Status of

HEALTH FINANCING

PAKISTAN


ایمان اتحاد نظم

MOVING TOGETHER
TO BUILD A HEALTHIER PAKISTAN

UNIVERSAL HEALTH COVERAGE

Status of

HEALTH FINANCING

PAKISTAN

December 2023

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Pakistan 2023: Status of Health Financing

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MESSAGE

The Government of Pakistan is committed to achieving the Sustainable Development Goals, particularly in ensuring the health and wellbeing of our populace. This report is not merely a collection of data; it represents our nation's enduring dedication to strengthening our health financing framework as a key driver of inclusive and sustainable economic growth.

Despite facing challenges such as the COVID-19 pandemic, natural disasters, and other emergencies, we have observed a positive shift in our health financing landscape. This report on the Status of Health Financing in Pakistan for the year 2023 is a testament to our resilience and dedication in overcoming these challenges. It highlights our progress in mobilising resources, enhancing efficiency in health expenditure, and reducing financial barriers to healthcare access.

Dr Nadeem Jan
Federal Health Minister

However, the journey does not end here. To further advance our health system, we must intensify our efforts and foster collaborative approaches. There is a need to scale up our investments in health to ensure comprehensive and equitable service coverage. It is imperative to strengthen our health financing as a way to support our citizens, enabling them to reach their full potential and fulfil their aspirations.

I reaffirm the need for stronger health systems providing cost-effective, high impact, evidence-informed, human centric, integrated health services to our people to achieve better health outcomes and to improve its quality and affordability of services to move towards Universal Health Coverage (UHC) priorities.

As we navigate through these times, let us reaffirm our pledge to invest in our nation's health, recognising it as the cornerstone of human development and national progress. Together, we can build a stronger, healthier, and more resilient Pakistan.

FOREWARD

As we progress toward the 2030 Agenda for Sustainable Development, it becomes increasingly evident that a robust health financing system is integral to creating an environment conducive to improved health and well-being. In Pakistan, the health sector's leadership is keenly focused on this aspect, recognising that effective health financing is crucial for the delivery of quality healthcare services to all.

The "Status of Health Financing - Pakistan 2023" report marks a significant step in our journey towards a more equitable and efficient health financing system. It provides a comprehensive assessment of our current strategies, highlights the progress we have made, and identifies the challenges that lie ahead. This report is instrumental in guiding our efforts to effectively allocate resources, ensuring that every Pakistani has access to essential healthcare services.

The journey toward sustainable health financing is multifaceted, requiring the mobilisation of resources, the engagement of all stakeholders, and a commitment from the society at large. The key to success lies in our collective resolve to overcome barriers and address gaps in service access. This report serves as both a mirror reflecting our status and a map guiding us towards our ultimate goal of health for all.

The Government of Pakistan is unwavering in its commitment to the Sustainable Development Goals, particularly regarding health and well-being. Through collaborative efforts, innovative financing mechanisms, and strategic investments, we are scaling up our response to meet the health needs of our population. Our ultimate aim is not just to achieve Universal Health Coverage but to create health systems that deliver for everyone, everywhere, ensuring that all Pakistanis can reach their full potential and fulfil their aspirations.

Let us collectively embark on this ambitious journey, leveraging the insights from the "Status of Health Financing - Pakistan 2023" report to build health systems that are both robust and responsive. Together, we can realise the vision of a healthier, more prosperous Pakistan.

Dr Iftikhar Ali Shallwani
Secretary Health

ACKNOWLEDGMENT

Universal Health Coverage (UHC) stands at the forefront of the Government's agenda, aligning seamlessly with the Sustainable Development Goals (SDGs) and our National Health Vision 2016-25. Progressing UHC through robust health financing is key to unlocking rapid, enduring, and inclusive growth. However, Pakistan's journey towards UHC has been only somewhat measured, primarily due to the federal and provincial governments' hesitancy in fully embracing the development of efficient health financing systems. Yet, this alignment of strategic thought among stakeholders heralds a unique opportunity to harness the economic benefits inherent in the progressive realisation of UHC.

This report aims to enlighten stakeholders about this complex topic and pave the way for systematic reforms. I am optimistic that this report will mark the beginning of formulating a Health Financing Strategy for Pakistan, anchored in the principles of equity, efficiency, transparency, accountability, effective partnerships, and evidence-based decision-making.

In the sphere of health financing, our collaboration with top leaders at the national and provincial levels, alongside ministries/ departments of finance, planning, development, health, and other stakeholders, is crucial. We must collectively address the challenges and forge a united path towards health financing reforms.

My gratitude extends to the British High Commission, Pakistan, and the Evidence for Health Programme for the invaluable support. I am thankful to Dr Sabeen Afzal for leading the task with technical support of Health Planning, System Strengthening and Information Analysis Unit (HPSIU), especially Dr Raza Zaidi, Wahaj Zulfiqar and Javeria Yousaf for producing the report and to Dr Mahwish Hayee from the OPM for quality assurance. I look forward to receiving regular updates on health financing status, utilising this knowledge to inform and shape future reform.

In closing, I earnestly hope for the successful advancement of health financing reforms within Pakistan, aiming for enhanced health outcomes for all citizens, while adeptly managing and reducing their catastrophic health expenditures.

Dr Muhammad Ahmad Kazi

Director General (Health)

EXECUTIVE SUMMARY

Pakistan is firmly committed to achieving the targets set for Universal Health Coverage (UHC) and addressing the health- and poverty-related Sustainable Development Goals (SDGs). To achieve this, it is crucial that urgent steps be taken to strengthen and strategically manage health financing within the nation. As we approach the 2030 deadline for the SDGs, a significant challenge remains: approximately half of Pakistan's population, which equates to around **117 million people, not covered for provision of essential health services** (SDG 3.8.1).[1] Moreover, in 2022, approximately **13.4 million individuals were at a risk of entering into poverty due to substantial out-of-pocket (OOP) health expenditures** - exceeding 10 percent of total household income (SDG 3.8.2).[2]

The advancement towards UHC, a principal objective of SDG 3, is critical for inclusive and sustainable economic growth. However, this goal is unattainable without Pakistan making tangible advancements in health financing[3], this encompasses ensuring funding levels that are both adequate and sustainable, achieving sufficient pooling to distribute the financial risks associated with ill-health, and ensuring spending is both efficient and equitable. It is essential to guarantee the desired levels of health service coverage, quality, and financial protection for all citizens, thereby ensuring resilience and sustainability.

The UHC financing agenda aligns perfectly with the Government of Pakistan's policies to promote sustainable, inclusive growth and mitigate potential risks to the national economy and security. Pakistan stands to benefit from the realisation of quality and efficiency improvements, liberating productive resources for health, while concurrently encouraging health security by diminishing the frequency, spread, and impacts of disease outbreaks and disasters.

Enhancing coherence among the ministries and departments of finance, planning & development, and health at the national and provincial levels and partners presents a unique opportunity for health financing reforms. It allows for the breaking down of existing silos and addressing the political economy challenges that have consistently impeded the progress of health financing for UHC.

Health Financing and Inclusive Growth

Health financing represents not merely an expenditure but a strategic investment that reaps multifaceted benefits for the economy. These benefits include:

a. Building Human Capital:	Investment in essential health services is instrumental in developing human capital, particularly during the critical early years of a child's life, setting a robust foundation for enhanced educational outcomes and increased future earning potential. Promotive, preventive, and curative health services significantly enhance worker productivity across their lifetimes, often yielding rapid impacts.
b. Enhancing Skills, Employment, and	The evolving nature of work necessitates skills such as complex problem-solving, teamwork, innovation, and self-reliance. Investment in health is a fundamental prerequisite for cultivating and sustaining these skills, thereby increasing the capacity for

1 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.1 reported
2 Federal Bureau of Statistics, 2018; Household Income and Expenditure Survey
3 International Bank for Reconstruction and Development / The World Bank, 2019; High-Performance Health Financing-Universal Health Coverage

Labour Market Dynamics:	job creation and growth. Health financing also plays a pivotal role in providing financial protection, facilitating new opportunities, and reducing the costs for private firms to expand and generate employment. Such investment leads to increased workforce formalisation and a rise in full-time employment opportunities.
c. Reducing Poverty and Inequality:	Expanding prepaid and pooled financing mechanisms to minimise out-of-pocket payments can swiftly and significantly contribute to poverty reduction. Financial protection offers additional benefits, such as obviating the need for asset liquidation or borrowing to cover health costs, thereby conserving resources for other expenditures or investments.
d. Enhancing Efficiency and Financial Discipline:	Enhancing the efficiency of resource pooling and allocation enables the expansion of both the variety and quality of guaranteed health services and offers more comprehensive financial protection, all within the limits of existing resources. This, combined with measures to enhance efficiency in resource mobilisation and utilisation through improved public financial management, ensures financial discipline in the sector, impacting public spending short and long term.
e. Stimulating Consumption and Competitiveness:	Financial protection liberates individuals from the need for precautionary savings, potentially stimulating expenditure on other goods and services. By driving efficiency gains in the health sector, health financing also releases productive resources for strategic uses, aiding the country in gaining or maintaining a competitive edge in international trade.
f. Strengthening Health Security with Investment in Emergency Preparedness and Response:	The COVID-19 pandemic and floods in 2022 have underscored the lasting economic impacts of disease outbreaks and health emergencies, which can derail development for years, if not decades. The economic shock from the pandemic resulted in negative growth for the first time in Pakistan's history. While the risks associated with Covid-19 have reduced, future pandemics may emerge from different pathogens. Investments in preparedness capabilities, including surveillance, primary and community health workers, public-health laboratory networks, and information systems, are crucial for the early detection and mitigation of infectious disease outbreaks. Beyond saving lives, such proactive investments help avert macro-economic shocks and mitigate the costs associated with emergency response efforts.

Critical Health Financing Constraints

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

1

Per Capita Health Expenditure: Pakistan's total per capita health expenditure from all sources is **markedly low at $42.52 (2019-20)**[4], in stark contrast 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

Government Health Spending: The proportion of government spending allocated to health in Pakistan is relatively low. **Public expenditure on health was about Rs 919 billion/ $3.9 billion in 2021-22**, accounting for approximately 9 percent of total government expenditure. This figure is below the average of 10 percent in developing countries and significantly lower than the 15 percent in HICs[5], insufficient to support essential quality health services for all.

3

Revenue Mobilisation Capacity: A portion of the low government spending can be attributed to Pakistan's limited capacity to mobilise revenues. The country's **efforts to raise taxes have consistently fallen short at 10.1 percent (base year 2016)[6] of the GDP in 2022**, below the International Monetary Fund's (IMF) identified minimum threshold of 15 percent of Gross Domestic Product (GDP) necessary for sustained, inclusive growth.

4

Financing Gap: The low levels of domestic government financing have resulted in a substantial gap between the costs of providing an essential package of quality health services for everyone and the available resources. Good economic growth and a robust **political commitment to Universal Health Coverage (UHC) reforms** are imperative to bridge this gap.

5

Out of Pocket Payments: As a result of low government investment in health, **out of pocket (OOP) payments constitute a large share of total health expenditure in Pakistan – 53.16 percent**[4], significantly higher than the global average of about 15 percent. These payments deter some people from using necessary health services and push others into poverty.

6

Inefficiencies and Inequities: In Pakistan, inefficiencies and inequities in health financing are prevalent. It is estimated that between **20 and 40 percent of health funding is wasted**.[7] Additionally, poorer individuals often contribute a higher proportion of their income to health payments than wealthier individuals, without adequate compensation, often receiving fewer and lower quality health services.

4 Pakistan Bureau of Statistics, 2020; National Health Accounts 2019-20
5 World Bank, 2019; WB database
6 Ministry of Finance, Pakistan Economic Survey 2022-23
7 WHO, 2010; World Health Report

7

Official Development Assistance (ODA):

ODA for health has seen stagnation in recent years. Currently, **extra-budgetary support stands at a mere 0.5 percent of Pakistan's total health expenditure**[4] wherein the ratio of donor contributions to the overall health expenditure stood at **6.4 percent**. There is a crucial need for additional international investment to catalyse advancements, strengthen health systems, support government efforts in tackling low revenue generation, support government efforts in tackling low revenue generation, and strengthened capacities for health-financing functions essential for UHC.

8

Emerging Challenges:

Various challenges, including **rising consumer expectations, rapid population growth, an ageing population, the burgeoning burden of non-communicable diseases, advances in medical technology, limited capacity for revenue collection, slow formalisation of economies, changes in work patterns, pandemic threats, antimicrobial resistance, and forced displacement**, are driving up healthcare costs. These challenges pose risks to future domestic revenue mobilisation, efficiency, and equity, and if unaddressed, may impede the attainment of health financing required for UHC.

Pakistan requires a strong combination of domestic and international investments to address the significant UHC financing gap. Fiscal measures to increase taxes as a percentage of GDP and the proportion of government expenditures dedicated to health, alongside economic growth, could help reduce the estimated financing gap. Additional contributions may emanate from the private commercial sector, although limited. A substantial increase in ODA, support for developing capacity to absorb external financing, enhanced private sector engagement, and innovative health-financing policy solutions are all essential for Pakistan to achieve UHC and realise the benefits of sustainable, inclusive growth.

The Way Forward

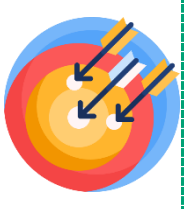
Elevate What's Proven

Pakistan needs to rapidly advance in health financing by adapting globally proven principles to its distinct context. This means focusing on **resource efficiency and fairness, channelling funds into optimal primary and community healthcare, and increasing health investments from general revenue**. Additionally, exploring practical, mandatory health insurance for those who can afford it should, where feasible should be considered.

Forge Powerful Alliances

The **integration of the Sehat Card Programme with the UHC Benefit Package** constitutes a pivotal element of Pakistan's healthcare future. The Sehat Card's remarkable reach, extending across regions like Khyber Pakhtunkhwa and Punjab, marks a groundbreaking stride. This convergence, which unites social protection with universal health coverage, presents a unique opportunity for comprehensive health reform in the country.

Big Picture, Bigger **Impact**



Pakistan needs a visionary approach to health financing. This necessitates the integration of policies across multiple sectors to establish a **unified, government-wide approach, with a vigilant focus on medium-term strategic planning**. It is about pre-emptively navigating potential pitfalls in revenue, costs, and equity, ensuring health financing is robust and future ready.

Empower Health Financing **Leadership**

A **synchronised leadership across finance, planning and development, and health ministries and departments** can support health financing reform. It is crucial in areas where consensus exists but progress stumbles, often due to political gridlocks. Strengthening ties with health insurance entities and pertinent ministries and departments at both federal and provincial levels is key. Forming an **independent Health Financing Advisory Committee**, representing a spectrum of stakeholders, is essential for ongoing dialogue and a transition towards enduring financial health sustainability.

In addition, global partnerships, and platforms such as the WHO's Global Action Plan, UHC 2030, Global Alliance for Vaccines and Immunisation (Gavi), Global Financing Facility (GFF), and the Global Fund are instrumental in guiding Pakistan through its current health financing challenges. Yet, to truly conquer UHC financing hurdles, Pakistan requires novel international collaboration focused on two main fronts:

A

RESEARCH AND INNOVATION IN HEALTH FINANCING

This involves generating insights on unresolved issues, crafting strategies to bolster financial resilience, and exploring innovative financing solutions that could dramatically accelerate progress towards UHC.

B

LEADERSHIP AND CAPACITY ENHANCEMENT

A significant increase in investment and a strategic pivot towards enhancing health-financing leadership, governance, and organisational capacity, alongside better domestic resource utilisation and mobilisation, are crucial for heightening health security and sustainability.

Key Areas of Reforms

- **Maximising Efficiency and Fairness in Resource Allocation:** Embrace strategic purchasing to transition from conventional input-based budgeting to dynamic output-driven approaches. This shift ensures not just efficiency and equity but also high-quality service delivery at sustainable costs. Decisions about service locations, types, and payment methods are pivotal in shaping this efficient and equitable landscape.
- **Boosting Resource Mobilisation for UHC Aspirations:** To ensure universal access to essential health services, Pakistan must significantly ramp up its financial resources. This involves innovative financing methods, including public health taxes, with a strict earmark on health expenditure. A bold and continuous push towards novel funding avenues is key to building a robust health service infrastructure, public health functions, and governance systems.
- **Effective Pooling to Mitigate Financial Health Risks:** Pool funds strategically to distribute the financial burden of ill-health. This approach enables affordable access to a guaranteed set of health services, cushioning citizens against the economic shocks of healthcare needs.
- **Strengthening Health-Financing Governance:** The government must bolster its capacity to develop and uphold a robust regulatory framework for health financing. This involves leadership synergy between finance, planning, development, and health ministries. Strengthening the research, monitoring, and evaluation agenda is also crucial in this regard.
- **Evolving Health Benefit Packages with Local Evidence:** Regularly revise and update health benefit packages, anchoring them in localised, scientific evidence. This ensures that health services remain relevant, effective, and attuned to the changing health needs of the population.
- **Tracking regular health sector allocation and expenditures not only in the public sector but also the rest of the world (including Global Health Initiatives) and out-of-pocket:** Allocation and expenditure data is available in the public sector where quality of information could be further improved with appropriate changes in the classification of accounts and capacity building of staff. Allocation and expenditure data of development partners including Global Health Initiatives (GHI), needs to be regularly collected and reviewed by the Ministry, making alignment with the government data and establishing a sustainable funds monitoring system, while avoiding double counting of data. A mechanism (Development Assistance Database (DAD)) existed in the Economic Affairs Division in past which may be revived again. Tracking of financing data should be used for setting and achieving health financing objectives.

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ACRONYMS

ADB	Asian Development Bank
ADP	Annual Development Programme
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 & Melinda Gates Foundation
BP	Benefit Package
CBHI	Community-Based Health Insurance
CGA	Controller General Accountant
CHC	Community Health Centres
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 Immunisation
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 Income and Expenditure 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	Kreditanstalt für Wiederaufbau
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 Indicator 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 Programme
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
SCP	*Sehat* Card Programme
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 Programme
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
WRT	With Respect To
WPV	Wild Polio Virus
YLD	Years Lived with Disability
YLL	Years of Life Lost

1

MACRO-ECONOMIC OUTLOOK AND HEALTH EXPENDITURE TREND IN PAKISTAN

Country Context

As of 2023, Pakistan is the world's fifth-most populous country, ensconced within the lower-middle-income tier, with a staggering population of approximately 247.7 million. This figure encapsulates the federating areas of Azad Jammu & Kashmir (AJK) and Gilgit-Baltistan (GB). There is an additional contingent of over 1.4 million officially registered Afghan refugees. The nation's demographic vitality is further underscored by a robust 57.3 percent of its populace, equivalent to 132 million individuals in 2022, falling within the prime working ages of 15 to 65 years. This is juxtaposed against a youthful base of 99 million children below 15 years.

Highlighted by the United Nations Development Programme (UNDP), Pakistan boasts a demographic dividend that is **one of the globe's most youthful, with an overwhelming 64 percent of its population under the age of 30, and 29 percent between the crucial developmental ages of 15 and 29 years**. Despite a discernible downtrend, the nation's fertility patterns hint at an inexorable surge in its young demographic, setting the stage for a burgeoning population in the future.

Occupying a geographical footprint as the world's 33rd largest nation, Pakistan extends over 881,913 square kilometres. The administrative framework of the country is organised into four principal provinces—Punjab, Sindh, Khyber Pakhtunkhwa (KP), and Balochistan—along with the three federating areas Gilgit-Baltistan (GB), Azad Jammu & Kashmir (AJK), and the Islamabad Capital Territory (ICT). Each province is systematically subdivided into administrative divisions, with Punjab comprising 10, Sindh 7, KP 7, Balochistan 6, and GB and AJK each with 3. These divisions are further delineated into districts and tehsils/ talukas, which are then demarcated into union councils at the most localised level of governance. The divisions do not include the ICT, which is counted at the same level as the provinces.

TABLE 1 - PROVINCE/FEDERATING AREA WISE POPULATION AND POPULATION DENSITY

Province/ Area	Population (2023)	Area (Km^2)	Projected Population (2030)	Density per Km^2 (2023)
Punjab	127,688,922	205,344	143.46 million	621.8
Sindh	55,696,147	140,914	63.79 million	395.2
Khyber Pakhtunkhwa	40,856,097	101,741	47.9 million	401.6
Balochistan	14,894,402	347,190	18.46 million	42.9
Islamabad Capital Territory	2,363,863	906	2.85 million	2,609.1
Gilgit Baltistan	1,685,895	72,971	1.93 million	23.1
Azad Jammu & Kashmir	4,568,257	13,297	5.23 million	343.6
Pakistan	247,753,583	881,913	283.6 million	280.9
Urban Rural	38.80% 61.20%			

The rural populace is 61.2 percent of the total population**,** whereas the urban population constitutes 38.8 percent. Notably, Sindh is the only province where the urban dwellers surpass 50 percent of its population. According to the 2023 Census, the national sex ratio stands at 106 males for every 100 females, with a slight variance between rural (103.7 males, per 100 females) and urban areas (107.4 males, per 100 females).

As per Pakistan, official multidimensional poverty analysis from 2019 reveals that nearly four out of ten Pakistanis, or 37 percent, are living in conditions of multidimensional poverty. Urban centres have a lower poverty incidence at 32.1 percent compared to 39.3 percent in rural settings. A provincial breakdown shows a varied landscape of poverty: Punjab presents the most favourable scenario with a 31.6 percent poverty rate, while Balochistan faces the most severe situation, where 56.8 percent of its population is impoverished. Meanwhile, Khyber Pakhtunkhwa has a poverty rate

of 36.1 percent, and Sindh's rate is observed at 43.7 percent.

In Pakistan's federal governance structure, power is constitutionally distributed between the central government and the provincial governments. After the 18th Constitutional Amendment in 2010, the federal government relinquished its direct control over critical sectors, including health, education, and social welfare, redefining the role of provincial authorities in these areas. This reorganisation led to the dissolution of several federal ministries, such as those for health, education, and agriculture. To streamline federal health responsibilities and foster intergovernmental coordination, the Ministry of National Health Services, Regulations & Coordination (NHSR&C) was instituted on May 4, 2013. The transfer of health sector governance to the provinces, together with the implications of the National Finance Commission (NFC) award, has significantly influenced the formulation of Pakistan's health financing framework.

Pakistan's healthcare framework is an amalgam of public and private sector entities. The Constitution delegates the primary responsibility for healthcare delivery to the provincial governments, with certain functions reserved for the federal level as delineated in the Federal Legislative Lists I & II, also reflected in the operational mandate of the health division. The state endeavours to facilitate healthcare services across a tiered delivery system, encompassing five key levels that operate within both the public and private sectors: community-based services, Primary Health Care (PHC) centres, first-level referral hospitals, tertiary care hospitals, and services aimed at the population at large.[8] Building on the integrated healthcare system of Pakistan, community-based interventions are delivered through a network of lady health workers, vaccinators, field staff specialising in environmental and infectious diseases, and community-based organisations. At the heart of the primary healthcare infrastructure are Basic Health Units (BHUs), Community Health Centres (CHCs), also known as round-the-clock BHUs, and Rural Health Centres (RHCs) within the public domain, complemented by general practitioners and physicians in the private sector. For more advanced care, patients are referred to Tehsil/ Taluka Headquarter Hospitals (THQs) and District Headquarter Hospitals (DHQs) for acute, ambulatory, and inpatient services in the public sector, alongside smaller (<50 beds) and medium-sized (>50 beds) hospitals in the private sector. These facilities are bolstered by tertiary academic hospitals that operate across both sectors. Public health initiatives are progressively moving towards a model of horizontal integration, while population-level health interventions continue to expand the reach and efficacy of the healthcare system.

