) have been introduced. Civil registration of births and deaths, and registration of pregnant women and children on the RCH portal has also been stressed upon. Moreover, the duration of average occupancy of health personnel at specific administrative positions at state and district-level have been included.

The third set of performance criteria under the Conditionalities framework has been with respect to ensuring adequate human resources for health and availability of free medicines in public health facilities (Table 2). Conditionalities in this set have included incentives to reduce vacancies of regular and contractual staff in health facilities, particularly those associated with service delivery (Multipurpose Workers (MPWs), staff nurses, laboratory technicians, specialists, etc.). Rational and equitable deployment of human resources within states have also been stressed upon. Additionally, incentives have also been laid down for creation of a separate public health cadre in states. On provisioning of free medicines in all public health facilities, incentives have been provided to states to implement relevant policies and systems.

The fourth set of performance criteria within the Conditionalities framework pertains to the usual performance benchmarks encompassing various health output and outcome indicators (Table 2). While the overarching goal of reduction of Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR) has been stressed upon since 2015-16, these were later targeted through the state-level Health Index constructed by the National Institution for Transforming India (NITI) Aayog between 2017-18 until 2023-2024. The NITI health index focussed on specific aspects and drivers of IMR and MMR like neonatal mortality, under-five mortality, total fertility rate, coverage of immunization, antenatal care, proportion of institutional deliveries along with case notification/treatment

success of Tuberculosis/HIV and screening of 30+ population for NCDs. In addition, it included indicators like proportion of low birthweight among newborn and sex ratio at birth in its earlier iterations (See Appendix Table A1 for detailed list of indicators included in Round One of NITI Health Performance Index).

The fifth and final set of performance criteria under the framework included conditionalities on the health budget, administrative processes related to fund transfers and out-of-pocket expenditures. Specifically, it incentivizes states to achieve significant increases to state health budgets, reduce the time taken to release NHM funds disbursed by the central government from state treasuries to implementing agencies and free service at the point of care. It also provides incentives for enacting and adopting specific regulations like the Clinical Establishment Act, 2010 to ensure improved health services.

The current Conditionalities Framework (2024–2026) prioritizes performance across multiple strategic domains. Service delivery and disease control are emphasized through defined targets under the National Tuberculosis Elimination Programme (NTEP), the National Viral Hepatitis Control Programme (NVHCP), compliance with the Mental Healthcare Act, and expanded screening for Non-Communicable Diseases (NCDs), while continuing focus on maternal and child health. System strengthening is addressed through weighted indicators for the functionality of Ayushman Arogya Mandirs (AAMs), availability of human resources in line with IPHS norms, and infrastructure compliance. IT and governance are incentivized through the use of logistics and digital tracking platforms like DVDMS and the RCH portal. Quality assurance is promoted by rewarding facility-level certifications under NQAS and LaQshya standards, while financial aspects are encouraged by linking incentives to increases in state health budgets and timely release of funds.

D. Performance Assessment Under the NHM Conditionalities Framework

Measurable performance indicators have been instituted in the NHM Conditionalities Framework since 2015-16. Prior to that the framework was vague and provided limited information as to the precise calculation and measurement of the incentive/penalty. For instance, “Responsiveness, transparency and accountability” was accorded an incentive of up to 8% of the outlay in both 2013-14 and 2014-15, but the mode of its measurement, consolidation and conversion into monetary value was not specified.

Performance assessment under the framework on most indicators is carried out based on self-reported data by states. Information on health service coverage and progress on various programs under NHM are uploaded by states on various online platforms like HMIS, HRMIS, MCTS, RCH-portal and Nikshay for performance assessment. Also, reports on quality achievements, free drug supplies and improvements in deployment of human resources are based on reports submitted by states and/or assessments made by the National Health Systems Resource Centre (NHSRC), a think-tank under the Ministry of Health and Family Welfare (MoHFW). Progress on specific disease control programs like Mental Health and Tuberculosis are ascertained based on reports provided by relevant divisions under MoHFW. These reports are also based on information submitted by states to MoHFW. Only assessment of performance on health outcomes like IMR, MMR,

TFR are based on an external source Sample Registration System (SRS). Also, for out-of-pocket expenditure on delivery in public facilities, assessment is based on an independent survey, the National Family Health Survey (NFHS).

The weights assigned to different performance criterion in the Conditionalities Framework have varied over the years. The highest weight assigned to any single indicator in the framework has been the NITI Aayog's relative ranking of states. These state rankings were based on relative incremental performance of states in the health sector, and was measured through the NITI Health Index. The index used a multitude of indicators to arrive at a composite index spanning across three major domains: a) Health Outcomes, b) Governance and Information and c) Key Inputs and Processes.[10] The list of indicators used in these domains and their sub-domains within the NITI health index is shown in Appendix Table A1. The index was introduced in the Conditionalities framework in 2017-18 with a weightage of 50 per cent. Subsequently, the weight attached to this indicator was reduced: 40 per cent in 2018-19 and 2019-20, 30 per cent in 2021-22 and again increased to 40 per cent in 2022-24. Irrespective of the changes, the indicator had the highest weightage among all conditionalities in the framework between 2017-18 to 2022-24. In recent years, a high weightage has also been assigned to Ayushman Bharat- Health and Wellness Centres (AB-HWCs), reflecting its priority in the policy arena.[11]

[10] The scores of states for each of the indicators was derived by scaling the attained value of the indicator. A weighted average of the scaled values was then calculated to arrive at the composite index score for each state. The difference between the index score in the reference year and the base year was used to measure the states' incremental performance. This incremental performance was normalized by the best/worst incremental progress over all states– in case of decline in performance, the incremental score was normalized by the worst decline witnessed over all states; in case of improvement, it was normalized by the highest increase in composite score over all states.

[11] The multitude of indicators in the NITI Health Index and their reporting added to the complexity of the Conditionalities framework.

Box: Key Issues and Challenges with the NITI Aayog Health Performance Index

The NITI Aayog Health Performance Index (HPI) was used as a significant component of the National Health Mission (NHM) conditionalities framework until 2024, accounting for 40% of performance-based incentives and penalties tied to state health funding. While the index served as a tool to foster competition and track health sector progress across Indian states and union territories, certain conceptual and methodological challenges underscored the need for careful interpretation and further refinement.

Conceptual Issues:

- ***Clarity of thought- Inputs, outputs or processes?-*** The HPI combined diverse indicator types—inputs (e.g., health workforce vacancies), processes (e.g., timeliness of fund transfers, data completeness), and outcomes (e.g., infant mortality, sex ratio at birth)—into a single composite measure. This blending complicates clear distinctions between health system performance and broader social determinants affecting population health.
- ***Multi-dimensionality of outcomes-*** Some outcome indicators, notably infant mortality and sex ratio at birth, are influenced by factors beyond direct health sector control, including socio-cultural and multisectoral influences, raising questions as to the index's attribution to health services alone.
- ***Examining indicators-*** Aggregating such heterogeneous indicators using arithmetic averaging assumes substitutability, meaning a decline in a key health outcome could be offset by improvement in a less directly related input or process indicator, raising questions about conceptual coherence.

Methodological Issues:

- ***Ignoring the base effect-*** The use of annual min-max scaling relative to peer states prioritized relative positioning over absolute progress, potentially disadvantaging states already performing well (the "base effect").
- ***Data integrity and lags-*** Reliance on self-reported Health Management Information System (HMIS) data raised concerns about data quality and potential gaming of reported metrics. Outcome data sources like the Sample Registration System (SRS) carry time lags, with some data points being two or more years old, posing risks to timely performance assessment.
- ***Comparability-*** Indicator selection and weights frequently changed across annually released index rounds, introducing challenges for longitudinal comparability and interpretation of incremental improvements.
- ***Relationship between indicators-*** High correlations among some indicators (e.g. proportion of ANC registered within the first trimester and proportion of pregnant women with 4 or more ANC) pointed to redundancy in data collection and included measures, reducing the efficiency and distinctiveness of the information captured.

