Pakistan 2022: Status of Health Financing

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Status of Health financing

PAKISTAN

July 2022

Ministry of National Health Services,
Regulations & Coordination

@ July 2022

Pakistan: Status of Health Financing

Produced by
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PREAMBLE

FROM THE DIRECTOR GENERAL (HEALTH)

Health is an investment, not a cost.

Let's invest in systems that leave no one behind.

EXECUTIVE SUMMARY

Pakistan is committed to achieve the target for Universal Health Coverage (UHC) and the health- and poverty-related Sustainable Development Goals (SDGs). In order to do so urgent steps are needed to strengthen and strategize financing health and healthcare in the country. With just eight years from the deadline of SDGs in 2030, half of the population in Pakistan (approximately115 million) do not receive the most essential health services they need (SDG 3.8.1).[1] Further, more than 10 million people are pushed into poverty every year from paying out-of-pocket (OOP health expenditure of >10% of total household income) for health (SDG 3.8.2).[2]

The progress towards UHC, as the overarching target of SDG 3, will contribute to inclusive and sustainable economic growth, yet this will not happen unless Pakistan make concrete progress in advancing **health financing**[3], defined here as 1) funding levels that are adequate and sustainable; 2) pooling that is sufficient to spread the financial risks of ill-health; and 3) spending that is efficient and equitable to assure desired levels of health service coverage, quality, and financial protection for all people - with resilience and sustainability.

The UHC financing agenda fits squarely within the policies of the government of Pakistan to promote sustainable, inclusive growth and to mitigate potential risks to the national economy and security. Pakistan needs to benefit from realizing quality and efficiency gains and freeing productive resources for health, while strengthening health security by reducing the frequency, spread and impacts of disease outbreaks and disasters.

Promoting coherence between ministries & departments of finance, planning & development, and health at national and provincial level provides the opportunity to break down the silos and tackle the political economy challenges that continue to hamper progress of health financing for UHC.

Health Financing and Inclusive Growth

Health financing is not an expenditure but investment that benefits the economy through:

a. **Building human capital.** Investments in essential health services fuels the creation of human capital during children's critical early years, laying the foundation of improved educational performance and earning potential. Essential promotive, preventive, and curative health services boost workers' productivity throughout their lifetimes, often with rapid impact.

b. **Increasing skills and jobs, labour market mobility and formalization of the labour force**. The changing nature of work requires skills such as complex problem-solving teamwork, innovation, and self-reliance. Investing in health is a prerequisite to build and maintain these skills and increase capacities to innovate and generate jobs and growth. Health financing also guarantees financial protection by taking advantage of

1 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.1 reported
2 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.2 reported
3 International Bank for Reconstruction and Development / The World Bank, 2019; High-Performance Health Financing-Universal Health Coverage

new opportunities. It also reduces the costs for private firms to grow and create jobs, increasing the rate of workforce formalization and the proportion of people in full-time employment.

c. **Reducing poverty and inequity**. Scaling up prepaid and pooled financing to reduce out-of-pocket payments can have a swift, substantial benefit for poverty reduction. Financial protection has other benefits: people no longer need to sell assets or borrow to meet health payments. They conserve resources that they can then spend or invest in other ways.

d. **Improving efficiency and financial discipline**. Improvements in the efficiency of pooling and purchasing allow expanding the range and quality of guaranteed health services and increasing the extent of financial protection within existing resource envelopes, while controlling cost escalation. Combined with measures to increase efficiency in resource mobilization and efficient utilization through better public financial management, financial discipline is ensured in the sector over the short and long term with an immediate impact on public spending.

e. **Fostering consumption and competitiveness**. Financial protection frees people from making precautionary savings and can stimulate expenditures on other goods and services. By driving efficiency gains in the health sector, health financing also frees productive resources for new strategic uses, supporting country to gain or keep a comparative advantage in international trade.

f. **Strengthening health security through investment in emergency preparedness and response**. The Covid-19 pandemic demonstrated that disease out-breaks can leave lasting economic scars and set development back for years, if not decades. The shock to the economy due to pandemic was so strong that it led to a negative growth rate for the first time in the history of Pakistan. The risks of Covid-19 had dramatically reduced now but potentially new pandemic would likely stem from a different pathogen. Investments in preparedness capabilities including surveillance, primary and community health workers, public-health laboratory networks, and information systems are essential to detect and mitigate infectious disease outbreaks before they spread out of control. In addition to saving lives, investing in preparedness and early action to stop outbreaks also help prevent macro-economic shocks and much more costly emergency response efforts.

Critical Health Financing Constraints

Despite benefits, Pakistan has yet to seize the growth and development opportunities offered by health financing and the constraints include:

1. **Total per capita health expenditure from all sources is very low in Pakistan**, at $52 (2017-18)[4] compared to $135 in lower middle-income countries (LMICs), $477 in upper middle-income countries (UMICs) and $3,135 in high-income countries (HICs).[5]

2. **Low spending in Pakistan is because the country allocates relatively small shares of total government spending to health** - level that is inadequate to support coverage with essential quality health services for all. Pakistan public expenditure on health (Rs 656 billion/ $ 4.1 billion in 2020-21)[6] was around 6 percent of total government expenditure, compared to on average 10 percent in developing countries and 15 percent in HICs.[5]

3. **Part of low government spending is also attributed to the low capacity to mobilize revenues**. In Pakistan, government efforts to raise taxes consistently fall short at 9.4 percent (base year 2016) in 2021[6] compared to 15 percent of gross domestic product (GDP), a threshold that the International Monitory Fund (IMF) has identified as critical to engender sustained, inclusive growth.

4 Pakistan Bureau of Statistics, 2020; National Health Accounts 2017-18
5 World Bank, 2019; WB database
6 Ministry of Finance, 2022; Economic Survey of Pakistan 2021-22

4. **Low levels of domestic government financing mean that there is currently a substantial gap** between the costs of financing an essential package of quality health services for everyone and resources available. Good economic growth is critical to fill the gap, along with strong political commitment for UHC reforms.

5. **As a result of low levels of government spending, out-of-pocket payments constitute a large share** of health expenditures in Pakistan - 51.9 percent of total health expenditure,[4] as opposed to the global average of about 15 percent. These payments deter some people from using needed health services, and push others into poverty or trap them once there.

6. **Inefficiencies and inequities in health financing are widespread**. Estimates suggest that between 20 and 40 percent of health funding is wasted on average.[7] In terms of equity, poor people often contribute a higher proportion of their incomes in health payments than the rich, without subsequent compensation through fiscal transfers in cash or in kind, while frequently receiving fewer health services of lower quality.

7. **Official Development Assistance (ODA) for health has stagnated in recent years** and development assistance must evolve to help accelerate progress toward UHC. Official development assistance was very low at 0.6 percent of the total health expenditure in Pakistan.[4] Additional international investment is needed to catalyse advancements in disease areas, strengthen health systems, support governments in tackling low government revenue generation and strengthen their capacities to carry out all health-financing functions required for accelerated progress towards UHC.

Emerging and intensifying challenges are driving up health care costs and pose risks for future domestic revenue mobilization, efficiency, and equity. Some of the leading challenges include rising consumer expectations; rapid population growth; population aging and the corresponding increase in the burden of non-communicable diseases and demand for long-term care; progress in medical technology; limited administrative capacity to raise revenues; slow formalization of economies; changes in the form and content of work; pandemic threats; anti-microbial resistance; and forced displacement of populations. If not addressed early, these factors may make it even harder to attain the health financing required for UHC.

Closing the substantial UHC financing gap Pakistan will require a strong mix of domestic and international investment. Pakistan's own fiscal measures to increase taxes as a share of GDP and the share of government expenditures dedicated to health, on top of economic growth, could reduce the estimated financing gap. Additional inflows may come from the private commercial sector, but the amounts are likely to be limited. A substantial increase in ODA with support to develop the capacity to absorb external financing, stronger engagement of the private sector, and innovative health-financing policy solutions will all be needed to have a chance of reaching UHC and realizing the ensuing benefits of sustainable, inclusive growth.

The Way Forward

Four lines of action to build health financing in Pakistan:

1. **Scale-up what works.** Pakistan can make substantial progress by adapting proven health-financing principles and policies to its contexts. Key options include: improve the efficiency and equity of resource use, for example through prioritizing investments in evidence based essential package of health services and inter-sectoral interventions, good quality primary and community health services; increase resources for health from general revenue, and, where appropriate and feasible, obligatory health insurance contributions from those with the ability to pay.

2. **Developing synergy between the *Sehat Sahulat* Programme and the UHC Benefit Package of Pakistan** is where the future of healthcare of Pakistan lies. Steps taken for the implementation of *Sehat Sahulat* Programme with huge investments (so far through general taxation) to cover all people from Khyber Pakhtunkhwa, Punjab and Federating areas is an extraordinary response. Pakistan holds a unique

7 WHO, 2010; World Health Report

opportunity of having an established *Sehat Sahulat* Programme (Universal Health Insurance) and the Essential Package of Health Services (EPHS)/ UHC Benefit Package interventions for all people.

3. **Focus on the "big picture"**. There is a need to improve health-financing results by developing a "big-picture" perspective in two ways: first, by connecting health-financing policy across sectors in a whole-of-government approach; second, by consistently adopting a medium-term timeframe and routinely assessing the likely future threats to revenue generation, health costs, efficiency, and equity, adjusting their health-financing strategies before emerging problems become entrenched. Together, these two approaches will reinforce health-financing resilience and sustainability.

4. **Strengthen health-financing leadership, governance, and organizational capacity**. Joint leadership between ministries and departments of finance, planning & development and health can accelerate the development and implementation of health-financing solutions, particularly in areas where, despite broad consensus about principles and policies, progress lags. Often such slowdowns are due to political obstacles. Joint leadership between ministries and departments of finance, planning & development and health is equally critical to strengthen health-financing governance and organizational capacity. In addition, developing synergy with the health insurance organizations and relevant ministries and departments at the federal and provincial levels would be equally important. This should culminate in the establishment of an independent Health Financing Advisory Committee with representation by all relevant stakeholders for continued dialogue and transition towards greater financial sustainability in health.

Bilateral and multilateral agencies and development banks, and global alliances, networks, and platforms are making important contributions beyond development finance to facilitate technical collaboration, policy dialogue, and global learning. These include, inter alia, the World Health Organization (WHO)-led Global Action Plan for Healthy Lives and Well-being; UHC 2030; the Global Alliance on Vaccines and Immunization (Gavi); the Global Financing Facility for Women, Children and Adolescents (GFF); and the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). Each of these partnerships and platforms plays a valuable role in helping Pakistan respond to today's pressing health-financing problems. However, given the persistent challenges in overcoming UHC financing shortcomings, new avenues for international collaboration to support country UHC financing efforts are needed in two main areas:

a. health-financing research and analysis, and development that will provide Pakistan and its provinces with new evidence on open questions and areas of controversy, new strategies to improve financial resilience and sustainability, and financing innovations that might allow step changes in progress toward UHC; and

b. a sizeable increase as well as a strategic shift toward strengthening health-financing leadership, governance, and organizational capacity, improved domestic resource use and mobilization, and increased health security.

CONTENTS

ACRONYMS

ADB	Asian Development Bank
ADP	Annual Development Program
AG	Accountant Generals
AGP	Accountant General of Pakistan
AGPR	Accountant General Pakistan Revenues
AIDS	Acquired Immunodeficiency Syndrome
AJK	Azad Jammu and Kashmir
AMC	Advanced Market Commitment
BHU	Basic Health Unit
BMGF	Bill & Malinda Gates Foundation
BP	Benefit Package
CBHI	Community Based Health Insurance
CGA	Controller General Accountant
CHC	Community Health Centers
CHE	Current Health Expenditures
CKD	Chronic Kidney Disease
CMW	Community Midwife
COPD	Chronic Obstructive Pulmonary Disease
COVID	Corona Virus Disease
CPR	Contraceptive Prevalence Rate
CVD	Cardiovascular Disease
DALY	Disability Adjusted Life Years
DAO	District Accounts Office
DCP3	Disease Control Priorities – 3rd Edition
DDO	Drawing and Disbursing Officers
DG (H)	Director General (Health)
DHQ	District Head Quarter
DRG	Diagnosis-Related Groups
EPHS	Essential Package of Health Services
ESSI	Employees' Social Security Institution
FABS	Financial Accounting & Budgeting System
FBR	Federal Board of Revenue
FCDO	UK's Foreign, Commonwealth and Development Office
FR	Fundamental Rules
FY	Financial Year
GATS	Global Adult Tobacco Survey
GAVI	Global Alliance for Vaccine and Immunization
GB	Gilgit Baltistan
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GFF	Global Financing Facility
GFR	General Financial Rules
GGE	General Government Expenditure
GGHE	General Government Health Expenditure

GYTS	Global Youth Tobacco Survey
HDI	Human Development Index
HIC	High-Income Countries
HIES	Household Integrated Economic Survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPSIU	Health Planning, System Strengthening & Information Analysis Unit
HRH	Human Resource for Health
ICT	Islamabad Capital Territory
IFA	International Financial Assistance
IFMIS	Integrated Financial Management Information System
IHD	Ischemic Heart Disease
IHME	Institute of Health Metrics & Evaluation
IHR	International Health Regulations
IMF	International Monetary Fund
IMR	Infant Mortality Rate
KFW	KFW Development Bank
KP	Khyber Pakhtunkhwa
LHV	Lady Health Visitor
LHW	Lady Health Worker
LIC	Low- Income Countries
LMIC	Low- and Middle-Income Countries
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MIC	Middle-Income Countries
MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MSDS	Minimum Service Delivery Standards
MTBF	Medium Term Budgetary Framework
MTDF	Medium Term Development Framework
NADRA	National Database Registration Authority
NAM	New Accounting Model
NAPHS	National Action Plan on Health Security
NCD	Non-Communicable Disease
NFC	National Finance Commission
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSRC	National Health Services Regulations and Coordination
NHV	National Health Vision
NSER	National Socio-Economic Registry
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket Expenditure
OPD	Outpatient Department
PAC	Provincial Assembly Conducts
PAEC	Pakistan Atomic Energy Commission
PDHS	Pakistan Demographic Health Survey

PEFA	Public Expenditure and Financial Accountability
PFM	Public Finance Management
PHC	Primary Health Care
PMC	Pakistan Medical Commission
PMMS	Pakistan Maternal Mortality Survey
PNC	Pakistan Nursing Council
PRSP	Poverty Reduction Strategy Paper
PSDP	Public Sector Development Program
PSLM	Pakistan Social and Living Standards Measurement Survey
PVT	Private Limited
RHC	Rural Health Centre
RMNCH	Reproductive, Maternal, New-born & Child Health
SAARC	South Asian Association for Regional Cooperation
SAP	Systems Applications and Products
SCI	Service Coverage Index
SDG	Sustainable Development Goal
SEWA	Self Employed Women's Association
SHI	Social Health Insurance
SHPI	Social Health Protection Initiative
SR	Supplementary Rules
SSB	Sweetened-Sugary Beverages
SSP	*Sehat Sahulat* Program
STEP	STEP wise Approach to NCD Risk Factor Surveillance
TB	Tuberculosis
TFR	Total Fertility Rate
THE	Total Health Expenditure
THQ	Tehsil/Taluka Headquarter Hospitals
TSA	Treasury Single Account
UHC	Universal Health Coverage
UK	United Kingdom
UMIC	Upper Middle-Income Countries
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	United States Dollar
VAT	Value Added Tax
WB	World Bank
WHO	World Health Organization
WPV	Wild Polio Virus
YLD	Years Lived with Disability
YLL	Years of Life Lost

MACRO-ECONOMIC OUTLOOK AND HEALTH EXPENDITURE TREND IN PAKISTAN

Country Context

The Islamic Republic of Pakistan, is the fifth largest country (population wise) in the world and a low-middle income country. With a population of 236 million people (including Azad Jammu & Kashmir (AJK) and Gilgit-Baltistan (GB)) in 2022, Pakistan also accommodates more than 1.4 million registered Afghan refugees. Relatedly, 56 percent of the total population in Pakistan belongs to the productive age group (15-65 years of age)[8], i.e., around 132 million people in 2022, compared to 99 million children under the age of 15 years. According to UNDP, Pakistan currently has the fifth largest number of youth population in the world, with 64 percent of the total population below the age of 30 years, and 29 percent between 15 and 29 years old. With gradual declining but high fertility rate, an increase in the youth population is expected in the years to come.

Area-wise, Pakistan ranks as the 33rd largest country, spanning 881,913 square kilometers. The country is divided into provinces of Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan, and three federating areas of GB, AJK and Islamabad Capital Territory (ICT). Furthermore, the provinces are subdivided into administrative 'divisions' – 10 in Punjab, 7 in Sindh, 7 in KP, 6 in Balochistan, 3 in GB and 3 in AJK. Divisions are in turn subdivided into districts, tehsils/talukas and finally union councils. The divisions do not include the ICT, which is counted at the same level as the provinces.

Table: Province/Federating Area Wise Population and Population Density

Province/Area	Population (2017)	Area (Km^2)	Projected Population (2022)	Density per Km^2 (2022)
Punjab	110,012,422	205,344	120.2 million	585
Sindh	47,886,051	140,914	53.0 million	376
Khyber Pakhtunkhwa	35,525,047	101,741	40.1 million	394
Balochistan	12,344,408	347,190	14.3 million	41
Islamabad Capital Territory	2,006,572	906	2.5 million	2,759
Gilgit Baltistan	1,492,000	72,971	2.0 million	28
Azad Jammu & Kashmir	4,045,366	13,297	4.4 million	338
Pakistan	**213,311,886**	**881,913**	**236 million**	**267**
Urban	36.43%			
Rural	63.57%			

8 The 2017 Census data of Pakistan

In Pakistan, 63.5 percent of the population lives in rural areas, while 36.5 percent of the population is in urban areas. Only Sindh and ICT have more than 50 percent of the population residing in urban areas. As per 2017 Census, sex ratio in the country is 106 males: 100 females (103.7 in rural areas and 107.4 in urban areas).

According to Pakistan's official report on multidimensional poverty released in 2019, nearly 37 percent of Pakistanis live in multidimensional poverty. Poverty in urban areas is 32.1 percent, while rural areas display 39.3 percent of poverty levels. Disparities also exist across provinces, as the report found that the poverty rate is lowest for Punjab (31.6 percent) and highest for Balochistan (56.8 percent). Poverty level in KP stands at 36.1 percent, while that in Sindh is 43.7 percent.

Pakistan has a federal system of government in which sovereignty is constitutionally divided between a central governing authority (federal government) and constituent political units (provinces). Different levels of authority manage and fund different public programs, with a certain degree of overlap. The 18th Constitutional Amendment of 2010 introduced profound changes in multi-order governance, which included stripping the federal government of responsibilities for health, education, industry, agriculture, rural development, social services and welfare including social protection. It reasserted provincial control of local government functions and institutions. This resulted in abolition of 17 ministries including the ministries of food and agriculture, education and health. Ministry of National Health Services, Regulations & Coordination (NHSR&C) was re-created on 4 May, 2013 to execute federal health functions in an integrated way. Major devolution of the health sector functions from the federal to the provincial level has shaped the current architecture of the health financing system.

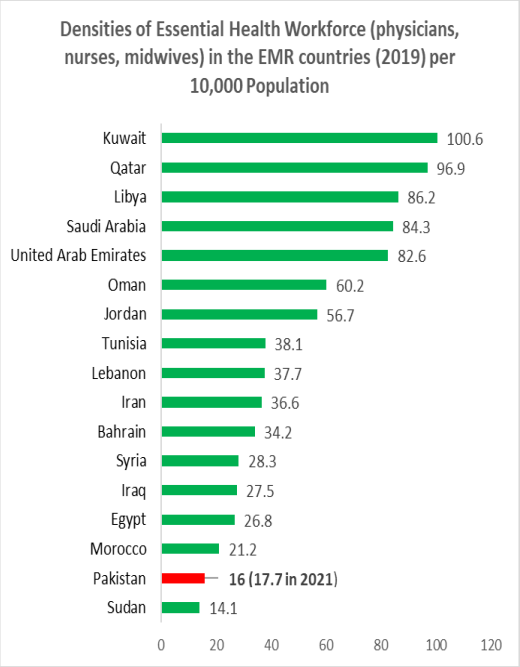
Healthcare system of Pakistan consists of a mix of public and private sector. As per Pakistan's constitution, provision of health is mainly the responsibility of provincial governments other than some federal health function mentioned in the federal legislative list I & II and accordingly in the rules of business of the health division. The state attempts to provide healthcare through five platforms for healthcare delivery system (both public and private sector) including: community; Primary Health Care (PHC) center; First level hospital; Tertiary hospitals; Population level.[9] In addition to community-based services through lady health workers, vaccinators, environmental/ infectious diseases field staff and community-based organizations, the core of the primary healthcare system are Basic Health Units (BHUs), Community Health Centers (CHCs/ or 24/7 BHUs) and Rural Health Centers (RHCs) in public sector and general practitioners/ physicians in the private sector. Referral services are provided for acute, ambulatory and inpatient care through the Tehsil/Taluka Headquarter Hospitals (THQs), and District Headquarter Hospitals (DHQs) in the public sector and small (<50 bedded) & medium (>50 bedded) size hospitals in the private sector. These hospitals are supported by tertiary care from teaching hospitals both in public and private sector. Services are augmented through public health programs (moving gradually towards horizontal integration) and through population level interventions.

Due to increasing demand in public health service delivery, the health services delivery infrastructure has expanded significantly. During 2021, national health infrastructure comprised of 1,276 hospitals, 5,558 BHUs, 736 RHCs, 5,802 Dispensaries, 780 Maternity & Child Health Centers and 416 TB Centers.[10] During 2021, total availability of hospital beds was estimated at 120,334 in the public sector and 112,841 in the private sector.

Adequate numbers, quality and well-performing health workers are crucial for effective functioning of health systems. Pakistan has one of the lowest numbers and densities of essential health workforce in the region and globally, with 270,168 registered doctors, 31,703 registered dentists, 138,107 registered nurses and lady health visitors by the end of 2021. A significant number of physician and nurses are working abroad especially in the middle east, UK, US and Canada. The SDG target for Pakistan is 314,170 Physicians and 942,511

9 Ministry of NHSR&C, 2020; Essential Package of Health Services/ UHC Benefit Package of Pakistan
10 Ministry of Finance, 2022; Pakistan Economic Survey 2021-22

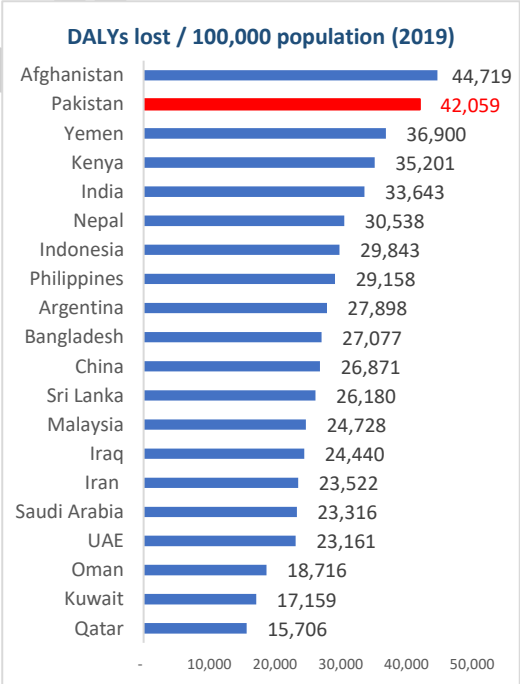
Nurses, LHVs & Midwives by 2030. Number of community-based Lady Health Workers (LHW) is also on decline with 89,240 in 2021.



Health plays a key role in determining the human capital and is actually an investment in human capital especially through provision of essential health services at community and PHC center level, both through public and private sector. Health investment fuels the creation of human capital during children's critical early years, laying the foundation of improved educational performance and earning potential. Health services boost workers' productivity throughout their lifetimes, often with rapid impact.

Better health improves the efficiency and the productivity of the labor force, ultimately contributing to the economic growth and human welfare. Pakistan has shown some improvement in health as life expectancy has increased from 66.9 years in 2017 to 67.3 years in 2019, but is still much behind the global average of 73.5 years.

Pakistan is currently going through epidemiological[11] and demographic[12] transitions. However, both transitions in Pakistan are slow compared to other countries in the region. Paralleling both these transitions are recognized related changes such as "**nutrition transition**" and "**ageing transition**". [13] All these patterns are evident in Pakistan and it is recognized that they may not be unidirectional. Indeed, different "speeds" of transition may occur in different places and sometimes reverses or mixed patterns are observed.



According to Institute of Health Metrics & Evaluation (IHME)[14], the annual rate of DALYs lost per 100,000 population indicates that Pakistan has very high burden of disease (BoD) i.e., 42,059 DALYs/ 100,000 population in 2019, which is very high among the regional and developing countries. Median age is 22.8 years in Pakistan, compared to global median age of 29.6 years, indicating a very young population in Pakistan.

Burden of the communicable, maternal, child and nutritional group in Pakistan, which was more than 65 percent (40,962 DALYs lost per 100,000 population) of the total burden of diseases in the year 2000, has gone down to 49.9 percent (21,004 DALYs lost per 100,000 population) in 2019. However, the burden of non-communicable disease (NCD) group which was 29.9 percent (18,698 DALYs lost per 100,000 population) of the total burden in the year 2000 has increased its share to 43.7 percent (18,385 DALYs lost per 100,000 population) in 2019. The share of burden of injuries

11 **Epidemiological transition** considers patterns of mortality change and causes of death (and sometimes ill health) from patterns dominated by maternal & child health and infectious diseases to those in which chronic, degenerative physical ailments predominate with increasingly non-communicable and mental ill-health conditions

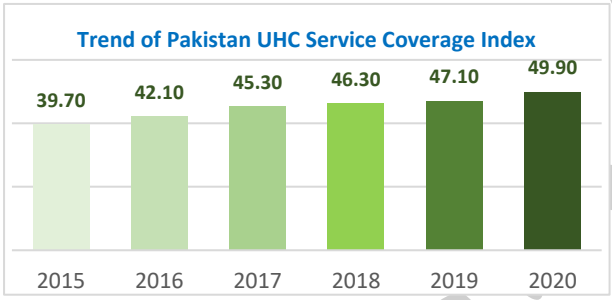
12 **Demographic transition** refers to the shift in vital rates within population groups at various geographical scales from a pattern of high birth (fertility) and death (mortality) rates to one of low rates

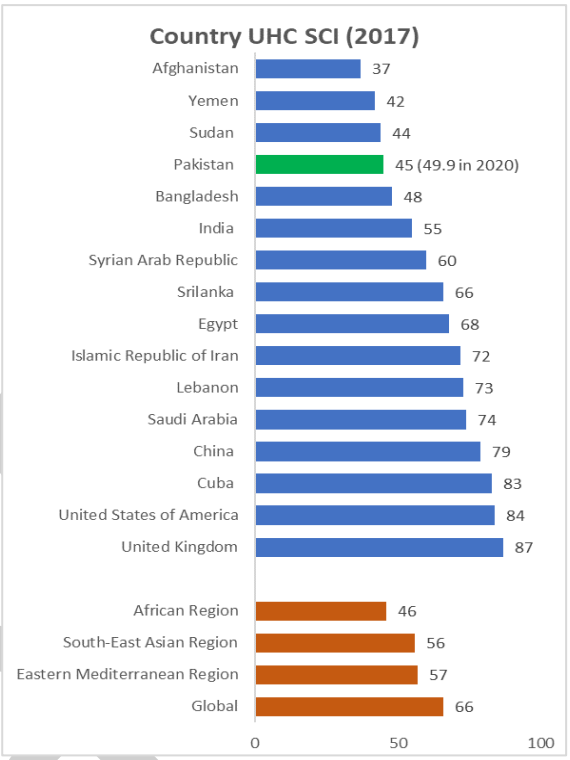
13 https://doi.org/10.1002/9781118786352.wbieg0063

14 https://vizhub.healthdata.org/gbd-compare/

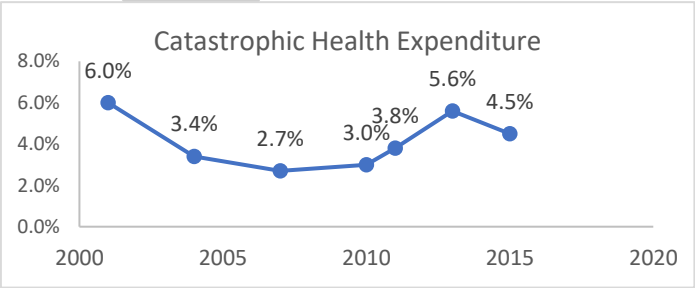
also increased from 4.73 percent (2,958 DALYs lost per 100,000 population) to 6.35 percent (2,669 DALYs lost per 100,000 population) over the same period. These facts illustrate the reduction in the BoD of RMNCH-N and communicable diseases with a concomitant increase in the BoD share of NCDs and Injuries.

Universal Health Coverage (UHC) Service Coverage Index – a single indicator computed from tracer indicators of coverage of essential services (that include reproductive, maternal, new-born and child health; infectious diseases; non-communicable diseases; and service capacity & access) – was developed by WB and WHO. The index is correlated with under-five mortality rates, life expectancy and the Human Development Index (HDI). Pakistan's UHC service coverage index is improving but the pace of improvement is very slow and much low compared to other countries and regions.[15]





Another dimension of UHC is the catastrophic health expenditure, which is a healthcare-related bill that exceeds a person's capacity to pay. It often involves the encashment of savings and assets, including, at times, homes and businesses. It can impoverish and devastate families for many years. In Pakistan, population with household expenditures on health >10 percent of total household expenditure or income (%) was 4.5 in 2015 compared to 3 in 2010. Current high inflation rate is expected to have a further negative impact on the health of poor. In advanced societies, particularly the United Kingdom and Western Europe, the existence of cradle-to-grave social welfare programmes buffers individuals from the cost. It's also worth pointing out that catastrophic health expenditure usually occur in the last few years of a person's lifetime, contributing in no small way to the dissatisfaction with the spending. All this, only to see them die.

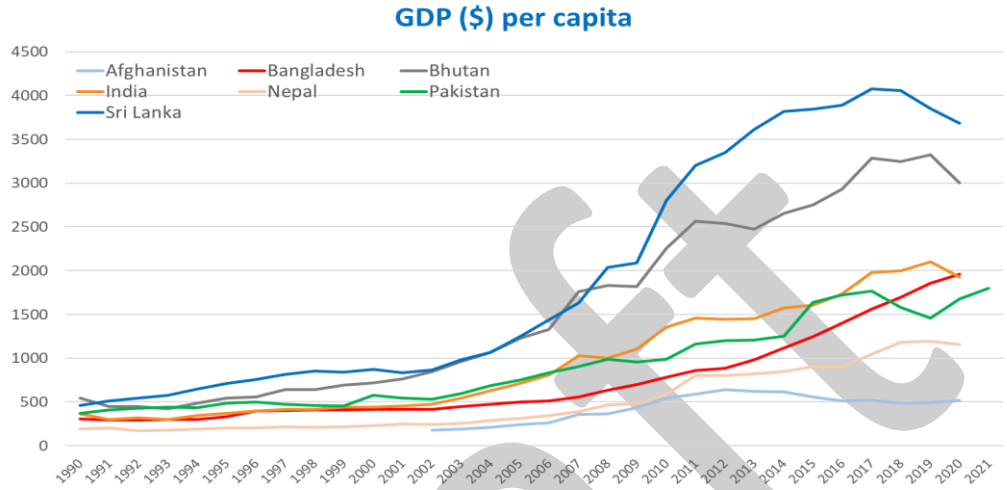


Catastrophic health expenditure is an escalating issue in Pakistan where many people cannot afford health care services when these expenditures increase up to a certain level. A sharp and immediate increase in current health expenditures is required to achieve cost-effectiveness, efficiency, and equity in the health care system. The devastating economic event makes a strong case for UHC programmes with a focus more on primary, preventive and promotive health care services. Government should protect the poor from the health expenditure catastrophe but simultaneously it is also essential to protect non-poor or middle-income people from health expenditure shock. In this regard, some major reforms on health care financing and health policies are required to improve the efficiency and equity in the health care system of Pakistan.

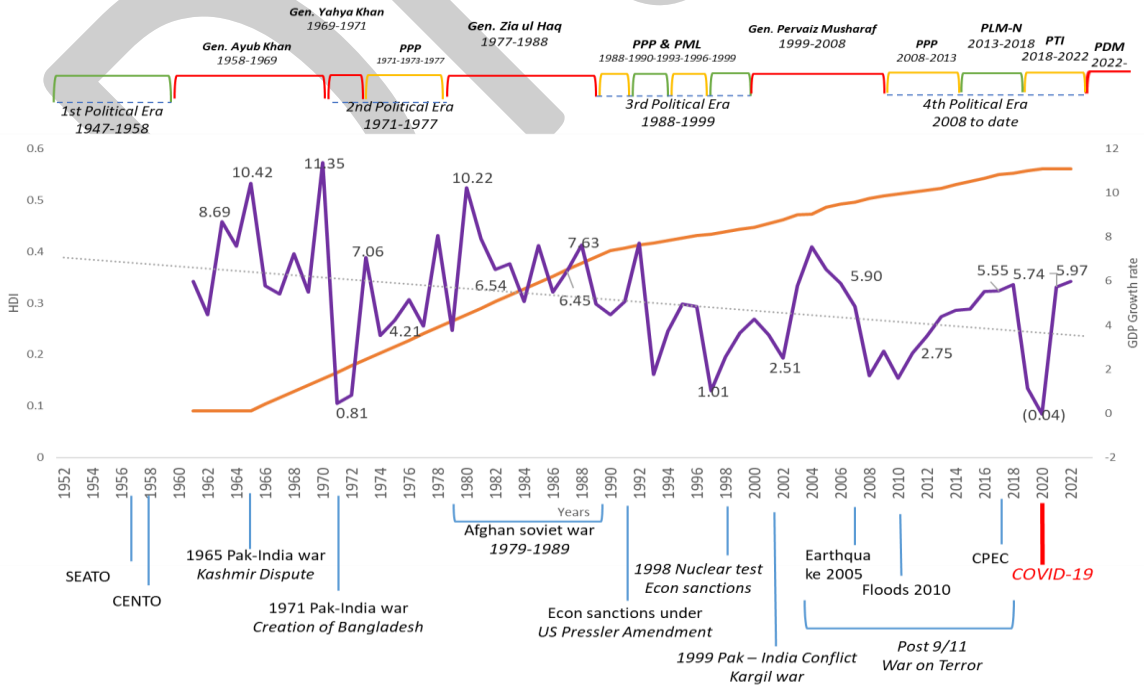
15 WHO, 2021; World health statistics 2021, monitoring health for SDGs

Pakistan Economic Outlook

Pakistan experienced gradual economic growth in the last three decades, with a steady increase in Gross Domestic Product (GDP) per capita between 1990 and 2020. However, compared to other countries in South Asia, performance is not satisfactory. Pakistan per capita GDP ranked third out of seven countries of South Asia in 1990, but has declined to fifth rank at present. This mean that macroeconomic outlook of Pakistan is facing more challenges than other countries in the region. More recently, the macroeconomic situation deteriorated almost in all countries of the region with the onset of COVID-19, followed by ongoing V shaped recovery.[16]

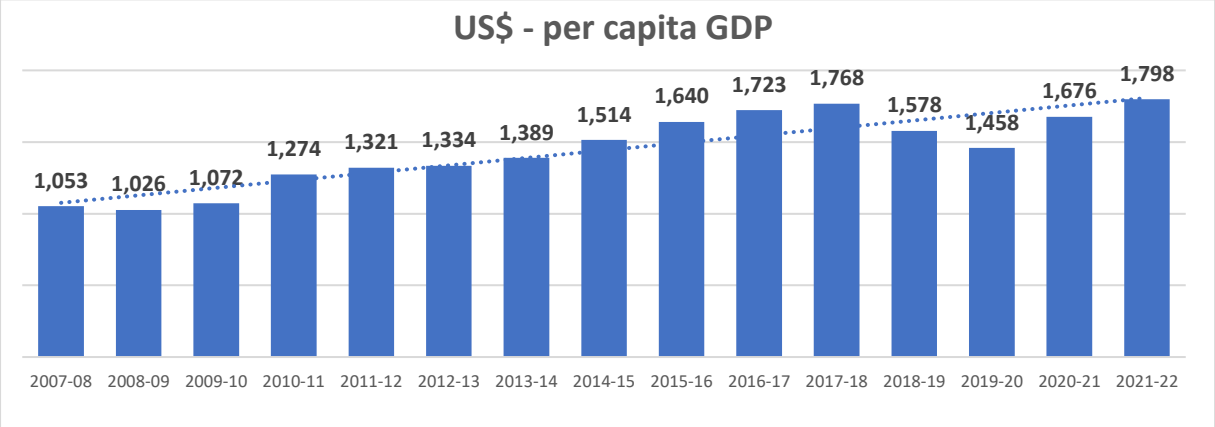


Despite poor performance, the macroeconomic outlook of Pakistan looks promising due to structural reforms, improved energy availability, effective response against COVID-19 and investments on the China–Pakistan Economic Corridor. However, rising food & fuel prices, inflation, macro-economic imbalances and global/local security issues are major threats to the economic outlook. Following picture illustrates trend in economic growth rate and human development index in Pakistan.[17]

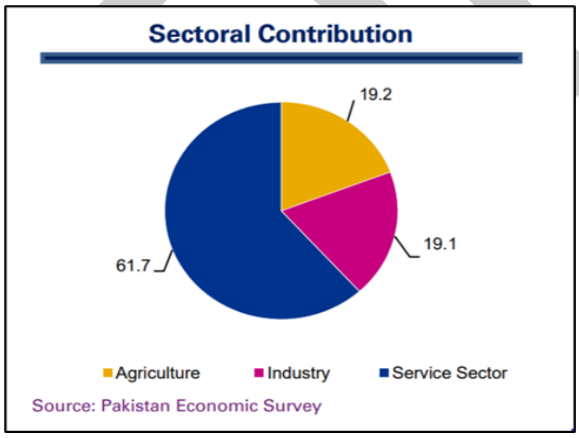


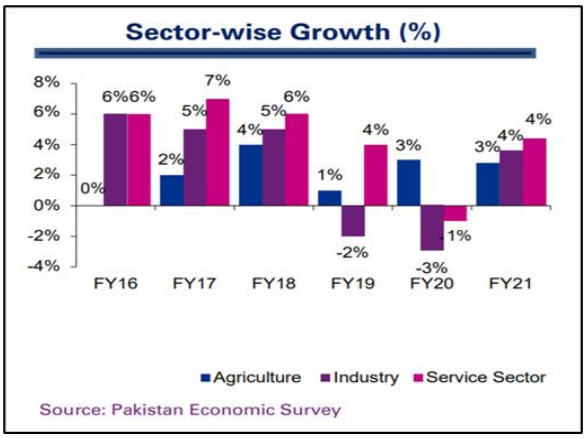
16 Source: World Bank; https://data.worldbank.org/indicator and Pakistan Economic Surveys
17 Economic surveys of Pakistan for Economic growth rate and UNDP for HDI Index

Pakistan's economy rebounded strongly in FY2021-22 and witnessed a V-shaped recovery, following slowed economic growth due to macroeconomic imbalances and setback due to COVID-19 outbreak. The economy of Pakistan saw a growth of 5.74 percent in FY2020-21 and 5.96 percent in 2021-22, which is not only substantially higher than the previous two years (FY2019 and FY2020), but also surpassed the target. Moreover, GDP at current market prices stood at Rs 47,709 billion ($ 299 billion), showing a growth of 14.8% during FY2021 over last year (Rs 41,556 billion/ $ 263 billion). Per capita income increased from US$ 1,053 in 2007-08 to US$ 1,651 in 2017-18. However, it started declining after 2017-18 and a level of US$ 1,360 was observed in 2019-20, since the economic situation was under stress mainly due to fiscal crisis and then as a result of COVID-19 pandemic. Thereafter, economic activity in Pakistan regained momentum and per capita income increased to $1,798 in 2021-22.[18]



This economic growth rate has been attributed mainly to the country's performances in different sectors. The 2020-21 GDP growth is based on 2.77, 3.57 and 4.43 percent growth in agriculture, industrial and services sector, respectively. Pakistan's current GDP composition consists mainly of the services sector of approximately 61.7 percent, followed by agriculture and industry at 19.2 percent and 19.1 percent, respectively, illustrated in the figures below.



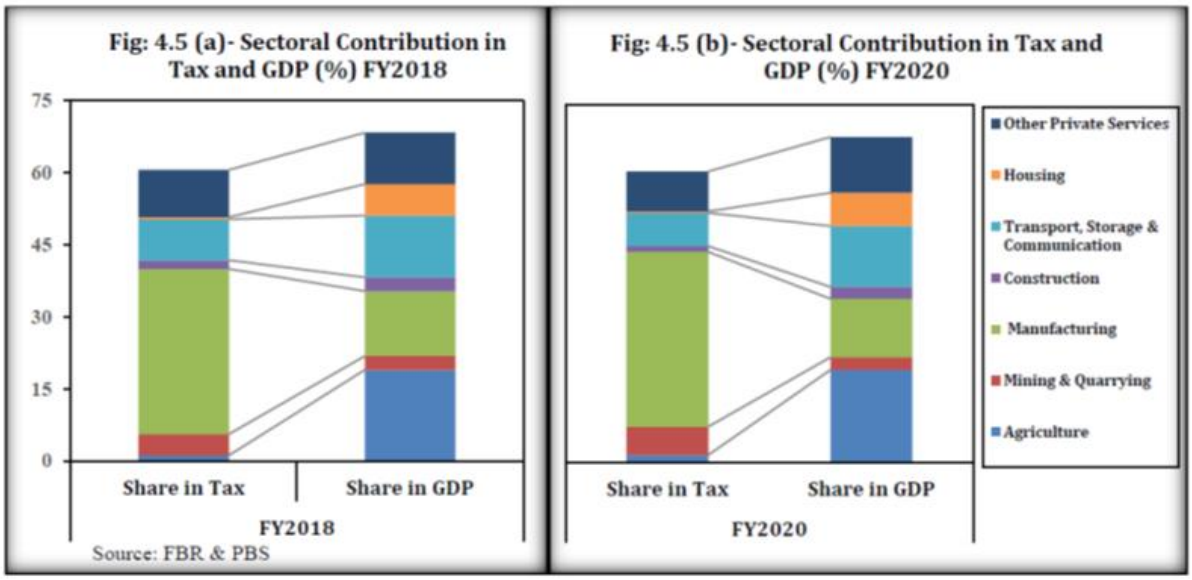


While Pakistan's economy has potential to grow, the country continues to suffer from several macroeconomic challenges. The figures below indicate that taxes in the different sectors are not equitable with reference to their contribution in GDP. Consequently, the tax to GDP ratio remained low. The tax-to-GDP ratio compares a country's tax revenue to the size of its economy, which in this case is measured by its GDP.