Reflecting the escalating demands for public health services, Pakistan has considerably enlarged its health service delivery infrastructure. As of 2023, the public health infrastructure encompasses 1,276 hospitals, 5,559 BHUs, 736 RHCs, 5,802 dispensaries, 780 Maternity and Child Health Centres, and 416 Tuberculosis (TB) Centres. This expansion illustrates the country's commitment to enhancing the accessibility and quality of healthcare services to meet the needs of its growing population.[9] As the year 2022 concluded, the collective count of hospital beds reached 126,458 in the public sector, supplemented by a marginally higher figure of 132,624 in the private sector, totalling 259,082 beds nationwide. Notably, only in Punjab and the Islamabad Capital Territory does the private sector surpass the public sector in the number of hospital beds available. Despite this growth, the overall density of hospital beds across both sectors stood at 10.67 beds per 10,000 individuals, which falls short of the recommended threshold of 18 beds per 10,000 individuals to adequately serve the population's healthcare needs.[10]

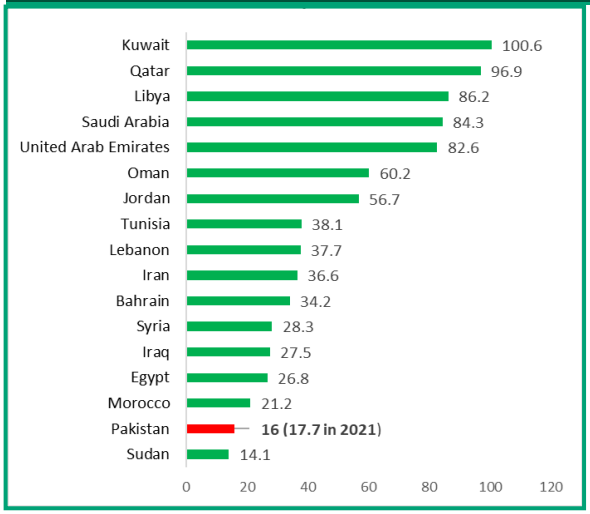
8 Ministry of NHSR&C, 2020; Essential Package of Health Services/ UHC Benefit Package of Pakistan

9 Ministry of Finance, 2023; Pakistan Economic Survey 2022-23

10 Ministry of NHSR&C, 2023; Pakistan-2023 UHC Monitoring Report

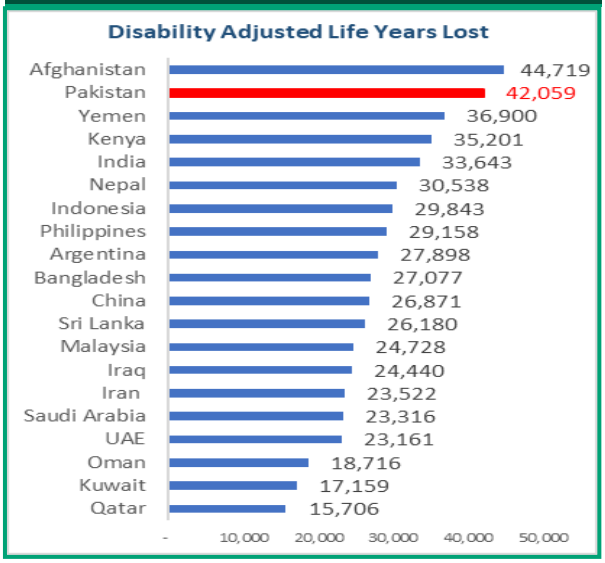
The strength of a health system is directly correlated to the availability and performance of its health workers, a domain where Pakistan is facing a significant challenge. With one of the leanest health workforces in the world, the country had 285,808 registered doctors, 34,365 dentists, and 150,364 nurses and allied professionals by the end of 2022. The emigration of a considerable portion of this workforce to countries in the Middle East, Europe, and North America further exacerbates the shortage. Striving towards the Sustainable Development Goals, Pakistan is tasked with substantially scaling up its medical staff to 314,685 doctors and 946,890 nursing and midwifery personnel by 2030. Compounding the situation, the network of Lady Health Workers (LHWs) — vital for community-based care — saw a decline to 87,119 in 2022, indicating an urgent need for strategic initiatives to bolster the healthcare labour force.

FIGURE 1 - DENSITIES OF ESSENTIAL HEALTH WORKFORCE IN THE EMR COUNTRIES (2019) PER 10,000 POPULATION



Health investment is a cornerstone in the edifice of human capital, serving as both a determinant and a contributor, particularly through the delivery of essential health services at the community and PHC levels across both public and private sectors. Such investments are instrumental in nurturing human capital from the early stages of childhood, setting a solid groundwork for enhanced health and future income potential. Moreover, the provision of health services is integral to bolstering the productivity of the workforce, producing immediate and lasting impacts throughout an individual's working life.

FIGURE 2 - DALYS LOST PER 100,000 POPULATION (2019)



Enhanced health not only elevates the efficacy and output of the labour market but also substantially fuels economic advancement and human well-being. In recent years, Pakistan has observed incremental progress in its health indicators, with life expectancy at 65 years in 2020. Despite these gains, the country's average life expectancy lags the global average of 73 years, underscoring the necessity for continued and focused health sector improvements., albeit at a pace that is more gradual compared to other regional counterparts.

Pakistan is navigating through critical epidemiological[11] **and demographic**[12] **shifts.** Accompanying these shifts are ancillary transitions, notably those related to **nutrition** and **aging**.[13] The country is bearing witness to these complex patterns, acknowledging that they are not invariably linear. The rate of transition varies by region, and at times, non-linear or even regressive patterns have been observed, indicating a multifaceted trajectory of health and demographic change.

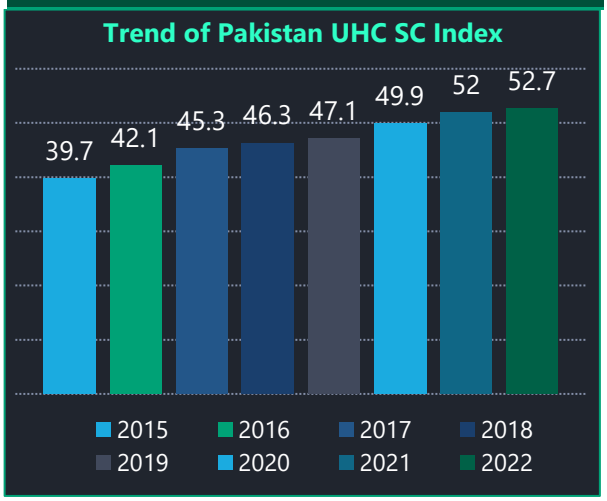
11 **Epidemiological transition** considers patterns of mortality change and causes of death (and sometimes ill health) from patterns dominated by maternal & child health and infectious diseases to those in which chronic, degenerative physical ailments predominate with increasingly non-communicable and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

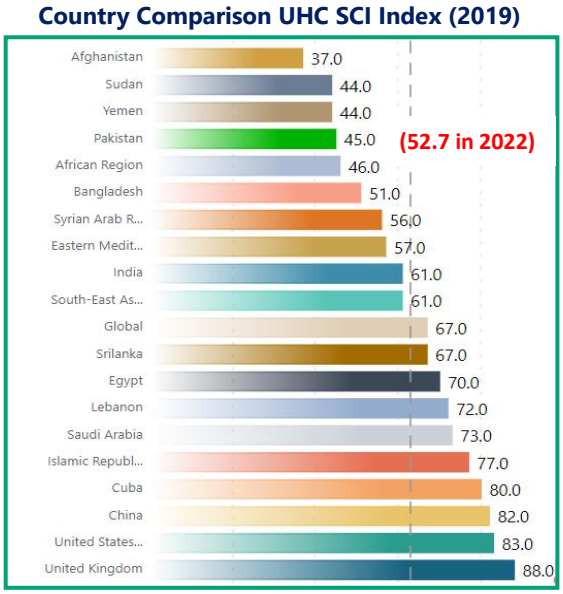
The Institute of Health Metrics & Evaluation (IHME) data reveals that Pakistan is grappling with a substantial disease burden, with an annual rate of 42,369 Disability-Adjusted Life Years (DALYs) lost per 100,000 population in 2021 — a figure that stands out as particularly high among nations in the region and other developing countries. The median age in Pakistan is a youthful 22.8 years, in stark contrast to the global median of 29.6 years, underscoring the predominantly young demographic profile of the nation.

FIGURE 3 - TREND OF UHC SERVICE COVERAGE INDEX IN PAKISTAN AND STATUS ON OTHER COUNTRIES



In Pakistan, the burden associated with communicable diseases, maternal and child health, and nutritional deficiencies has notably declined from over 65 percent (40,962 DALYs lost per 100,000 population) of the total disease burden in 2000, to 46.2 percent (19,590 DALYs lost per 100,000 population) by 2021. Conversely, the incidence of non-communicable diseases (NCDs) has escalated from 29.9 percent (18,698 DALYs lost per 100,000 population) of the disease burden in 2000 to 42.7 percent (18,082 DALYs lost per 100,000 population) in 2021. There has also been a rise in the proportion of disease burden attributable to injuries, increasing from 4.73 percent (2,958 DALYs lost per 100,000 population) to 7.1 percent (3,006 DALYs lost per 100,000 population) during the same period. Additional 4 percent (1,688 DALYs lost per 100,000 population) burden of other Covid was added in 2021. This shift reflects a significant transition in Pakistan's health landscape, with a simultaneous reduction in the burden of reproductive, maternal, neonatal, child health, and communicable diseases and an uptick in the burden of NCDs/ other Covid and injuries.

FIGURE 4 - TREND OF UHC SERVICE COVERAGE INDEX IN PAKISTAN AND STATUS ON OTHER COUNTRIES



The World Bank and the World Health Organization have established the Universal Health Coverage (UHC) Service Coverage Index (SCI). This composite measure is derived from various tracer indicators that track the extent of coverage for essential health services, encompassing reproductive, maternal, neonatal, and child health, infectious diseases, non-communicable diseases, as well as service capacity and access. The index is a predictor of several critical health outcomes, including under-five mortality rates, life expectancy, and correlates with the Human Development Index (HDI). In Pakistan, while there is a discernible advancement in the UHC Service Coverage Index, progress is incremental and lags substantially behind other nations and global regions.[14]

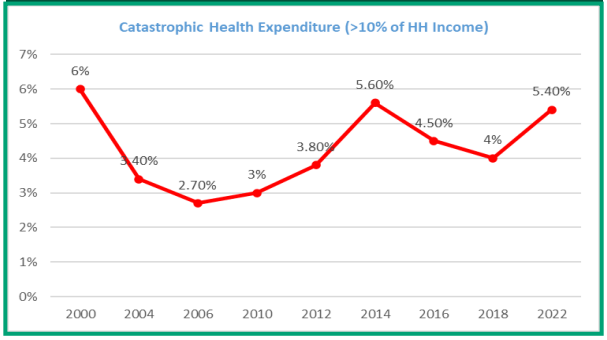
Another dimension of UHC is the catastrophic health expenditure, which is a healthcare-related bill that exceeds a person's capacity to pay. It often

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

involves the encashment of savings and assets, including, at times, homes, and businesses. It can impoverish and devastate families for many years.

In Pakistan, the population with household expenditures on health >10 percent of total household expenditure or income (%) was 5.4 in 2021-22, 4 in 2018-19, 4.5 in 2015 and 3 in 2010.[2] The current value indicate that more than 13.4 million of the population is at a risk of entering into poverty due to catastrophic health expenditure. Currently the inflation rate is expected to have a further negative impact on the health of the poor.

FIGURE 5 - CATASTROPHIC HEALTH EXPENDITURE



In advanced societies, particularly the United Kingdom and Western Europe, the existence of cradle-to-grave social welfare programmes buffers individuals from such costs, whereas in Pakistan social protection mechanisms are still emerging. It's also worth noting that catastrophic health expenditure (CHE) usually occurs in the last few years of a person's lifetime, contributing in no small way to the dissatisfaction with the spending.

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 government health expenditures is required to achieve cost-effectiveness, efficiency, and equity in the health care system. The devastating economic cost of CHE make a strong case for UHC investments with a focus more on primary, preventive, and promotive health care services. The government should protect the poor from health expenditure catastrophe, but simultaneously it is also essential to protect non-poor or middle-income people from health expenditure shock. In this regard, major reforms on health care financing and health policies are required to improve the efficiency and equity in the health care system of Pakistan.

Pakistan Economic Outlook

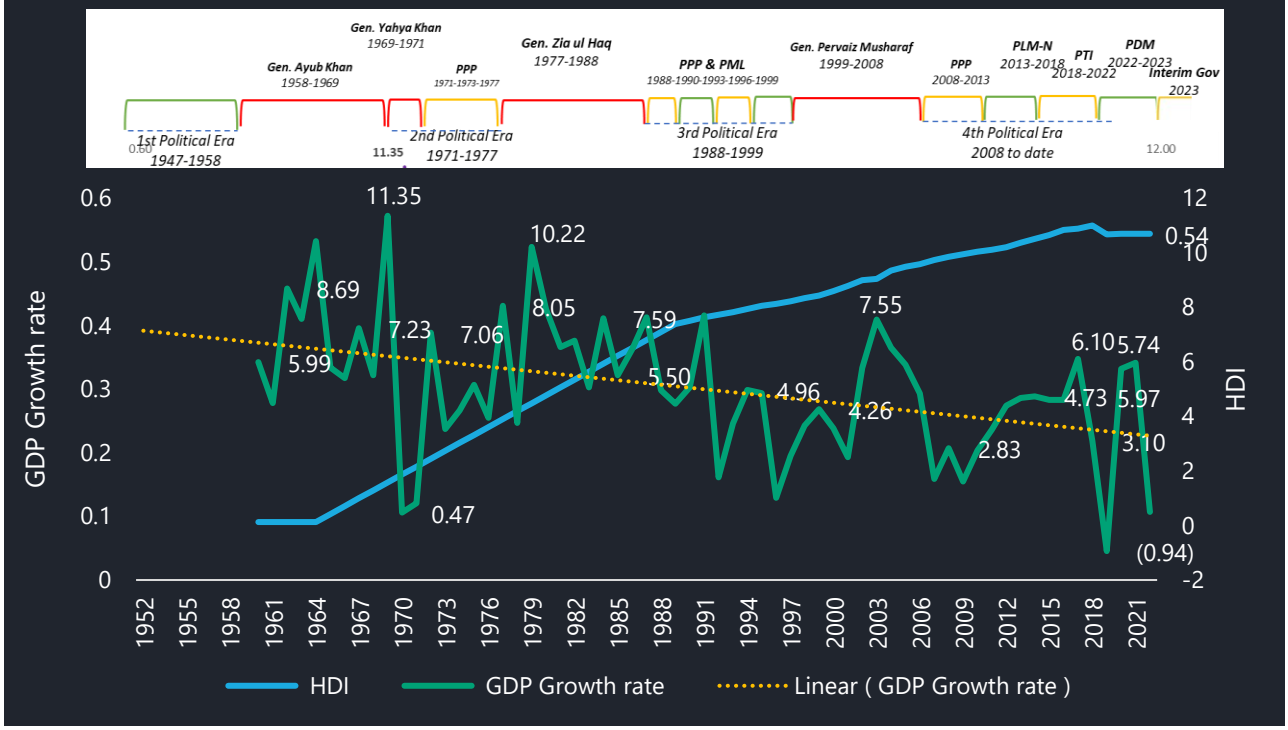
Pakistan's financial forecast for 2023-24 presents a multifaceted scenario. Current global geopolitical strains, fiscal tribulations, and surging inflation have dampened economic growth expectations worldwide, with Pakistan similarly affected. The country has also contended with specific adversities such as catastrophic flooding events and internal political instability.

In the fiscal year 2022, Pakistan's economy expanded by an unsustainable 6.1 percent, fuelled by internal demand, resulting in significant fiscal and current account deficits. **As fiscal year 2023** commenced, the nation faced four principal challenges: reestablishing macroeconomic equilibrium, diminishing poverty levels, consolidating its fiscal position, and mitigating external financial susceptibilities. The government's strategy focuses on promoting steady economic growth alongside maintaining price stability, employing domestically formulated reform measures.

In 2022, catastrophic floods inundated a third of Pakistan, inflicting substantial economic damage. The administration, installed in April 2022, embarked on a programme for macroeconomic stabilisation, emphasising prudent fiscal governance, phasing out subsidies, curtailing deficits, boosting revenues, and refining monetary policy to address inflation. Preliminary outcomes have manifested in reduced fiscal deficits and the resurgence of a current account surplus. Nonetheless, the situation retains elements of uncertainty, with ongoing global security issues, sustained inflation, and lingering economic hurdles.

The accompanying graphic depicts the trajectory of Pakistan's economic growth rate alongside the human development index.[15]

FIGURE 6 - ECONOMIC GROWTH RATE AND HUMAN DEVELOPMENT INDEX IN PAKISTAN



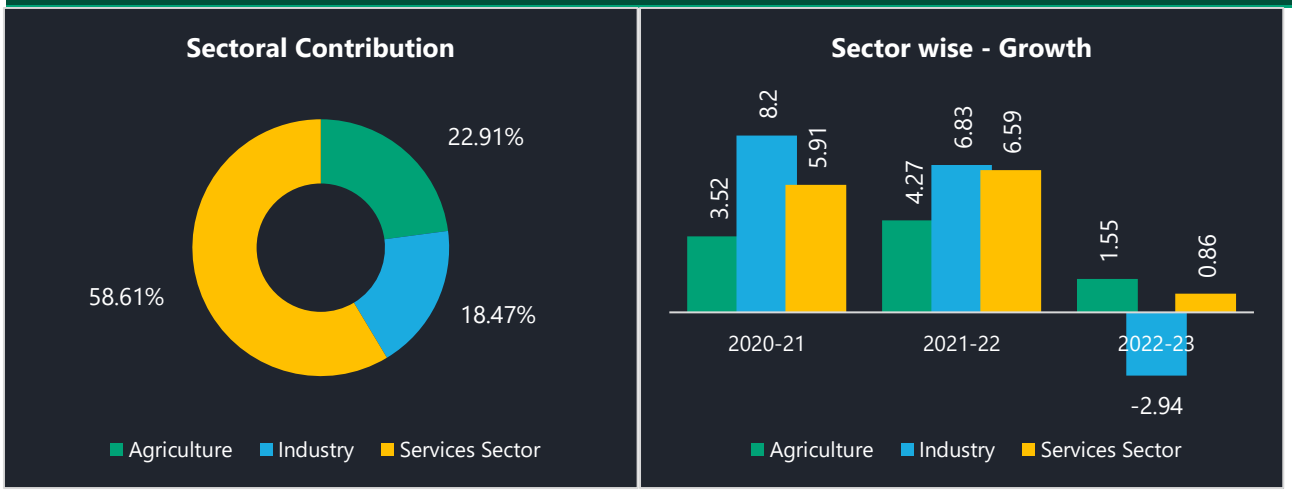
During fiscal year 2023, Pakistan's economic progress was significantly impeded by a confluence of adverse factors: macroeconomic disequilibrium, extensive flood-related destruction, local supply chain disruptions, and a downturn in the global economy. Post-budget expectations in June 2022 had initially forecasted a GDP expansion of around 5.0 percent. However, economic vigor waned in the fiscal year's initial quarter, beleaguered by worldwide economic issues and devastating flash floods in July and August 2022. These floods wrought damages estimated at 3.2 trillion Pakistani rupees (approximately US$14.9 billion), severely affecting the GDP, with rehabilitation needs further quantified at 3.5 trillion Pakistani rupees (US$16.3 billion). Additionally, the ongoing conflict between Russia and Ukraine exerted further negative impacts on global economic stability, while inflation rates persisted at unexpectedly elevated levels.

In the fiscal year 2023, Pakistan's GDP experienced marginal growth of 0.29 percent. Sector-wise, agriculture saw a growth of 1.55 percent, the industrial sector contracted by 2.94 percent, and the services sector expanded by 0.86 percent. Despite these figures, the GDP at current market prices saw a marked increase, surging to 84,658 billion Pakistani rupees, a 27.10 percent hike from the preceding year. In contrast, the **per capita income fell from US$ 1,765 to US$ 1,568,** influenced by the significant depreciation of the local currency and an overall economic downturn. The investment to GDP ratio also witnessed a downturn, settling at 13.6 percent against 15.6 percent in FY2022. However, Gross Fixed Capital Formation (GFCF) recorded an 8.1 percent increase from the last fiscal year. Noteworthy advancements were observed in public administration, social security, education, as well as the human health and social work sectors.[16]

15 Economic surveys of Pakistan for Economic growth rate and UNDP for HDI Index

16 Source: Pakistan Economic Survey 2022-23

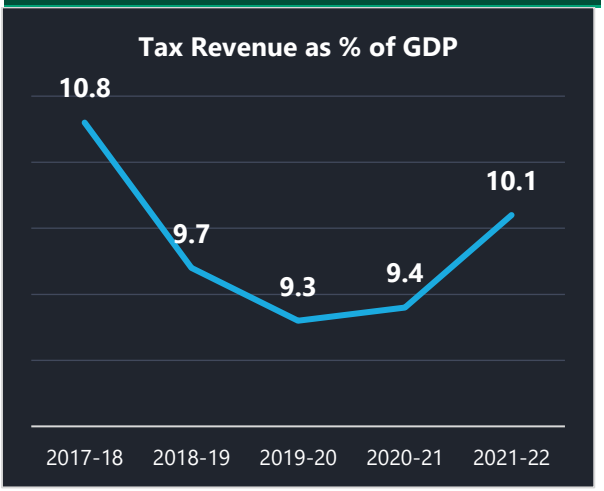
FIGURE 7 - GDP COMPOSITION (2023) AND SECTOR-WISE GROWTH



The modest economic growth rate observed in 2022-23 primarily stems from varied sectoral performances. Specifically, the figures for this period show a 1.55 percent in agriculture, a contraction of 2.94 percent in the industrial sector, and an increase of 0.86 percent in the services sector. Presently, Pakistan's GDP is predominantly composed of the services sector, which accounts for roughly 58.61 percent. This is followed by the agriculture sector, representing 22.91 percent, and the industrial sector, comprising 18.47 percent. These proportions are delineated in the subsequent figures.

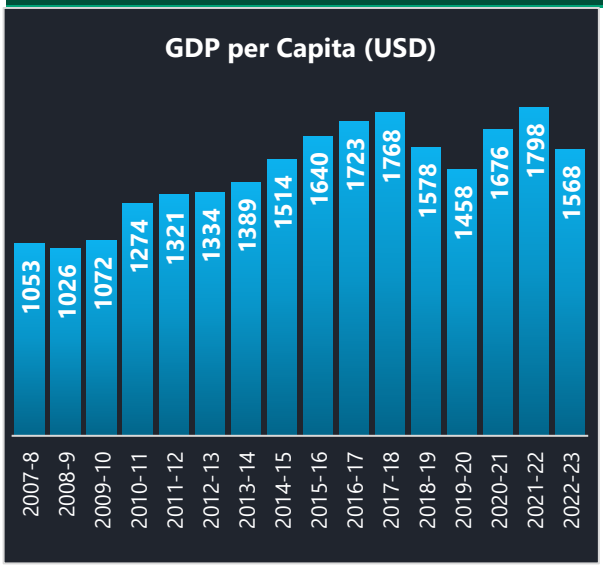
While Pakistan's economy has the potential to grow, the country continues to suffer from several macroeconomic challenges. The taxes in the different sectors are not equitable with reference to their contribution to the GDP. Consequently, the tax to GDP ratio remained low at 10.1 percent in 2021-22. 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. The higher the ratio, the higher the proportion of money for health would be available. Provincial efforts to generate more resources will be critical, considering health is mainly a provincial subject. If managed effectively, this can support the long-term health and prosperity of an economy.

FIGURE 8 - TAX REVENUES AS SHARE OF GDP



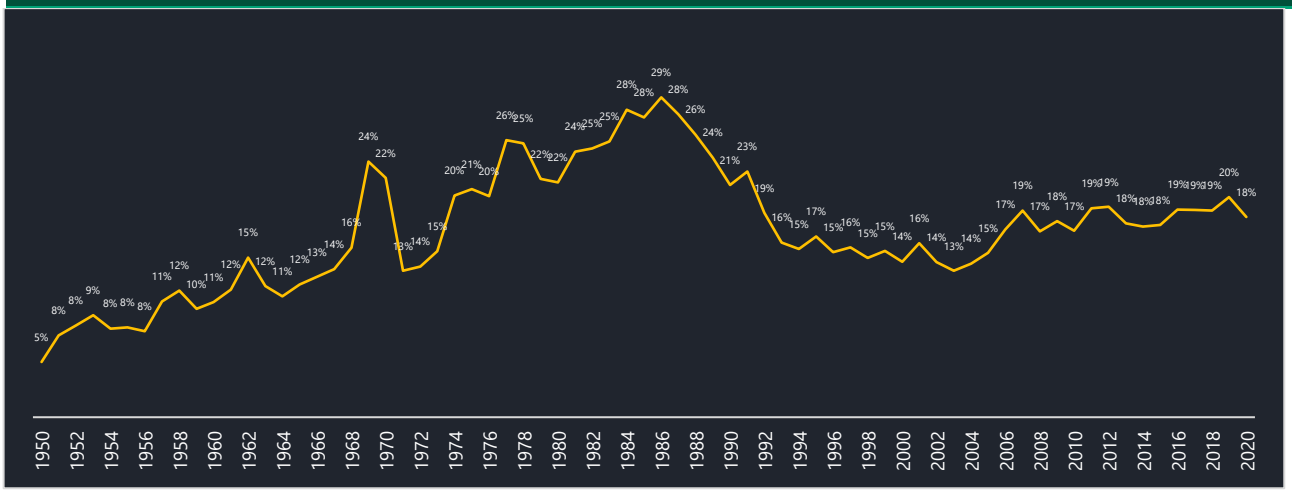
Over the past five years, Pakistan's combined tax-to-GDP ratio, encompassing both federal and provincial contributions, has oscillated between 9.3 and 10.1 percent. This metric dipped from 10.8 percent in FY2018 to 9.4 percent in FY2021, before a slight recovery to 10.1 percent in FY2021-22. For FY2022, the tax-to-GDP ratio stands at 10.1 percent. Pakistan's tax base currently falls short of its potential. The International Monetary Fund recommends that for a nation to foster expedited economic development, a minimum tax-to-GDP ratio of 15 percent is advisable. Therefore, there is a significant need to enhance Pakistan's tax-to-GDP ratio through an expansion of the tax base, which would enable greater allocation of resources for social expenditures, including the health sector.