Table 2: Performance Criteria on Different Dimensions under the NHM Conditionalities Framework in various years

Specific Programs Under NHM	Governance: Quality, Data systems and Monitoring	Inputs: Human Resources, and Medicines	Budget, Financial Processes & Regulations	Health Outcomes and Outputs
• **RBSK: Timely roll out and minimizing gaps in *Rashtriya Bal Swasthya Karyakram* (2013–15).** • **JSSK: Implementation and minimizing gaps in *Janani Shishu Suraksha Karyakram* (2013–16).** • **NUHM: Establishment of urban planning cells and expansion of State Health Society for Urban Health (2014–15).** • **RKSK: Timely roll out of *Rashtriya Kishor Swasthya Karyakram* (2014–15).** • **Mental Health (NMHP): Coverage of districts under National Mental Health Program (2017–20; 2021–24).** • **Health & Wellness Centres (HWCs): Operationalization of AB-HWCs (2017–20); AB-HWC State Score (2021–24).** • **ECD: Implementation of Early Childhood Development programs**	• **Responsiveness:** Transparency and accountability measures (2013–15). • **Quality Assurance:** General incentives for quality assurance (2013–15). • **Convergence:** Measures to improve inter-sectoral convergence (2013–15). • **Recording Vital Events:** Strengthening civil registration of births and deaths (2013–15). **District-wise RoP: Uploading district-wise Record of Proceedings (RoP) on NHM website within 30 days (2014–15; 2021–26)** • **Monitoring:** Facility-wise performance audits (2013–15); Supportive supervision (2014–15). • **IT Systems:** Introduction of HRIS and HMIS (2014–17). • **Facility Functionality:** Functionality of First Referral Units (FRUs) and CEmOC facilities (2015–17). • **Quality Certification:** Quality	• **HR Deployment:** Rational deployment to high priority districts (2013–15). • **Competency:** Baseline assessment of competencies (SNs, ANMs, LTs) and skill tests (2013–15). • **Public Health Cadre:** Creation of a specialist Public Health Cadre (2013–15). • **Nurse Practitioner:** Implementation of Nurse Practitioner model (2013–14). • **Free Services:** Policy and systems for Free Generic Medicines and Diagnostics (2013–17). • **Vacancies:** Reducing proportion of vacant positions (2017–18).	• **State Health Budget: Incentivizing >10% increase in State annual health budget (2013–16; 2022–26).** • **Regulations:** Enacting/adopting *Clinical Establishment Act, 2010* (2013–15). • **Fund Utilization:** Expenditure up to specific targets (e.g., 15% by June) (2014–15). • **Fund Transfers:** Reducing time lag in transfer of funds from State Treasury (2017–18).	• **MCH Outcomes:** Reduction in IMR and MMR (2015–17). • **Immunization:** Full Immunization Coverage (2015–17). Immunization Coverage continues to be employed as a screening criteria for receiving incentives from 2018 onwards. • **NITI Health Index:** Ranking of states on *Performance on Health Outcomes* (covering IMR, MMR, TB, HIV, etc.) (2017–24). • **NCD Screening:** % of 30+ population screened for NCDs (2017–20). *(Note: In 2024-26, major outcomes like TB, Hepatitis, and NCDs are tracked under Specific*

(2019–20). **• School Health: Implementation of Ayushman Bharat School Health & Wellness Ambassador initiative (2021–24).** **• Mental Health Act: Actions taken for fulfillment of provisions under *Mental Healthcare Act, 2017* (2021–26).** **• Viral Hepatitis (NVHCP): Screening and treatment targets for Hepatitis B & C (2021–26).** **• Tuberculosis (NTEP): Notification and Treatment Success targets (2022–26).** **• Ambulance Services: Implementation of National Ambulance Services as per norms (2022–24).** **• Ayushman Arogya Mandir (AAM): AAM State Score (2024–26).** **• NCDs (NP-NCD): Screening and care targets for Hypertension and Diabetes (2024–26).**	certification of facilities (2015–17). **• Data Integrity:** Validation of HMIS data (e.g., ANC registration) (2017–18). **• Leadership Tenure:** Occupancy of State/District health officers (2017–18). **• Facility Grading:** Star rating of PHCs; Grading of District Hospitals (2017–20; 2022–24). **• Transparency:** Uploading district-wise Record of Proceedings (RoP) on website (2021–26). **• Logistics IT (DVDMS): Implementation of DVDMS with API linkages (2021–26).** **• Surveillance (IDSP):** Reporting on IHIP and Public Health Lab functionality (2022–24). **• Beneficiary Tracking: Registration on RCH Portal (2022–26).** **• Certifications: NQAS and *LaQshya* (Labor Room) certification (2022–26).**	**• Regular HR: Increase in "in-place" regular service delivery HR (2021–26).** **• Contractual HR: Increase in "in-place" contractual HR (2022–26).** **• IPHS Compliance: Compliance with IPHS norms for infrastructure and HR availability (2022–26).**		*Programs)*.

Source- NHM Record of Proceedings (RoP) for states

II. Effectiveness of NHM Conditionalities Framework

While the preceding section outlined the conceptual underpinnings of the NHM Conditionalities Framework, this section examines its actual implementation and effectiveness. Focussing on the period 2019–20 to 2024–25, the analysis draws on allocation data from states' NHM Records of Proceedings (RoPs), information on actual disbursements from the incentive pool by the Ministry of Health and Family Welfare (MoHFW), and publicly available data on total central NHM releases.

A. Magnitude of Funds Earmarked for Incentive Pool

A precondition for the effectiveness of any PBF framework is that the magnitude of funds linked to performance should not be insignificant, so as to act as an incentive. If the financial rewards or penalties based on performance are too small, they may not sufficiently motivate systems to change behaviours and improve outcomes.

Currently, under the Conditionalities Framework, the allocation towards the incentive pool is stipulated to be 20 percent of NHM allocations. In practice, however, the actual share earmarked towards the incentive pool varies across states, suggesting that the basis for incentive allocation is less straight forward. Table 3 shows the allocation on incentive pool as a proportion of total NHM Flexi-pool for the period 2019-20 to 2024-25. In the larger states (excluding hilly states, northeastern states, and Union Territories), the incentive pool accounted for 17–24 percent of the allocation on NHM Flexi-pool. As a share of total NHM allocations, this proportion was lower, ranging from 7–15 percent (Table A2 in appendix).[12]

Table 3- Allocation on incentive pool as per cent of allocation on NHM Flexi-pool (per cent)

State	2019-	2020-	2021-	2022-	2023-	2024-25
	High-Focus States					
Bihar	19.6	21.1	18.8	23.0	23.0	23.2
Chhattisgarh	18.2	21.1	15.8	19.3	19.3	22.8
Jharkhand	18.5	20.7	15.6	19.8	19.8	23.5
Madhya Pradesh	23.6		18.1	23.1	23.1	23.1
Odisha	18.4	18.7	18.0	22.9	22.9	22.9
Rajasthan	19.2	21.5	18.2	23.1	23.1	23.5
Uttar Pradesh	19.7	21.5	18.1			23.0
	Hilly States					
Himachal Pradesh	20.7	22.0	16.2	23.2	23.2	23.5
Jammu and Kashmir	20.0	21.3	18.9	23.3	23.3	23.4
Uttarakhand	19.2	21.8	16.6	23.1	23.1	23.5

[12] For the hilly states, north-eastern states and UTs, the proportion was marginally higher.

	NE High Focus States					
Arunachal Pradesh	21.3	20.5	17.0	22.6	22.6	23.5
Assam	20.4	21.3	17.6	23.1	23.1	21.9
Manipur	21.3	17.6	16.8	22.1	22.1	23.5
Meghalaya	19.7	21.1	16.8	22.7	22.7	23.5
Mizoram	21.2	19.9	15.6	22.0	22.0	17.5
Nagaland	22.7	17.7	16.6	22.3	22.3	23.5
Sikkim	21.6	18.4	15.8	22.2	21.9	21.7
Tripura	19.1	20.2	16.9	22.4	22.4	21.8
	Other States					
Andhra Pradesh	18.2	20.7	18.2	20.7	20.7	23.5
Goa	17.5	20.8	17.8	21.8	21.8	23.5
Gujarat	19.2	21.1	17.9	22.6	22.6	19.0
Haryana	18.6	20.8	17.9	22.2	22.2	22.0
Karnataka	20.0	21.0	8.1	20.5	20.5	23.5
Kerala	18.7	21.0	17.9	22.2	22.2	21.9
Maharashtra	20.7	20.9	18.4	22.9	22.9	23.5
Punjab	18.0	19.9	17.8	22.1	22.1	23.5
Tamil Nadu	20.5	20.8	18.7	23.0	23.0	23.5
Telangana	19.5	21.4	18.3	22.8	22.8	23.5
West Bengal	19.4	21.1	18.3	22.9	22.9	22.8

Source- NHM Record of Proceedings (RoP) for states

B. State-wise Disbursement of Funds from the Incentive Pool

Table 4 indicates the share of funds actually disbursed to states as a proportion of their incentive allocation in each year.[13] This share provides a proxy measure of the performance of states, in the absence of information on the actual performance scores attained by them. Potentially, it also allows comparison of states' performance within each pool in any year[14].