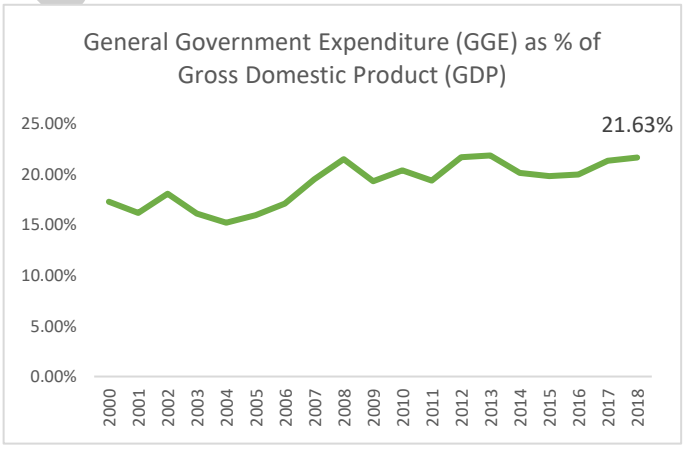
18 Source: Pakistan Economic Survey 2021-22

The higher the ratio, the higher the proportion of money that goes to government coffers. If managed effectively, this can support the long-term health and prosperity of an economy.

During the last five years, overall tax-to-GDP ratio (federal & provincial) remained within a range of 11.4 percent and 12.9 percent. This ratio fell to 11.4 percent in FY2020, down from 11.7 percent in FY2019. The economic downturn caused by the COVID-19 pandemic resulted in a further drop in the tax-to-GDP ratio during FY2020, with the result that Pakistan's overall tax base is less than optimal. According to the International Monetary Fund, countries should have a tax-to-GDP ratio of at least 12 percent in order to experience accelerated economic growth. The implication for health financing, and social spending more broadly, is that tax:GDP ratio below this threshold is inefficient. Thus, there is need to improve tax to GDP ratio by increasing tax base, so that more resources can be allocated for social spending, including health.



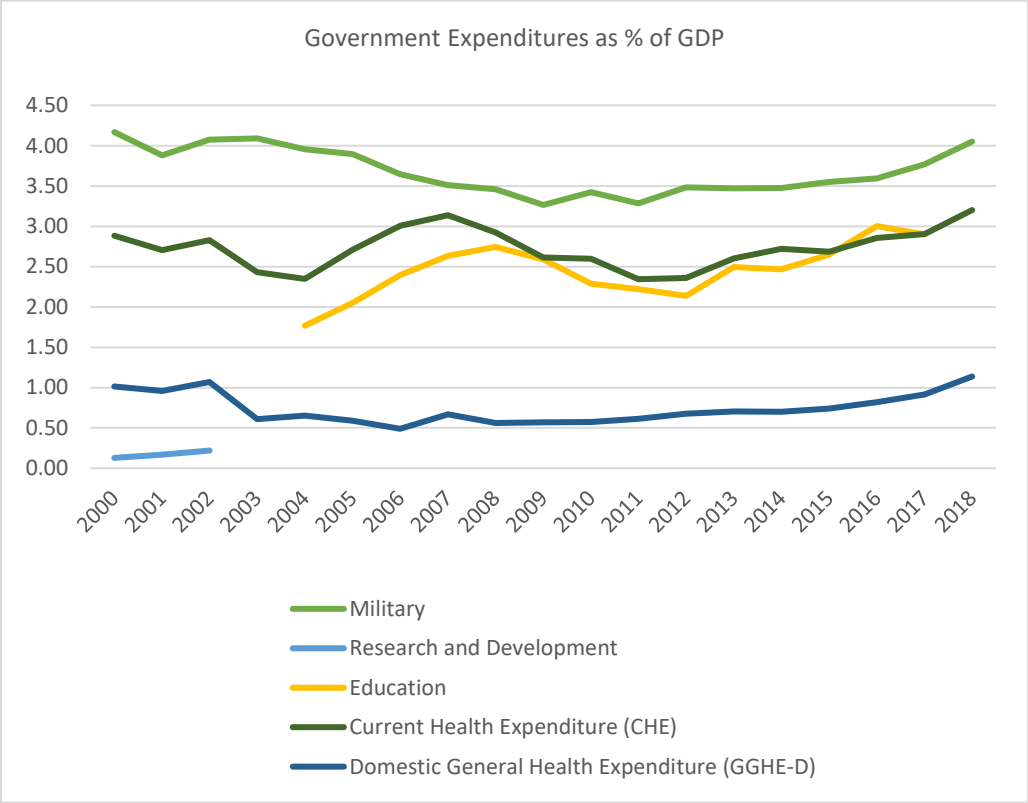
The total expenditure by the Pakistan's government as a share of the economy as measured by GDP (GGE as % of GDP) has varied significantly over the years, but has increased gradually between the years 2000 and 2018, and is illustrated in the figure below. The GGE as % of GDP stands at 21.6% for the year 2018. It is important to note here that an increasing GGE as % of GDP value does not necessarily mean an increase in the total resources spent, but could also indicate a decrease in the country's economy as measured by GDP. Likewise, a decreasing GGE as % of GDP value does not necessarily mean a decrease in government's expenditures but could also point to an increase in GDP.



Source: Global Health Expenditure Database, World Health Organization

The Government of Pakistan (GoP) has committed to making urgent and immediate progress towards universal health coverage (UHC). UHC means that all people in a society are able to obtain the health services that they need, of high-quality, without fear that the cost of paying for these services at the time of use, which will push them into severe financial hardship. This commitment and strategic direction was outlined five years ago in the National Health Vision 2016-2025, where Pakistan's domestic governments—federal as well as provincial—jointly committed to increasing health expenditures nationally from their then value of under 1% of GDP to 3%. However, investments into the public

health sector remain below the GoP's own stated commitments. The figure below demonstrates the trends in government expenditures on key sectors. It is evident from the figure that health has been given a relatively low priority in government budget compared to other sectors.



Source: Global Health Expenditure Database, World Health Organization & World Bank Development Indicators

The next section seeks to lay out the trends in health expenditures in Pakistan over the years 2000 to 2018, and how these compare with the other SAARC countries.

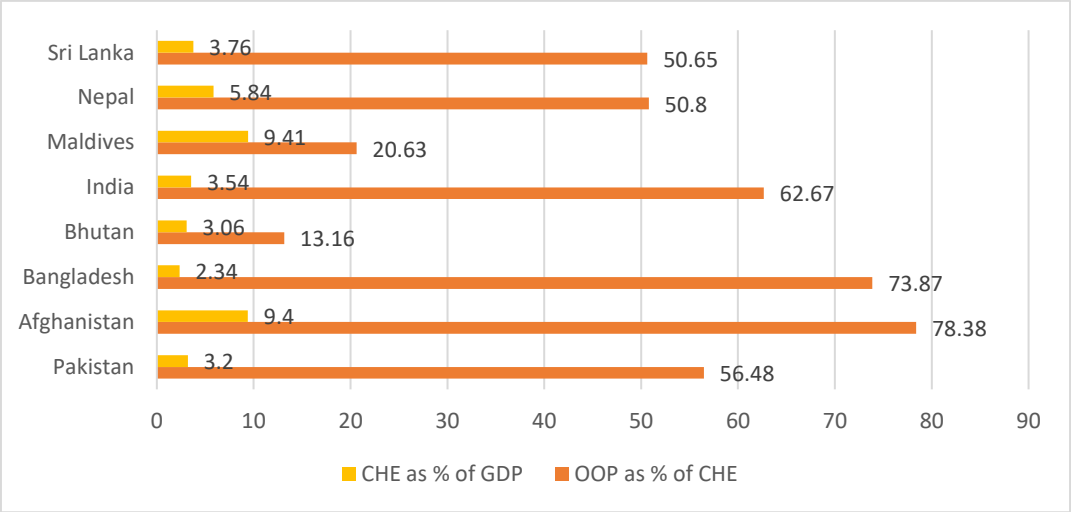
Evolution/ Changes in Health Expenditure in Pakistan

Health Financing Indicators

The table and graph below show comparison of the health financing indicators of Pakistan with the SAARC countries in 2018. Pakistan's level of health expenditures (2018) is low relative to other countries, whether measured as current health expenditures per capita or as CHE as a share of GDP. In the region, private sector makes up a greater portion of the current health expenditures than the public sector; in only two countries (Bhutan and Maldives) is the public spending on health more than the private spending. Given that, Pakistan's public spending on health as a share of current health expenditures is more than that for Afghanistan, Bangladesh, India and Nepal. Likewise, although the out-of-pocket spending as a share of current health expenditure is high for Pakistan, it is lower than that for Afghanistan, Bangladesh, and India. Furthermore, the level of donor funding is lowest for Pakistan compared to other countries in the region. Overall, with respect to health financing indicators, in particular out-of-pocket expenditure, Pakistan performs better than Afghanistan, Bangladesh, and India.

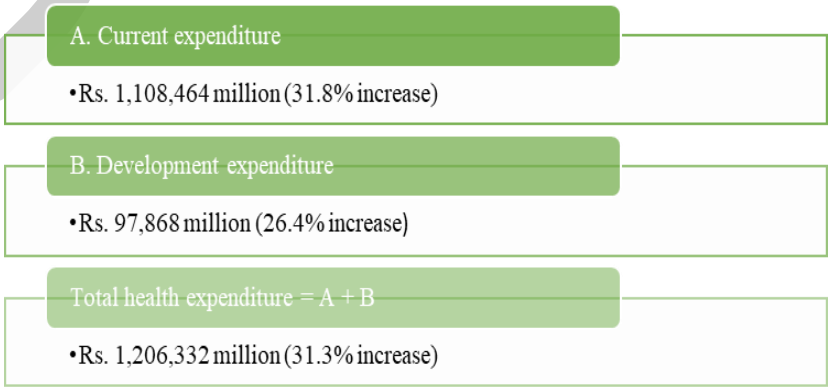
Table: Health Financing Indicators for Pakistan and SAARC Countries (2017-18)								
SAARC Countries	**CHE per Capita (USD)**	**CHE as % of GDP**	**GGHE-D as % of CHE**	**PVT-D as % of CHE**	**OOP as % of CHE**	**EXT as % of CHE**	**GGHE-D as % of GGE**	**GGHE-D as % of GDP**
Afghanistan	49.8	9.4	5.17	78.38	78.38	16.4	1.8	0.5
Bangladesh	41.9	2.34	16.98	76.5	73.87	6.5	2.98	0.4
Bhutan	102.7	3.06	79.55	14.4	13.16	6.1	7.61	2.4
India	72.8	3.54	26.95	72.35	62.67	0.7	3.39	1
Maldives	973.5	9.41	70.62	28.45	20.63	0.9	21.44	6.7
Nepal	57.9	5.84	25.05	65.86	50.8	9.1	4.58	1.5
Sri Lanka	157.5	3.76	41.09	56.67	50.65	2.2	8.29	1.5
Pakistan	**48.1**	**3.2**	**34.72**	**64.68**	**56.48**	**0.6**	**5.26**	**1.14**
Pakistan (NHA)	**48.1**	**3.2**	**34.72**	**64.68**	**56.48**	**0.6**	**5.26**	**1.14**

Source: National Health Accounts 2017-18 & Global Health Expenditure Database, World Health Organization

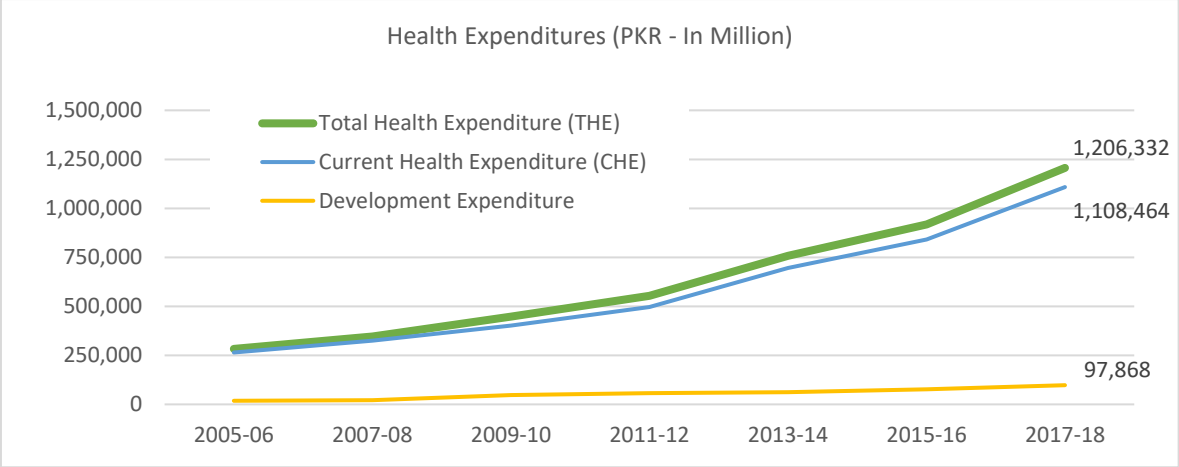


Source: National Health Accounts 2017-18 & Global Health Expenditure Database, World Health Organization

Total health expenditure is an aggregate of current expenditure (Rs. 1,108,464 million) and development expenditure (Rs. 97,868 million), and for FY 2017-18, it is estimated as Rs, 1,206,332 million. Compared to FY 2015-16, current, development and total health expenditures show increase of 31.8%, 26.4% and 31.3% respectively.[19] It is illustrated in the diagram. Current health expenditure (CHE) contributes more to the total health expenditure than the development expenditure. The graph below shows changes in health expenditures in Pakistan over the years 2005 to 2018.

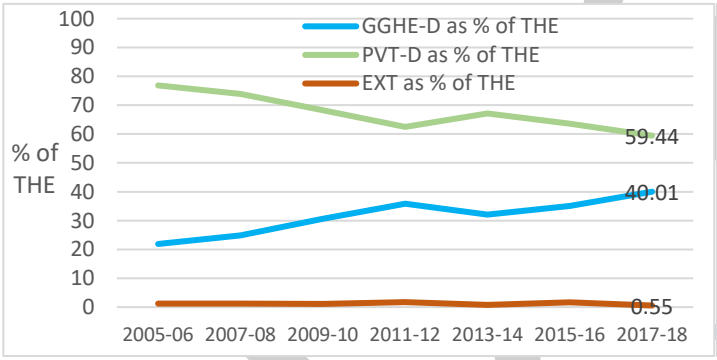


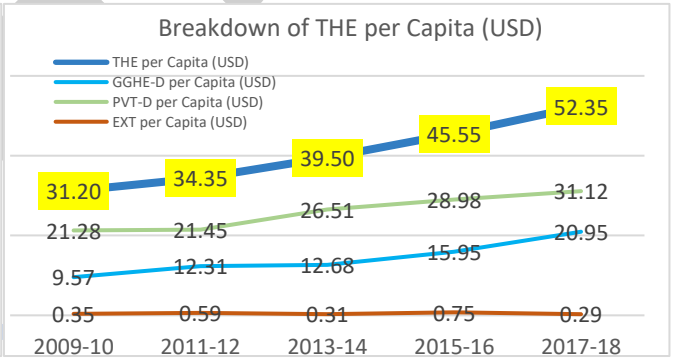
19 Pakistan Bureau of Statistics. National Health Accounts. 2017-18.



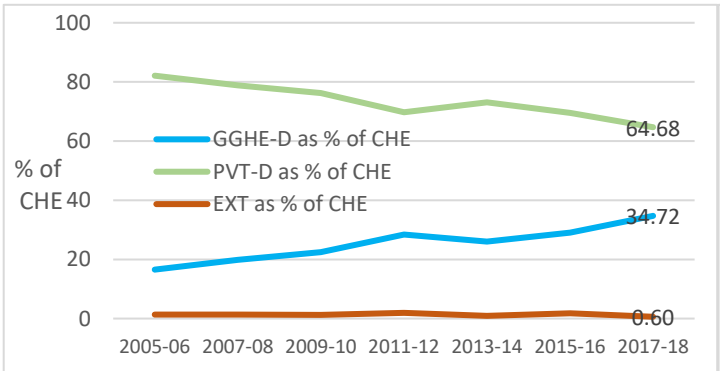
Source: National Health Accounts

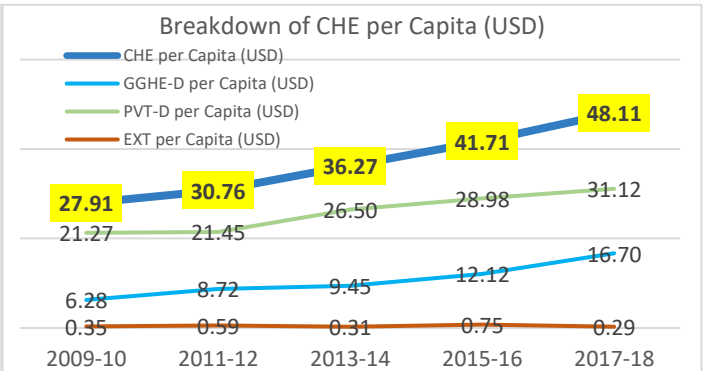
The annual per capita total health expenditure (THE) has increased from Rs 2,611 (US$ 31.2) in 2009-10 to Rs 5,750 (US$ 52.4) in 2017-18. For the year 2017-18, 40% of the resources for health were from the public sector, whereas 59.4% from the private sector, and 0.6% from external funding sources. As illustrated in the graph below, which shows the changes in contribution from these sources over the years. The share of total health expenditures funded from government resources (GGHE-D as % of THE) has increased gradually from 2014 onwards, resulting in decrease in the share of domestic private expenditures on health (PVT-D as % of THE) and the share of external sources spent on health (EXT as % of THE) of the total health expenditures.



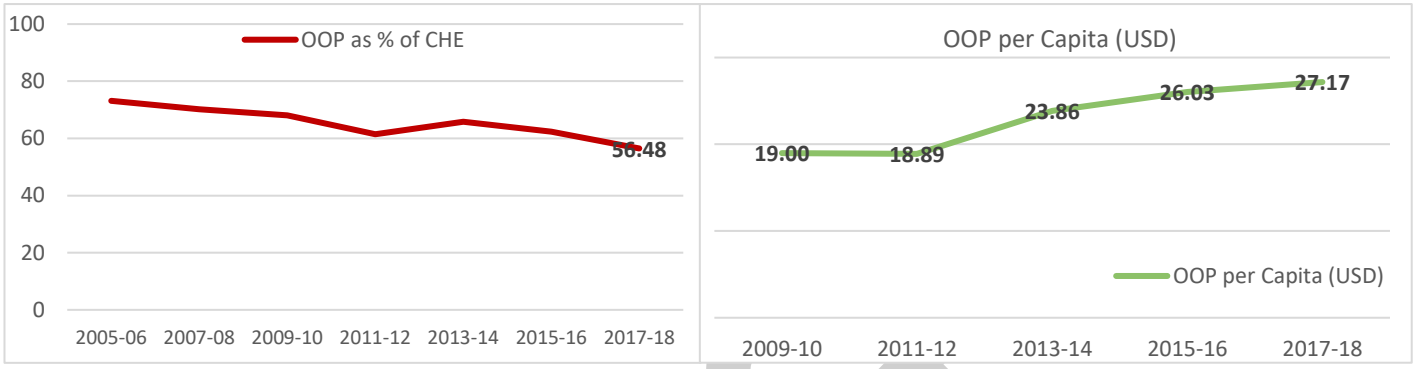


The annual per capita current health expenditure (CHE) has increased from Rs 2,335 (US$ 27.9) in 2009-10 to Rs 5,283 (US$ 48.1) in 2017-18, and is 3.2% of the GDP. For the year 2017-18, 34.7% of the resources for health were from the public sector, 64.7% from private sector, and 0.6% from external funding sources. As for total health expenditure, the share of public health expenditures (GGHE-D as % of CHE) has increased gradually from 2014 onwards, resulting in decrease in the share of private expenditures on health (PVT-D as % of CHE) and the share of external sources spent on health (EXT as % of CHE) of the total current health expenditures.



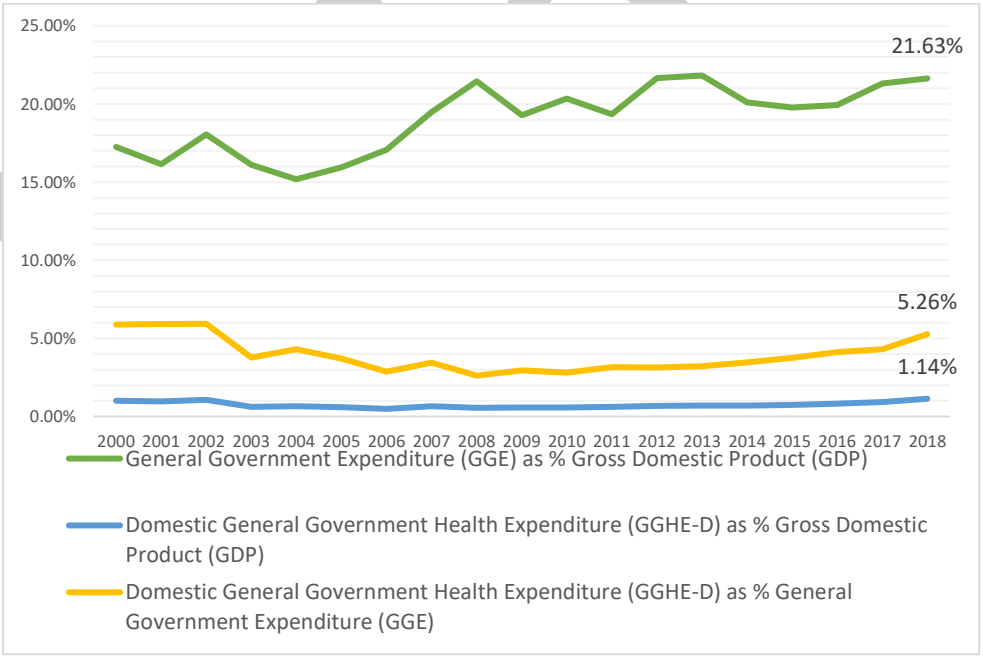


OOP per capita for Pakistan as per NHA 2017-18 was (27.2 US$) Rs. 2,984, which translates to OOP as % of CHE of 56.48%. OOP as % of CHE decreased from 73.1% in 2005-06 to 61.4% in 2011-12, but increased to 65.8% in 2013-14, before decreasing again over the next five years. The graphs below show trends in OOP over the years.



Source: National Health Accounts

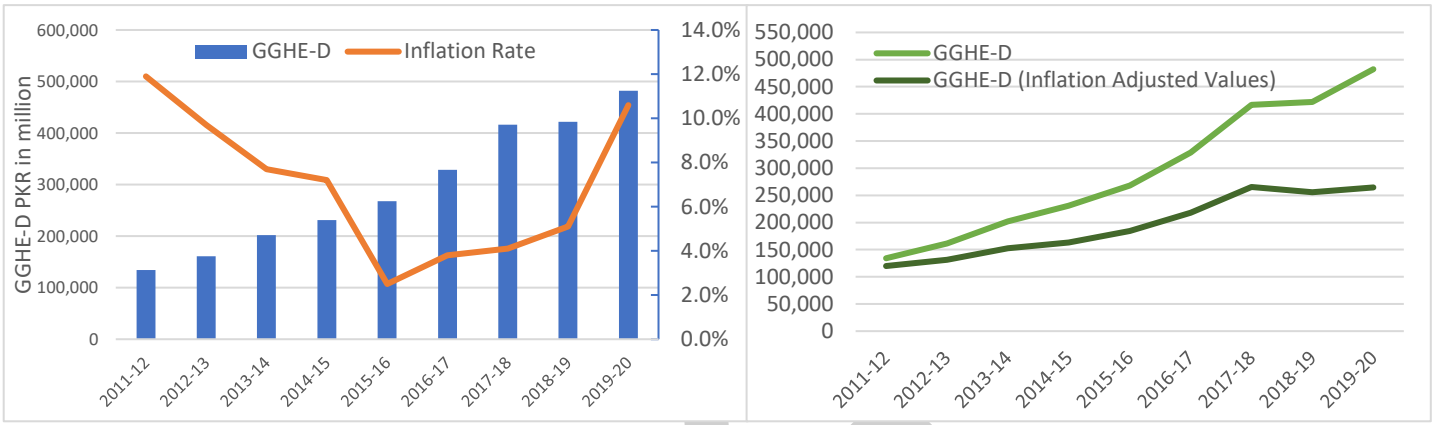
For 2018, the total expenditure by the Pakistan's government on all sectors as a share of the economy as measured by GDP (GGE as % of GDP) stands at 21.6%, while the share of government funding for health specifically (GGHE-D as % of GDP) is only 1.14% of the GDP. In the National Health Vision 2016-2025, the GoP committed to increasing health expenditures nationally from their then value of under 1% of GDP to 3%; however, by the end of FY2018, Pakistan had made little progress: public spending on health as a share of GDP was still only 1.14%. Of the general government expenditures, the share of government health expenditures from its own domestic public resources (GGHE-D as % of GGE), is 5.26%.



Source: Global Health Expenditure Database, World Health Organization

While Pakistan's economy has grown in the recent years, the country continues to suffer from several macroeconomic imbalances, such as inflation. The inflation rate in Pakistan has varied significantly over the years; the inflation rate decreased from 11.9% in 2011 to 2.5% in 2016, before increasing again over the next few years. It has continued to increase and the inflation rate was 10.6% in 2020. **Although the graphs above shows increase in health expenditures over the years, but taking inflation into account, the general**

government expenditures devoted for health sector have remained stagnant over the last few years. However, considering expenditure on COVID-19 pandemic from 2020 onward, a steep rise is expected.



Source: Pakistan Economic Survey 2020-21 & National Health Accounts 2017-18

CURRENT STATUS OF HEALTH FINANCING IN PAKISTAN

Recapitulating, health financing refers to the 'function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system'.[20] Health financing is a core function of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection. WHO's approach to health financing focuses on three core functions:

Figure: Three Key Health Financing Functions

Revenue Raising: Sources and Contribution Mechanisms

Revenue raising refers to how the health system generates and collects revenue. Apart from revenues that originate from abroad (e.g., external funds from donors), and revenues deriving from natural resources owned by the state (e.g., oil, gas, etc.), the population is the ultimate source of all funds for the system, whether in the form of direct out-of-pocket payments for services, insurance contributions, or taxes that people and firms pay to their governments. However, most focus is on the revenue raising mechanisms used. The 2011 System of Health Accounts[21] differentiates contribution mechanisms as follows:

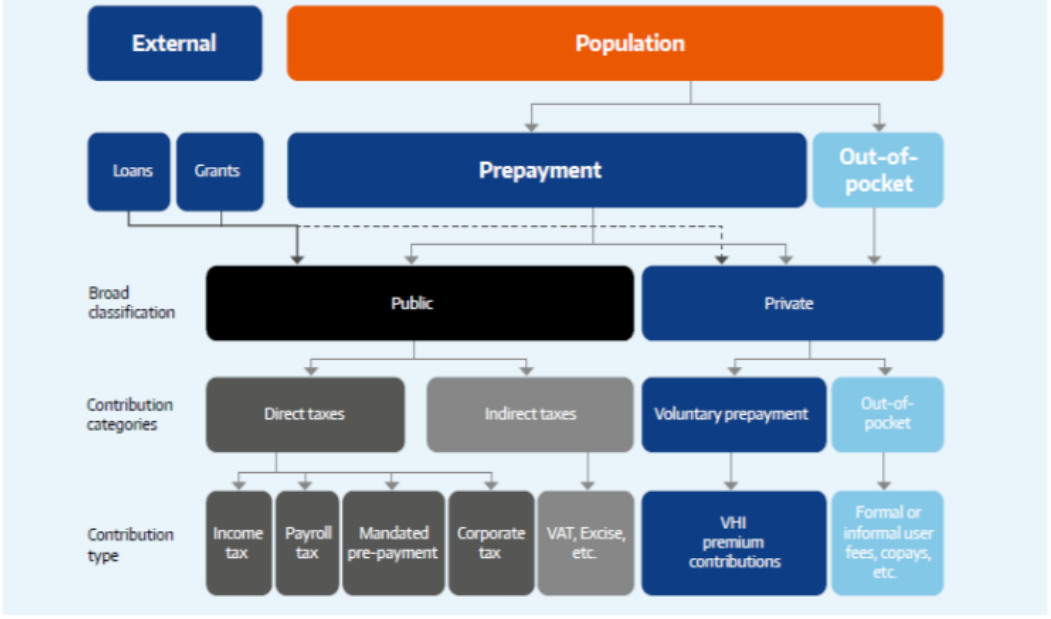
a) Prepaid versus payment at the time-of-service use (out-of-pocket);

20 WHO, 2000; The World Health Report 2000, Health Systems: Improving Performance
21 Organisation for Economic Co-operation and Development, Statistical Office of the European Communities & World Health Organization. (2011). A system of health accounts, 2011 edition.

b) Compulsory versus voluntary; and
c) Domestic versus foreign.

An overview of the major revenue sources and contribution mechanisms[22] is shown below.

Figure: Major revenue sources and contribution mechanisms



Financing Sources are institutions or entities that provide the funds used in the health care system. Financing sources have three major categories, namely public funds, private funds and rest of the world funds.

Financing Sources for Public funds include funds from the federal, provincial and district governments, as well as from autonomous bodies working under federal and provincial governments. At federal level, the Ministry of Finance is the source of funding which provides the money to civil government and military part. For provincial government, the provincial finance departments provide the money. And in case of local bodies/district government, there are district government and cantonment boards that spend on health in their respective jurisdiction areas. The last category of the public funds is autonomous bodies/corporations working under federal and provincial governments. They spend money on the health care of their employees through reimbursements/insurance and own health care facilities.

From a health financing policy perspective, public sources include those which are compulsory and pre-paid, whilst voluntary sources are considered private. Categorizing a source as compulsory implies that government requires some or all people to make the payment irrespective of whether they use health services. Thus, compulsory sources are also prepaid and essentially the same as taxes. Within this category, some of the most important distinctions are:

a) Direct taxes paid by households and companies on income, earnings, or profits, and paid directly to government or another public agency; examples include income tax, payroll tax (including mandatory social health insurance contributions), and corporate income or profits taxes.
b) Indirect taxes paid on what a household or company spends, not on what they earn, and paid to government indirectly via a third-party e.g., a retailer or supplier. Common examples are value-added tax (VAT), sales taxes, excise taxes on the consumption of products such as alcohol and tobacco, and import duties.

22 WHO, 2017; Developing a national health financing strategy – reference guide

c) Non-tax revenues e.g., from state-owned companies including "natural resource revenues" common in many mineral-rich countries e.g., oil and gas.
d) Financing from external (foreign) sources is typically categorized as public when these funds flow through recipient governments.

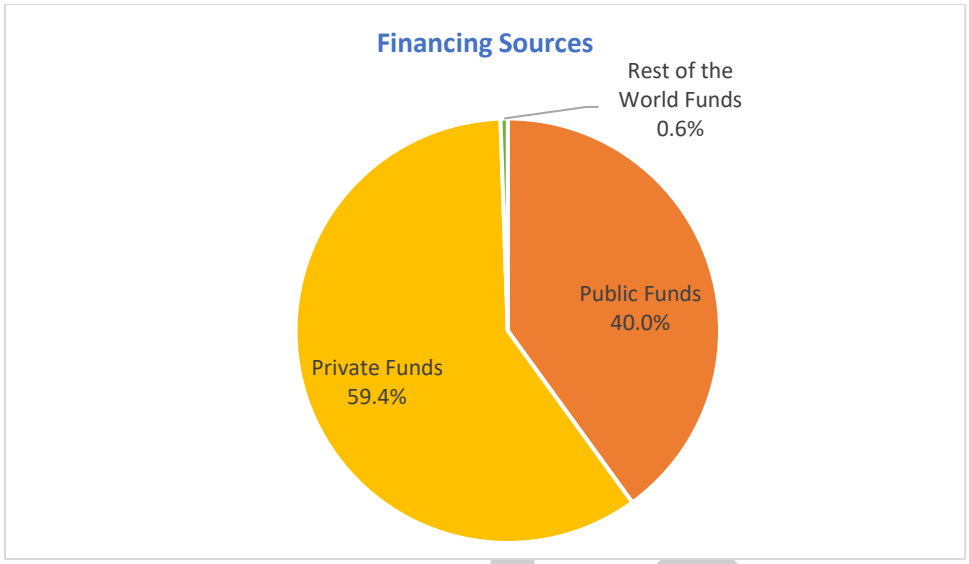
After the 18th Amendment, sources of revenue collection have been constitutionally split between the federal and provincial governments. Public sector revenues are collected at both the federal and provincial levels—with collection responsibilities overlapping even within revenue categories. For instance, the federal government has a constitutional right to collect taxes on the sales and purchases of goods (imported, exported, produced, manufactured or consumed), but not on the sales of services, which are a provincial responsibility. Beyond sales tax, revenue assignments given to the provinces include direct taxes on property, agriculture, income, and other indirect taxes such as excise duty on alcohol/liquor/narcotics, motor vehicle tax etc. Two important effects arise from the present constitutional split. First, the provinces raise very little of Pakistan's total collected taxes. And second, the vast majority of collection falls under the permit of the Federal Bureau of Revenue (FBR), the federal government's single tax collecting agency.

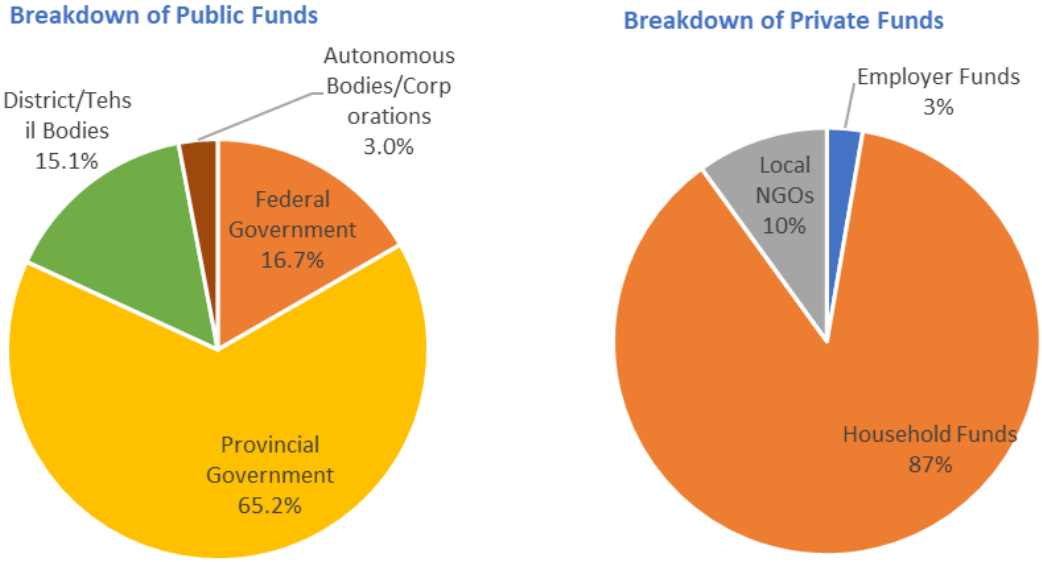
Provinces receive a proportion of federally-collected revenues (tax and non-tax) in the form of line transfers—and this is the primary source of provincial income. While the amount of provincially collected revenues has been increasing, transfers from the federal government—primarily via the formula-based National Finance Commission Award as well as other types of straight transfers—consistently make up approximately 80% or more of total provincial revenue every fiscal year. Fiscal transfers are then pooled with own-source revenues and a health sector allocation is determined during the provincial budget process each year. Funds are further transferred from the provinces to district/local governments for direct service delivery. At present, district governments have limited capacity and scope to raise own-source revenues, and so it is the provincial government that plays a pivotal role in raising public revenues for the health sector.

However, public revenues are not the major source of funds for the health sector; Pakistan over-relies on private sector to finance healthcare. The key characteristics of private revenue sources are that they are voluntary, i.e., the decision to spend on health is not required by government but is rather a decision made by individuals, households, or private companies. Such payments may be either prepaid or paid at the point of service as out-of-pocket (OOP) spending. Private funds include employer and household funds, and funds from NGOs. Employers are providing funds in three ways. They are contributing through occupancy health care, through social security (managed by ESSIs) or through health insurance of their employees (group insurance). Household funds mainly comprise of OOP health expenditures such as payment for services of a private doctor or the purchase of medicines at the time of use, insurance premiums, Bait-ul-Mal and Zakat contributions made by households.

The rest of the world category comprises of donor agencies. Development partners are also spending on health; however, only their direct spending is included. The money, which has been granted to the government (budgetary aid) and which thus is in the budget is reflected in government spending.

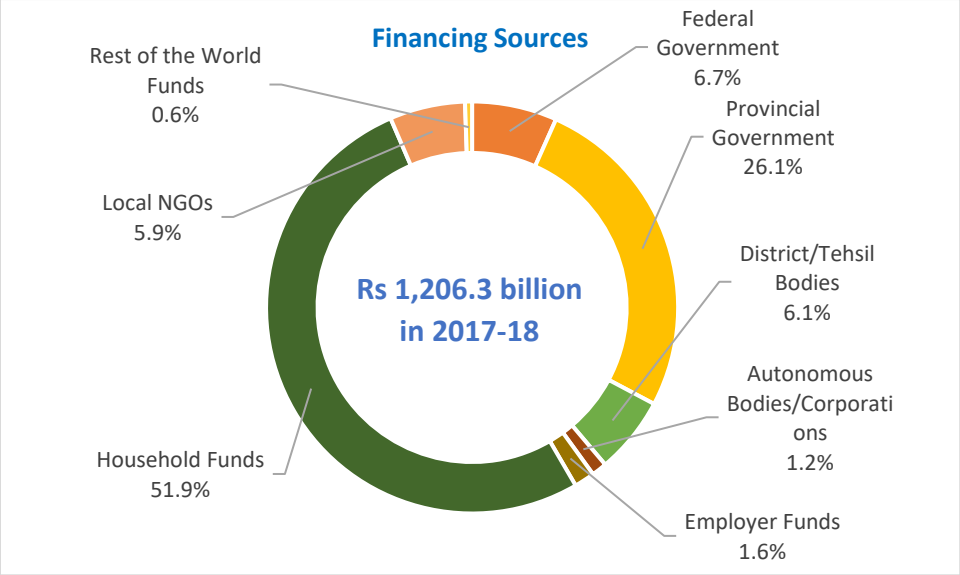
Of the total health expenditures amounting Rs 1206.332 billion in Pakistan for the year 2017-18, financing source of 59.4% (Rs 716,985 million) of health spending was funded by the private sector, 40% (Rs 482,704 million) by the public sector, and 0.6% (Rs 6,643 million) by the donor agencies.[19]





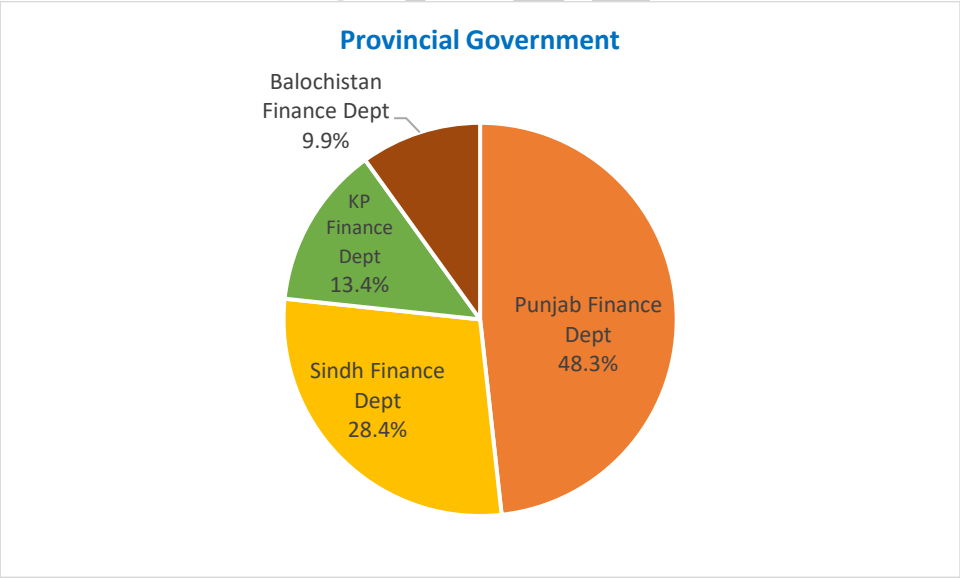
Source: National Health Accounts 2017-18

Of the total Rs 1206.332 billion in Pakistan for the year 2017-18, Rs 626,104 million (51.9% of the total) were household funds, followed by the share of provincial government (Rs. 314,606 million; 26.1%), federal government (Rs. 80,578 million; 6.7%), district/tehsil bodies (Rs. 73,044 million; 6.1%), NGOs (Rs 71, 537 million; 5.9%), employer funds (Rs 19,344 million; 1.6%); autonomous bodies (Rs 14,476 million; 1.2%) and donor agencies (Rs 6,643 million; 0.6%).