FIGURE 9 - TREND OF GDP PER CAPITA IN PAKISTAN



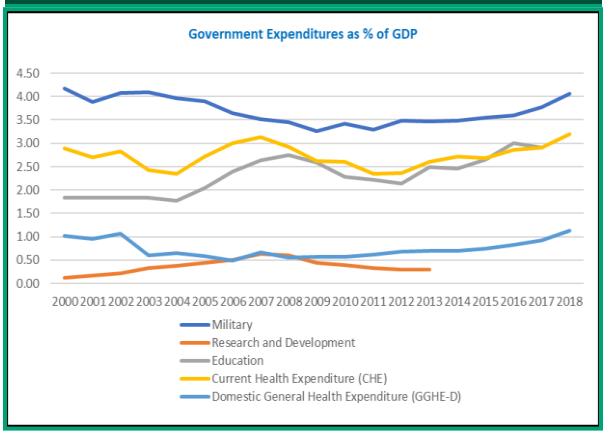
The proportion of government expenditure in relation to Pakistan's GDP, known as the Government General Expenditure (GGE) as a percentage of GDP, has seen considerable fluctuation over time. However, there has been a gradual ascent in this ratio from 2000 to 2021, as depicted in the ensuing figure. For 2021, the GGE to GDP ratio was recorded at 18 percent. It is critical to recognise that an upward shift in the GGE to GDP ratio does not inherently reflect a rise in absolute spending; it may also suggest a contraction in the nation's GDP. Conversely, a decline in the GGE to GDP ratio does not automatically imply reduced government spending; it could also indicate an expansion in the country's GDP.

FIGURE 10 - GENERAL GOVERNMENT EXPENDITURE AS SHARE OF GDP



The Government of Pakistan (GoP) has committed to making urgent and immediate progress towards achieving UHC. UHC means that all people in a society can 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 will push them into severe financial hardship. This commitment and strategic direction were outlined in the National Health Vision 2016-2025, where Pakistan's governments—federal as well as provincial—jointly committed to increasing health expenditures nationally from their then value of under 1 percent of GDP to 3 percent of GDP. However, investments into the public health sector remain below the GoP's own stated commitment. The following figure 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 the government budget compared to other sectors.

FIGURE 11 - GOVERNMENT EXPENDITURES ON DIFFERENT SECTORS AS SHARE OF GDP



Evolution/Changes in Health Expenditure in Pakistan

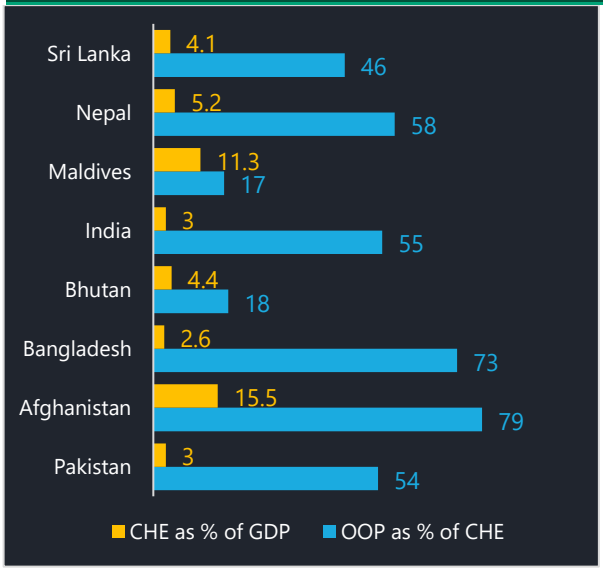
Health Financing Indicators

Relative to its counterparts, Pakistan's health expenditure for 2020 remains modest, both in terms of per capita current health expenditures and as a percentage of GDP allocated to current health expenditures (CHE). The accompanying table and graph offer a comparative analysis of Pakistan's health financing metrics against those of SAARC countries for the fiscal period of 2019-20. Within the region, the private sector constitutes a larger share of health expenditure compared to public funding, with Bhutan and Maldives being exceptions where public health investments surpass private ones. Despite this trend, Pakistan's public health expenditure as a percentage of total current health expenditures exceeds that of Afghanistan, Bangladesh, India, and Nepal. While Pakistan's OOP health expenditure remains high, it is comparatively lower than in Afghanistan, Bangladesh, and Nepal. Additionally, Pakistan receives the least donor funding for health among its regional counterparts. In terms of health financing indicators, particularly regarding OOP expenses, Pakistan ranks better than Afghanistan, Bangladesh, and Nepal.

TABLE 2 - HEALTH FINANCING INDICATORS FOR PAKISTAN AND SAARC COUNTRIES (2020)

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	80.29	15.53	7.64	76.23	79.00	16.13	4.25	1.19
Bangladesh	50.66	2.63	18.05	76.55	73.00	5.41	3.08	0.47
Bhutan	33.70	4.37	78.01	16.86	18.00	5.14	10.30	3.41
India	56.63	2.96	36.65	62.36	55.00	0.99	3.32	1.08
Maldives	25.57	11.35	79.99	18.31	17.00	1.69	18.17	9.08
Nepal	58.31	5.17	30.05	59.40	58.00	10.55	5.67	1.55
Sri Lanka	51.06	4.07	45.81	52.41	46.00	1.78	8.49	1.86
Pakistan	38.18	2.95	35.21	58.48	54.00	6.31	5.12	1.04
Pakistan (NHA)	40.70	3.00	35.94	63.54	55.54	0.53/ 6.4	5.20	1.10

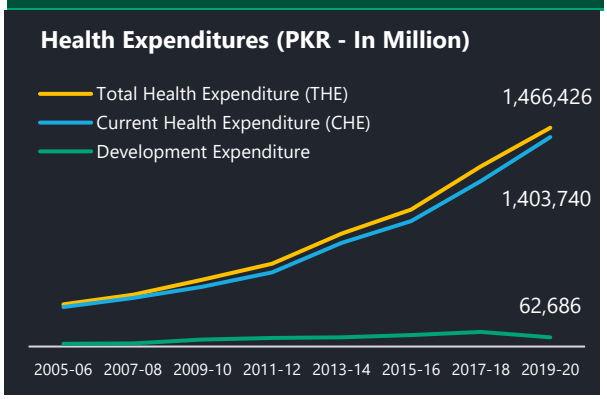
FIGURE 12 - HEALTH FINANCING INDICATORS FOR PAKISTAN AND SAARC COUNTRIES (2019-20)



The total health expenditure, comprising current expenditure (1,403,740 million PKR) and development expenditure (62,686 million PKR), was projected at 1,466,426 million PKR for FY 2019-20. This reflects an increase of 26.6 percent in current health expenditure and 21.6 percent in total health expenditure, compared to FY 2017-18. However, development expenditure experienced a decline of 35.9 percent. Notably, CHE constitutes a larger portion of the total health expenditure compared to the development expenditure.

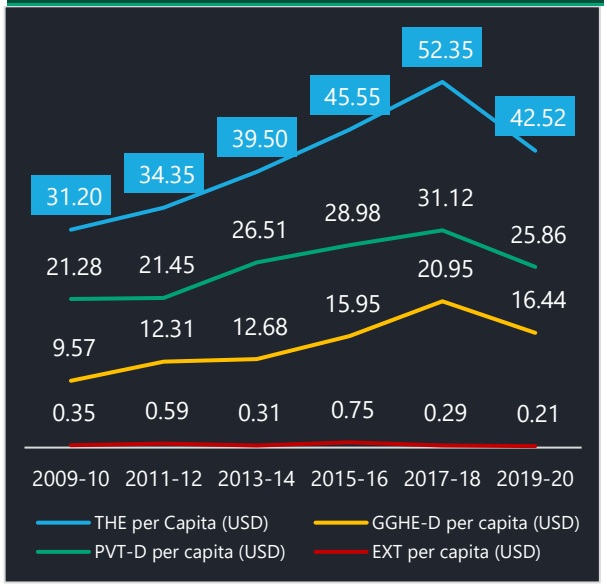
The following graph shows changes in health expenditures in Pakistan over the years 2005 to 2020:

FIGURE 13 - TREND OF HEALTH EXPENDITURE IN PAKISTAN



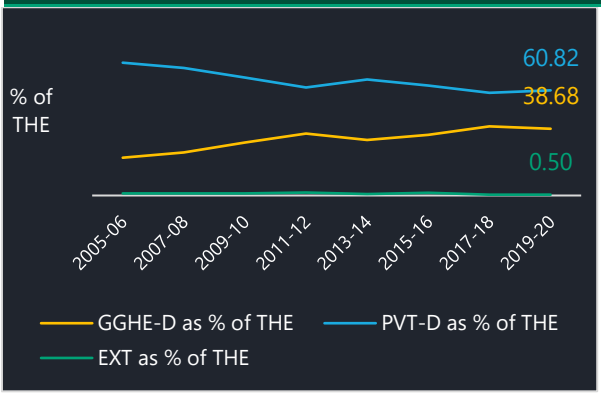
The annual per capita total health expenditure (THE) in Pakistan has risen from 2,611 PKR (equivalent to 31.2 USD) in 2009-10 to 6,919 PKR (42.5 USD) in 2019-20. In 2019-20, public sector contributions constituted 38.7 percent of health financing, while the private sector accounted for 60.8 percent, and external funding sources comprised 0.5 percent. The accompanying graph details the evolution of these funding streams over time. Notably, since 2014, there has been a gradual increase in the proportion of total health expenditures funded by government resources (GGHE-D as a percentage of THE), which has led to a corresponding decrease in the share of both domestic private health expenditures (PVT-D as a percentage of THE) and the proportion of health expenditures from external sources (EXT as a percentage of THE).

FIGURE 14 - BREAKDOWN OF TOTAL HEALTH EXPENDITURE PER CAPITA AND TREND



Per capita CHE in Pakistan has seen a rise from 2,335 PKR (27.9 USD) in the fiscal year 2009-10 to 5,283 PKR (48.1 USD) in 2017-18, amounting to 3.2 percent of the GDP. In the fiscal year 2017-18, public sector contributions to health resources stood at 34.7 percent, while the private sector provided 64.7 percent, and external funding sources made up 0.6 percent of contributions. Similar to the trend in total health expenditure, there has been a gradual increase in the public sector's share of current health expenditures (GGHE-D as a percentage of CHE) starting from 2014, which has led to a decline in the share of private health expenditures (PVT-D as a percentage of CHE) and the contribution of external funding sources to health (EXT as a percentage of CHE) within the total current health expenditures.

FIGURE 15 - BREAKDOWN OF CURRENT HEALTH EXPENDITURE PER CAPITA



OOP per capita for Pakistan as per NHA 2019-20 was Rs. 3,572 (22.6 US$), which translates to OOP as of CHE of 55.54 percent. OOP as % of CHE decreased from 73.1 percent in 2005-06 to 61.4 percent in 2011-12, but increased to 65.8 percent in 2013-14, before decreasing again over the next five years. The graphs below show trends in OOP over the years

FIGURE 16 - TOTAL HEALTH EXPENDITURE IN PAKISTAN (2019-20)

A. ▲	B. ▼	C. △
Current Expenditure	**Development Expenditure**	**Total Expenditure (A+B)**
Rs. 1,403,740 million (26.6%)	Rs. 62,686 million (35.9%)	Rs. 1,466,426 million (21.6%)

For 2020, 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) stood at 20.3 percent, while the share of government funding for

Figure 17 – Trend of Out-Of-Pocket Health Expenditure as Share of CHE and per Capita (USD)

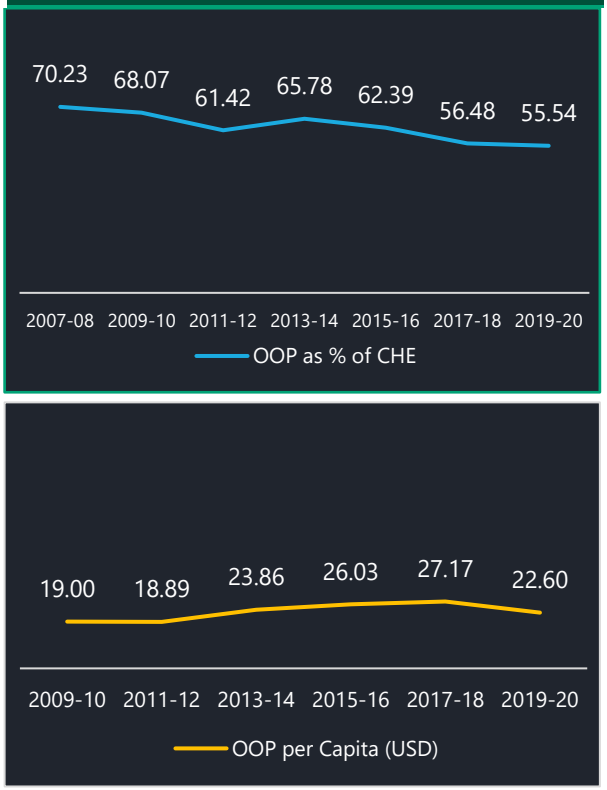
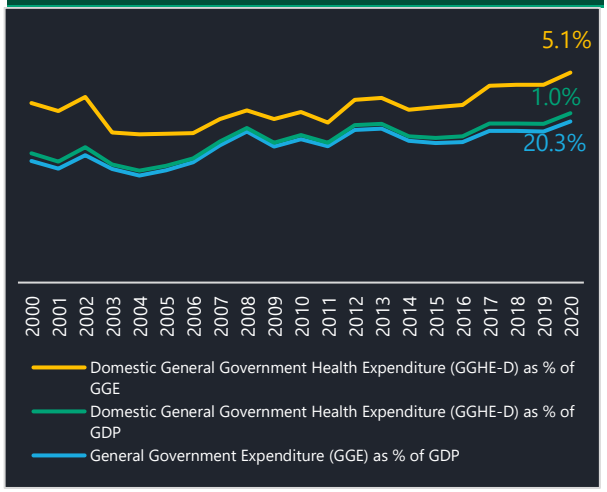


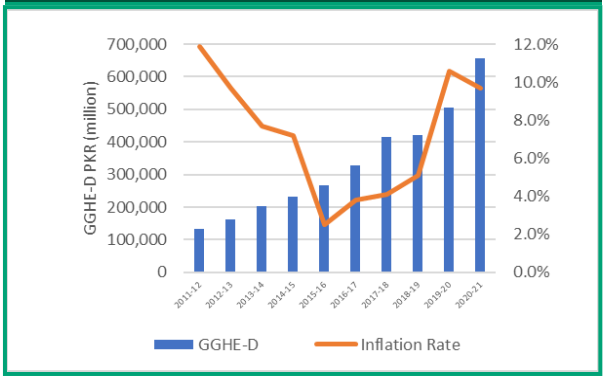
Figure 18 - General Government Expenditures and Government Health Expenditures



health specifically (GGHE-D as % of GDP) was only 1.1 percent 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 percent of GDP to 3 percent; however, by the end of FY2020, Pakistan had made little progress: public spending on health as a share of GDP remained 1.1 percent. Of the general government expenditures, the share of government health expenditures from its own domestic public resources (GGHE-D as % of GGE), is 5.1 percent.

Despite recent growth, Pakistan's economy faces persistent macroeconomic challenges, including inflation. The inflation rate has seen significant fluctuations; it declined from 11.9 percent in 2011 to 2.5 percent in 2016, only to rise in the subsequent years. The trend of increasing inflation continued, reaching 10.6 percent in 2020. By September 2023, the annual inflation rate soared to 31.4 percent, the highest recorded since May 1975, up from 27.4 percent in August, and there is potential for even higher rates given the prevailing economic conditions.

Figure 19 - Trend of Government Health Expenditure and Inflation Rate

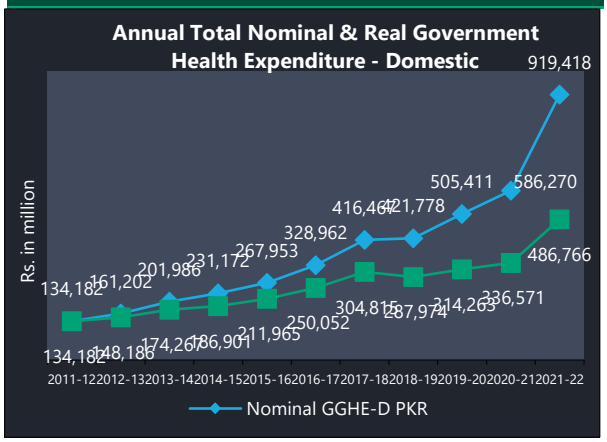


Inflation, while a worldwide phenomenon, is escalating at an alarming rate in Pakistan, necessitating prompt action. The previous five years have been marked by high inflation in Pakistan, attributed to expansionary monetary policies and elevated oil prices. Inflation poses a significant hindrance to economic development. The depreciation of the Pakistani rupee has led to steep increases in domestic prices, as the cost of crucial imports like petroleum products, electricity, gas, and edible oil have surged, further fuelling inflation. Moreover, the burden of foreign debt and its associated interest payments has become increasingly oppressive.

Everyday necessities and basic commodities are increasingly out of reach, significantly impacting the average citizen's ability to afford fundamental requirements, quality education for their children, and adequate healthcare.

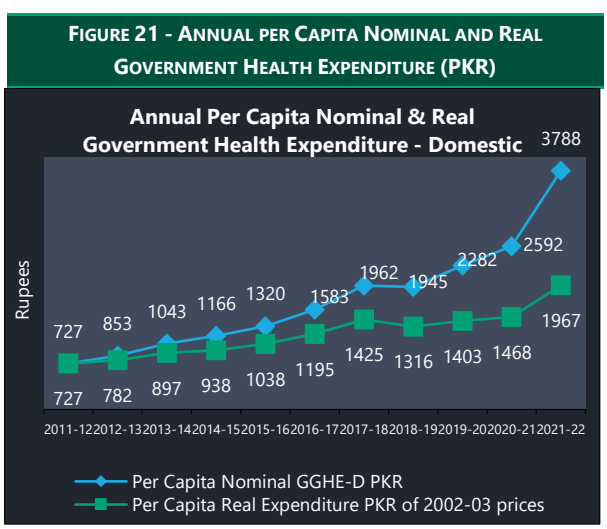
The following graphs show an increase in health expenditures over the years; however, taking inflation and dollar exchange rates into account, the real general government expenditures devoted for the health sector at 2011-12 prices have remained stagnant over the last few years. However, owing to expenditure on the COVID-19 pandemic from 2020 onward, a steep rise is observed.

FIGURE 20 - ANNUAL NOMINAL AND REAL GOVERNMENT HEALTH EXPENDITURE (PKR)



Per capita nominal government health expenditure – domestic increased from Rs 727 million in 2011-12 to Rs 3,788 million in 2021-22. However, in real terms, per capita expenditure increased to only Rs 1,967 million in 2021-22 at 2011-12 prices.

FIGURE 21 - ANNUAL PER CAPITA NOMINAL AND REAL GOVERNMENT HEALTH EXPENDITURE (PKR)



In USD exchange rates, the per capita increase in government health expenditure went from USD 7.7 in 2011-12 to USD 23.2 in nominal terms and only USD11.5 in real term at 2011-12 prices.

FIGURE 22 - ANNUAL NOMINAL AND REAL GOVERNMENT HEALTH EXPENDITURE (USD)

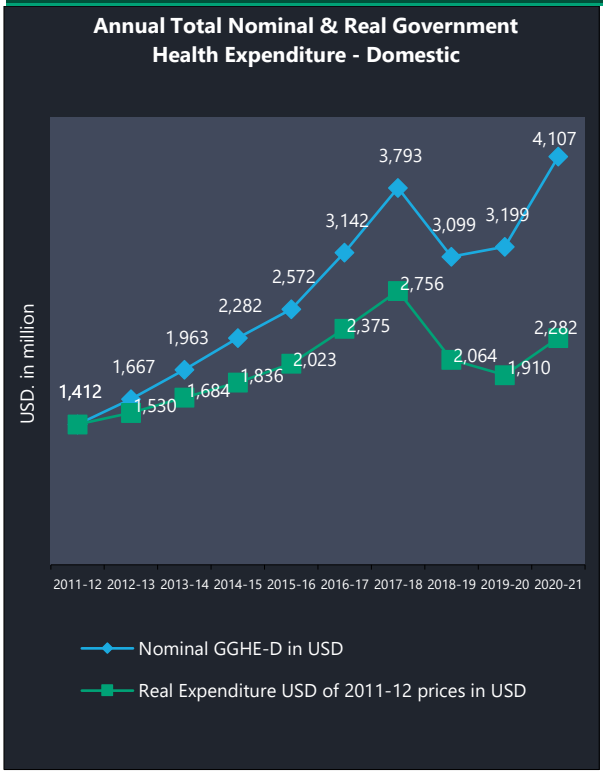
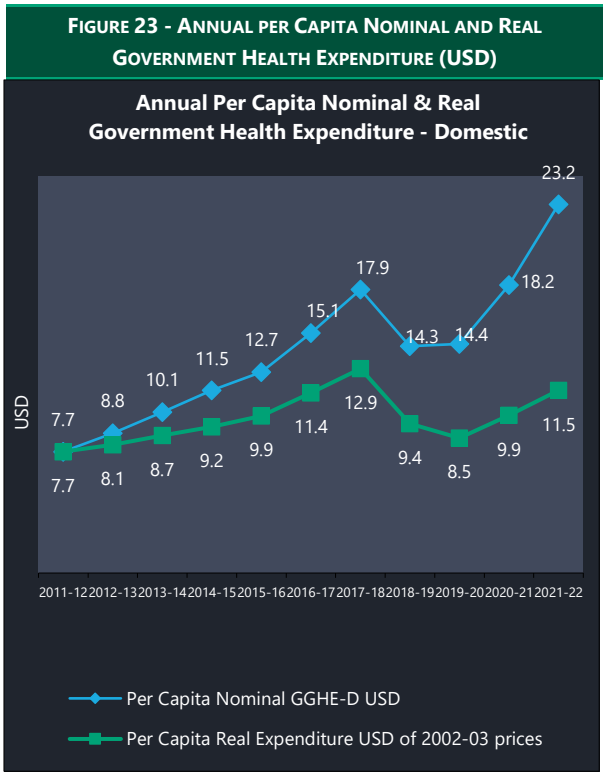


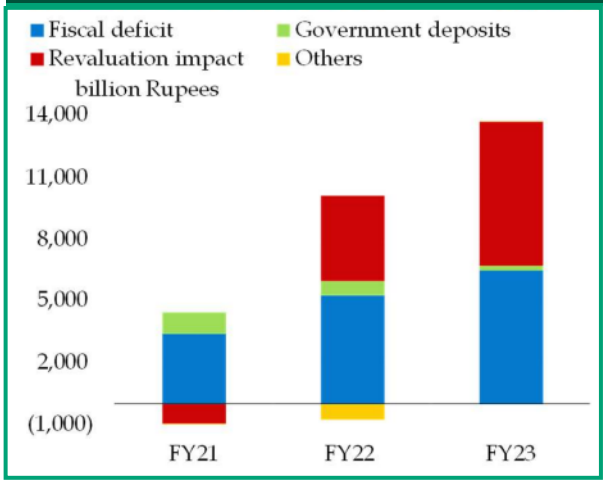
FIGURE 23 - ANNUAL PER CAPITA NOMINAL AND REAL GOVERNMENT HEALTH EXPENDITURE (USD)



Domestic and External Debt

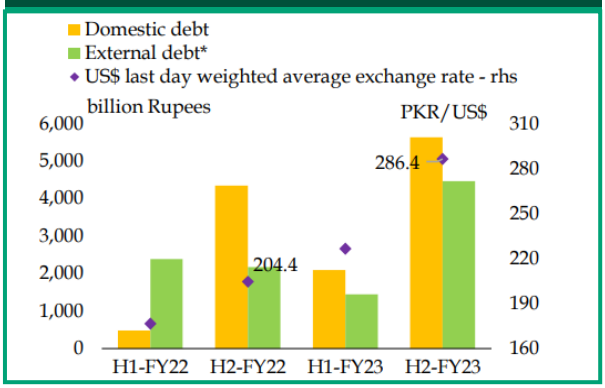
The rate at which debt accumulates has seen a notable acceleration, with gross public debt surging by 27.7 percent during FY23, a significant increase when compared to the 23.5 percent recorded in the previous fiscal year. Consequently, the gross public debt to GDP ratio has risen to 74.3 percent in FY23 from the 73.9 percent registered in FY22.[17] This upswing in debt is primarily attributed to heightened government financing requirements stemming from a substantial fiscal deficit and the depreciation of the PKR against the US dollar.

