HSS for UHC in EMR

EMR Health Financing Systems Analytical Reports Series

Pakistan

Pakistan Health Financing System Review 2019

WHO Mission Report

7-11 January 2019

14 July 2019

Contents

Acknowledgements

The mission team would like to express its thanks to the Ministry of Health Services, Regulations and Coordination, under the Leadership of Director General, Dr Asad Hafeez, for effectively organizing this mission and facilitating meetings with all relevant stakeholders. Special thanks are due to the teams from the provincial health departments of the visited provinces.

1. Introduction

In his Maiden Speech to the Nation, in 2018, the newly elected Prime Minister of Pakistan, H.E. Mr Imran Khan, stressed the central role of '*health'* in the human development agenda of his government. This was primarily the result of continuity of the smooth political transitions in the country over the past 10 years, where "health sector reforms" started to appear in the election manifestoes of major political parties. Another reason for the higher priority given to health is that Pakistan has some of the worst health indicators in the region, and in some cases, the world. Pakistan has the highest neonatal mortality in the world with approximately 46 deaths per 1000 live births, and one of the highest maternal mortality in the region with 178 deaths per 100,000 live births. As noted by the Prime Minister in the same speech, there is also a severe challenge with nutrition as 45% of infants under the age of 5 are stunted.

The 18th constitutional amendment of 2011 devolved the responsibility of health (along with other social sectors) to the provinces. The National Finance Commission award was revised; annual outlay of the federal government was reduced for devolved subjects, and provinces were given the additional resources for the same Overall, since devolution provincial allocations to the health sector as percentage of Gross Domestic Product (GDP) witnessed a steady increase between 2010 and 2017 – doubled in Punjab and Khyber Pakhtunkhwa (KP) provinces and increased by almost 50% in the provinces of Sindh and Balochistan. More recently, the National Health Vision 2016-2025 pledged to increase federal and provincial allocations to health up to 3% of GDP. In parallel, several initiatives took place to enhance financial protection in the health sector by introducing alternative provincial and federal social health protection arrangements, in particular to ensure provision of quality health care to families living below the poverty line, protecting them from the risk of financial hardship associated with paying for their needed health care.

To guide its efforts in ensuring sustained progress towards Universal Health Coverage (UHC), the Ministry of National Health Services, Regulations and Coordination (MoNHSRC), requested WHO's support to undertake an in-depth Health Financing Diagnostic Review of the various Social Health Protection initiatives – and within the overall scope of the health financing system – to assess their robustness, coherence and future sustainability. Accordingly, a WHO mission was organized, involving the three levels of the organization and supported by an international health financing expert. The mission visited Pakistan in the period from 7 to 11 January 2019, to undertake the following **Terms of Reference**:

1. Undertake an in-depth diagnostic review of the health financing system in Pakistan, taking into consideration the devolved political arrangement, to identify the challenges facing raising, managing and using financial health resources.
2. Engage in a policy dialogue with various stakeholders to promote more public money for health by undertaking a preliminary fiscal space analysis of the health sector and identifying alternative relevant resources mobilization options.
3. Initiate a technical cooperation with the MoNHSRC to develop a federal health financing policy to be followed by provincial health financing strategies.

4. Provide technical support to the design and implementation of the health insurance program in Pakistan in a manner to better enhance the goal of financial protection, especially for the poor.
5. Identify the institutional and technical support needed to support the development of the various social health protection schemes in Pakistan.

The **Mission Members** were:

1. Prof Soonman Kwon, Professor of Health Economics and Policy, at Seoul National University.
2. Dr Matthew Jowett, Senior Health Financing Specialist, WHO Headquarters.
3. Dr Awad Mataria, Regional Advisor of Health Economics and Financing, WHO Regional Office for the Eastern Mediterranean.
4. Dr Faraz Khalid, Consultant Health System Strengthening, WHO Regional Office for the Eastern Mediterranean.
5. Dr Zulfiqar Khan, Health System Expert, WHO Pakistan Country Office.
6. Dr Jamal Nasher, Health System Advisor, WHO Country Office.
7. Dr Afifa Munawar, Consultant Health System Strengthening, WHO Pakistan Country Office.

The mission used the recently developed "**Health Financing Progress Matrices**" approach – '*Progress Matrices*' for short – which is available here, along with a tutorial in this link. More details is provided in the next section.

The mission benefited from a close collaboration with a team from the MoNHSRC led by Dr Faisal Rifaq, Chief Executive Officer of Sehat Sahulat Program (SSP). The mission team would like to acknowledge the leadership of the MoNHSRC, represented by Dr Assad Hafeez, Director General of Public Health and Dean and Executive Director of Pakistan Health Service Academy.

The next Section describes the methodological approach used to undertake the health financing system assessment, based on the '*Progress Matrices*' approach. It is then followed with a summary of Pakistan Economic Outlook in Section 3. Section 4 describes the evolution in health expenditure in Pakistan over the last two decades – both at federal and provincial levels. Section 5 provides an overall description of the health financing system in Pakistan with a focus on the three health financing functions: revenue raising, pooling and purchasing, as well as, the benefit design. Section 6 summarizes the various Social Health Protection initiatives in the countries. This is followed by Section 7 which synthesizes the key issues to be addressed by a health financing reform agenda for Pakistan. Section 8 includes a proposed vision and selected strategic directions to be considered by the health financing policy in Pakistan and the related provincial health financing strategies. This concludes by setting up an agenda of collaboration, of both analytical work and technical cooperation, between WHO and the Government of Pakistan to enhance the performance of the health financing system towards the realization of the goals of UHC by the year 2030.

2. Methodological approach

In order to improve efforts to monitor progress in health financing at the country level, WHO has developed a series of '*Progress Matrices*' based around the different functions of health financing policy, which now forms the organization's standard approach to assessing the health financing situation in a

country, using systematic qualitative assessment to gauge whether a country is moving in a positive direction i.e. towards UHC.

Judgments on what represents progress towards UHC are, from WHO's perspective, guided by the health system framework and the contribution of health financing policy to the improvements in the final coverage goals, as measured through SDG indicators 3.8.1 and 3.8.2. Amongst other things the '*Progress Matrices*' aim to capture changes in the development of health financing policy, a typically lengthy and complex process, and assess whether it is consistent with UHC. For each health financing function, WHO proposes a number of guiding principles, detailed in the document titled and available at: Developing a National Health Financing Strategy: A Reference Guide. Guiding principles are based on country evidence of policy reforms or actions which have resulted in progress towards UHC and are the foundation of many questions in the '*Progress Matrices*'.[1]

A full version of the '*Progress Matrices*' comprises fifty questions, constructed within an excel application which allow users to conduct an assessment either from the perspective of health financing functions (i.e., revenue raising, pooling and purchasing), or objectives (equity, efficiency and transparency) and goals (i.e. service coverage, financial protection and quality).

Whilst the '*Progress Matrices*' are used to assess health financing systems at the national level, as background preparation for this mission the '*Progress Matrices*' were distributed to a number of stakeholders in Pakistan, including the Prime Ministers National Health Program, Social Health Protection Initiative (SHPI) in KP province and the Punjab Health Initiative Management Company (PHIMC) in Punjab province. The stakeholders in Pakistan partially completed the matrices which provided very useful information for the mission.

During the mission, this information was used to guide interviews held with key informants and stakeholders. In addition, the information was used to complete the '*Progress Matrices*' from a national perspective in the following way:

- **STEP 1**: Completion of a summary overview of health coverage schemes in Pakistan. This overview provides a useful, albeit largely descriptive analysis of the key design features of the different social health protection schemes and the relationship between them, facilitating an initial analysis of the country's health financing architecture.

- **STEP 2**: Completion of the 50 questions (as relevant) by a health financing expert, under the guidance of WHO, and in conjunction with key individuals in the Government of Pakistan. As mentioned, the questions were shared with the various stakeholders prior to the mission, discussed during the mission, and at present continue to be examined with the help of a national expert immediately recruited following the mission.

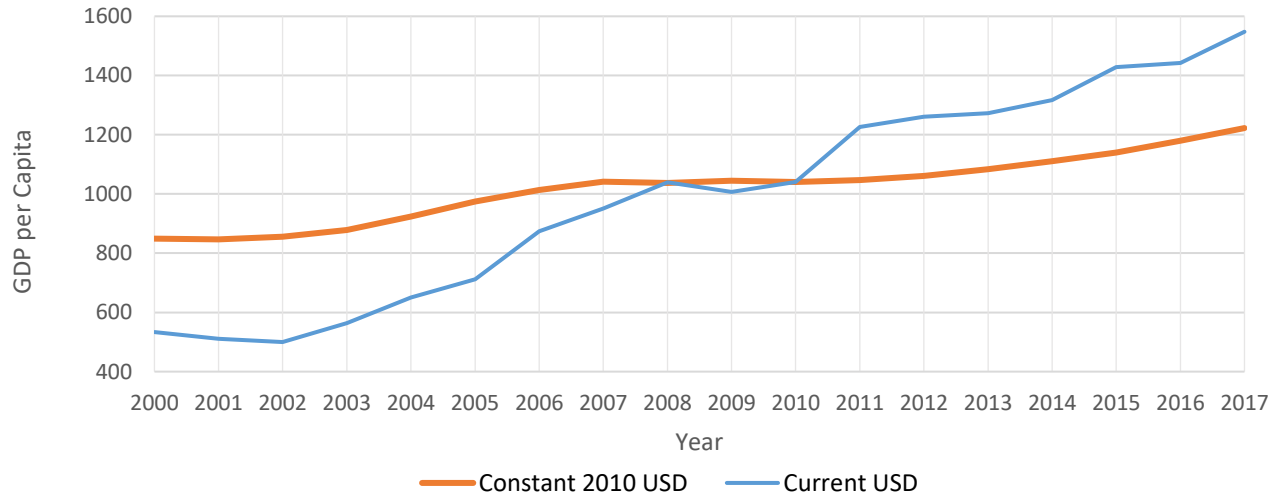
[1] Further information can be found at www.who.int/health_financing

- **STEP 3**: Presentation, discussion and validation of the '*Progress Matrix*' assessment by key stakeholders in Pakistan. This activity will be planned in agreement with the Government of Pakistan as a follow up activity to the mission report.

3. Pakistan Economic Outlook

Pakistan is the fifth most populous country in the world. The country's macroeconomic outlook is promising due to structural reforms, improved energy availability and investments on the China–Pakistan Economic Corridor. Pakistan experienced gradual economic growth in the last decade, with a steady increase in per capita GDP between 2000 and 2017 – both at current and constant prices [**Figure 1**]. In addition, **Figures A1** and **A2** in **Annex A** describe the evolution in the percentage change in GDP in absolute and per capita terms over the same period. It is worth noting that during the Great Recession of 2007-2009, the country's growth rate declined substantially, before it witnessed a strong recovery, achieving a growth rate of nearly 6% in 2017 (see **Figure A1 in Annex A**). This growth rate has been attributed mainly to the country's improved performances in the services and agricultural sectors.[2] Pakistan's current GDP composition consists mainly of the service sector of approximately 56%, followed by agriculture and industry at 24% and 19%, respectively[3].

Figure 1: Gross Domestic Product per Capita of Pakistan



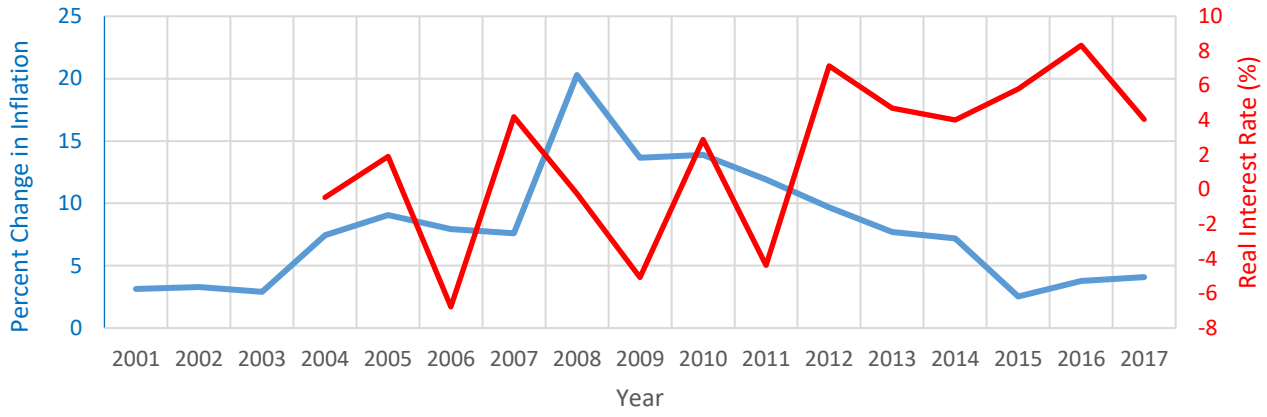
Source: World Development Indicators, The World Bank.

While Pakistan's economy has grown in the recent years, the country continues to suffer from several macroeconomic challenges. Notably, informal sector makes 72% of non-agricultural employment, more

[2] World Bank Overview. Available at: www.worldbank.org/en/country/pakistan/overview. (Accessed 06 December 2018).
[3] CIA World Factbook (Accessed 06 December 2018).

in rural (76%) than in urban areas (68.3%),[4] limiting taxation capacity where approximately only 10%[5] of government's revenue comes from taxes in proportion to GDP.[6] In addition, Pakistan suffers from macroeconomic imbalances, such as: inflation[7], where as shown in **Figure 2**, Pakistan experienced high rates of inflation at the onset of the Great Recession before gradually stabilizing in recent years, as demonstrated by the percent changes in inflation[8] against the Real Interest Rate for businesses. However, when assessing the Real Interest Rate[9], the trend shows more inflation volatility from the years 2005-2011 as the State Bank increased the lending interest rate during this period to combat inflation.[10] Yet in more recent years, inflation appears to have stabilized with a reduction of the lending rate, which has also been attributed to the recent growth rate in the country.[11]

Figure 2: Change in Inflation versus Real Interest Rate



Source: World Development Indicators, The World Bank

Figure 3 provides an overview of Pakistan's overall government expenditures in terms of absolute numbers (in current USD) and as a percentage of GDP, which can be used as a proxy for the level of fiscal space. Despite an apparent fluctuation in this indicator, **Figure 3** shows a declining trend in recent years, which is mainly due to the increase in the overall level of GDP. **Figure 4** demonstrates the trends in government expenditures on key sectors including health, where it is clear that with the exception of "Research and Development", health has been given a relatively low priority in government budget compared to other sector.

[4] Government of Pakistan, Ministry of Statistics. Labour Force Survey 2017-18

[5] This is calculated from the years 2000-2011 where revenue as a percentage of GDP in Pakistan has been about 13.6%. Of which approximately 73% of revenue is comprised of tax revenue. However, there is a limitation to this metric as the measurement does include revenue acquired from fines and penalties, and data was not available from 2012-2018.

[6] World Development Indicators.