Figures in the Table indicate that the degree of variation in the proportion across different categories of states is strikingly low, reflecting similar performance of states. For instance, in 2023-24 and 2024-25, the average incentive disbursement as a proportion of incentive allocation was 86.6 and 102.3 per cent in High-focus states as opposed to 83.9 and 101.2 per cent in non-high focus states. In general, although the disbursement of funds from the incentive pool ranged between 80 to 120 per cent of

[13] The actual disbursement of funds from the incentive pool to any state in a year is based on its performance scores in the previous year.

[14] While acknowledging that the final availability of the incentive pool might differ from the RoP incentive allocation, we proceed with this ratio given the plausible assumption that the final incentive allocation would be proportional to the initial allocation of incentives in the RoPs for states. This would imply that the comparison of this percentage across states would still be a valid measurement of states' relative performance for the same year under this framework.

their allocation, the shares were clustered around 100 per cent across all categories of states in almost all the years, with a few exceptions.[15]

Even within same categories (pools) of state, the variation in performance was low. This is evident from the mean and standard deviation of the states' disbursements of incentives as proportion of allocation (Table 5). Interestingly, in the last three years, the variation in performance was lower in relatively better off states (non-high focus other states) than those that are worse off (high-focus), implying similar performance in relatively well-off better performing states.

Table 4: Statewise Disbursement of Incentives as a proportion of Incentive Allocation (per cent)

	2019-20	2021-22	2022-23	2023-24	2024-25
State	**Incentive disbursement as of allocation**				
	High Focus States				
Bihar	33.3	87.5	85.0	80.8	80.0
Chhattisgarh	79.4	106.6	117.0	88.6	114.1
Jharkhand	76.9	105.7	95.0	85.2	100.0
Madhya Pradesh	45.8	102.9	109.6	87.3	100.2
Odisha	77.2	104.3	108.2	90.0	118.7
Rajasthan	76.3	100.5	95.0	87.7	102.6
Uttar Pradesh		101.2			100.4
	Hilly States				
Himachal Pradesh	74.6	100.0	100.0	89.2	100.0
Jammu and	76.0	107.2	103.7	90.4	111.5
Uttarakhand	59.1	100.0	100.0	89.3	100.0
	NE High Focus States				
Arunachal Pradesh		103.6	100.0	89.1	100.5
Assam	72.5	102.2	100.0	92.2	100.3
Manipur	65.6	84.4	100.0	93.4	95.0
Meghalaya		144.1	100.0	93.7	102.6
Mizoram	41.6	185.3	100.0	93.8	102.7
Nagaland			100.0	87.5	89.0
Sikkim			100.0	106.1	99.0
Tripura	67.6	102.7	100.0	92.3	105.7

[15] Notably, 2019-20 was an unusual year where every state received less than its allocation (share is less than 100 per cent) yielding a situation where the total incentive disbursement fell short of the total incentive pool allocated. This is likely due to constraints in available funds for distribution from the incentive pool in that year. It may be recalled that in the last quarter of 2019-20, the Ministry of Finance adopted a stricter budget control than earlier years as indicated in the circular https://dea.gov.in/files/budget_division_documents/Scan_20191227_160313.pdf
This could be a contributing factor for the budget constraint.

	Other States				
Andhra Pradesh	75.8	100.0	102.4	85.0	101.0
Goa	61.8	90.0	90.1	84.1	119.6
Gujarat	72.5	100.0	101.9	84.2	101.2
Haryana	76.5	100.0	101.0	82.6	101.7
Karnataka	73.8	203.7	102.1	85.0	100.4
Kerala	76.6	100.1	101.5	82.4	100.6
Maharashtra	71.7	100.0	100.9	84.4	100.1
Punjab	78.5	100.1	103.4	83.1	85.5
Tamil Nadu	69.9	100.0	102.1	83.5	100.9
Telangana	73.4	100.0	101.3	84.8	101.5
West Bengal	46.5	100.0	90.0	83.1	100.2

Source- NHM Record of Proceedings (RoP) for states, Disbursement of Incentives obtained from MoH&FW

Note: FY 2020-21 was declared as break year from the Conditionalities Framework due to the pandemic NHM RoP for Uttar Pradesh for 2022-24 does not explicitly demarcate the incentive pool separately from the total GoI support

Table 5 Intra-pool dispersion of disbursement measured as proportion of allocation (per cent)

Category of States		2019-20	2021-22	2022-23	2023-24	2024-25
High Focus States	Mean	64.8	101.2	101.6	86.6	102.3
	Standard	20.0	6.5	11.9	3.3	12.4
Hilly States	Mean	69.9	102.4	101.2	89.6	103.8
	Standard	9.4	4.2	2.1	0.6	6.6
NE High Focus	Mean	61.8	120.4	100.0	93.5	99.4
	Standard	13.8	37.4	0.0	5.6	5.2
Other States	Mean	70.7	108.6	99.7	83.9	101.2
	Standard	9.2	31.7	4.8	0.9	7.7

Source- NHM Record of Proceedings (RoP) for states, Disbursement of Incentives obtained from MoH&FW

C. Dilution of Incentives in-built in the design of the Conditionalities Framework

C.1 Relative Performance Assessment and Budget Constraint Induce Uncertainty in Incentive Receipts by States

The operational design of the Conditionalities framework dilutes the performance incentive for states. Currently, an incentive pool is allocated to each state annually, which is the amount received by the state if the state scores zero on the sum of all penalties and rewards. If the score (net of incentives and penalties) is positive for a

state, the state is entitled to an amount over and above this incentive allocation, and *vice-versa* if the net score is negative (NHSRC report 2019). However, the sum of the incentive pool allocation across all states within a group is the upper bound of the incentive payments that can be received by all states in a group taken together, i.e. the budget constraint of the incentive pool.

The above design weakens incentives for performance improvement, as incentive disbursements are determined not by states' absolute performance alone, but by states' relative performance within their respective peer categories. The assessment of performance in relative terms combined with the budget constraint induces uncertainty in incentive disbursement. For instance, a state scoring 10% on performance measurement with an allocated incentive pool of Rs. 100 crores, is eligible to receive Rs.100 crores plus another incentive of Rs. 10 crores. However, this incentive or penalty is subject to the budget constraint of the total available incentive pool. This means that hypothetically, if all states in a particular pool achieve a performance score of 10%, then the total calculated incentive would exceed the available pool by the same proportion, violating the budget constraint. In this case, the excess would have to be adjusted and states would actually receive less than the 10% incentive they are entitled to based solely on performance. This implies that even if a state performs remarkably well in any category, if all other states in the pool also perform similarly well, the actual disbursement received would be scaled downwards due to the budget constraint. On the other hand, if the net score is negative for all states taken together in a group, not all funds in the incentive pool will be disbursed based on performance. The funds left in the pool after distribution based on performance, are then distributed amongst them as per the NHM budget distribution formula.

To elucidate the potential impact of the in-built design, we reproduce an extract from the Table in Annexure II of the Conditionality Report by NHSRC 2018-19 (Table 6). The Table demonstrates the conversion of incentive scores of states to monetary incentives for non-high focus 'Other States' for the year 2019-20.[16] Two points are worth noting. First, as most states had earned an incentive reward based on performance, their total incentive entitlement (Rs. 1395.6 crores) exceeded the total budget of the incentive pool (Rs. 1148.8 crore). The excess of Rs. 246.8 crore had to be adjusted for all states, resulting in a lower incentive disbursement than their actual entitlement. Second, the redistribution of excess incentives dilutes the impact of performance on actual receipts. This is mirrored in the fact that while the standard deviation of the actual incentive earned was 28.5 per cent prior to redistribution, it fell to 20 per cent after redistributing the excess incentives. Interestingly, in the case of Tamil Nadu, such an adjustment led to a situation where the state actually ended up getting less than its incentive entitlement in spite of having a positive performance score!