FIGURE 24 – SOURCES OF INCREASE IN PUBLIC DEBT



In terms of its composition, the predominant impetus for this increase is derived from domestic debt, which contributed approximately 56.6 percent to the expansion of public debt in FY23, as compared to the 51.4 percent seen in FY22. This rise in reliance on domestic sources for deficit financing is a direct result of lower-than-expected external inflows. Conversely, the escalation in external debt (measured in PKR) is solely attributed to the depreciation of the PKR against the US dollar during FY23.[18] This has effectively offset the decline in external debt in dollar terms, primarily due to increased scheduled repayments and constrained external inflows.

FIGURE 25 – CATEGORY WISE CHANGE IN PUBLIC DEBT



Within the domain of domestic debt, the government predominantly sourced funds from non-bank institutions during FY23, which marks a departure from the FY22 pattern where the banking sector was the primary source.[19],[20] The driving factor behind this shift is the attraction of more lucrative rates combined with lower risks when compared to alternative investment avenues, making government securities an appealing prospect for non-bank investors.

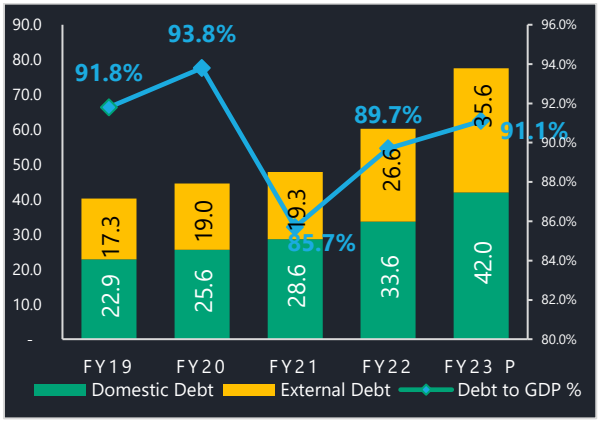
Public Debt

Pakistan's public debt reached PKR 62,880 billion, increasing by PKR 13,638 billion since June 2022. This rise is higher than the PKR 9,376 billion increase observed during the same period last year. The depreciation of the PKR against the US Dollar by approximately 39 percent contributed to the significant growth in the external public debt when converted into PKR. The government repaid PKR 310

17 State bank of Pakistan and Ministry of finance
18 The PKR depreciated by around 28.6 percent against the US dollar at end June 2023 compared to end June 2022.
19 Non-bank institutions include insurance companies, holding companies, investment companies, refinance companies, etc. that does not have full banking license and cannot accept deposits from the public. However, they do facilitate alternative financial services such as investment, risk pooling, financial consulting, brokering, money transmission and check cashing.
20 The banking sector includes both scheduled banks and SBP.

billion of its debt to the State Bank of Pakistan (SBP) and rolled over deposits of USD 3,000 million each from China and Saudi Arabia for budgetary support.

The primary factors that contributed towards the rise in external public debt, include federal primary surplus, interest on debt, currency depreciation and decrease in government cash balance. The Debt-to-GDP ratio of Pakistan stood at 91.1 percent as of 2023.



Domestic Debt

Domestic debt was recorded to the tune of PKR 41,982 billion at the end of Jun 2023, measuring an increase of PKR 8,300 billion since FY2022.

External Debt

By the end of Jun 2023, Pakistan's external public debt was PKR 35,597 billion, showing an increase of PKR 8,961 billion during FY2023.

The major portion of the Pakistan's external public debt, is represented by Multilateral loans, followed by Bilateral loans, Commercial loans, Eurobonds and Sukuks

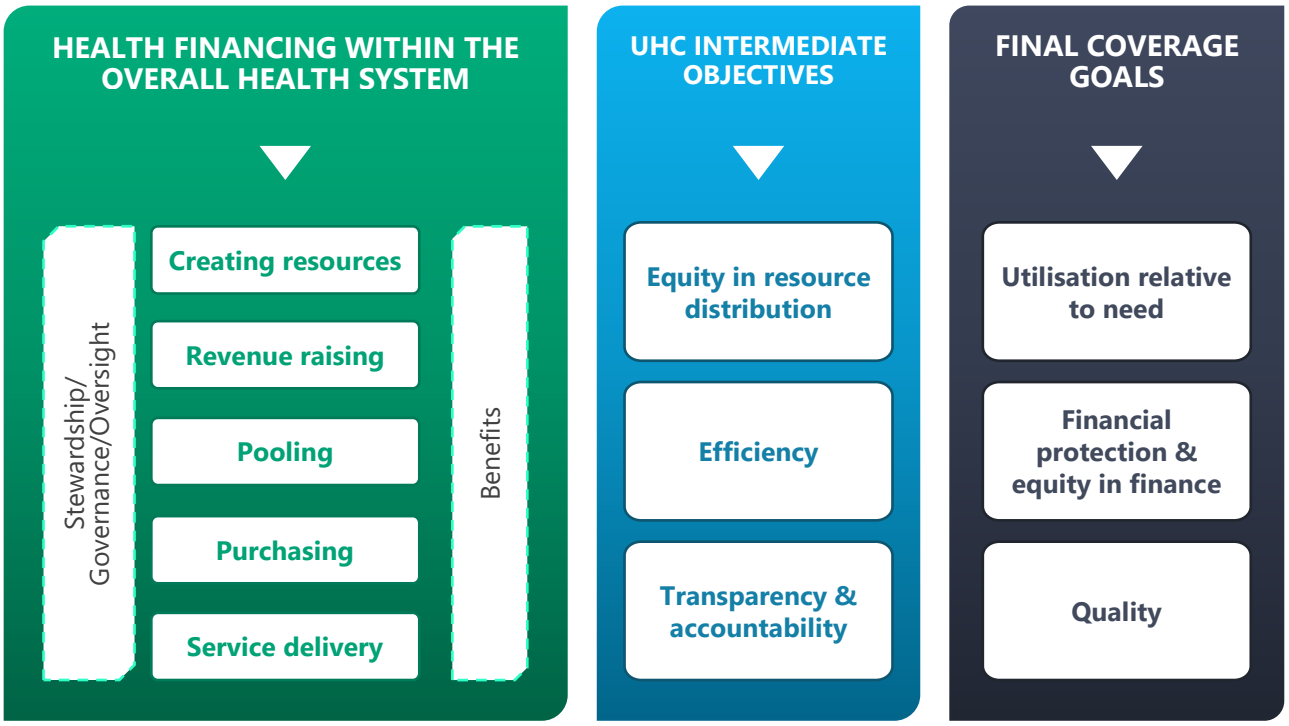
2

CURRENT STATUS OF HEALTH FINANCING IN PAKISTAN

Recapitulating, health financing refers to the **'function of a health system concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system'**.[21] Health financing is integral to health systems, facilitating the advancement toward universal health coverage through the enhancement of service coverage and financial protection. The WHO's methodology in health financing is built upon three principal functions: (i) generating revenue, (ii) consolidating funds, and (iii) procuring services strategically. This is complemented by the establishment of structured benefit packages and governance structures:

Revenue Raising: Sources and Contribution Mechanisms

FIGURE 26 - WHO'S FRAMEWORK FOR HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE



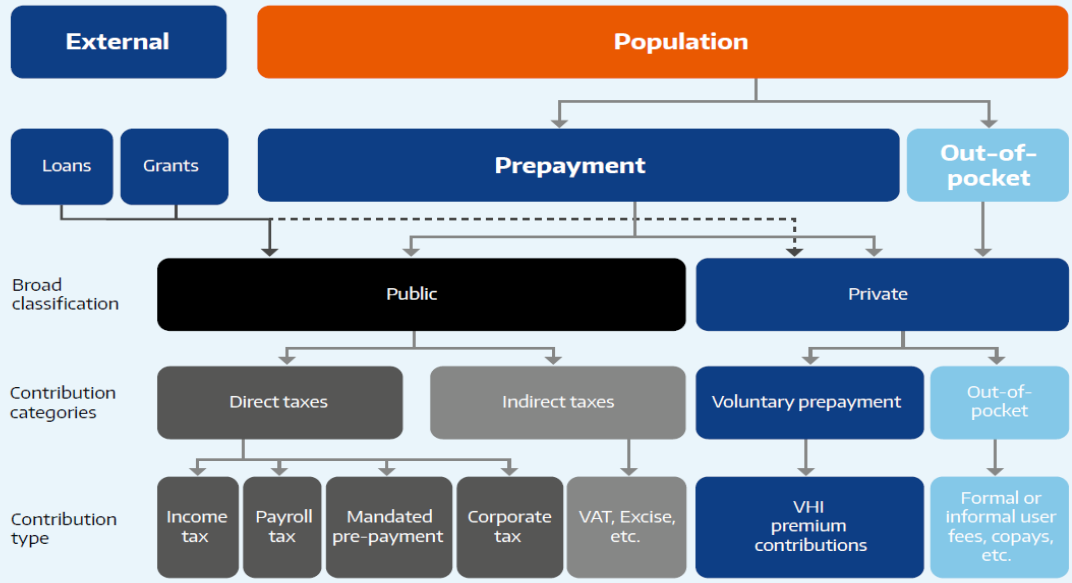
Revenue raising in the context of health systems pertains to the mechanisms through which these systems generate and accumulate funds. This encompasses not only international contributions, such as donor funding, and revenue from state-owned natural resources like oil and gas, but also acknowledges that the populace is the foundational source of financing. This public contribution comes via direct payments for health services, insurance premiums, and taxes levied on individuals and businesses. Emphasis is commonly placed on the methods employed to collect these revenues, as delineated in the 2011 System of Health Accounts, [22] which distinguishes contribution mechanisms into three categories:

A	B	C
Prepaid versus payment at the time-of-service use (out-of-pocket expenditure)	Compulsory versus voluntary contributions	Domestic versus foreign funding

An overview of the major revenue sources and contribution mechanisms[23] is shown below.

21 WHO, 2000; The World Health Report 2000, Health Systems: Improving Performance
22 Organisation for Economic Co-operation and Development, Statistical Office of the European Communities & World Health Organisation. (2011). A system of health accounts, 2011 edition.
23 WHO, 2017; Developing a national health financing strategy – reference guide

FIGURE 27 - MAJOR REVENUE SOURCES AND CONTRIBUTION MECHANISMS



The provision of financial resources for healthcare systems is sourced from public, private, and rest of the world funds.

A. Public Financing

Public financing sources include contributions from the government, at multiple levels—federal, provincial, and district. These are further complimented by autonomous entities operating under the federal and provincial jurisdictions. At the federal level, the Ministry of Finance is the primary funder, allocating resources to both the civil administration and the military establishment. Provincial funding is managed by the respective provincial finance departments. Local or district-level funding is handled by district governments and cantonment boards, each responsible for health expenditure within their specific localities. Finally, autonomous bodies or corporations under the federal and provincial governments finance healthcare for their employees via reimbursements or insurance schemes. Some large entities and corporations may also have their own healthcare facilities to cater to their employees.

From a policy perspective, public sources include those that 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. 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. This money flows to the 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.
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 categorised as public when these funds flow through recipient governments.

Following the 18th Constitutional Amendment, revenue collection responsibilities have been divided between the federal and provincial

governments. Both tiers of the public sector are involved in revenue collection, with some overlap in their responsibilities across various categories of revenue. For example, the federal government is constitutionally empowered to levy taxes on goods that are imported; exported; produced; manufactured; or consumed. However, taxation on services is the purview of provincial governments.

Provincial governments in Pakistan are responsible for collecting direct taxes on property, agriculture, and income, as well as indirect taxes such as excise duties on narcotics and motor vehicle taxes. This division of tax authority between the states and the federation leads to two significant outcomes. Firstly, the provinces' contribution to the country's total tax revenue is comparatively small. Secondly, the Federal Board of Revenue (FBR) is the primary tax collection body at the federal level, centralizing the majority of tax management.

Provincial governments primarily derive their income from a share of revenues collected federally, encompassing both tax and non-tax sources, allocated through line transfers. While the quantum of revenues generated at the provincial level has seen an uptick, the bulk of provincial income—typically 80 percent or more each fiscal year—comes from the federal government. This is mainly disbursed through the formula-driven National Finance Commission (NFC) Award and other direct transfers.

During the annual provincial budgeting process, these fiscal transfers are amalgamated with revenues raised within the province, from which allocations for the health sector are decided. Subsequently, a portion of these funds is redistributed from provincial coffers to district and local governments to facilitate direct service delivery.

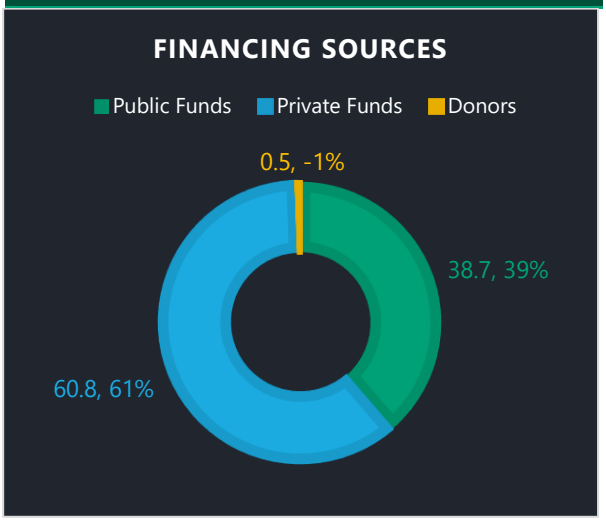
B. Private Financing

The private sector contributes over half of the total spend. Private sector revenue funds, unlike legally mandated taxes, 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. Employer funding may come through contributions to occupancy healthcare (managed by ESSIs) or through health insurance of their employees (group insurance). On the other hand, household funds mainly comprise of OOP health expenditures. Some households may also opt for private insurance, as well as make Bait-ul-Mal, and Zakat contributions made by households.

C. Rest of the World Financing

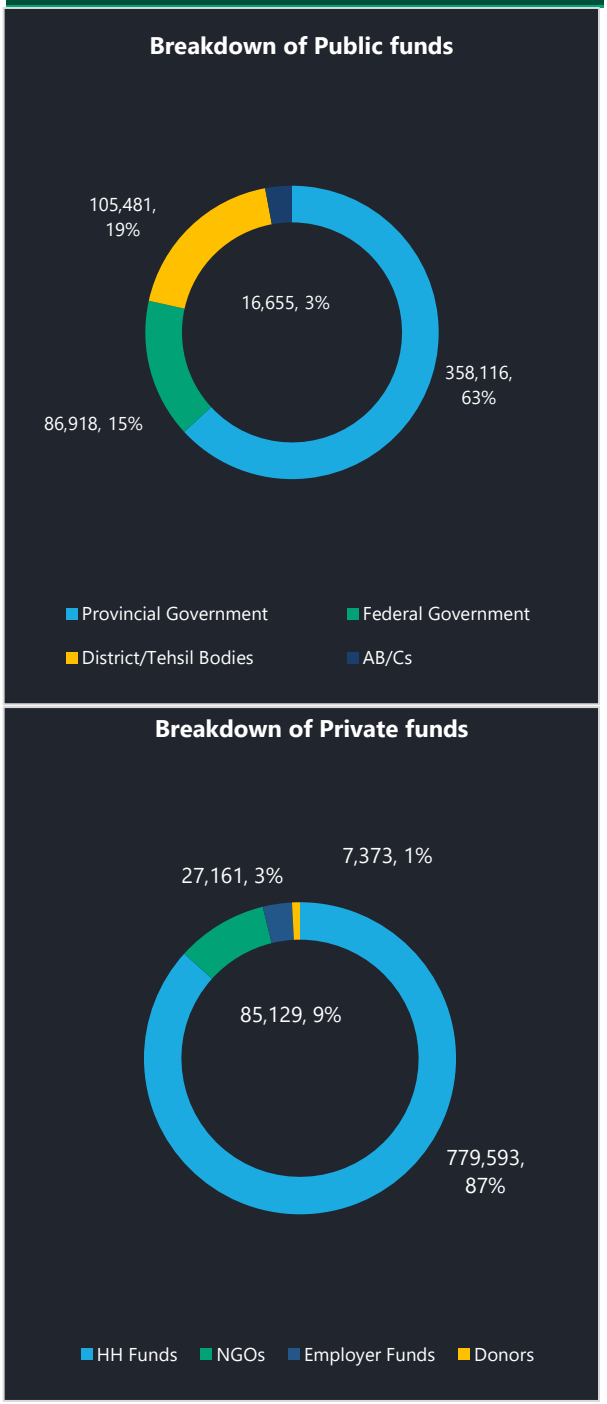
The rest of the world category comprises of development partners spending on health; however, only their direct spending is included. The money, which has been granted to the government (budgetary aid) and which thus is in the budget is reflected in government spending.

FIGURE 28 - FINANCING SOURCES



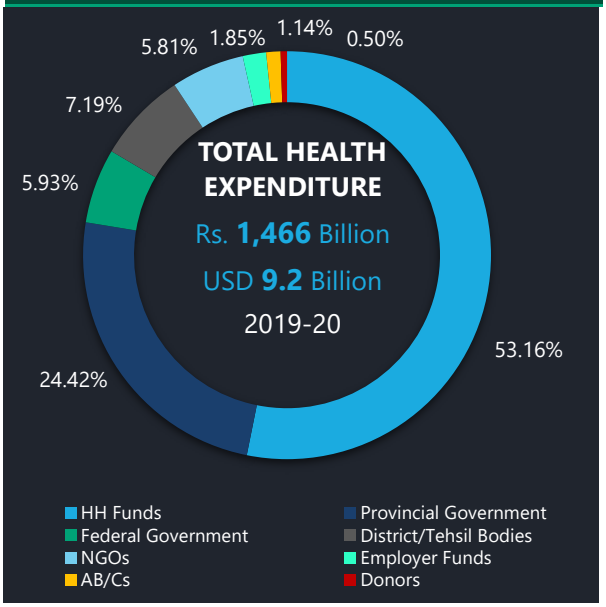
Of the total health expenditures amounting Rs 1,466.426 billion in Pakistan for the year 2019-20, financing source of 60.8 percent (Rs 891,587 million) of health spending was funded by the private sector, 38.7 percent (Rs 567,507 million) by the public sector, and 0.5 percent (Rs 7,332 million) by donor agencies.

FIGURE 29 - BREAKDOWN OF PUBLIC AND PRIVATE FUNDS



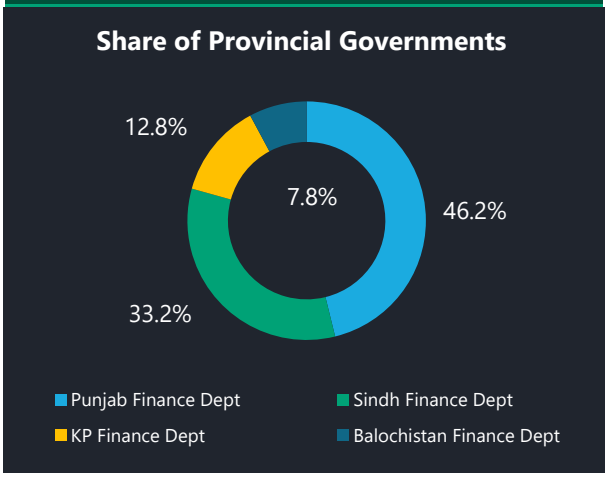
Of the total Rs 1466.426 billion in Pakistan for the year 2019-20, Rs 779,593 million (53.16 percent of the total) were household funds, followed by the share of provincial government (Rs. 358,116 million; 24.42 percent), federal government (Rs. 86,918 million; 5.93 percent), district/tehsil bodies (Rs. 105,481 million; 7.19 percent), NGOs (Rs 85,129 million; 5.81 percent), employer funds (Rs 27,161 million; 1.85 percent); autonomous bodies (Rs 16,655 million; 1.14 percent) and donor agencies (Rs 7,373 million; 0.5 percent).

FIGURE 30 - BREAKDOWN OF TOTAL HEALTH EXPENDITURE ACCORDING TO FINANCING SOURCES



In the context of total health expenditures by provincial governments, Punjab Finance Department contributed the most with Rs. 165,289 million (46.2 percent), followed by Sindh Finance Department at Rs. 118,825 million (33.2 percent), and KP Finance Department with Rs. 45,919 million (12.8 percent). Balochistan Finance Department allocated the least, contributing Rs. 28,083 million (7.8 percent).

Figure 31 - BREAKDOWN OF PROVINCIAL GOVERNMENT SHARE



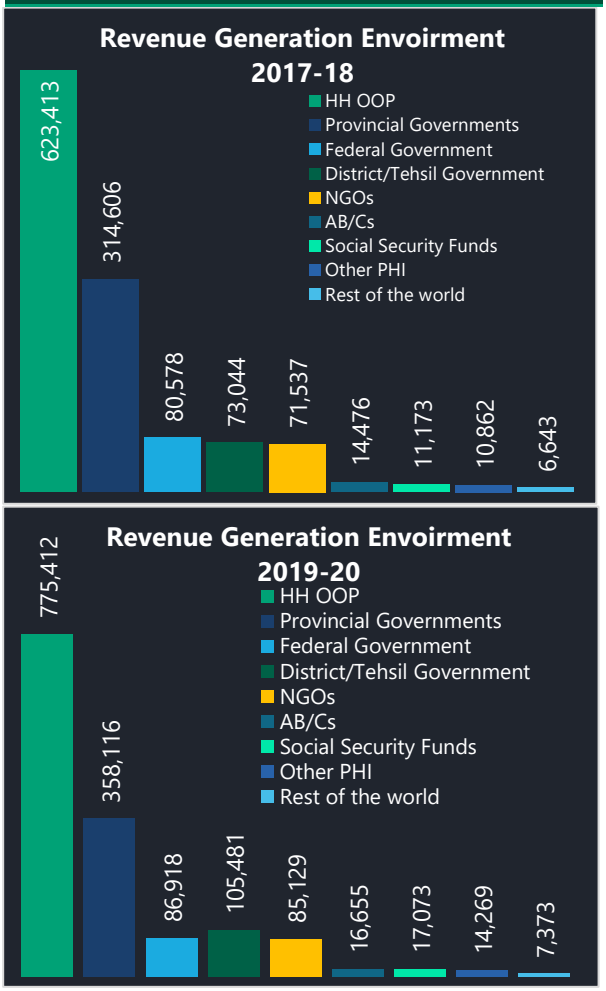
According to the National Health Accounts for the fiscal year 2019-20, rest of the world which is extra budgetary support to the Government indicates that 0.5 percent of the total health expenditure pertains to donor contributions. This information is inaccurate, as the government has already incorporated donor

contributions in its allocation. To prevent double counting, the National Health Accounts only consider donor contributions once. However, data gathered from donors (including GHI) indicates a committed sum of 658 million USD, with actual expenditures reaching approximately 593.9 million USD—signifying the realization of roughly 90 percent of the commitment. In comparison to the financial year 2019, the allocation amounted to 701.1 million USD, representing a 6 percent decrease. Expenditures against the fiscal year 2019 allocation totalled 620.3 million USD, approximately 88 percent of the commitment.