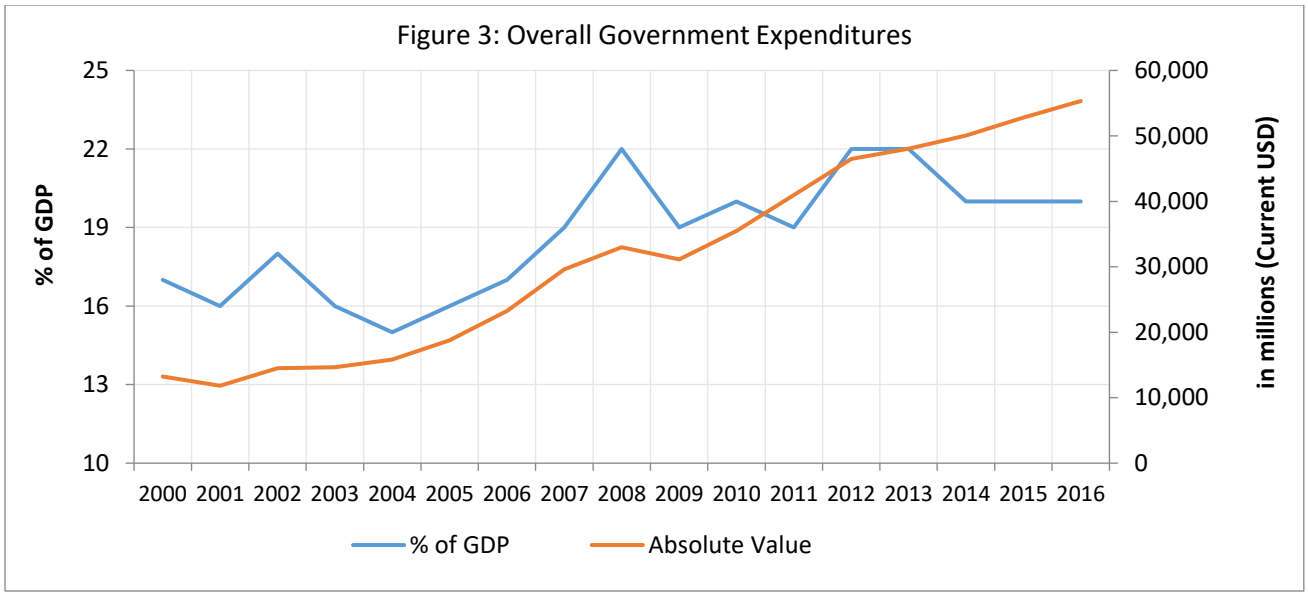
[7] World Bank Overview (Accessed 06 December 2018).

[8] Change inflation is calculated as the percent change of Consumer Price Index (CPI) with a base year of 2010 prices.

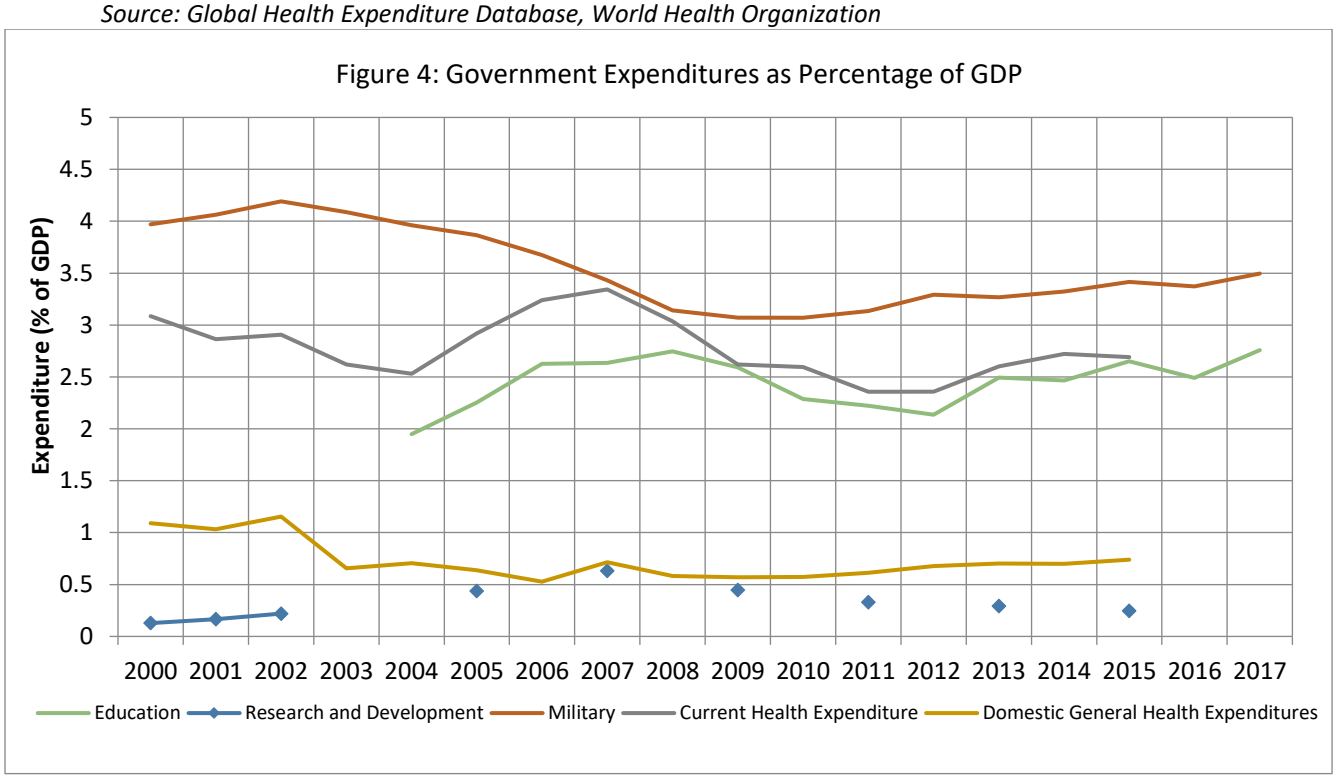
[9] The Real Interest Rate is the nominal interest rate set by Pakistan's Central Bank, State Bank of Pakistan, and takes into account inflation. If the Real Interest Rate is negative, it indicates that the inflation rate is greater than the nominal interest rate.

[10] World Development Indicators.

[11] World Bank (Accessed 06 Dec 2018).



Source: Global Health Expenditure Database, World Health Organization



Source: World Development Indicators, The World Bank

At the provincial level, data on government revenues and expenditures for the four provinces: Punjab, Sindh, KP and Balochistan, along with the territory Azad Jammu & Kashmir (AJK), were analyzed using

the provinces'/territories' respective Bureaus of Statistics and Planning.[12,13] Notable findings were that in Punjab and KP, and AJK, the majority of government revenue has come from Federal transfers as shown in **Figure A3** and **A4**, and **Table A1** and **A2**, respectively [**Annex A**]. Within the provinces, the majority of revenue for Punjab came from general capital receipts, indirect taxes, and foreign project assistance which collectively account for approximately 30% of the remaining revenue. In KP, the largest sources of non-tax revenue accounted for 15%; and in AJK, the highest sources of revenue came from deficit grants, income from the Kashmir Council, and electricity. The other major comparable finding was that Sindh, KP, and Balochistan all had similar shares for government expenditure allocation, shown in **Figures A5**, **A6**, and **A7**, respectively [**Annex A**]. Across all three provinces, the highest shares for government expenditures were allocated towards general public services and educational affairs.

In addition to regional reports, data from the Federal budget from 2016-2018 is shown for provincial allocation[14] in **Table A1** [**Annex A**].[15] The report does not mention any allocation to AJK, only loans which are not comparable here. When allocating funds, the Federal government uses the following ratio for approximation: Punjab: 51.74%; Sindh: 24.55%; Khyber Pakhtunkhwa: 14.62; Balochistan: 9.09.[16]

4. Evolution in Health Expenditure in Pakistan

Pakistan's health system has been chronically under-funded, both in total and by governmental spending.. Pakistan's current health expenditure (CHE) has been marginally increasing every year, and has gone from USD 16 per person in 2000 to USD 27 per person in 2010 to USD 40 per person in 2016 [**Table 1**]. In 2016, Pakistan's General Government Health Expenditure from domestic sources (GGHE-D) represented only 0.8% of its GDP; a decrease from 2000 when Pakistan GGHE-D constituted 1% of GDP [**Table 1**]. Government spending as a percentage of CHE was 35% in 2000 and dipped to 22% between 2005 and 2010, followed by a slight increase to 28% in 2015 and 2016 [**Table 1**]. This has been supplemented by an increase in aid spending from 2000 to 2015, but the total aid share is still limited at around 4% of CHE. The low government spending has led to a high out-of-pocket payment, which has been consistently over 60% in the last 15 years. The most recent estimate shows that Pakistan OOP was 65% in 2016.

Table 1. Key health financing and expenditure indicators (2010-2016)

	2000	2005	2010	2015	2016
GDP per capita US$	555	765	1,023	1,410	1,438
CHE per Capita in US$	16	21	27	38	40

[12] Azad Jammu & Kashmir Statistical Year Book 2017; Bureau of Statistics Khyber Pakhtunkhwa; Sindh Bureau of Statistics Planning & Development Department; Bureau of Statistics Balochistan; and Bureau of Statistics Punjab, Statistical Pocket Book.

[13] Comparing certain provinces and territories was difficult for some territories given that certain reports were more comprehensive in terms of revenue and expenditure source. Furthermore, some of the years may vary as the most recent reports for some of the territories were in 2016 and 2017.

[14] Federal Budget of Pakistan 2016-2017; Federal Budget of Pakistan 2017-2018

[15] An additional 1% of pooled taxes was allocated for Khyber Pakhtunkwha to meet expenses on the War on Terror.

[16] Federal Budget of Pakistan 2016-2017; Federal Budget of Pakistan 2017-2018

GGHE-D%CHE	35%	22%	22%	28%	28%
OOPS%CHE	62%	71%	70%	66%	65%
GGHE-D%GDP	1.0%	0.6%	0.6%	0.7%	0.8%
GGE%GDP	17%	16%	20%	20%	20%
GGHE-D%GGE	6%	4%	3%	4%	4%
Population	138,523,285	153,909,667	170,560,182	189,380,513	193,203,476

This results in the government of Pakistan being one of the lowest spenders on health amongst lower-middle income countries globally and in the region [**Figures 5** and **6**].

Figure 5: General Government Health Expenditure as % of GDP and per capita - Comparison with other LMICs

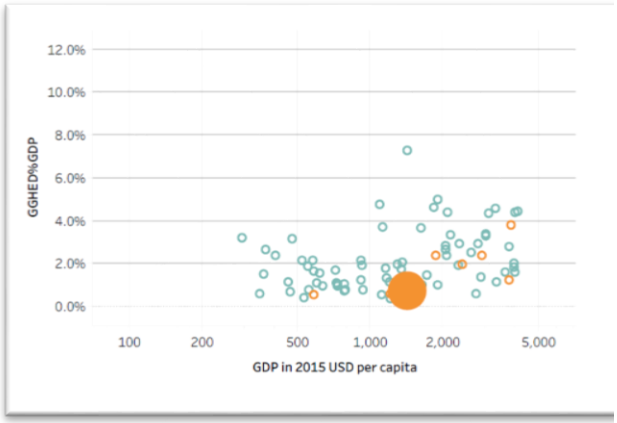
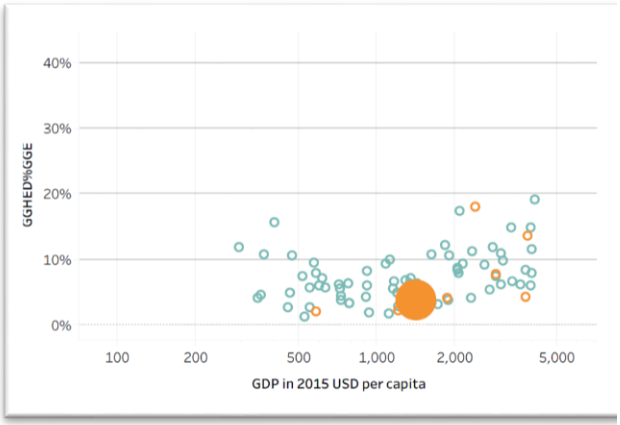


Figure 6. Health prioritization and GDP per capita - Comparison with other LMICs



The 18th constitutional amendment in 2011, and the resultant devolution in the health sector resulted in increased spending on health care, due to the increased fiscal space available to the provinces. However, a large portion of this spending has been going towards salaries and administrative costs, which have even increased in some provinces. Zaidi et al have noted that the sudden change in governance with a lack of stewardship from the federal government has meant that provinces are developing the capacity for health financing policy making and governance on the job.[17]

Budget allocation and expenditure by province

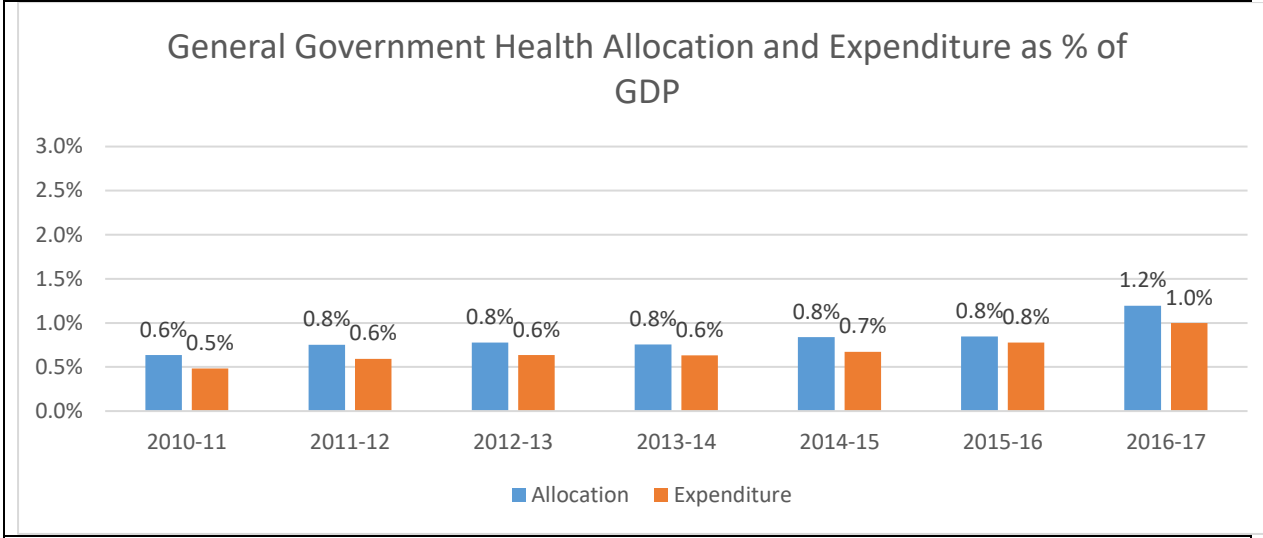
Punjab

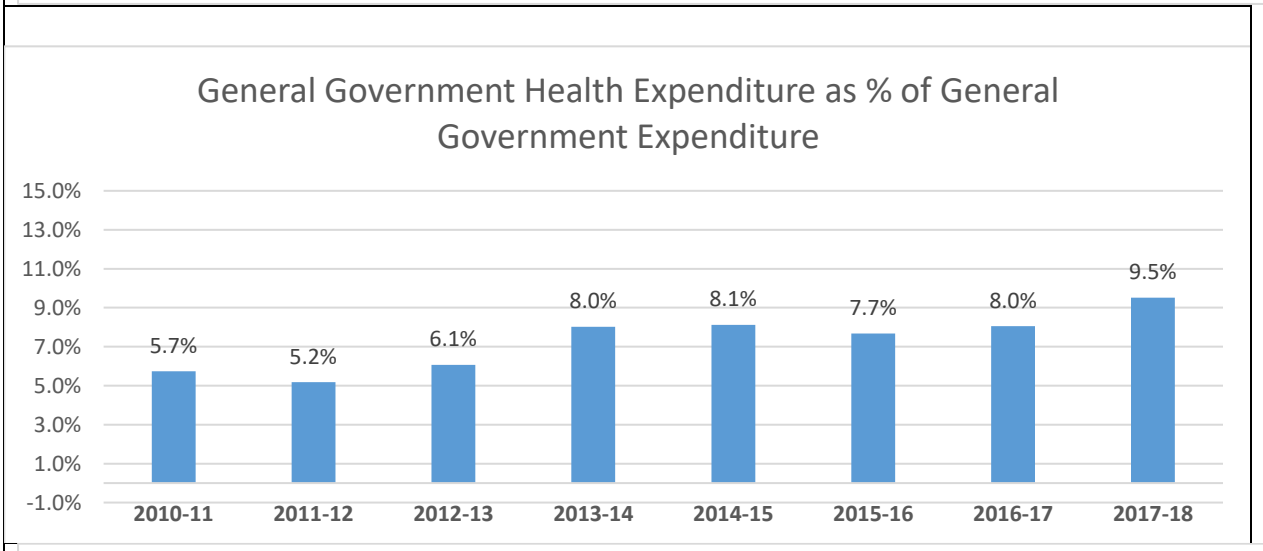
Punjab is the Pakistan's most populous province with a population of over a 100 million people. The 18th amendment and increase in fiscal space has had encouraging results for Punjab which has doubled health sector allocation from 0.6% in 2010 to 1.2% of its GDP in 2016-17; the amount of money allocated to the health sector has increased from 60.5 billion PKR (710 million dollars) in 2010 to over 193 billion PKR (1.89 billion USD) in 2016-17, leading to a per