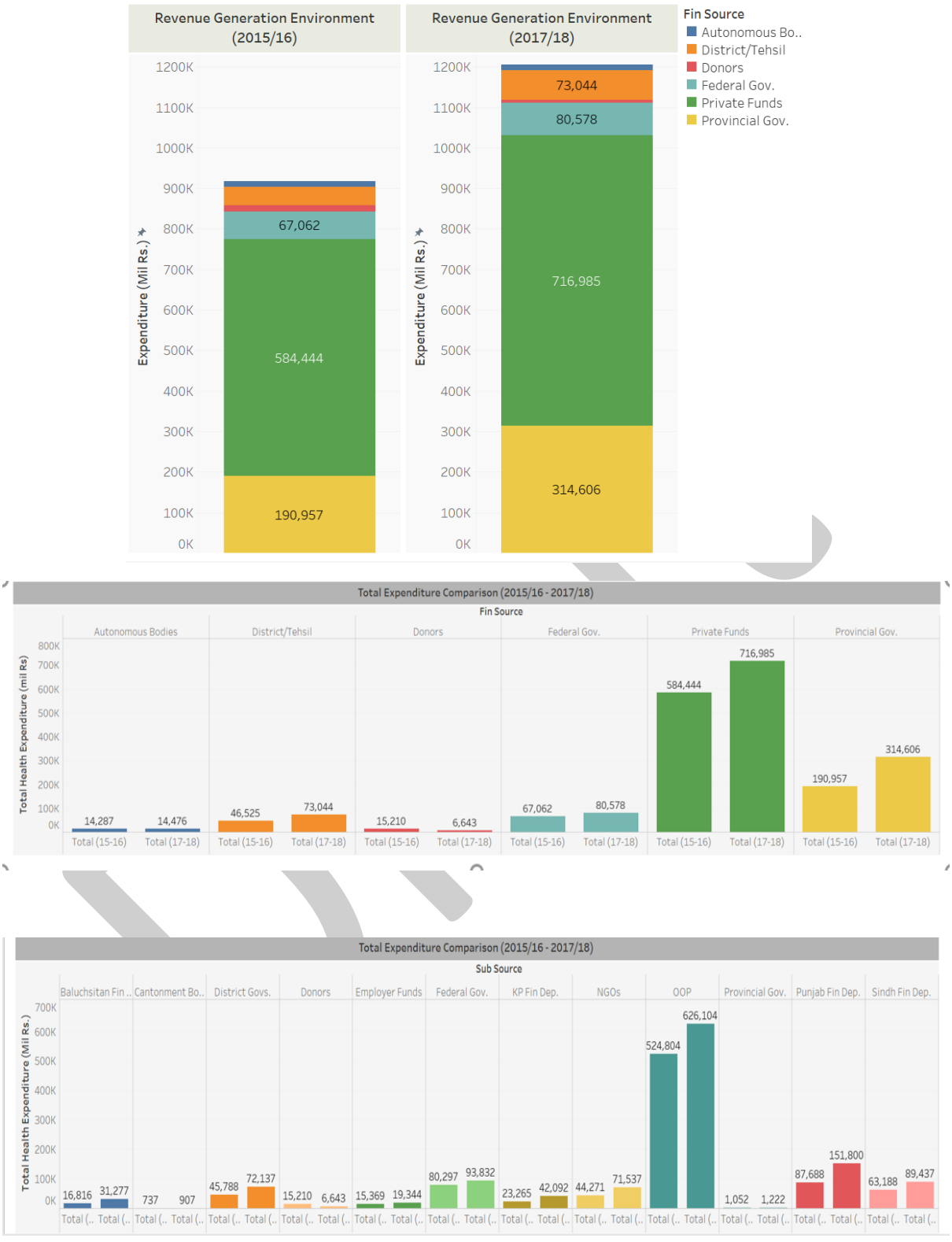
Source: National Health Accounts 2017-18

Of the total health expenditures by the provincial government, share of the Punjab Finance Department was the most (Rs. 151,800 million; 48.3%), followed by the Sindh Finance Department (Rs. 89,437 million; 28.4%) and the KP Finance Department (Rs. 42,092; 13.4%). The lowest funding was by the Balochistan Finance Department (Rs. 31,277 million, 9.9%).



Source: National Health Accounts 2017-18

The following graph illustrate the comparison of total healthcare expenditure per financing sources and sub-sources between the 2015-16 and 2017-18 in the NHA of Pakistan. Overall, the total healthcare expenditure per financing source increased, except for funds from the category "rest of the world", which includes donors (56.3% decrease). The greatest percentage of increase was observed in funds from the provincial governments (64.8% increase). District/tehsil bodies, private funds and federal government categories also saw significant increase from 2015-16 to 2017-18.



Source: National Health Accounts 2015-16 and 2017-18

Pooling of Funds

Pooling is the health system function whereby collected health revenues are transferred to purchasing organizations. Pooling ensures that the risk related to financing health interventions is borne by all the members of the pool and not by each contributor individually. Its main purpose is to share the financial risk associated with health interventions for which there is uncertain need.

Financing Agents include institutions or entities that channel the funds provided by financing sources and use those funds to pay for, or purchase, the activities inside the health care boundary. Financing agents also have public funds, private funds and rest of the world funds as the main categories. The public funds include:

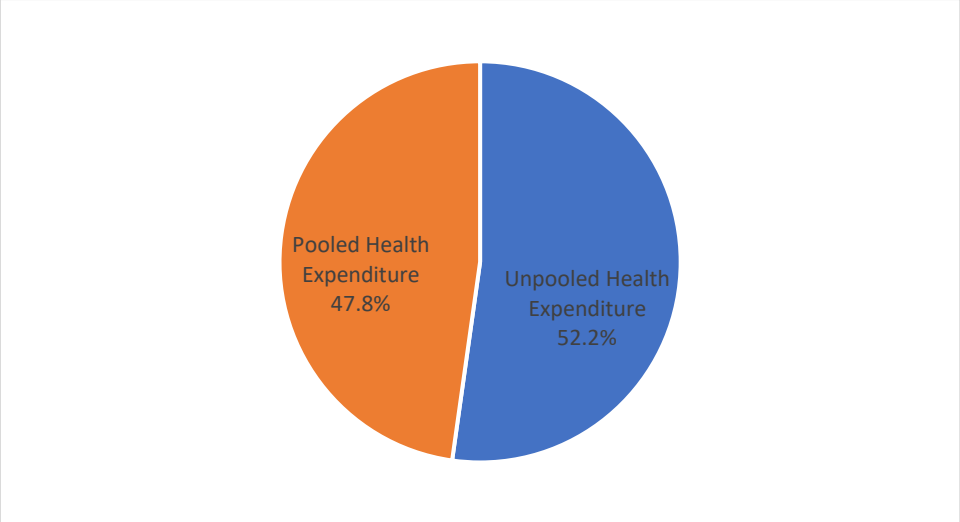
a) Territorial government, which can be disaggregated into federal government, provincial government and district government/local bodies;
b) Social security funds, which include employees social security institutions (ESSI), zakat funds and Bait-ul-Mal;
c) Autonomous bodies/corporations which is further disaggregated into federal and provincial ABs/C.

Funds from private sector include out-of-pocket payments, local NGOs and other private health insurance. The rest of the world category comprises of donor agencies.

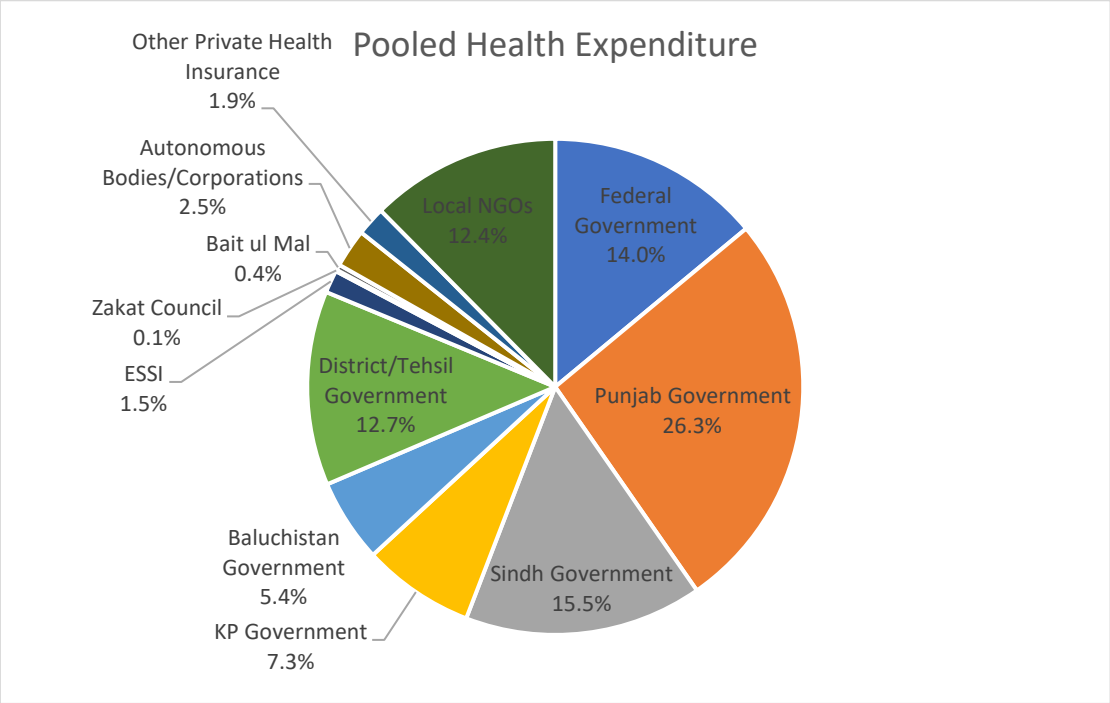
In Pakistan, prepaid and pooled funds for health remain relatively small and fragmented. Overall, Pakistan has multiple pools and each caters to a different population group with some overlap. The main government pools are (a) direct provision/tax-based pool (b) social protection program pools (c) autonomous organizations. The government also has smaller pools for military and armed forces, and government employees. Private sources of pooled funds for the health sector include private health insurance, and social security funds (which include Zakat, Bait-ul-Mal, employees social security institutions (ESSI)).

There are different funds for different population groups, with the affiliation being based on socio-economic or (socio-) demographic criteria. Voluntary health insurance or employee led insurance are only accessible for richer populations, while Zakat and Bait-ul-Mal are designated for the poor populations. Other forms of pooling such as military pools and ESSI are also restricted to specific populations with limited diversity in pooling.

In countries like Pakistan, where informality remains a significant characteristic of the domestic economy, the scope for increasing private or social health insurance pools via formal sector employee contributions to cover significant portions of the population is low. As such, the de facto pool for most of the population is the government health budget. Government health budgets determine allocations for health down to the district and local government levels, and therefore have the ability to pool and redistribute resources between geographies and income groups based on need. **However, un-pooled, private OOP expenditures comprise the greatest share of resources for the national health sector.**



In Pakistan, un-pooled OOP expenditures comprise 52.2% of total health expenditures, while pooled expenditures constitute only 47.8% of total health expenditures. Of the pooled health expenditures, 81.2% of the expenditure is made by territorial governments (26.3% by Punjab Government, 15.5% by Sindh Government, 14% by Federal Government, 12.7% by District/Tehsil Government, 7.3% by KP Government, 5.4% by Balochistan Government); 12.4% by local NGOs, 2.5% by autonomous bodies/corporations, 2% by social security funds (1.5% by ESSI, 0.4% by Bait-ul-Mal, 0.1% by Zakat funds), and 1.9% by other PHI.



Source: National Health Accounts 2017-18

Purchasing and Provider Payment

Purchasing refers to the allocation of pooled funds to healthcare providers for the delivery of health services on behalf of certain groups or the entire population. Purchasing agencies can take many forms, such as a ministry of health, subnational authorities, a mandatory or voluntary health insurance, or a non-governmental organization, for example. The health care providers are the end recipients of the health care funds, and include entities that receive money from the purchasing agencies in exchange for or in anticipation of producing the activities inside the health accounts boundary. Examples of providers are public and private hospitals, clinics, community health centers in the public and private sectors, private practitioners, traditional health care providers, dispensaries, pharmacies, laboratories, etc. Following are the three broad categories of the health care providers:

a) Public Provider
b) Private Provider
c) Non-Government Organization Providers/Non-Profit Institutions

The design of purchasing mechanisms are based on the following four issues:

a) What services should be purchased? Often, governments or health insurance providers will identify a benefits package that specifies the health services they will partially or fully pay for. The design of benefits packages is typically based on the need for, effectiveness of, and cost of specific health services.

b) Who should services be purchased for? Governments often try to reduce out-of-pocket payments by subsidizing or providing free health services for different segments of the population.
c) Who should services be purchased from? Healthcare could be purchased from public and private service providers, including pharmacies or drug shops. In some countries, governments may purchase services exclusively from public providers, while others may contract with private providers.
d) How should providers be paid for services? Purchasing may be "passive" or "strategic". There are different methods for paying providers that could incentivize the quantity and quality of services provided.

Important dimensions of provider payment mechanisms include: passive versus active/strategic purchasing; payment rates determined before or after the use of services; prospective versus retrospective payment of providers; and existence and composition of complementary administrative mechanisms. The way that providers are paid creates incentives that influence their behavior. Several types of payment mechanisms (or methods) exist, and often co-exist within the same system or indeed as part of an overall payment mechanism.

Strategic purchasing can be defined as the transfer of revenues to providers based on information on either the health needs of the population served and/or the performance of the providers, while passive purchasing involves simply transferring the resources to the providers without a consideration of such information. This is not an "all-or-nothing" proposition as there are many examples of arrangements that combine a passive mechanism with a strategic element.

Common prospective provider payment methods include line-item budgets, global budgets, capitation, and salaries. Line-item budgeting is when the budget information is organized according to the types of expenses or cost categories. For health, these generally focus on staff, supplies (operational costs), and capital investment/equipment, all of which can be characterized as inputs for health systems. Providers receive a fixed amount for a specified period to cover specific input expenses (e.g. personnel, medicines, utilities). Global budgets are an alternative payment model in which providers—typically hospitals—are paid a prospectively-set, fixed amount for the total number of services they provide during a given period of time. Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Under salary payment mechanism, doctors are paid a fixed income which is not linked to output such as quantity of items or quality of services.

Common retrospective provider payment methods include fee-for-service, and case-based. Within retrospective provider payment methods, the unit of service to which the payment applies is important. For inpatient services many countries use case-based payment, usually on the basis of some variant of DRGs. The Diagnosis-Related Groups (DRG)-system is a patient classification system developed to classify patients into groups economically and medically similar, expected to have comparable hospital resource use and costs. Under DRGs providers are reimbursed at a fixed rate per discharge based on diagnosis, treatment and type of discharge. This is distinguished from fee-for-service, where providers are paid based on the number and types of services provided, or from "in-between" methods such as payment per hospital day.

Provider/Purchaser Payment Mechanisms	
Payment Mechanism	**Unit of Payment**
Line-item budgets	• Line-item budgeting is when the budget information is organized according to the types of expenses or cost categories. • For health, these generally focus on staff, supplies (operational costs), and capital investment/equipment, all of which can be characterized as inputs for health systems. • Providers receive a fixed amount for a specified period to cover specific input expenses (e.g., personnel, medicines, utilities).

Global budgets	• Global budgets are an alternative payment model in which providers—typically hospitals—are paid a prospectively-set, fixed amount for the total number of services they provide during a given period of time.
Capitation	• Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. • The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided.
Salaries	• Under salary payment mechanism, doctors are paid a fixed income which is not linked to output such as quantity of items or quality of services
Per Case	• Payment to a hospital is made per admitted patient, regardless of length of stay
Per Diem	• Payment to a hospital is made per night stayed per patient.
Fee-for-Service	• Fee-for-service is where providers are paid based on the number and types of services provided

Currently, private sector facilities predominantly use fee-for-service mechanisms, whereas for public sector facilities there are three main payment systems. The first and most dominant mechanism is through line-item budgets. The second payment system is the global budget available to some specialized tertiary care facilities. The third payment mechanism used for many primary and secondary care facilities is contracting out. This has become extremely popular over the last decade, and through this payment mechanism, public facilities are handed over to private sector organization with a global budget, excluding salaries of government employees. Allocation to facilities is based on available financing and previous allocation. There is no needs assessment to determine how much a health facility should receive based on the population requirements.

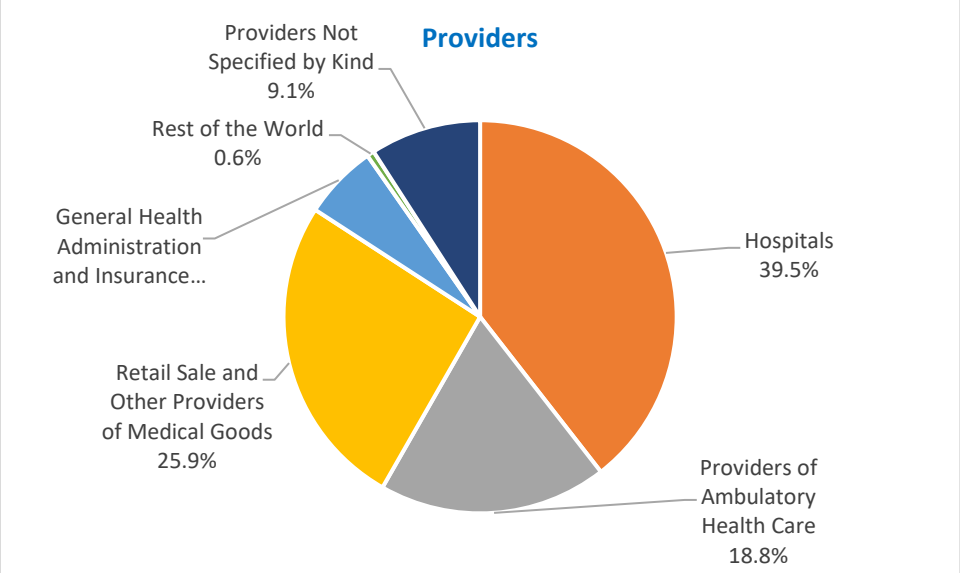
Purchasing of health services is largely fragmented. The federal and provincial health departments, the military, ESSI, autonomous bodies, and cantonment boards provide health care services directly through their own facilities. The federal government also finances national vertical programs, and a few dedicated programs for illnesses, like cancer and diabetes. Most public facilities receive line-item budgets, while private facilities predominantly use fee-for-service mechanisms. Since 2015, Pakistan has established three social protection programs which use case-based payment mechanisms. The three social protection programs are currently being contracted out to the same company in the private sector, which also allows harmonizing between the different programs. However, there is no coordination between different insurance companies, and there is no authority or mechanism at this stage which would ensure that payments reflect population needs.

The payment levels are substantially different for public and private sector providers. The salaries received in the public sector vary by province, grade and facility type, but are generally fixed and much lower than the amount doctors earn in the private sector using a fee-for-service payment mechanism. Many doctors in the public sector also provide services in private facilities. The different payment levels and payment types creates perverse incentives for doctors to refer patients to their own private facilities for treatment and/or follow up.

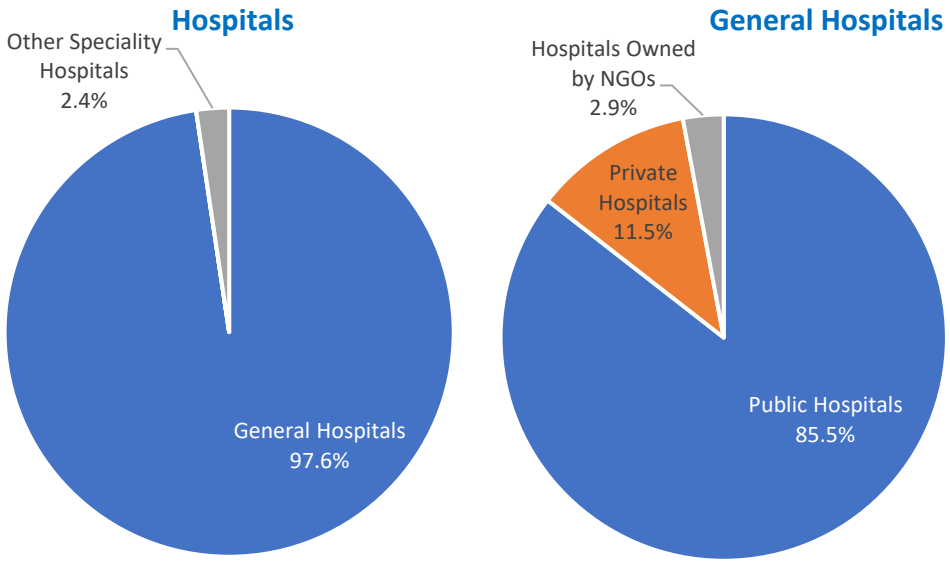
Public sector providers predominantly use fixed salaries for employees, which does not promote quality of care. There are no additional financial incentives for employees to improve quality of care. In the private sector, the main purchasing mechanism is using fee-for-service which incentivizes quality of care to some extent, while some private health facilities also include profit sharing mechanisms to improve quality of care. However, there are no additional financial incentives or payment systems to incentivize an improved quality of care or improved coordination of care.

With regards to providers, hospitals have the largest expenditure share (Rs. 437,442 million; 39.5%), followed by retailers and other providers of medical goods (Rs. 287,022 million; 25.9%), ambulatory health care (Rs. 208,466 million; 18.8%), providers not specified by kind (Rs. 101,017 million; 9.1%), general health administration and insurance (Rs. 67,874 million; 6.1%), and rest of the world (Rs 6,643 million; 0.6%). Of the

hospital expenditure share, 97.6% is expenditure by the general hospitals (Rs. 427,104 million). The general hospitals can further be classified into public and private hospitals, and hospitals run by NGOs. Public hospitals contribute 85.5%, private hospitals make up 11.5%, and hospitals owned by NGOs contribute to 2.9% to the general hospitals' expenditure. Specifically speaking, general hospitals and retailers and other providers of medical goods are the largest purchasers. Mental health and substance abuse hospitals (Rs. 44 million) have the least expenditure share.



Source: National Health Accounts 2017-18



Source: National Health Accounts 2017-18

LEAVE NO ONE'S HEALTH BEHIND:

Invest in Health Systems for All

HEALTH FINANCING POLICY AND GOVERNANCE

Health Financing Policy Environment

Health policies are considered as the strategies, actions and resolutions which are necessary to attain specific healthcare goals within the state, whereas health financing policy refers to how financial resources are used to ensure that the health system can adequately cover the collective health needs of every person. In Pakistan, the Five-Year Plans for the National Economy of Pakistan, were the series of nationwide centralised economic plans and targets as part of the economic and social development initiatives. The plan was conceived by the Ministry of Finance (MoF) based on the theory of cost-of-production value, and also covered the areas of trickle-down system. Supervision and fulfilment of this became the watchword of Pakistan's civil bureaucracy since early 1950s. The first five-year plans were approved by the prime minister Liaqat Ali Khan in 1950 for the period of 1950–55; it was accepted in a view to serve in the rapid and intensified industrialisation, expansion of banking and financial services, with a major focus on heavy industry. Although five-year plans did not take up the full period of time assigned to them, some of the plans were failed and abandoned whilst some completed successfully.

From June 2004, the Planning Commission gave a new name to the Five-Year Plan – Medium Term Development Framework (MTDF). Drafted and launched in 2005, the programme was envisioned to turn the country into a major industrialized nation, to increase the speed of human development and to sustain a new economic system which aimed to reduce poverty and achieve Millennium Development Goals (MDGs). The programme replaced the centralized economic system of Pakistan - Five-Year Plans. In 2003, the Poverty Reduction Strategy Paper (PRSP-I) offered a powerful policy framework tool to forge a consensus, priorities and resources needed at all levels of the government to reduce poverty and inequalities, impeding the pace of economic and social development in Pakistan. PRSP-I was followed by PRSP-II in 2005.

With eighteenth constitutional amendment in 2011, national planning is still a function under the federal legislative list-II. Unfortunately, the medium-term development framework process is currently feeble. An effort was made in 2018 to produce the 12th five-year plan but could not be finalized. The Planning Commission is currently producing Annual Plan on a regular basis to define short term strategic priorities. Over last two years, the strategic focus of the Annual Plans was to tackle economic impacts of COVID-19 on all sectors.

In addition to the Five-Year Plans for the National Economy/ Medium Term Development Framework, health sector strategic priorities were defined in the National Health Policies (1990, 1997 and 2001). After

eighteenth constitutional amendment, the National Health Vision (NHV) 2016–2025[23] and National Action Plan, NHSR&C (2019-23)[24] strives to provide a responsive unified direction to overcome various health challenges, while ensuring adherence to universal health coverage (UHC) as the ultimate goal. The Government's National Health Vision is:

> ***"to improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities"***

The NHV and its eight thematic pillars have been agreed by all provincial governments. Pillar 2 is related to the following strategic priorities in health financing:

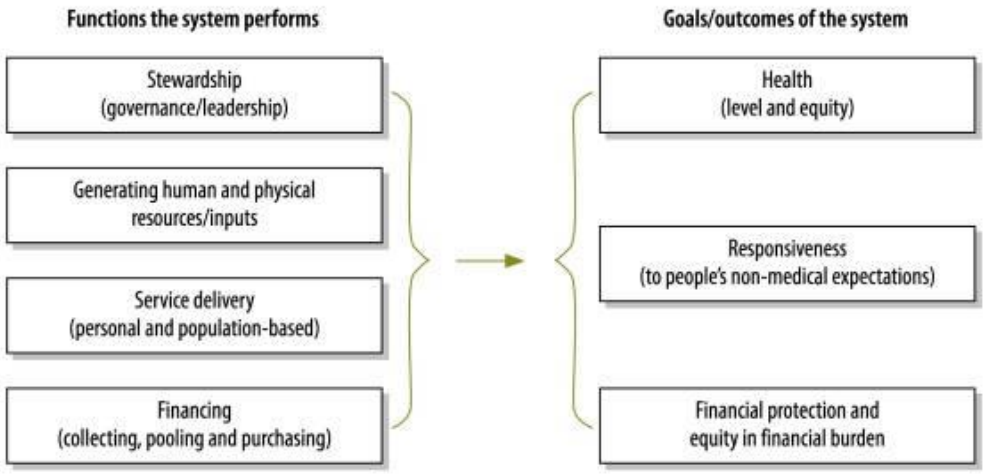
- Government is cognizant that adequate, responsive, and efficient health financing is the cornerstone of a country's well-functioning health systems. Spending on health will be advocated as an "investment" to the line ministries, finance departments, and international development partners.
- Federal and provincial governments will increase health allocations as pledged in Pakistan Vision 2025 to 3% of GDP, to maximize the pay-offs from investing in health.
- Priorities for health allocations will be revisited, and a higher share for essential health service delivery, preventive programs, communication, capacity building of frontline health workers, and governance ensured.
- Pro-poor social protection initiatives (including the Prime Minister National Health Program) will continue to be financed and new initiatives (conditional cash transfers, vouchers) launched to facilitate access to essential primary and secondary health services and priority diseases, with a vision for coverage for the entire population, and protected through necessary legislation.
- There will be progressive movement toward universal health coverage. Reproductive, maternal, new-born, child and adolescent health and nutrition investments will be increased in phases.
- Governments will develop mechanisms to build capacity to implement fiscal discipline, revisit formulae for district allocations to maintain parity, and grant financial autonomy to health institutions.
- Federal and provincial governments will develop joint strategies to enhance resource mobilization for health from official development assistance/international development partners, private sector engagement, and taxes, such as sin tax.

Pakistan is committed to the 2030 agenda of sustainable development. Hence, the pursuit of UHC is relevant to the country. Health financing policy is an integral part of efforts to move towards UHC, but for health financing policy to be aligned with the pursuit of UHC, health system reforms need to be aimed explicitly at improving coverage and the intermediate objectives linked to it, namely, efficiency, equity in health resource distribution and transparency and accountability.

The starting point for the approach used goes back to *the world health report 2000*, on health system performance.[25] The framework used for that report identified three generic goals and four generic functions of all health systems (WHO reconfigured these four functions into six "building blocks",[26]). The aim of any health system is to maximize the attainment of the goals, conditioned by contextual factors from outside the

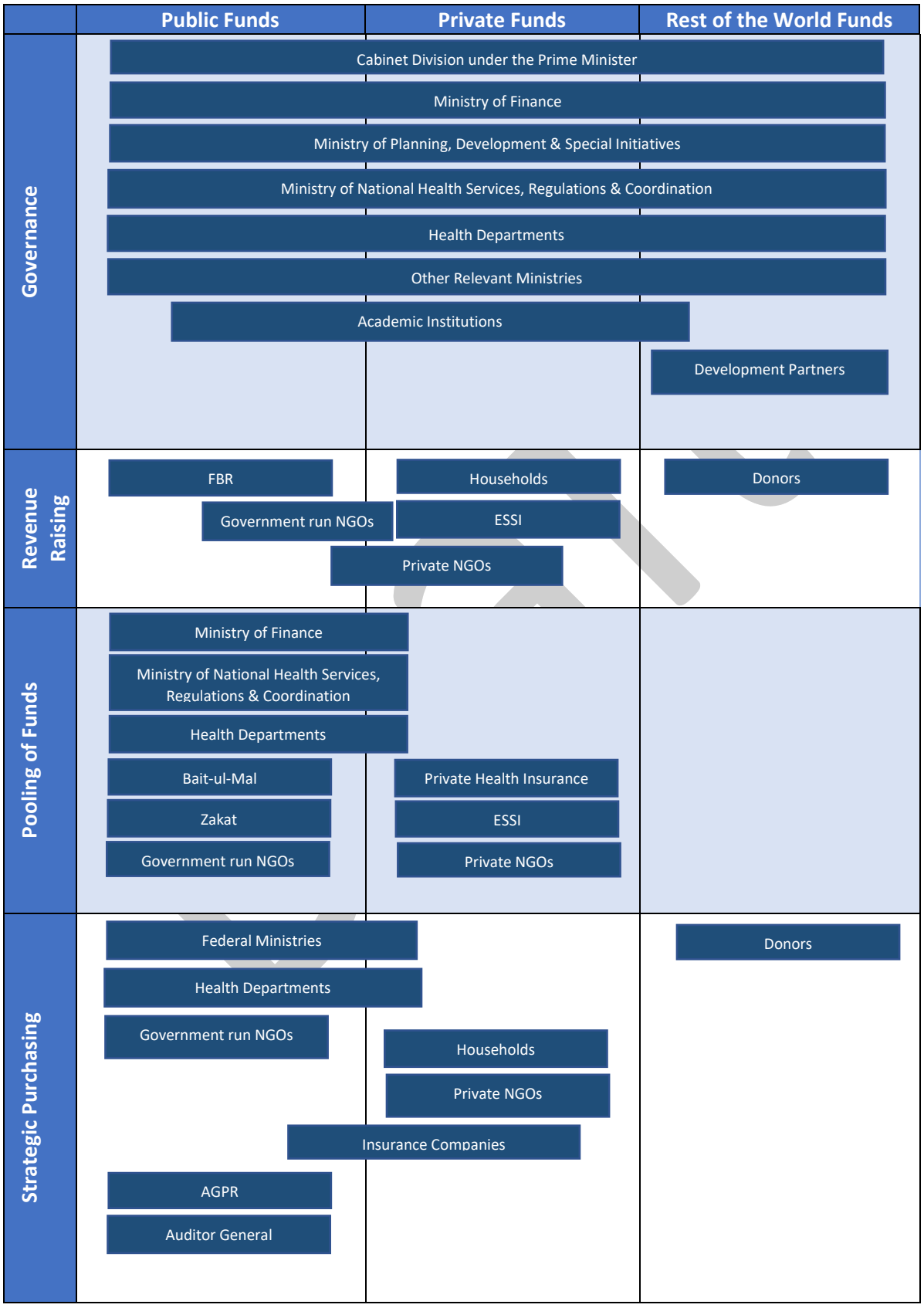
23 Ministry of NHSR&C, 2016; National Health Vision 2016-25
24 Ministry of NHSR&C, 2016; Action Plan NHSR&C 2019-23
25 The World Health Report – Health systems: improving performance. Geneva: World Health Organization; 2000
26 Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action Geneva: World Health Organization; 2007. Available from: http://www.who.int/entity/healthsystems/strategy/everybodys_business.pdf

health system that influence the level of goal attainment that can be reached. A simplified depiction of this framework is shown in the following figure.



In Pakistan, strategic prioritization on different functions of the health is done through different sub-sectoral strategic documents. However, for health financing no specific unified health financing strategy exist to set clear objectives and developing a consensus on health financing priorities and reforms. More recently the Ministry and Provincial/ Area Health Departments have finalized Essential Packages of Health Services/ UHC Benefit Package along with expansion of Health Insurance/ *Sehat Sahulat* Programme, which tackle different aspects of health financing but both reforms need an overarching health financing strategy.

Health Financing Key Stakeholders



Health Financing Governance

Governance is the way power is exercised in the management of a country's economic and social resources for development.[27] The notions of attaining social justice in health as a basic human right, good governance in health financing is expected to be a responsibility of any government to its citizens or of policymakers to meet the public interests of society.

Being a federal system in Pakistan, different levels of authorities only prioritize and manage funds in the health sector with poor synergies among resource generation, pooling and strategic purchasing of health services. Engagement and involvement of the private sector in policy reforms is shaky. Since eighteenth constitutional amendment, more financial and administrative powers are now executed at the provincial level, whereas district local government system is still in evolutionary phase. Public health financing agents include:

a. Federal government and its related ministries: the Ministry of National Health Services, Regulation and Coordination, Ministry of Defence, Ministry of Interior and others;
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

The 18th constitutional amendment of 2011 not only devolved the major responsibility of health (along with other social sectors) to the provinces but the National Finance Commission award was also revised. At present vertical share to provinces has increased to 57.5% of the divisible pool under the 7th National Finance Commission Award. Annual outlay of the federal government has been reduced for devolved subjects. 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. In 2017-18, responsibility of vertical primary healthcare programmes has been fully shifted to the provincial governments, which has further enhanced expenditure at provincial level.

Differences of opinion exist concerning the optimal way of financing health in a country. In Pakistan the **budget** is approved by the Prime Minister/ National Assembly (and the Chief Ministers/ Provincial Assemblies). The health budget is the part of the federal/provincial budget to support financial commitments to implement the health policies and strategies. The structure of the **health budget** decides the level of health spending. The health budget is composed of the current and development budget. The current budget usually is non-discretionary and used to run the day-to-day affairs of the federation. It includes salaries and administrative expenses, debt servicing, loan repayment, etc. The federal ministries (executing health functions) and provincial departments have very little control over this budget and cannot re-appropriate it easily. **The Public Financial Management rules** govern the processes of the budget cycle. The box below lists the steps of the **budget call circular** in Pakistan that starts from setting the budget strategy and ends at budget review[28].

During the **budgetary process**, the finance section of the M/o NHSR&C is responsible for liaison with Ministry of Finance on the budget ceiling for health, expenditure control, and tracking expenditure as per line-item budget allocations. This close collaboration between the M/o NHSR&C and Ministry of Finance ensures that spending is in line with the health policy objectives and moving towards implementing the health sector reforms outlined in the National Health Policy.

The **MTBF** – a PFM tool – has been used across the government to link the policy priorities to health expenditure allocations within the fiscal envelope. Line-item budgeting is a major constraint in appropriating

27 World Bank, 1994; Governance: The World Bank's experience
28 In Pakistan budget cycle consist of six steps and includes: Setting of budget strategy, preparation, authorization, implementation, reporting and monitoring and budget review

budget to priority health intervention. Line-item costing allocates and tracks expenditure by the type of expenses or cost categories available in the financial system of the country.

To allocate and track health spending, the Ministry works with the Controller General of Accounts (CGA). The CGA is responsible for the smooth functioning of the SAP-based **Financial Accounting & Budgeting System (FABS)**, which is an Integrated Financial Management Information System (IFMIS) being run at government offices at the federal, provincial, and district levels.

The current IFMIS generates general purpose financial reports through the system of Charts of Accounts (CoA) – a critical element of the IFMIS for classifying, recording, and reporting information on financial plans, transactions, and events.[29] These charts of accounts cover transactions related to expenditure and revenues. The Accountant General Pakistan (AGP) demands that all the expenditures and receipts must be classified as per CoA rules. This CoA framework is based on the Entity Element, Fund Element, Function Element, Object Element, Project Element, and Location Element. A brief description of each is given in the table below.

BUDGET CALL CIRCULAR PROCESS

The budgetary allocation/ estimation on Pakistan is an annual exercise initiated by the additional finance secretary (budget) by issuing a budget call circular for the ongoing financial year to all secretaries/ additional secretaries in charge of ministries/divisions. Key steps in budget circular are listed below.

1. Issuance of 'Budget Call Circular' to the Principal Accounting Officers (PAOs).
2. Preparation of Budget Strategy Paper and its presentation in the Cabinet.
3. Issuance of Indicative Budget Ceilings for current and development budget to all PAO's.
4. Preparation of medium-term Strategic Plan.
5. Filling of the Budget Forms.
6. Submission of forms by Ministries / Divisions for current budget to FAs / DFAs for Quality Assurance.
7. Submission of forms by Ministries / Divisions for development budget to Sector Chiefs in Planning Commission and copy to FAs/DFAs.
8. Submission of Forms Budget Computerization (Budget Wing – Finance Division).
9. Review and approval of budget estimates and additional demands (current + development) by the Priorities Committee.
10. Completion of budget review and approval process – APCC meeting
11. Completion of budget review and approval process – NEC meeting
12. Finalization and Submission of Final 'Medium Term Budget Estimates for Service Delivery' (to Finance Division.
13. Completion of all Budget Documents (including 'Green Book'), Schedules and Summaries for Cabinet etc.
14. Presentation of Budget (including 'Green Book') to the Cabinet and Parliament

Monitoring and accountability of the health spending is done through the National Health accounts. National Health Accounts (NHA) is a framework for estimating the total healthcare expenditures (both public and private) at national level. NHA tracks the flow of funds through the healthcare sector by compiling the four selected dimensions:

(i) Financing sources
(ii) Financing agents
(iii) Health care providers
(iv) Health care functions.

NHA is a tool specifically designed for health sector policymakers and managers. It aims to aid them in their efforts to improve health system performance.

Health system in Pakistan faces the challenges of governance, finances, service delivery, human resources, introduction of new technologies and coping with huge burden of supplies requirement specially medicines.

29 The AGPR uses the New Accounting Model (NAM), a system of classifying expenditure under new Chart of Accounts (CoA). NAM was prescribed by the Auditor General of Pakistan under the Project to Improve Financial Reporting and Auditing (PIFRA).

After devolution, the functions of provincial government were modified and the provincial governments are responsible of making policy, approving laws on health issues, drug control, recruitments, planning and implementing health programs in the province. The federal government does the monitoring and regulatory function, health research, gathering health related data, negotiate with donors on possible avenues of support, participate in international meetings, manage federally controlled hospitals and offices and procurement.

Health Financing Governance in the private health sector is ill defined and largely un-regulated. Although Healthcare Authority and Commissions have been established but are not fully functional to appropriately regulate the sector. They aim to improve the quality of healthcare service delivery for the people through implementation of Minimum Service Delivery Standards (MSDS) in both public and private sector healthcare establishments including allopathic system of medicine & surgery, alternate systems of medicine like Homeopathy and Tibb.

There is hardly any systematic reform for resource generation, pooling and strategic purchasing of services in the private health sector. Private sector also looks towards public budgetary resources rather than introducing reforms within itself. More effective dialogue on the subject is required for effective reforms.

Code Classification for Budgeting	Reporting of transaction by
Entity Element	Financial reporting by: government, ministry, division, attached department, district and drawing and disbursing Officer (DDC)
Fund Element	Financial reporting by: consolidated fund or the public account fund
Function Element	Financial reporting by ten heads: 01- General Public Service; 02- Defence Affairs & Services; 03- Public Order and Safety Affairs; 04- Economic Affairs; 05- Environment Protection; 06- Housing and Community Amenities; 07- Health Affairs; 08 Recreation, Culture and Religions; 09- Education Affairs and Services; 10- Social Protection
Objective Element	Financial reporting by thirteen heads: A01- Employee Related Expense; A02- Project Pre-investment analysis; A03- Operating Expenses; A04- Employee Retirement Benefits; A05- Grants, Subsidies and Write-off of Loans/Advances/Others; A06- Transfers; A07- Interest Payments; A08- Loans and Advances; A09- Expenditure on Acquiring of Physical Assets; A10- Principal Repayments of Loans; A11- Investments; A12- Civil Works; and A130- Repairs and Maintenance
Project Element	Financial reporting by: core projects developments, sectoral projects development, and non-development
Location Element	Financial Reporting by: district, tehsil and union council

Source: Budget manual first edition, January 2020, Finance Division GoP

In addition to public private partnership, the government also provide financial support to the private sector through Health Foundations and Banking Institutions, evidence for which is generally not available.

BENEFITS AND CONDITIONS OF ACCESS

Health Benefits

As mentioned in the earlier sections, health financing comprises the functions of revenue raising, pooling, and purchasing, as well as policies on benefits. Benefit design is concerned with policy decisions regarding the entitlements, in terms of both services and population groups. Benefit design also concerns defining conditions of access to these entitlements. Conditions of access to publicly funded health services include decisions related to price e.g. whether patients make co-payments, and non-price e.g. which treatments are subsidized, in which facilities, and whether a referral system must be followed. Policies define who is covered, for which services and related products e.g. medicines, and with what if any charges at the point of service.

Benefit design should account for the use of all public funding for individual health services, not only those in schemes with explicitly defined entitlements, or those serving a limited population. Benefit design is also concerned with policies regarding the use of private revenues for publicly mandated benefits.

The process of defining which services and goods to publicly fund, and which conditions of access to use, should result from a consideration of technical and political issues. The use of evidence is critical to make informed decisions and should be organized around explicit criteria. Financial and economic considerations include the quality of evidence on cost effectiveness of available treatments and diagnostics, the extent to which services drive financial hardship, and estimates of the fiscal impact in the short, medium, and long term. Countries should develop and institutionalize a systematic process to govern decisions on benefit entitlements. The process should define a range of criteria to guide decisions, using available data and evidence, and be agreed by a range of stakeholders, not only health financing agencies.