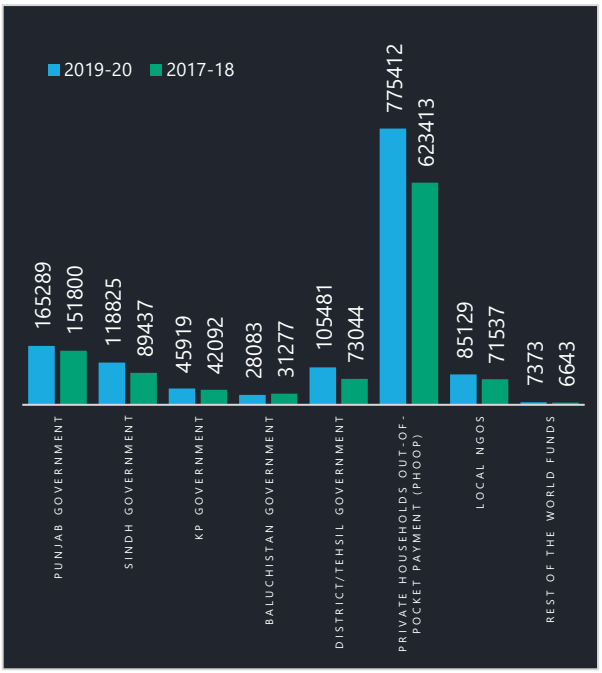
It is noteworthy that the National Health Accounts for the fiscal year 2019-20 recorded a total expenditure of 9.2 billion USD, wherein the ratio of donor contributions to the overall health expenditure stood at 6.4 percent. The data highlights a commendable level of expenditure against commitment from donors, as evidenced by the substantial realization of pledged funds, particularly when compared to the preceding fiscal year.

FIGURE 32 - TOTAL COMMITMENT VS ACTUAL EXPENSES FY 20

FIGURE 33 - COMPARISON OF REVENUE GENERATION BETWEEN 2017-18 AND 2019-20

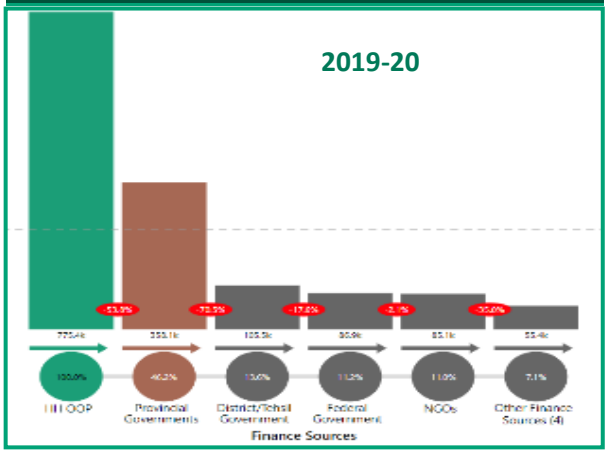


The following graph illustrate the comparison of total healthcare expenditure per financing sources and sub-sources between the 2017-18 and 2019-20 in **the total healthcare expenditure per financing source**



also indicating an increase. The Social Security Funds saw the highest percentage increase of 52.81 percent, while the Federal Government saw the smallest increase of 7.87 percent. Household OOP remains the largest contributor to finance in both years. In contrast, the proportion of financing from Provincial Governments and the Federal Government decreased from 2017-18 to 2019-20.

FIGURE 34 – THE COMPARISON W.R.T FINANCING SOURCES BETWEEN 2017-18 AND 2019-20



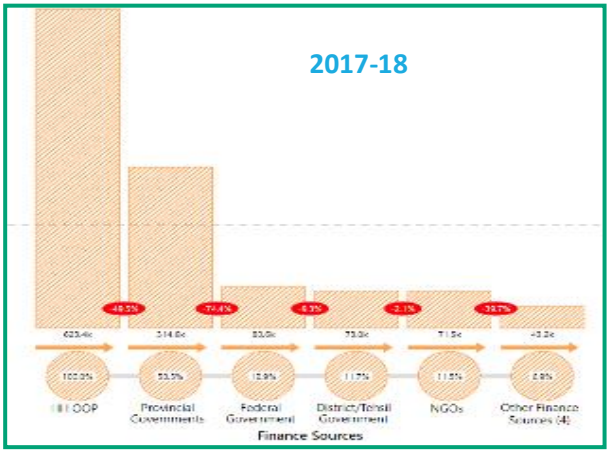
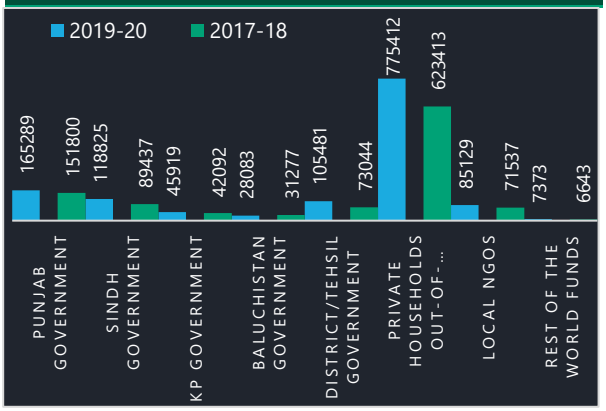


FIGURE 35 - THE COMPARISON W.R.T FINANCING SUB-SOURCES BETWEEN 2017-18 AND 2019-20

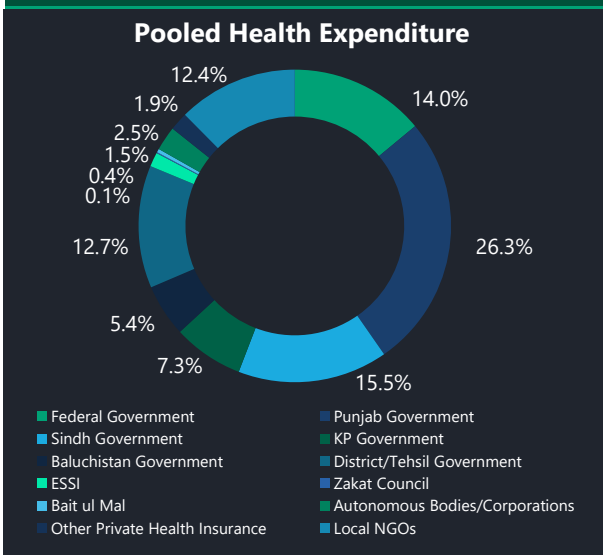


Pooling of Funds

Pooling is the consolidation of health-related funds into a central entity responsible for purchasing health services. This approach spreads the financial risks of healthcare among all members of the pool, rather than burdening individuals.

Financing agents are organisations or bodies that manage and allocate funds sourced from various financiers to pay for activities within the healthcare system. They handle a spectrum of funds, broadly categorised into public, private, and rest of the world funds.

FIGURE 36 - BREAKDOWN OF POOLED HEALTH EXPENDITURE



Pakistan's health financing structure is characterised by a multitude of distinct funds, each serving specific segments of the population with some degree of overlap. Key government-managed pools include: (a) the tax-funded pool for

direct healthcare services, (b) various social protection programme pools, and (c) funds managed by autonomous organisations. Additionally, dedicated funds exist for the military and armed forces, as well as for government employees. On the private side, pooled health funding sources encompass private health insurance schemes and social security funds.

Various funds are tailored for specific population groups, with access often based on socio-economic or demographic factors. Wealthier individuals typically have options like voluntary health insurance or employer-provided schemes, while those in poverty may rely on aid-based funds such as zakat and Bait-ul-Mal. Additionally, distinct pools exist for specific groups like military personnel and members of the ESSI, indicating a limited range in risk pooling diversity.

In Pakistan's largely informal economy, the scope for expanding health insurance through formal employment is limited. Thus, the public health budget emerges as the primary pool for most citizens. This budget plays a crucial role in fair resource distribution across different regions and socio-economic levels. Despite this, individual OOP expenditure, which falls outside any pooling mechanism, constitutes the largest source of funding in the health sector.

Out of Pocket expenses account for 53.14 percent of Pakistan's total health expenditures. In contrast, pooled funds make up 46.6 percent of the health financing. Of this pooled portion, the majority, 80.5 percent, is managed by territorial governments, with contributions detailed as follows: 24.2 percent by the Punjab Government, 17.4 percent by the Sindh Government, 12.7 percent by the Federal Government, 15.4 percent by District/Tehsil Governments, 6.7 percent by the Khyber Pakhtunkhwa Government, and 4.1 percent by the Balochistan Government. Local NGOs contribute 12.5 percent, autonomous bodies/corporations provide 2.4 percent, social security funds make up 2.5 percent (with 1.9 percent from ESSI, 0.4 percent from Bait-ul-Mal, and 0.2 percent from zakat funds), and the remaining 2.1 percent comes from other private health insurance (PHI) sources.

Purchasing and Provider Payment

The process of purchasing within the healthcare system involves directing pooled funds towards healthcare providers to facilitate the delivery of health services for designated groups or the entire population. Entities responsible for this financial distribution vary and can include a national or regional health department, insurance entities whether compulsory or elective, or non-governmental organisations.

Healthcare providers represent the final beneficiaries of these funds, and they encompass a range of organisations and individuals who receive payments from purchasing bodies in return for, or in expectation of, delivering healthcare services within the defined scope of health accounts. This includes a spectrum of providers such as government and private hospitals, clinics, public community health centres, private medical practices, indigenous health practitioners, as well as pharmacies, dispensaries, and laboratories. Healthcare providers can be broadly classified into the following three categories:

a) Public Providers	b) Private Providers	c) Non-Governmental or Non-Profit Organisation Providers

The framework for purchasing in the healthcare system is structured around four key considerations:

- **The Scope of Services:** Decisions about which health services to purchase are crucial. Typically, governments or health insurance agencies determine a benefits package detailing the

specific health services to be subsidised or covered in full. The crafting of these packages usually takes into account the population's needs, the effectiveness of the services, and their costs.

- **The Beneficiaries:** Identifying the target population for purchased services is another critical element. Governments aim to alleviate the burden of out-of-pocket expenses by offering subsidised or complimentary health services to various population segments.
- **The Choice of Providers:** Decisions regarding from whom healthcare services should be purchased are strategic. Options include public and private providers, pharmacies, and drug stores.
- **The Payment Model:** How healthcare providers are compensated is a pivotal part of purchasing. Payment methods can be 'passive' or 'strategic', with each approach influencing the volume and quality of healthcare services delivered. Payment strategies are designed to motivate providers to deliver higher quality care and manage resources efficiently.

Provider payment mechanisms are multifaceted, encompassing a spectrum of strategies that range from passive to active or strategic purchasing. These mechanisms also vary based on whether payment rates are set before or after services are utilised, whether payments to providers are prospective or retrospective, and the specific administrative processes involved.

The method of payment to providers establishes incentives that affect provider behaviour. Within healthcare systems, multiple payment mechanisms may operate simultaneously, or they might be integrated into a comprehensive payment strategy.

Active or strategic purchasing is characterised by allocating funds to healthcare providers based on an assessment of the population's health needs and/or the provider's performance. In contrast, passive purchasing involves disbursing funds without leveraging such evaluative data. Typically, healthcare payment systems employ a mix of passive and strategic approaches.

Prospective payment methods include arrangements like line-item budgets, global budgets, capitation, and fixed salaries. Line-item budgeting organises funds according to different expense categories, typically including staffing, operational costs, and capital investments. Global budgets allot a predetermined sum to healthcare providers, such as hospitals, to cover all services provided within a set timeframe. Capitation involves a pre-arranged, per-patient payment made to healthcare providers over a certain period, which covers the agreed-upon range of services. Under a salary-based model, healthcare professionals receive a consistent income that does not fluctuate based on the quantity or type of services rendered.

Retrospective payment methods, such as fee-for-service and case-based payments, are based on services rendered. Fee-for-service payments are calculated on the volume and type of provided services. Case-based payments, often influenced by Diagnosis-Related Groups (DRGs), provide a fixed reimbursement rate per patient discharge, with the rate determined by the diagnosis, administered treatment, and type of discharge. DRGs aim to classify patients into economically and medically homogenous categories to standardise resource use and costs. Meanwhile, intermediate methods, like per diem payments for hospital stays, offer a compromise between fee-for-service and fixed-rate models.

TABLE 3 - DESCRIPTION OF PROVIDER/PURCHASER PAYMENT MECHANISMS

Payment Mechanism	Unit of Payment
Line-item budgets	▪ Line-item budgeting is when the budget information is organised 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 characterised as inputs for health systems.

Payment Mechanism	Unit of Payment
	▪ 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

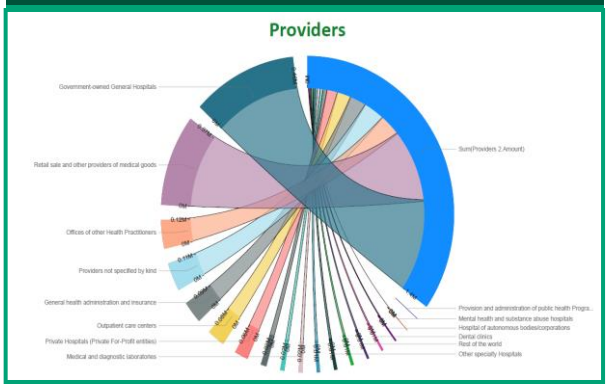
In Pakistan's healthcare landscape, private sector facilities largely operate on a fee-for-service payment model, while the public sector employs a triad of payment systems. The most prevalent of these is line-item budgeting, which governs the allocation of resources within public facilities. Specialised tertiary care institutions often operate under global budgets, and a growing number of primary and secondary care facilities are embracing contracting out as a payment method. This latter approach, gaining traction over the past ten years, involves public facilities being managed by private entities under a global budget, salaries of government employees excluded. However, funding allocation to health facilities is not needs-based but rather dependent on existing financial availability and historical allocations, disregarding the specific health demands of the population they serve.

Health service purchasing remains highly segmented. Various bodies, including federal and provincial health departments, military services, ESSI, autonomous bodies, and cantonment boards, provide healthcare directly through their facilities. The federal government also funds vertical programmes targeting specific diseases such as cancer and diabetes. Public entities typically receive fixed line-item budgets, while private ones predominantly utilise fee-for-service models. Since 2015, three social protection programmes employing case-based payments have been established, all contracted to a single private sector company, allowing for some standardisation across the programmes. Nonetheless, there is an absence of coordination among different insurers and a lack of a regulating body to align payments with the health needs of the population.

There is a significant disparity in payment levels between public and private sector healthcare providers. Public sector salaries are fixed and standardised by province, grade, and facility type, and are generally lower than earnings in the private sector, which operates under fee-for-service. This discrepancy can lead to conflicting interests, with public sector doctors potentially incentivised to refer patients to their private practices for further treatment.

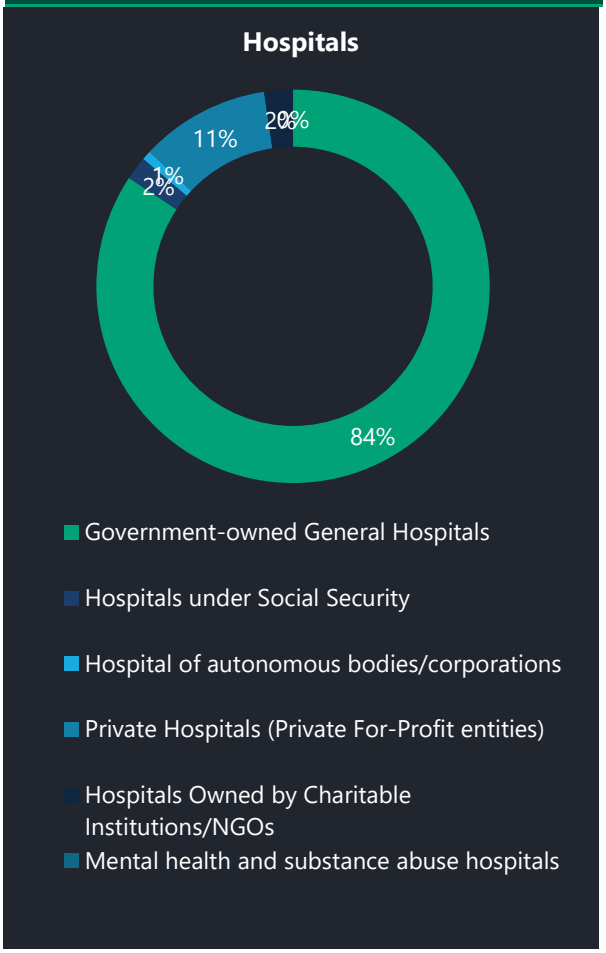
In terms of incentivizing improvements in quality of care, public sector providers typically receive fixed salaries without additional performance-based incentives. In contrast, the private sector's fee-for-service model does offer some motivation for quality care, with profit-sharing arrangements in place in some facilities to encourage better service delivery. However, across both sectors, there is a lack of financial incentives specifically designed to promote higher quality or better-coordinated care.

Figure **37 - SHARE OF PROVIDERS IN TOTAL HEALTH EXPENDITURE**



Regarding healthcare expenditure distribution among providers, hospitals account for the largest share at Rs. 549,488 million (39.1 percent), with retailers and other medical goods providers at Rs. 374,635 million (26.7 percent). This is followed by ambulatory health care at Rs. 255,132 million (18.2 percent), unspecified providers at Rs. 114,857 million (8.2 percent), general health administration and insurance at Rs. 89,712 million (6.4 percent), and international expenditure at Rs 7,373 million (0.5 percent). Within hospital expenses, general hospitals, encompassing public, private, and NGO-run institutions, account for the majority, with public hospitals making up 87 percent of this expenditure. In contrast, mental health and substance abuse services represent a minimal share of healthcare spending.

FIGURE 38 - CLASSIFICATION OF HOSPITALS AND GENERAL HOSPITALS



3

FINANCING POLICY AND GOVERNANCE

Health Financing Policy Environment

Health policies are frameworks comprising strategies, initiatives, and decisions aimed at achieving specified health objectives within a nation. Health financing policy, specifically, involves the strategic use of financial resources to ensure the health system can meet the health needs of all individuals. Pakistan's strategic direction has historically been guided by **the Five-Year Plans -** a series of centralised economic goals focused on national development, initiated by the Ministry of Finance. These plans are rooted in production cost theory and aimed at facilitating a trickle-down effect. It, became a central focus for the civil bureaucracy starting in the 1950s. The inaugural plan, endorsed by Prime Minister Liaqat Ali Khan for 1950–1955, aimed at accelerating industrialization, expanding the financial sector, and prioritizing heavy industry. While not all Five-Year Plans were fully realized within their designated periods, with some being halted or deemed unsuccessful, others achieved their intended outcomes.

In 2004, a rebranding of this approach led to the Medium Term Development Framework (MTDF), introduced by the Planning Commission. Launched in 2005, this new framework sought to transform Pakistan into a significant industrial power, expedite human development, and foster an economic system targeted at poverty alleviation and achieving the Millennium Development Goals (MDGs), thereby moving away from the previous centralised planning model.

Moreover, in 2003, the introduction of the Poverty Reduction Strategy Paper (PRSP-I) marked a milestone in policy development, offering to align consensus, set priorities, and allocate resources at all governmental tiers to combat poverty and the social inequalities. This strategy was further advanced with the advent of PRSP-II in 2005.

The 18th amendment retains national planning within the purview of the Federal Legislative List-II. Despite this, the development and implementation of the MDTF have been less than robust. The twelfth Five-Year Plan, initiated in 2018, was not brought to completion. The Planning Commission, however, continues to produce an Annual Plan, delineating short-term strategic priorities. The focus of these plans over the last couple of years has been to mitigate the economic fallout of the COVID-19 pandemic across diverse sectors. In 2022, the incumbent government initiated the 'Turn Around Pakistan' programme, aiming to realign national development objectives with the ambitious targets set forth in Pakistan Vision 2025.

Furthermore, the strategic direction for the health sector has also been periodically articulated through the **National Health Policies introduced in the years 1990, 1997, and 2001**. These policies have historically provided a framework for health sector priorities within the country's broader economic plans. The **National Health Vision (NHV) 2016–2025**[24] and National Action Plan, NHSR&C (2019-23)[25] strives to provide a responsive unified direction to overcome various health challenges, while ensuring adherence to universal health coverage (UHC) as the goal.

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

- The Government is cognizant that adequate, responsive, and efficient health financing is the cornerstone of a country's well-functioning health system. Spending on health will be advocated as an "investment" to the line ministries, finance departments, and international development partners.

24 Ministry of NHSR&C, 2016; National Health Vision 2016-25

25 Ministry of NHSR&C, 2016; Action Plan NHSR&C 2019-23

- Federal and provincial governments will increase health allocations as pledged in Pakistan Vision 2025 to 3 percent of GDP, to maximise the payoffs from investing in health.
- Priorities for health allocations will be revisited, and a higher share for essential health service delivery, preventive programmes, communication, capacity building of frontline health workers, and governance ensured.
- Pro-poor social protection initiatives (including the Prime Minister National Health Programme) 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 UHC. 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 mobilisation 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 the effort 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.[26] 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",[27]). The aim of any health system is to maximise the attainment of the goals, conditioned by contextual factors from outside the 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.

FIGURE 39 - WHO'S FRAMEWORK OF GOALS AND FUNCTIONS OF HEALTH SYSTEMS

Pakistan's approach to strategic health prioritisation is reflected through various sub-sectoral strategic documents, each focusing on different aspects of the healthcare system. Despite this, a cohesive and unified health financing strategy has not been established, which would delineate clear objectives and foster consensus on priorities and reforms for health financing. Recent developments have seen the Ministry and Provincial/Area Health Departments finalise Essential Packages of Health Services and UHC Benefit Packages. These are complemented by the expansion of the Social Protection/Sehat Card Programme, addressing distinct facets of health financing. Nonetheless, these reforms would benefit from being integrated within a comprehensive health financing strategy to ensure alignment and direction.

26 The World Health Report – Health systems: improving performance. Geneva: World Health Organisation; 2000

27 Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action Geneva: World Health Organisation; 2007. Available from: http://www.who.int/entity/healthsystems/strategy/everybodys_business.pdf

Health Financing Key Stakeholders

TABLE 4 – ROLE OF VARIOUS STAKEHOLDERS IN DIFFERENT COMPONENTS OF HEALTH FINANCING

	Public Funds	Private Funds	Rest of the World Funds
GOVERNANCE	Cabinet Division under the Prime Minister and Chief Ministers		
	Ministry and Departments of Finance		
	Ministry of Planning, Development & Special Initiatives and Departments of P&D		
	Ministry of National Health Services, Regulations & Coordination		
	Health Departments		
	Other Relevant Ministries & Departments		
	Academic Institutions		
			Development Partners
REVENUE RAISING	FBR and Provincial govts	Households	Donors
	Government run NGOs	ESSI	
	Private NGOs		
POOLING OF FUNDS	Ministry & Departments of Finance		
	Ministry of National Health Services, Regulations & Coordination		
	Health Departments		
	Bait-ul-Mal	Private Health Insurance	
	Zakat	ESSI	
	Government run NGOs	Private NGOs	
STRATEGIC PURCHASING	Federal Ministries		Donors
	Health Departments		
	Government run NGOs		
		Households	
		Private NGOs	
		Insurance Companies	
	AGPR		
	Auditor General		

Health Financing Governance

In Pakistan's federal system, various levels of government prioritise and administer health sector funds, but coordination between resource generation, pooling, and the strategic purchasing of health services is often lacking. The involvement of the private sector in policy reforms remains tentative. The public health financing landscape comprises:

Federal government bodies, including the Ministry of National Health Services, Regulation and Coordination, the Ministry of Defence, the Ministry of Interior, among others.

a	Provincial governments;
b	District governments; and
c	Social assistance and protection schemes aimed at aiding the poor, operated by federal and provincial entities, either independently or in collaboration.

Following the 18th amendment, the provinces now receive 57.5 percent of the divisible pool under the 7th National Finance Commission Award, leading to a reduction in the federal allocation for devolved subjects. From 2010 to 2017, provincial funding for the health sector relative to GDP notably increased—doubling in Punjab and Khyber Pakhtunkhwa and rising by nearly 50 percent in Sindh and Balochistan. Post-2017-18, the onus of primary healthcare programmes vertically transitioned entirely to the provinces, thereby boosting provincial expenditure levels.

Opinions vary on the ideal health financing model for a country. In Pakistan, the health budget is sanctioned by the Prime Minister/National Assembly (and the Chief Ministers/Provincial Assemblies). This budget is an integral part of the federal/provincial budgets, underpinning financial commitments to actualise health policies and strategies. **The composition of the health budget, split into current and development expenditures, dictates the magnitude of health spending**. The current budget, typically fixed, caters to routine operational costs, including salaries, administrative expenses, debt servicing, and loan repayments. Both federal ministries performing health-related functions and provincial departments have limited discretion over this segment of the budget, with re-allocation proving challenging. **Public Financial Management rules** stipulate the budgetary process. The stages of Pakistan's budget call circular range from establishing a budget strategy to conducting a budget review.[28].