[16] The first three columns show the incentive points, the incentive pool available to the states and the monetary incentive calculated based on the first two variables. Adding the monetary incentive (Column 3) to the state's available incentive pool (Column 2) gives the net amount that the state is entitled to receive (Column 4). Column 5 shows how this net entitlement stacks up against the incentive pool for the state. The excess of actual entitlement over budget allocation is shown in Column 6. Column 7 shows the states' readjusted entitlement after accounting for this residual distribution.

Table 6- Impact of Budget Constraint on Distribution of Incentives

State/UT	Net Incentive/Penalty (%)	Incentive Pool after Earmarking (Rs Cr)	Net incentive/penalty	Net amount proposed for released in excess of 80% of budget	Proportion of allocation that is calculated to be given as incentive	Residual distribution of Incentive/Penalty of Pool (Rs Cr)	Net Amount Available after residual Distribution (Rs Cr)	Proportion of allocation that is calculated to be given as incentive after residual distribution
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Andhra	7	110.5	40.7	151.3	136.85	-28.6	122.7	110.96
Telangana	5	80.9	21.3	102.2	126.31	-20.4	81.8	101.05
Goa	-3	3.6	-0.6	3.0	84.23		3.0	84.23
Gujarat	5	126.0	33.2	159.1	126.32	-32.6	126.5	100.46
Haryana	13	49.9	34.2	84.1	168.42	-13.1	71.0	142.22
Karnataka	6	132.2	41.7	173.9	131.58	-34.6	139.3	105.42
Kerala	8	53.5	22.5	76.0	142.11	-12.6	63.4	118.58
Maharashtra	5	240.0	63.1	303.1	126.31	-56.4	246.7	102.81
Punjab	8	53.7	22.6	76.2	142.11	-14.2	62.0	115.58
Tamil Nadu	4	134.9	28.4	163.2	121.05	-34.3	129.0	95.62
West Bengal	-7	163.8	-60.4	103.5	63.16		103.5	63.16
Total		1148.8	246.8	1395.6		-246.8	1148.8	
Mean					124.40			103.64
Standard					28.56			20.02

Source- Health System Strengthening - Conditionalities Report of States 2018-19 by NHSRC (NHSRC 2019)

C.1 Performance Impinges on the Incentive Disbursement Only at the Margin

Under the Conditionalities Framework, the true performance of a state impinges on the incentive disbursement only at the margin. This is because, the incentive pool allocation is defined as a fixed proportion of each state's overall NHM allocation[17], and therefore, directly proportional to the overall NHM fund allocation in states. Even if a state earns a cumulative performance score of zero, it is still entitled to this base allocation. Rewards or penalties apply only as marginal additions or deductions around this amount. As actual incentive disbursements range between 80-120 per cent of the initial incentive

[17] 20 per cent as per specification.

pool allocation in most states (Refer Table 4), the marginal gain or loss to any state is only +/- 20 per cent of the initial incentive allocation.

The incentive disbursement for the year 2024-25 can be used as an illustration to this effect. In that year, Odisha received the highest incentive payout at 118.69 percent, while Bihar received the minimum 80 percent (Table 3). In absolute terms, this translated into incentive disbursements of ₹193.85 crore for Odisha and ₹231.79 crore for Bihar, representing deviations of +₹30.52 crore and –₹57.95 crore, respectively, from their initial incentive allocations (Table 7). These deviations amounted to only about ±5 percent of the total NHM Flexi-pool allocations of the two states. This underscores the fact that the effective incentive embedded in the design of the Conditionalities Framework is modest at best.

Table 7 Actual performance-based disbursement for Odisha and Bihar in 2024-25

State	Total Support from GoI (Rs. Crores)	Flexible Pool GoI (Rs. Crores)	Incentive pool (Rs. Crores)	Incentive disbursement (Rs. Crores)	Excess of disbursement over allocation (Rs. Crores)	Actual incentive disbursement as proportion of flexi pool
Odisha	1945.85	1250.57	289.74	231.79	-57.95	-4.63%
Bihar	1203.584	711.814	163.33	193.85	30.52	4.29%

Source- NHM Record of Proceedings (RoP) for states, Disbursement of Incentives obtained from MoH&FW

The weak effective incentive is reflected in the close alignment between states' shares of total NHM releases (excluding incentives) and their shares of incentive disbursements in a given year (Table 8). The low effective incentive to states results in a visible concordance between the share of the total NHM releases (non-incentive portion) and the share of the total incentive component received by states in any particular year (Table 8).[18] The correlation coefficient between the two shares is as high as 0.96-0.97 in almost all the years. This suggests that the incentive distribution mirrors the distribution of the NHM releases (excluding incentives). This raises the question as to the extent the Conditionalities Framework truly departs from the underlying NHM allocation logic, and whether it is delivering a distinct, performance-sensitive redistribution of resources or simply replicating the pre-existing pattern of fund flows. Notably, the share of a state in total incentive disbursement by Government of India has remained fairly stable for each state over this period.

[18] The year 2019-20 is an exception.

Table 8 State wise disbursement of incentive and non-incentive component under NHM as a proportion of total

	2019-20		2021-22		2022-23		2023-24		2024-25	
States	**Incentive disbursement as % of total**	**NHM Releases (excluding incentive) as % of total central NHM releases**	**Incentive disbursement as % of total**	**NHM Releases (excluding incentive) as % of total central NHM releases**	**Incentive disbursement as % of total**	**NHM Releases (excluding incentive) as % of total central NHM releases**	**Incentive disbursement as % of total**	**NHM Releases (excluding incentive) as % of total central NHM releases**	**Incentive disbursement as % of total**	**NHM Releases (excluding incentive) as % of total central NHM releases**
	High Focus States									
Bihar	4.6	5.3	6.9	6.1	6.5	4.9	7.2	6.0	6.0	6.6
Chhattisgarh	4.4	2.7	3.5	3.5	3.8	3.9	3.3	2.6	3.6	2.6
Jharkhand	4.3	2.8	3.3	2.1	3.0	2.6	3.1	2.9	3.1	2.6
Madhya Pradesh	6.9	6.0	7.4	8.3	7.9	8.4	7.3	7.8	7.3	6.7
Odisha	5.7	5.1	4.3	4.5	4.5	4.1	4.4	6.0	5.0	5.3
Rajasthan	9.8	6.0	7.0	6.9	6.6	4.4	7.0	8.6	7.2	6.6
Uttar Pradesh		17.6	14.8	11.0	14.8	16.9	14.6	15.0	14.6	16.4
Sub-total	**35.7**	**45.4**	**47.2**	**42.5**	**47.1**	**45.2**	**46.9**	**48.8**	**46.8**	**46.8**
	Hilly States									
Himachal	1.9	1.7	1.4	2.1	1.6	1.6	1.6	1.4	1.6	1.4
Jammu and Kashmir	3.9	2.3	2.6	1.5	2.5	2.1	2.5	2.4	2.8	2.9
Uttarakhand	1.8	1.2	1.7	2.0	1.9	1.6	1.9	2.2	1.9	1.6
Sub-total	**7.6**	**5.3**	**5.7**	**5.6**	**5.9**	**5.3**	**6.0**	**6.0**	**6.3**	**6.0**
	NE High Focus States									
Arunachal	0.0	0.7	1.1	0.6	1.1	0.7	1.2	1.2	1.2	1.1
Assam	8.4	5.9	6.1	7.1	6.2	6.5	6.6	6.9	6.7	5.6
Manipur	0.9	0.6	0.6	0.3	0.8	0.1	0.8	0.5	0.8	0.8