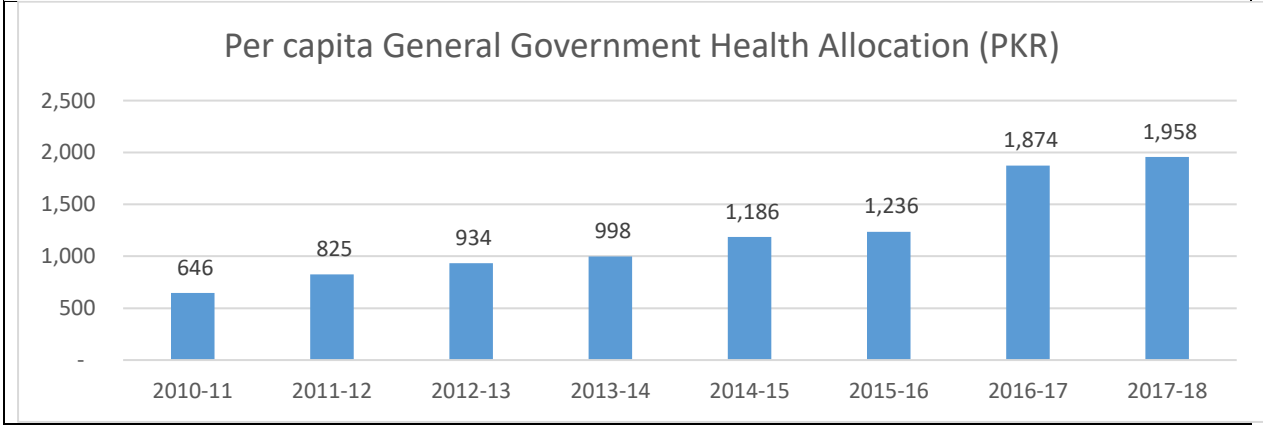
[17] Zaidi SA, Bigdeli M, Langlois EV, et al Health systems changes after decentralisation: progress, challenges and dynamics in Pakistan BMJ Global Health 2019;4:e001013.

capita spending of PKR 1958 [**Figure 7**]. However, the trend of was stagnant at 0.8% between 2011-12 and 2015-16 and increased sharply to 1.2% in 2016-17. The period 2016-17 was also the year before the general elections in Pakistan.

Figure 7: General Government Health Allocation and Expenditure as Percentage of GDP, General Government Expenditure and in Absolute Term – Punjab Province





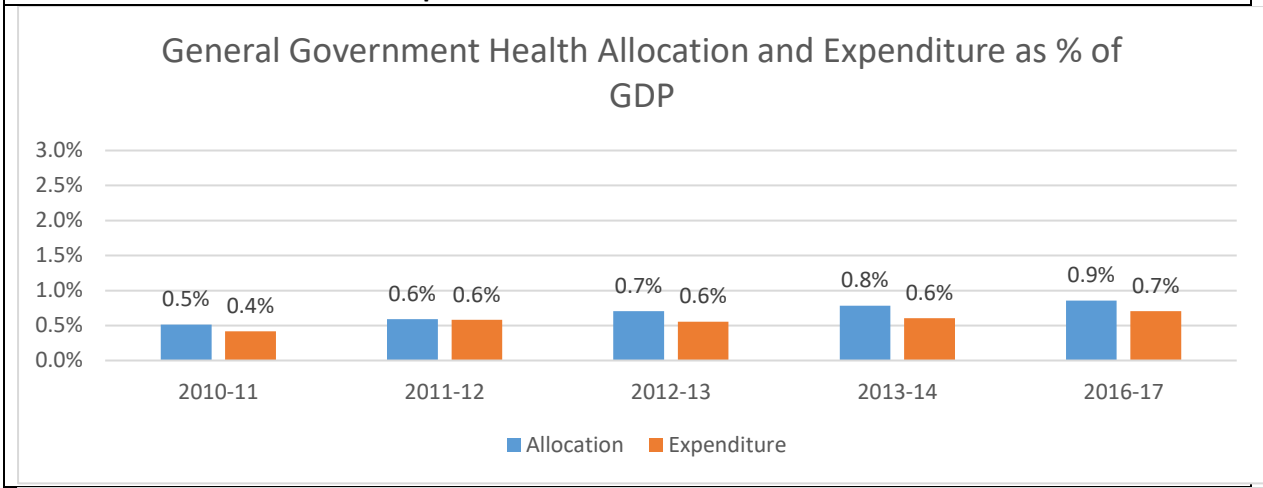


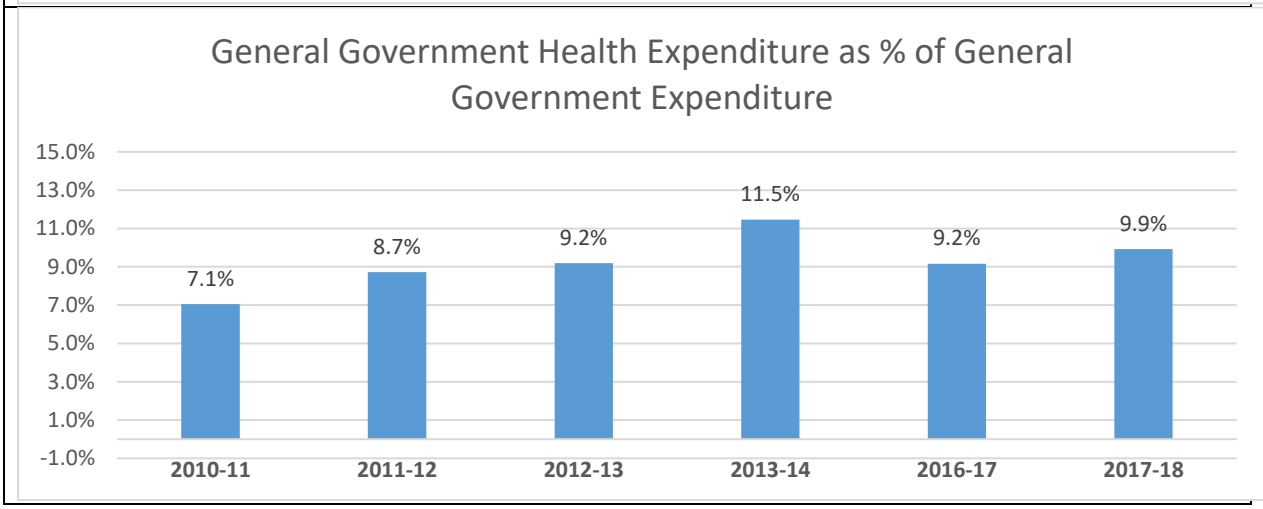
Source: PIFRA – Annual Budget Statements and White Paper

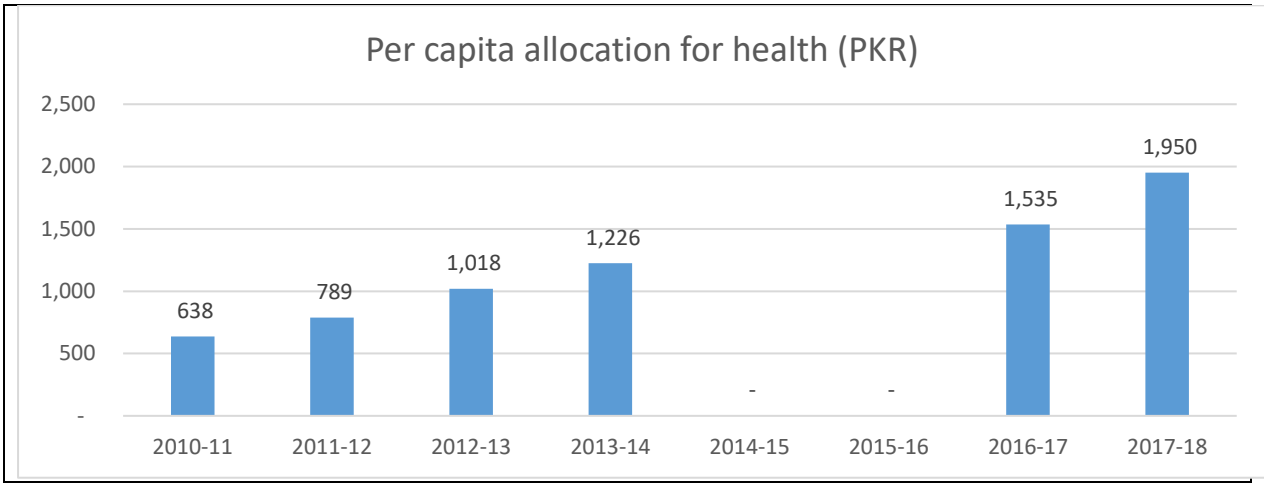
Sindh

Sindh is Pakistan's second most populated province which has also had positive results in terms of budgetary allocations for health. The percentage allocated as share of GDP has steadily increased by 1-2% every year, resulting in an increase from 0.5% in 2010-2011 to 0.9% in 2016-17 [**Figure 8**]. The GDP of Sindh has seen a considerable increase over the last eight years, and as a result the amount of spending has almost doubled through an increase from PKR 22.2 billion to PKR 43.4 billion, and spending per capita is now PKR 1950. Overall, Sindh has had the lowest allocation to health as a percentage of GDP amongst the four main provinces in Pakistan through the period of 2010 to 2016.

Figure 8: General Government Health Allocation and Expenditure as Percentage of GDP, General Government Expenditure and in Absolute Term – Sindh Province





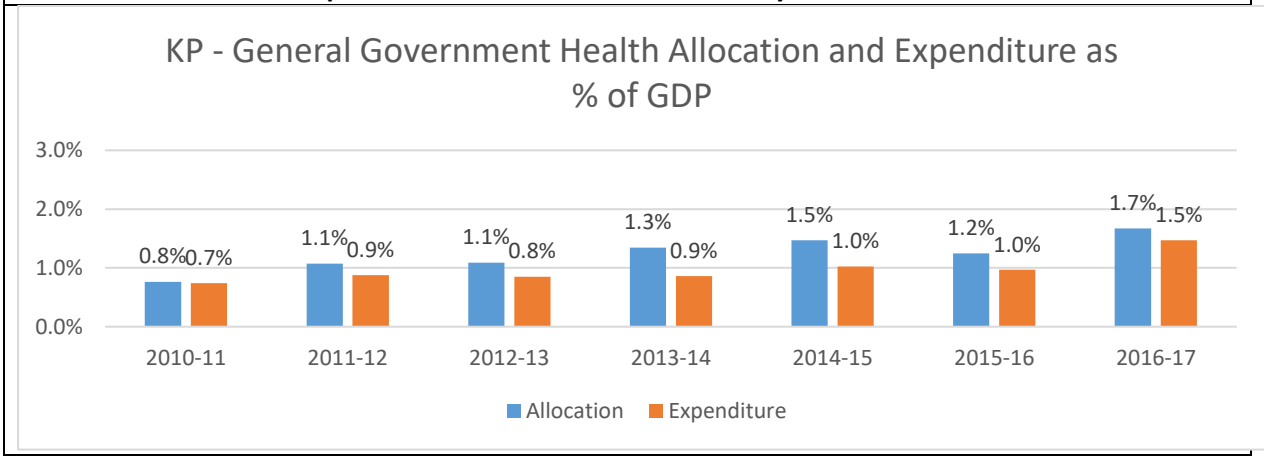


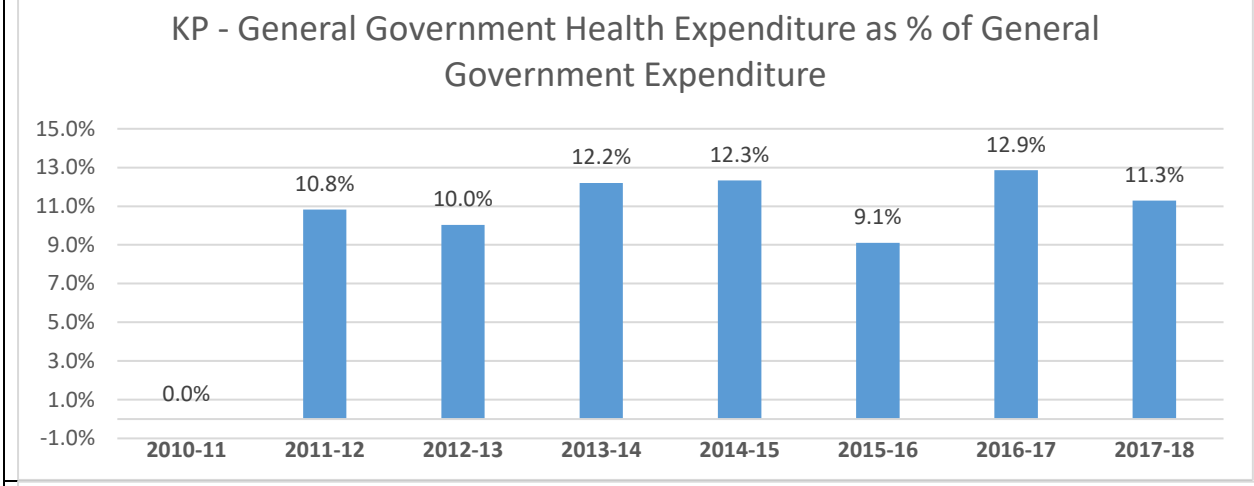
Source: PIFRA – Annual Budget Statements and White Paper

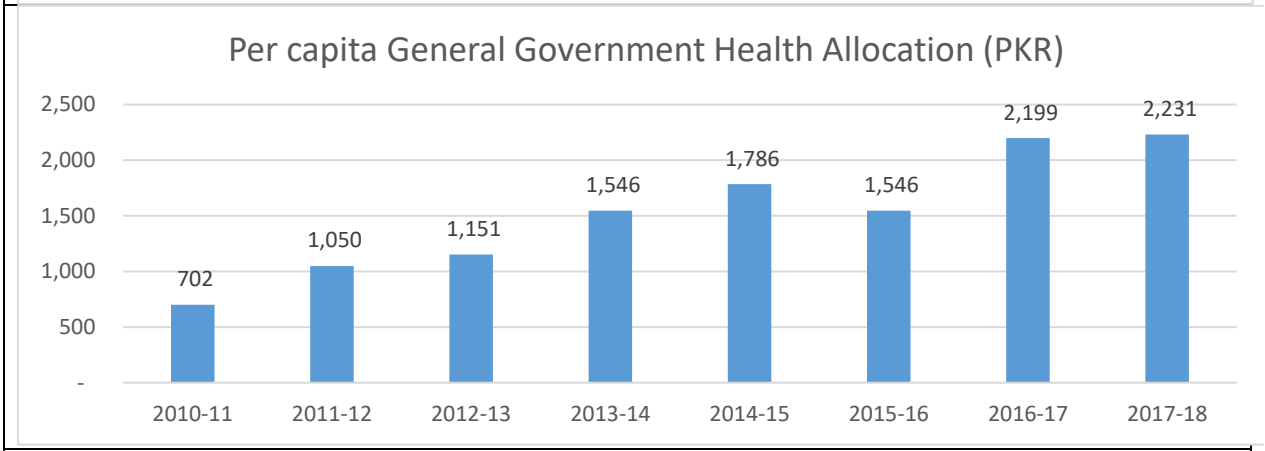
Khyber Pakhtunkhwa (KP)

Budgetary allocations to health care have shown an increasing trend for KP with a slight dip in 2015-16. The percentage allocated as % of GDP was 0.8% in 2010, but has steadily increased by 1-2% every year, resulting in an increase from 0.8% in 2010-2011 to 1.7% in 2016-17 [**Figure 9**]. With the increase in GDP of KP from 283 billion to 505 billion rupees, the amount allocated to the health sector has more than doubled with an increase from approximately 17 billion PKR (0.2 billion USD) in 2010 to 57 billion PKR (0.56 million USD) in 2016-17. At 1.7%, KP has the second highest spending on health as a proportion of GDP, and had the highest per capita allocation of approximately PKR 2200 (21 USD) per person [**Figure 9**]. Much like Punjab, KP also had a sharp increase in health sector allocation which increased from 1.2% in 2015-16 to 1.7% in 2016-17 an increase which may have been incentivized by the general elections for the following year.