Benefit design policy should be comprehensive, explicit, and consider all public funds available for the health system. Once funding is allocated to population-based services and functions, benefit design should focus on driving progress to UHC through the strategic use of public funds through the government budget, as well as purchasing agencies responsible for mandatory health insurance schemes. Benefit design also includes steering private health expenditures in support of UHC, for example through publicly mandated benefits

In health systems where multiple coverage schemes and benefit packages operate side by side, policy makers must ensure coherence across them. Defining clear boundaries between benefit packages both in terms of service entitlements, conditions of access, and the target population, is necessary to reduce uncertainty and ensure transparency for both providers and service users, and to minimize inefficiency resulting from overlaps and duplication.

Reducing uncertainty for both service users and providers is a central objective of benefit design; uncertainty around entitlements and conditions of access constitutes a significant barrier to access and can increase inefficiency in the health system. Entitlements should be explicit but not overly detailed, particularly for first-contact care. Co-payments, if applied, should be fixed in absolute terms, and kept low, both to reduce uncertainty and to protect users against financial hardship.

Benefit design must be closely aligned with the different elements of health financing policy and with service delivery objectives. This means ensuring there are adequate revenues to fund defined entitlements, and allocating funds to priority health services. Well-designed programme budgets can help improve alignment with priority needs, provide greater flexibility in resource use, and support improved tracking of results.

Essential Package of Health Services/UHC Benefit Package of Pakistan

National Health Vision for Pakistan provides a well thought strategic framework for implementation of good governance parameters that can positively influence the achievement of health-related Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) targets within Pakistan. To transform the National Health Vision into reality, one of the key actions was to develop a UHC Benefit Package for Pakistan. UHC Benefit Package consists of i) Essential Package of Health Services (EPHS) at five platforms and ii) Inter-sectoral interventions/policies.

Pakistan is one of the first countries in the world to use the global review of evidence by Disease Control Priorities (DCP3) to inform the definition of its UHC benefit package. With support of DCP3 secretariat, global evidence was reviewed and adjusted to the needs of Pakistan to inform the prioritization of health interventions at community and PHC centre level for inclusion in the EPHS.

Designing of an essential package of health services required gathering and analysing evidence on the burden of disease, unit cost and cost-effectiveness of each intervention, budget impact, expected health gains, health plans, health system capacity, efficiency, feasibility, financial risk protection, equity and socio-economic context of Pakistan. The aim was to define which services are to be covered by government funding for the whole population through five different platforms (community level, health centre level, first level hospitals, referral level hospitals, and population). The data was used to organize priority services into four clusters:

1. RMNCH (Reproductive, maternal, new-born, child, adolescent health and nutrition) cluster
2. Infectious diseases cluster
3. Non-communicable diseases and Injury prevention cluster, and
4. Health services cluster.

The evidence was then reviewed by technical experts and stakeholders to select those health services that should be provided immediately and those in the longer-term pathway to Universal Health Coverage, given the best estimates of the funding available to the government. The UHC Benefit Package of Pakistan/Essential Package of Health Services was finalized and endorsed by the Inter-Ministerial Health & Population Council on 22 October 2020. In the same meeting, all Health & Population ministers decided to localize scientific evidence at provincial/federating area level and accordingly develop Provincial/Federating Area EPHS. Sindh was the first province to finalize its EPHS document and getting endorsement from its UHC Steering Committee, followed by AJK and Gilgit Baltistan.

Table: Summary of Provincial/ Federating Area EPHS in 2021

Platform	Number of Interventions Range	Unit Cost US$ (person/ year) without inflation	DALYs avert [in millions]
Community level	19-23	3.12	3.52
Special Initiatives	10-12	4.99	0.88
PHC Centre level	35-39	3.23	7.6
First Level Hospital	36-42	9.47	4.2
Tertiary Hospital	22-25	6.93	2.1
Population level	10-12	(0.79 National)	?
TOTAL	**132-153**	**28.53**	**18.3+**

Province	District EPHS			Tertiary Level		
	Immediate Priority			Immediate Priority		
	No. of Interventions	Cost per Capita for 2021 (with 8% inflation)	DALYs Avert (in Million)	No. of Interventions	Cost per Capita for 2021 (with 8% inflation)	DALYs Averted
Punjab	103	13.53	7.95	22	11.66	1.16
Sindh	94	19.45	2.86	25	7.87	0.54
Balochistan	96	21.50	1.33	25	4.76	0.08
KP	98	17.60	2.10	22	8.81	0.34
AJK	96	18.94	0.30	22	3.19	0.21
GB	96	12.09	0.23	22	5.34	0.008
		17.19	**15.37**		**6.94**	**2.15**

Based on the DCP3 recommendations, work on Intersectoral National Action Framework is also under process.

The EPHS outlines what services should be provided at each health facility in Pakistan. The EPHS and its costing have been carefully developed to represent minimum standards of care at each tier or level of the health service in order to be able to meet the essential needs of people through life course.

The UHC Benefit Package is a policy framework for strategic service provision based on scientific localized evidence on essential health services. It helps to clarify health priorities and directs resource allocation. It aims to address current poor access to health and inequalities in health service provision. It provides a road map for action and is costed to enable for advocacy purposes and for government, donors, districts and communities to plan on how to align and focus their contributions.

Social Health Protection Programmes

In an attempt to reform the health sector, the federal and provincial governments have introduced various social health protection programs in their constituencies, such as the Sehat Sahulat Program (SSP), and the Social Health Protection Initiative. The target population of these programs is the poorest population. In total, these programs have expanded to 65 districts across the country and have enrolled over 81 million individuals/18 million families.

Sehat Sahulat Program includes treatment packages for priority diseases and for secondary care, with distinct financial limit for each package. For priority diseases, there is an initial annual financial ceiling of Rs 300,000 per family, with an additional allowance of Rs 300,000 per household in case of need. It covers cardiac treatments (stents, open heart, valvular replacement etc), oncological management including surgery, chemotherapy and radiotherapy; burns and trauma management, organ failure management, dialysis, management of complications arising from diabetes mellitus and chronic infections, neurosurgical procedures, abdominal surgeries, fracture management, and other medical and surgical interventions. For secondary care,

there is an initial financial limit of Rs 60,000 per family per year, with an additional allocation of Rs 60,000 per family if need arises. It includes all medical and surgical cases not included in the priority package, such as maternity services, eye procedures, emergencies, and pre-existing conditions. The program so far does not offer facility for transplants (kidney or liver), implants (cochlear and other), cosmetic and dental procedures, and other general exclusions list for health insurance such as self-inflicted injuries, out-patient services, take home medicines, sports injuries etc.

Only Indoor/Day-Care Procedures		
Name of Package	**Priority Disease Treatment Package**	**Secondary Care Treatment Package**
Financial Limits	**Initial Financial Limit:** Rs 300,000/family/year	**Initial Financial Limit:** Rs 60,000/family/year
	Additional Financial Limit (if required): Rs 300,000/family/year	**Additional Financial Limit (if required):** Rs 60,000/family/year
Diseases Covered in Package	• Heart diseases • Diabetes mellitus complications • Burns and accidents • Dialysis • Chronic infections complications • Organ failure management • Cancer management including chemotherapy, radiotherapy & surgery. • Neuro-surgical procedures	• All medical cases not covered in priority disease treatment package • All surgical cases not covered in priority disease treatment package • Maternity services including normal delivery, C-Section, 3 antenatal visits, one postnatal visit of mother, one postnatal visit of new-born, nutritional counselling, immunization counselling, family planning counselling, and one long term family planning intervention, if agreed by family. • Eye procedures • All emergencies covered • All pre-existing conditions covered
Additional Coverage	• Transportation cost of Rs: 1,000 per discharge 3 times in any given year • Burial support expense of Rs: 10,000 per death in empanelled hospitals • One free post discharge follow-up	
Exclusions	• Cosmetic interventions • Transplants (liver, kidney, others) • Normal dental coverage • Self-Inflicted injuries • Dental services, other than accidental injuries	

Presently, these initiatives provide coverage for inpatient care, and the benefits package for each social protection program includes secondary care up to a limit which differs by each initiative. Funding for the social protection initiatives comes from a mix of federal, provincial and donor revenues, and none of the initiatives includes any form of co-payment from patients. For patient enrolment and hospital empanelment, these programs have contracted with the insurance companies, which in turn have negotiated treatment package rates with individual hospitals and reimburse checks to the hospitals once the services are availed by the beneficiaries.

Province/Federating Area	Current Status	Families Covered
Islamabad	Below poverty	65,157
Azad Jammu & Kashmir	Universal	763,807
Gilgit-Baltistan	Below poverty	72,678
Punjab	Below poverty and Universal in 7 districts (moving towards Universal in 2022)	8,592,745 plus
Khyber Pakhtunkhwa	Universal	7,469,666
Tribal Districts	Universal	1,213,159

Balochistan	Nil	Nil
Tharparkar (Sindh)	Universal	314,666
Sindh	Nil	Nil
	Total	**18 Million +**

***Sehat Sahulat* Program is a publicly funded, social health protection initiative of Federal and provincial governments.** The aim is to provide financial health protection to targeted families against catastrophic health expenditure. SSP uses data from the National Socio-Economic Registry (NSER), and defines poverty as families/households having daily income of less than $2. The unit of enrolment is family, and all family members registered with National Database Registration Authority (NADRA) are automatically enrolled in SSP.

***Sehat Sahulat* Programme is being implemented in a phased manner, starting from below poverty families and eventually targeting universal families and providing coverage eventually to all people across Pakistan.** It is functional in Islamabad Capital Territory, Azad Jammu Kashmir, Gilgit Baltistan, Punjab, Khyber Pakhtunkhwa and Tharparker district of Sindh; so far, the program has not been implemented for the families of Balochistan and Sindh (other than District - Tharparkar). 18 million families (approx. 81 million individuals) have been enrolled in the program. The program will be expanded to approximately 39 million families during fiscal year of 2021- 2022.

***Sehat Sahulat* Programme only provide services to families which requires indoor health care services.** The services include, but are not limited to, cardiac treatments, cancer management, burn management, organ failure management (dialysis etc), complication of diabetes mellitus, accident/trauma management, neurosurgical procedures, abdominal surgeries, fracture management and other medical and surgical interventions. The program so far does not offer facility for transplants, implants, and other categories such as self-inflicted injuries, cosmetic surgeries, out-patient services, sports injuries etc. SSP has a wide network of more than 500 panelled hospitals – both in public and private sector - across Pakistan. Beneficiaries from any district can avail treatment from any of these empanelled hospitals.

Social Health Protection Initiative (SHPI) was launched by the provincial government of Gilgit-Baltistan in 2016. SHPI defines poverty as families/households having daily income of less than $1.00 per day. The unit of enrolment in SHPI is household; the basis for enrolment is automatic; and a maximum 7 household members can be enrolled in the program. Currently, SHPI provides coverage to 5,340 households (approx. 35,671 individuals). Like SSP, it provides services for inpatient care, but does not currently cover tertiary care. It also provides multiple additional benefits, such as medication coverage and transportation expenses in varying amounts. SHPI is largely donor funded, with KFW paying 75%, and remaining 25% being covered by the provincial tax-based pool. For patient enrolment and hospital empanelment, SHPI has contracted with Aga Khan Development Network. The beneficiaries can access services from a combination of public and private sector facilities empaneled with the insurance companies.

Other than these major initiatives, poor population also have access to Zakat and Bait-ul-mal funds to pay for health care. Zakat is a 2.5% tax paid by Muslims on their annual savings, which is collected and allocated by the Ministry of Religious Affairs for each province. Health care is one of six programs administered under the Zakat fund. Bait-ul-mal, on the other hand, is a publicly funded social protection initiative created for the welfare of vulnerable populations such as the disabled, orphans and women; such people are supported through general assistance, education, medical treatment and rehabilitation. 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.

In addition, there are also separate health service delivery programs for armed forces and employees of autonomous institutions, 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, employers 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 deduction of 7%, which is used to provide outpatient and inpatient services. ESSI provides medical care facilities and different cash benefits to secured workers and their dependents. ESSI has their own network of hospitals and clinics where free services are offered to the employees and their families. According to 2013 estimates, provincial ESSIs provide coverage to 6.89 million individuals in total.

Other Programmes

Other than these social protection programs, poor population also have access to **Zakat** and 'Bait-ul-Mal' funds to pay for health care.

Bait-ul-Mal is a publicly funded social protection initiative created for the welfare of vulnerable populations such as the poor, widows, destitute women, orphans and disabled persons. Such people are supported through general assistance, education, medical treatment and rehabilitation.

Any individual can apply for general finance assistance once a year only. Any of the two services i.e. (i) Medical treatment (ii) General financial assistance (iii) Education stipend (iv) Individual rehabilitation may be granted simultaneously within a period of one year to the same applicant. However, general financial assistance and rehabilitation cannot be combined. For IFA (General) preference will be given to widows, infirm and disabled every year. Other categories of individuals would be catered only twice in the entire life. Preference is given to accommodate them in other dispensations i.e., IFA (Medical), IFA (Education), IFA (Rehabilitation) as per requirement.

First time a family that consists of 02 or more disabled person has been given status of Special Friend of Pakistan Bait-ul-Mal. Which mean, Pakistan Bait-ul-Mal, provides financial assistance to these special friends amounting to Rs.10,000/- to a family having one special person and Rs. 25000 to a family having two or more special persons.

Zakat, on the other hand, is a 2.5 percent zakat paid by Muslims on their annual savings, which is collected and allocated by the Ministry of Religious Affairs for each province. Health care is one of six programmes administered under the Zakat fund. These initiatives are important reforms to reduce catastrophic expenditures of the poorest families. However, these need to be expanded both in terms of breadth of services and coverage of people.

Employers 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 deduction of 7 percent, which is used to provide outpatient and inpatient services. ESSI provides medical care facilities and different cash benefits to secured workers and their dependents. ESSI has their own network of hospitals and clinics where free services are offered to the employees and their families.

There are also separate health service delivery programmes for armed forces and employees of autonomous institutions, private and commercial establishments.

Social Health Protection Initiatives

Criteria	Public System (Federal and State Budgets)	Sehat Sahulat Program (SSP)	Social Health Protection Initiative (SHPI) Gilgit Baltistan	Employees Social Security Institution (ESSI)
Year Started	Since the creation of country (1947)	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 $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 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		As of today, the program is providing services to more than 18 million families (81 million lives) of Punjab, Khyber Pakhtunkhwa (KP), Azad Jammu and Kashmir (AJK), Gilgit-Baltistan (GB), Islamabad Capital Territory (ICT) and Tharparkar – Sindh	5,340 households (approx. 35,671 individuals) in one district of Gilgit Baltistan	Provincial ESSIs provide coverage to 6.89 million individuals in total

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)	Secondary Care Treatment Package Initial Financial Limit: Rs 60,000/family/year Additional Financial Limit (if required): Rs 60,000/family/year Diseases Covered in Package: • All medical cases not covered in priority disease treatment package • All surgical cases not covered in priority disease treatment package • Maternity services including normal delivery, C-Section, 3 antenatal visits, one postnatal visit of mother, one postnatal visit of newborn, nutritional counselling, immunization counselling, family planning counselling and one long term family planning intervention, if agreed by family • Eye procedures • All emergencies covered • All pre-existing conditions covered Priority Disease Treatment Package Initial Financial Limit: Rs 300,000/family/year Additional Financial Limit (if required): Rs 300,000/family/year Diseases Covered in Package: • Heart diseases • Diabetes mellitus complications • Burns and accidents • Dialysis • Chronic infections complication • Organ failure management	Cashless Indoor Healthcare: • Secondary care: PKR 25,000/person/ household/ year & 175,000/household/year • Tertiary care not provided and no priority diseases	Both outpatient and inpatient services, and there is a financial cap on the latter wages for days of work lost is also provided

		• Cancer management including chemotherapy, radiotherapy & surgery • Neuro-surgical procedures		
		Additional Benefits 1. Admission Coverage: One day pre- admission coverage 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. Ambulance/ Transportation: PKR 1,000.00 2. Medication: Five days medicine at time of discharge 3. Day-care surgeries are covered Limit Beyond Coverage: Nil	
Revenue Sources	• GGE = 21.6% of GDP • Public revenues collected at federal level, from direct and indirect taxes • General budget allocations to provincial governments (NFC Award) • Users make co-payments (registration	• 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	• 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

	fee, payments for diagnostics, out of stock medicines and supplies) at public facilities • Sin tax under discussion	premium amount will be paid by provincial governments • No co-payment by the beneficiary		
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 • Limited (but growing) revenue raising by provincial governments	Some national pooling through federal contributions; otherwise through provincial pools (based in turn on national pooling through NFC Award)	Donor funding pooled with provincial tax based pool	Provincial
Purchasing/ Payment	• Extensive supply-side funding i.e. of salaries and other inputs • Approx. 90% total public spending on health	• Payment against agreed treatment package • 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		Sehat Sahulat Program has a wide network of more than 500 paneled hospitals across Pakistan	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. 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/expansion to approximately 39 million families during fiscal year of 2021- 2022 2. Incorporation of Primary Health Care services (Pilot) 3. Incorporation of take-home medications in benefit package	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 4. Continuation of wider enrollment in Phase-II	

FINANCING GAP

UHC is based on the principle that all individuals and communities have equitable access to their needed health care, in good quality, without suffering financial hardship. In order to achieve UHC, Pakistan has adapted a set of costed priority interventions named as UHC-Benefit Package based on the Disease Control Priorities-3. To achieve Universal Health Coverage, increase access to quality health care services and protect against catastrophic health expenditure, an amount of Rs. 1.28 trillion is required as per the World Bank analysis[30]. The government commitment is Rs. 477 billion and donors' support is Rs. 102 billion. The gap is of Rs. 841 billion which is required to spend on health sector to achieve Universal Health Coverage. With the current population of Pakistan of 232 million, the financing gap per capita is PKR 5,804 or USD 36.70.

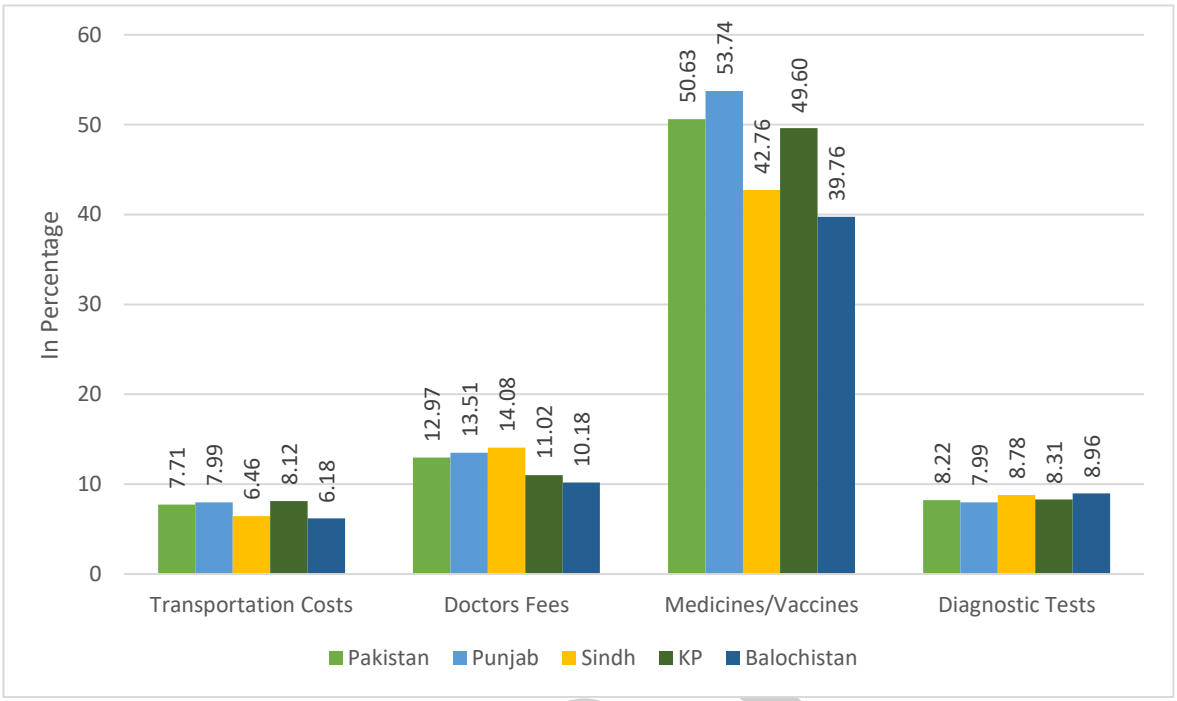
Table: Financing Gap (PKR – In Million) 2019-20	
GoP Commitment – Current	401,091
GoP Commitment - Development	76,499
Total – GoP Commitment	477,590
International Development Partners - Commitment	102,025
Total Commitment	579,615
(Less) commitment for non-prioritized interventions	(132,257)
Prioritized commitments	447,358
Cost of UHC Interventions	1,288,589
Financing Gap	**841,231**

Financial Risk Protection/Catastrophic Health Expenditure

As mentioned in the other sections, Pakistan over-relies on private including OOP expenditures to finance healthcare. OOP expenditures are dramatically high and make up 56.5% of the current health expenditures, and 51.90% of the total health expenditures. The graph below gives the breakup of the gross OOP by region/province. Punjab has the highest share (53%), while Islamabad has the lowest share (1%) of the total OOP health spending. Furthermore, the level of OOP health expenditure in urban areas is higher as compared to rural areas. Urban percentage share of OOP health expenditures in Pakistan is 58.89% while in rural areas it is 41.11%.

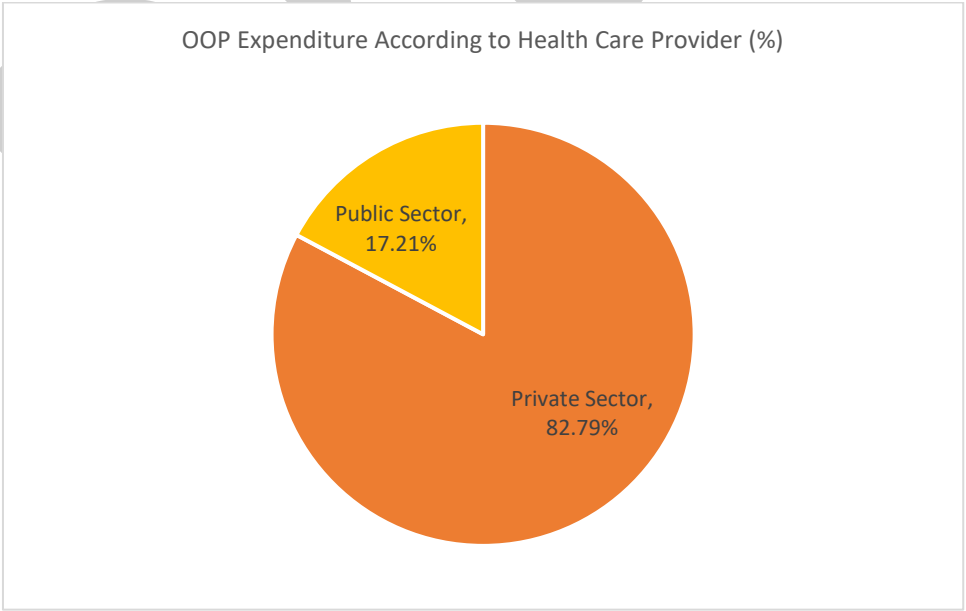
Analysis of the NHA 2017/18 and Household Integrated Economic Survey (HIES) 2018/19 reveals that more than half of the total OOP spending is incurred on medical products, appliances and equipment. Other categories with high share of OOP spending include doctors' fee, costs of diagnostic tests and transportation costs. This is illustrated in the graph below.

30 Earnest & Young_World Bank, 2021; Resource mapping for UHC in Pakistan for FY 2019-20

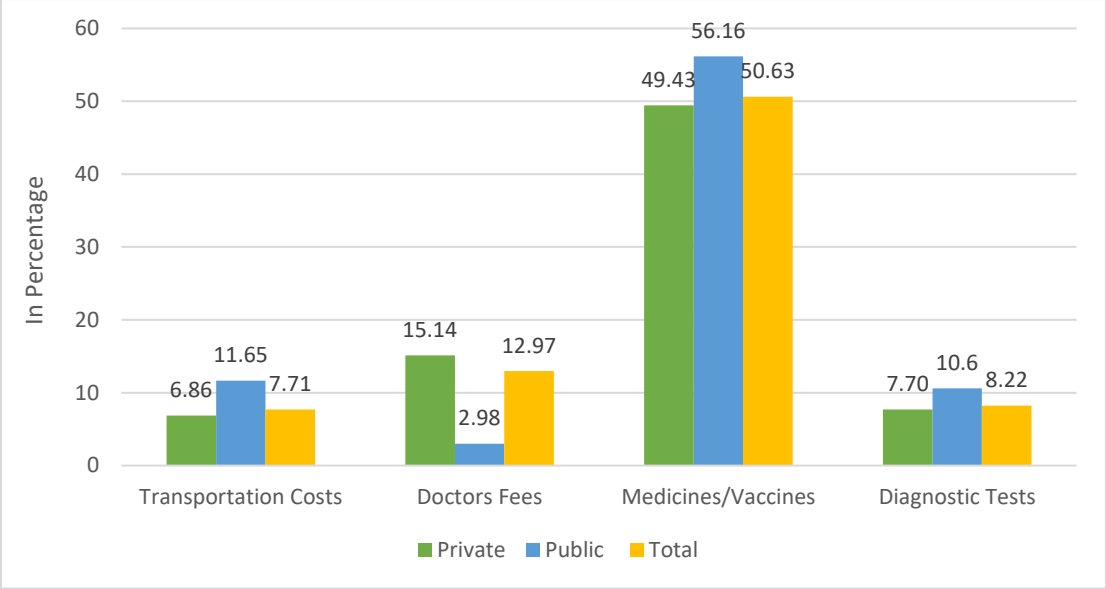


Source: National Health Accounts 2017-18

In Pakistan, share of OOP health expenditures incurred by private sector overall is significantly higher than public sector. However, breakdown of the OOP expenditure shows that the OOP spending on medicines/vaccines, diagnostic tests, transportation costs is considerably higher for the public sector as compared to the private sector. OOP spending on doctors' fees is higher in the private sector.

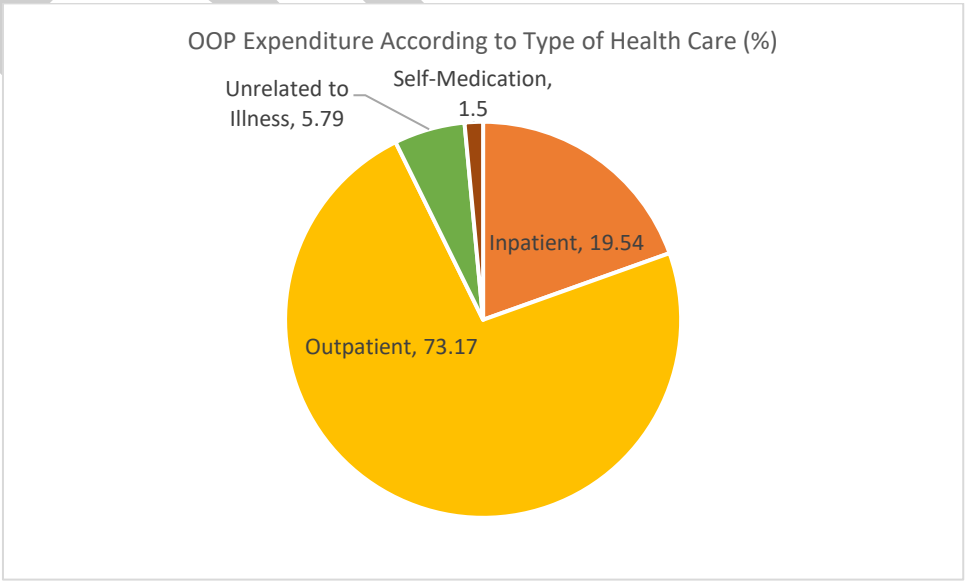


Source: National Health Accounts 2017-18

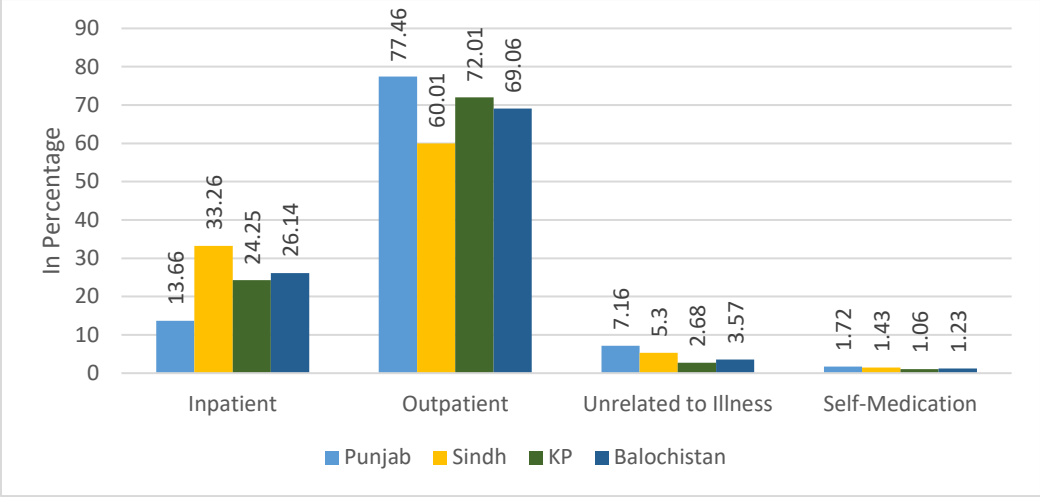


Source: National Health Accounts 2017-18

Analysis of the NHA 2017/18 reveals that in Pakistan, around 73% of the total OOP expenditures incurred on outpatient services while around 20% of total OOP spending incurred on inpatient care for their illness. 5.79% of total OOP spending goes to "unrelated to illness" and just 1.5% expenditures reflect self-medication which include all those people who are taking medicines without consultation/prescription, or all those people who are taking medicines for long lasting diseases like diabetes and high blood pressure that was already prescribed by doctors. Further analysis of data on the type of health care by provinces reflects that percentage share of outpatient is highest in Punjab (77.46%) followed by KP (72.01%), Balochistan (69.06%) and the lowest share is of Sindh (60.01%). For the inpatient services, the highest share is of Sindh (33.26%) and the lowest share is of Punjab (13.66%). According to HIES 2018-19, 30.32% of OOP expenditure is spent on indoor/outdoor patient services, which are highest for Sindh (39.26%) and lowest for KP (25.96%). Further breakdown is not available.



Source: National Health Accounts 2017-18



Source: National Health Accounts 2017-18

OOP Expenditures Per Household on Health by Category and Provinces According to Household Integrated Economic Survey 2018-19 (In %)

OOP Expenditure Categories	Pakistan	Punjab	Sindh	KP	Balochistan
Medical Products, Appliances & Equipment	69.68	71.10	60.74	74.04	64.60
Indoor/Outdoor Services	30.32	28.90	39.26	25.96	35.40
Total	100.00	100.00	100.00	100.00	100.00

The ideal indicator of financial risk protection is the proportion of the population that is incurring catastrophic health expenditure due to OOPs. WHO has defined financial catastrophe for the last 8 years as direct OOP exceeding 40 percent of household income net of subsistence needs. Subsistence needs are taken to be the median household's food expenditure in the country. Expenditures in excess of the 40% cut point generally require reallocation of household expenditures from basic needs. More recently, the World Bank has found it simpler to define financial catastrophe occurring when OOPs exceeds 10% of a household's total income. While this does not incorporate the progressivity allowed by the deduction of basic subsistence needs, it is probably simpler to estimate and seems to provide more or less the same estimates as the WHO method.

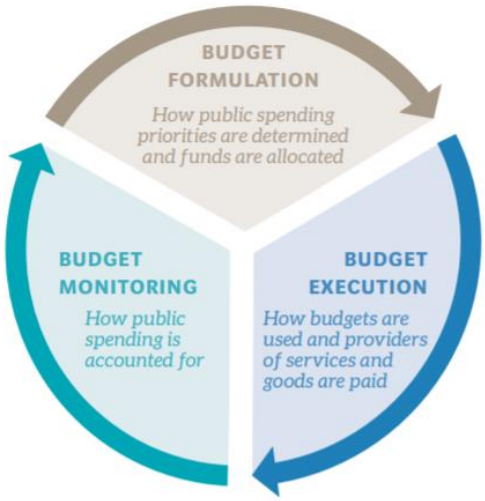
The two indicators used in this analysis are: (1) Percentage of population with household expenditures on health greater than 10% of total household expenditure or income; and (2) Percentage of population with household expenditures on health greater than 25% of total household expenditure or income. In 2018, the population with household expenditures on health greater than 10% of total household expenditure or income was 4%, whereas the population with household expenditures on health greater than 25% of total household expenditure or income was only 0.5%. This reflects the fact that in many countries the quintile with the lowest income (or lowest level of total expenditure) has a lower incidence of catastrophic payments than richer quintiles. When people are very poor, they simply do not use services for which they have to pay, so do not suffer financial catastrophe. As they grow slightly richer, they begin to use services, but then suffer the adverse financial consequences linked to paying for care. The ratio is not likely to change dramatically over time unless there are substantial health financing reforms.

Despite the logic of using the incidence of financial catastrophe as the core indicator, it is sometimes argued that a simpler indicator of financial risk protection is the ratio of out-of-pocket spending to total health expenditure (OOP as % of THE). Undoubtedly there is a high correlation between this indicator and the incidence of financial catastrophe (and impoverishment), therefore we have also included this indicator in the analysis. However, experience has shown that policy makers can immediately see the political relevance of the incidence of financial catastrophe and/or impoverishment, whereas the ratio of OOPs to THE may not have the same immediate policy impact.

IMPROVING PUBLIC FINANCIAL MANAGEMENT

The Public Financial Management (PFM) system is the set of rules and institutions governing all processes related to public funds. It provides sectors with a platform for managing resources from all sources and across national and subnational levels. Public finance processes are typically structured around the annual budget cycle, which is meant to ensure that public expenditure is well planned, executed and accounted for. A standard budget cycle includes three distinct stages:

i. Budget formulation.
ii. Budget execution.
iii. Budget monitoring.



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

Figure: The Public Financial Management System

Budget formulation involves making macroeconomic projections to help determine what level of total government expenditure will be feasible and how much of the total expenditure will be allocated to each of the line (sector) ministries based on strategies and policy priorities. This step also involves negotiation at different levels, including with individual ministries. Budget execution involves the release of funds to line ministries or departments/agencies according to the approved budget and making payments for goods and services. It is during this stage that government agencies make payments to health care providers (both public and private) for covered services.

Budget monitoring involves ensuring that spending agencies and entities comply with laws and regulations, implement good financial management systems with reliable financial reports and internal controls and audits, and achieve budgetary objectives. Health authorities should engage at each step of the budget cycle to ensure alignment with sector priorities and effective and efficient use of public resources. The PFM system has an underlying mandate to help maintain a sustainable fiscal position for the country and allocate resources effectively, ensure effective and efficient delivery of publicly funded goods and services, maintain transparency and accountability, and ensure compliance and oversight. Good PFM systems balance fiscal discipline with the need to meet government policy objectives, including for the health sector.

PFM Structure in Pakistan is consisted of extensive legislative and institutional structures. Pakistan's PFM system is regulated and guided by different sets of regulations and procedures, including General Financial Rules (GFR), Treasury Rules, New Accounting Model, Fundamental Rules and Supplementary Rules (FR & SR),

Account Code, Audit Code, Drawing and Disbursing Officers Handbook, etc., which contain contradictions and gaps. Also, there is no clear requirement for budget funds to be held in a Treasury Single Account (TSA) nor any limit on in-year re-appropriations. In addition, there are no fiscal transparency requirements and no provision of recording new commitments. While there is an internal audit function established and housed within the Finance Department, its coverage remains limited to a few departments.

While there has been significant progress in reforming the PFM systems with implementation of financial accounting and budgeting system, introduction of mid-term budgetary framework and output-based budgeting, yet budget credibility and execution remain a key area of weakness. A risk based internal controls framework is yet to be implemented. The federal and Khyber Pakhtunkhwa internal audit functions require improvements while internal audit functions in remaining provinces are yet to be established. Delays in settlement of audit observations made by Auditor General of Pakistan (AGP) remain a key challenge. In a relatively recent timeframe, supported by the key development partners including ADB and the World Bank, the government has embarked upon a six pillar PFM Reforms Strategy (2018–2027) to address the risks and system inefficiencies. A robust monitoring and course correction mechanism is needed to ensure that envisaged benefits from recent initiatives for PFM reforms are achieved in a timely and effective manner.

Institutional Framework: Accounting and auditing are federal mandates which are performed by offices of AGP and Controller General of Accounts (CGA) respectively, while budgeting and expenditure management is performed by provincial governments. The constitutionally independent office of AGP conducts external audits of public funds.

Legal framework: Pakistan has adopted a unified PFM system, which is provisioned under the Constitution of Pakistan, through articles 78-88, setting out the management of federal consolidated fund and public account. Also, by virtue of articles 90 and 99 of the Constitution, the allocation of business made to Federal Finance Division with respect to PFM elements is outlined in article 25 of the Rules of Business 1973. The Auditor General's Ordinance, 2001, regulates the external audit of public funds and extends to the whole of Pakistan with responsibility for auditing the accounts for the Federation, Provinces and districts. The Controller General of Accounts Ordinance, 2001 requires the CGA to prepare and maintain the accounts of the Federation, the Provinces and district governments in such forms and in accordance with such methods and principles as the Auditor-General may, with the approval of the President, prescribe from time to time. In June 2019, the parliament approved the Public Finance Management Act, 2019. The act deals with federal consolidated fund and public account of the federation, and other matters of the federal government. PFM Act, 2019 focuses at implementation of a Treasury Single Account; publication of tax expenditure and contingent liabilities in budget document; submission of mid-year budget performance review to the parliament and sharing of the reports with the public; establishment of Chief Finance and Accounts Officers in the ministries and implementation of Internal Audit Function (please refer section VI of the Report for further information on key features of PFM Act, 2019). Preparation of annual budget statement is provisioned under Articles 73, 74, 80 and 82 of the Constitution. It is regulated through NAM Framework, System of Financial Control and Budgeting, 2006, using Medium Term Budgetary Framework (MTBF). The MTBF involves preparation by line ministries of three-year expenditure estimates within the ceilings provided by the Ministry of Finance (for the recurrent budget) and by the Planning Commission (for the development budget). Each year, the MTBF process involves the rolling forward of the previous MTBF estimate by one year and the addition of a new outer year. Budget execution is provisioned under Article 99 of the Constitution and is regulated through General Financial Regulations (GFRs), Delegation of Financial Power Rules and FTR.

Operational framework: The preparation of annual budget statements, budget execution, revenue generation, treasury function, public debt and fiscal transfers are managed by the federal and provincial level finance ministries. The provincial Accountant Generals (AG) and the Accountant General Pakistan Revenues (AGPR) report to the CGA at the Federal level. The CGA carries out policy formulation, coordination and administration responsibilities.

The Government of Pakistan uses a Chart of Accounts under the New Accounting Model (NAM) which is IMFGFSM2001 compliant for the formulation and reporting of the budget, recording of the current and development expenditure and revenue. The Chart of Accounts allows tracking of spending on the following dimensions: administrative unit, economic, functional and program.

The Federal budget for the implementing agencies is prepared with detailed functional and object classifications. Approved budget is fed into the Financial Accounting & Budgeting System which is operational at federal, provincial and district levels. The PFM process starts with the budget preparation. The Ministry of Finance (MOF) compiles the budget in accordance with budget calendar. The budget is debated by the national assembly during review and approval.

Drawing and Disbursing Officers (DDO), nominated officers in the spending units, submit expenditure bills to the account's offices for payment. The accounts offices at the district, provincial and federal level process payment claims while exercising budgetary controls and compliance checks. The CGA maintains the accounts of financial transactions and prepares periodic and annual financial reports, for the federal government, provinces and districts.

The external audit of the accounts is conducted by the AGP and the audited accounts and related management letter for the Federal Government are submitted to the President who then lays these before the National Assembly for scrutiny.

The PFM process at the provincial level starts with budget preparation. The Finance Department compiles the budget in accordance with defined timetables and discussions with the line departments. The Planning and Development (P&D) Department is responsible for the annual development program (ADP) and its monitoring. The budget is laid before the provincial legislature for review and approval. Drawing and disbursing officers (DDOs), nominated officers in the spending departments, submit expenditure bills to the accounts offices for payment. The district and provincial-level accounts offices process (district accounts office [DAO] or treasury offices) payment claims while exercising budgetary controls and compliance checks. According to the legal framework, the CGA, through the provincial AG maintains the accounts of financial transactions and prepares financial reports—both in-year and the annual financial statements for the Province. The DG Provincial Audit conducts external audit of the accounts on behalf of the office of the AGP, and the audited accounts and audit reports are submitted to the Governor of the province for tabling them at the Provincial Assembly for legislative scrutiny. The Directorate General District Audit audits the local governments and the DG Commercial Audit audits public sector entities. The PAC of the Provincial Assembly conducts the legislative oversight of the provincial financial operations.

The Public Expenditure and Financial Accountability (PEFA) program provides a framework for assessing and reporting on the strengths and weaknesses of public financial management (PFM) using quantitative indicators to measure performance. PEFA is designed to provide a snapshot of PFM performance at specific points in time using a methodology that can be replicated in successive assessments, giving a summary of changes over time. The outcome of the performance assessment, the PEFA report, provides the basis for dialogue on PFM reform strategies and priorities. The methodology can be replicated in successive assessments, giving a summary of changes over time as well as providing a pool of information that contributes more broadly to research and analysis of PFM.

PEFA Assessments in Pakistan: Last federal level PEFA assessment was performed in 2012. The results of 2019 PEFA Assessment have not yet been made public. Provincial level PEFA assessments were completed as follows:

(i) Balochistan and Khyber Pakhtunwa PEFA were completed in 2017;
(ii) Sindh PEFA was completed in 2020;
(iii) Punjab PEFA was completed in 2019.