Meghalaya	0.0	0.5	1.0	1.0	0.8	0.9	0.8	0.8	0.8	0.8
Mizoram	0.4	0.4	0.7	0.3	0.4	0.4	0.5	0.4	0.5	0.4
Nagaland	0.0	0.5	0.0	0.5	0.6	0.2	0.6	0.6	0.6	0.6
Sikkim	0.0	0.2	0.0	0.2	0.2	0.2	0.3	0.2	0.2	0.2
Tripura	1.0	0.8	0.8	0.8	0.8	0.7	0.9	0.8	0.9	0.7
Sub-total	**10.7**	**9.7**	**10.5**	**10.8**	**10.9**	**9.7**	**11.6**	**11.3**	**11.7**	**10.2**
	Other States									
Andhra Pradesh	4.8	3.8	3.4	4.4	3.5	5.0	3.3	3.3	3.4	3.7
Goa	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.2
Gujarat	5.3	3.8	3.8	3.9	3.9	3.6	3.7	4.7	3.8	3.7
Haryana	2.2	2.0	1.6	2.1	1.6	2.3	1.5	1.6	1.6	1.6
Karnataka	5.5	4.0	4.0	4.6	4.0	4.0	3.9	3.6	3.9	3.5
Kerala	2.3	2.9	1.7	2.9	1.6	3.6	1.5	0.4	1.5	4.0
Maharashtra	9.8	5.7	7.0	6.2	6.9	7.1	6.7	8.5	6.7	6.7
Punjab	2.4	2.5	1.7	1.2	1.8	1.4	1.6	0.1	1.4	2.6
Tamil Nadu	5.4	4.9	4.1	6.1	4.0	5.6	3.8	6.4	3.8	4.9
Telangana	3.4	3.3	2.5	2.6	2.6	2.2	2.5	1.6	2.5	3.1
West Bengal	4.3	6.2	5.1	6.0	4.5	4.0	4.9	2.4	4.9	1.6
Sub-total	**45.4**	**39.3**	**35.1**	**40.2**	**34.6**	**39.0**	**33.7**	**32.7**	**33.6**	**35.5**
Correlation coefficient	**0.93**		**0.96**		**0.97**		**0.97**		**0.96**	

Source- Disbursement of Incentives obtained from MoH&FW, Central Releases under NHM from https://sansad.in/getFile/annex/268/AU2994_11hEQ4.pdf?source=

NHM Releases excluding the Incentive calculated by subtracting amount of incentive disbursement from total NHM releases.

IV. Discussion: Conceptual and Design Issues in the Conditionalities Framework

The NHM Conditionalities Framework is affected by several conceptual and design limitations.

D.1 Conditionalities Beyond the Scope of the NHM Framework

The success of any PBF scheme hinges on the locus of control principle, which dictates that performance measurement must be based on indicators that are directly under the command and influence of the incentivized entity. In the case of NHM Conditionalities Framework, not all indicators included in the framework are under the direct control of the Office of the National Health Mission in states (State Health Society), the state-level entity with which conditionalities are agreed upon. For example, increase in annual health budget of states and enhancement of regular health personnel 'in-place' are not determined by the effort of State Health Societies alone. Although SHSs along with the health department may initiate processes on these dimensions, the final decision on these aspects lies with the Finance Departments of states and are subject to availability of fiscal space and the sectoral priorities of individual state governments. Similarly, governance indicators like the average occupancy of a full-time officer in specific positions of the health department are not directly under the control of SHSs in states. Also, performance on several facility-level output and outcome indicators like ante-natal care, immunization etc. are driven by the effort of both the centre and states together, and not through NHM funding alone. To that extent, larger issues with state-health systems, which are beyond the control of SHSs drive performance. Even in the context of the indicators in the Conditionalities framework that intend to promote data transparency and monitoring through IT systems including data integrity, the support from non-NHM stakeholders is critical for enhancing performance. With NHM funding a relatively small part of total health expenditure in States, a large part of the performance at the state-level is driven by factors exogenous to the effort made by NHM implementation machinery in states.

D.2 Behavioural Assumption and the Missing Reach of Incentive to Health Care Providers

PBF frameworks rest on the premise that weaknesses in healthcare delivery arise primarily from insufficient incentives for providers. In a similar way, the NHM Conditionalities framework implicitly assumes that the prevailing shortcomings in health outcomes or service delivery across states are the result of insufficient effort, political will, or managerial focus from state governments. In practice, however, health service delivery in states is shaped by various structural, fiscal, and capacity constraints, that extend beyond incentives alone. Performance indicators like health outputs and outcomes depend critically on the availability of health personnel, essential drugs and diagnostics, factors often constrained by broader structural and fiscal constraints. To the extent that many deficiencies in state health systems lie outside the behavioural realm,

the scope of an incentive-based Conditionalities framework in driving improvement in performance is inherently limited.

The Conditionalities framework also does not imbibe the usual PBF feature of directly incentivising healthcare providers for performance improvement. Instead, incentives are awarded at the state level, with no clearly defined mechanism for translating these rewards into incentives for frontline providers engaged in service delivery. Several performance indicators included under the NHM Conditionalities framework relate to health outputs that are produced at the facility level. To the extent that these outputs are influenced by provider effort, improvements in state-level performance on such indicators will depend on the actions of healthcare workers at the point of service delivery.

D.3 Absence of Third-party Involvement in Performance Assessment for Most Indicators

PBF frameworks in their canonical form, involve the engagement of third-party independent agencies for verification of data on performance in order to ensure the integrity of the incentivization process. Such verification typically includes external audits/surveys, community validation and peer reviews. In the NHM Conditionalities Framework, performance on most indicators is based on self- reported data from states, and not verified through independent external agencies through audits or surveys. With the exception of the NITI Health Index, which was reviewed and validated by an independent validation agency, most of the performance information is generated by stakeholders within state health departments or NHM systems. In such an arrangement, reporting of performance is prone to gaming and misreporting, thereby weakening credibility of performance assessments.

D.4 Zero Sum Game and Dilution of Incentive for States

The Conditionalities Framework is effectively structured as a zero-sum game, as the total incentive pool is capped within the budget earmarked for each category of states. As a result, gains by one state are possible only to the extent that other states in the same category incur penalties, ensuring adherence to the overall budget constraint. The required adjustment is made by scaling down incentive amounts in proportion to each state's NHM allocation formula share. This implies that while this approach maintains discipline from the point of view of public finance, it weakens the strength and predictability of incentives from a behavioural standpoint.

Importantly, the framework emphasizes relative performance across states rather than absolute improvements within a state. Under such a relative assessment system, even exceptional performance may not translate into substantial financial rewards. Empirical evidence shows that the proportion of total incentives received by states has remained fairly stable over the past few years, and there is a strong correlation between incentive shares and underlying NHM funding shares. suggesting the incentive mechanism has so far mirrored existing allocation patterns more than driving differentiated performance

improvements. This underscores the fact that the effective incentive embedded in the framework is limited.

V. Summary and the Way Forward

Performance-based financing within the National Health Mission needs to be anchored within the framework's inherent potential. While the Conditionalities framework has served as a signalling mechanism for communicating the Centre's health sector priorities and reform agenda to states, its potential to function as an incentivising tool for improving states' health sector performance is limited. NHM constitutes a relatively small proportion of health expenditure in states, and therefore, improvements in health sector performance extend well beyond the remit of NHM funding alone. Health achievements are predominantly shaped by broader state-level structural and fiscal parameters, many of which are exogenous to the incentivised entity under NHM. Any redesign, must therefore, acknowledge that performance-based transfers under NHM are a complementary instrument, operating at the margin, rather than a substitute for predictable, adequate, and equitable baseline financing.

Notwithstanding its limited scope, the NHM Conditionalities Framework has marked a significant beginning. By using conditional incentives to promote the adoption of IT-based monitoring platforms such as HMIS, HRMIS, and DVDMS, the framework has laid the groundwork for future systematic performance measurement platforms for both the Central and state governments. This can be viewed as a first stage advancement, or an intermediate step in achievement of the broader goal of health service delivery enhancement through such a framework. The foundation of IT systems prepared by this step can be potentially used to advance towards more evolved methods of performance-based financing.

Currently, performance assessments are primarily based on self-reported achievements from state-level healthcare providers and stakeholders, which creates perverse incentives and undermines both the credibility of performance data and the overall integrity of the framework. Also, short-term annual performance assessments are not very meaningful as systemic reforms often require a medium time horizon to yield results. Keeping these in view, adopting a three-year performance assessment cycle aligned with the years in which the National Family Health Survey (NFHS) is conducted may help in enhancing the credibility of the framework. This will facilitate validation of performance on service delivery outputs reported by healthcare providers and state-level stakeholders with survey data collected through NFHS. Not only will this enhance data credibility and integrity of the performance framework, but also ensure a meaningful time horizon to allow states to achieve results.

Setting performance benchmarks (conditionalities) separately for different groups of states is also likely to be a more effective approach as health systems maturity, epidemiological profiles, and institutional and fiscal capacities vary significantly across states. It may be helpful to define performance targets for clusters of states with broadly comparable characteristics, similar to the existing grouping for incentive allocation.