Figure 9: General Government Health Allocation and Expenditure as Percentage of GDP, General Government Expenditure and in Absolute Term – Khyber Pakhtunkhwa Province





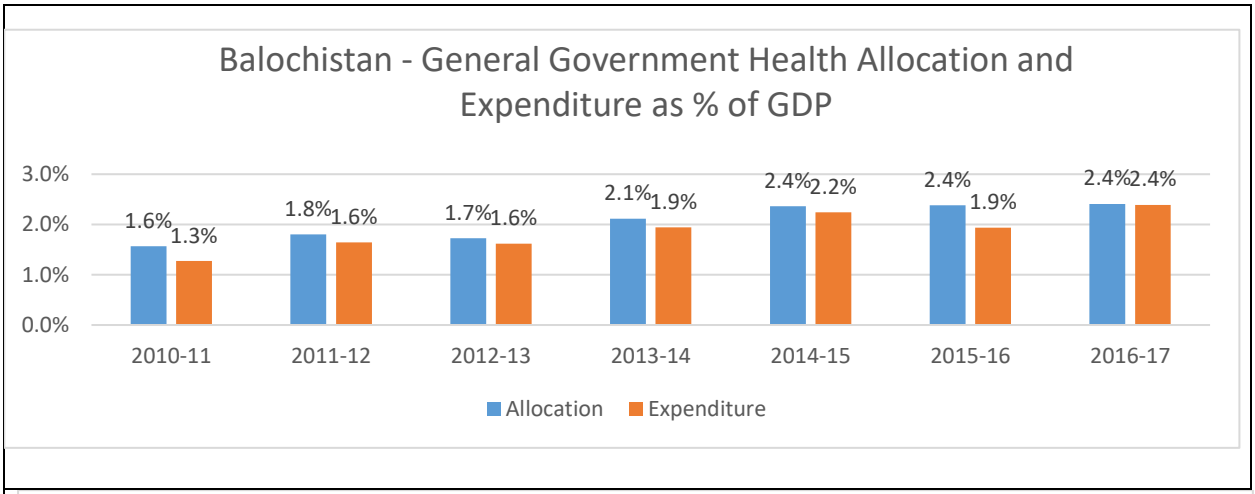


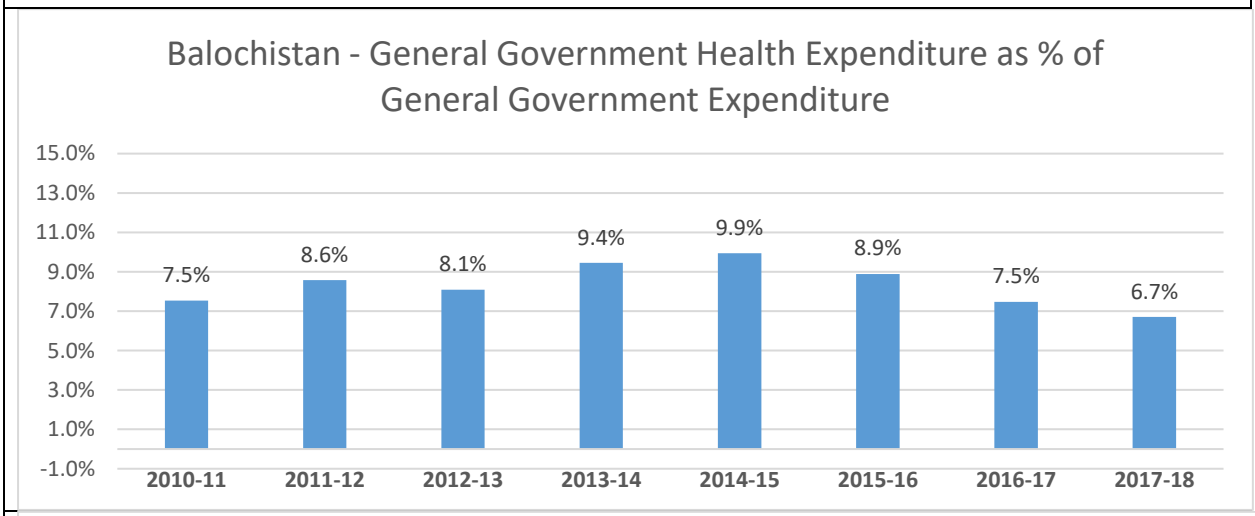
Source: PIFRA – Annual Budget Statements and White Paper

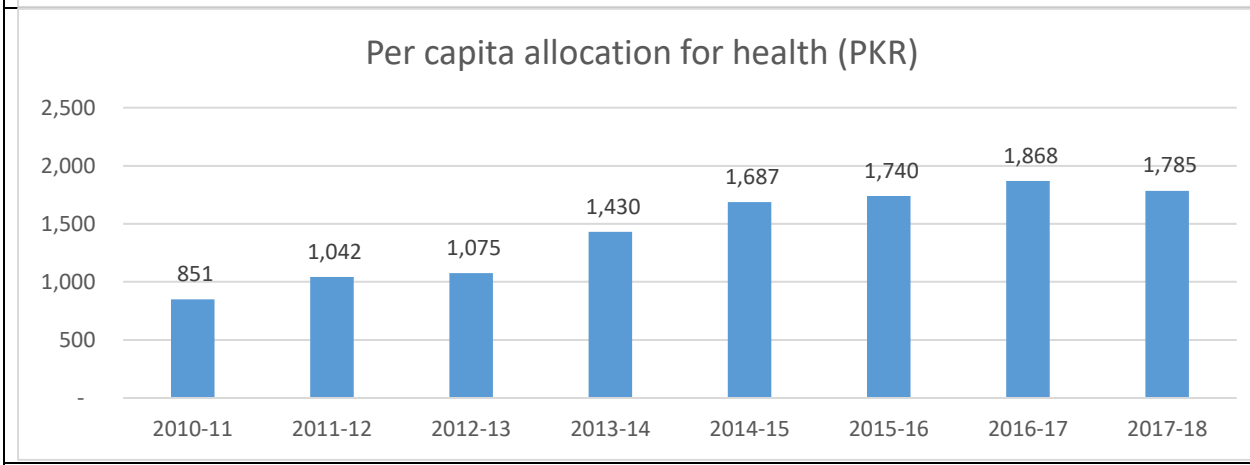
Balochistan

Balochistan is Pakistan's least developed province, with the lowest population of 12.34 million. The percentage of GDP spent on health in 2015-16 was 2.4%, which is a substantial increase from 1.6% in 2010/2011 [**Figure 10**]. Balochistan has had the highest spending as a proportion of GDP relative to the other provinces, and its overall allocation to health has increased from PKR 110 billion (1.3 billion USD) in 2010-11 to PKR 289 billion (2.84 billion USD) in 2015-16 [**Figure 10**]. However due to the relatively low GDP, the spending per capita is still lower than the other three provinces at PKR 1785 (17 USD) per person.

Figure 10: General Government Health Allocation and Expenditure as Percentage of GDP, General Government Expenditure and in Absolute Term – Balochistan Province







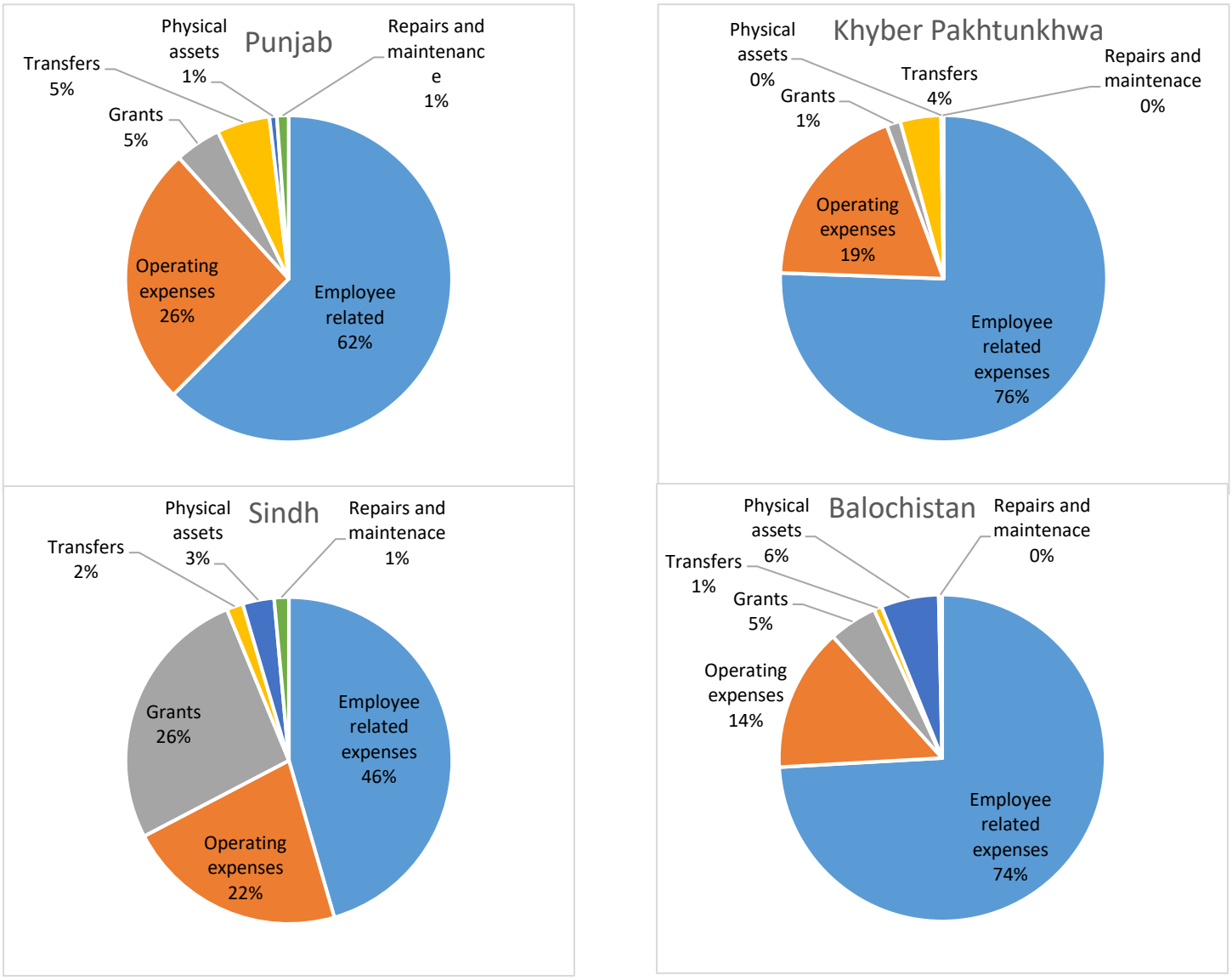
Source: PIFRA – Annual Budget Statements and White Paper

Budget allocation by inputs

While the overall increased spending on health is promising, the budget allocations are disproportionally made for the non-discretionary health expenditure (like, employee related expenses) which can have negative consequences on the equity and efficiency of health

spending. For instance, **Figure 11** shows that for Balochistan and KP, employee related expenses made up 76% and 74% of total health spending. Employee related expenses were much lower for Sindh, but this may be because Sindh has outsourced primary care to different NGOs and pays in single line budgets which often include employee related expenses. This may explain 26% of funding to grants. The next largest portion of budget allocation are operating expenses which range from 14% to 26% across the different provinces.

Figure 11: Budget Allocations by Line-items (inputs) at the provincial level*



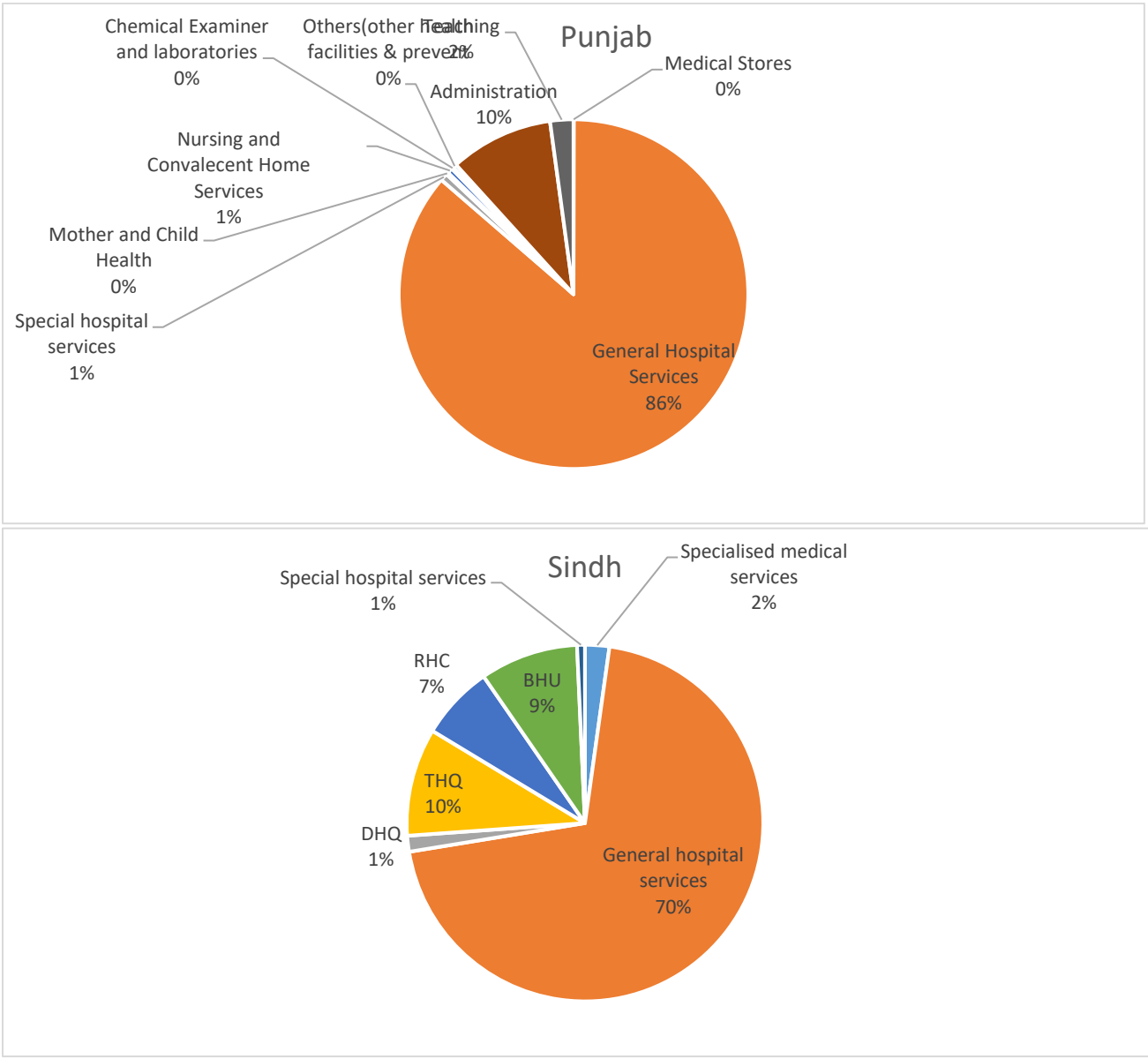
* Source: PIFRA – Annual Budget Statements and White Pape