The results of PEFA Assessment are as follows:

Pillars	Indicators	PUNJAB	SINDH	BALOCHISTAN	KP
I. Budget reliability	1. Aggregate expenditure outturn	B	C	C	C
	2. Expenditure composition outturn	D+	C+	D+	D+
	3. Revenue outturn	D	C+	D	D+
II. Transparency of public finances	4. Budget classification	A	A	A	A
	5. Budget documentation	C	B	D	B
	6. Central government operations outside financial reports	D	D	D	D
	7. Transfers to subnational governments	B	B	D	B
	8. Performance information for service delivery	D	D	D	B
	9. Public access to fiscal information	A	B	D	D
III. Management of assets and liabilities	10. Fiscal risk reporting	D+	D	D	D
	11. Public investment management	C+	B	D	C
	12. Public asset management	D+	D+	D	D+
	13. Debt management	B	D+	D	C
IV. Policy-based fiscal strategy and budgeting	14 Macroeconomic and fiscal forecasting	C	C	D	C
	15. Fiscal strategy	D+	D+	D	D
	16. Medium-term perspective in expenditure budgeting	D	D+	D	C
	17. Budget preparation process	C	C	D	B
	18. Legislative scrutiny of budgets	C+	C+	C+	C+
V. Predictability and control in budget execution	19. Revenue administration	D+	C+	D	D
	20. Accounting for revenue	C+	C+	D+	C
	21. Predictability of in-year resource allocation	C+	C+	D+	C+
	22. Expenditure arrears	D	D	D	D
	23. Payroll controls	C+	B+	D+	C+
	24. Procurement	D+	B+	D+	B
	25. Internal controls on non-salary expenditure	B+	B	C	B+
	26. Internal audit	D+	D+	D	D+
VI. Accounting and reporting	27. Financial data integrity	D+	D+	C+	B
	28. In-year budget reports	C+	C	C+	C+
	29. Annual financial reports	C+	C+	C+	C+
VII. External scrutiny and audit	30. External audit	C	D+	D+	D+
	31. Legislative scrutiny of audit reports	B	D	D	C+

PEFA on Federal level indicated strong performance by the federal government in terms of comprehensiveness (performance indicators 5–6), transparency (performance indicators 8 and 10), policy-based budgeting (performance indicators 11–12), moderate performance in revenue administration (performance indicators 13–15) and budget execution, and cash/debt management (performance indicators 16–17). Performance in the areas of credibility of budget (performance indicators 1–4) is improving. Weak areas included overall internal control (performance indicators 18-21); accounting, recording and reporting (performance indicators 22– 25); and external scrutiny and audit (performance indicators 27–28)

INNOVATIVE FINANCING, RESEARCH & DEVELOPMENT

Over the past decade, there has been a tremendous surge in attention to global health issues, and the world's wealthiest countries have made a correspondingly large increase in international development assistance for health. Despite the expanded financial effort, progress on the ground toward global health goals, including those embodied in the Millennium Development Goals (MDGs) has been slow and inadequate, and the gap in required funding remains large. In response to this situation, over the past few years a number of nations in the Organization for Economic Cooperation and Development (OECD) and their developing country partners have intensified efforts to identify and put in place new funding mechanisms that, along with increases in the traditional forms of development assistance, could help bridge the resource gap and thus finance essential health care for the poor. While each of these new innovative financing mechanisms has limitations, taken together they could be an important part of the solution to the global funding gap.

Innovative financing mechanisms refer to "non-traditional applications of Official Development Assistance (ODA), joint public-private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground." Innovative financing mechanisms are key components in resource mobilization for global health and are of particular importance with regard to the attainment of the objectives set by major donors and stakeholders, notably as these pertain to the Millennium Development Goals (MDGs) for 2015. Their main role is to fill the existing financial gap in order to reach the MDGs.

At the beginning of 2010 the majority of innovative financing mechanisms being implemented were directed at meeting the needs of the health sector in developing countries. Various mechanisms have raised significant amounts for global health and have proven successful not only in the way they have developed but also in the way they function and disburse funds once they are implemented. A number of organizations, notably the Global Fund, the GAVI Alliance and UNITAID, have deemed innovative financing mechanisms to be a vital and increasingly important element of their resource mobilization and diversification strategies, and as a result have experienced a significant expansion of their activities.

Among the key innovative financing mechanisms implemented is the International Finance Facility for Immunization (IffIm) created in 2006 to support the Global Alliance for Vaccine and Immunization (GAVI). IffIm is a frontloading mechanism for long term ODA commitments from 8 donor countries that are drawn on in the form of bond issues on the international capital markets. By converting pledges into directly available cash resources, this innovative financing mechanism has been a key factor in the resource mobilization and success of the GAVI Alliance. Since the launch of IffIm, the mechanism has raised US$ 2.3 billion on the capital markets, US$ 1.6 billion of which being disbursed for vaccine purchase and delivery.

GAVI also receives support from a second innovative financing mechanism, known as the Advanced Market Commitment (AMC), which is designed to fund the purchase of new vaccine research, manufacturing and distribution. The added value of this mechanism is to increase effectiveness by creating incentives for the development of non-profitable vaccines. A pneumococcal vaccine pilot mechanism was officially launched in June 2009 with a US$ 1.5 billion subsidy.

The Global Fund has also developed two innovative financing mechanisms in its funding structure to harness additional resources for its programmes and activities. The first is the Debt2Health initiative, in which donor countries agree to forgo part of the repayment of the money due to them against the debtor's commitment to invest half of the amount of the debt forgiven on Global Fund-approved programs.

The Global Fund also benefits from the Product RED initiative, in which companies commit a share of their profits on goods branded with the Product Red trademark to support the Global Fund. As of year-end 2009 the Product RED mechanism, based on a strong marketing and communications campaign, is estimated to have raised US$ 140 million to support programmes in Ghana, Lesotho, Rwanda and Swaziland.

Another significant innovative financing mechanism is the air-ticket levy used to fund UNITAID, a global drug purchase facility for HIV/AIDS, Tuberculosis and Malaria. UNITAID seeks to redress market failures by guaranteeing a minimum volume of drugs, thus impacting prices. The main added value of the mechanism through UNITAID's action is to increase drug availability. UNITAID has raised, through traditional ODA and the air-ticket levy, US$ 1.5 billion to date and financed projects addressing MDG 6 in 93 countries. Innovative financing constitutes the bulk of UNITAID's funding with 60% of funds raised coming from the air-ticket levy.

Innovative financing mechanisms can be classified into 5 main categories:

1. Results-Based Financing
2. Catalytic Funding
3. Impact Investing
4. Socially Responsible Investing
5. New Taxation Channels

CLASSIFICATIONS OF INNOVATIVE FINANCE	RESULTS BASED FINANCING	CATALYTIC FUNDING	IMPACT INVESTING	SOCIALLY RESPONSIBLE INVESTING	NEW TAXATION CHANNELS
• MECHANISMS (PRIMARY EXAMPLES)	• DEBT SWAPS • CASH ON DELIVERY AID • PERFORMANCE BASED FINANCING • DEVELOPMENT IMPACT BONDS	• POOLED INVESTMENT FUND • COFUNDING • SEED FUNDING • VOLUME GUARANTEES • CREDIT GUARANTEES • REVOLVING FUNDS • ADVANCED MARKET COMMITTMENTS	• FUND OF FUNDS • INTERMEDIATED FUNDS • DIRECT INVESTMENT FUNDS • BLENDED FINANCE FACILITIES • IMPACT FOCUSED CAPITAL MARKET SOLUTIONS	• SOCIAL BONDS • MUTUAL FUNDS • PENSION FUNDS	• DOMESTIC HEALTH TAXES • INTERNATIONAL SOLIDARITY LEVY • EARMARKED TAXES, E.G. SIN TAXES

CHALLENGES AND THE WAY FORWARD

Health financing in Pakistan needs a clear vision to provide financial protection and serve as an effective means to promote fair and equal access to good quality health services for all. Not only should more resources be invested in the health sector, but those resources should be used in the most cost-effective way to ensure effective access for all. Attention needs to be paid to improving quality of care, enhancing financial protection for all and ensuring financial sustainability of health financing. In order to bring a health financing reform and to achieve the desired goals (financial protection, equity, efficiency, quality, and financial sustainability), certain challenges need to be addressed.

Current funding levels for health are insufficient to ensure sustained progress towards the objective that all people receive the health services they need, in line with SDG3. Total health expenditure per capita from all sources is very low in Pakistan, at $52 (2017-18), compared to $135 in lower middle-income countries (LMICs), $477 in upper middle-income countries (UMICs) and $3,135 in high-income countries (HICs). Low spending in Pakistan is because the country allocates relatively small shares of total government spending to health - level that is inadequate to support coverage with essential quality health services for all. Pakistan public expenditure on health (Rs 482 billion in 2019-20) is around 6 percent of total government expenditure, compared to on average 10 percent in developing countries and 15 percent in HICs. Part of low government spending is also attributed to the low capacity to mobilize revenues. In Pakistan, government efforts to raise taxes consistently fall short (at 11.4 percent in 2019-20) of 15 percent of gross domestic product (GDP), a threshold that the IMF has identified as critical to engender sustained, inclusive growth.

Literature on health financing suggests that increased public investment in health can positively impact health outcomes and financial protection indicators. Additionally, there is a stated commitment by the Federal and Provincial governments to increase public spending on health to 3% of GDP by 2023. To achieve this target, and to improve financial protection and the health of population, Pakistan needs to invest more in the health sector. Budget allocation to the health sector should be increased, and needs to be stable and flexible, considering the priorities of the health sector. The impact of increase in the tax on tobacco or other health-related commodities, such as sweetened-sugary beverages (SSBs), needs to be evaluated. Taxes on consumption of goods that adversely affect public health can discourage consumption, help reduce disease burden, reduce demand for health services, which can in turn reduce the pressure for more resources in the health sector in the long term, contributing to health financing efficiency and positive contribution to fiscal space for health. Earmarking of the sin taxes for the health sector can also be an option. 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.

Health's share of total government expenditures (GGHE-D as % of GGE) in Pakistan is low, approximately 5.3% (2018), relative to the target of 15% of total GGE for health in the Abuja Declaration. In comparison, military expenditures occupy a much greater a share of total government spending (18.4% in 2019). Hence, there is a scope for reprioritization for health, which can deliver significant increase in per capita spending on health.

Additionally, Pakistan lacks the resources to handle health emergencies and epidemics. In the first quarter of 2020, the world was faced with COVID-19 pandemic, which severely impacted the global economy. Pakistan particularly faced difficulties in handling COVID-19 related health and socioeconomic challenges. The government needs to ensure adequate funding for pandemic and emergency response. Donors and government of Pakistan need to invest in epidemic and pandemic preparedness, research and development, and population-based health education.

Official Development Assistance (ODA) for health has stagnated in recent years, and for the year 2017-18 only 0.6% of the total funding for the health sector came from the donor agencies. Although donor dependence comes with its own negative externalities—such as excessive fragmentation and sustainability problems, and expanding fiscal space through external support is not viewed as an attractive option in the global health financing literature, additional international assistance is needed to catalyse advancements in disease areas, strengthen health systems, support governments in tackling low government revenue generation and strengthen their capacities to carry out all health-financing functions required for accelerated progress towards UHC. Accordingly, there is a need to advocate for increasing external assistance for health, and development assistance must evolve to help accelerate progress toward UHC.

In addition to insufficient resources and limited government funding for the health sector, there are inefficiencies and inequities in health financing. About 20-40% of health spending worldwide is misallocated or wasted, and reducing this requires spending on the right things, spending in the right places and spending it right. By improving the efficiency—in terms of budget allocation and utilization—of existing expenditures, fiscal space can be realized. Increases in efficiency increase fiscal space indirectly, creating space within the existing envelope, rather than expanding the resource envelope through expansion of revenues, external grants, etc. Sustainable financing for SDG3 requires not only raising more revenues, but also spending them more efficiently and equitably. In terms of equity, poor people often contribute a higher proportion of their incomes in health payments than the rich, without subsequent compensation through fiscal transfers in cash or in kind, while frequently receiving fewer health services of lower quality.

As a result of low levels of government spending, out-of-pocket payments constitute a large share of health expenditures in Pakistan - 51.9% of total health expenditure. These payments deter some people from using needed health services, and push others into poverty. Financial protection is one of the fundamental goals of health financing and is used as a key indicator for measuring progress toward UHC. Enrolment in social health protection schemes does not guarantee financial protection for the beneficiaries by itself. There is a need to monitor and evaluate the impact of the social health protection initiatives on financial protection, and to evaluate the extent to which the out-of-pocket payments of the poor have been reduced after the implementation of the social health protection schemes. OOP payment and financial protection, such as catastrophic expenditure, are determined by many factors in addition to enrolment in the financing scheme. OOP can be high due to number of reasons: essential services not included in the benefit package, benefit ceiling not high enough to cover the expenses; health seeking behavior or coping strategy of patients, such as over- or under-utilization of services; and provider behavior, with some providers charging higher than the rate set by the insurer, or providing services/interventions which are not considered cost-effective, contributing to financial burden of patients. Government needs to monitor hospital/provider behavior not only to ensure quality of care but also financial protection for the beneficiaries.

Moreover, the government needs to consider extending the benefit and population coverage of social health protection initiatives to cover outpatient and primary care, and the vulnerable or near poor. 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 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. Additionally, as medicines expenditure is the major source of out-of-pocket payment, according to the base-line survey, coverage of medicines in the benefits is of high priority.

Inpatient-based coverage, like that for SSP and SHPI, can lead to 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, therefore it is important to introduce policies for coordination between primary and hospital care. Government should give priority to the public primary care and require the beneficiaries to register in public health centers and mandate a referral letter to be eligible for hospital benefits, which will strengthen the referral system and primary care in the public sector. To earn trust from the enrolled and encourage them to use public health centers more willingly, 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.

Presently, various social health protection initiatives exist nationwide. Academic literature on health financing shows that different and parallel health coverage programs reduce efficiency. Therefore, serious consideration should be given to integrating/ pooling the various social health protection initiatives. Merging all schemes into one big pool will improve equity and efficiency in purchasing and risk pooling capacity.

Pakistan also faces constraints on health financing data. The mechanisms for revising the data are inefficient, resulting in a delay in updating the data. The latest available National Health Accounts are from 2017-18, and therefore the data used in this analysis is not up-to-the-minute. Therefore, there is a need to assist the lead agencies that produce NHA on specific technical areas and to build capacity for institutionalization of annual NHA production.

Low levels of domestic government financing mean that there is currently a substantial gap of Rs. 681 billion between the costs of financing an essential package of quality health services for all and the resources available. Relatedly, OOP expenditures are dramatically high. There is a need to close the financing gap to ensure provision of services. Good economic growth is critical to fill the gap, along with strong political commitment for UHC reforms and a pre-payment mechanism to reduce catastrophic/out-of-pocket health expenditure.

Emerging and intensifying challenges are driving up health care costs and pose risks for future domestic revenue mobilization, efficiency, and equity. Some of the leading challenges include rising consumer expectations; rapid population growth; population aging and the corresponding increase in the burden of non-communicable diseases and demand for long-term care; progress in medical technology; limited administrative capacity to raise revenues; slow formalization of economies; changes in the form and content of work; pandemic threats; anti-microbial resistance; and forced displacement of populations. If not addressed early, these factors may make it even harder to attain the health financing required for UHC.

In order for health financing reforms in Pakistan's politically and fiscally devolved health system to advance towards UHC and move closer towards the four foundational principles of equity, resiliency, efficiency, and quality, a nationally coordinated health financing strategy is necessary. Although provincial governments are responsible for health financing policy, it would be more cost-effective to have a national entity play the role of role of technical lead in the development and dissemination of guidelines, protocols, manuals for the health financing system, which 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. 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. Moreover, without a nationally coordinated approach, particularly one that takes into consideration the differing needs of the different provincial health systems, Pakistan risks further exacerbating local disparities in health outcomes and health access and, ultimately, impeding improvements at a national level.

Pakistan can make substantial progress by adapting proven health-financing principles and policies to its contexts. Key options include: improve the efficiency and equity of resource use, for example through prioritizing investments in evidence based essential package of health services and inter-sectoral interventions, good quality primary and community health services; increase resources for health from general revenue, and, where appropriate and feasible, obligatory health insurance contributions from those with the ability to pay.

Developing synergy between the *Sehat Sahulat* Programme and the UHC Benefit Package of Pakistan is where the future of healthcare of Pakistan lies. Steps taken for the implementation of *Sehat Sahulat* Programme with huge investments (so far through general taxation) to cover all people from Khyber Pakhtunkhwa, Punjab and Federating areas is an extraordinary response. Pakistan holds a unique opportunity of having an established *Sehat Sahulat* Programme (Universal Health Insurance) and the EPHS (Universal Health Service Coverage) interventions for all people.

There is a need to improve health-financing results by developing a "big-picture" perspective in two ways. First, by connecting health-financing policy across sectors in a whole-of-government approach; second, by consistently adopting a medium-term timeframe and routinely assessing the likely future threats to revenue generation, health costs, efficiency, and equity, adjusting their health-financing strategies before emerging problems become entrenched. Together, these two approaches will reinforce health-financing resilience and sustainability.

Lastly, to achieve the health financing goals, there is a need to strengthen health-financing leadership, governance, and organizational capacity. Joint leadership between ministries and departments of finance, planning & development and health can accelerate the development and implementation of health-financing solutions, particularly in areas where, despite broad consensus about principles and policies, progress lags. Often such slowdowns are due to political obstacles. Joint leadership between ministries and departments of finance, planning & development and health is equally critical to strengthen health-financing governance and organizational capacity.

Closing the substantial UHC financing gap Pakistan will require a strong mix of domestic and international investment. Pakistan's own fiscal measures to increase taxes as a share of GDP and the share of government expenditures dedicated to health, on top of economic growth, could reduce the estimated financing gap. Additional inflows may come from the private commercial sector, but the amounts are likely to be limited. A substantial increase in ODA with support to develop the capacity to absorb external financing, stronger engagement of the private sector, and innovative health-financing policy solutions will all be needed to have a chance of reaching UHC and realizing the ensuing benefits of sustainable, inclusive growth.

Bilateral and multilateral agencies and development banks, and global alliances, networks, and platforms are making important contributions beyond development finance to facilitate technical collaboration, policy dialogue, and global learning. These include, inter alia, the World Health Organization (WHO)-led Global Action Plan for Healthy Lives and Well-being; UHC 2030; Gavi, the Vaccine Alliance; the Global Financing Facility for Women, Children and Adolescents (GFF); and the Global Fund to fight AIDS, Tuberculosis, and Malaria. Each of these partnerships and platforms plays a valuable role in helping Pakistan respond to today's pressing health-financing problems. However, given the persistent challenges in overcoming UHC financing shortcomings, new avenues for international collaboration to support country UHC financing efforts are needed, especially in the areas of: a) research, analysis and development; and b) leadership, governance, and organizational capacity.

ANNEXURES

GLOSSARY

Abbreviation	Stands for	Definition
CHE	Current Health Expenditure	Current Health Expenditure (CHE) is defined as the final consumption expenditure of citizens/residents on healthcare goods and services. It includes only direct health expenditures, and excludes health related expenditures on training, research, environmental health etc.
CHE per capita		This indicator calculates the average expenditure on health per person.
CHE as % of GDP	Current Health Expenditure (CHE) as percentage of Gross Domestic Product (GDP)	Current health expenditure as a share of GDP provides an indication on the level of resources channeled to health relative to other uses. It shows the importance of the health sector in the whole economy and indicates the societal priority which health is given measured in monetary terms.
ESSI	Employees' Social Security Institution	A body corporate established under the Provincial Employees Social Security Ordinance, 1965, on recommendation of International Labour Organization (ILO). A self-sustaining body, without any financial aid from the Provincial or Federal Government, that provides medical care facilities and different cash benefits to secured workers and their dependents.
EXT	External Health Expenditure	This indicator calculates the average external sources spent on health. External sources compose of direct foreign transfers and foreign transfers distributed by government encompassing all financial inflows into the national health system from outside the country.
EXT as % of CHE	External Health Expenditure (EXT) as percentage of Current Health Expenditure (CHE)	The share of external sources spent on health as percentage of current health expenditures indicates how much is the health system dependent on external funding sources relative to domestic government and private sources.
GDP	Gross Domestic Product	Gross Domestic Product is a monetary measure of the market value of all the final goods and services produced in a specific time period by countries.
GGE	General Government Expenditure	General Government Expenditure (GGE) includes all government current expenditures for purchases of goods and services across different sectors.
GGHE-D	Domestic General Government Expenditure on Health	Domestic General Government Expenditure on Health (GGHE-D) is the expenditure on health from the government's resources.
GGHE-D as % of GDP	Domestic General Government Expenditure on Health as a percentage of GDP	The total spending by Pakistan's government on health sector as a share of the economy as measured by GDP.
GGHE-D as % of GGE	Domestic General Government Expenditure on Health as a percentage of General Government Expenditure	This indicator contributes to understand the weight of public spending on health within the total value of public sector operations. It indicates the priority of the government to spend on health from own domestic public resources.

Abbreviation	Stands for	Definition
GGHE-D as % of CHE	Domestic General Government Expenditure on Health as a percentage of Current Health Expenditure	The total spending by Pakistan's government on health sector as a share of current health expenditures indicates how much is the health system dependent on domestic sources relative to private and external sources.
NFC	National Finance Commission	The National Finance Commission was established under the Constitution of Pakistan, which laid the foundation of distribution of revenues between the federal and four provincial governments of Pakistan.
OOP	Out-of-Pocket	This indicator estimates the average health expenditure through out-of-pocket payments. It indicates how much the citizens pay out of pocket on average at the point of use. High out of pocket payment are associated with catastrophic and impoverishing household spending.
OOP per capita		Out-of-pocket per capita indicates how much each individual pays out of pocket on average in USD at the point of use. This indicator describes the OOP expenditure in relation to the population size in USD facilitating international comparison.
OOP as % of CHE	Out-of-Pocket as a percentage of Current Health Expenditure	This indicator estimates how much are households in each country spending on health directly out of pocket. It estimates the share of out-of-pocket payment of total current health expenditures.
OOP as % of THE	Out-of-Pocket as a percentage of Total Health Expenditure	This indicator contributes to understanding the relative weight of direct payments by households in total health expenditures. High out-of-pocket payments are strongly associated with catastrophic and impoverishing spending.
PVT-D	Domestic Private Health Expenditure	Domestic Private Health Expenditure (PVT-D) is the expenditure on health from the private sector.
PVT-D as % of CHE	Domestic Private Health Expenditure as a percentage of Current Health Expenditure	The share of domestic private expenditures on health of the current health expenditures indicates how much is funded domestically by the private sector. Private sector funds stem from households, corporations and non-profit organizations. Such expenditures can be either prepaid to voluntary health insurance or paid directly to healthcare providers. This indicator describes the role of the private sector in funding healthcare relative to public or external sources.
SDG	Sustainable Development Goals	The Sustainable Development Goals are a collection of 17 interlinked global goals designed to be a blueprint to achieve a better and more sustainable future for all.
SHI	Social Health Insurance	Social Health Insurance is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other. Thus, it protects people against financial and health burden and is a relatively fair method of financing health care.
THE	Total Health Expenditure	Total health expenditure (THE) is an aggregate of current health expenditure and development expenditure. It includes not only the direct health expenditures, but also health related expenditures on training, research, environmental health etc.
THE per capita		It shows the total expenditure on health relative to the beneficiary population, expressed in US$ to facilitate international comparisons.
UHC	Universal Health Coverage	Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.
VHI	Voluntary Health Insurance	Voluntary health insurance can be defined as a prepaid pooling arrangement that receives voluntary funds and pools them separately.

HEALTH FINANCING

in Low- and Middle-income countries

The purpose of this section is to provide health and other stakeholders with a short overview on the objectives of health financing in low- and middle-income countries, as a critical component of health system. The section starts with the definition of health financing (see box below)[31] and its core objectives and three components of raising funds, pooling funds and then paying for health services.

> **Health financing** *refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care".*

Objectives and Components of Health Financing

The overall objective of health financing is to raise resources for health in order to fund essential health services for the whole population, in ways that encourage equity and efficiency in use of resources. This can be elaborated to include:

- **Effectiveness** in providing **adequate / more funding** to meet basic health needs of the population and in providing **financial risk protection** – so that people are not driven into poverty due to the costs of health care
- **Equitable** in terms of access – **enabling access for the poor** and vulnerable groups, and in terms of **fair financing** – so the rich pay more than the poor
- **Efficiency** in service delivery - both ***technical efficiency***[32] to provide services at low cost and ***allocative efficiency***[33] in terms of **appropriate health services**, avoiding under or over treatment

It is also important to consider **the impact** on the wider economy – the health benefits need to outweigh any costs imposed by the financing approach.

31 WHO, 2000; The World Health Report – Health System: Improving Performance
32 **Technical efficiency** – Minimising the costs of service delivery e.g., through low-cost medicines, appropriate staffing, patients using the right level of care – 'doing things right'
33 **Allocative efficiency** – allocating resources to the most appropriate and cost-effective interventions in the country context – 'doing the right things'

This is in line with the **National Health Vision** and the **Universal Health Coverage (UHC) Benefit Package of Pakistan,** which highlight the need for:

- more resources for improving essential health services, from both domestic and external sources
- including more predictable, long term and effective investment for health; and
- increased access to essential health services including for the poor and socially excluded (including removal of user fees)

There are three core components of health financing:

1) **Raising resources** – how financial resources are collected for health care; how this is done is critical for equity, sustainability and access
2) **Pooling resources** – collection and management of resources in one or more 'pools' in order to share the risks of high health care costs; it also enables cross subsidies between rich and poor, and between high risk/sick and well people
3) **Purchasing health services** – how healthcare providers are remunerated, which greatly affects efficiency, equity and quality of care.

1. Options for Raising resources

There are various approaches to raising resources. Four are often discussed for low- and middle-income countries (LICs ad MICs) – General taxation; Social Health Insurance (SHI); User fees; Community Based Health Insurance (CBHI). Some other options include – Private Medical Insurance; Medical Savings Accounts; and Aid Finance.

Whilst countries are often characterised as having one system (e.g., the UK National Health Service funded from taxation, Social Health Insurance in Europe, Private Insurance in USA), in practice all countries have a mix of approaches for raising funds. For example, the UK has co-payments (user fees in the form of prescription fees within the NHS), as well as private health insurance for those who want it. The USA has large publicly funded schemes for the poor and the elderly. European countries have social insurance topped up with tax funding for the poor. This mix of systems is healthy and normal, and likely to occur in LICs ad MICs. It raises the issue of how the systems interact e.g., if you want people to join voluntary insurance schemes then there need to be user fees (rather than free services), so they have incentives to join the scheme.

As countries' income increases, they tend to move towards greater coverage with insurance schemes and reduce reliance on out-of-pocket payments. This is desirable as a way to reduce risks of catastrophic payment and improve equity. But most LICs cannot move directly to a universal system and will be in a transition towards a more comprehensive system. What is key is to establish a framework that will encourage equity and efficiency as the system develops, and enable increased coverage of the poor. For example, for different schemes to access the same providers, in order to avoid a two-tier health service developing for the insured and the poor. Or to put regulation in place for private insurance before the insurance sector becomes too influential and can resist measures to control costs and improve equity. It is also worth recognising that countries usually want to build on their existing systems.

General taxation

Whilst general taxation as a funding source provides coverage for the population in general, it is important to recognise that in practice the poor usually have lower coverage with public services (benefit incidence favours the better off, i.e.; the better off use more public health services, especially public hospital care). The extent of this inequity is greater in some places than others.

The capacity to raise more funds for health depends on underlying capacity of the tax system to increase tax take and the political will to increase the allocation to health. Increasing the allocation for health needs to be

seen in the context of competing demands from other sectors – recent estimates indicate that the amounts required for meeting the SDGs far outstrip resources available.

Some countries have added specific health taxes e.g., on tobacco. This can raise more funding for health, but only if the Ministry of Finance does not reduce the allocation for health from general taxation from what it would have been.

Social Health Insurance

Social or mandatory health insurance (SHI) involves a legal requirement to join a health insurance scheme. Typically, schemes are run at national/provincial level as part of the social security system or under a specific public agency, but in some countries, there are multiple insurance providers. The key characteristics are that membership for groups covered by the scheme is compulsory – this ensures risk sharing across the well and the sick – in contrast with voluntary insurance where there are risks of adverse selection[34]. In addition, premiums are typically related to ability to pay, so the rich pay more (whereas private insurance usually assess individual risk). Usually, contributions are set as a payroll tax, at x% of salary, up to a ceiling. However other types of contributions are possible, e.g., Ghana has raised contributions through a sales tax.

Most countries establish SHI initially for those in formal employment. It has proved more difficult to enrol those in the informal sector, and this is usually voluntary. The poor can be covered by paying their contribution from general taxation - this approach is used in higher income countries and increasingly in MICs, but is difficult to achieve where the majority of the population are not in employment and would need a subsidy. Aid funds can be channelled to pay this subsidy for those not covered. The key health policy issues is not whether a government uses general revenue versus payroll taxes, but the amounts raised and the extent to which they are used in an efficient and sustainable manner.[35]

SHI is not a magic bullet but can make a contribution in a suitable context. It needs to be designed in ways that avoid worsening equity; includes the informal sector; identifies how to cover the poor; and addresses the risks of high administrative costs, weak governance, and rising health care costs. Tax or aid funding will still be needed to finance health care for the poor.

To decide whether this is a good time to start SHI, countries need to assess: what would be the likely additional revenue, taking into account extra administrative costs; the requirements for administrative capacity and skills e.g., in financial management and contracting; likely impact on health care access for the poor; and potential impact of increasing payroll taxes on growth. It cannot be assumed that substantial revenue will be raised – as shown by experience in Eastern Europe in the 1990s.[35]

Out of Pocket Payments (OOP) including user fees for public services

Out of pocket payments (OOP) including user fees are an inefficient and inequitable way to fund health care. People have to pay when they are sick. They bring incentives for over-treatment by providers. They inhibit access by the poor. Yet they make up a major part of health financing in most developing countries. The majority of fees/OOP are paid to the private sector – to buy drugs from shops etc. as well as for doctors, nurses and formal health facilities. In such cases they usually cover the full cost of services (although some may be subsidised e.g., faith-based services, socially marketed contraceptives).

In the public sector, user fees typically raise a small share of total service costs. Once the cost of collection is allowed for, the contribution is even lower; hence they are not an effective way to raise funds. However, they bring benefits in providing funds at the service delivery level in countries where the flow of funds and drugs to rural health units is poor or non-existent, as they provide revenue to motivate staff and buy drugs and other essential supplies. They are argued to bring benefits in terms of accountability and community engagement.

34 **Adverse selection** – in a voluntary insurance scheme, those who expect to be ill or have a chronic condition join the insurance, while the healthy do not. This leads to heavy use of services, the costs and premiums go up as a result, further deterring the healthy from joining.
35 Gottret, P et al, 2006. Health Financing Revisited _World Bank

There has been extensive debate on whether to remove user fees in public health services, or at least to give waivers for the poor or for vulnerable groups such as pregnant women and children under five. The evidence from Uganda, Zambia and Kenya shows that removing fees can improve access with a rapid increase in utilisation. However, it is critical to replace the fee income and allow for additional utilisation by providing sustained, increased funding and supplies. There is also a risk that informal fees replace formal ones.

Many countries with user fees have waiver and exemption arrangements to increase access for certain groups. These may be service specific exemptions e.g., free TB treatment, or waivers for individuals such as for the poorest or for children under 5 and pregnant women. Although there has been success in the areas of free TB treatment and free immunizations, it is a common finding in LICs that waivers and exemptions are not always applied as intended.

A review of experience in seven low- and middle-income countries found that coverage of the poor with waivers in LICs was extremely low.[36] A critical lesson is the importance of providing sufficient and timely funding to replace the income that the provider would otherwise have received. The review also highlighted the importance of clear criteria, process and guidance for assessing who is eligible for waivers; effective publicity on who is eligible, and support for non-fee costs of seeking treatment.

Community based health insurance (CBHI)

The idea is attractive but has rarely been scaled up. CBHI usually involves a community level insurance or managed care arrangement, voluntary and not-for-profit.[37] Schemes can be adapted to suit local conditions e.g., collect premiums at the time of year when cash crops are harvested, and can be subsidised to enable cover of the poorest. Such schemes collapses when the public sector introduces free services. CBHI is being implemented on a substantial scale in Rwanda. India: Self Employed Women's Association (SEWA) is a larger scale example.

CBHI has some modest positive impacts, however it suffers from problems including inadequate management capacity, small risk pools, and inability to include the very poorest. As a result, the schemes tend to run out of funds. Voluntary membership brings risks of *adverse selection*. This risk can be reduced by adding health insurance functions to organisations that are established for other reasons, such as BRAC in Bangladesh (primarily for micro-credit). Strong local community solidarity is also seen as a pre-requisite.

Table: Resource Raising Options against Financing Objectives

Option for financing	Effective in raising more funds for health	Effective in protecting against risk of high health care costs	Equity – enables access for the poor and vulnerable	Encourages efficient and appropriate health services	Equity in terms of fair contributions
Social Health Insurance	May raise extra funds - depends on growth, employment, compliance	Less protection if high co-payments and over-treatment	Requires extra funding from tax or aid to pay for their cover in SHI	Depends on design – risks of over-treatment & high costs. Cost control required	Neutral in fairness terms if set as a fixed % of income
Tax Funding	Amount for health depends on government priorities and economic conditions	Protection if user charges are limited or exemptions are effective	Yes, if allocated well and services are free, have low user fees or effective waivers	Depends on funding mechanisms; less cost pressure than SHI	Taxation may or may not be progressive
Fees and other out of pocket charges	Major funding source in private sector. Small	No – no protection, barrier to use	No – fees inhibit access	Providers have incentive to over-treat, limited by	Not fair

36 Bitran et al, 2003; Waivers and exemptions for health services in developing countries, World Bank
37 Ekman, B, 2004. CBHI in LICs: A systematic review of the evidence, Health Policy and Planning

	amounts from public user fees			patients' ability to pay	
CBHI	Limited amounts mobilised in most cases	Limited protection in most cases, as reduces OOP but only for a limited-service package	Reach lower income groups but excludes the poorest, unless subsidised	Depends on design and package of services covered	Contributions usually flat rate, so not progressive
Medical Savings Accounts	Limited additional funds	Some protection but need additional risk protection	No, since tend to cover the employed	Depends on design - Not good impact	Neutral in fairness
External aid	Levels should increase, but problems of predictability and limited flexibility	Depends on use, e.g., whether helps fund hospitals so fees can be reduced	Yes, usually targeted to diseases of or services for the poor	Depends on how used; e.g., may help focus on cost effective interventions	
Private insurance	Raises extra funds to meet demands of those able to pay	Yes, for those covered - less so if high co-payments or if the chronically sick are excluded	Can undermine access for non-beneficiaries by attracting human and financial resources	Depends on design – high risks of over-treatment, cost escalation, high admin costs	Fair as long as not diverting resources.

Financing from general taxation or SHI (if combined with tax or aid funding to cover the poor) are best for promoting equity, risk protection and moving towards universal access. It is better to introduce SHI when the economy is growing and the formal sector is expanding. Heavy reliance on CBHI, user fees, pre-payment such as private health insurance are less desirable, although they can play a minor role. What is critical is the way that the funds are used to purchase or fund health services, and how these impact on service distribution and access.

2. Pooling resources

Insurance and tax mechanisms both pool resources collected in advance of illness. The benefit of pooling is that it allows for subsidies from high to low-risk individuals and high to low-income groups. The larger the pool, the more predictable the costs of health care become. A tax-based system usually has a single national pool, or at least provincial pool. A system with competing voluntary health insurance schemes or local CBHI tends to have multiple smaller pools. In order to even out risks from well financed pools to those with inadequate funds, there can be a mechanism for redistribution across pools, but this can be difficult to manage in practice.

The Good Practices in Health Financing studies[35] reviewed experience in nine countries that have succeeded in increasing health care coverage. They found that several countries had consolidated risk pools, to increase pool size and reduce fragmentation. This had enabled transfers to improve equity. Two countries that had created regional pools in the name of decentralisation had recentralised them to national level to improve equity and efficiency. Once funds are pooled, resource allocation formulae can be designed to favour deprived areas and be pro-poor.

3. Provider payment arrangements

How funds are raised does not dictate how providers are paid – but tends to be related. In general, tax funding is used to finance public sector provision, through funding salaries and other inputs. Insurance systems tend to fund based on services delivered, and often fund both private and public sectors. However, public funding can be used for private providers and can be performance based. Insurance can fund block grants as well as reimbursements.

The key issue is the incentives that the payment system gives – for which services to provide and for quality. This has become topical in aid circles with the interest in "results-based financing" and "payment for results". Providers need incentives to provide appropriate, good quality services, and to do so efficiently. The problem is to avoid incentives to over–treat, with the resulting *cost escalation* and unnecessary, possibly harmful treatment.

What care is funded? Defining an essential package of health services (EPHS) is a widespread approach in health strategies. It is also necessary for insurance systems.

Who purchases the care? This will affect the incentives for efficiency and equity. Local level purchasers (e.g., a district health office) may find it hard to make demands for better efficiency upon the local district hospital, while a strong national/provincial insurance agency may be able to push harder for efficiency and quality.

How payments are decided? Major options are: direct funding of inputs; pay fee for service; capitation; performance related with mechanisms to encourage equity and avoid over-treatment. Many systems involve a combination of methods to try to balance the incentive effects.

Direct funding of inputs – as in the typical public sector, funding is provided to pay salaries and for buildings, supplies etc. This brings no incentives to over treat, but also no incentives to raise quality, be efficient or to attract patients to use services.

Simple fee for service – e.g., set fees per visit, per night in hospital and per drug, gives providers incentives to attract patients, but also to over-treat, and over-state numbers, in order to claim more money. This may be less of a problem if coverage is very low or for preventive services (e.g., immunization). But fee for service can have negative impacts, for example paying providers on a per person basis led to forced sterilisations in family planning programmes; and paying hospitals or doctors per caesarean can lead to excessively high rates.

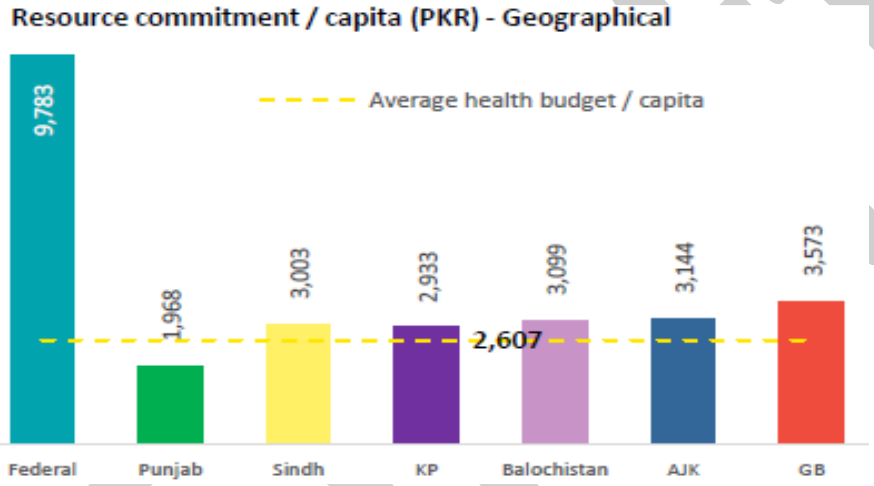
Capitation mechanisms – where funding is set on the basis of the population covered – this encourages coverage with preventive services and reduces incentives to over-treat, but may result in under-treatment.

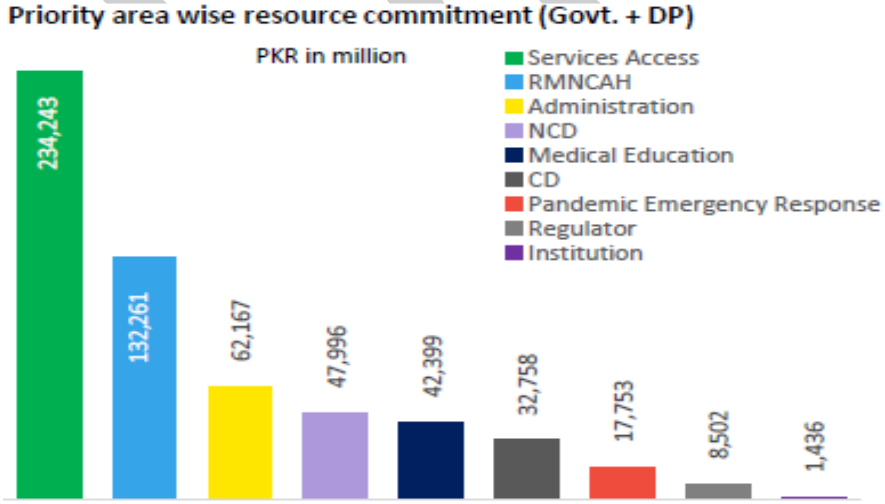
Payment linked to performance beyond simple fee for service - with mechanisms to avoid incentives for over-treatment. There is extensive experience from developed countries in payment mechanisms to encourage efficient and appropriate treatment, especially in insurance systems. Most involve some form of standard payment linked to the patient's diagnosis, bringing incentives to treat patients but also to be efficient in-service delivery.

Demand side payments are where payments are channelled to service users, or via them. Examples include vouchers, conditional cash transfers and safe delivery incentives. They tend to be used to target poor or specific vulnerable groups, with the aim to incentivise them to take up services, rather than as a basic mechanism for funding health services. There is typically funding to providers to improve services alongside the demand side incentives. The incentives are thus a complementary approach rather than the main route for funding health care or paying providers.

In summary, one attraction of insurance system is that they tend to pay providers based on outputs – usually services delivered, and this provides incentives for providers to attract patients and treat them well, and to increase outputs (in contrast with the standard public sector funding of inputs). There is substantial experience on how to design payment for results in order to avoid the dangers of simple payment by results/fees per person. In designing payment mechanisms, it is important to learn from experience in other countries and build in safeguards to avoid cost escalation and unnecessary provision, and to incentivise access for the poor and public health objectives.