However, if such an approach is adopted within the recommended three-year performance assessment cycle, separate data on achievements by different clusters of states need to be collected through National Family Health Surveys for validation. In addition, regular epidemiological surveys will be helpful to track shifting disease burdens and ensure that the disease specific service delivery performance indicators incorporated within the NHM Conditionalities framework, remain aligned with the incidence of diseases at the ground-level.

Importantly, the current design of relative performance assessment within state groups weakens incentives for states, as performance rewards depend not only on their own performance but also on the performance of peer states within the same group. The design aspect has possibly contributed to the fact that the share of each state in total incentive disbursement to states by the Central Government has been relatively stable over recent years, and the receipt of NHM funds by states on the incentive and non-incentive component being highly correlated. This indicates either a lack of substantial variation in states' performance or limitations in the translation of performance into financial rewards. To ensure that receipt of rewards is based entirely on own efforts of states, and are not driven by factors outside their control, progress in performance of a state should be measured against a state's own achievements in the past. This will eliminate the zero-sum nature of the existing framework, in which some states can be rewarded only at the expense of others.

In sum, the NHM Conditionalities Framework has evolved over more than a decade of implementation. Going forward, it requires strengthening through a careful review of the choice of performance conditionalities, the design of performance assessment cycles, and the mechanisms for performance verification. In carving the way ahead, two considerations will be important. First, given the mixed global evidence on Performance-Based Financing, a cautious approach is warranted. Second, in the Indian context, where states operate within markedly different fiscal capacities and structural conditions, the framework should function as a complementary lever to improve health service delivery, rather than a substitute for adequate and predictable baseline funding.

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APPENDIX TABLES

Table A1: Indicators included in NITI Aayog Health Performance index 2017-18

Health Outcomes	Governance and Information	Key Inputs and Processes
1. Key Outcomes (weight-500) • **Neonatal Mortality Rate (NMR)** • **Under-five Mortality Rate (U5MR)** • **Total Fertility Rate (TFR)** • **Proportion of Low Birth Weight (LBW) among newborns** • **Sex Ratio at Birth (SRB)** **2. Intermediate Outcomes (weight- 300)** • **Full immunization coverage** • **Proportion of institutional deliveries** • **Total case notification rate of TB** • **Treatment success rate of new microbiologically confirmed TB cases** • **Proportion of people living with HIV (PLHIV) on ART** • **Average out-of-pocket expenditure per delivery in public health facility (INR)**	1. Health Monitoring and Data Integrity (weight-70) • Data Integrity Measure: a. Institutional deliveries b. ANC registered in 1st trimester 2. Governance (weight- 60) • Average occupancy of an officer (in months), combined for following three posts at State level for last three years: 1. Principal Secretary 2. Mission Director (NHM) 3. Director (Health Services) • Average occupancy of a full-time officer (in months) for all the districts in last three years - District Chief Medical Officers (CMOs) or equivalent post (heading District Health Services)	1. Health Systems/Service Delivery (weight-200) • Proportion of vacant healthcare provider positions (regular + contractual) in public health facilities • Proportion of total staff (regular + contractual) for whom an e-payslip can be generated in the IT-enabled Human Resources Management Information System (HRMIS) • a. Proportion of specified type of facilities functioning as First Referral Units (FRUs) b. Proportion of functional 24x7 PHCs • Proportion of districts with functional Cardiac Care Units (CCUs) • Proportion of ANC registered within first trimester against total registrations • Level of registration of births • Completeness of IDSP reporting of P and L forms • Proportion of public health facilities with accreditation certificates by a standard quality assurance program (NQAS/NABH/ISO/AHPI) • Average number of days for transfer of Central NHM fund from State Treasury to implementation agency based on all tranches of the last financial year

Source- 'Healthy States, Progressive India' Report on the Ranks of States and Union Territories (Round I), NITI Aayog

Table A2- Allocation on Incentive Pool as a Proportion of total GoI support under NHM (per cent)

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
State	**Incentive (as proportion of total GoI support)**	**Incentive (as proportion of total GoI support)**	**Incentive (as proportion of total GoI support)**	**Incentive (as proportion of total GoI support)**	**Incentive (as proportion of total GoI support)**	**Incentive (as proportion of total GoI support)**
	High Focus States					
Bihar	14.6	15.6	14.3	15.9	15.9	14.9
Chhattisgarh	13.4	14.2	12.3	13.8	13.8	14.3
Jharkhand	13.8	15.2	12.3	14.2	14.2	14.9
Madhya Pradesh	16.7		12.0	13.7	13.9	13.1
Odisha	13.7	12.0	12.4	14.3	14.4	13.6
Rajasthan	13.0	14.2	12.7	14.4	14.6	13.3
Uttar Pradesh	13.6	13.7	12.3			12.7
	Hilly States					
Himachal Pradesh	11.6	12.2	10.1	13.0	13.2	12.9
Jammu and	12.8	13.2	12.5	14.0	15.0	14.2
Uttarakhand	10.7	15.6	10.2	12.7	12.8	14.9
	NE High Focus States					
Arunachal Pradesh	16.2	15.7	13.7	16.2	16.2	17.0
Assam	14.6	14.7	12.9	15.0	15.1	16.3
Manipur	15.1	13.3	13.0	15.3	15.4	15.6
Meghalaya	14.3	15.2	12.8	15.4	15.4	15.7
Mizoram	12.2	11.6	10.2	12.8	13.0	11.4
Nagaland	14.7	11.9	11.5	13.9	14.0	14.1
Sikkim	12.5	10.4	9.8	12.2	12.4	12.2
Tripura	13.3	13.9	12.1	14.4	14.6	14.4
	Other States					
Andhra Pradesh	11.2	11.6	10.3	11.7	11.9	9.7
Goa	9.2	10.9	9.6	10.8	11.0	10.0
Gujarat	12.6	13.9	12.4	14.0	14.1	12.9
Haryana	10.8	12.1	10.6	12.0	12.1	11.3
Karnataka	11.6	11.8	5.6	12.8	13.0	12.7
Kerala	8.4	8.4	7.8	8.8	9.0	7.2
Maharashtra	12.1	14.7	13.4	14.9	15.0	11.8
Punjab	9.8	14.1	13.0	14.6	14.7	13.1
Tamil Nadu	10.7	10.2	9.8	11.0	11.2	9.9
Telangana	13.5	12.6	11.4	12.9	13.1	12.0
West Bengal	9.2	12.1	11.5	13.0	13.2	11.9

Source- NHM Record of Proceedings (RoP) for states

Key conditionalities to be enforced (Column1) and areas in which initiatives would draw additional allocations by way of incentivisation of performance (Column 2) during the year 2013-14.

KEY CONDITIONALITIES	INCENTIVES (2013-14)
1. **Rational and equitable deployment of HR with the highest priority accorded to high priority districts and delivery points.** 2. **Facility wise performance audit and corrective action based thereon.** 3. **Performance Measurement system set up and implemented to monitor performance of regular and contractual staff.** 4. **Baseline assessment of competencies of all SNs, ANMs, Lab Technicians to be done and corrective action taken thereon.** 5. **Gaps in implementation of JSSK may lead to a reduction in outlay upto 10% of RCH base flexipool.**	A. Responsiveness, transparency and accountability (upto 8% of the outlay). B. Quality assurance (upto 3% of the outlay). C. Inter-sectoral convergence (upto 3% of the outlay). D. Recording of vital events including strengthening of civil registration of births and deaths (upto 2% of the outlay). E. Creation of a public health cadre (by states which do not have it already) (upto 5% of the outlay) F. Policy and systems to provide free generic medicines to all in public health facilities (upto 5% of the outlay) G. Timely roll out of RBSK (upto 5% of the outlay) H. Enacting/adopting a bill like the Clinical Establishment Act, 2010 as per their requirement, to regulate the quality and cost of health care in different public and private health facilities in the State (upto 5% of outlay). I. States providing more than 10% increase in its annual health budget as compared to the previous year will attract additional incentive. J. States to implement the nurse practitioner model to strengthen the nursing services.