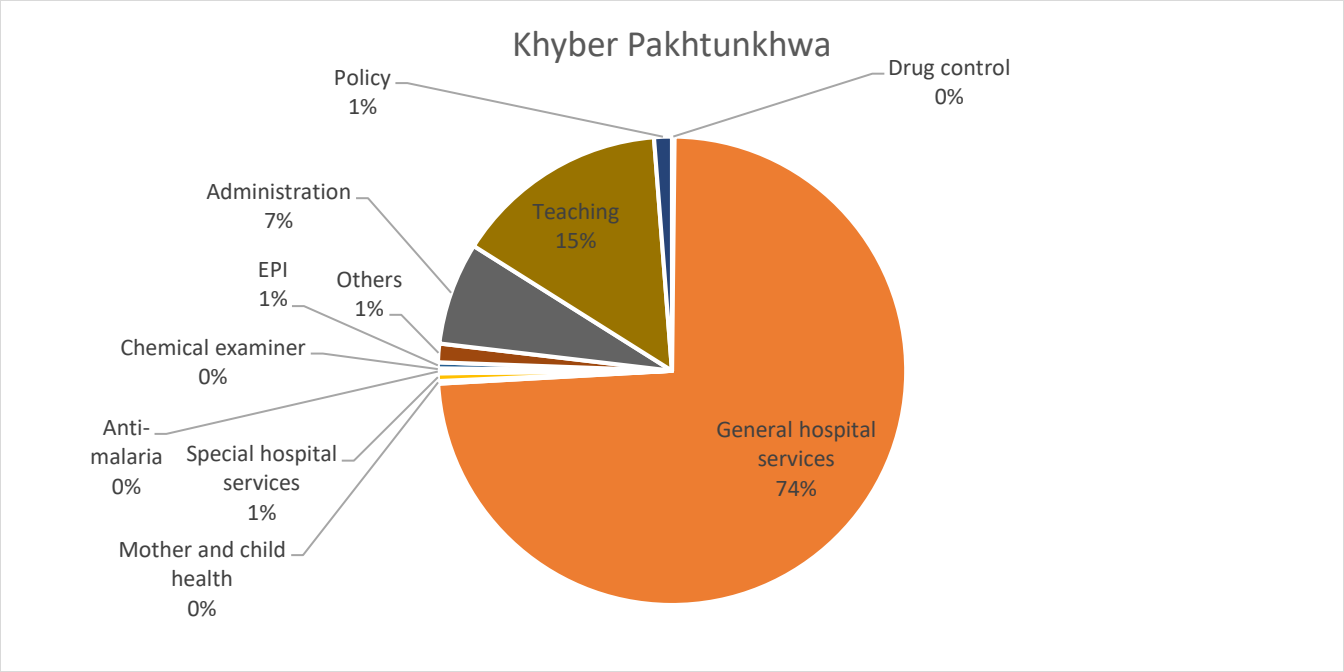
Budget allocation by purpose

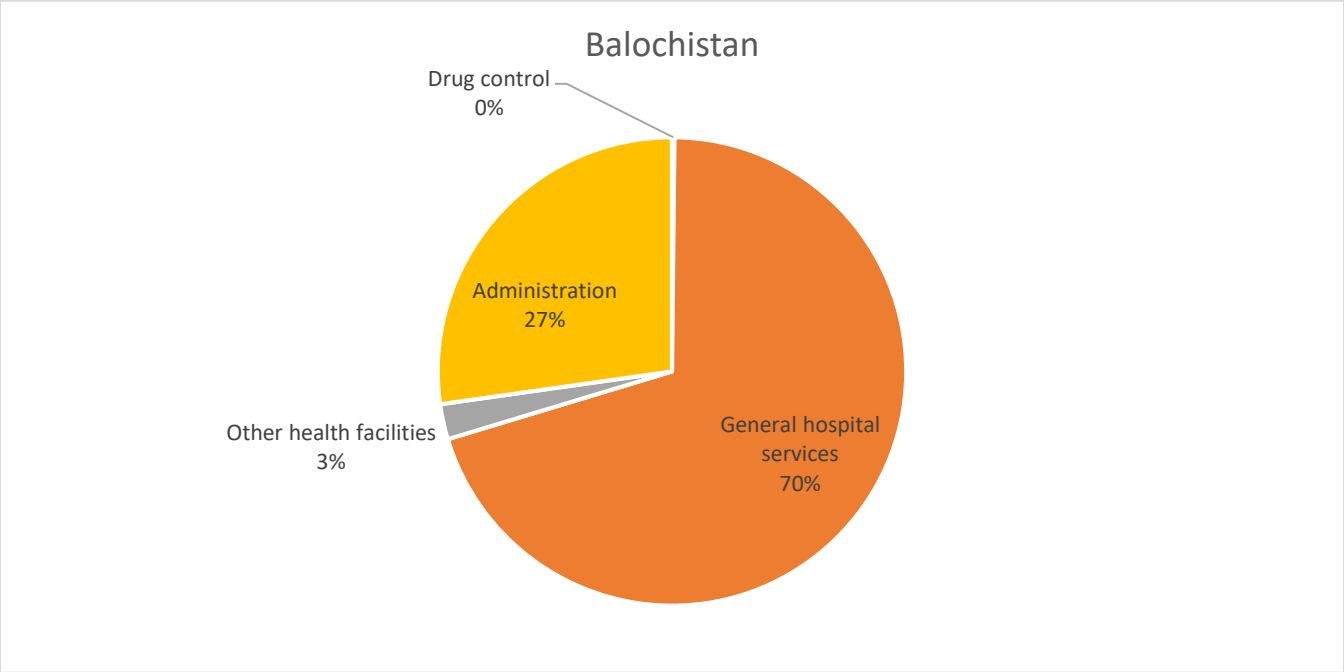
Based on the information available, a disaggregation of budget allocations by purpose is shown in **Figure 12, which** reveals a concerning trend, whereby a disproportionately higher allocation

has been reserved for curative care, and most specifically on hospital expenses. Punjab had the highest allocation for general government expenditures, and spent 86% of its total budget on general hospital services, while Sindh and Balochistan spent 70%. This information is based on provincial classifications which may have led to the somevariation.

Figure 12: Budget Allocations by Purpose (functions) at the provincial level*







* Source: PIFRA – Annual Budget Statements and White Paper

5. Health Financing System architecture and organizational arrangements:

Pakistan has a federal system where different levels of authority manage and fund different public programs, with a certain degree of overlap. In 2011, a constitutional amendment resulted in the

devolution of the health sector from the federal to the provincial level, shaping the current architecture of the health financing system. Public health financing agents include: (a) federal government and its related ministries: the Ministry of National Health Services, Regulation and Coordination, and the Ministry of Defense etc; (b) provincial governments; (c) district governments; and (d) social assistance and protection schemes, targeting the impoverished and implemented either separately or jointly by federal and provincial authorities.

While the above analysis provides an overview of the current situation of health spending at federal and provincial levels, more analysis is ongoing in relation to overall architecture of the health financing system and particular relations between various levels of the government as well as across various institutions and stakeholders. This work shall be prepared as one of the follow up deliverables from the present mission.

6. Overview of current Social Health Protection Initiatives

In the 2013 elections, Pakistan's two mainstream political parties announced launching of national health insurance programs in their election manifestoes, and since then the federal and three provincial governments have launched social health protection programs in their constituencies. The Prime Minister's National Health Program (PMNHP), which is also now labelled Sehat Sahulat Program (SSP), and Sehat Sahulat Program (SSP) were launched by the federal and Khyber Pakhtunkhwa (KP) governments respectively in 2015. A year later, the provincial government of Gilgit-Baltistan (GB) also started its Social Health Protection Initiative (SHPI) in 2016.

The target population of these programs is the poorest population. All three programs use data from the National Socio-Economic Registry (NSER) developed by Benazir Income Support Program (BISP) and use the benchmark of defining poverty as families/households having daily income of less than $ 2.00, except for GB that uses the benchmark of $ 1.00 per day. The unit of enrolment in federal SSP is family and in KP's SSP and SHPI is household. All family members (husband, wife, and unmarried children) registered with National Database Registration Authority (NADRA) are automatically enrolled infederal SSP , while in SSP and SHPI there is a limit of 8 and 7 household members, respectively.

In total, these programs have been expanded to 65 districts across the country and have enrolled about 5.7 million households (approx. 29 million individuals). Federal SSP is functional in 38 districts of Islamabad Capital Territory, Azad Jammu Kashmir, Punjab, Sindh, and Balochistan; 3.2 million families (approx. 18 million individuals) have been enrolled in the program. SSP is operational in all 26 districts of KP and has enrolled 2.4 million households (approx. 11 million individuals). SHPI has been launched in 1 district of GB and has enrolled 5,340 households (approx. 35,671 individuals).

Presently, all the three initiatives provide coverage for treatments that require hospital admission. The benefits package for each social protection program includes secondary care up to a limit which differs by each initiative. Federal and KP's SSPs have also defined the list of priority diseases and services to be covered under tertiary care, while SHPI does not currently cover tertiary care. All three programs also provide additional benefits, such as medication coverage and transportation expenses in varying amounts, while SSP also provides a small wage replacement benefit.

Funding for the social protection initiatives comes from a mix of federal, provincial and donor revenues, and none of the three initiatives includes any form of copayment from patients. Federal SSP is entirely funded by public funds; so far, premium for secondary care has been paid by the provincial governments, and federal government has been paying the premium for priority diseases. Lately, a decision has been made that all the premium amount will be paid by provincial governments. For SSP, the first four pilot districts were funded by KFW, but the remaining 22 districts have been funded by provincial tax revenues. SHPI has been largely donor funded, where KFW is paying 75%, while the provincial tax based pool is covering the remaining the 25%.

Federal and KP's SSPs have contracted with State Life insurance company, while the SHPI has contracted with Aga Khan Development Network for patient enrolment and hospital empanelment. The beneficiaries of the three programs can access services from a mix of public and private sector facilities empaneled with the insurance companies. The insurance companies have negotiated treatment package rates with individual hospitals and reimburse checks to the hospitals once the services are availed by program beneficiaries.

Other than these larger initiatives, poor populations also have access to Zakat and 'Bait ul mal' funds to pay for health care. 'Bait ul mal' is a publically funded social protection initiative created for the welfare of vulnerable populations such as the disabled, orphans and women. Zakat, on the other hand, is 2.5% tax paid by Muslims on their annual savings, which is collected (centrally) and allocated by the Ministry of Religious Affairs for each province. Health care is one of 6 programs administered under the Zakat fund. For both Zakat and 'Bait ul mal', patients need to apply to receive payment for their treatment, which must be provided at a government hospital or selected hospitals for Zakat and NGOs for 'Bait ul mal' assistance.

There are also separate social health protection programs for armed forces and employees of private and commercial establishments. According to 2013 estimates, the armed forces cover health care for 6.18 million individuals (including military personnel and their dependents) and manage their own health care infrastructure through public revenues. 'Fauji' foundation covers 9.1 million retired military personnel using commercially generated funds from their businesses and have their own health care infrastructure.

Furthermore, under a 1965 ordinance, employees of private and commercial institutions, which employ 10 or more persons must provide insurance to employees under the employees' Social Security Institution (ESSI). The revenue for insurance is collected and distributed by the provincial ESSIs using a mandatory contribution n of 7%, which is used to provide outpatient and inpatient services. According to 2013 estimates, provincial ESSIs provide coverage to 6.89 million individuals in total. ESSIs also runs a network of dispensaries, hospitals and treatment centers.

Table 2 below provides a summary of the preliminary findings from implementing the '*Progress Matrices*' in the context of Pakistan. Further analysis is ongoing and shall result in a further refined analysis.

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
Year started	Since the creation of country (1947)	December 2015	January 2015	August 2016	Four provinces (Punjab, Sindh, KP, and Balochistan) established their social security institutions under 1965 ordinance
Target population	Nationwide / all citizens	• Enrolment Unit: Family • Beneficiary selection criteria: Families earning less than $2 per day (PMT score of less than and equal to 32.5) • Members covered: All family members as per National Database Registration Authority database (Husband, wife, and unmarried children)	• Enrolment Unit: Household • Beneficiary selection criteria: Households earning less than $2 per day (PMT score of less than and equal to 32.5) in KP • Members covered: 8	• Enrolment Unit: Household • Beneficiary selection criteria: Households earning less than $1 per day (PMT score of less than and equal to 16.19) in Gilgit Baltistan • Members covered: 7	• Under the ordinance, it's compulsory for all the establishments (private industries and commercial establishments) that employ 10 or more persons to register for health insurance to their employees and their dependents.
Basis for enrolment	Automatic, based on citizenship	• Automatic (beneficiary families earning an income of less than or equal to $2 per day) as per data from National Database Registration Authority (32.5 PMT).	• Automatic (beneficiary households earning an income of less than or equal to $2 per day) as per data from National Database Registration Authority (32.5 PMT).	• Automatic (beneficiary families earning an income of less than or equal to $1 per day) as per data from National Database Registration Authority (16.19 PMT).	• Mandatory – deducted from source
Population covered / enrolled		• 3.22 million families (approx. 18 million individuals) across 38 districts of Punjab, Balochistan, Sindh, KP, AJK, GB and ICT (Jan 2019).	• 2.4 million households (approx. 11 million individuals) across all the 26 districts of KP	• 5,340 households (approx. 35,671 individuals) in one district of Gilgit Baltistan	• Provincial ESSIs provide coverage to 6.89 million individuals in total

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
Benefits / entitlements covered	Vaccinations Public health programs Subsidized care - primary, secondary and tertiary, depending on the level of facility (basic health unit, rural health center, district headquarter hospital, and tertiary care hospital)	Cashlesss indoor healthcare *1. Secondary care:* PKR 50,000/family/year *2. Tertiary care* (priority diseases): PKR 250,000/family/year *Priority diseases* 1. Cardiovascular Disease. 2. Hospitalization required for Complications of Diabetes Mellitus 3. Emergency and Trauma. 4. Organ Failure Management. 5. Chronic Infections complications. 6. Cancer management 7. End Stage renal disease. *Additional benefits* 1. Admission Coverage: One day pre-admission coverage	Cashless indoor healthcare *1. Secondary care:* PKR 30,000/member / household/year 240,000/household/year *2. Tertiary care* (priority diseases): PKR 300,000/household/year *Priority diseases* 1. Cardiovascular diseases including: 2. Complications from Diabetes Mellitus requiring hospitalization 3. Emergency and Trauma including: 4. Oncological diseases a. Chemotherapy (Day care or hospitalization) b. Radiotherapy (Day care or hospitalization) c. Medical and Surgical management requiring hospitalization 5. HCV & HBV Complications 6. Organ failure management 7. Cerebro-Vascular Accidents (CVA)	Cashless indoor healthcare 1. *Secondary care*: PKR 25,000/person/household/ year & 175,000/household/year 2. Tertiary care not provided and no priority diseases *Additional benefits* 1. Ambulance/transportation: PKR 1000.00 2. Medication: Five days medicine at time of discharge. 3. Day-care surgeries are covered *Limit beyond coverage:* Nil	Both outpatient and inpatient services, and there is a financial cap on the latterwages for days of work lost is also provided

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
		2. Medication: Five days medicine at time of discharge. 3. Follow-up: One free follow up visit after discharge 4. Referral Transportation of indoor patient: Responsibility of Insurance Company 5. Maternity Coverage: Four antenatal visits and One Postnatal visit is free. 6. Transportation Cost: Rs. 350 Transport charges at time of discharge up to 3 times per year 7. Day care procedures covered (Dialysis and others) *Limit beyond coverage* For costs exceeding the specified limit, an "Excess of loss mechanism" of matching amount by premium payment of Rs. 45 per family per year to insurance company.	*Additional benefits* 1. Wage Replacement: Rs. 250 per day for a maximum of three days upon discharge. 2. Tertiary care Transportation: Rs. 2,000 to be paid upon discharge. 3. Maternity Transportation: Rs. 1,000 to be paid upon discharge in case of normal or surgical delivery. 4. OPD Voucher: One OPD voucher will be provided to each beneficiary upon discharge that may be utilized for one post discharge follow up visit. 5. Burial Insurance: Rs: 10,000 in case of a death of a beneficiary during admission. *Limit beyond coverage* For costs exceeding the specified limit, a reserve Fund of Rs. 200 million has been created by payment of Rs. 50 per household per year to insurance company.		