INDICATORS


Resource commitment / capita (PKR) - Geographical
Average health budget / capita
9,783
1,968
3,003
2,933
2,607
3,099
3,144
3,573
Federal
Punjab
Sindh
KP
Balochistan
AJK
GB


Priority area wise resource commitment (Govt. + DP)
PKR in million
Services Access
RMNCAH
Administration
NCD
Medical Education
CD
Pandemic Emergency Response
Regulator
Institution
234,243
132,261
62,167
47,996
42,399
32,758
17,753
8,502
1,436

Federal and Provincial Budgets

Federal Budget (PKR – In Billion)		
	Budget 2021-22	**Budget 2020-21**
Current Expenditure	7,523	6,346
Development Expenditure	964	792
Total Expenditure	8,487	7,138

Punjab Budget (PKR – In Million)		
	Budget 2021-22	**Budget 2020-21**
Current Revenue Expenditure	1,427,900.273	1,314,906.737
Current Capital Expenditure	540,114.158	569,193.228
Development Expenditure	560,000.000	375,222.332
Total Expenditure	2,528,014.431	2,259,322.297

Sindh Budget (PKR – In Million)		
	Budget 2021-22	**Budget 2020-21**
Current Expenditure	1,089,372.00	954,424.00
Development Expenditure	329,033.00	160,315.00
Total Expenditure	1,418,405.00	1,114,739.00

Khyber Pakhtunkhwa Budget (PKR – In Million)		
	Budget 2021-22	**Budget 2020-21**
Current Expenditure	724,934.336	619,345.098
Development Expenditure	371,074.667	249,991.520
Total Expenditure	1,096,009.003	869,336.618

Balochistan Budget (PKR – In Million)		
	Budget 2021-22	**Budget 2020-21**
Current Revenue Expenditure	319,451.07	269,013.34
Current Capital Expenditure	27,410.63	13,357.48
Development Expenditure	237,221.27	104,645.44
Total Expenditure	584,082.96	387,016.27

Out-of-Pocket Expenditure

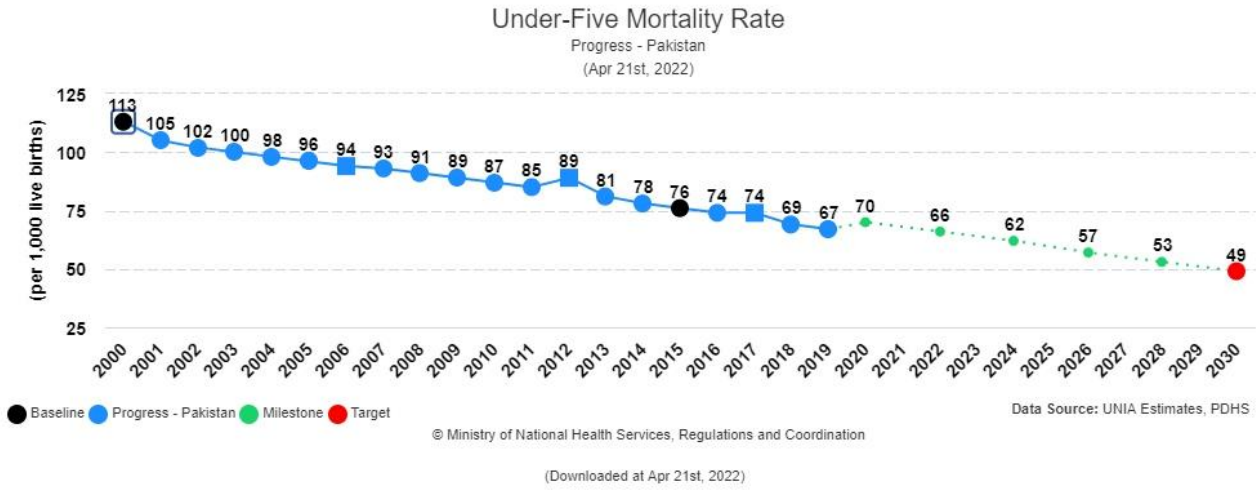
Out-of-Pocket Expenditures According to The National Health Accounts							
	2005-06	**2007-08**	**2009-10**	**2011-12**	**2013-14**	**2015-16**	**2017-18**
Total Health Expenditure (In Million)	283,048	346,694	448,403	554,453	757,196	918,485	1,206,332
Current Health Expenditure (In Million)	264,640	324,787	401,068	496,465	695,203	841,120	1,108,464
OOP (In Million)	**193,568**	**228,108**	**273,015**	**304,944**	**457,285**	**524,804**	**626,104**
Population (In Million)		165.94	171.73	180.71	186.18	193.56	209.80
OOP per Capita (PKR)		1,374.64	1,589.79	1,687.48	2,456.14	2,711.32	2,984.29
USD Exchange Rate			83.69	89.31	102.96	104.18	109.83

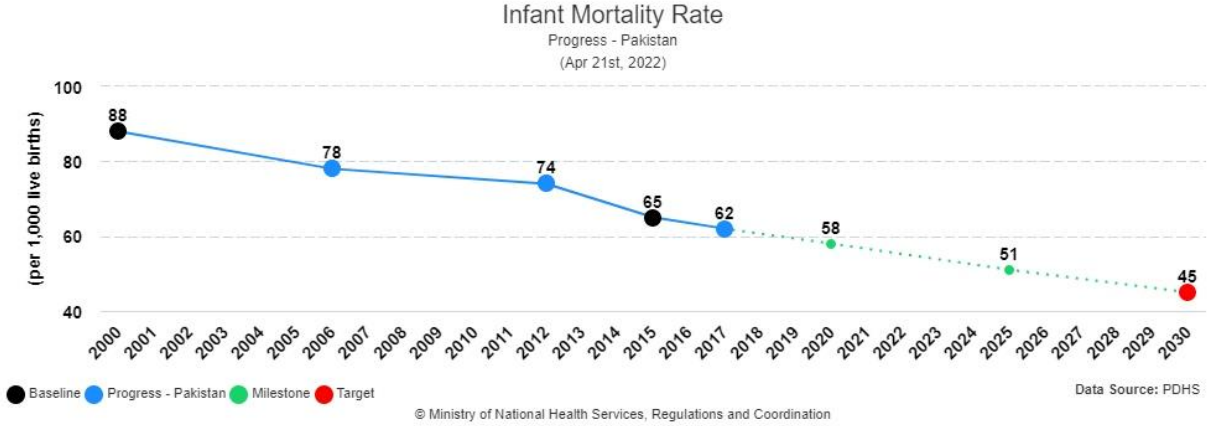
OOP per Capita (USD)			19.00	18.89	23.86	26.03	27.17
OOP as % of CHE (%)	73.14	70.23	68.07	61.42	65.78	62.39	56.48
OOP as % of THE (%)	68.39	65.80	60.89	55.00	60.39	57.14	51.90

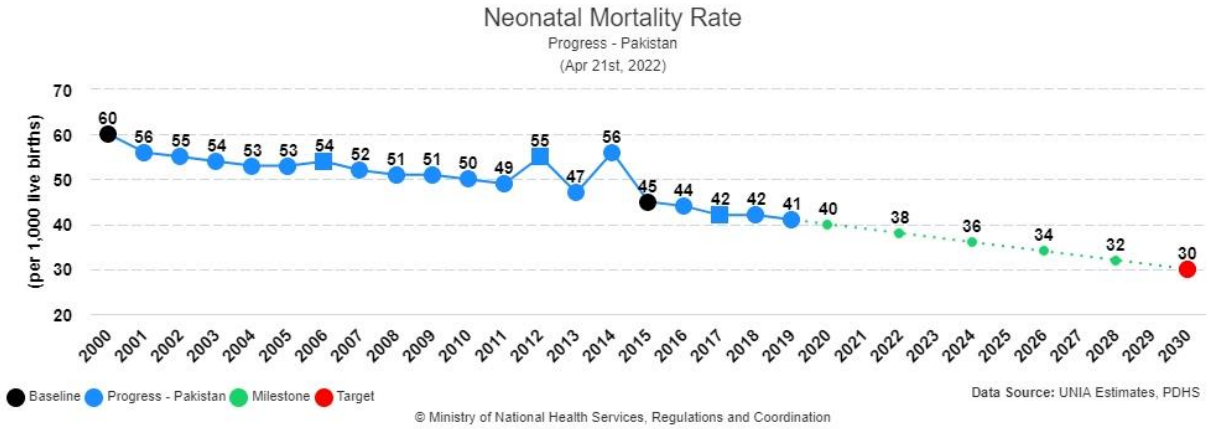
OOP Expenditures of Private Households 2017-18 by Category and Provinces in %					
OOP Expenditure Categories	**Pakistan**	**Punjab**	**Sindh**	**KP**	**Balochistan**
Transportation Costs	7.71	7.99	6.46	8.12	6.18
Admission Fees	1.47	1.17	1.70	1.97	2.41
Doctors Fees	12.97	13.51	14.08	11.02	10.18
Medicines/Vaccines	50.63	53.74	42.76	49.60	39.76
Medical Supplies	2.43	1.87	2.77	3.78	1.94
Medical Durables	0.42	0.29	0.92	0.36	0.58
Diagnostic Tests	8.22	7.99	8.78	8.31	8.96
Costs of Surgeries	7.10	4.76	10.55	9.90	14.34
Food	2.06	1.84	2.53	2.33	1.84
Tips	0.23	0.21	0.26	0.23	0.21
Accompanying Person Cost	0.55	0.50	0.37	0.91	0.26
Other	6.21	6.13	8.82	3.47	13.34
Total Expenditure	100.00	100.00	100.00	100.00	100.00

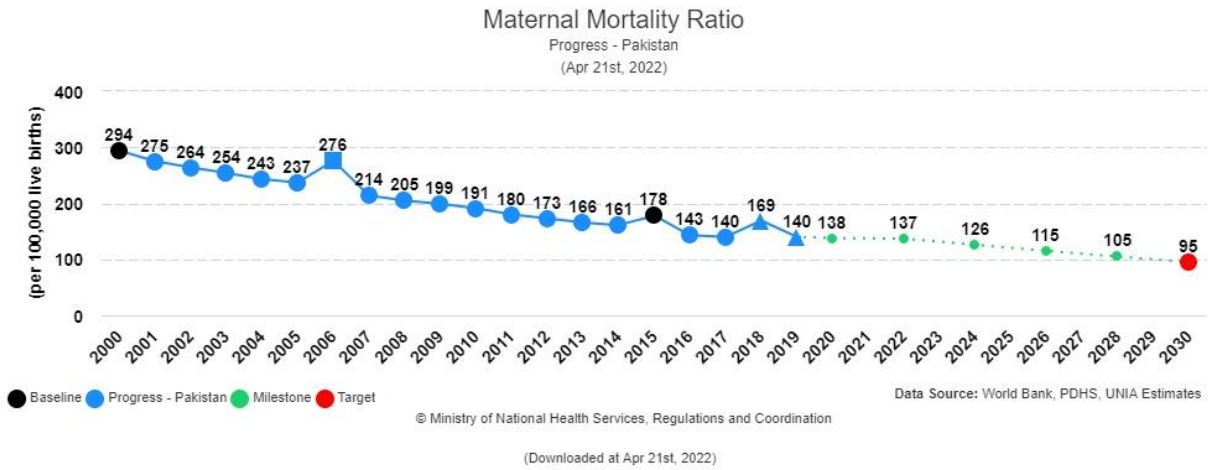
OOP Expenditures in Health Care Providers by Categories 2017-18 in %			
OOP Expenditure Categories	**Private**	**Public**	**Total**
Transportation Costs	6.86	11.65	7.71
Admission Fees	1.55	1.05	1.47
Doctors Fees	15.14	2.98	12.97
Medicines/Vaccines	49.43	56.16	50.63
Medical Supplies	2.30	3.05	2.43
Medical Durables	0.42	0.43	0.42
Diagnostic Tests	7.70	10.6	8.22
Costs of Surgeries	7.84	3.68	7.10
Food	1.67	3.85	2.05
Tips	0.15	0.57	0.23
Accompanying Person Cost	0.48	0.91	0.56
Other	6.46	5.07	6.21
Total Expenditure	100.00	100.00	100.00

Out of Pocket Health Expenditure by Type of Health Care 2017-18 in %					
Province	**Inpatient**	**Outpatient**	**Unrelated to Illness**	**Self-Medication**	**Total**
Pakistan	19.54	73.17	5.79	1.5	100.00
Punjab	13.66	77.46	7.16	1.72	100.00
Sindh	33.26	60.01	5.3	1.43	100.00
KP	24.25	72.01	2.68	1.06	100.00
Balochistan	26.14	69.06	3.57	1.23	100.00








Maternal Mortality Ratio
Progress - Pakistan
(Apr 21st, 2022)
(per 100,000 live births)
400
300
200
100
0
294 275 264 254 243 237 276 214 205 199 191 180 173 166 161 178 143 140 169 140 138 137 126 115 105 95
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030
Baseline
Progress - Pakistan
Milestone
Target
Data Source: World Bank, PDHS, UNIA Estimates
© Ministry of National Health Services, Regulations and Coordination
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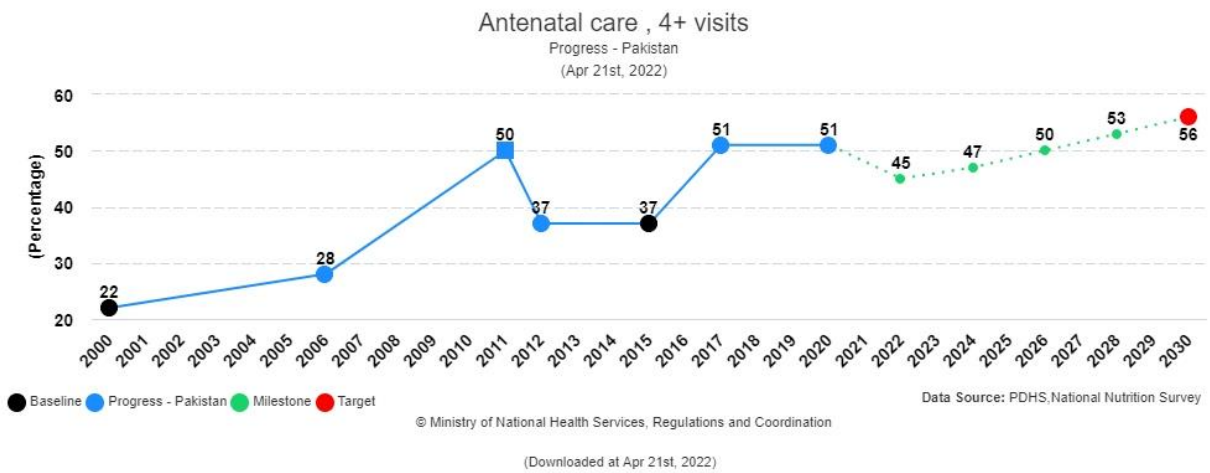
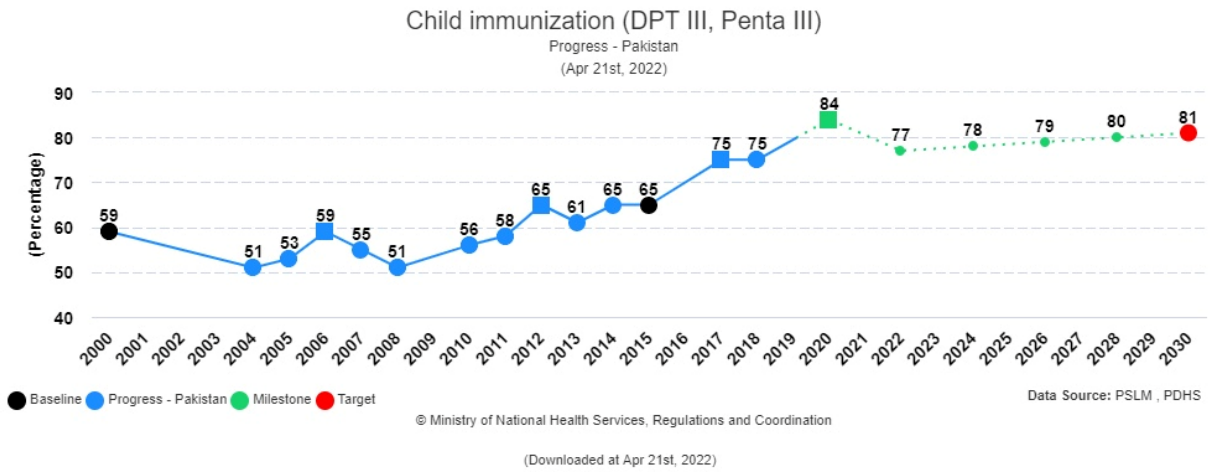
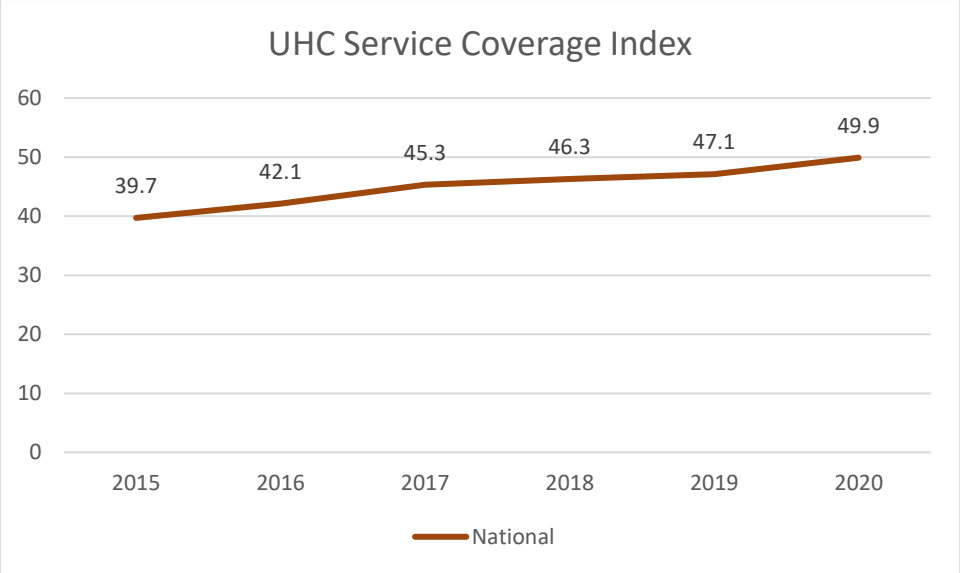
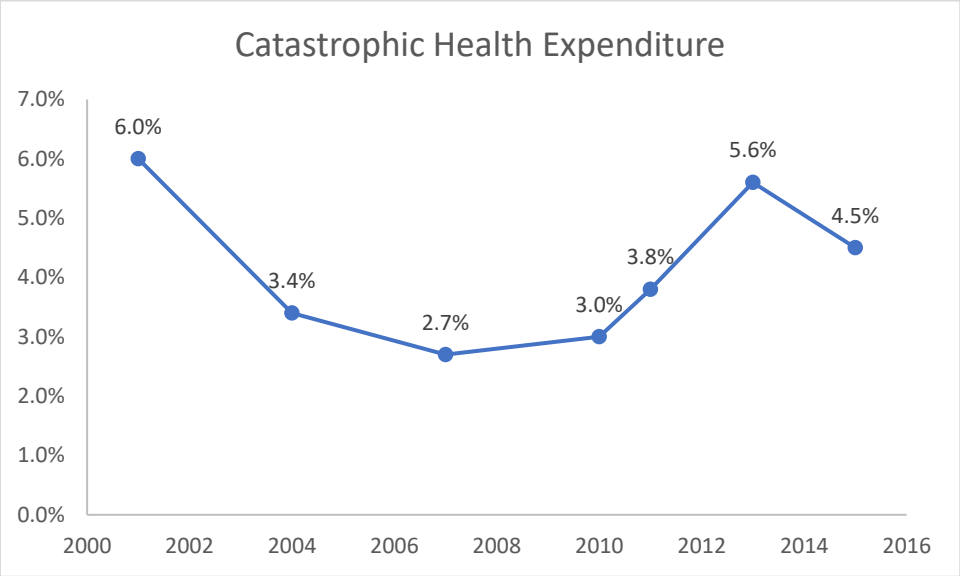

Antenatal care , 4+ visits
Progress - Pakistan
(Apr 21st, 2022)
(Percentage)
60
50
40
30
20
22 28 50 37 37 51 51 45 47 50 53 56
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030
Baseline
Progress - Pakistan
Milestone
Target
Data Source: PDHS,National Nutrition Survey
© Ministry of National Health Services, Regulations and Coordination
(Downloaded at Apr 21st, 2022)


Child immunization (DPT III, Penta III)
Progress - Pakistan
(Apr 21st, 2022)
(Percentage)
90
80
70
60
50
40
59 51 53 59 55 51 56 58 65 61 65 65 75 75 84 77 78 79 80 81
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030
Baseline
Progress - Pakistan
Milestone
Target
Data Source: PSLM , PDHS
© Ministry of National Health Services, Regulations and Coordination
(Downloaded at Apr 21st, 2022)

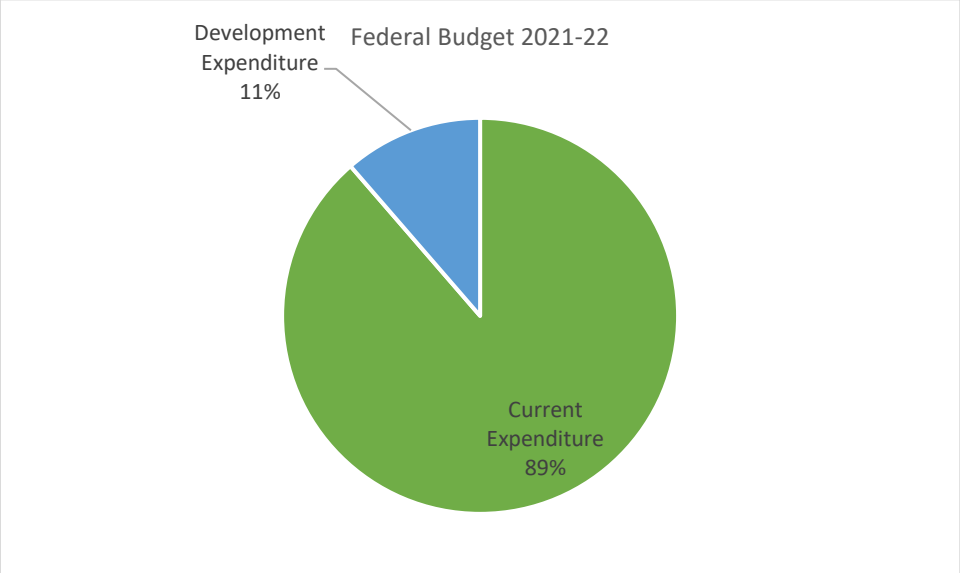

UHC Service Coverage Index
60
50
40
30
20
10
0
39.7
42.1
45.3
46.3
47.1
49.9
2015
2016
2017
2018
2019
2020
National


Catastrophic Health Expenditure
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
6.0%
3.4%
2.7%
3.0%
3.8%
5.6%
4.5%
2000
2002
2004
2006
2008
2010
2012
2014
2016

FEDERAL & PROVINCIAL BUDGET ANALYSIS

Federal Budget Analysis

Estimate of total expenditure for the year 2021-22 in the federal budget is PKR 8,487 billion; almost 19 percent higher than last year's PKR 7,138 billion. Compared to 2020-21, the budget for current expenditure has increased by 18.5%, development expenditure by 21.7%, leading to an overall increase of 18.9% in the total federal budget. In addition, the re-current expenditure is 89% of total budget.

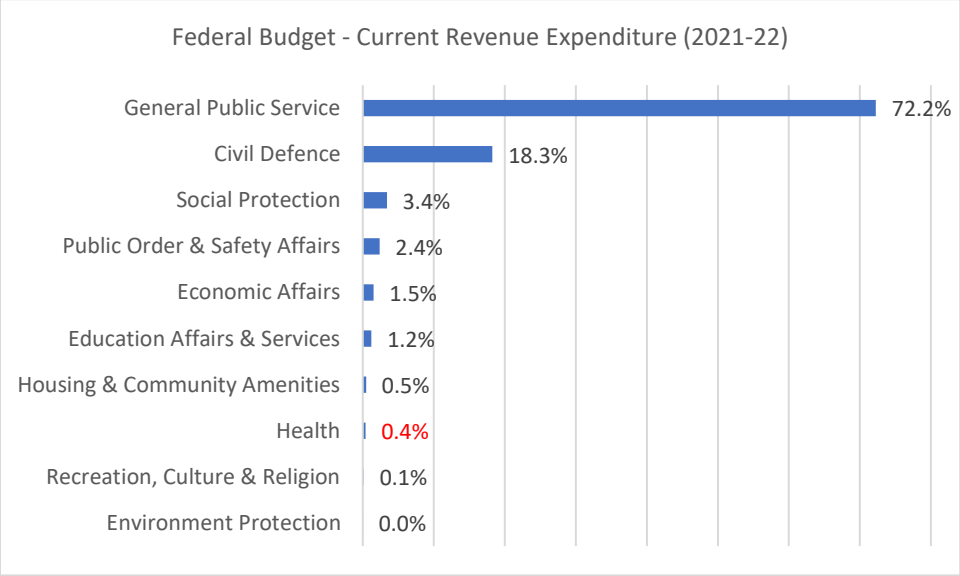


Source: Federal Budget of Pakistan 2021-22

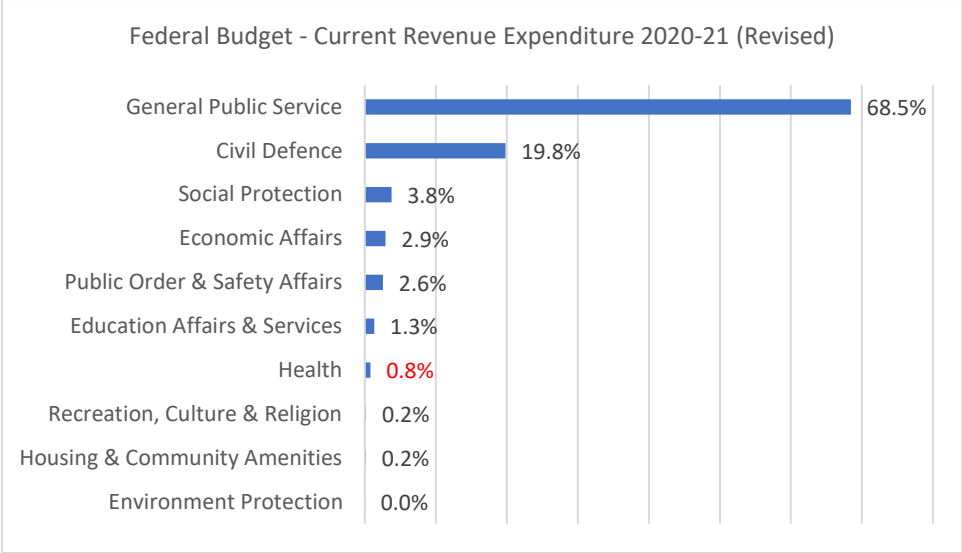
Federal Budget – Breakdown of Current Revenue Expenditure		
	2021-22	**2020-21 (Revised)**
Current Revenue Expenditure (PKR In Million)	**7,523,248.00**	**6,561,002.00**
General Public Service	5,435,200.00	4,491,028.00
Civil Defence	1,373,275.00	1,299,188.00
Public Order & Safety Affairs	178,511.00	168,952.00

Economic Affairs	115,243.00	192,452.00
Environment Protection	436.00	399.00
Housing & Community Amenities	34,597.00	9,997.00
Health	**28,352.00**	**52,325.00**
Recreation, Culture & Religion	10,372.00	12,160.00
Education Affairs & Services	91,970.00	88,090.00
Social Protection	255,292.00	246,411.00

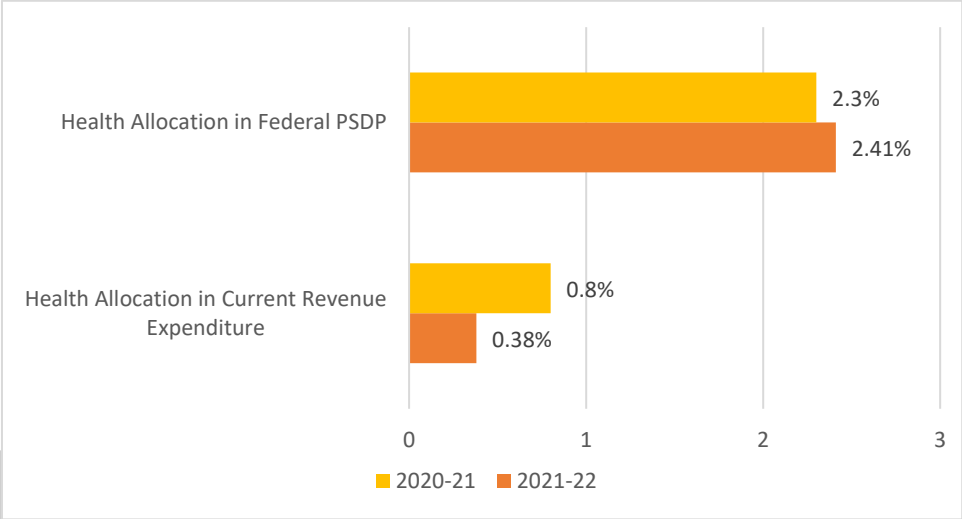
The budget analysis of the health sector intends to enable different stakeholders like the Ministry of National Health Services, Regulation and Coordination (M/o NHSRC), Department of Health Services (DoH), etc. to understand the trends in allocation and expenditure over the years. For 2021-22, the budget allocated to the health sector is 0.38% of the current revenue expenditure, and the allocation for M/o NHSRC is 2.4% of the total Federal Public Sector Development Program (PSDP). It is evident from these figures that health has been given a relatively low priority in the federal budget compared to other sectors. Of the current revenue expenditure, health is the government's third last share for funding. 72.2% of the current revenue expenditure has been set aside for the general public services, in contrast to 0.4% for the health sector. It is illustrated in the graphs below.



Source: Federal Budget of Pakistan 2021-22



Source: Federal Budget of Pakistan 2021-22

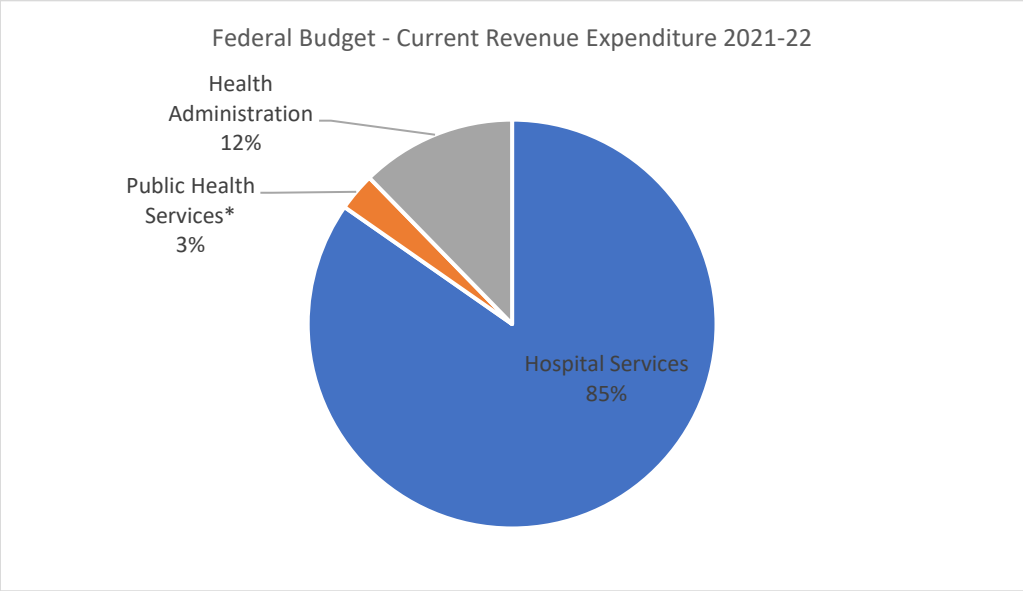


Source: Federal Budget of Pakistan 2021-22

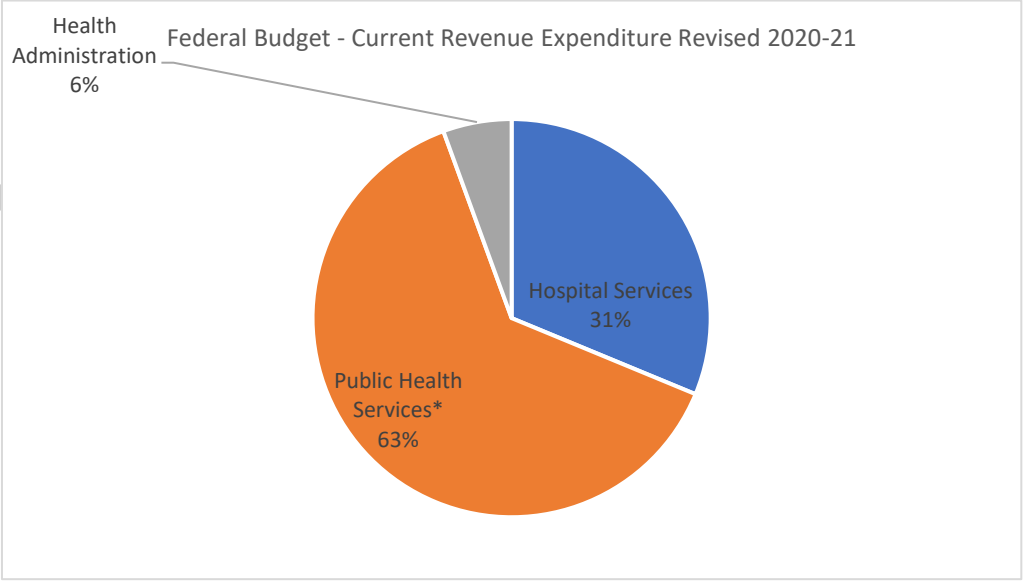
The revised allocation for health was increased from 25 billion to 52 billion PKR in 2020-21 due to COVID-19 pandemic. An amount of Rs. 100 billion was allocated only for COVID related expenditures in FY 2021-22. The table below shows comparison of the budget allocation of FY2020-21, revised budget allocation of FY20-21 and allocation of FY 2021-22.

Federal Budget - Breakdown of the Current Revenue Expenditure for Health (PKR - In Million)			
Classification	**Budget 2020-21**	**Revised 2020-21**	**Budget 2021-22**
Hospital Services	22,805	16,347	24,013
Public Health Services*	504	33,061	849
Health Administration	2,184	2,916	3,489
Total Health Affairs and Services	**25,493**	**52,324**	**28,351**
**An amount of Rs. 100 billion is allocated only for COVID related expenditures in FY 2021-22*			

For 2021-22, almost 85% of the current revenue expenditure is allocated to hospital services, 12% to health administration, and 3% to public health services. Compared to 2020-21, there is an increase in allocation to hospital services and health administration, but decrease in allocation to public health services. In addition, most of the health budget, including salaries, support services, capacity building and program activities, has been devolved to Provincial Governments.



Source: Federal Budget of Pakistan 2021-22



Source: Federal Budget of Pakistan 2021-22

The table below shows breakdown of the health budget in terms of allocation, release and expenditure for current and PSDP spending. Not all the amount that is allocated for the health sector is spent on healthcare, and there is a gap between allocation and expenditures. For the current expenditures, the allocations and expenditures have increased greatly from 2015-16 onwards. However, for PSDP, allocation and expenditure decreased in 2017-19, before increasing again in 2019-20.

Federal Budget - Allocation and Expenditure								
Health Budget in PKR Million		**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
Current Expenditure	Allocation	1,756.68	2,769.74	3,173.10	11,045.17	11,669.95	Data yet to be released	
	Release	1,756.39	2,769.20	3,173.10	10,994.05	11,669.95		
	Expenditure	1,676.36	2,736.47	3,172.36	11,017.48	11,278.96		
Public Sector Development Programs (PSDP)	Allocation	24,638.66	32,382.01	28,821.30	11,805.08	15,596.26	Data yet to be released	
	Release	24,419.51	31,769.50	18,300.90	10,595.71	15,054.35		
	Expenditure	23,274.34	31,635.22	17,923.76	10,292.71	13,553.63		

Provincial Budget Analysis

Punjab

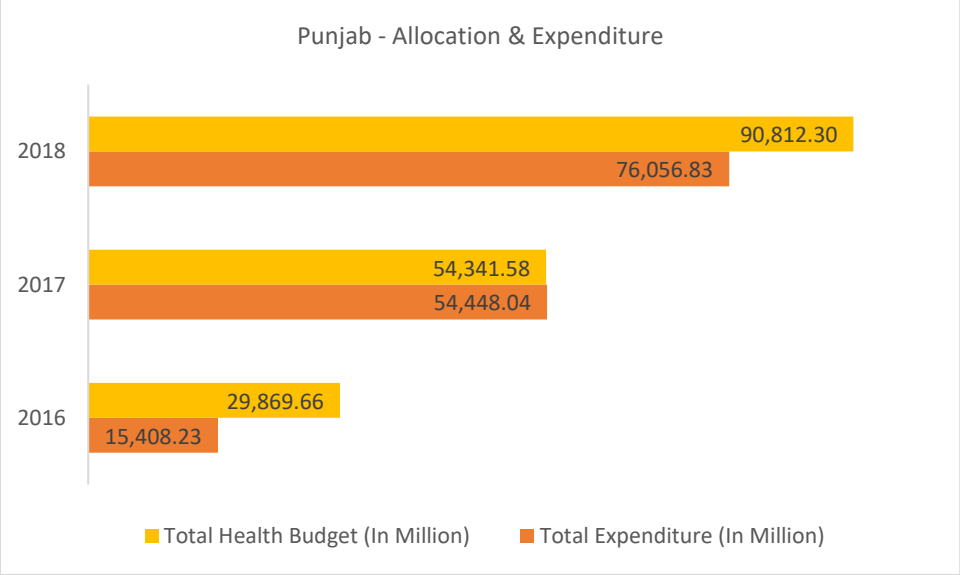
Punjab is Pakistan's most populous province with a population of around 126 million. The budget for health has increased over the three years and there is also an improvement in utilization. The amount of money spent on health sector has increased from 15.41 billion PKR in 2016 to over 76 billion PKR in 2018. In 2018, 84% of the budget devoted to the health sector was spent, with a per capita spending of PKR 603. In addition, primary and secondary care received the greatest proportion of the health expenditure. However, not all the amount that was allocated for the health sector was spent on healthcare, and there is a gap between allocation and expenditures, as evident from the tables and graphs below.

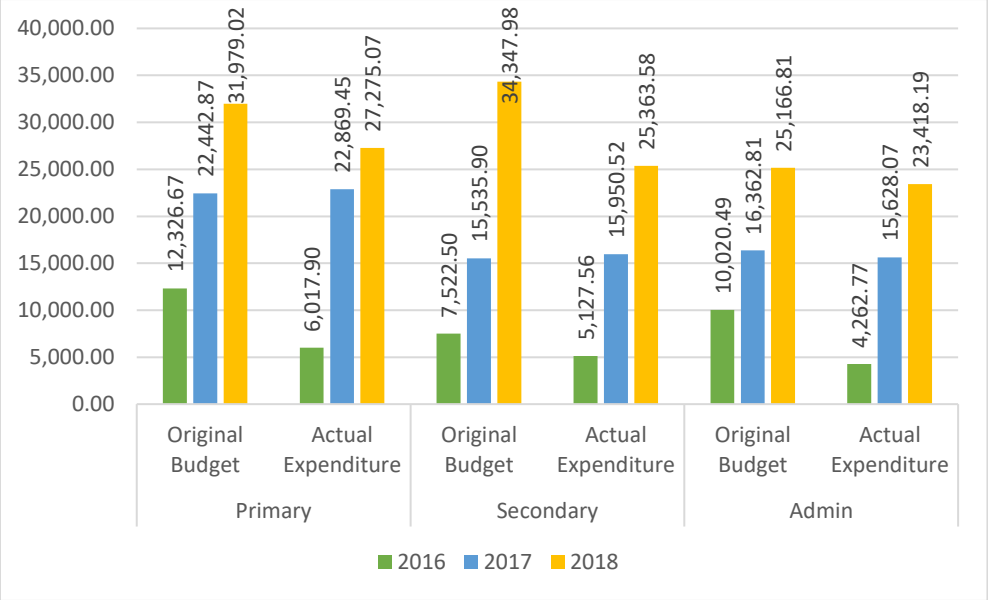
Punjab Budget - Allocation and Expenditure

	Population (In Million)	Total Health Budget (In Million)	Total Expenditure (In Million)	Percentage Change in Budget	Utilization	Expenditure per Capita
2016	107.650	29,869.662	15,408.232		52%	143
2017	119.990	54,341.581	54,448.043	82%	100%	454
2018	126.045	90,812.300	76,056.830	67%	84%	603

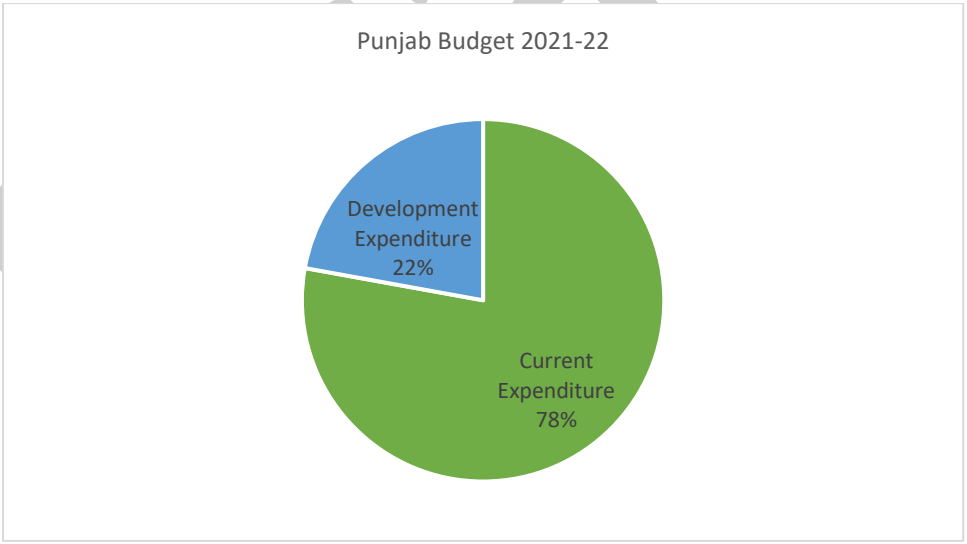
Punjab Budget - Allocation and Expenditure According to Different Levels of Health Care (PKR – In Million)

		2016	2017	2018
Primary	Original Budget	12,326.671	22,442.868	31,979.022
	Actual Expenditure	6,017.896	22,869.452	27,275.068
Secondary	Original Budget	7,522.502	15,535.903	34,347.975
	Actual Expenditure	5,127.562	15,950.520	25,363.576
Admin	Original Budget	10,020.489	16,362.810	25,166.806
	Actual Expenditure	4,262.774	15,628.070	23,418.186





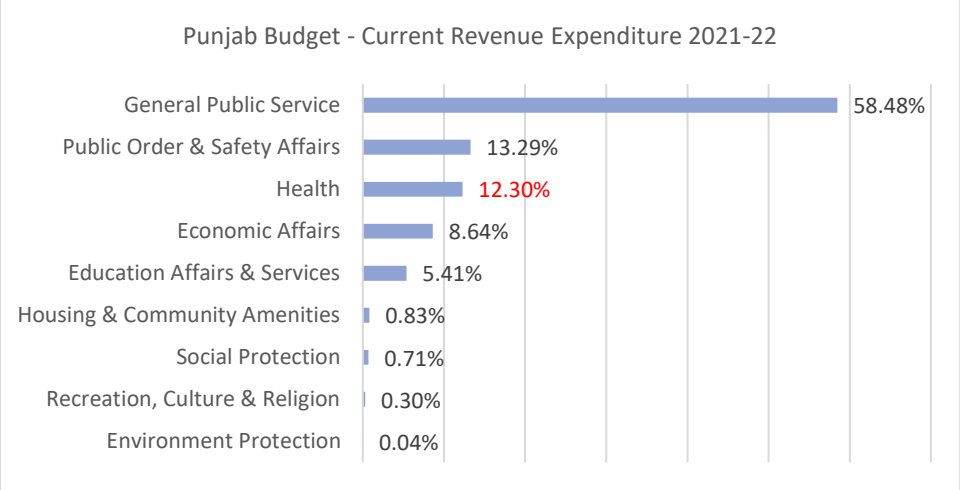
Total expenditure for the year 2021-22 is estimated at PKR 2,528 billion; 11.9 percent higher than last year's PKR 2,259 billion, with the current expenditure comprising 78% of the total budget. For 2021-22, the budget allocated to the health sector is PKR 175.6 billion, and has increased by 14.5% or 22,191 million rupees in real terms compared to the previous year. Moreover, the health budget is 12.3% of the current revenue expenditure, and 15.1% of the development expenditure.