Source- NHM Record of Proceedings (RoP) for states for 2013-14

Conditionalities Framework set for 2014-15

Key Conditionalities	Incentives under NRHM-RCH POOL (NRP)	Disincentives
A. **Rational and equitable deployment of HR with the highest priority accorded to high priority districts and delivery points and facilities located in slum and low-income neighbourhoods in urban area.** B. **Introduction of Human resource Information Management System for regular and contractual staff in a manner that salary bill is generated through the HRIS web portal, which ensures that the HR deployment information remains updated** C. **Facility wise performance audit and corrective action based thereon.** D. **Performance Measurement system set up and implemented to monitor performance of regular and contractual staff.** E. **RBSK to be rolled out in at least 30% of the districts.** F. **Baseline assessment of competencies of all SNs, ANMs, Lab Technicians to be done and corrective action taken thereon.** G. **State should ensure expenditure upto 15% by June 2014 and another 30% by September 2014 of their approved budget under each pool in the FY 2014-15.** H. **Expand the Governing Body (GB) and the Executive Committee of the State Health Mission/Society to include Minister(s) in charge of Urban Development and Housing, and Secretaries in charge of the Urban Development and Housing departments.** I. **Urban Health planning cell should be established in the State Health Society (SPMU). However, the thematic areas will be appropriately strengthened at the State Health Society and District Health Societies to support both NUHM and NRHM. Parallel structures shall not be created for NRHM and NUHM.** J. **State/UT will adopt Competency based Skill Tests and transparency in selection and recruitment of all doctors, SNs, ANMs and LTs sanctioned under NHM.** K. **All services under the National Health Programme/Schemes should be provided free of cost.** L. **Investments in U-PHCs must lead to improved service offtake at these facilities, which should be established through a baseline survey & regular reporting through HMIS.** M. **The UPHCs should provide the whole range of services enumerated in the NUHM**	A. Responsiveness, transparency and accountability (upto 8% of the outlay). B. Quality assurance (upto 3% of the outlay). C. Inter-sectoral convergence (upto 3% of the outlay). D. Recording of vital events including strengthening of civil registration of births and deaths (upto 2% of the outlay). E. Creation of a public health cadre (by states which do not have it already) (upto 5% of the outlay) F. Policy and systems to provide free generic medicines to all in public health facilities (upto 5% of the outlay) G. Timely roll out of RBSK (upto 5% of the outlay) H. Timely roll out of RKSK (incentive of upto 5% of the outlay) I. Regular supportive supervision and corrective action based on reports of visits. (Incentive of upto 5% of the outlay) J. Enacting/adopting a bill like the Clinical Establishment Act, 2010 as per their requirement, to regulate the quality and cost of health care in different public and private health facilities in the State (upto 5% of outlay). K. States providing more than 10% increase in its annual health budget as compared to the previous year will attract additional incentive.	A. Gaps in implementation of JSSK may lead to a reduction in outlay upto 10% of RCH base flexipool. B. Gaps in introduction of Human Resource Information Management System may lead to reduction in outlay of upto 10% C. Gaps in roll out of RBSK in at least 30% of the districts may lead to reduction in outlay of upto 5%.

Implementation Framework.		

Source- NHM Record of Proceedings (RoP) for states for 2014-15

Criteria for Conditionalities Framework 2015-16

Conditionalities	Weightage	Source
1. Reduction in IMR	5%	SRS
2. Reduction in MMR	5%	SRS
3. Full Immunization Coverage	5%-(-5)%	MCTS
4. Functionality of FRUs/ CEmOCfacilities (excluding Medical Colleges)	5%-(-5)%	HMIS
5. Quality Certification	5%	NHSRC report
6. JSSK Implementation	-10%	MCTFC Report
7. Governance: Quality of Services and functionality of public health facilities	-5% 5%	HMIS District report certified by State Nodal officers and assessments made by NHSRC teams and MCTFC
8. Implementation of Free drugs and diagnostics Services	5%	State budget
9. Increase in State Health budget		

Source- NHM Record of Proceedings (RoP) for states for 2015-16. *Note*-Negative weightage indicates an item carrying a penalty

Criteria for Conditionalities Framework 2016-17

Conditionalities	Weightage	Source
1. **Reduction in IMR**	5%	SRS
2. **Reduction in MMR**	5%	SRS
3. **Full Immunization Coverage**	5%-(-5)%	MCTS
4. **Functionality of FRUs/ CEmOCfacilities (excluding Medical Colleges)**	5%-(-5)%	HMIS
5. **Quality Certification**	5%	NHSRC report
6. **Governance: Quality of Services and functionality of public health facilities**	-5%-(-5)% 5%	MCTFC Report HMIS
7. **Implementation of Free drugs scheme**	5%	District report certified by State Nodal officers and assessments made by NHSRC teams and MCTFC
8. **Implementation of Free diagnostics services**	10%-(-	HRIS generated summary and pay roll, HMIS report

9. **Implementation of integrated HRIS and updated annual formats of HMIS**	10)%	

Source- NHM Record of Proceedings (RoP) for states for 2016-17
Note-Negative weightage indicates an item carrying a penalty

Criteria for Conditionalities Framework 2017-18

Conditionalities	Weightage	Source
1. Ranking of states on 'Performance on Health Outcomes'	+50 to -50	NITI Aayog Report
2. Rating of District Hospitals in terms of input and service delivery	+10 to -10	HMIS and NITI Aayog DH Ranking Report
3. Operationalization of Health and Wellness Centers (HWC)	+10 to -10	State Report
4. % districts covered under Mental health program and providing services as per framework	+10 to -10	NHSRC Report
5. % of 30 plus population screened for NCDs	+10 to -10	Report from Mental Health Division, MoH&FW
6. **HMIS and HRIS: HR data to be in sync and to be used in performance monitoring**	+5 to -5	Report from NCD Division, MoH&FW and State reports
7. **Star rating of PHCs (both Urban and rural) based on inputs and provision of the service package agreed**	+5 to -5	Any survey data available HRIS (state) & HMIS report HMIS

Source- NHM Record of Proceedings (RoP) for states for 2017-18

Criteria for Conditionalities Framework 2018-19

Conditionalities	Weightage	Source
1. Ranking of states on 'Performance on Health Outcomes'	+40 to -40	NITI Aayog Report
2. Grading of District Hospitals in terms of input and service delivery	+10 to -10	HMIS and NITI Aayog DH Ranking Report
3. Operationalization of Health and Wellness Centers (HWC)	+20 to -20	State Report
4. % districts covered under Mental health program and providing services as per framework	+5 to -5	NHSRC Report
5. % of 30 plus population screened for NCDs	+5 to -5	Report from Mental Health Division, MoH&FW
6. **HRIS implementation**	+15 to -15	Report from NCD Division, MoH&FW and State reports
7. **Grading of PHCs (Urban & rural) based on inputs and service package**	+5 to -5	

		Any survey data available HRIS (state) & HMIS report

Source- NHM Record of Proceedings (RoP) for states for 2018-19 ; Note- Immunization Coverage was designated a screening criteria for the Conditionalities Framework. Therefore, EAG, NE and hill states were eligible for Conditionalities assessment only if they were able to achieve at least 85% full immunization coverage and 90% for the rest of the States and UTs.

Criteria for Conditionalities Framework 2019-20

Conditionalities	Weightage	Source
1. Ranking of states on 'Performance on Health Outcomes'	+40 to -40	NITI Aayog Report
2. Grading of District Hospitals in terms of input and service delivery	+10 to -10	HMIS and NITI Aayog DH Ranking Report
3. Operationalization of Health and Wellness Centers (HWC)	+20 to -20	State Report
4. % districts covered under Mental health program and providing services as per framework	+5 to -5 +5 to -5	NHSRC Report Report from Mental Health Division, MoH&FW
5. % of 30 plus population screened for NCDs	+10 to -10	Report from NCD Division, MoH&FW and State reports
6. **HRIS implementation**	+5 to -5	Any survey data available
7. **Grading of PHCs (Urban & rural) based on inputs and service package**	+5 to -5	HRIS (state) & HMIS report
8. **Early Childhood Development (ECD)**		HMIS State Reports Report from CH division

Source- NHM Record of Proceedings (RoP) for states for 2019-20

Note: In the wake of the Covid Pandemic, 2020-21 was declared as a break year from the Conditionalities Framework. Immunization Coverage was designated a screening criterion for the Conditionalities Framework. Therefore, EAG, NE and hill states were eligible for Conditionalities assessment only if they were able to achieve at least 85% full immunization coverage and 90% for the rest of the States and UTs.