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
Revenue sources	• GGE = 15.2% GDP[18] • Public revenues collected at federal level, from direct and indirect taxes. • General budget allocations to provincial governments (NFC Award) • Users make co-payments (registration fee, payments for diagnostics, out of stock medicines and supplies) at public facilities • Sin tax under discussion	• Full premium payment by public exchequer (Federal and provincial governments) represented as separate budget line. • Phase 1: PKR 8.1 Billion for 3.2 million families for 3 years • Phase 2: PKR 33 Billion of Federal Share for 5 years (Approved in 2018) • So far, secondary care premium was paid by provincial governments and premium for priority diseases was paid by federal government. Lately, a decision has been made that all the premium amount will be paid by provincial governments. • No co-payment by the beneficiary.	• KFW funding in 4 pilot districts, KP provincial government funding for rest of 22 districts • Phase 1: PKR 3.8 Billion per year for about 2.5 million households • No co-payment by the beneficiary.	• KFW and provincial government contributions make 75% and 25% of funding respectively • Phase I: PKR 193.833 million for 5340 households in 1 district • Phase 2: PKR 393.104 Million for 21000 households in 5 districts	• Employers contribution (7% of employees' salary) towards health insurance of employees
Pooling arrangements	• National pool of public revenues allocated through NFC Award to provinces; represents the bulk of public expenditure. Provincial govts. decide on allocations to health.	• Some national pooling through federal contributions; otherwise through provincial pools (based in turn on national pooling through NFC Award)	Provincial tax based pool (federal transfers make approx. 60%)	• Donor funding pooled with provincial tax based pool	Provincial

[1818] https://en.wikipedia.org/wiki/Economy_of_Pakistan

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
	• Limited (but growing) revenue raising by provincial governments.				
Purchasing / payment	• Extensive supply-side funding i.e. of salaries and other inputs. Approx. 90% total public spending on health	• Payment against agreed treatment packages. Reimbursement cheques issued by insurance company to service providers as per already agreed package rates.	• Payment against agreed treatment packages. Reimbursement cheques issued by insurance company to service providers as per already agreed package rates.	• Payment against agreed treatment packages. Reimbursement cheques issued by insurance company to service providers as per already agreed package rates.	• ESSI owns and runs its network of dispensaries, hospitals, and treatment centers
Other information e.g. service delivery		• Hospitals empaneled (public plus private): 153 (16+137)	• Hospitals empaneled (public plus private): 106	• Hospitals empaneled (public plus private): 5 (2+3)	
Implementing partners		1. Federal Govt 2. Provincial Govt 3. Regional Govt 4. State Life Insurance Company	1. KP Govt 2. State Life Insurance Company	1. Gilgit Baltistan Govt 2. KfW 3. Agha Khan Development Network Consortium	• Four provinces (Punjab, Sindh, KP, and Balochistan) have their own social security institutions
Future plans		1. Expansion to all district of Pakistan/enhanced benefit package 2. Incorporation of Primary Health Care services (Pilot). 3. Incorporation of take-home medications in benefit package	1. Enhanced benefit package 2. Wider enrolment with volunteer enrolment (pilot) 3. Shifting from household coverage to family coverage as per NADRA family tree	1. Incorporation of priority care in social health protection initiative. 2. Expansion to 04 additional districts 3. OPD to be incorporated and piloted in the benefit package	

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	SEHAT SAHULATPROGRAM (FEDERAL GOVERNMENT SOCIAL HEALTH PROTECTION INITIATIVE)	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INTIATIVE)	SOCIAL HEALTH PROTECTION INTIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)
				4. Continuation of wider enrollment in Phase-II	

7. Synthesis of Implementation Challenges in Health Financing Reform in Pakistan

This section provides a synthesis of the analyses pursued as part of implementing the implementation of the '*Progress Matrices*' and the associated questions on the various parts of the health financing system in Pakistan – both at Federal and Provincial levels:

A. Achievements and Visions

Pakistan has achieved significant progress in health financing in provinces through allocating and spending increasing amount of budget to the health sector and establishing subsidized programs such as federal and KP's SSPs and SHPI. The fully subsidized programs aim to mobilize/allocate government financial resources to purchase medical services from both public and private providers, targeting the poor and catastrophic conditions. It can be viewed as an insurance mechanism but the premium contribution is fully subsidized by the government, similar to, for example, the 'UC scheme' in Thailand, and the 'Ayushman Bharat scheme' in India. The poor have free access to health care – with a ceiling – mainly in the inpatient care, and can choose among public and private providers. Purchasing mechanism and competition among public and private providers are expected to improve health system performance.

B. Harmonization

Provincial governments are responsible for health financing policy. However, it would be more cost-effective – and indeed a driver to more equitable system – to have a coordination and policy learning mechanism in health financing across provinces. If a national entity plays a role of technical lead in the development and dissemination of guidelines, protocols, manuals for the health financing system, it can support provincial governments and improve the overall efficiency and equity of the health system. Design and implementation of different health financing arrangements across provinces is costly, and instead, sharing a core value and essential elements nationwide would be efficient and equitable (considering the mobility of people across provinces).

A national entity as a technical lead can work on the key elements of health financing and support provincial governments in policy design and implementation in the following areas: design of benefit packages (based on, e.g., DCP3); development of treatment protocols linked to, e.g., family practice initiative; design of provider payment system (payment method and tariffs – including costing of services); manual for empanelment and contracting with providers; review and assessment of clinical quality and provider performance; M&E of financial protection; curriculum for the training and education in health financing, etc. Each province can take into account or adjust the key elements of health financing system, which are provided by a national entity, in the design and implementation of its own strategy. They do not have to re-invent the wheel and can avoid a potential wasteful competition, while also incurring equity across various parts of the country.

C. Coordination with Primary Care

It is logical for federal and KP's SSPs and SHPI to start the program with targeting catastrophic conditions and hospitalization, considering budget constraints of the government. However, inpatient-based coverage has the potential to generate over-hospitalization/specialization at the expense of primary care. Enrolled beneficiaries can prefer hospital-based care because outpatient or primary care services are not covered. By-passing of primary care will result in inefficiency in service delivery and harm the financial sustainability of the health system.

There can be several policy options for the coordination between primary and hospital care. Federal and KP's SSPs and SHPI can extend the benefits coverage to outpatient and primary care (for both public and private providers), which requests more funding. For example, government can consider priority between extending the benefit coverage of the subsidized SHP schemes to outpatient care and extending the current population coverage to the vulnerable or near poor (or extending the current inpatient benefits to cover more conditions).

Alternatively, government can give priority to the public primary care and require the beneficiaries to register in public health centers (e.g., Basic Health Units) and mandate a referral letter to be eligible for hospital benefits. In this scenario, the beneficiaries of the SHP programs can use private primary care providers by paying out-of-pocket – if they prefer to – but should get a referral letter from the registered public health center when they want to use the hospital care in the benefits package of the program. This option will strengthen the referral system and primary care in the public sector. In order to earn trust from the enrolled and encourage them to more willingly use public health centers, government needs to invest in the capacity of Human Resources for Health, equipment, medicines, etc. of public primary care providers. This needs to be accompanied by a change in budget allocation along with performance assessment of public health centers.

D. Empanelment and Assessment of Provider Performance

Empanelment of providers and assessment of their performance is an essential role of strategic purchasing. Currently empanelment of hospitals is based on input measures (staffing, beds, equipment, etc.), which has had positive impacts on quality, but should further consider quality of care and patient outcomes. Selective empanelment of providers would be difficult to implement in rural areas where only a limited number of providers are available. Although an adjustment of empanelment criteria may be necessary in rural areas in the short run, how to improve quality of care and capacity of providers in those areas should be considered in the long run.

Empaneled providers should be required to report treatment/utilization information to the purchaser to get reimbursement. In other words, providers should report detailed information on services provided and patient outcomes although the reimbursement is a fixed rate for a given package of services. These information should be analyzed and used to revise benefits package, payments, empanelment, etc. Health financing provides an opportunity for the purchaser to monitor/control and improve the quality of care of private providers (and public providers) by relying on those information. Information system and capacity of the purchaser to review and assess treatment and utilization is a key to quality of care, financial protection and financial sustainability of health financing.

Contracting with insurance carrier (e.g., State Life Insurance), instead of directly managing by the government, has been necessary, considering limited capacity of the government in insurance management and the need to rapidly expand the coverage to target population. However, it is not clear whether the current division of purchasing roles between provincial governments and insurance carrier is optimal. Transaction cost associated with the contracting with insurance carrier and ensuring its performance should also be considered. Governments need to ensure that insurance carrier has capacity and correct incentive for purchasing, e.g., financial protection of beneficiaries, increasing enrollment, monitoring provider behavior, etc.

Governments need to consider whether to rely on contracting with insurance carrier in the long run, from the perspective of political as well as financial sustainability. In most other countries, SHP programs are managed by a public agency specializing in health financing, e.g., Philippine Health Insurance Corporation, National Health Insurance Authority of Ghana, National Health Insurance Service of Korea, etc. There is a fundamental difference in goals between private insurance and public insurance. For public insurance, surplus is not the most important performance criterion. Rather, financial protection for the enrollees and improvement in service delivery are key performance measures of public insurance. Pakistan needs to balance the pros and cons of different governance arrangements for purchasing and insurance contracting and agree on the future policy direction for contract-out versus direct management of social health protection mechanisms.

E. Benefits Coverage and Provider Payment

Current benefits coverage targets inpatient conditions, but there are no clear rationales documented on the selected conditions. Benefits coverage needs to be expanded to provide sufficient financial protection for the poor by taking into account the burden of diseases, cost-effectiveness, clinical effectiveness, budget impact, equity concerns, etc. As medicines expenditure is the major source of out-of-pocket payment, according to the base-line survey[19], coverage of medicines in the benefits is of high priority. Huge out-of-pocket payment for medicines is a common phenomenon in many low- and middle-income countries. According to the implementation evaluation, there is still communication and literacy concern for the beneficiaries.[20] Therefore, social marketing and education to improve the knowledge of beneficiaries on the benefits and other key characteristics of the SHP programs should be strengthened.

Currently, payment to providers is based on package rates and the rates are determined by negotiations with individual hospitals. Package rate is more effective than fee-for-service payment but it can still result in perverse incentives for providers, e.g., under-provision, because it does not take into account the severities of patients. Most case-based payment, such as DRG (Diagnosis Related Group)-based payment, takes into account the major severity types of patients. Therefore, the amount of services in the treatment should be closely monitored. In the future, Pakistan needs to elaborate packages rates toward case-based payment system, supported by: review and monitoring, case mix classifications, costing, etc.

[19] Faraz Khalid, *Baseline Survey Report: Prime Minister National Health Insurance Program*, May 29, 2017.
[20] Faraz Khalid, *Implementation Process Evaluation: Prime Minister National Health Program*, July 27, 2018.

Price negotiations with individual hospitals end up with complicated fee structure with different rates for different hospitals that provide the same services. In most other countries, insurer/purchaser implements a uniform fee schedule although fees can be adjusted upward for tertiary or teaching hospitals or for other policy goals. Compared with individual negotiations, it is more effective to set a uniform payment system applied for all hospitals. Aforementioned national entity can provide standard (base) rates for each conditions based on costing. Each province can then take those standard rates into consideration in implementing the rates for its empaneled hospitals. Rates for hospitals need to be set on the basis of additional cost for a hospital to provide services for the program beneficiaries, i.e., marginal cost pricing rather than average cost pricing. Most hospitals do not need to hire more personnel or equipment to treat the patients of SHP programs, therefore reimbursement of marginal cost can provide enough incentives for hospitals to join the program.

Currently, public hospitals are paid by SSPs or SHPI on the top of state budget allocations – although 1/4 to 1/3 of insurance reimbursements are paid back to the government. In the future, government needs to harmonize budget allocation and insurance reimbursement for public hospitals to avoid paying twice for the same services. Reimbursement from those subsidized insurance programs is an additional source of funding for public hospitals, but divided funding from state budget and insurance reimbursement cannot provide strong incentives for them to improve performance. Ensuring a clear distinction between what is paid for out of the provincial health budget, and what is covered under the PNHMP and other SHP initiatives in necessary, especially as the latter grows. In this regard, stream-lining funding to public hospitals will provide more coherent incentives for performance.

F. Financial Protection

Financial protection is one of the fundamental goals of health financing – besides ensuring equitable use of services in good quality – and is used as a key indicator for measuring progress toward UHC. Enrollment in social health protection schemes does not guarantee financial protection for the beneficiaries by itself. For example, although the social health insurance covers 80-90% of the population, OOP payment is on average greater than 55% in the Philippines.[21] Currently, there is little rigorous M&E of the impact of the SHP schemes on financial protection. In other words, there is no evidence documented yet on how much OOP payment of the poor has been reduced after the implementation of the SSPs or other SHP schemes.

OOP payment and financial protection, such as catastrophic expenditure, are determined by many factors in addition to the enrollment in the financing scheme. When the benefits package does not include essential services, e.g., medicines, OOP payment can still be high. If the benefit ceiling is not high enough, the enrollees are exposed to financial risk of high OOP payment because actual health expenditures can easily be greater than the ceiling. Health seeking behavior or coping strategy of patients, such as over- or under-utilization of services, also determines health expenditure and financial protection.

[21] Konrad Obermann, Matthew Jowett and Soonman Kwon, "The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis," *Global Health Action*, 11:1, 2018.

Government and stakeholders needs to pay more attention to the effect on financial protection than how many people are enrolled.

Provider behavior matters a lot because financial burden of patients are determined by balance billing – when providers charge higher than the rate set by the insurer, demand inducement, provision of cost-ineffective care, etc. Under the current packaged payment, private providers may have incentives to keep patients shorter with minimal amount of services for a given hospitalization, admit less severe patients or induce hospitalization. Government needs to monitor hospital behavior not only to ensure quality of care but also financial protection for the enrollees. It is also worthwhile to compare the behavior of private and public providers to examine if the length of stay, for example, in private hospitals is too shorter compared with that in public ones.

G. More Investment in Health

Pakistan needs to invest more in the health sector to improve financial protection and the health of population. It is good news that health and education are of the highest government priority and SSP has been regarded as a politically important program. Policy priority needs to be realized by increased budget allocation to the health sector. Budget allocation needs to be stable and flexible, taking into account the priorities of the health sector.

Increase in the tax on tobacco or other health-related commodities needs to be considered. Earmarking of those tax for the health sector can be an option. Unless finance ministry tries to reduce funding to the health sector, comparable to the increase in budget as a result of earmarking (i.e., no crowding-out effect), dedicated tax can increase the overall funding to the health sector. Even if the earmarked health tax does not substantially increase funding to the health sector, it will contribute to behavioral change and better health of the population.

H. Progress toward UHC

In order to progress towards the goals of UHC, Pakistan needs to avoid fragmentation, reduce inequity, and maximize purchasing power. The toughest challenge for the extension of population coverage is to cover the non-poor informal sector (who are not currently covered by social health protection programs). The best option would be to extend the population coverage of the subsidized health insurance beyond the poor and toward the vulnerable population. Global experience shows that it is very difficult to use contributory schemes to cover the informal sector or at least partial subsidy is required for their enrollment, e.g., China, Philippines, Vietnam, Ghana, Ethiopia, etc., because it is difficult to assess their capacity to pay and collect contribution from them. Therefore, increasing the current threshold level of poverty in the fully subsidized schemes seems an ideal approach to extend the population coverage to the non-poor informal sector.

There are currently two major financing arrangements for formal sector workers in Pakistan: reimbursement mechanism for public employees and mandatory social security for private-sector workers in business with more than 10 employees. One needs to consider converting the reimbursement mechanism for public employees into a prepayment system, including merging with the existing subsidized system of SSP or SHPI. Prepayment system is more transparent (with clear benefits

and entitlements); and efficient in risk pooling and purchasing than the current reimbursement mechanism for public employees.

On the other hand, one also needs a road map of how to coordinate the social security for private sector workers with SSP/SHPI or public employees scheme. Merging all schemes into one big pool will improve equity and efficiency in purchasing and risk pooling capacity. If the merger of all schemes is difficult in the short run due to political and technical reasons, government needs a plan to coordinate benefits and provider payment (or minimize the difference) across schemes to move to ensure functional harmonization and possibly move towards a unified scheme incrementally.