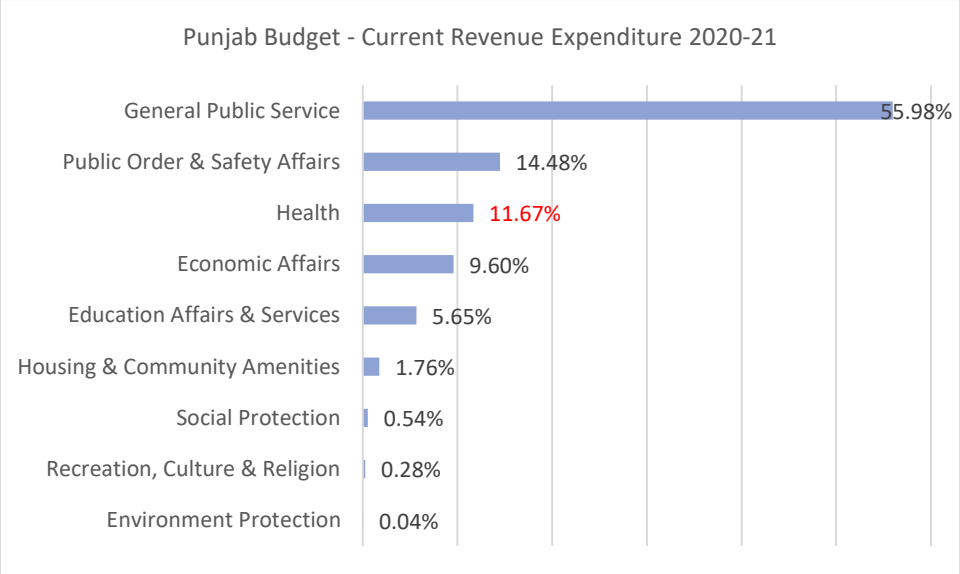
Source: Annual Budget Statement

Punjab Budget – Breakdown of Current Revenue Expenditure		
	2021-22	**2020-21**
Current Revenue Expenditure (PKR In Million)	**1,427,900.27**	**1,314,906.74**
General Public Service	835,089.98	736,043.95
Public Order & Safety Affairs	189,716.03	190,437.53
Economic Affairs	123,408.02	126,187.41
Environment Protection	517.415	537.738

Housing & Community Amenities	11,909.07	23,165.79
Health	**175,646.81**	**153,455.99**
Recreation, Culture & Religion	4,343.02	3,624.80
Education Affairs & Services	77,183.19	74,336.40
Social Protection	10,086.75	7,117.13

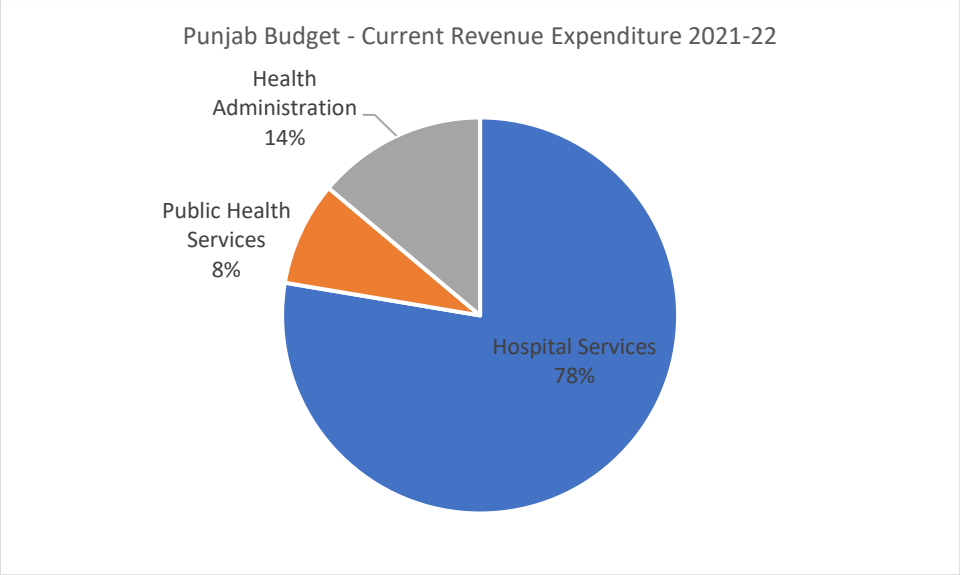


Source: Annual Budget Statement

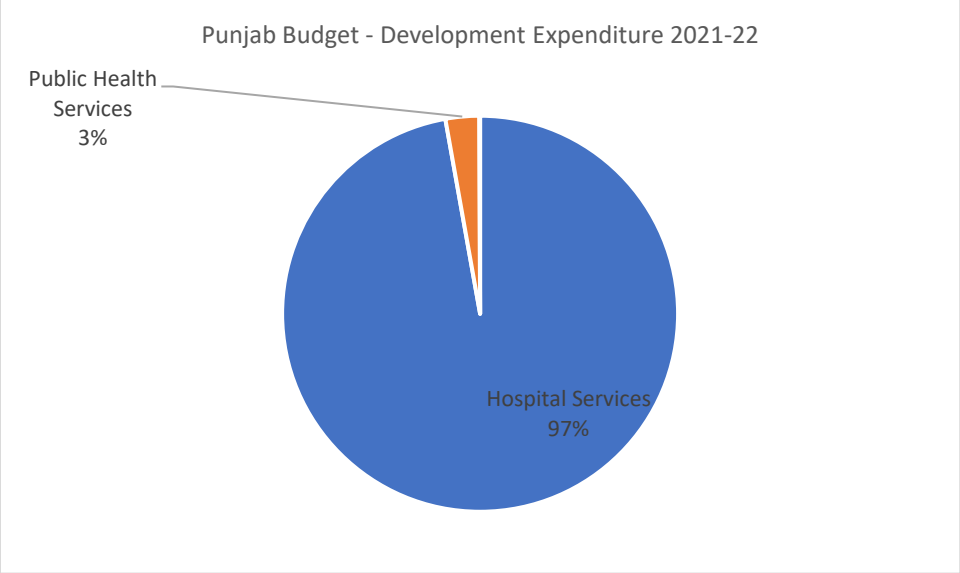


Source: Annual Budget Statement

For 2021-22, almost 78% of the current revenue expenditure is allocated to hospital services, 14% to health administration, and 8% to public health services. Compared to 2020-21, the allocations for these categories have changed only slightly. Of the development expenditures, Punjab allocates 97% to the hospital services, and 3% to the public health services.



Source: Annual Budget Statement



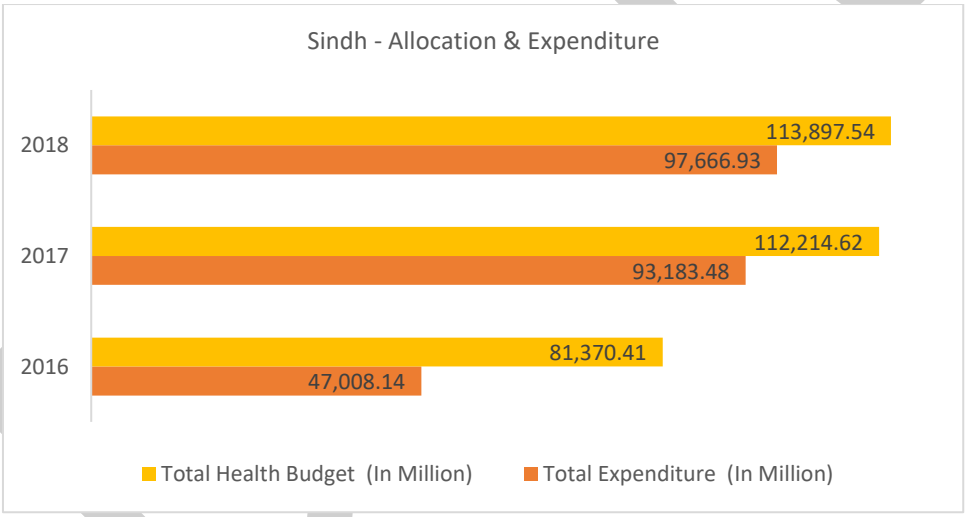
Source: Annual Budget Statement

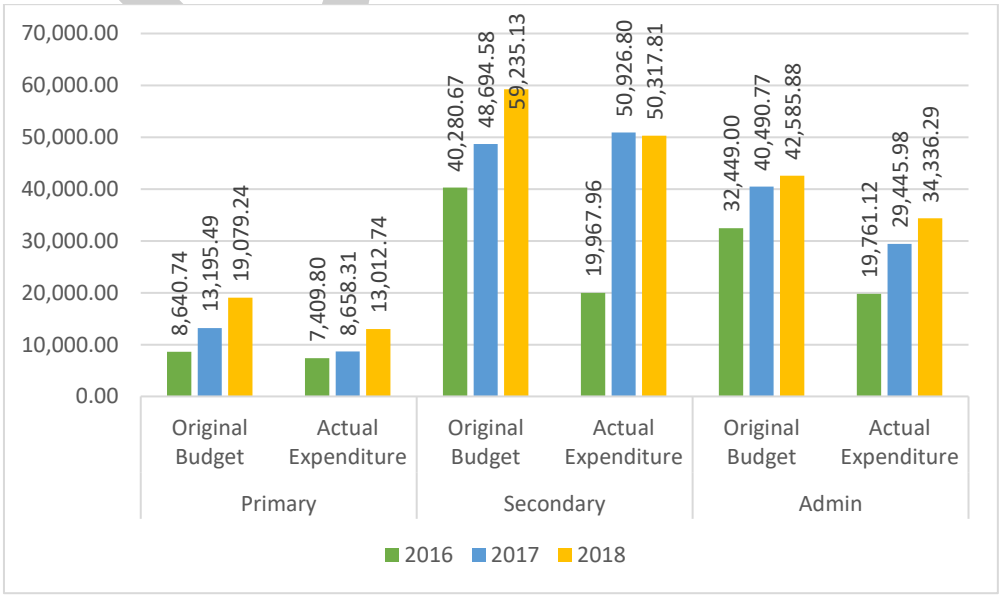
Sindh

Sindh is Pakistan's second most populated province which has also had positive results in terms of budgetary allocations for health. The amount of health spending has doubled and increased from PKR 47 billion in 2016 to PKR 97.67 billion in 2018, with a spending per capita of PKR 2,149. However, unlike Punjab, more priority is given to secondary care and health administration in terms of expenditures. Moreover, like ICT and other provinces, there is a gap between allocation and expenditure, as shown in the tables and graphs below.

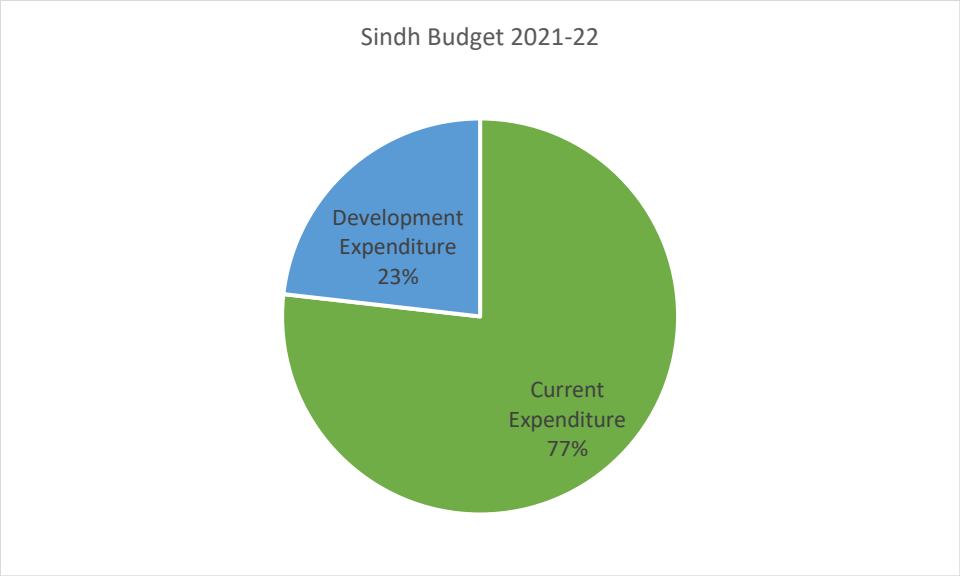
Sindh Budget – Allocation and Expenditure						
Year	**Population (In Million)**	**Total Health Budget (In Million)**	**Total Expenditure (In Million)**	**Percentage Change in Budget**	**Utilization**	**Expenditure per Capita**
2016	44.152	81,370.405	47,008.142		58%	1,065
2017	44.829	112,214.615	93,183.483	38%	83%	2,079
2018	45.452	113,897.544	97,666.927	1%	86%	2,149

Sindh Budget – Allocation and Expenditure According to Different Levels of Health Care (PKR – In Million)				
		2016	**2017**	**2018**
Primary	Original Budget	8,640.736	13,195.485	19,079.242
	Actual Expenditure	7,409.796	8,658.314	13,012.741
Secondary	Original Budget	40,280.667	48,694.580	59,235.129
	Actual Expenditure	19,967.956	50,926.802	50,317.805
Admin	Original Budget	32,449.002	40,490.772	42,585.882
	Actual Expenditure	19,761.118	29,445.979	34,336.290



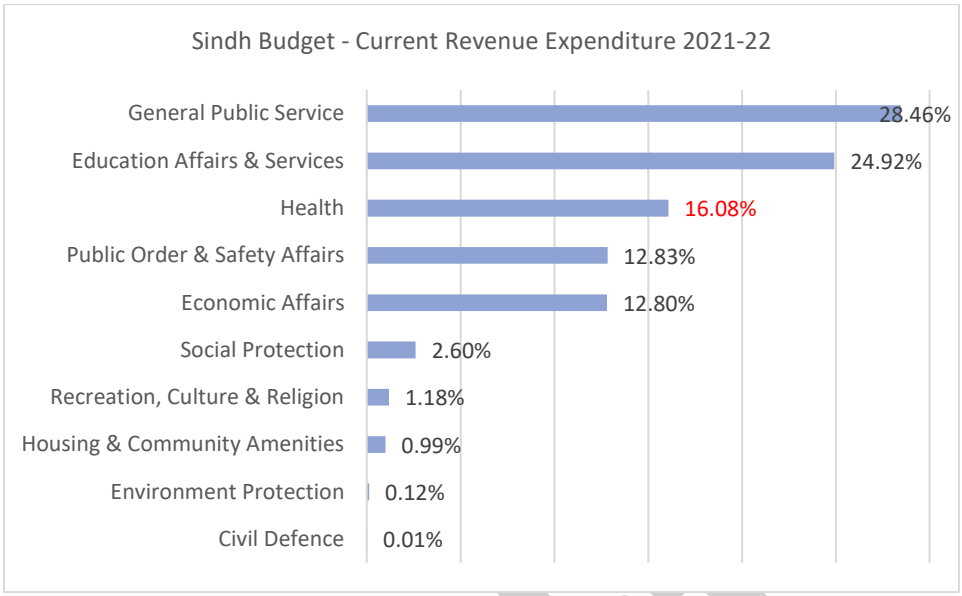


Total expenditure for the year 2021-22 is estimated at PKR 1,418 billion; almost 27 percent higher than last year's PKR 1,115 billion. Compared to 2020-21, the allocation for current expenditure has increased by 14%, development expenditure budget has more than doubled and increased by 105%, leading to an overall increase of 27.2% in the total budget. In addition, the current expenditure is 77% of total budget. For 2021-22, the total budget allocated to the health sector is PKR 175.2 billion, and has increased by 11.4% or 17,919 million rupees in real terms compared to the previous year. Furthermore, the health budget is 16.1% of the current revenue expenditure, and 6.5% of the development expenditure.

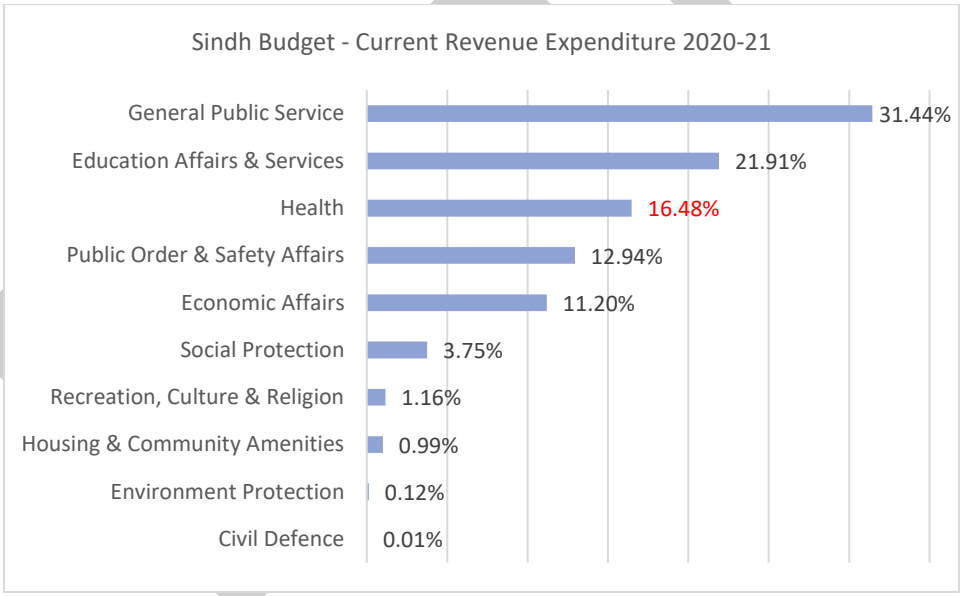


Source: Annual Budget Statement

Sindh Budget – Breakdown of Current Revenue Expenditure		
	2021-22	**2020-21**
Current Revenue Expenditure (PKR In Million)	**1,089,372.26**	**954,424.04**
General Public Service	310,055.19	300,110.30
Civil Defence	137.851	96.306
Public Order & Safety Affairs	139,777.38	123,490.06
Economic Affairs	139,430.11	106,856.00
Environment Protection	1,351.27	1,158.96
Housing & Community Amenities	10,832.81	9,494.12
Health	**175,176.30**	**157,257.30**
Recreation, Culture & Religion	12,859.26	11,073.26
Education Affairs & Services	271,438.77	209,067.21
Social Protection	28,313.32	35,820.54

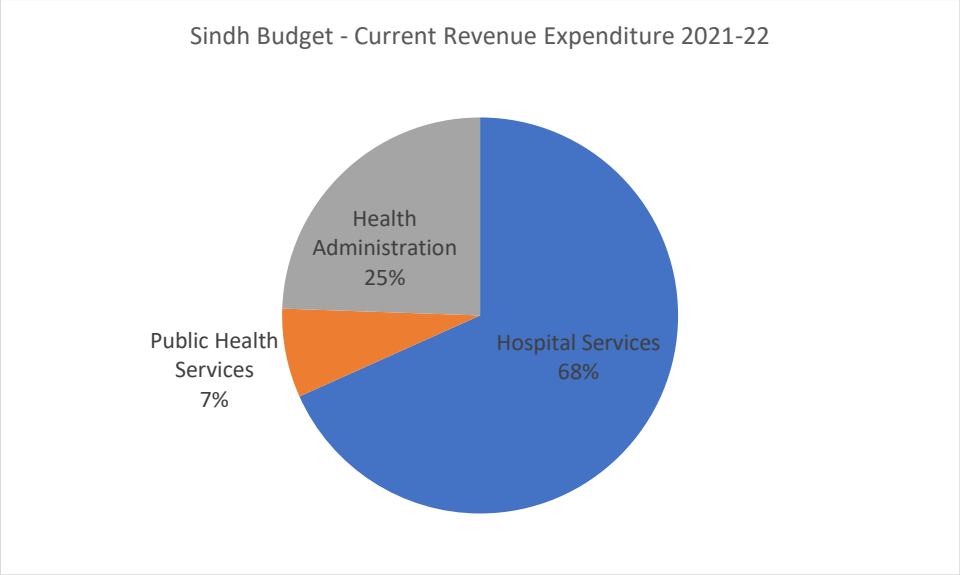


Source: Annual Budget Statement

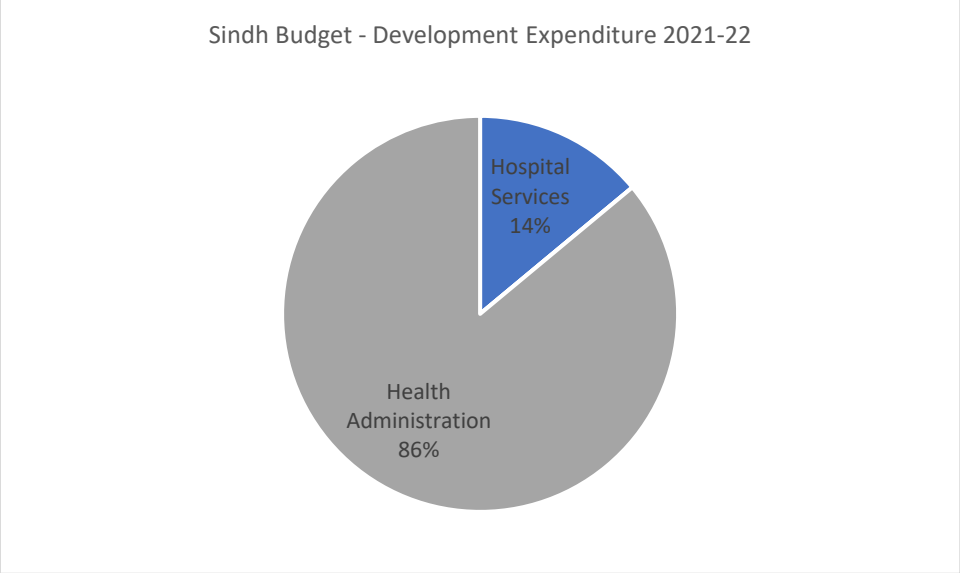


Source: Annual Budget Statement

In 2020-21, 72% of the current revenue expenditure was allocated to hospital services, 20% to health administration, and 8% to public health services. In 2021-22, although the health budget increased in real terms, the share of total health budget allocated to hospital services decreased to 68%, the share of health budget allocated to health administration increased to 25%, and the share of health budget allocated to public health services decreased to 7%. Of the development expenditures, 86% is allocated for health administration and 14% for hospital services.



Source: Annual Budget Statement



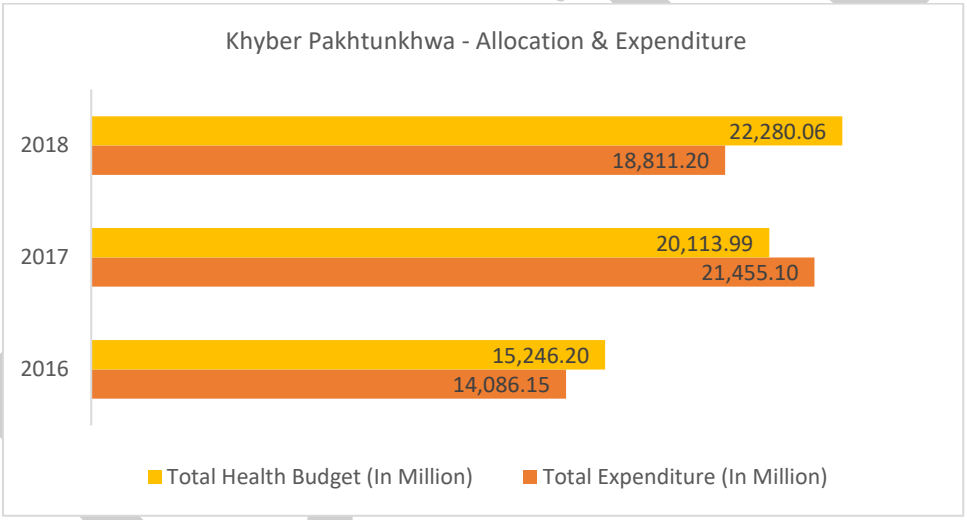
Source: Annual Budget Statement

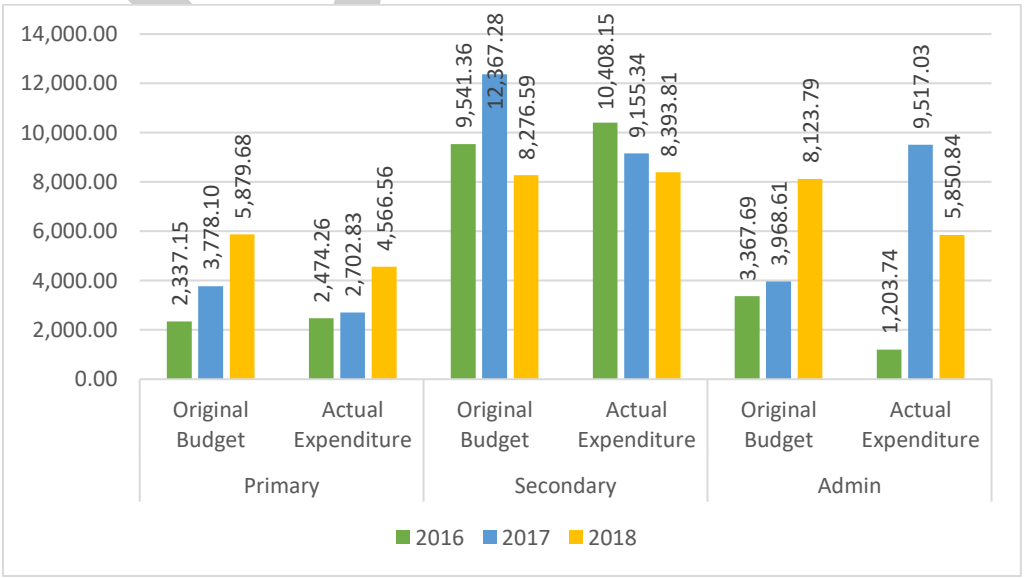
Khyber Pakhtunkhwa

Budgetary allocations to health care have shown an increasing trend for KP, with a slight dip in 2018. The amount spent on the health sector increased from PKR 14.09 billion in 2016 to PKR 21.46 billion in 2017, and decreased to PKR 18.81 billion in 2018, with a per capita spending of PKR 601. Much like Sindh, more priority is given to secondary care and health administration in terms of expenditures, with a difference between health allocation and expenditure. This is illustrated in the graphs below.

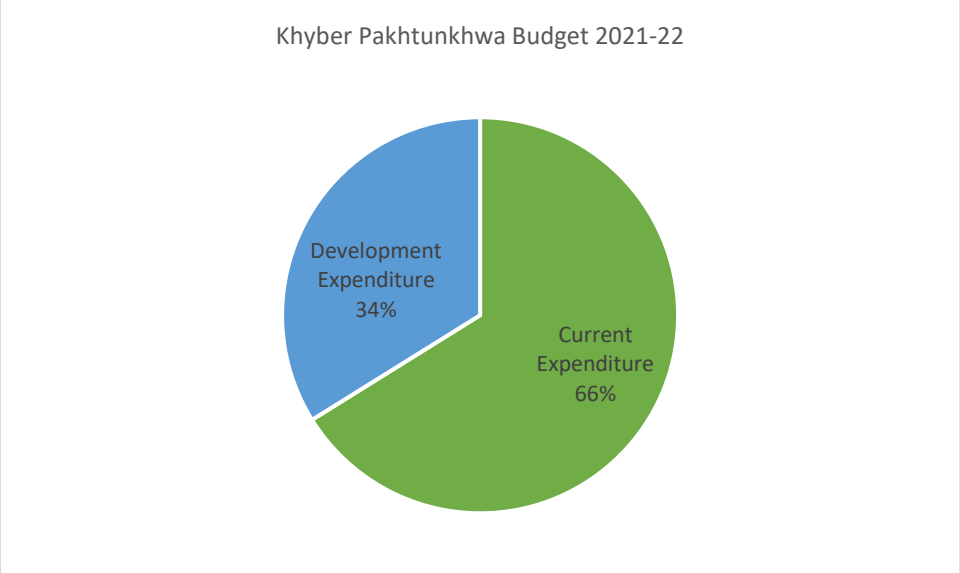
Khyber Pakhtunkhwa Budget – Allocation and Expenditure						
Year	**Population (In Million)**	**Total Health Budget (In Million)**	**Total Expenditure (In Million)**	**Percentage Change in Budget**	**Utilization**	**Expenditure per Capita**
2016	29.631	15,246.204	14,086.145		92%	475
2017	30.509	20,113.990	21,455.097	31.93%	107%	703
2018	31.300	22,280.058	18,811.202	10.77%	84%	601

Khyber Pakhtunkhwa Budget – Allocation and Expenditure According to Different Levels of Health Care (PKR – In Million)				
		2016	**2017**	**2018**
Primary	Original Budget	2,337.148	3,778.102	5,879.680
	Actual Expenditure	2,474.262	2,702.834	4,566.556
Secondary	Original Budget	9,541.364	12,367.281	8,276.588
	Actual Expenditure	10,408.145	9,155.336	8,393.806
Admin	Original Budget	3,367.692	3,968.607	8,123.790
	Actual Expenditure	1,203.737	9,517.031	5,850.840



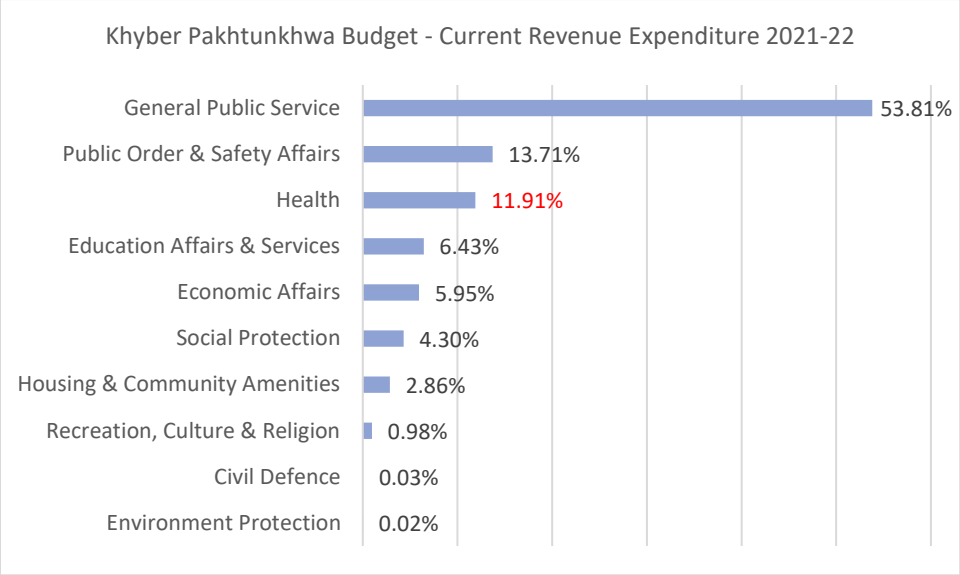


Total expenditure for the year 2021-22 is estimated at PKR 1,096 billion; almost 26 percent higher than last year's PKR 869 billion. In addition, the re-current expenditure is 66% of total budget. For 2021-22, the total budget allocated to the health sector is PKR 86.3 billion, and has increased by 47.6% or 27,850 million rupees in real terms compared to the previous year. The health budget is 11.9% of current revenue expenditure, and 6.1% of the development expenditure.

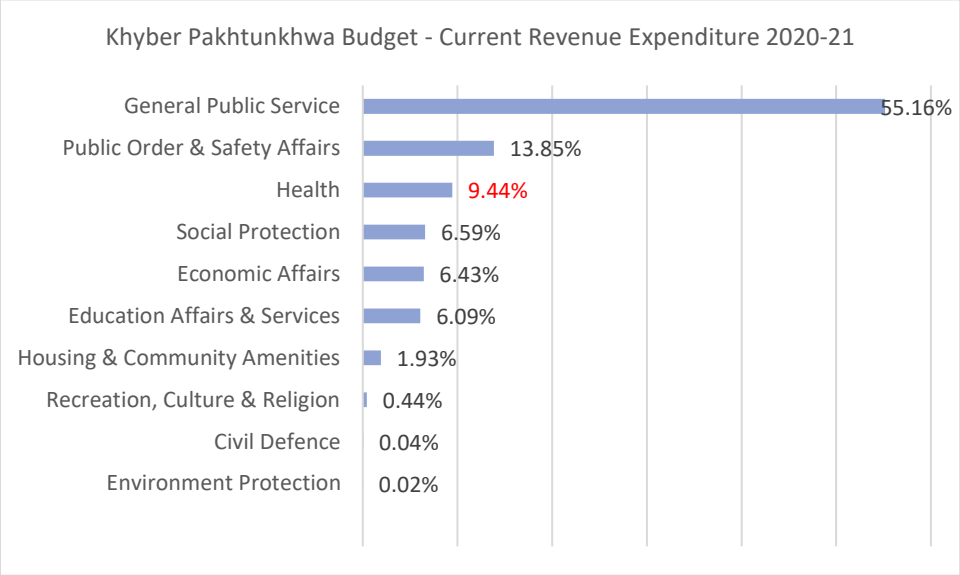


Source: Annual Budget Statement

Khyber Pakhtunkhwa Budget – Breakdown of Current Revenue Expenditure		
	2021-22	**2020-21**
Current Revenue Expenditure (PKR In Million)	**724,934.336**	**619,345.098**
General Public Service	390,070.163	341,615.220
Civil Defence	249.469	268.250
Public Order & Safety Affairs	99,396.211	85,800.180
Economic Affairs	43,122.509	39,849.143
Environment Protection	152.258	135.576
Housing & Community Amenities	20,721.579	11,966.793
Health	**86,306.402**	**58,455.760**
Recreation, Culture & Religion	7,082.976	2,752.130
Education Affairs & Services	46,628.908	37,709.698
Social Protection	31,203.861	40,792.348

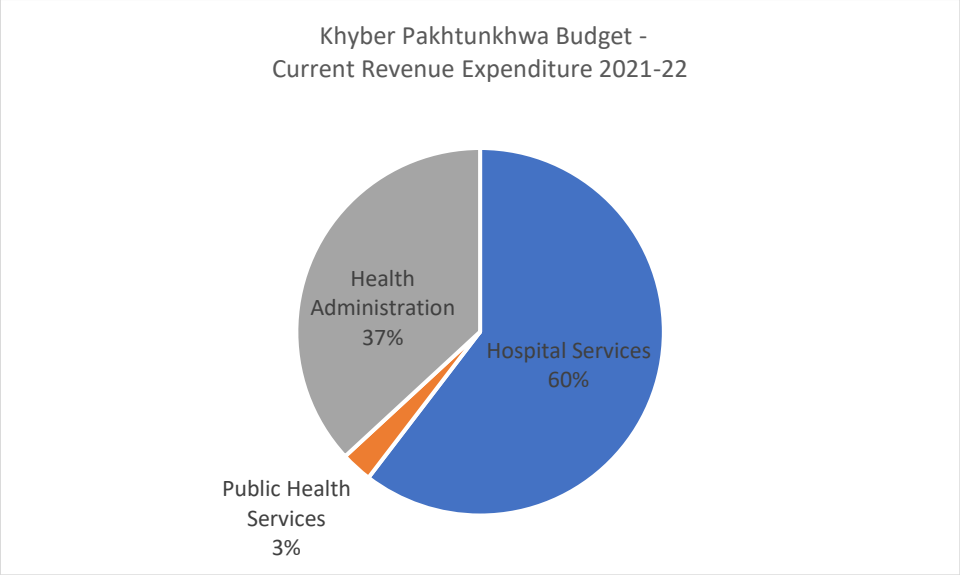


Source: Annual Budget Statement



Source: Annual Budget Statement

In 2020-21, 78% of the current revenue expenditure was allocated to hospital services, 21% to health administration, and 1% to public health services. In 2021-22, although the health budget increased in real terms, the share of current revenue expenditure allocated to hospital services decreased to 60%, the share of allocated to health administration increased to 37%, and the share allocated to public health services increased to 3%. Of the development expenditures, 64% is allocated for hospital services, 28% for public health services and 8% for health administration.



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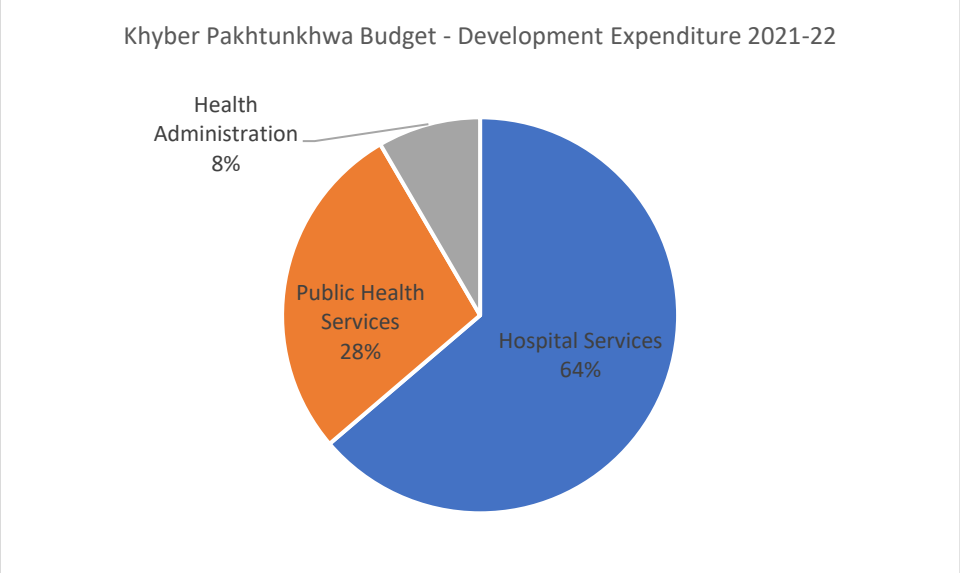


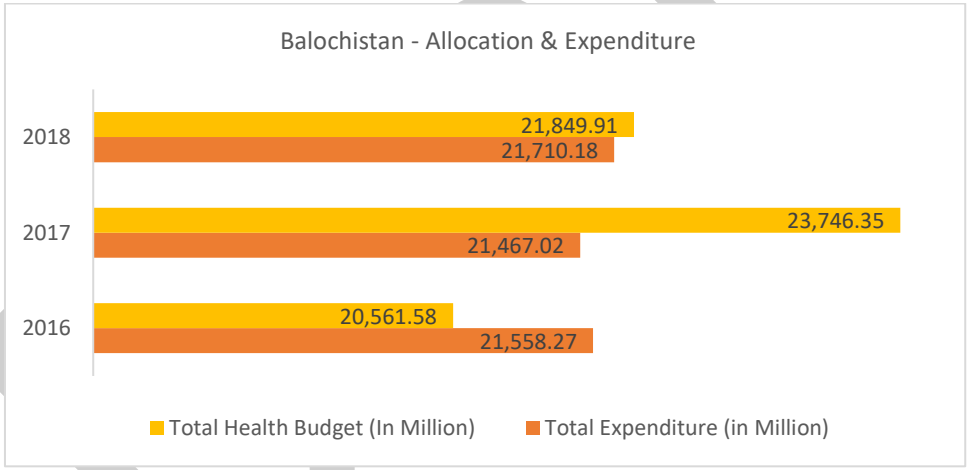
Source: Annual Budget Statement

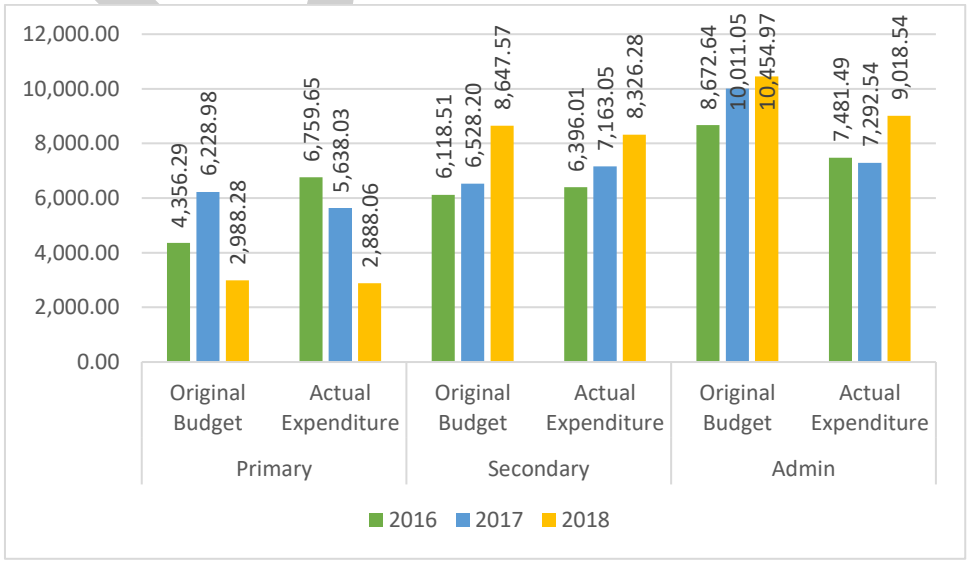
Balochistan

Balochistan is Pakistan's least developed province, with the lowest population of 12.7 million. Its overall spending on health has increased from 2016 to 2018, but not significantly. However, due to the relatively low population, the spending per capita is high, i.e., PKR 1,706. Like other provinces, with the exception of Punjab, secondary care and health administration received the greatest share of the health expenditure. Moreover, there is a discrepancy between allocation and expenditure for the health sector, which is shown in the tables and graphs below.