During the **budgetary process**, the finance section of the M/o NHSR&C is responsible for liaising with Ministry of Finance on the budget ceiling for health, expenditure control, and tracking expenditure as per line-item budget allocations.

The MTBF has been employed across various government departments to establish a connection between policy objectives and the allocation of health expenditures within the available fiscal space. However, line-item budgeting presents a significant bottleneck when it comes to allocating funds for prioritised health interventions. This method involves allocating and monitoring expenditures according to distinct types or categories of expenses as recognised in the country's financial system.

To allocate and monitor health expenditures, the Ministry collaborates with the Controller General of Accounts (CGA). The CGA oversees the effective operation of the SAP-based **Financial Accounting & Budgeting System (FABS).** FABS represents an Integrated Financial Management Information System (IFMIS) that functions across government offices at federal, provincial, and district levels, ensuring streamlined financial management and budgeting processes.

The current IFMIS generates general purpose financial reports through the system of Charts of Accounts (CoA).[29] These charts of accounts cover transactions related to expenditure and revenues. 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 5.

Monitoring and accountability of the health spending is done through the NHA is a framework for estimating the total healthcare expenditures (both public and private) at the national level. It is a tool specifically designed for health sector policymakers and managers, and it aims to aid them in their efforts to improve health system performance.

28 In Pakistan budget cycle consist of six steps and includes: Setting of budget strategy, preparation, authorisation, implementation, reporting and monitoring and budget review

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).

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 the budget circular are listed below:

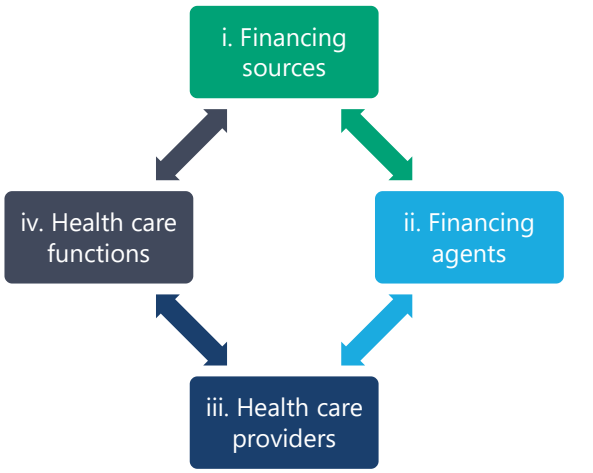
TABLE 5 - CHART OF ACCOUNTS FRAMEWORK

Code Classification for Budgeting	Reporting of transactions 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 project 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

NHA tracks the flow of funds through the healthcare sector by compiling the four selected dimensions:

FIGURE 40 - BUDGET CALL CIRCULAR PROCESS



The health system in Pakistan faces the challenges of governance, finances, service delivery, human resources, introduction of new technologies and coping with a huge burden of supplies especially medicines.

After devolution, the provincial governments are responsible for making policy, approving laws on health issues, planning and implementing health programmes 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, participating in international meetings, managing federally controlled hospitals and offices and procurement.

Health Financing Governance in the private health sector is unregulated. However, Islamabad Healthcare Authority and Provincial Healthcare 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 the implementation of Minimum Service Delivery Standards (MSDS) in both public and private sector healthcare establishments, including allopathic systems 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. The 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.

In addition to public private partnerships, the government also provides financial support to the private sector through Health Foundations and Banking Institutions, evidence generally not available.

4

BENEFITS AND CONDITIONS OF ACCESS

Health Benefits

Health financing is a multifaceted endeavour encompassing the essential pillars of revenue collection, fund pooling, purchasing, and critically, the formulation of benefit policy. Benefits policy defines which services and population groups are entitled to healthcare, delineating the parameters for service accessibility. This encompasses considerations of both cost, such as co-payment structures, and service delivery factors, including the scope of subsidised treatments and the mechanics of the referral system. Policies must decisively outline the coverage scope, the spectrum of services provided, and any associated costs at the point of care.

In developing benefit design, there must be a comprehensive review of the distribution of all public health finances, extending beyond the confines of schemes with explicit entitlements or select demographic coverage. This includes the judicious orchestration of private funds channelled towards publicly endorsed benefits.

The curation of publicly funded health services and goods, alongside the stipulations for their access, should be a balanced interplay of technical acumen and political will underpinned by evidence-driven rationale. It calls for a methodical approach to benefit entitlements, steered by well-defined criteria that weigh cost-effectiveness, risk of financial strain to individuals, and thorough fiscal impact evaluations. The governance of these decisions hinges on a transparent process buttressed by broad stakeholder endorsement.

Benefit policies need to be all-encompassing and unambiguous, reflecting the totality of public investment within the health sector. Following allocation, benefit design should harness these public finances to fuel strides towards UHC—whether through government disbursements or insurance scheme procurements—whilst guiding private health expenditure in supporting UHC objectives.

Amidst an array of coverage schemes, policymakers must ensure uniformity and lucidity in the entitlements and access conditions across services, precluding confusion, fostering transparency, and circumventing inefficiencies stemming from service duplication.

Dispelling ambiguity is a pivotal goal of benefit design; uncertainty can obstruct access and give rise to wastefulness. Entitlements should be clearly delineated yet avoid excessive granularity, particularly in initial care services. Any co-payments should be nominal and standardised to minimise uncertainty and safeguard against economic distress.

Finally, benefit design must be in lockstep with broader health financing strategies and service delivery aims, guaranteeing funds are sufficient for entitlements and that pivotal health services are prioritised. When programme budgets are aligned with health needs, they increase resource agility and bolster the monitoring of outcomes.

Essential Package of Health Services/UHC Benefit Package of Pakistan

To transform the NHV into reality, one of the key actions was to develop a UHC Benefit Package for Pakistan. UHC Benefit Package consists of i) an 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 the support of the DCP3 secretariat, global evidence was reviewed and

adjusted to the needs of Pakistan to inform the prioritisation of health interventions at community and PHC centre levels for inclusion in the EPHS.

Platform	Number of Interventions	Unit Cost US$ (person/ year)	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+

Designing 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 organise 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.

TABLE 6 - SUMMARY OF PROVINCIAL/FEDERATING AREA EPHS IN 2021

Province	District EPHS			Tertiary Level		
	Immediate Priority			Immediate Priority		
	No. of Interventions	Cost per Capita for	DALYs Avert (in Million)	No. of Interventions	Cost per Capita for	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	21.5	1.33	25	4.76	0.08
KP	98	17.6	2.1	22	8.81	0.34
AJK	96	18.94	0.3	22	3.19	0.21
GB	96	12.09	0.23	22	5.34	0.008
		17.19	**15.37**		**6.94**	**2.15**

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 UHC, given the best estimates of the funding available to the government. The UHC Benefit Package of Pakistan/Essential Package of Health Services was finalised and endorsed by the Inter-Ministerial Health & Population Council on 22 October 2020. In the same meeting, all Health & Population ministers decided to localise scientific evidence at the provincial/federating area level and develop Provincial/Federating Area EPHS accordingly. Sindh was the first province to finalise its EPHS document and get an endorsement from its UHC Steering Committee, followed by other federating areas and provinces. Based on the DCP3 recommendations, Intersectoral National Action Framework is underway.

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.

Social Health Protection Programmes

In the effort to extend affordable care across the country, the government introduced the Sehat Card Programme (SCP) and the Social Health Protection Initiative. These programmes are primarily aimed at the nation's most economically disadvantaged citizens. Together, they have extended their reach to over 90 districts, encompassing a staggering 170 million individuals.

The Sehat Card Programme provides a comprehensive range of indoor treatment options for both priority diseases and secondary care, each subject to a financial limit. For priority diseases, families are initially granted an annual financial ceiling of Rs 400,000, with the option to access an additional Rs 500,000 per household in more pressing circumstances. This scheme covers an extensive array of indoor treatments including cardiac procedures (stents, open-heart surgery, valve replacements, etc.), cancer treatments (surgery, chemotherapy, radiotherapy), care for burns and trauma, organ failure treatments, dialysis, managing complications from diabetes and chronic infections, neurosurgical procedures, abdominal surgeries, fracture care, and various other medical and surgical interventions. In terms of secondary care, families are initially provided with a financial limit of Rs 60,000 per annum, with the provision for an additional Rs 60,000 if the situation necessitates. This includes all medical and surgical cases not covered under the priority package.

Table 7 - Sehat Card Programme

Only Indoor/Day-Care Procedures		
Name of Package	**Priority Disease Treatment Package**	**Secondary Care Treatment Package**
Financial Limits	Initial Financial Limit: Rs 400,000/family/year	Initial Financial Limit: Rs 60,000/family/year
	Additional Financial Limit (if required): Rs 500,000/family/year	Additional Financial Limit (if required): Rs 40,000/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, immunisation 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 empaneled 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	

Currently, these programmes offer coverage for inpatient services, with each social protection initiative encompassing a benefits package that covers secondary care up to a varying limit, distinct to

each scheme. The financial backing for these social protection endeavours is sourced through a combination of federal, provincial, and donor funds, and notably, none of these initiatives require any co-payment from the patients.

To enrol patients and incorporating hospitals into the scheme, these programmes have established partnerships with insurance companies. In turn, these companies have negotiated to settle treatment package rates with the individual hospitals. Following this, the insurance companies reimburse the hospitals once the enrolled beneficiaries have accessed the services.

TABLE 8 - CURRENT STATUS OF SEHAT CARD PROGRAMME

Province/Federating Area	Current Status
Islamabad	Below poverty and Universal in 2022
Azad Jammu & Kashmir	Universal
Gilgit-Baltistan	Universal
Punjab	Universal
Khyber Pakhtunkhwa	Universal
Tribal Districts	Universal
Balochistan	Universal
Tharparkar (Sindh)	Universal
Rest of Sindh	TBD

SCP uses data from the National Socio-Economic Registry (NSER), defining poverty as families/households with a daily income of less than $2. The enrolment unit is family, and all family members registered with the National Database Registration Authority (NADRA) are automatically enrolled in SCP.

SCP is being implemented in a phased manner, starting from below-poverty-line families and eventually targeting universal families and finally providing coverage 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 programme has not been implemented for the families of Balochistan and Sindh (other than District -Tharparkar). The programme expanded to approximately 40 million families during fiscal 2021-2022.

SCP only provides services to families requiring indoor health care services. The services include, but are not limited to, cardiac treatments, cancer management, burn management, organ failure management (dialysis etc.), complications of diabetes mellitus, accident/trauma management, neurosurgical procedures, abdominal surgeries, fracture management and other medical and surgical interventions. The programme so far does not offer facility for transplants, implants, and other categories such as self-inflicted injuries, cosmetic surgeries, outpatient services, sports injuries etc. SCP has a wide network of more than 900 panelled hospitals – both in public and private sectors - across Pakistan. Beneficiaries from any district can avail treatment from any of these empanelled hospitals.

SHPI was launched by the provincial government of Gilgit-Baltistan in 2016. SHPI defines poverty as families/households with a daily income of less than $1.00. The unit of enrolment in SHPI is household; the basis for enrolment is automatic a maximum of 7 household members can be enrolled in the programme. Currently, SHPI provides coverage to 5,340 households (approx. 35,671 individuals). Like SCP, 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 percent, and remaining 25 percent 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 empanelled with the insurance companies.

Besides these major initiatives, poor populations also have access to Zakat and Bait-ul-mal funds to pay for health care. Zakat is a 2.5 percent 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 programmes 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 programmes 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 healthcare infrastructure through public revenues. 'Fauji' foundation covers 9.1 million retired military personnel using commercially generated funds from their businesses and having their own health care infrastructure.

Furthermore, employers of private and commercial institutions which employ ten or more persons must provide insurance to employees under the 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 its own network of hospitals and clinics where free services are offered to employees and their families. According to 2013 estimates, provincial ESSIs provide coverage to 6.89 million individuals in total.

5

FINANCING GAP

UHC is predicated on the principle that every individual and community should have equitable access to necessary, quality healthcare without the risk of financial hardship. Pakistan has embraced this ethos by developing a costed set of priority interventions, termed the UHC-Benefit Package, drawing inspiration from DCP-3. According to a World Bank analysis, an estimated Rs. 1.28 trillion is required to attain UHC, increase access to quality healthcare services, and safeguard against catastrophic health expenditure.

The Government of Pakistan has pledged Rs. 477 billion, and international donors have committed Rs. 102 billion towards this goal. However, a significant financing gap of Rs. 841 billion still remains, which needs to be addressed to achieve UHC in Pakistan. With Pakistan's population at 227 million in 2020, this translates to a per capita financing gap of PKR 5,804 or USD 36.70.

TABLE 9 - FINANCING GAP IN 2019-20

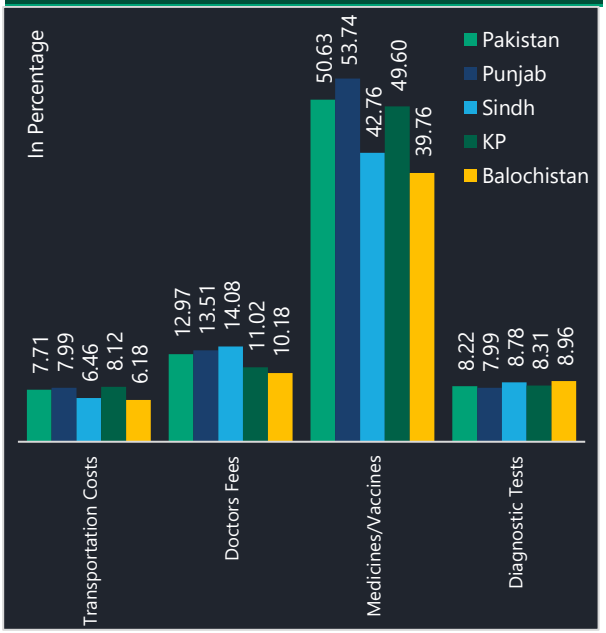
GoP Commitment – Current	**401,091**
GoP Commitment - Development	76,499
Total – GoP Commitment	477,590
International Development Partners - Commitment	102,025
Total Commitment	579,615
(Less) commitment for non-prioritised interventions	(132,257)
Prioritised commitments	447,358
Cost of UHC Interventions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

Financial Risk Protection/Catastrophic Health Expenditure

Pakistan's reliance on OOP expenditures to finance healthcare is notably high. Punjab records the highest percentage of total OOP health spending at 53 percent. Additionally, OOP health expenditure is more prevalent in urban areas (58.89 percent) compared to rural areas (41.11 percent).

Analysis of the NHA 2019/20 and the Household Integrated Economic Survey (HIES) 2018/19 indicates that over half of the total OOP spending is on medical products, appliances, and equipment. Other significant OOP expenditures include doctors' fees, diagnostic tests, and transportation costs.

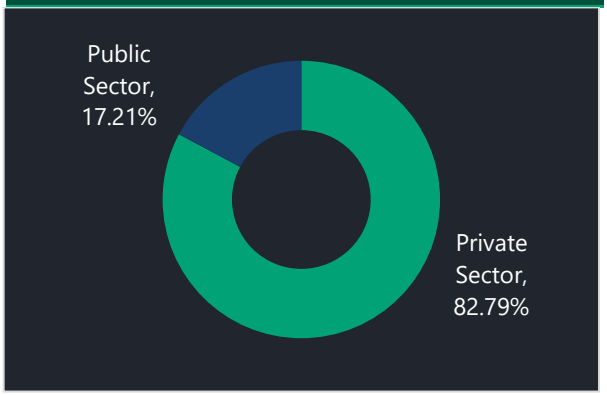
FIGURE 41 - NATIONAL AND PROVINCIAL COMPARISON OF OOP EXPENDITURE ACCORDING TO CATEGORIES (PERCENT)



In Pakistan, OOP health expenditures incurred by the private sector overwhelmingly surpass those in the public sector. However, a breakdown of OOP expenditure shows that spending on medicines/vaccines, diagnostic tests, and

transportation costs is considerably higher in the public sector than in the private sector, where doctors' fees dominate.

Figure 42 - OOP Expenditure According to Health Care Provider (%)



According to the latest NHA, around 73 percent of the total OOP expenditures was incurred on outpatient services, while around 20 percent of total OOP spending was incurred on inpatient care for their illness. 5.79 percent of total OOP spending goes to "unrelated to illness" and just 1.5 percent expenditures reflect self-medication which includes 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 doctors already prescribed. Further analysis of data on the type of health care by provinces reflects that the percentage share of outpatient is highest in Punjab (77.46 percent) followed by KP (72.01 percent), Balochistan (69.06 percent), and the lowest share is Sindh (60.01 percent). For inpatient services, the highest share is of Sindh (33.26 percent), and the lowest share is of Punjab (13.66 percent). According to HIES 2018-19, 30.32 percent of OOP expenditure is spent on indoor/outdoor patient services, highest for Sindh (39.26 percent) and lowest for KP (25.96 percent).

Figure 43 - OOP Expenditure According to Categories in Public and Private Sectors (%)

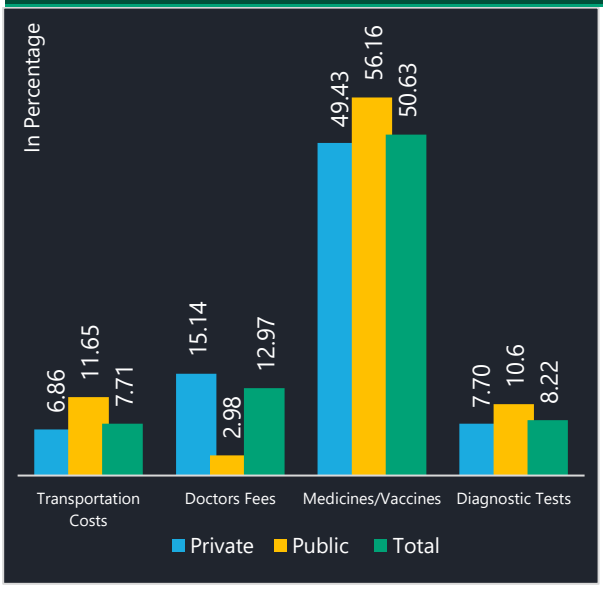


Figure 44 - OOP Expenditure According to Type of Health Care (%)

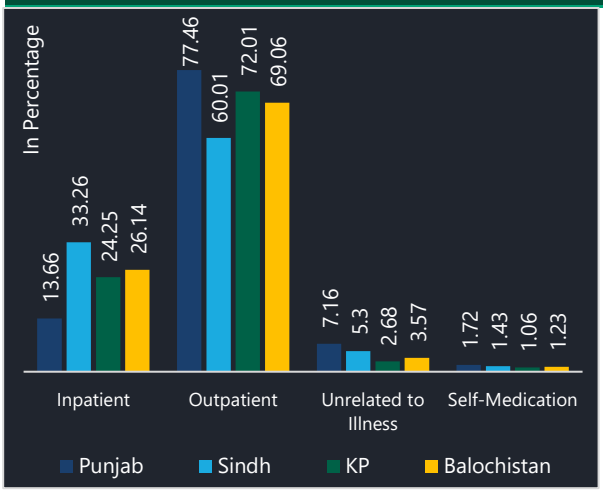


Figure 45 - Province Wise Comparison of OOP Expenditure According to Type of Health Care (%)

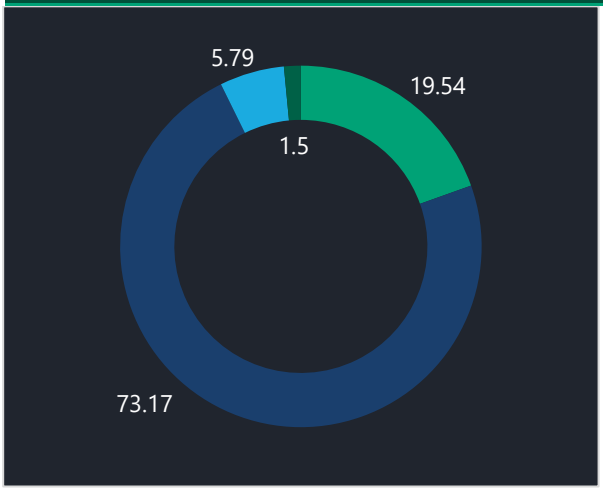


Table 10 - OOP Expenditures on Health by Category and Provinces according to Household Income & Expenditure Survey 2018-19					
OOP Expenditures on Health by Category and Provinces (%)					
OOP Expenditure Categories	Pakistan	Punjab	Sindh	KP	Balochistan
Medical Products, Appliances & Equipment	69.68	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 incurring catastrophic health expenditures due to OOPs. The WHO has defined financial catastrophe for the last eight years as direct OOP exceeding 40 percent of household income net of subsistence needs. Subsistence needs are the median household's food expenditure in the country. Expenditures in excess of the 40 percent cut point generally require the reallocation of household expenditures from basic needs. More recently, the World Bank has found it more straightforward to define financial catastrophe when OOPs exceed 10 percent 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. It seems to provide more or less the same estimates as the WHO method.

The two indicators used in this analysis are: (1) the Percentage of the population with household expenditures on health greater than 10 percent of total household expenditure or income; and (2) the Percentage of the population with household expenditures on health greater than 25 percent of total household expenditure or income. In 2018, the population with household expenditures on health greater than 10 percent of total household expenditure or income was 4 percent. In contrast, the population with household expenditures on health greater than 25 percent of total household expenditure or income was 0.5 percent. This reflects 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. Families with lower income, especially those below or around poverty lines, more often than not opt out of getting medical treatment due to their inability to pay out, leading to illnesses getting worse and possibly causing life-altering and life-threatening damage Individuals are more likely to pay for medical treatment as household income increases, leading to adverse financial consequences. The ratio will not change dramatically over time unless substantial health financing reforms exist.

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 OOP 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 included this indicator in the analysis. However, experience has shown that policymakers can immediately see the political relevance of the incidence of financial catastrophe and/or impoverishment. In contrast, the ratio of OOPs to THE may not have the same immediate policy impact.

6

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 a platform for managing resources from all sources and across national and subnational levels. A standard budget cycle includes three distinct stages:

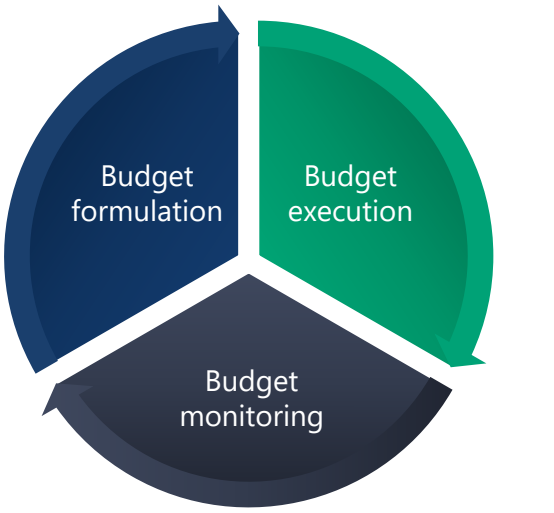
1) Budget formulation involves making macroeconomic projections to help determine what level of total government expenditure will be feasible and how much will be allocated to each line (sector) ministry based on strategies and policy priorities. This step also involves negotiations at different levels, including with individual ministries.

2) 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. During this stage, government agencies make payments to health care providers (both public and private) for covered services.

3) 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 meeting government policy objectives, including for the health sector.

In Pakistan however, there is a lack of a definitive mandate for budgetary funds to be maintained in a Treasury Single Account (TSA), alongside an absence of constraints on re-appropriations within the financial year. Additionally, the framework lacks fiscal transparency mandates and does not stipulate the recording of new fiscal commitments. An internal audit function does exist within the Finance Department; however, its scope is restricted to a limited number of departments.

FIGURE 46 - PUBLIC FINANCIAL MANAGEMENT SYSTEM



Notable progress has been made in enhancing PFM systems, including the implementation of a financial accounting and budgeting system, the introduction of an MTBF, and the adoption of output-based budgeting. Despite these advancements, budget credibility and execution remain significant areas of concern. The establishment of a risk-based internal controls framework remains pending. The internal audit functions at the federal level and in Khyber Pakhtunkhwa require enhancements, while such functions in other provinces are yet to be instituted. A major challenge persists in resolving audit observations raised by the Auditor General of Pakistan (AGP). In recent years, with the support of prominent development partners such as the Asian Development Bank and the World Bank, the government has initiated a six-pillar PFM Reforms Strategy (2018–2027) to tackle identified risks and systemic inefficiencies. A robust monitoring and corrective mechanism is essential to ensure the effective and timely realisation of the anticipated benefits from these PFM reform initiatives.