8. Moving towards Developing a Health Financing Policy and Strategy for Pakistan

A. Vision of Health Financing Reform towards UHC in Pakistan

Health financing in Pakistan needs a clear vision to provide financial protection and serve as an effective means to improve equitable access to good quality health services for all. More resources need to be invested in the health sector, and at the same time, those resources should be used in the most cost-effective way to ensure effective access for all to a clear set of benefits/entitlements in a good quality.

Defining a set of entitlements and ensuring the effective access for all though equitable and sustainable prepayment arrangement is what has been qualified as the approach of '*progressive universalism*'.

This can only be materialized by strengthening of service delivery, which could be an important rationale for the introduction of purchaser or insurance carrier, instead of increased budget allocation through a supply-side financing. In addition, in order to develop adequate payment systems for providers, there is a need to build robust information systems that provides a good M&E of providers' behavior and patients' financial burden. Attention needs to be paid to improving quality of care, enhancing financial protection for all and ensuring financial sustainability of health financing.

The health financing vision would need to emerge from an inclusive policy and societal dialogue on the future of the health financing system in the country.

B. Raising more public money and enhancing financing protection and efficiency

Whilst the short to medium term fiscal outlook in Pakistan is challenging, there is a stated commitment by the Federal and Provincial governments to increase public spending on health to 3% of GDP by 2023. This reflects a growing government commitment to funding the health sector, which is of central importance given the current extremely low levels of public spending on health in Pakistan; and the need for a predominant reliance on public funding for health services in order to make progress towards UHC.

As part of this commitment, Pakistan is considering increasing existing, and introducing new 'sin', or public health taxes. This is a welcome move which is primarily a public health intervention to combat the high and growing levels of non-communicable diseases in the country, through the sending of price signals to consumers to reduce unhealthy consumption. Such taxes will raise important revenues for the

government and earmarking them to the health sector, will help moving towards achieving the 3% of GDP target – provided that discretionary budgetary allocations to health are not reduced as a result.

Increased funds for health sector should be held at the national level, for example under the federal SSP rather than allocated through the National Finance Commission Award process/formula. By channeling these funds through the federal SSP, strategic relationships between Islamabad and Provincial Governments will be enhanced and can be used to drive progress nationally towards the goals defined in the National Health Vision 2016-25.

Serious consideration should be given to integrating the various social health protection initiatives nationwide – at least functionally. This could be achievable in the relative short term given that the schemes in KP and Punjab are almost identical in design to the federal SSP. In doing this, the future coherence of these initiatives will be ensured, which is critical to enhance equity and efficiency across the country.

Whilst the SSPs and related SHP initiatives have created a new dynamic within the publicly-funded health system, there are a number of design elements which require improvement, if when scaling up they are to have a greater impact on efficiency, equity and quality in the health system and hence its sustainability. For example, the benefits and conditions of access under the schemes need to be designed in a way which strengthens and promotes prevention and primary care, and further development of payment mechanisms are required to eliminate potential supplier-induced demand and control of costs.

Even as the Social Health Protection schemes are scaled up, the success of these initiatives will also depend on better use of the bulk of public spending on health, which takes place primarily through input-based budgetary spending by provincial governments, and are essential to fund human resources for health, capital expenditure on health facilities and equipment and its maintenance, medicines etc. Evaluation of provincial level initiatives e.g. programme-budgeting in Punjab, and the People's PHC Initiative (PPHI) in Sindh Province, is useful a useful starting point to inform the next steps to reforming and transforming the health financing system in Pakistan towards UHC.

9. Next steps

A. Policy dialogue for HFS development

The Mapping of the health financing system shall be further refined by filling in all questions included in the '*Progress Matrices*'. This is ongoing. The outcome shall then be summarized in a health financing options paper for Pakistan to be tabled for a policy dialogue on developing a National Health Financing Policy for Pakistan to be followed with the development of provincial health financing strategies. The latter needs to be the culmination of an inclusive policy and societal dialogue on the future of the health financing system in Pakistan.

B. Priority areas for further analyses

Below are four areas of further **Technical Cooperation** proposed for the consideration of the MoNHSRC to inform the way forward:

1. **Health Financing Diagnostics**
    a. In-depth analysis of HFS using the '*Progress Matrices*' approach
2. **Fiscal Decentralization**
    a. Budget structure analysis in a devolved setting and Public Financial Management
    b. Health Accounting with provisions for Provincial Health Accounts
3. **Financial Protection**
    a. Capacity building on equity analysis using primary data to monitor progress
    b. Capacity building in implementation of prepayment arrangements
4. **Health Financing Policy/Strategy**
    a. Policy dialogue at national and provincial levels for vision formulation
    b. Health Financing Options paper
    c. Technical Cooperation in National Health Financing Policy and Provincial Health Financing Strategies development

In addition, the following list of further **in-depth analytical work**/policy notes development are suggested to be also pursued in parallel:

1. **Strategic Purchasing** – inclusive of governance issues; e.g., harmonization, tariff setting, etc., and Provider Payment System; e.g., benefit package design
2. **Health Budget Structure Analysis** – inclusive of fiscal decentralization, budget formulation and financial flows
3. **Financial protection and equity** – inclusive of measuring catastrophic expenditures and impoverishment; M&E
4. **Additional revenue raising mechanisms** – role and contribution of sin/public health taxes (with earmarking); corporate responsibilities; financial sustainability; financial modeling
5. **Financing of Health System Inputs: medicines and HRH** – inclusive of procurement, monopoly and pricing; and investment in medical and nursing education and dual practice

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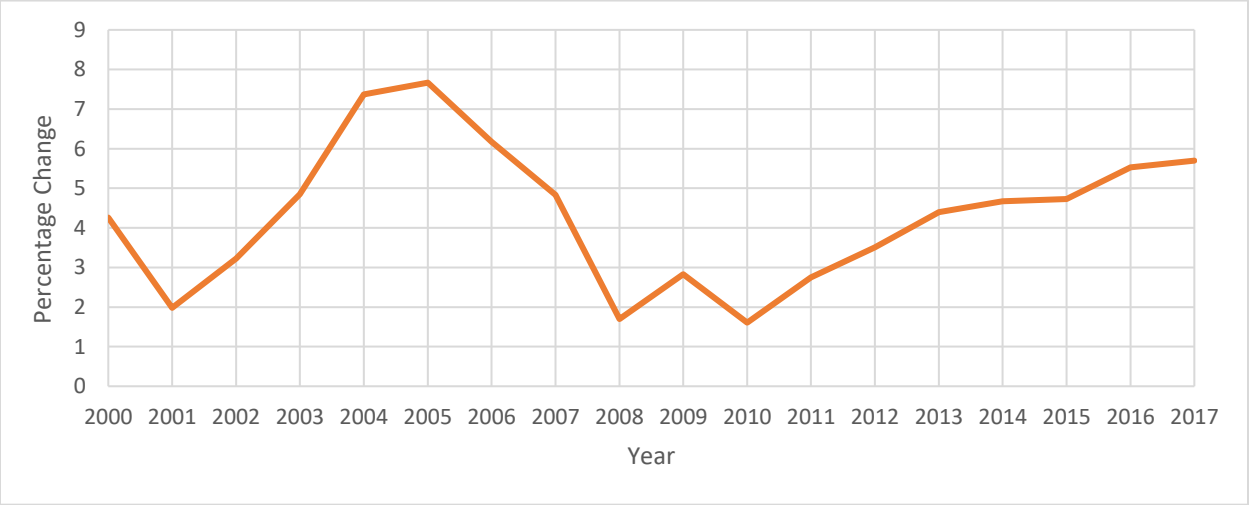
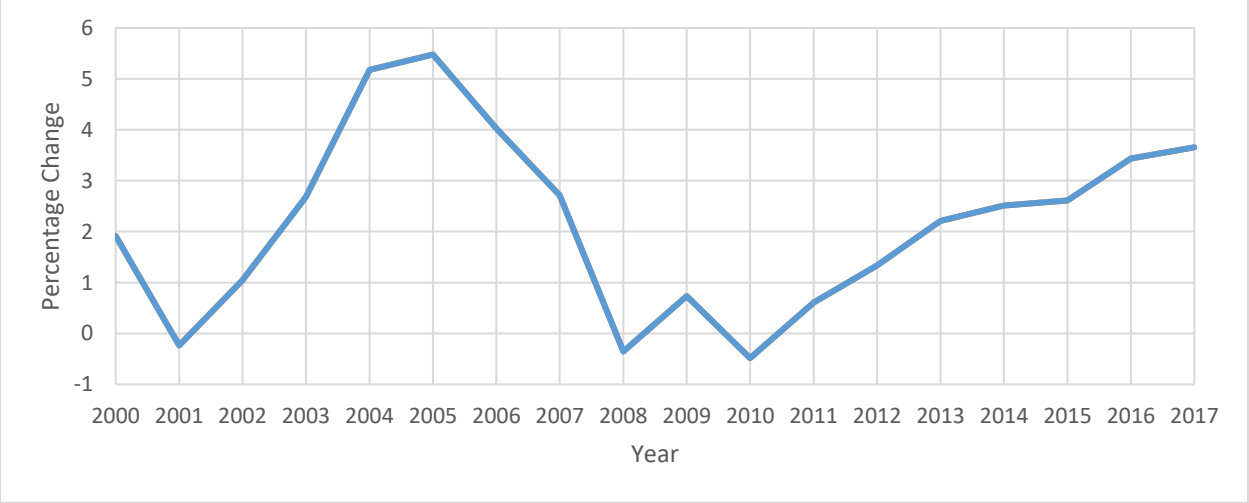
11. Annexes:

Figure A1. Gross Domestic Product (GPD) Growth of Pakistan



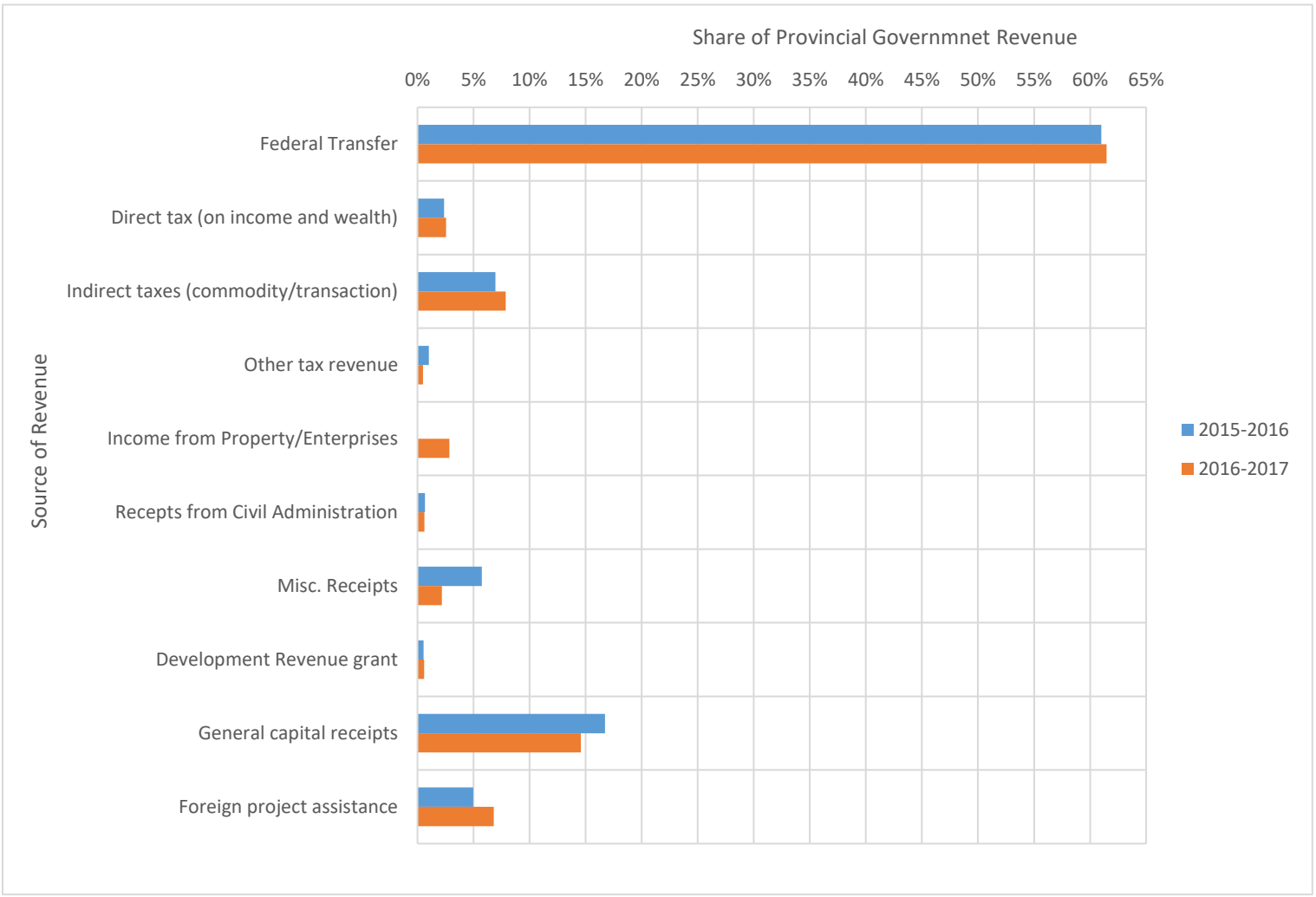
Source: World Development Indicators, The World Bank

Figure A2. Gross Domestic Product (GPD) per Capita Growth of Pakistan



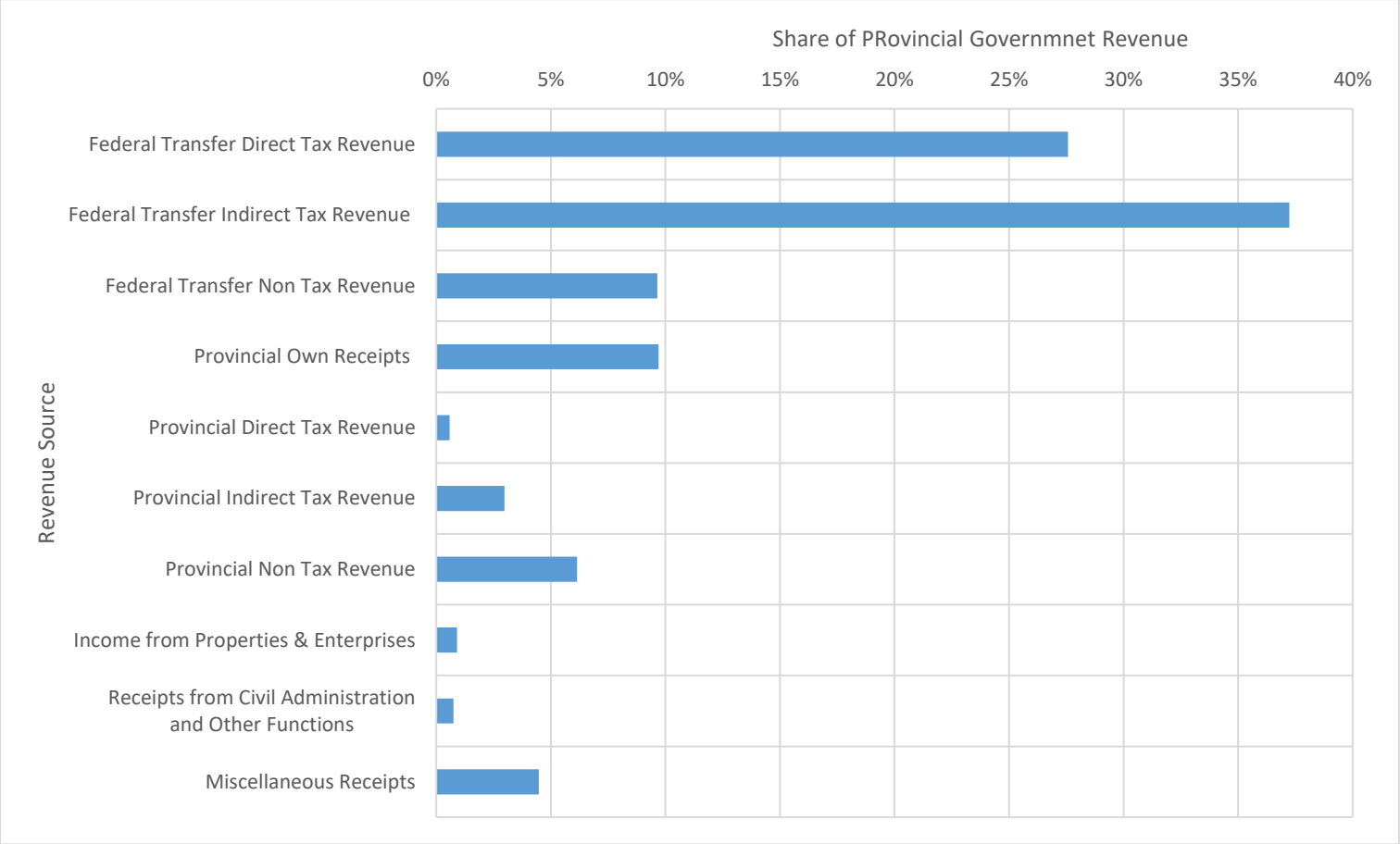
Source: World Development Indicators, The World Bank