Criteria for Conditionalities Framework 2021-22

Conditionalities	Weightage	Source
1. Incentive or penalty based on NITI Aayog ranking of states on 'Performance on Health Outcomes'	+30 to -30	NITI Aayog report
2. AB-HWCS State/UT Score	+25 to -25	AB-HWC portal
3. Implementation of Ayushman Bharat- School Health and Wellness Ambassador initiative	+5 to 0 +5 to -5	AH division, MOHFW DVDMS Portal
4. Implementation of DVDMS or any other logistic management IT software with API linkages to DVDMS up to PHC level	+10 to -10	Notifications, ads, and PIP
5. Increase in proportion of 'in-place' regular service delivery HR delivery cadres of MPW, Staff Nurses, lab technicians, and specialists in-place in regular cadre as on 31st December 2020 against 31st March 2020	+5 to -5	State NHM website and D.O. letter
6. District-wise RoP uploaded on NHM website within 30 days of issuing RoP by MoHFW to State	+10 to -10	NVHCP Division, MOHFW
7. Implementation of National Viral Hepatitis Control Programme (NVHCP) **7.a. Percentage of districts having treatment sites for NVHCP** **7.b. Percentage screened for hepatitis B and C against proposed target** **7.c. Percentage of pregnant women screened for hepatitis B (HBsAg) against proposed target**	+10 to -10	Mental Health Division, MoHFW
8. Implementation of National Mental Health Program (NMHP) **8.a. % districts covered under Mental health program and providing services as per framework** **8.b. Actions taken for fulfilment of provisions under Mental Healthcare Act, 2017 (MHCA 2017)**		

Source- NHM Record of Proceedings (RoP) for states for 2021-22

Note- Immunization Coverage was designated a screening criteria for the Conditionalities Framework. Therefore, EAG, NE and hill states were eligible for Conditionalities assessment only if they were able to achieve at least 85% full immunization coverage and 90% for the rest of the States and UTs.

Criteria for Conditionalities Framework 2022-24

Conditionalities	Weightage	Source
1. Incentive or penalty based on NITI Aayog ranking of states on Performance Health Outcomes	+40 to -40	NITI Aayog report
2. DH Ranking	+10 to -10	NITI Aayog DH ranking report
3. AB-HWCs State/UT score	+25 to -25	AB-HWC portal
4. Implementation of Ayushman Bharat–School Health and Wellness Ambassador initiative	+5 to -5	AH division, MoHFW
5. Implementation of DVDMS or any other logistic management IT software with API linkages to DVDMS up to PHC level	+5 to -5	DVDMS Portal or similar
6. Registration of pregnant women and children (0–1 yr) on RCH or equivalent portal	+5 to -5	RCH Portal
7. Human Resources for Health:	+7.5 to -7.5	State notifications,
7.a. Increase in 'in-place' Regular Service Delivery HR	+7.5 to -7.5	advertisements, and PIP HRH
7.b.Increase in 'in-place' Contractual HR	+5 to -5	Division, NHSRC
8. District-wise RoP uploaded on NHM website within 30 days of issuing of RoP by MoHFW to State	+3 to -3 +3 to -3	State NHM website and D.O. letter
9. Implementation of National Viral Hepatitis Control Programme (NVHCP):	+2 to -2	Report from NVHCP Division,
9.a. Percentage put on treatment for hepatitis B against target	+2 to -2	MoHFW
9.b. Percentage put on treatment for hepatitis C against target		
9.c. Percentage of pregnant women screened for hepatitis B	+5 to -5	
9.d. Percentage of newborns administered HBIG among newborns delivered to HBsAg positive pregnant women at health facility	+5 to -5	
10. Implementation of National Mental Health Programme (NMHP)		Report from Mental Health
10.a.% Districts covered under Mental health program and providing services as per framework	+5 to -5	Division, MoHFW
10.b.Actions taken for fulfillment of provisions under Mental Healthcare Act, 2017	+5 to -5	
11. National Tuberculosis Elimination Programme (NTEP)	+5 to -5	NTEP Nikshay Report
11.a.% Districts achieving 90% of TB Notification targets		Quality & Patient Safety Division,
11.b.% Districts achieving ≥85% treatment success rate		NHSRC
11.c.% AB-HWCs providing drugs to TB patients		
12. Implementation of National Quality Assurance Programme (NQAS) and LaQshya	+10 to -10	State Reports
12.a. NQAS certification	+5 to -5	

12.b. LaQshya certification	+20 to -20	
13. Compliance to IPHS for infrastructure	+10 to 0	NHM PIP
14. Implementation of National Ambulance Services as per norms	+10 to 0	State report, State Health Budget
15. Increase in State Health Budget		

Source- NHM Record of Proceedings (RoP) for states for 2022-24

Note- Immunization Coverage was designated a screening criteria for the Conditionalities Framework. Therefore, EAG, NE and hill states were eligible for Conditionalities assessment only if they were able to achieve at least 85% full immunization coverage and 90% for the rest of the States and UTs.

Integrated Disease Surveillance Programme (IDSP): Conditionalities Framework for 2022-24

Conditionalities	Weightage	Source
1. % Reporting in IHIP	+2 to -2	IHIP reporting weekly assessment
2. Presence of essential IDSP-IHIP staff at district level	+2 to -2	As reported to CSU, IDSP or updated on IHIP platform
3. **District Public Health Labs (DPHLs)sanctioned/ strengthened for diagnosis/testing of epidemic prone diseases**	+2 to -2	Annual RoPs or Communication from State/UT
4. **Functionality/capacity of sanctioned DPHLs for testing and lab-confirmation of epidemic prone diseases under IDSP mandate**	+2 to -2	Monthly DPHL report or Weekly L form/IHIP data

Source- NHM Record of Proceedings (RoP) for states for 2022-24

Criteria for Conditionalities Framework 2024-26

Conditionalities	Weightage	Source
1. AAMs State/UT score	+25 to -25	AB-HWC portal
2. Implementation of DVDMS or any other logistic management IT software with API linkages to DVDMS up to PHC level	+5 to -5	DVDMS Portal or similar
3. Registration of pregnant women and children (0–1 yr) on RCH or equivalent portal	+5 to -5	RCH Portal or similar state portal
4. Human Resources for Health:	+7.5 to -7.5	
4. a. Availability of regular service delivery HRH as per IPHS norms		

4. b In-place contractual HRH against the approved posts	+7.5 to -7.5	State notifications, advertisements, and PIP HRH Division, NHSRC
5. District-wise RoP uploaded on NHM website within 30 days of issuing of RoP by MoHFW to State	+5 to -5	
6. Implementation of National Viral Hepatitis Control Programme (NVHCP):	+3 to -3	
6.a. Percentage put on treatment for hepatitis B against target	+3 to -3	State NHM website and D.O. letter
6.b. Percentage put on treatment for hepatitis C against target	+2 to -2	
6.c. Percentage of pregnant women screened for hepatitis B	+2 to -2	
6.d. Percentage of newborns administered HBIG among newborns delivered to HBsAg positive pregnant women at health facility	+5 to -5	
7. Actions taken for fulfillment of provisions under Mental Healthcare Act, 2017	+5 to -5	Report from NVHCP Division, MoHFW
8. National Tuberculosis Implementation Programme (NTEP):	+5 to -5	
8.a. % Districts achieving 90% of TB Notification targets	+5 to -5	Report from Mental Health
8.b. % Districts achieving ≥85% treatment success rate	+10 to -10	Division, MoHFW
8.c. % AAMs providing drugs to TB patients	+5 to -5	NTEP Nikshay Report
9. Implementation of National Quality Assurance Programme (NQAS) and LaQshya	+20 to -20	AAM report
9.a. NQAS certification		
9.b. LaQshya certification		
10. Compliance to IPHS for infrastructure	+10 to 0	Quality & Patient Safety Division,
11. Increase in State Health Budget		NHSRC
12. National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD)	+5 to -5	State Reports
12.a.% of annual screening for Hypertension of target population (30+)	+5 to -5	State report, State Health Budget
12.b.% of annual screening for Diabetes of target population (30+)	+5 to -5	National NCD
12.c.% of people on standard of care for hypertension against the targeted population		Portal

Source- NHM Record of Proceedings (RoP) for states for 2024-26

Note- Immunization Coverage was designated a screening criteria for the Conditionalities Framework. Therefore, EAG, NE and hill states were eligible for Conditionalities assessment only if they were able to achieve at least 85% full immunization coverage and 90% for the rest of the States and UTs.

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