Institutional Framework: Accounting and auditing are federally mandated tasks performed by the offices of the AGP and the Controller General of Accounts

(CGA), respectively. Budgeting and expenditure management are handled by the provincial governments. The AGP, independent of constitutional design, conducts external audits of public finances.

Legal Framework: Pakistan has embraced a unified PFM system under the Constitution of Pakistan, specifically articles 78-88, which govern the management of the federal consolidated fund and public account. The allocation of business to the Federal Finance Division regarding PFM components is detailed in Article 25 of the Rules of Business 1973, as per Articles 90 and 99 of the Constitution. The Auditor General's Ordinance, 2001 regulates the external audit of public funds across Pakistan, covering the Federation, provinces, and districts. The Controller General of Accounts Ordinance, 2001 mandates the CGA to maintain accounts of the Federation, provinces, and district governments in formats and according to methods and principles approved by the Auditor-General and the President. In June 2019, the Parliament enacted the PFM Act 2019, addressing issues pertaining to the federal consolidated fund, the public account of the federation, and other federal government matters. The Act focuses on implementing a TSA, publishing tax expenditures and contingent liabilities in the budget document, submitting mid-year budget performance reviews to the Parliament, and making these reports publicly accessible. It also mandates the establishment of Chief Finance and Accounts Officers in ministries and the implementation of an Internal Audit Function (further details are available in section VI of the Report on the key features of the PFM Act, 2019). The preparation of annual budget statements is stipulated under Articles 73, 74, 80, and 82 of the Constitution and regulated through the NAM Framework, System of Financial Control and Budgeting, 2006, using the MTBF. The MTBF process involves line ministries preparing three-year expenditure estimates within the ceilings provided by the Ministry of Finance (for recurrent budgets) and the Planning Commission (for development budgets). Each year, the process includes updating the previous MTBF estimate by one year and adding a new outer year. Budget execution is governed under Article 99 of the Constitution and 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 operations, public debt management, and fiscal transfers are overseen by the federal and provincial finance ministries. The provincial Accountant Generals (AGs) and the Accountant General Pakistan Revenues (AGPR) report to the CGA at the federal level, which is responsible for policy formulation, coordination, and administrative duties.

The Government of Pakistan employs a Chart of Accounts under the New Accounting Model (NAM), compliant with IMFGFSM2001, for budget formulation and reporting and for recording current and development expenditures and revenues. This Chart of Accounts facilitates expenditure tracking across various dimensions: administrative unit, economic, functional, and programme.

The federal budget for implementing agencies includes detailed functional and object classifications. Once approved, the budget is integrated into the Financial Accounting & Budgeting System, which is operational at the federal, provincial, and district levels. The PFM process commences with budget preparation by the Ministry of Finance (MOF), following a predefined budget calendar. The budget undergoes debate and approval in the national assembly.

Drawing and Disbursing Officers (DDOs), designated officers in spending units, submit expenditure bills to the account offices for payment processing. These offices, located at the district, provincial, and federal levels, execute payment claims while ensuring budgetary control and compliance. The CGA maintains financial transaction accounts and prepares periodic and annual financial reports for the respective governments.

The AGP conducts the external audit of these accounts, with the audited accounts and related management letters for the Federal Government submitted to the President, who then presents them to the National Assembly for examination.

At the provincial level, the PFM process begins with budget preparation, undertaken by the Finance Department in line with set timelines and consultations with line departments. The Planning and Development (P&D) department oversees the annual development programme (ADP) and its monitoring. The budget is then presented to the provincial legislature for review and approval. Similar to the federal level, DDOs in spending departments submit expenditure bills to the account offices for payment processing. The district and provincial-level account offices (district accounts office [DAO] or treasury offices) manage these payment claims, upholding budgetary controls and compliance checks. As per the legal framework, the CGA, through the provincial AG, maintains financial transaction accounts and prepares both in-year and annual financial statements for the Province. The DG Provincial Audit performs external audits on behalf of the AGP office, with the audited accounts and reports submitted to the province's governor for presentation at the Provincial Assembly for legislative scrutiny. The Directorate General District Audit audits local governments, while the DG Commercial Audit examines public sector entities. The Public Accounts Committee (PAC) of the Provincial Assembly oversees the legislative scrutiny of provincial financial operations.

The Public Expenditure and Financial Accountability (PEFA) programme offers a framework to assess and report on the strengths and weaknesses of PFM using quantitative indicators to measure performance. Designed to provide a point-in-time snapshot of PFM performance, the PEFA methodology can be replicated in successive assessments, summarising changes over time. The outcome of this assessment, the PEFA report, serves as a foundation for dialogue on PFM reform strategies and priorities. The methodology's repeatability allows for tracking changes over time and contributes to broader research and analysis of PFM.

PFM is expected to play a crucial role in the implementation of national and sectoral policies and ensuring more efficient provision of public services. In the health sector, for example, scarce funds can be allocated to treatments that are not cost effective, shrinking funds available for treatments that are cost effective and reducing the impact of public spending on overall population`s health. PEFA methodology is not calibrated to measure sector-specific efficiency nor to assess the equal access for all to public services.

PEFA assessments should introduces a sector specific Service Delivery assessment module which should present a set of diagnostic questions mapped to the relevant PEFA framework indicators to collect and analyse information, aiming to assess the extent to which a Sub National Governments public financial management (PFM) performance enables effective service delivery.

PEFA Assessments in Pakistan: The last federal level PEFA assessment was performed in 2012. 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). Provincial-level PEFA assessments were completed as follows:

1. Balochistan and Khyber Pakhtunkhwa PEFA were completed in 2017
2. Sindh PEFA was completed in 2020
3. Punjab PEFA was completed in 2019

The results of these PEFA Assessment are as follows:

Table 11 – Results of PEFA Assessments

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+

Health sector specific fiduciary risk assessments needs to be conducted to develop risk mitigation plans.

7

INNOVATIVE FINANCING, RESEARCH & DEVELOPMENT

The past decade has seen a seismic shift in global health focus, matched by a significant influx of international health development aid from the world's richest nations. Despite this, the journey towards global health goals, including the MDGs, remains frustratingly sluggish, with a daunting funding chasm still to bridge. In a bold response, members of the Organisation for Economic Cooperation and Development (OECD) and their developing country allies are pioneering new financial pathways. These groundbreaking mechanisms, supplementing traditional aid, are pivotal in narrowing the resource divide and ensuring critical healthcare reaches the underserved.

Innovative financing in this context means "revolutionary applications of Official Development Assistance (ODA), synergistic public-private alliances, and groundbreaking financial flows." These channels are not just additional funding sources; but lifelines in achieving SDGs, primarily by plugging financial voids.

By 2010, a major portion of these avant-garde financing solutions was channelled towards bolstering health sectors in developing countries. These novel methods have garnered substantial funds for global health and excelled in operational and disbursement efficacy. Heavyweights like the Global Fund, Gavi Alliance, and UNITAID now view these innovative finance channels as a cornerstone of their funding strategies, catalysing significant expansion in their global health missions.

One standout innovation is the International Finance Facility for Immunisation (IffIm), which was initiated in 2006 to bolster the Gavi. This trailblazing mechanism, converting long-term ODA pledges into immediate cash via international bond markets, has been a game-changer in Gavi's funding arsenal. To date, IffIm has mobilised a staggering US$ 2.3 billion, injecting US$ 1.6 billion directly into vaccine procurement and delivery.

Another strategic initiative supporting Gavi is the Advanced Market Commitment (AMC), a unique mechanism to bankroll new vaccine research and production. Its genius lies in incentivizing the creation of vaccines that would otherwise not see the light of day due to market unprofitability. A pioneering pneumococcal vaccine project, kickstarted in 2009 with a US$ 1.5 billion backing, exemplifies this approach.

The Global Fund, too, has embraced innovative finance, introducing the Debt2Health initiative. Here, creditor nations write off a part of their loans with the condition that the debtor invests half of the waived sum in Global Fund-approved projects.

Additionally, the Global Fund reaps benefits from the Product RED initiative, where corporates allocate a slice of their profits from RED-branded products to fight global health crises. By 2009's close, Product RED had rallied an impressive US$ 140 million, fuelling health initiatives across Ghana, Lesotho, Rwanda, and Swaziland.

UNITAID's financing strategy is equally remarkable, leveraging an air-ticket levy to combat HIV/AIDS, Tuberculosis, and Malaria. This innovative approach addresses market imbalances, ensuring drug availability and affordability. To date, 60 percent of UNITAID's funding, totalling US$ 1.5 billion, comes from this levy, supporting transformative health projects in 93 countries.

These pioneering financing models fall into five key categories:

Results-Based Financing	**Catalytic Funding**
Impact Investing	**Socially Responsible Investing**
Innovative Taxation Avenues	

FIGURE 47 - Classification **OF INNOVATIVE FINANCING MECHANISMS**

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 ▪ Co-funding ▪ Seed funding ▪ Volume guarantees ▪ Credit guarantees ▪ Revolving funds ▪ Advanced market commitments	▪ 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

8

CHALLENGES AND THE WAY FORWARD

Vision for Financial Protection: A well-defined vision is needed in Pakistan for health financing to ensure service availability and prevent financial hardship due to healthcare costs, thus promoting equitable access to healthcare for all citizens.

Resource Utilisation: Merely increasing the budget is not enough. The focus must be on cost-effective utilisation of these resources, ensuring that every rupee spent contributes effectively towards improving healthcare access and quality.

Addressing Insufficient Funding: The stark difference in health spending per capita between Pakistan and other income groups indicates an urgent need for increased funding. This is critical to meet the population's health needs and to progress towards global health targets like SDG3.

Government Health Expenditure: The current low percentage of government spending on health, compared to the global average, highlights a gap that needs to be filled. This would involve increasing the budget and ensuring a higher proportion is dedicated to health.

Taxation and Revenue Mobilisation: Efficient revenue mobilisation, particularly through taxes on products detrimental to public health, could serve a dual purpose: reducing consumption of harmful goods and increasing the funds available for healthcare.

Utilizing 'Sin Taxes': Revenues from taxes on tobacco and sugary beverages, often termed 'sin taxes', can be explicitly earmarked for healthcare expenditures. This promotes healthier choices and provides a dedicated funding source for health.

Proportion of Government Expenditure: With health's share in total government expenditure being low, there is a significant opportunity for reprioritisation. Increasing the health budget can lead to better health outcomes and more robust health systems.

Pandemic Preparedness: The COVID-19 crisis has underlined the importance of being prepared for health emergencies. Funding in this area needs to be increased to ensure readiness for future pandemics and health crises.

Stagnant ODA for Health: The stagnation in Official Development Assistance for health signifies a need for renewed efforts in garnering international support, which is vital for overcoming challenges in health financing and system strengthening.

Efficiency and Equity in Spending: Global trends indicate substantial waste in health spending. Pakistan must rectify this by ensuring that funds are used where they are most needed and benefit all sections of society, especially the underprivileged.

Reducing OOP Expenses: High OOP expenses for health services can deter people from seeking necessary care and lead to financial hardship. Effective social health protection schemes are needed to mitigate this.

Broadening Coverage: Expanding the scope of social health protection to include outpatient and primary care is crucial, especially for vulnerable groups and those in the informal sector who often lack coverage.

Balance in Care Types: There is a risk of over-emphasising hospital care at the expense of primary care. Policies should encourage a balance, ensuring that primary care is available and integrated with hospital care.

Unified Health Protection Initiatives: Consolidating various health protection initiatives can enhance efficiency and equity in the system. A unified approach can lead to better risk pooling and resource allocation.

Data Constraints: Up-to-date and accurate health financing data from government, donors and OOP is essential for informed decision-making. Strengthening the data collection and processing infrastructure is crucial for effective health financing policy development and implementation. Allocation and expenditure data of development partners including Global Health Initiatives (GHI), needs to be

regularly collected and reviewed by the Ministry, making alignment with the government data and establishing a sustainable funds monitoring system, while avoiding double counting of data. A mechanism (Development Assistance Database (DAD)) existed in the Economic Affairs Division in past which may be revived again. Tracking of financing data should be used for setting and achieving health financing objectives.

Bridging the Financing Gap: There is a significant gap between the current funding levels and what is needed to provide comprehensive health services. Addressing this gap requires a combination of economic growth, political commitment, and innovative financing mechanisms.

Proactive Response to Emerging Challenges: Demographic changes, technological advancements, and new health threats necessitate proactive health financing reforms. Addressing these challenges early can ensure the sustainability and effectiveness of the health system.

Nationally Coordinated Strategy: A national strategy is needed to ensure consistency and efficiency in health financing across Pakistan's provinces. This would involve central guidelines that can be adapted to local needs.

Adapting Global Principles: Applying globally recognised health-financing principles, tailored to the local context, is key for advancing healthcare reforms in Pakistan.

Synergy in Health Programmes: Creating synergies between programmes like: the Sehat Card Programme and the UHC Benefit Package can streamline efforts and maximise impact.

Comprehensive Policy Approach: A holistic approach to health-financing policy, encompassing sector-specific and broader economic considerations, is necessary to address potential future challenges.

Strengthening Leadership and Governance: Effective health-financing governance requires strong leadership, coordination, and capacity-building across relevant government departments including Ministry of Finance and Ministry of Planning, Development and special Initiatives.

Domestic and International Investments: Closing the UHC financing gap will require a strategic mix of domestic funding, international aid, private sector involvement, and innovative health financing solutions.

9

ANNEXURES

HEALTH FINANCING STATUS - PAKISTAN 2023

CURRENT SITUATION

247 M

52.7

UNIVERSAL HEALTH COVERAGE INDEX

0.2 %

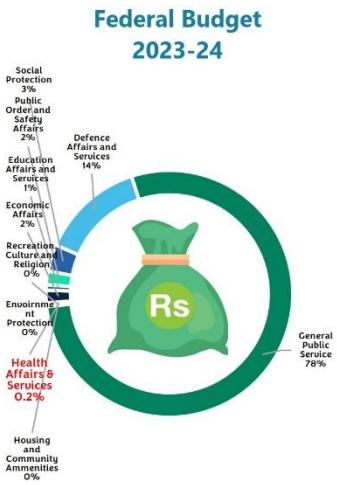
FEDERAL HEALTH BUDGET ALLOCATION

GENERAL FINANCING

GDP
Rs. 84,657.9 billion
Economic Survay of Pakistan 2023

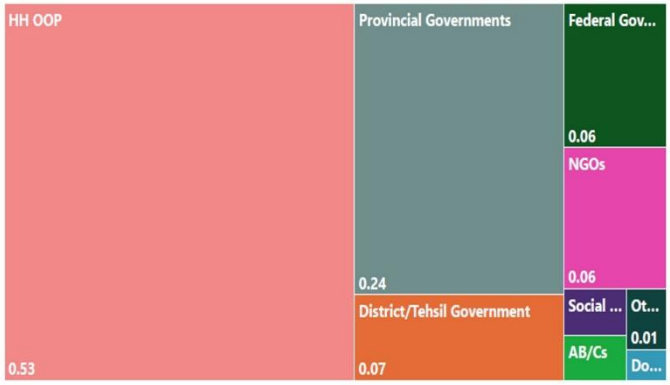
GDP Growth rate
0.29%
Economic Survay of Pakistan 2023

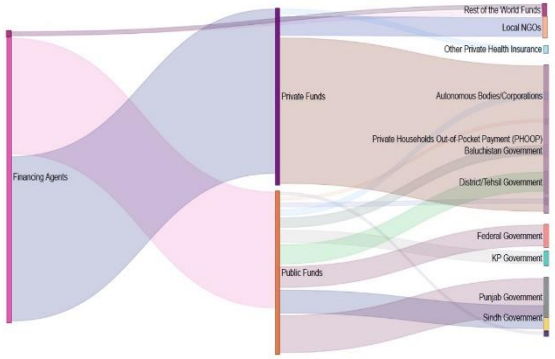
Income Per Capita
USD 1,568
Economic Survay of Pakistan 2023

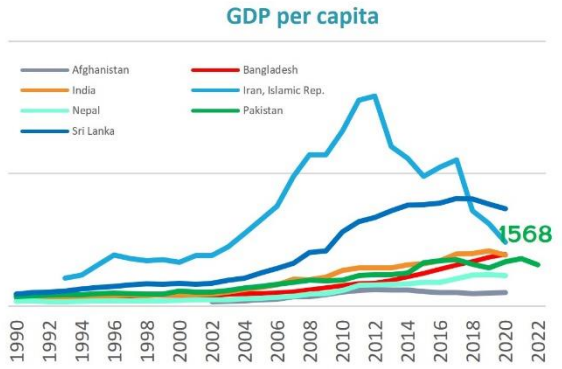


HEALTH FINANCING

Total Health Expenditure Rs. 1,466,426 billion *NHA 2019-20*	Current Health Expenditure Rs. 1,403,740 billion *NHA 2019-20*	Development Health Expenditure Rs. 62,686 billion *NHA 2019-20*	Total Health Expenditure per Capita USD 42.52 *NHA 2019-20*	Current Health Expenditure per capita USD 40.7 *NHA 2019-20*	Out of Pocket Expenditure per capita USD 22.6 *NHA 2019-20*	OOP as % of THE 53.16% *NHA 2019-20*	GGHE-D as % of THE 38.68% *NHA 2019-20*	GGHE-D as % of GDP 1.4% *Economic Survay of paksiatn 2023*



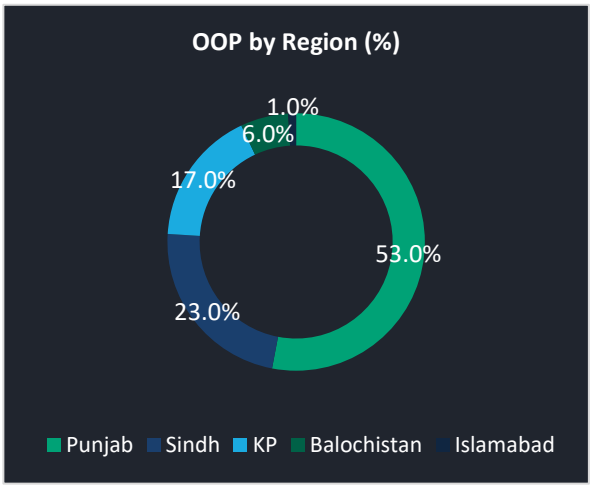


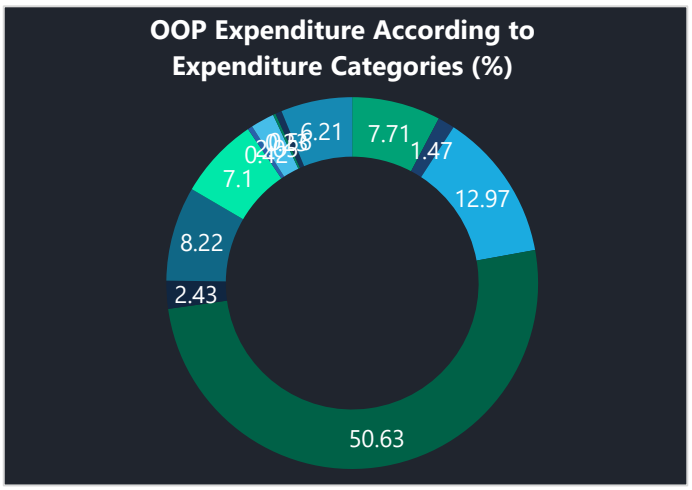


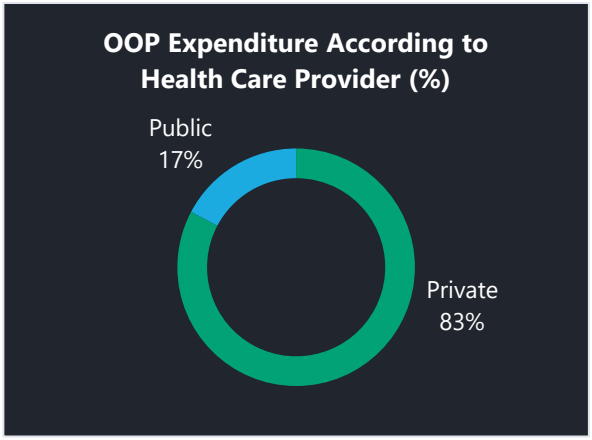
ANNEX 1 OUT-OF-POCKET EXPENDITURE

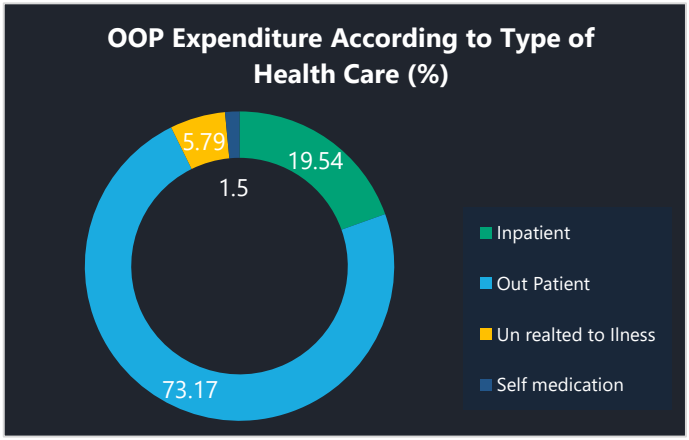
Out-of-Pocket Expenditures According to The National Health Accounts								
	2005-06	2007-08	2009-10	2011-12	2013-14	2015-16	2017-18	2019-20
Total Health Expenditure (In Million)	283,048	346,694	448,403	554,453	757,196	918,485	1,206,332	1,466,426
Current Health Expenditure (In Million)	264,640	324,787	401,068	496,465	695,203	841,120	1,108,464	1,403,740
OOP (In Million)	193,568	228,108	273,015	304,944	457,285	524,804	626,104	779,593
Population (In Million)		165.94	171.73	180.71	186.18	193.56	209.80	218
OOP per Capita (PKR)		1,374.64	1,589.79	1,687.48	2,456.14	2,711.32	2,984.29	3572.18
USD Exchange Rate			83.69	89.31	102.96	104.18	109.83	158
OOP per Capita (USD)			19.00	18.89	23.86	26.03	27.17	22.60
OOP as % of CHE (%)	73.14	70.23	68.07	61.42	65.78	62.39	56.48	55.54
OOP as % of THE (%)	68.39	65.80	60.89	55.00	60.39	57.14	51.90	53.16

OOP Expenditures of Private Households 2019-20 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 2019-20 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 2019-20 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**

ANNEX 2 HEALTH-RELATED POINTS FROM THE PAKISTAN ECONOMIC SURVEY (2022-23)

1. Economic Indicators

- Fiscal deficit was reduced to 4.6 percent of GDP
- Significant reduction in trade and current account deficits
- Real GDP growth was 0.29 percent, with a per capita income decrease
- Headline CPI national inflation averaged 29.2 percent during Jul-May FY 2023

2. Social Protection

- Government provided Rs. 400 billion to the BISP for executing Social Protection programmes
- Benazir Kafaalat Programme disbursed Rs 128.90 billion to around 9.00 million beneficiaries
- Various other programmes like Wheat Seed Subsidy and Benazir Taleemi Programme were also implemented

3. Information Technology and Telecommunication

- IT and ITeS Industry achieved a trade surplus of US$ 1.72 billion during Jul-Mar FY2023
- IT exports were US$ 1.94 billion during this period, constituting 35.1 percent of all services sector exports
- Pakistan Software Exports Board added seven Software Technology Parks to support the IT industry

4. Education

- Educational institutions increased to 279.4 thousand in 2021-22 from 275.6 thousand in 2020-21
- Teacher numbers grew to 1.81 million in 2021-22 from 1.79 million in 2020-21
- Literacy rate improvements were noted across all provinces
- Cumulative education expenditures by the Federal and Provincial Governments in FY2022 were 1.7 percent of GDP
- Total enrolments reached 55.37 million in 2021-22, a rise from 53.86 million in 2020-21

5. Energy

- Total installed electricity capacity in the country is 41,000 MW, with hydel contributing about 25.8 percent, thermal 58.8 percent, nuclear 8.6 percent, and renewables 6.8 percent
- Electricity generation during Jul-Mar FY2023 was 94,121 GWh
- The industrial, agriculture, and commercial sectors consumed 28.2 percent, 8.2 percent, and 7.8 percent of electricity, respectively

6. Public Debt

- Total public debt as of the end of March 2023 was Rs. 59,247 billion
- Domestic debt amounted to Rs. 35,076 billion, while external public debt was Rs. 24,171 billion or US$ 85.2 billion

7. Climate Change

- National Clean Air Policy (NCAP) was launched to improve air quality by reducing pollution
- The Ten Billion Tree Tsunami Programme planted/regenerated/distributed 2027.01 million plants by March 2023

8. Health and Nutrition

- PSDP allocation for the health sector in FY2023 was Rs. 22,356.5 million, accounting for 2.8 percent of the total development budget
- Public health expenditures increased by 56.8 percent in FY2022 from the previous fiscal year

9. Public Health Expenditure

- PSDP Allocation: For the health sector during FY2023 was Rs. 22,356.5 million, equating to 2.8 percent of the total development budget and 0.05 percent of GDP
- Increase in Expenditure: Public health expenditure increased by 56.8 percent during FY2022, from Rs. 586,270 million recorded during FY2021. The expenditure was 1.4 percent of GDP during FY2022 compared to 1 percent in the same period of the previous year
- The increase in public health expenditure is a positive step towards achieving UHC, one of the targets of SDG 3. However, the total expenditure as a percentage of GDP (1.4 percent) is still low compared to the WHO's recommendation of at least 4-5 percent of GDP for low- and middle-income countries.