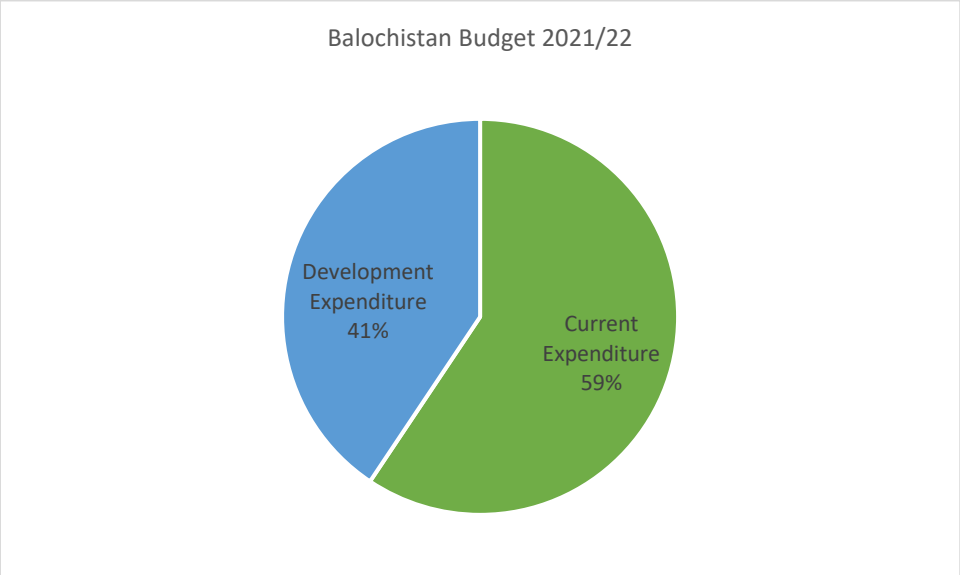
Balochistan Budget – Allocation and Expenditure						
Year	**Population (In Million)**	**Total Health Budget (In Million)**	**Total Expenditure (in Million)**	**Percentage Change in Budget**	**Utilization**	**Expenditure per Capita**
2016	11.823	20,561.580	21,558.274		105%	1,823
2017	12.262	23,746.352	21,467.016	-0.4%	90%	1,751
2018	12.725	21,849.906	21,710.178	1.1%	99%	1,706

Balochistan Budget – Allocation and Expenditure According to Different Levels of Health Care (PKR – In Million)				
	Year	**2016**	**2017**	**2018**
Primary	Original Budget	4,356.289	6,228.979	2,988.277
	Actual Expenditure	6,759.654	5,638.026	2,888.058
Secondary	Original Budget	6,118.508	6,528.197	8,647.574
	Actual Expenditure	6,396.005	7,163.052	8,326.283
Admin	Original Budget	8,672.644	10,011.052	10,454.969
	Actual Expenditure	7,481.485	7,292.535	9,018.542



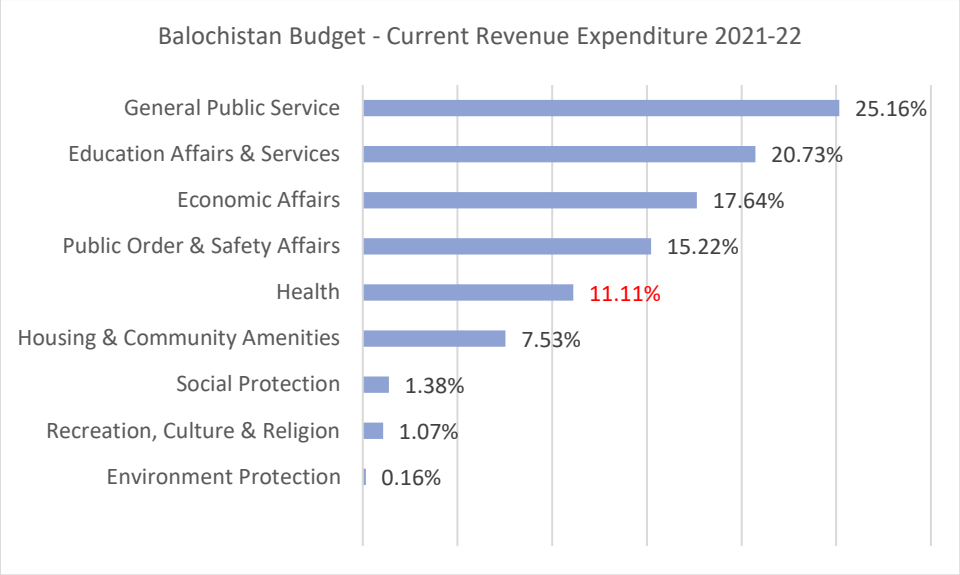


Total expenditure for the year is estimated at PKR 584 billion; almost 51 percent higher than last year's PKR 387 billion. Compared to 2020-21, the current expenditure has increased by 22.8%, development expenditure by 126.7%, leading to an overall increase of 50.9% in the total expenditure. In addition, the current expenditure is 59.4% of total budget. For 2021-22, the total budget allocated to the health sector is PKR 38.5 billion, and has increased by 31% or 9,116 million rupees in real terms compared to the previous year. The health budget as share of current revenue expenditure is 11.1%, and 6.4% of the development expenditure.

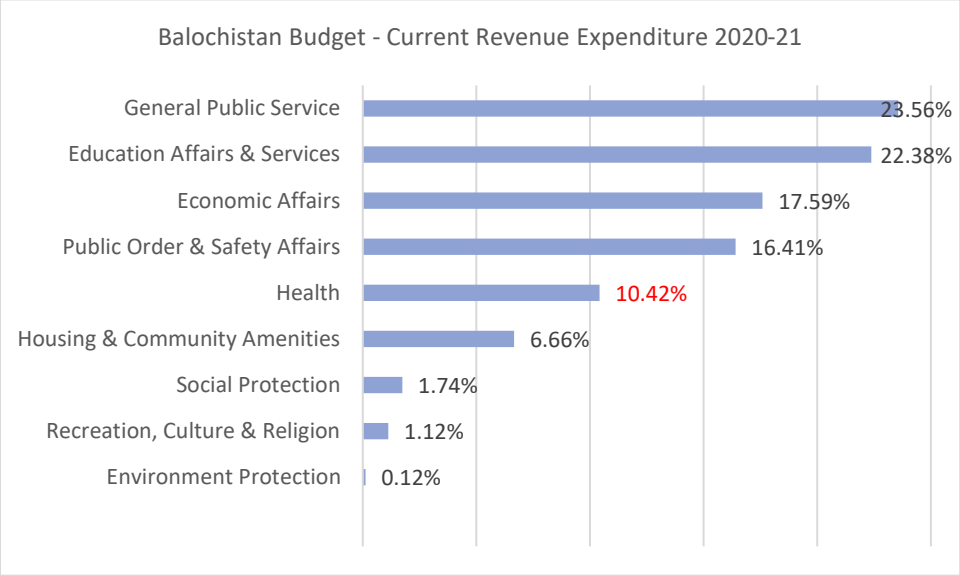


Source: Annual Budget Statement

Balochistan Budget – Breakdown of Current Revenue Expenditure		
	2021-22	**2020-21**
Current Revenue Expenditure (PKR In Million)	**346,861.70**	**282,370.82**
General Public Service	87,281.05	66,532.96
Public Order & Safety Affairs	52,789.28	46,323.30
Economic Affairs	61,180.53	49,669.20
Environment Protection	538.47	334.115
Housing & Community Amenities	26,131.68	18,807.44
Health	**38,530.59**	**29,414.98**
Recreation, Culture & Religion	3,718.84	3,173.75
Education Affairs & Services	71,903.67	63,199.72
Social Protection	4,787.60	4,915.37

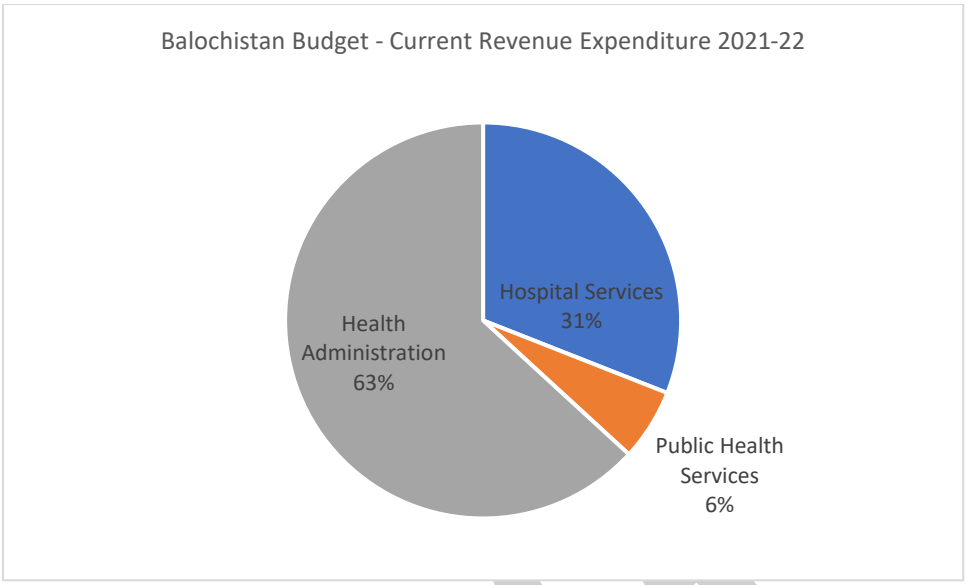


Source: Annual Budget Statement

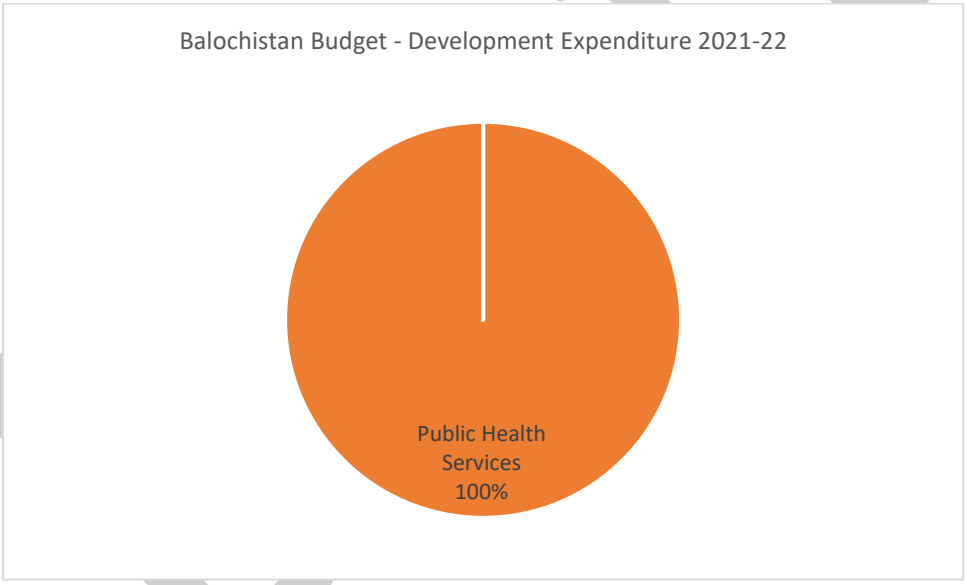


Source: Annual Budget Statement

In 2020-21, 52% of the current revenue expenditure was allocated to health administration, 41% to hospital services, and 7% to public health services. In 2021-22, although the health budget increased in real terms, the share of current revenue expenditure allocated to health administration increased to 63%, the share of allocated to hospital services decreased to 31%, and the share allocated to public health services decreased to 6%. However, all of the development expenditures are allocated for public health services.



Source: Annual Budget Statement



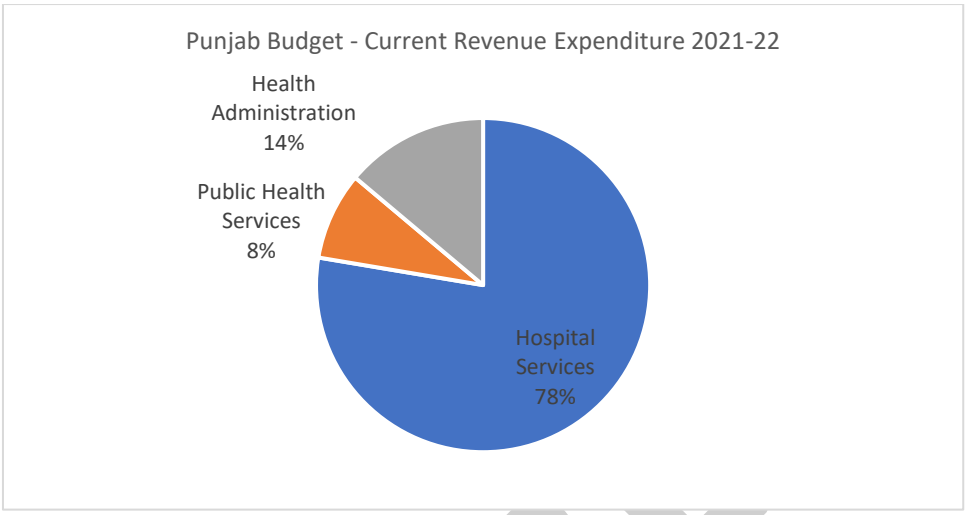
Source: Annual Budget Statement

Budget Allocation by Functions/Purpose at the Provincial Level

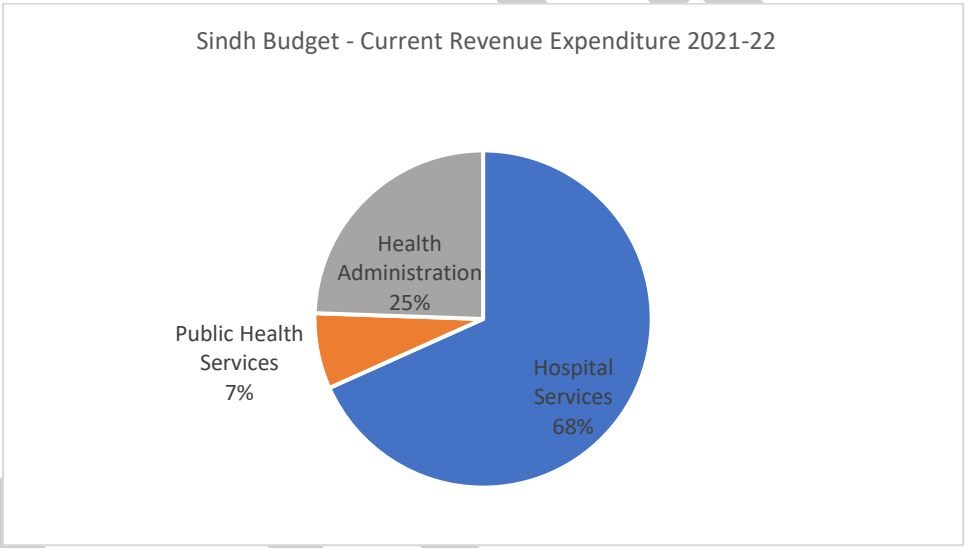
Health care budget can be broadly categorized into hospital services, public health services and health administration. Hospital services include but are not confined to general hospital services; special hospital services; nursing and convalescent care; medical and maternity centers; outpatient care; medical products, appliances, and equipment.

A disaggregation of budget allocations by purpose shows a concerning trend, whereby a disproportionately higher allocation has been reserved for hospital expenses, a significant proportion is devoted to health administration, and public health services have the least share of budget allocation. Punjab has the highest allocation of current expenditures for health, and devotes 78% of its total budget on hospital services, while Sindh and KP allocate 68 and 60% respectively. Balochistan has the lowest allocation for current health expenditures, and apportions only 31% for hospital services. The health administration allocations are lowest for Punjab (14%) and are the highest for Balochistan (63%). Sindh and KP assign 25% and 37% respectively on health administration costs. Public health services have been given the least priority in budget and allocation ranges from 3% in Khyber Pakhtunkhwa to 8% in Punjab. **Overall, Punjab has the most efficient distribution of resources, with more focus on hospital and public health services.**

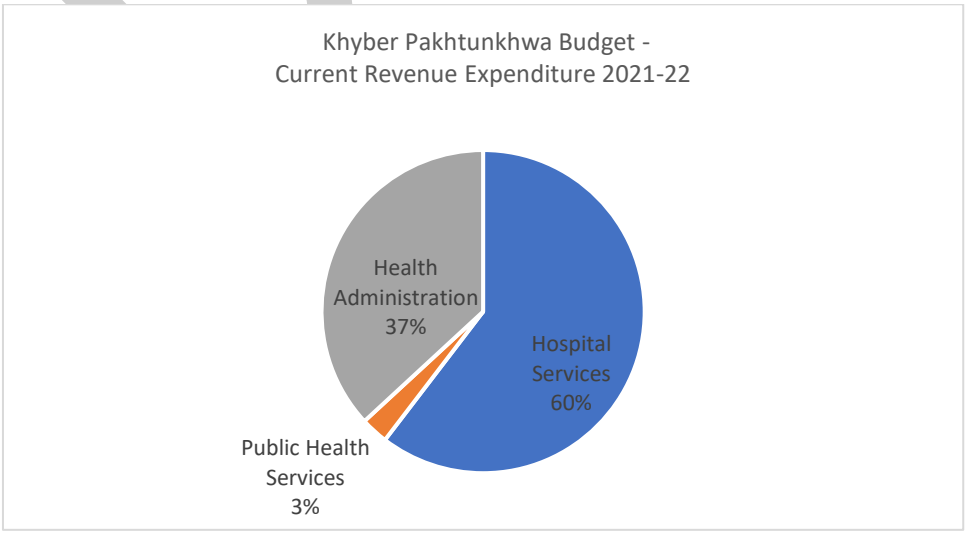
Budget (Current Revenue Expenditure) Allocation by Functions/Purpose at the Provincial Level (PKR – In Million)			
	Accounts 2019-20	**Revised Budget Estimate 2020-21**	**Budget Estimate 2021-22**
Sindh			
Hospital Services	84,648.328	113,885.856	119,628.499
Public Health Services	5,779.878	11,962.437	12,724.210
Health Administration	21,305.833	31,409.002	42,823.586
Total Health Current Expenditure	**111,734.039**	**157,257.295**	**175,176.295**
Balochistan			
Hospital Services	9,350.017	12,128.400	11,901.899
Public Health Services	886.267	1,892.724	2,247.996
Health Administration	11,735.600	15,393.852	24,380.695
Total Health Current Expenditure	**21,971.884**	**29,414.976**	**38,530.590**
Khyber Pakhtunkhwa			
Hospital Services	29,852.197	45,430.435	52,124.474
Public Health Services	45.751	879.714	2,368.299
Health Administration	5,641.875	12,145.611	31,813.629
Total Health Current Expenditure	**35,539.823**	**58,455.760**	**86,306.402**
Punjab			
Hospital Services	113,440.253	118,476.957	136,384.098
Public Health Services	4,829.148	11,930.082	14,900.318
Health Administration	20,910.792	23,048.950	24,362.390
Total Health Current Expenditure	**139,180.193**	**153,455.989**	**175,646.806**



Source: Annual Budget Statement



Source: Annual Budget Statement



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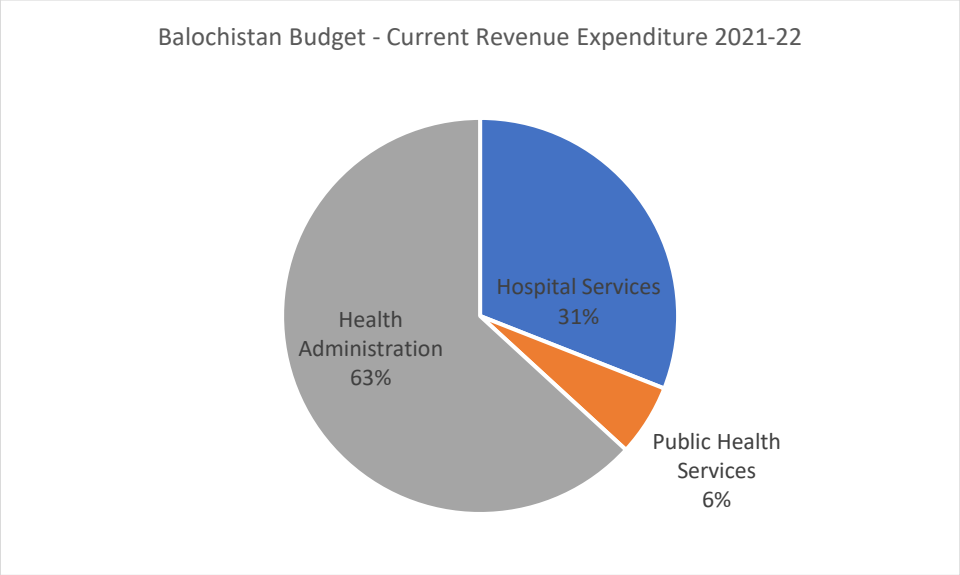
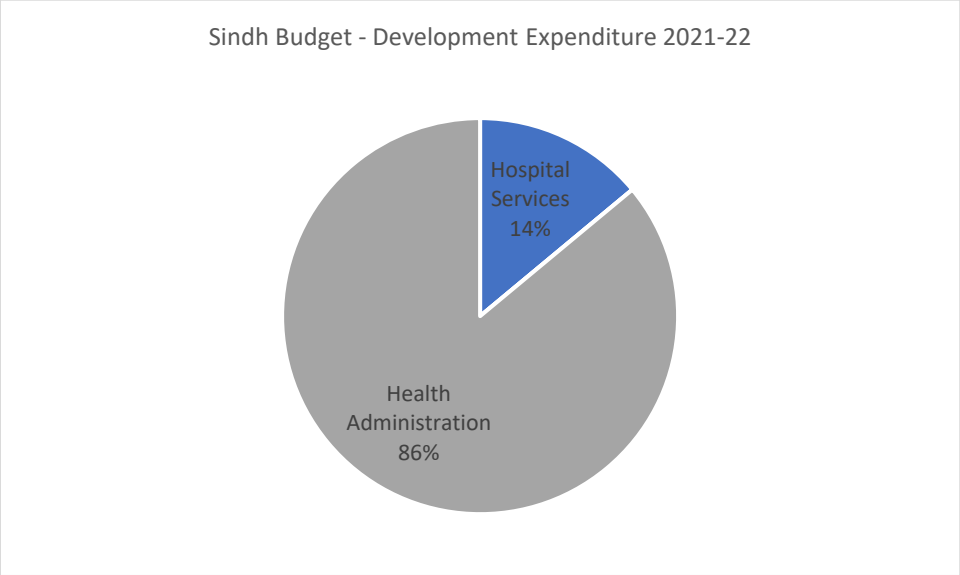


Source: Annual Budget Statement

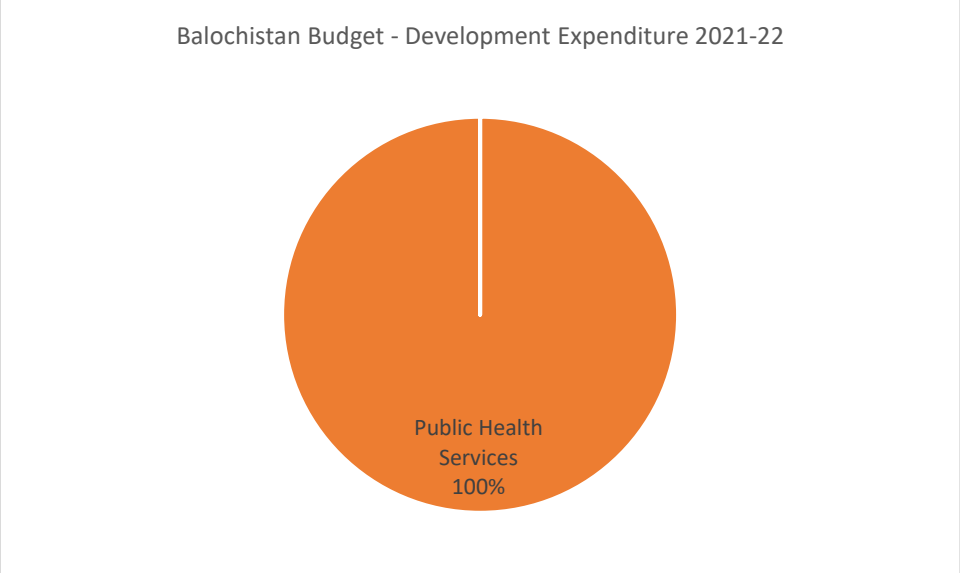
Analysis of the development expenditure shows a varied and an alarming trend. Allocation to the health sector as a share of total development expenditure is highest for Punjab (15.1%), and is roughly the same for other three provinces (6.1% in KP, 6.4% in Balochistan, and 6.5% in Sindh). Punjab has the highest allowance of development expenditure for hospital services (97%), while KP and Sindh assign 64% and 14% respectively. There is no allocation for hospital services in the development expenditure for Balochistan. The health administration expenditures as a percentage of total development expenditures is 86% in Sindh and 8% in KP. There is no share for administration costs in the development expenditure for Punjab and Balochistan. The allotment for public health services is 3% in Punjab and 28% in KP. Balochistan allocates all, while Sindh allocates none of the development expenditure for the public health services.

Budget (Development Expenditure) Allocation by Functions/Purpose at the Provincial Level (PKR – In Million)			
	Accounts 2019-20	**Revised Budget Estimate 2020-21**	**Budget Estimate 2021-22**
Sindh			
Hospital Services	100.000	1,100.000	2,973.998
Public Health Services	-	70.449	-
Health Administration	6,896.647	10,870.383	18,319.082
Total Health Development Expenditure	**6,996.647**	**12,040.832**	**21,293.080**
Balochistan			
Hospital Services	-	-	-
Public Health Services	-	7,212.887	15,292.005
Health Administration	-	-	-
Total Health Development Expenditure	**-**	**7,212.887**	**15,292.005**
Khyber Pakhtunkhwa			
Hospital Services	3,074.514	9,438.986	14,486.906
Public Health Services	6,020.192	6,556.578	6,325.359

Health Administration	-	34.971	1,911.028
Total Health Development Expenditure	**9,094.706**	**16,030.535**	**22,723.293**
Punjab			
Hospital Services	24,610.471	55,670.989	81,959.614
Public Health Services	1,186.295	2,579.154	2,322.452
Health Administration	47.272	68.277	50.000
Total Health Development Expenditure	**25,844.038**	**58,318.420**	**84,332.066**



Source: Annual Budget Statement



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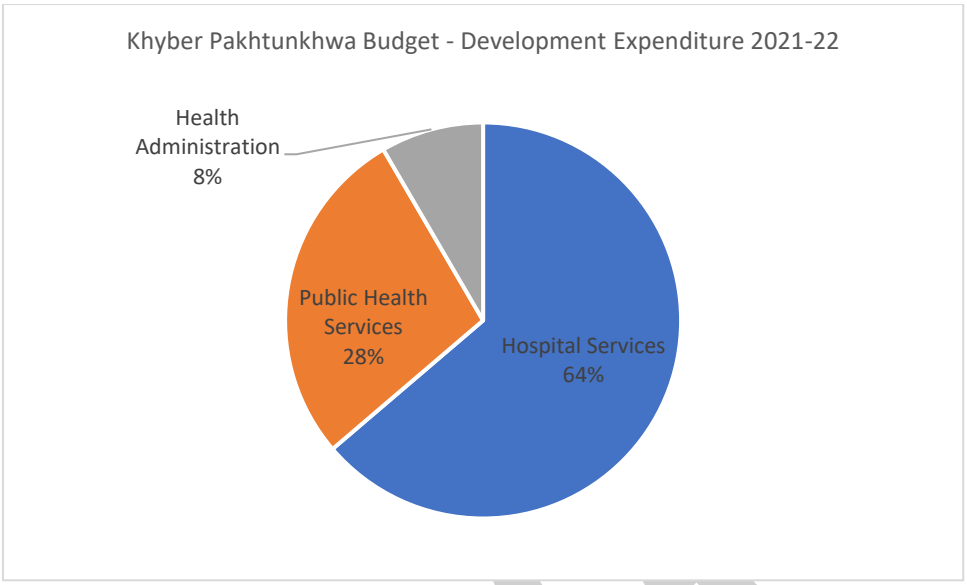

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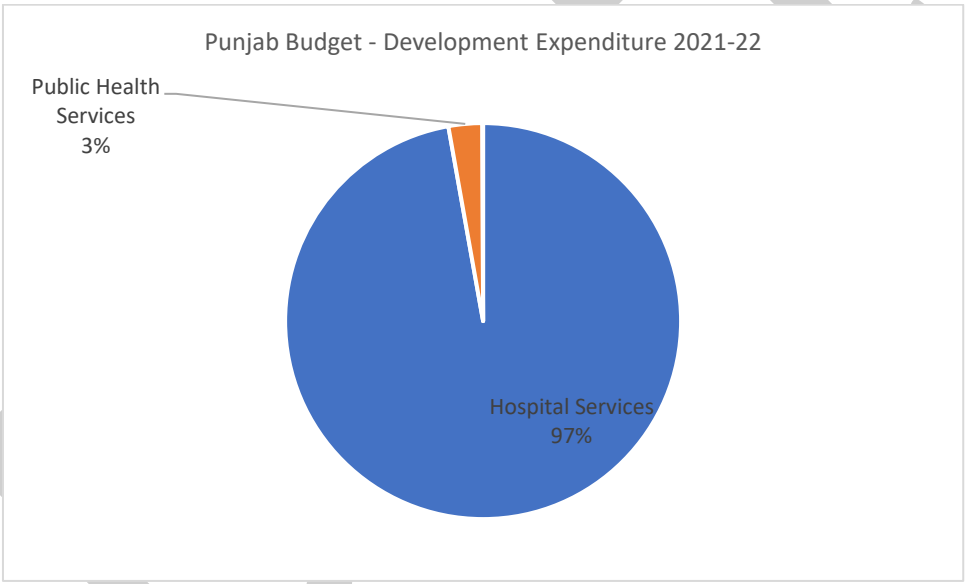


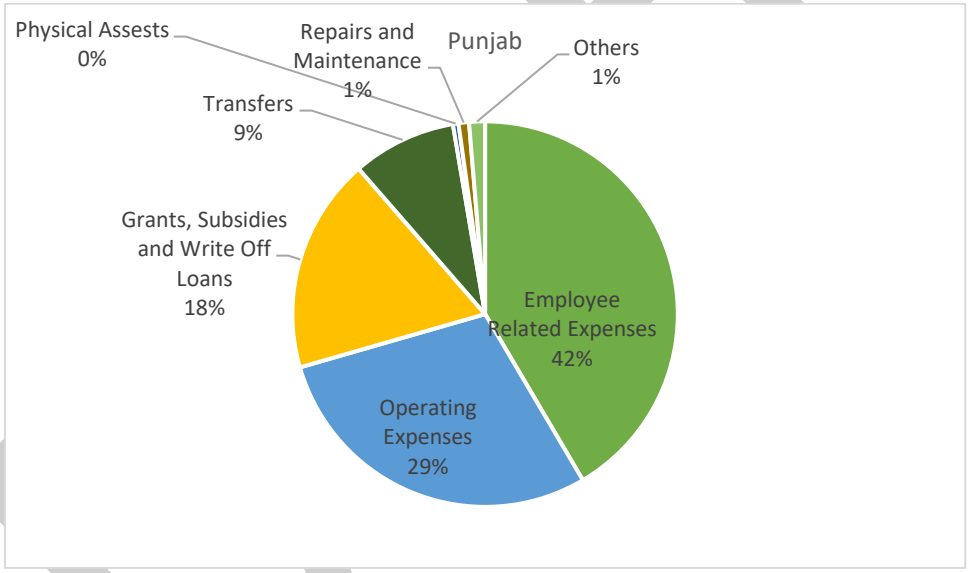
Source: Annual Budget Statement

Budget Allocation by Inputs at the Provincial Level

While the overall increased spending on health is promising, the budget allocations are disproportionally made for different components of health expenditure (like, employee related expenses), which can have negative consequences on the equity and efficiency of health spending. For Balochistan, the share of employee related expenses is 66% of the current revenue expenditure. Punjab and Sindh allocate 42% of the current revenue expenditure on the salaries (42%). Employee related expenses are much lower for Khyber Pakhtunkhwa (15%). The next largest portion of budget allocation are operating expenses which range from 18% to 29% across the different provinces. The transfers component shows the greatest variation, ranging from 0% in Balochistan to 60% in Khyber Pakhtunkhwa.

Budget Allocation by Inputs at the Provincial Level (PKR – In Million)		
Sindh		
	Revised Budget Estimate 2020-21	**Budget Estimate 2021-22**
Employee Related Expenses	68,421.33	72,104.70
Operating Expenses	28,390.76	35,405.65
Grants, Subsidies and Write Off Loans	50,988.18	53,945.93
Transfers	3,134.85	2,376.44
Physical Assests	1,926.58	6,648.65
Repairs and Maintenance	1,419.61	1,594.68
Others		
Total Current Revenue Expenditure	**154,281.30**	**172,076.06**
Balochistan		
	Revised Budget Estimate 2020-21	**Budget Estimate 2021-22**
Employee Related Expenses	18,282.79	12,871.50
Operating Expenses	5,179.75	3,516.98
Grants, Subsidies and Write Off Loans	4,230.78	2,116.80
Transfers	238.94	13.67
Physical Assets	1,201.33	997.60
Repairs and Maintenance	281.39	84.15
Others		
Total Current Revenue Expenditure	**29,414.98**	**19,600.70**
Khyber Pakhtunkhwa		
	Revised Budget Estimate 2020-21	**Budget Estimate 2021-22**
Employee Related Expenses	11,941.37	14,127.90
Operating Expenses	18,416.43	20,794.84
Grants, Subsidies and Write Off Loans	738.61	1,893.77
Transfers	35,770.10	56,633.95
Physical Assets	248.03	336.78
Repairs and Maintenance	62.58	321.91

Others	224.92	84.92
Total Current Revenue Expenditure	**67,402.04**	**94,194.06**
Punjab		
	Revised Budget Estimate 2020-21	**Budget Estimate 2021-22**
Employee Related Expenses	52,002.37	71,290.71
Operating Expenses	53,459.71	49,805.28
Grants, Subsidies and Write Off Loans	25,415.42	31,013.28
Transfers	12,995.05	14,960.45
Physical Assets	2,281.07	798.92
Repairs and Maintenance	2,001.97	1,506.96
Others	1,074.29	2,286.75
Total Current Revenue Expenditure	**149,229.87**	**170,155.40**



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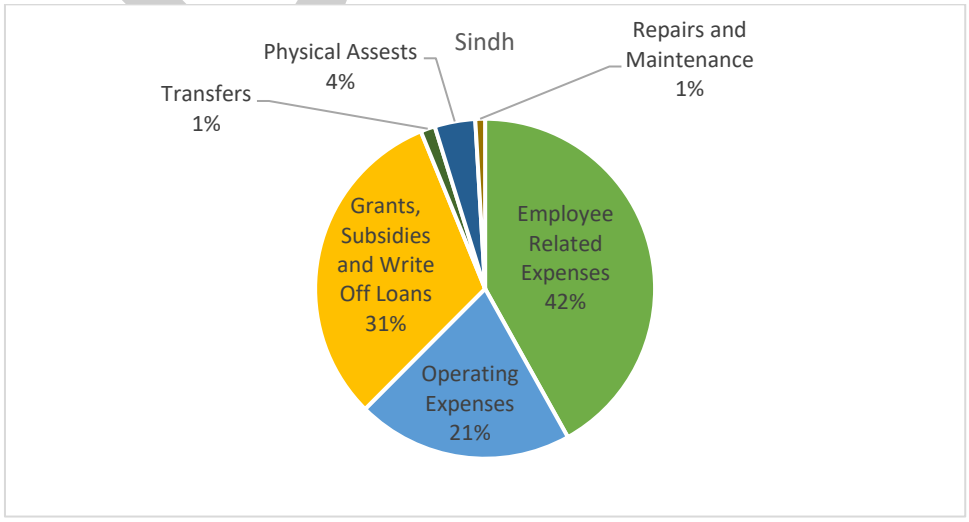

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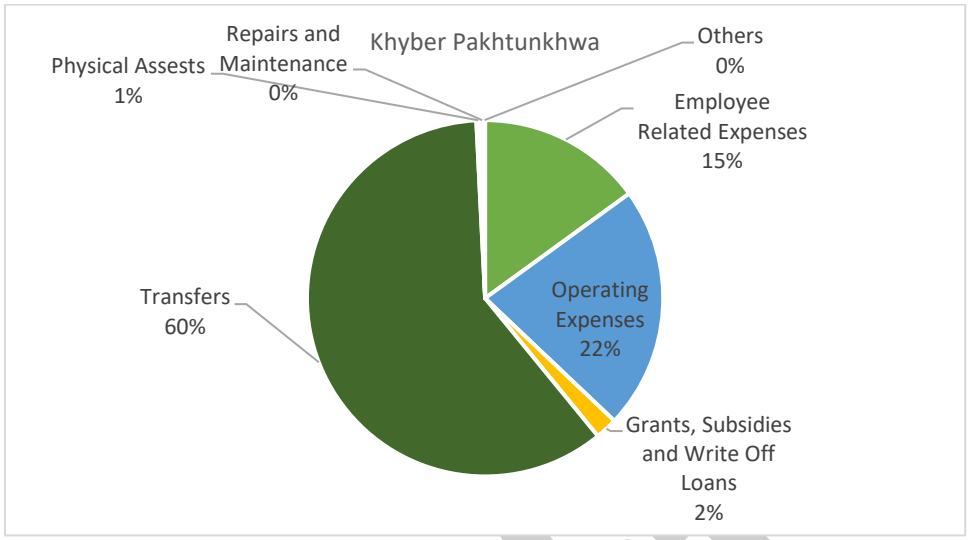

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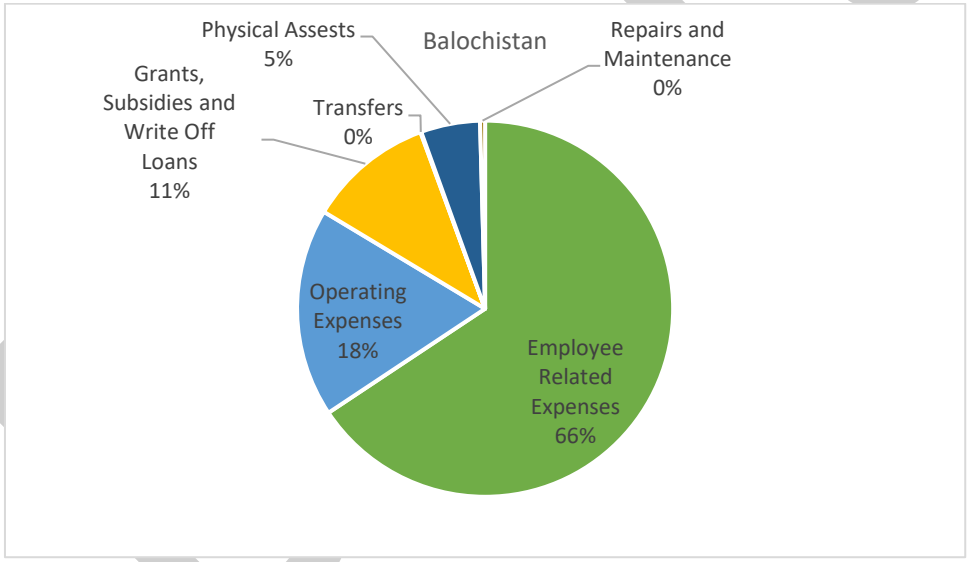

Source: Annual Budget Statement

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