Figure A3: Share of Provincial Government Revenue from 2015-2017 for Punjab Province



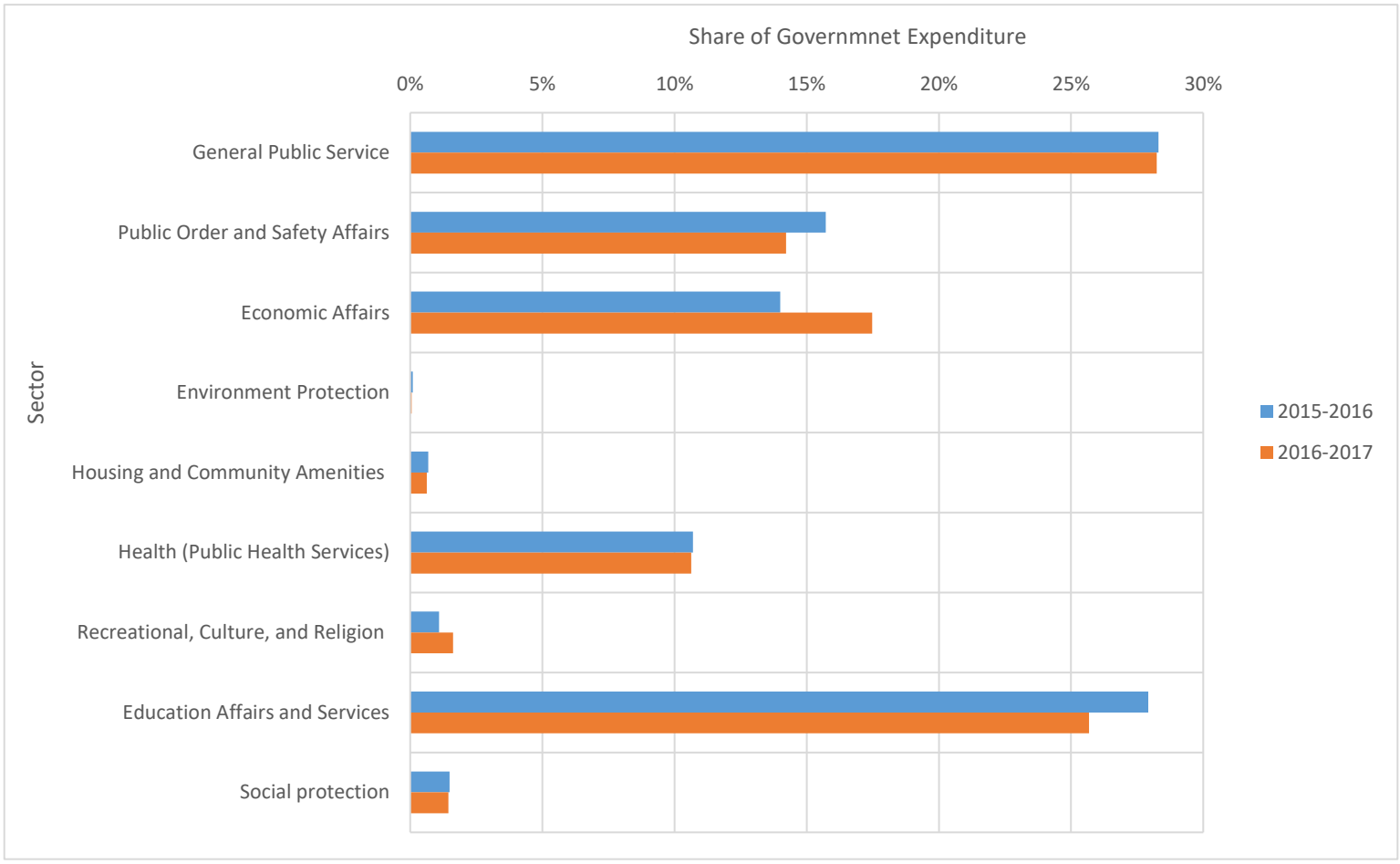
Source: Bureau of Statistics Punjab, Statistical Pocket Book

Figure A4: Share of Provincial Government Revenues in 2016-2017 for Khyber Pakhtunkhwa Province



Source: Bureau of Statistics Khyber Pakhtunkhwa

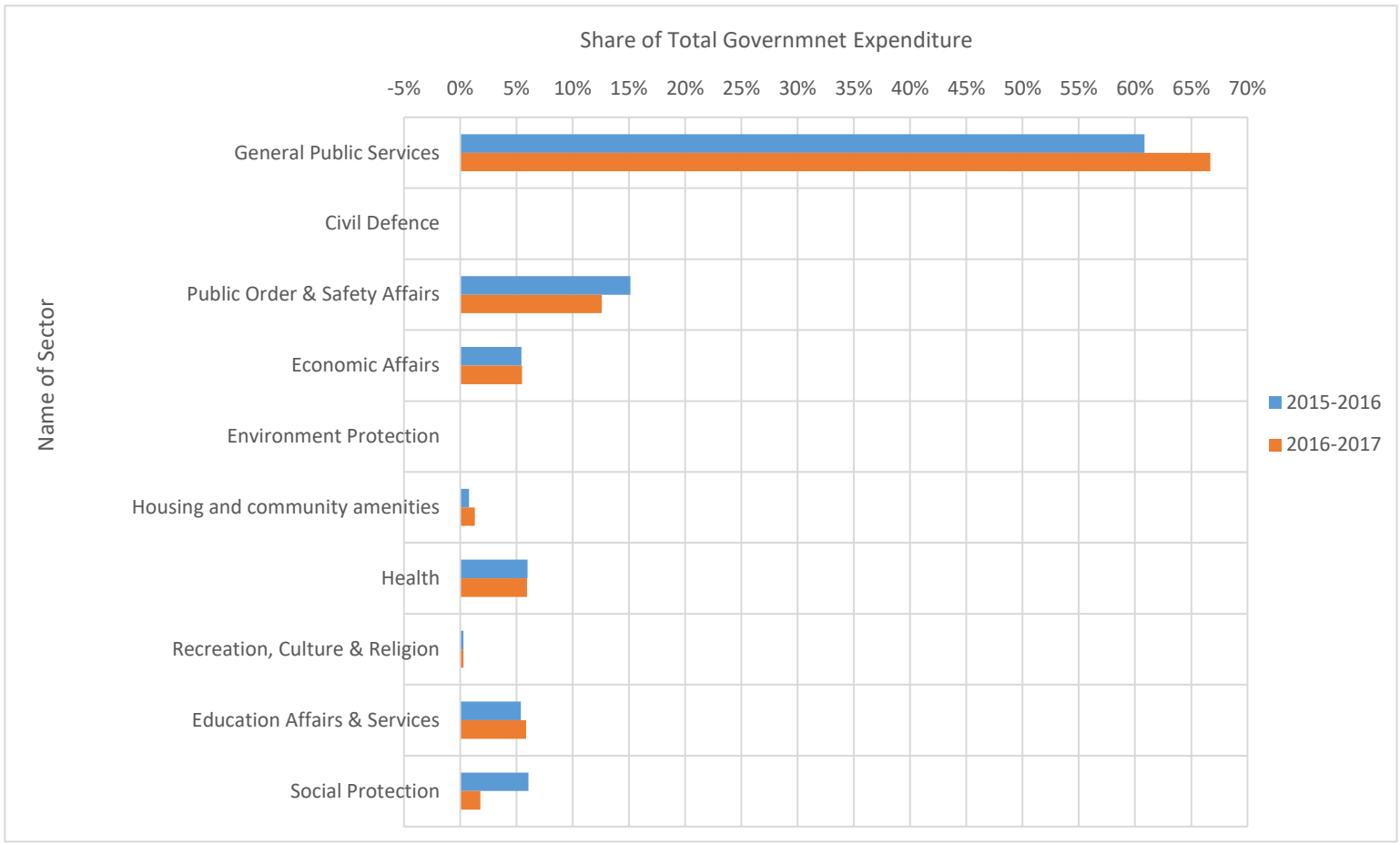
Figure A5: Share of Provincial Government Expenditure[22] from 2015-2017 for Sindh



Source: Sindh Bureau of Statistics Planning & Development Department

[22] Both years use revised estimates.

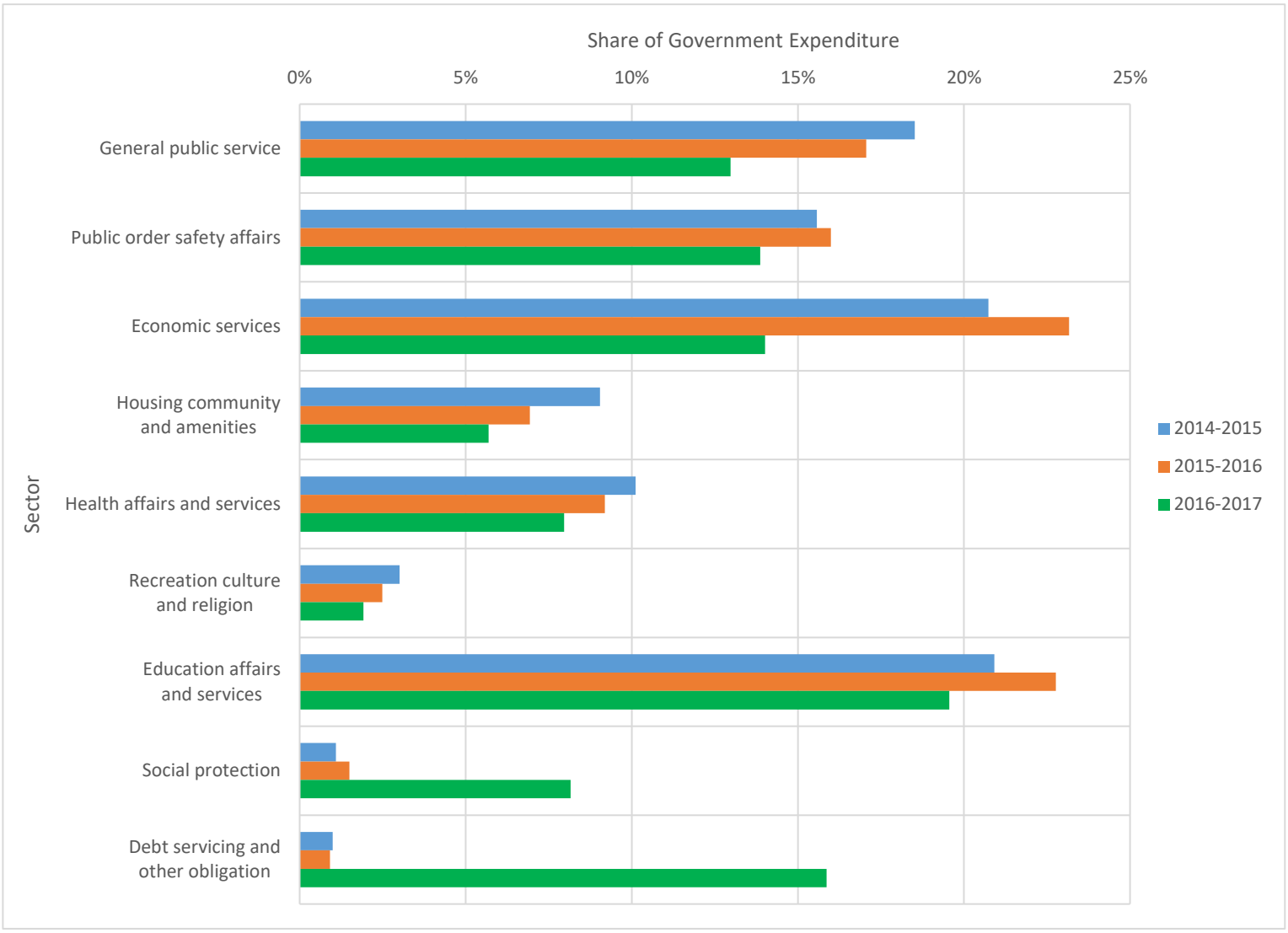
Figure A6: Share of Government Expenditures[23] from 2015-2017 for Khyber Pakhtunkhwa



Source: Bureau of Statistics Khyber Pakhtunkhwa

[23] 2015-2016 uses the Revised Estimates. 2016-2017 uses the Budget Estimates

Figure A7: Share of Government Expenditures[24] from 2014-2017 for Balochistan



Source: Bureau of Statistics Balochistan

[24] 2014-2015 uses the Revised Estimates. 2015-2017 uses the Budget Estimates.

Table A1: Provincial Shares from the Federal Government

Province	2015-2016 Revised estimate	2016-2017 Revised estimate	2017-2018 Budget estimate
Absolute Values (in Rs millions)			
Punjab	896,524	1,020,095	1,161,824
Sindh	482,956	554,111	612,590
Khyber Pakhtunkhwa	301,262	343,547	389,854
Balochistan	171,203	203,594	219,974
Total	1,851,945	2,121,347	2,384,243
Provincial Shares			
Punjab	48.41%	48.09%	48.73%
Sindh	26.08%	26.12%	25.69%
Khyber Pakhtunkhwa	16.27%	16.19%	16.35%
Balochistan	9.24%	9.60%	9.23%
Total	100.00%	100.00%	100.00%

Source: Federal Budget Review of Pakistan 2016-2017 and 2017-2018

Table A2: General Revenue Receipts and Share of Revenue for Azad Jammu and Kashmir

General Revenue Receipts	2014-2015 Revised estimate share (%)	2015-2016 Revised estimate share (%)	Difference in Shares
Provincial Excise	8.62	6.31	-2.31
Land Record and Settlement	0.05	0.36	0.31
Stamps	0.23	0.26	0.03
Forests	0.47	0.29	-0.18
Registration	0.08	0	-0.08
Administration of Justice	0.13	0.15	0.02
Jails	0	0	0
Home (Police)	0.06	0	-0.01
Education	0.23	0.21	-0.02
Health	0.11	0.13	0.02
Agriculture	0.01	0.01	0
Animal Husbandry	0.03	0.05	0.02
Co-operative	0	0	0
Industries, Labour and Minerals	0.05	0.07	0.02
Sericulture	0.01	0.01	0
Miscellaneous	3.26	0.67	-2.59
Communication and Works	0.29	0.32	0.03
Electricity	17.96	15	-2.96
Printing Press	0.03	0.03	0
Armed Service Board	0.03	0.03	0
Religious Affairs	0.49	0.05	-0.44
Food	2.16	0.42	-1.74
Tourism/Wildlife/Fisheries	0.07	0.09	0.02
Adjustment overdraft	0	0	0
Water usage charges Mangla	1.4	1.86	0.46
80% Income from Kashmir Council	17.06	18.4	1.34
Federal Tax Share	28.29	29.01	0.72
Revenue Deficit Grant	18.9	26.23	7.33
Total	100.02	100.01	

Source: Azad Jammu & Kashmir Statistical Year Book 2017