10. Healthcare Regulation and Standards

- Development of Standards: The government developed six standards for quality healthcare services, including a digital map of all healthcare facilities of the ICT and the launch of an online Complaint Management System.
- Developing standards for quality healthcare and establishing systems for monitoring and complaints aligns with global best practices for improving healthcare quality

11. Immunisation Programmes

- Typhoid Conjugate Vaccine (TCV): Introduced into the routine immunisation programme, post-campaign coverage showing 92 percent effectiveness
- TB Control Programme: Achieved treatment coverage for 339,256 patients with a success rate of 94 percent .
- The high coverage rates in immunisation programmes like TCV and TB treatment are commendable achievements and contribute towards the targets of SDG 3, specifically in reducing communicable diseases

12. Disaster Response and Nutrition Security

- Post Disaster Need Assessment: Conducted for the health sector, estimating recovery and reconstruction costs at Rs. 40,294 million (US$187.6 million)
- Multi-sectoral National Nutrition Policy (MS-NNP): Initiated to substantially reduce malnutrition levels and mainstream nutrition in national socio-economic development plans
- The formulation of MS-NNP is a strategic approach to tackle malnutrition, a critical aspect of SDG 2 (Zero Hunger) and SDG 3 (Good Health and Well-being)

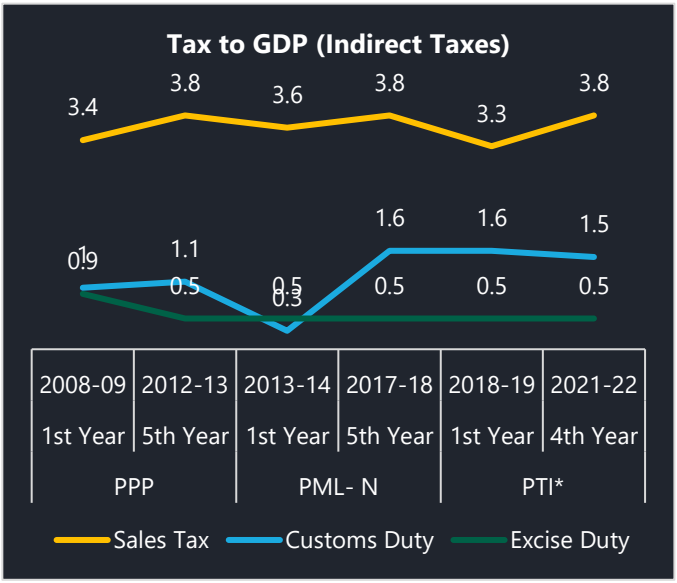
ANNEX 3 SUMMARY OF ECONOMIC INDICATORS

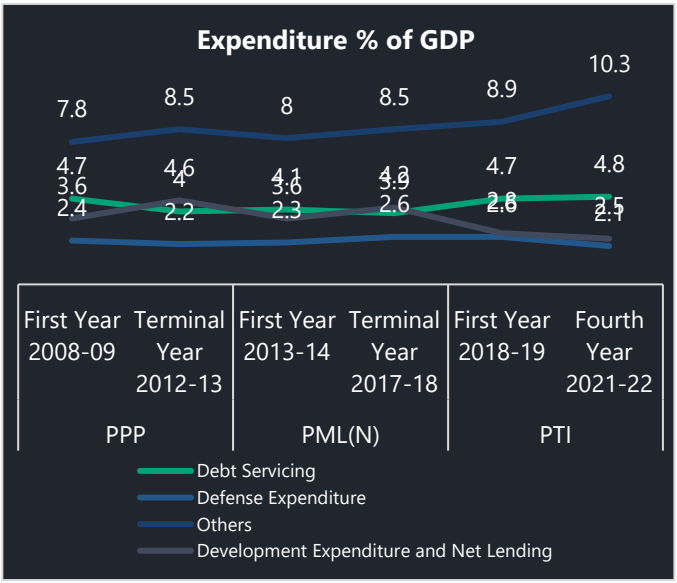
	FY 2023	FY 2022	FY2021	FY2020	FY 2019	FY 2018	FY2017	FY2016
GDP growth rate	0.29%	5.97%	5.74%	-0.94%	3.10%	6.10%	4.60%	4.60%
Per capita income	USD 1,568	USD 1,797.50 (PKR 314,353)	USD 1,676.20 (PKR 268,223)	USD 1,457.60 (PKR 230,349)	USD 1,577.60 (PKR 214,695)	USD 1,767.90 (PKR 194,181)	USD 1,723.00 (PKR 180,401)	USD 1,639.70 (PKR 170,924)
GDP at current market prices	PKR 84,657.9 billion	PKR 66,950 billion (USD 383 billion)	PKR 55,796 billion (USD 349 billion)	PKR 47,540 billion (USD 301 billion)	PKR 43,798 billion (USD 322 billion)	PKR 39,190 billion (357 billion)	PKR 35,553 billion (USD 340 billion)	PKR 32,725 billion (USD 314 billion)
USD-PKR exchange rate	235.4	174.8	160	158	136.1	109.8	104.7	104.2
Gross Fixed Capital Formation	PKR 10,093 billion	PKR 8,992 billion	PKR 7,217 billion	PKR 6,230 billion	PKR 6,040 billion	PKR 6,019 billion	PKR 5,199 billion	PKR 4,657 billion
Agricultural Growth rate	1.55%	4.40%	3.48%	3.91%	0.94%	3.88%	2.22%	
Industry Growth rate	-2.94%	7.19%	7.81%	-5.75%	0.25%	9.18%	4.61%	
Services Growth rate	0.86%	6.19%	6.00%	-1.21%	5.00%	5.95%	5.62%	
Total revenues as % of GDP	8.20%		12.40%	13.20%	11.20%	13.30%	13.90%	13.60%
Tax revenues as % of GDP		10.1%	9.40%	9.30%	9.70%	10.80%	10.40%	10.40%
Non-tax revenues as % of GDP		1.90%	2.90%	3.90%	1.50%	2.50%	3.50%	3.20%
Total expenditures as % of GDP		19.70%	18.50%	20.30%	19.10%	19.10%	19.10%	17.70%
Current expenditures as % of GDP		17.30%	16.30%	17.90%	16.20%	14.90%	14.60%	14.30%
Development expend as % of GDP		2.40%	2.40%	2.50%	2.80%	4.10%	4.70%	4.00%
Fiscal deficit as % of GDP	3.60%	3.90%	6.10%	7.10%		5.80%	5.20%	4.10%
SBP policy rate	21%	13.75%	7%					
CPI inflation	29.20%	11.3%	8.80%					
Sensitive Price Indicator (SPI)	32.80%	16.7%	13.50%					
Wholesale Price Index (WPI)	33.90%	23.60%	8.40%					
Exports of goods	USD 23.2 billion	USD 23.7 billion	USD 25.6 billion	USD 22.5 billion	USD 24.3 billion	USD 24.8 billion	USD 22.0 billion	USD 22.0 billion
Exports of services	USD 5.5 billion	USD 5.2 billion	USD 5.9 billion	USD 5.4 billion	USD 6.0 billion	USD 5.9 billion	USD 5.9 billion	USD 5.5 billion
Imports of goods	USD 46.9 billion	USD 53.8 billion	USD 54.3 billion	USD 43.6 billion	USD 51.9 billion	USD 55.7 billion	USD 48.0 billion	USD 41.1 billion
Imports of services	USD 5.7 billion	USD 12.9 billion	USD 8.5 billion	USD 8.8 billion	USD 10.9 billion	USD 12.3 billion	USD 10.6 billion	USD 9.0 billion
Balance of trade in goods and services	USD -20.6 billion	USD -44.8 billion	USD -31.2 billion	USD -24.4 billion	USD -32.6 billion	USD -37.3 billion	USD -30.7 billion	USD -22.7 billion
Current account balance	USD -3.3 billion	USD -13.2 billion	USD -2.8 billion	USD -4.4 billion	USD -13.4 billion	USD -19.2 billion	USD -12.3 billion	USD -5.0 billion

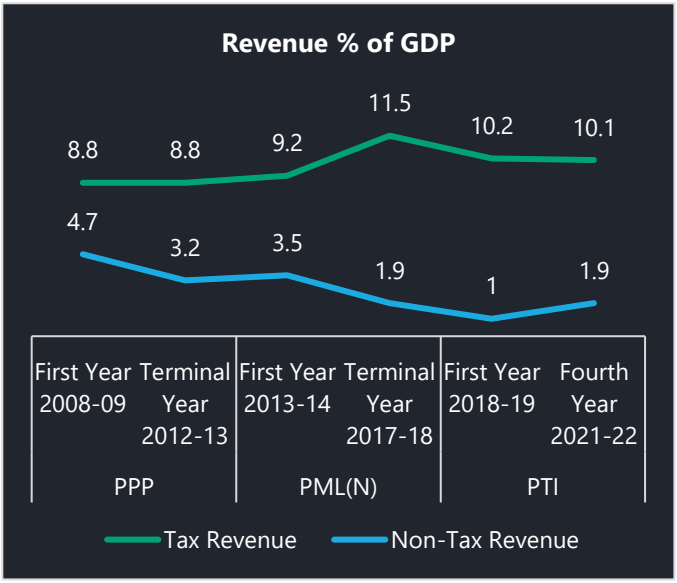
	FY 2023	FY 2022	FY2021	FY2020	FY 2019	FY 2018	FY2017	FY2016
Total public debt	Rs 59,247 billion	Rs 44,366 billion	Rs 39,866 billion	Rs 36,399 billion	Rs 32,708 billion	Rs 24,953 billion		
Domestic debt	Rs 35,076 billion	Rs 28,076 billion	Rs 26,265 billion	Rs 23,283 billion	Rs 20,732 billion	Rs 16,416 billion		
External public debt	Rs 24,171 billion (US$ 85.2 billion)	Rs 16,290 billion	Rs 13,601 billion	Rs 13,116 billion	Rs 11,976 billion	Rs 8,537 billion		
Education related expenditures		Rs 1,101.0 billion	Rs 802.0 billion	Rs 901.0 billion	Rs 868.0 billion	Rs 829.2 billion	Rs 699.2 billion	Rs 663.4 billion
Public expenditures on education as % of GDP	1.7% (FY2022 data)		1.80%	1.90%	2.00%	2.10%	2.00%	2.00%
Public sector health expenditure as % of GDP		1.40%	1.20%	1.10%	1.00%	1.10%	0.90%	0.80%
Total public sector expenditure on health		PKR 919.4 billion	PKR 586.2 billion	PKR 505.4 billion	PKR 421.8 billion	PKR 416.5 billion	PKR 329.0 billion	PKR 268.0 billion
Current health expenditure		PKR 712.2 Billion	PKR 494.6 billion	PKR 427.9 billion	PKR 363.2 billion	PKR 329.0 billion	PKR 230.0 billion	PKR 192.7 billion
Development health expenditure		PKR 201.6 billion	PKR 91.9 billion	PKR 77.5 billion	PKR 58.6 billion	PKR 87.5 billion	PKR 99.0 billion	PKR 75.3 billion
Unemployment rate			6.30%		6.90%	5.80%		
Kamyab Jawan Youth Scheme		Rs 44,972 million						
Ehsaas Emergency Cash Programme (ECAP-II)		Rs 30.18 billion						
Ehsaas Taleemi Wazaif Programme		Rs 25 billion						
Ehsaas Undergraduate Scholarship Programme		Rs 9.5 billion						
Ehsaas Nashonuma Centres		Rs 310.81 million						
Pakistan Poverty Alleviation Fund (PPAF)		Rs 2.11 billion						
Pakistan Baitul Mal (PBM)		Rs 6.505 billion						
Workers Welfare Fund (WWF)		Rs 2.09 billion						
EOBI		Rs 33.54 billion						

ANNEX 4 ECONOMIC PERFORMANCE OF THREE GOVERNMENTS

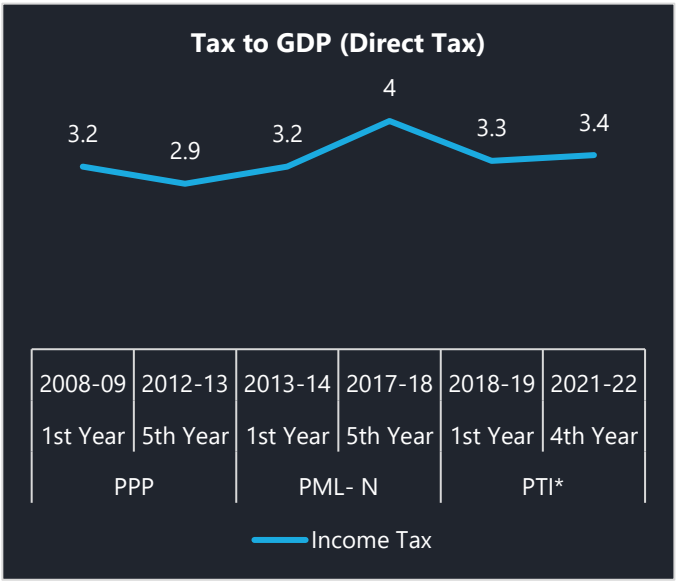
- The increase in tax revenue during PML-N's term might indicate successful tax reforms or economic growth that expanded the tax base.
- The decline in non-tax revenue could raise concerns about the sustainability of revenue sources and might require attention to diversify and stabilise non-tax revenue streams.
- The slight decline in tax revenue during PTI's tenure might reflect the impact of economic policies, administrative changes, or external economic factors.
- The increasing trend in 'Others' and Debt Servicing expenditures relative to GDP could put fiscal pressure on the government's budget if not matched by corresponding revenue increases.
- The decreasing proportion of GDP spent on Defence could be due to reallocations of the budget towards other priorities, reduced defence spending in absolute terms, or faster growth of the GDP compared to defence spending.
- The data could be a reflection of changing government priorities, with a potential focus on development or social spending evident in the 'Others' category during the PTI period.
- The rise in Debt Servicing as a percentage of GDP signals growing debt concerns that the government may need to address to ensure fiscal sustainability.
- The trends suggest that while there are fluctuations, the overall tax to GDP ratio has remained above 2.9 percent for the periods shown. The data indicates a general stability in the income tax to GDP ratio with a notable peak in the 5th year of the PML-N government.
- The stability of Sales Tax suggests it is a consistent and reliable source of revenue for the government.

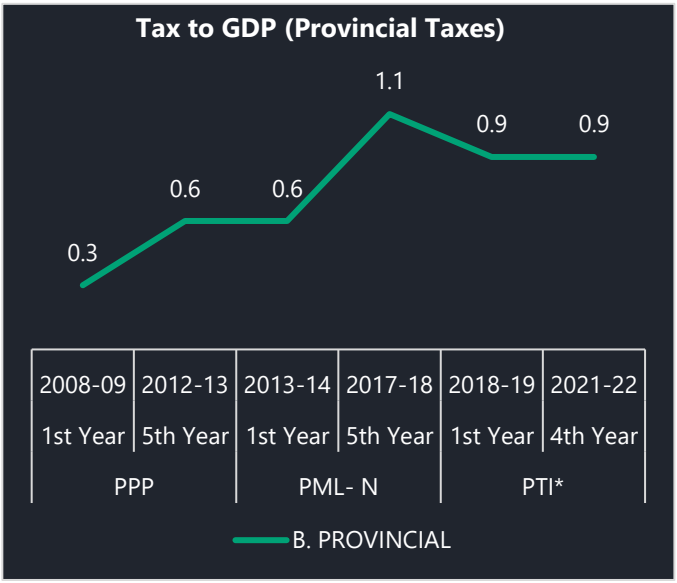






- The variability in Customs Duty could be influenced by changes in international trade policies, fluctuations in imports, or alterations in customs tariffs.
- The gradual decline in Excise Duty might indicate policy changes that affect the consumption of excisable goods, or it could reflect changes in the economic structure or consumer behaviour.
- The spikes in Customs Duty during PML-N's term could be associated with policy measures aimed at increasing import revenues or could also result from increased imports.
- For PTI, the maintenance of Sales Tax and Customs Duty suggests an effort to sustain revenue despite potential economic challenges.
- There has been a general upward trend in the ratio of provincial taxes to GDP from the first year of the PPP to the fifth year of the PML-N, which then stabilises during the PTI's term.
- The spike during PML-N's term could be attributed to effective fiscal policies at the provincial level, changes in the tax laws, or growth in the provincial sectors that are subject to taxation.





ANNEX 5 PAKISTAN1S DEBT SUMMARY THE MONEY FLOW IN THE ECONOMY

The money flow into and out of the Pakistani economy is a complex system encompassing various income streams and expenditure lines.

On the income side, the majority of the inflow (51 percent) comes from borrowings. This includes foreign debts/grants (55 percent), domestic debts from non-banks (20 percent), and banks (20 percent). Surplus from provinces, a minor source, contributes 5 percent. This dependence on borrowings, particularly foreign debts/grants, suggests that the country is heavily reliant on external and internal lenders to finance its spending and implies a need to repay these loans in the future.

Direct revenue streams comprise income tax (15 percent), sales tax (14 percent), customs duty (6 percent), and Federal Excise Duty (FED) (2 percent). This indicates a multi-faceted revenue collection system where different forms of taxes are collected from individuals and businesses. Non-tax revenue contributes another 12 percent, which could come from sources like profits from state-owned enterprises, fees, and charges.

Turning to the expenditure side, debt servicing, and foreign loan repayments consume a significant share of the budget at 30 percent and 18 percent respectively. This implies a substantial portion of government revenue goes towards meeting past borrowing commitments, leaving less room for developmental and operational expenditure.

The provincial share in federal taxes accounts for 21 percent of expenditure. This is part of federal revenue that is distributed among the provinces, and it signifies a mechanism of financial resource redistribution across the country. Federal Government expenses, including pensions, account for another 12 percent of the spending, reflecting the cost of running the government and serving its employees and retirees.

Development expenditure and defence affairs and services consume 6 percent and 7 percent of the outflow respectively. While the development expenditure signifies the budget for growth and infrastructure projects, the defence outflow represents the cost of ensuring national security. Grants and transfers also make up 6 percent of the expenditure, which could include foreign aid, support to local governments, or welfare payments.

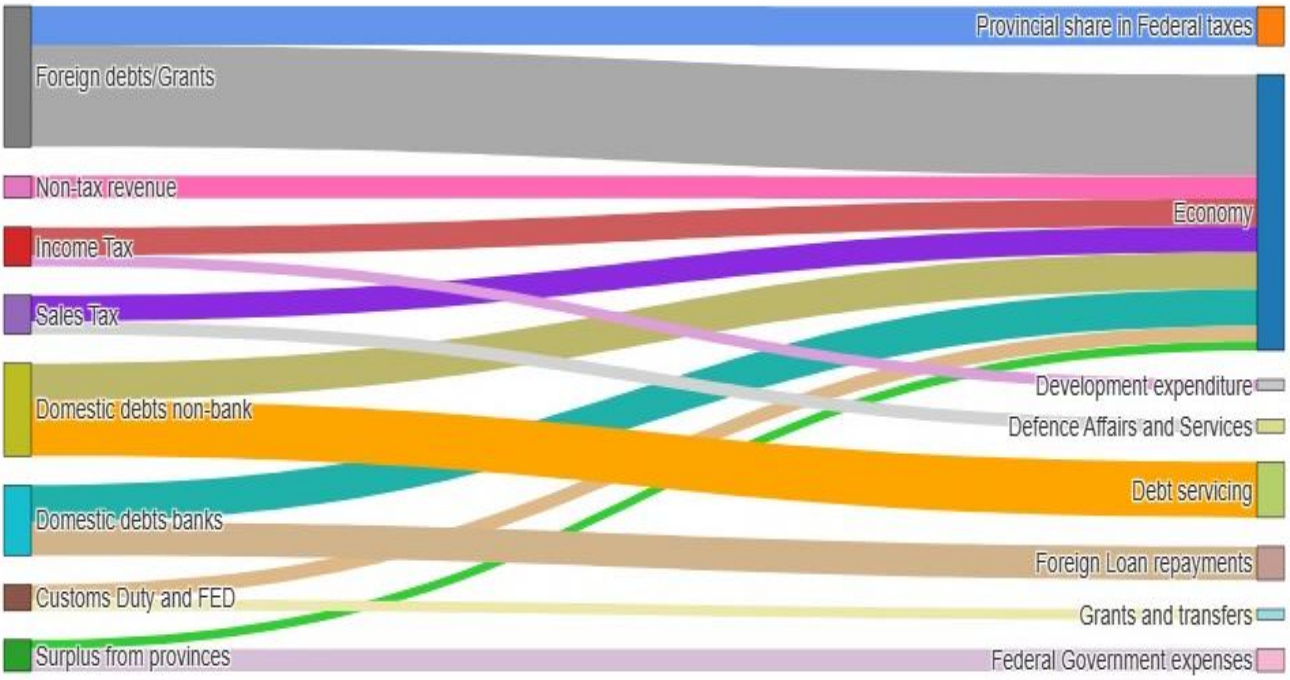
The money inflow and outflow in the Pakistani economy reflect a challenging fiscal situation with heavy reliance on borrowings to finance its budget, and substantial amounts of revenue going towards debt servicing and loan repayments. The allocations towards development expenditure and defence also reveal the government's dual commitment to economic growth and national security.

The Money Flow in Pakistani Economy:

Category	Percentage of Total	Type
Income/Inflows		
Foreign debts/Grants	55% *(varies)*	Borrowings
Domestic debts non-bank	20%	Borrowings
Domestic debts banks	20%	Borrowings
Surplus from provinces	5%	Borrowings
Income Tax	15%	Revenue
Sales Tax	14%	Revenue
Customs Duty and FED	8%	Revenue
Non-tax revenue	12%	Revenue
Expenditure/Outflows		

Category	Percentage of Total	Type
Provincial share in Federal taxes	21%	Expenditure
Debt servicing	30%	Expenditure
Foreign Loan repayments	18%	Expenditure
Federal Government expenses including pensions	12%	Expenditure
Development expenditure	6%	Expenditure
Defence Affairs and Services	7%	Expenditure
Grants and transfers	6%	Expenditure

Table: The table provides a clear overview of the sources of income and areas of expenditure for the Pakistani economy, showing how funds are raised and where they are allocated.



ANNEX 6 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	Current health expenditure per person	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 indicates the level of resources channelled 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 measured in monetary terms.
ESSI	Employees' Social Security Institution	A body corporate was established under the Provincial Employees Social Security Ordinance, 1965, on the recommendation of the 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 are composed of direct foreign transfers and foreign transfers distributed by the 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 a percentage of current health expenditures indicates how much the health system depends on external funding sources relative to domestic government and private sources.
GDP	Gross Domestic Product	GDP 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 the 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 understanding 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 its own domestic public resources.
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 the health system depends 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 the distribution of revenues between the federal and four provincial governments of Pakistan.

Abbreviation	Stands for	Definition
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 payments are associated with catastrophic and impoverishing household spending.
OOP per capita	Out-of-Pocket per person	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 households in each country spend directly out of pocket on health. It estimates the share of out-of-pocket payments 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 & 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 organisations. 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 health relative to public/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	Total health expenditure per person	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.

Ministry of National Health Services, Regulations and Coordination

Government of Pakistan
Ministry of National Health Services, Regulations & Coordination

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